



Tackling Obesity

NHS Overview and Scrutiny

Joint Select Committee Report

Parts I and II



December 2006

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Foreword



On behalf of the NHS Overview and Scrutiny Joint Select Committee on Tackling Obesity, I am pleased to present the Committee's report. The report seeks to assess best practice in reducing obesity, as a means of preventing disease, through improving levels of physical activity – across Kent and across all age groups – with particular reference to collaborative partnerships.

The Joint Select Committee has gathered evidence from a wide range of sources on the nature and scope of obesity as a public-health issue and on measures that can be undertaken at the local level to address the problem.

As we heard, a strong consensus now exists within the public-health field that there is a worrying major trend towards obesity and that – if left unchecked – this will have serious consequences for the future health, and life-expectancy, of an increasingly large section of the population. However, we also heard much that is encouraging about measures that are already being taken, in a variety of settings, to promote healthier lifestyles and thereby help to combat and prevent obesity.

The recommendations contained in this report are primarily aimed at Kent County Council itself, district councils, NHS bodies within the county and Kent's employers – including local authorities and the NHS, all of which employ significant numbers. Some recommendations are aimed at national bodies. As well as seeking to highlight and disseminate best practice in promoting healthier lifestyles, the recommendations aim to foster a coherent strategic approach to combating obesity in Kent, involving all those with a role to play.

I am pleased to be able to say that the contents of this report represent a cross-party consensus view of all members of the Joint Select Committee.

I would like to thank all my colleagues on the Joint Select Committee for their contribution – both County Council Members and others, representing district authorities in each of Kent's "local health economy" areas, and Patient and Public Involvement Forums.

Particular thanks must go to members from our three local-government partners, whose own initiatives on obesity form such a key element in this report – Canterbury City Council, Gravesham Borough Council, and Tonbridge and Malling Borough Council.

I also wish to thank everyone who came to give evidence to the Joint Select Committee and answer our questions, and those who sent us written evidence – as well as those members of the public who responded to our appeal for information on barriers to people becoming physically more active.

Finally, I would like to thank the Centre for Public Scrutiny, which provided funding for an “Action Learning” component to this topic review – allowing lessons to be learned about best practice in health scrutiny – as well as funding to allow us to implement a project arising from our conclusions.

A handwritten signature in black ink, consisting of the initials 'M J' followed by a stylized, cursive name that appears to be 'Fittock'.

Mark Fittock

Chairman of the Joint Select Committee

Health Overview and Scrutiny

The Health and Social Care Act 2001 made statutory provision for local authorities with social-services responsibilities to extend their overview and scrutiny functions to include health.

Kent County Council established a pilot NHS Overview and Scrutiny Committee (OSC) in November 2001. This committee became a legal entity when the Local Authority Overview and Scrutiny Committees Health Scrutiny Functions Regulation 2003 was implemented on 1 January 2003.

In July 2003, the Department of Health issued *Overview and scrutiny of health – guidance*, which includes guidance on the establishment of joint committees with other local authorities. This guidance has been followed in undertaking this topic review.

Membership of the Joint Select Committee

The Joint Select Committee on Tackling Obesity consisted of:

- seven Members of Kent County Council (four Conservative; two Labour; and one Liberal Democrat);¹
- district council members representing local authorities in three of Kent's four NHS "local health economy" areas:²
 - Dartford
 - East Kent
 - South of West Kent
- one representative of Patient and Public Involvement Forums in Kent

Kent County Council Members (county councillors)



Mr. Alan Chell (Con.,
Maidstone South)



Mr. Jeff Curwood
(Con., Maidstone
Central)



Mr. Mark Fittock
(Lab., Swanley)
Chairman



Mr. Roger Gough
(Con., Darent Valley)

¹ An eighth County Council member, Mr. Mike Angell (Con., Ashford Rural South), withdrew from the Joint Select Committee, and from the NHS Overview and Scrutiny Committee, as a result of a perceived conflict of interest, arising from his becoming a non-executive director of Kent and Medway NHS and Social Care Partnership Trust.

² A seat on the Joint Select Committee was also available for a district representative from the Medway and Swale "local health economy" area, but this was not filled. The equivalent seat on the NHS Overview and Scrutiny Committee is also vacant.



Ms. Elizabeth Green
(Lab., Ramsgate)



Mr. George
Koowaree (Lib. Dem.,
Ashford East)



Dr. Tony Robinson
(Con., Tonbridge)

District council representatives of “local health economy” areas (councillors)



Cllr. Leon Baker³
Sevenoaks DC



Cllr. Patrick Heath⁴
Dover DC



Cllr. Marilyn Peters
Dartford BC

Patient and Public Involvement Forum representative



Mr. Jim Reece
Kent Ambulance
PPIF

³ Cllr. Baker represented the South of West Kent “local health economy” area jointly with Cllr. Mervyn Warner (Maidstone BC) – who ceased to be a member of the Joint Select Committee (and of the NHS Overview and Scrutiny Committee) prior to the publication of this report.

⁴ Cllr. Heath replaced Cllr. Alex Perkins (Canterbury City C), who initially represented the East Kent “local health economy” area on the Joint Select Committee.

In addition, eight district council members, drawn from the three partner local authorities co-sponsoring the Joint Select Committee, attended meetings of the Joint Select Committee that were hosted by their respective authorities:

- Canterbury City Council
- Gravesham Borough Council
- Tonbridge and Malling Borough Council

District council representatives from partner local authorities (councillors)



Cllr. Valerie Ashenden
Gravesham BC



Cllr. Raymonde Collins
Gravesham BC



Cllr. Nick Eden-Green
Canterbury City C



Cllr. Jean Law
Canterbury City C



Cllr. Julia Seath
Canterbury City C



Cllr. Paul Drury
Tonbridge and Malling BC



Cllr. Janet Sergison
Tonbridge and Malling BC



Cllr. Allan Sullivan
Tonbridge and Malling BC

Terms of Reference of the Joint Select Committee

The overarching terms of reference for the Joint Select Committee topic review on Tackling Obesity were:

- *To prepare a strategic report and recommendations, on behalf of Kent County Council's NHS Overview and Scrutiny Committees (OSC), and Borough/City Council partners which assess best practice in reducing obesity through improving activity levels across the County, across all age groups, as an instrument in prevention of disease through working in collaborative partnerships*
- *For each partner to investigate a different perspective of this overarching term of reference*
- *To examine national and local practice and to consider the application of best practice in the wider Kent context*
- *To take evidence from stakeholders including relevant national organisations, local Primary Care Trust (PCT) staff, local authority staff, partner organisations and community groups*
- *To report the Committee's recommendations to both Kent County Council NHS OSC, Kent County Council, the Borough/City Councils and local health organisations*

The terms of reference for Kent County Council's element of the review were:

- *To consider how local initiatives to increase participation in obesity reducing schemes can be communicated to best effect*
- *To investigate how KCC and local employers are encouraging healthier workplaces*
- *To explore funding streams for implementing initiatives*
- *To explore the role and efficacy of local partnerships in developing and delivering this agenda*

- *To consider the evidence gathered and make specific recommendations applicable to Kent County Council and partner organisations*

The terms of reference for Canterbury City Council's element of the review were:

- *To consider the barriers that prevent public participation in initiatives to prevent obesity*
- *To consider barriers that prevent those from hard to reach groups taking part in local initiatives and make recommendations that reduce barriers and encourage inclusive participation*
- *To investigate the effectiveness of local partnerships in delivering outcomes that promote healthy living, with particular reference to reducing obesity levels*
- *To consider evidence and make local recommendations and those appropriate for the wider Kent context*

The terms of reference for Gravesham Borough Council's element of the review were:

- *To investigate what projects are in place to address the issue of obesity in the young people of the borough*
- *To assess the effectiveness of these projects in achieving their outcomes and how the opportunities they offer are made available to minorities and hard to reach groups*
- *To consider the role local partnerships play in the promotion and delivery of out of school activities for young people*
- *To use the evidence gathered to make recommendations specific to Gravesham and in the wider Kent context*

The terms of reference for Tonbridge and Malling Borough Council's element of the review were:

- *To consider national best practice relating to the prevention and treatment of obesity in adults with a particular focus on physical activity*

- *To investigate current and planned local initiatives that contribute to this agenda supported by local authority, health organisations and community groups*
- *To consider the partnerships involved in developing and delivering the obesity agenda*
- *To consider the evidence gathered and to make specific recommendations for local partners and for the wider Kent context*

A full list of witnesses who attended Joint Select Committee hearings, and of other evidence gathered, is given in Appendix 1.

Part I

Executive Summary

Chapter 1: Obesity – a growing problem

Obesity is having excessive body-fat to the point where health is endangered. The condition is spreading rapidly among the population both in England and worldwide – a trend that amounts to a public-health timebomb. Obesity results from an imbalance between diet and physical activity, and it can be avoided by adopting a healthy lifestyle. In Kent and Medway, obesity is more prevalent than in the South East as a whole; but it is only marginally more prevalent in Kent and Medway than it is across England as a whole.

Chapter 2: Public-health goals

Central government has recognised the importance of obesity as a public-health issue and has set targets relating to obesity, diet and exercise. These national targets are reflected in the Kent Agreement, which also contains ambitious local targets.

Chapter 3: Partnership working to tackle obesity in Kent

There is significant scope for local government, together with partners (including the National Health Service), to promote and encourage healthy lifestyles in a whole range of ways. Planning of the built environment must contribute to facilitating exercise and the availability of healthier food choices. The role of local authorities in respect of business and consumer-protection must include aiding healthier food choices. Services for children and families must help foster healthy lifestyles. Provision of Adult Services must take account of clients' need for healthy lifestyles. The education sector must inform and assist students in making healthy lifestyle choices. Leisure and recreation facilities are vital ways of facilitating physical activity. Planning of transport, highways and streets must take account of the need to facilitate healthier modes of transport. Everyday exercise, as part of people's ordinary working and domestic routines, must be encouraged. Referral by primary-care practitioners to exercise and weight-loss programmes must be facilitated. In all these areas, there is already much good work going on in Kent that can be shared and emulated.

Chapter 4: Strategic leadership

Tackling obesity in Kent requires strong strategic leadership. Despite commendable work in the formulation by Primary Care Trusts of local obesity strategies, and the formation of an Obesity Sub-Committee of the Kent Public Health Network, the National Health Service has not given a county-wide strategic lead. Kent County Council's recently-formed Department of Public Health, working in partnership with the National Health Service, should be seeking to give such strategic leadership. The government envisages an important public-health leadership role for Local Strategic Partnerships, but their structure and their funding will need to change if they are to play such a part.

Chapter 5: Healthier workplaces in Kent

Employers have a responsibility to facilitate and promote healthier lifestyles among their staff. There is a sound business case for doing so, since a healthy workforce tends to be more productive. The public sector, including the National Health Service and local government, has a duty to set an example. There are examples of good practice within Kent County Council and these deserve to be copied both within the County Council and further afield.

Chapter 6: Obstacles to physical activity

Among the general public, significant perceived obstacles to physical activity include lack of time, cost, difficulty of accessing facilities, childcare arrangements and poor health or disability. There are specific issues regarding obstacles to physical activity on the part of black and minority ethnic groups, people with mental-health issues and people with disabilities. All of these can be, and in some cases are already being, addressed by culturally sensitive and otherwise appropriate approaches to delivering services and undertaking initiatives.

Chapter 7: Funding sources

Financial allocations to Primary Care Trusts for public-health purposes, under the *Choosing Health* White Paper, are not ring-fenced. Consequently, in the current climate of shortfalls and financial instability within the NHS, these sums are being used to bridge gaps in Primary Care Trusts' finances. Funding is available from a range of sources, including the European Union and the Big Lottery Fund, for community projects relating to healthy lifestyles.

Chapter 8: Measuring success

In the context of concerns about the effectiveness, and cost-effectiveness, of public-health interventions, the Department of Health is seeking to develop a model of health-promotion based on the concept of “Social Marketing”. The National Institute for Health and Clinical Excellence has recommended the use of brief interventions with individuals in primary care to encourage physical activity.

List of recommendations

No.	Recommendation	For	Page
1.	All future developments in Kent should be required by planning authorities to make provision for healthy lifestyles – including adequate footpaths and cycle paths, and sports and leisure facilities.	Planning authorities	60
2.	Food manufacturers should adopt a standard system of food-labelling, to enable consumers to make better-informed choices.	Food manufacturers	62
3.	<ul style="list-style-type: none"> • All district councils should include in local guides reference to the availability of facilities for breastfeeding. • All Sure Start schemes and Children's Centres should systematically collect and report data on the extent of breastfeeding among their client group. 	<ul style="list-style-type: none"> - District councils - Sure Start schemes - Children's Centres 	64
4.	Kent County Council's Children, Families and Education Directorate should continue to promote the Healthy Schools programme and the Extended Schools concept – including Breakfast Clubs and use by the wider community of school sports facilities.	Children, Families and Education Directorate (KCC)	80
5.	<p>All local authorities in Kent should:</p> <ul style="list-style-type: none"> • support initiatives that encourage young people (including girls) to participate in sport; • consider appointing Sports and Health Managers, to promote active lives for all the community; • do as much as possible to capitalise on the public interest generated by the 2012 London Olympics in order to promote wider participation in sport. 	All Kent local authorities	85
6.	Kent County Council's Sports Development Unit and Public Health Department, and the Kent Physical Activity Alliance must work more closely together to promote physical activity.	<ul style="list-style-type: none"> • Sports Development Unit (KCC) • Public Health Department (KCC) • Kent Physical Activity Alliance 	86
7.	All Primary Care Trusts should encourage GPs to prescribe exercise to patients where appropriate. This prescribing should include referral to sports and leisure centres with staff trained to provide specialist services tailored to individuals' clinical needs.	Primary Care Trusts (NHS)	96

8.	In order for Local Strategic Partnerships to play their part in addressing obesity, and other public-health issues, the government must ensure they are properly funded and resourced for this purpose. Local Strategic Partnerships also need more direction and more structures of accountability.	Department for Communities and Local Government	102
9.	The production by Kent County Council's Public Health Department of a detailed obesity strategy for the whole of Kent, in collaboration with partners and stakeholders, must take place as soon as possible following the reorganisation of the National Health Service in Kent and Medway.	Public Health Department (KCC)	103
10.	<ul style="list-style-type: none"> • Kent County Council should seek to set an example of good practice in encouraging and facilitating healthy lifestyles among its workforce. • The innovative work of the Environment and Regeneration Directorate in this regard should be copied by all KCC Directorates. • A business case setting out the benefits for employers of this approach should be developed by KCC and shared with other employers in Kent. 	KCC	112
11.	All sports and leisure centres should seek to remove perceived barriers to using their service (relating to age, gender, ethnicity, disability, etc.), so that they can serve all groups in the community.	Sports and leisure centres	123
12.	<ul style="list-style-type: none"> • The money allocated to Primary Care Trusts to fulfil <i>Choosing Health</i> objectives should be ring-fenced by the Department of Health. • Kent County Council's National Health Service Overview and Scrutiny Committee should receive a breakdown of how this money has been spent each year by Primary Care Trusts in Kent. 	<ul style="list-style-type: none"> • Department of Health • NHS Overview and Scrutiny Committee (KCC) • Primary Care Trusts (NHS) 	126
13.	Kent County Council's National Health Service Overview and Scrutiny Committee should initiate a research programme, in partnership with Canterbury Christ Church University's Department of Sport Science, Tourism and Leisure, to evaluate the effectiveness of brief interventions in primary care in tackling obesity. This should include evaluation of giving patients pedometers, referral to leisure centres and referral to Health Walks.	NHS Overview and Scrutiny Committee (KCC)	137

Part II

Chapter 1: Obesity – a growing problem

1.1 Defining obesity⁵

1. Obesity can be defined as having excessive body-fat to the point where health is endangered. Overweight can be defined as having excessive body-fat without actually being obese, but to the point where one is at risk of obesity (“pre-obesity”).
2. The standard clinical indicator of obesity and overweight is Body Mass Index (BMI) – which is a measure of an individual’s weight, scaled according to his or her height. BMI is calculated by dividing the individual’s weight (measured in kilograms) by the square of his or her height (measured in metres). The resulting BMI score can be used as follows, in respect of adults, to determine whether the individual’s weight is within the optimal range for his or her height, in relation to the attendant risk of disease:

Table 1

BMI range (kg/m²)	Classification	Risk of weight-related disease
<17	Malnourished	Low (but risk of other clinical problems increased)
17 – <18.5	Underweight	
18.5 – <25	Normal weight	Average
25 – <30	Overweight / Pre-obese	Increased
30 – <35	Obese class I	Moderate
35 – <40	Obese class II	Severe
≥40	Obese class III/Morbidly obese	Very severe

⁵ This section is based on: SEPHO (2005), pp. 5–6; WHO / FAOUN (2003), p. 69;

<http://www.scotpho.org.uk/web/site/home/Clinicalriskfactors/Obesity/Obesityreport/definitions/definitions.asp>

3. BMI is easy to measure routinely; and it provides a good rough indication of overweight and obesity in respect of most individuals – as well as of the extent of overweight and obesity within a given population. As such, it is the most widely used of the available clinical indicators for obesity. However, there are limitations to the use of BMI, all of which are related to the fact that BMI is essentially an imperfect proxy measure of body composition.
4. The optimal BMI range for children varies with age, due to normal changes in body composition as children grow. In UK government statistics, “A child is classified as obese when their BMI is in the highest 5 per cent of values for boys or girls of their age based on the 1990 UK BMI reference data (above the 95th percentile)”.⁶

1.2 Obesity and disease⁷

5. Obesity is a major risk-factor (both direct and indirect) for a number of serious, potentially life-threatening, conditions (both long-term and short-term), including:
 - Cardiovascular (heart and circulation) disease:
 - Hypertension (high blood-pressure)
 - Coronary heart disease:
 - Myocardial infarction (heart attack)
 - Angina (chest pain)
 - Cerebrovascular accident (stroke)
 - Non-insulin dependent diabetes mellitus (Type 2 diabetes)
 - Cancer:

⁶ Stamatakis (2006), p. 48.

⁷ This section is based on the following: NAO (2001), pp. 14–15 and App. 5, pp. 55–56; WHO (1998), Section 4; WHO (2003).

- Cancer of the colon
 - Ovarian cancer
 - Gall-bladder diseases
6. Abdominal obesity, and the obesity-related conditions of insulin-resistance and hypertension, are significant components in “metabolic syndrome” – which is defined as a clustering of risk-factors for cardiovascular disease.⁸
 7. Obesity significantly increases the risk of death in all age groups. It has been suggested that rising obesity rates could lead to the halting, and even reversal, of the continuing long-term rising trend in average human life-expectancy.⁹
 8. Obesity is also associated with several other conditions that are less serious – although they can be debilitating and / or adversely affect quality of life. These include:
 - respiratory problems (such as asthma)
 - chronic musculoskeletal problems (including osteoarthritis, back-pain and gout)
 - skin problems
 - reduced fertility
 9. Recent research has indicated that obesity is a risk-factor for dementia.¹⁰
 10. In addition, there are serious social and psychological dimensions to obesity, with some obese individuals reported to suffer from low self-esteem, lack of confidence, social stigma, limited mobility and a poor general quality of life.

⁸ <http://www.bhf.org.uk/questions/index.asp?secondlevel=1163&thirdlevel=1323&artID=6167#6167>

⁹ House of Commons Health Committee (2004), para. 10, p. 9 (quoting Dr. Mary Rudolf); DoH (2004b), p. 10

¹⁰ “Dementia risk predictor devised”, BBC News online, 3 August 2006 – <http://news.bbc.co.uk/1/hi/health/5238542.stm>

11. Although it is the case that the diseases linked to obesity are essentially diseases of adulthood, there is evidence that certain obesity-related diseases can affect children. There is particular concern at the emergence among children of Type 2 diabetes (previously regarded as a disease of adulthood) – apparently as a consequence of the rising prevalence of childhood obesity.¹¹

1.3 The obesity epidemic

12. The World Health Organization (WHO) talks of a “global epidemic” of obesity, with rates of prevalence and incidence¹² growing rapidly in developed and developing nations alike – the term “Globesity” has also been used by WHO to refer to this phenomenon.¹³ It is estimated that obesity is now more prevalent worldwide than malnutrition.¹⁴

13. The Joint Select Committee heard in evidence from Paul Lincoln (Chief Executive of the National Heart Forum) that the UK had the fastest growing rate of obesity within the European Union. Mr. Lincoln said that UK obesity levels were only eight years behind those of the United States of America, where the obesity epidemic was at an advanced stage – a recent study had revealed that, in the Bronx district of New York, half of the population now suffered from the obesity-related condition Type 2 diabetes.¹⁵

14. Over the past quarter-century, there has been a steady and significant increase in the prevalence of obesity among both men and women in England. Although historically men were less likely than women to be obese, this gap has been closing and obesity rates among both sexes are now almost identical (although there are still variations between age-groups). The Health Survey for England

¹¹ Parliamentary Office of Science and Technology, *Postnote* no. 205, September 2003, p. 2.

¹² In epidemiology (“the study of how often diseases occur in different groups of people and why”), “prevalence” is defined as the proportion of a given population that has a condition at a given point in time or over a given period of time. “Incidence” is defined as the rate at which new cases of a condition occur in a given population over a given time-period – Coggon *et al.* (1997).

¹³ WHO (1998); WHO (2003); <http://www.who.int/nutrition/topics/obesity/en/index.html>

¹⁴ “Overweight ‘top world’s hungry’”, BBC News online, 15 August 2006 – <http://news.bbc.co.uk/1/hi/health/4793455.stm>

¹⁵ Oral evidence: Paul Lincoln, 22 February 2006.

(HSE) shows the following increases in rates of obesity in adults aged 16 and over (BMI ≥ 30):¹⁶

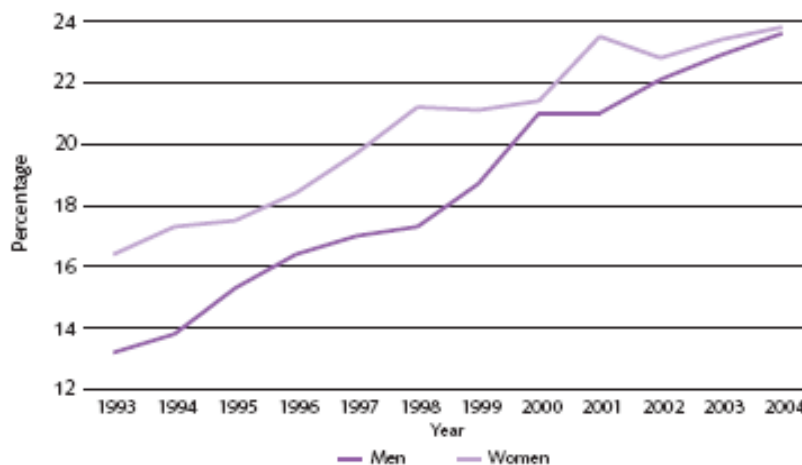
Table 2

	1993	2004
	(%)	(%)
Men	13.2	23.6
Women	16.4	23.8

15. It has been predicted that, if recent trends continue, by 2010 these figures will be 33% for men and 28% for women.¹⁷

16. The following graph shows the annual rise in obesity prevalence among adults, by sex, in England as reflected in HSE data for 1993–2004:¹⁸

Figure 1



Source: Health Survey for England 2004

¹⁶ ONS / HSCIC, Health Survey for England 2004, Table 6: “Body mass index (BMI), by survey year, age and sex”. The figures shown here are not weighted for non-response. The weighted figures for 2004 are 22.7% in respect of men and 23.2% in respect of women.

¹⁷ Zaninotto *et al.* (2006), p. 26.

17. The HSE data shows the following changes in obesity prevalence among children aged 2–15:¹⁹

Table 3

	1995	2004
	(%)	(%)
Boys	10.9	18.9
Girls	12.0	17.8

18. It has been predicted that, if recent trends continue, by 2010 these figures will be 19% for boys and 22% for girls.²⁰

19. The anticipated long-term health consequences of these trends, and their continuation, are often referred to as representing a public-health “timebomb”.

20. Prevalence of obesity is not uniform throughout the population in England. HSE data indicate that:

- obesity prevalence increases steeply with age to mid-life, is relatively stable through middle-age and early older-age, and declines among the oldest age group (those aged 75 and over);²¹
- women in lower socio-economic groups have an increased risk of obesity (for men, however, there is no clear correlation between socio-economic group and obesity);²²

¹⁸ DoH (2006), Fig. 2.3, p. 33.

¹⁹ ONS / HSCIC, Health Survey for England 2004, Table 12: “Children's overweight and obesity prevalence, by survey year and sex”. The figures shown here are not weighted for non-response. The weighted figures for 2004 are 19.2% in respect of boys and 18.5% in respect of girls.

²⁰ Zaninotto *et al.* (2006), p. 26.

²¹ Stamatakis (2006), p. 50.

²² *Ibid.*, pp. 50–1.

- for both boys and girls, obesity is less prevalent in professional/managerial and higher-income households than in other households;²³
- men from Black Caribbean and Irish backgrounds have a higher prevalence of obesity than men in general; and women from Black African, Black Caribbean and Pakistani backgrounds have a higher prevalence of obesity than women in general – these trends may be due to genetic, cultural and socio-economic factors.²⁴

1.4 The cost of obesity

21. A report published by the National Audit Office (NAO) in 2001 estimated that, in England in 1998, obesity and its consequences had led to:²⁵

- 18 million working days lost through illness;
- 31,000 deaths – 9,000 of these before retirement age, resulting in 40,000 lost years of working life;
- shortening of each individual's life-span by an average of nine years where death was linked to obesity.

22. On this basis, the annual financial cost of obesity in England in 1998 was estimated as follows by the NAO:

- £½ billion in treatment costs to the NHS;
- possibly £2 billion impact on the economy.²⁶

23. In 2004, the House of Commons Health Committee conservatively estimated the total annual economic cost of obesity in England for 2002 at between £3.3 billion and £3.7 billion (including NHS treatment costs of around £1 billion).²⁷

²³ *Ibid.*, p. 49.

²⁴ NAO (2001), App. 4, p. 53; HSCIC (2005), pp. 21–7.

²⁵ NAO (2001), p. 1 and App. 6, pp. 57–61.

²⁶ *Ibid.*, App. 6, pp. 57–62.

24. The annual cost of obesity in the United Kingdom has recently been estimated as follows in a joint publication of the NAO, the Healthcare Commission and the Audit Commission:

- £1 billion a year in treatment costs to the NHS;
- £2.3 billion to £2.6 billion-a-year impact on the economy (rising to a £3.6 billion-a-year impact by 2010, if current trends continue).²⁸

1.5 How obesity is caused and prevented

25. Overweight and obesity result from an imbalance between diet and physical activity – when the energy an individual takes in (through eating) exceeds the energy he or she uses in physical activity. (Energy is usually measured in calories.)

26. Some people are genetically more susceptible than others to weight-gain – but the recent significant global increase in the incidence of obesity has come about far too rapidly for it to be due solely, or mainly, to genetic factors. Obesity can also be caused by certain medical conditions and by the side-effects of some medications (notably those prescribed to people with mental-health issues).²⁹ However, there is no evidence that these causes are significantly responsible for the current obesity epidemic.

27. In 2003, a Joint Expert Consultation by WHO and the Food and Agriculture Organization of the United Nations considered the strength of evidence on factors that might promote, or protect against, weight-gain and obesity.³⁰ The conclusion reached was that there was convincing evidence of an increased risk of obesity associated with:

²⁷ House of Commons Health Committee (2004), paras. 65–6, pp. 21–2. The total cost of obesity and overweight combined was put at between £6.6 billion and £7.4 billion.

²⁸ NAO *et al.* (2006), p. 9.

²⁹ Written evidence: Cheryl Ives, 4 February 2006. There appears to be some association between depression and obesity. However, given that mood-enhancing medication can cause obesity, and that obesity is apparently associated with adverse psychological outcomes (see para. 10 above), determining the cause-and-effect relation is problematic.

- sedentary lifestyles (*i.e.* low levels of physical activity);
- high intake of energy-dense micronutrient-poor foods (which tend to be processed foods that are high in fat and / or sugars).

28. It was also agreed that there was convincing evidence of a reduced risk of obesity associated with:

- regular physical activity;
- high intake of dietary fibre (found only in foods of plant origin – fruit, vegetables, cereal, pulses, nuts, *etc.*).

29. Other factors that were regarded as probably increasing the risk of obesity were:

- heavy marketing of energy-dense foods and fast-food outlets;
- high intake of sugary drinks;
- adverse socioeconomic conditions (in developed countries, this applies particularly to obesity among women).

30. The following factors were regarded as probably reducing the risk of obesity:

- home and school environments that encourage children to eat healthily;
- breastfeeding.

31. Evidence regarding the causes of obesity in England is not entirely unproblematic – but it does indicate the existence in this country of what has been termed an “obesogenic [*i.e.* obesity-causing] environment”,³¹ as regards both diet and physical activity levels.

³⁰ WHO / FAOUN (2003), Table 7, p. 63.

³¹ House of Commons Health Committee (2004), para. 3, p. 9.

32. Data from the annual National Food Survey, and the Expenditure and Food Survey seem to indicate a long-term trend towards falling energy intake.³² However, given that these data are derived from self-reported information, there are strong grounds for doubting their reliability – not least the discrepancy between what the food industry is selling and what survey respondents report they are eating.³³
33. Whether or not overall calorie consumption has fallen, there have clearly been changes in patterns of eating. There does appear to have been a substantial increase in consumption of energy-dense foods (those that are very high in calorific value relative to weight), including snacks and various kinds of “fast food” and “convenience food”.³⁴ These patterns of consumption arguably stem from a number of social changes in recent decades, including higher disposable income, more hurried lifestyles, a culture of working long hours, the tendency for both partners in a household to be working and a loss of cooking skills.
34. The view has been expressed that poor-quality school-catering (due to inadequate budgets and a lack of nutritional standards) has contributed to childhood obesity.³⁵ Recent years have seen a range of measures taken to address this issue, although there is some doubt as to their effectiveness. The Office for Standards in Education (Ofsted), whose remit now extends to inspecting school catering, has found continuing poor nutritional standards where school meals are not prepared on the premises.³⁶
35. It has been suggested that there is a link between the rise of obesity and the dramatic increase in alcohol consumption in recent years. However, the relationship between alcohol and obesity is surprisingly little understood, there being apparently a lack of research in this area.³⁷

³² ONS / DEFRA (2006), p. 49.

³³ House of Commons Health Committee (2004), para. 71, p. 24 (citing Dr. Tim Lobstein); Oral evidence: Carol Healy, 8 March 2006.

³⁴ House of Commons Health Committee (2004), paras. 70–84, pp. 24–8.

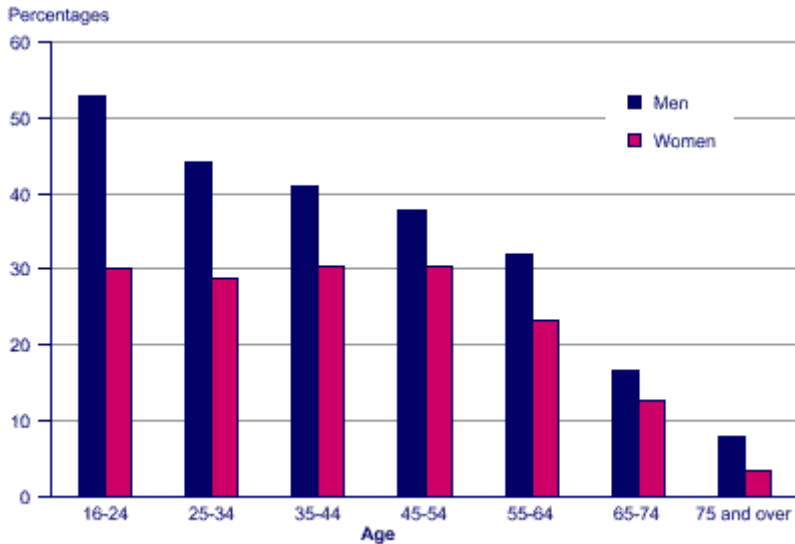
³⁵ http://www.rcplondon.ac.uk/college/statements/response_choosehealth_obesity.asp

³⁶ <http://www.ofsted.gov.uk/pressreleases/index.cfm?fuseaction=news.details&id=1754>

³⁷ House of Commons Health Committee (2004), paras. 85–7, p. 28.

36. The HSE clearly shows unhealthily low levels of physical activity among a substantial majority of adults and a significant minority of children.³⁸ The following chart, published by the Office for National Statistics, shows the percentage of adults in England, by sex and age, who were meeting the government's recommended level of physical activity in 2003, according to HSE data.³⁹

Figure 2



37. However, as the National Institute for Health and Clinical Excellence recently noted, “Relatively little is known about trends in physical activity over recent decades”.⁴⁰ Consequently, it cannot be definitively stated that changes in exercise levels have caused the obesity epidemic. Also, government research has shown “a weak correlation between obesity and physical activity levels, with small differences in the percentage of obese children classified as active or inactive”,⁴¹ which would seem to indicate the importance of diet in causing childhood obesity.

38. Nevertheless, there does seem to be good reason to believe there has been a long-term decline in the part played by physical activity in people’s everyday lives

³⁸ ONS / HSCIC (2005), p. 7; ONS (2003)

³⁹ <http://www.statistics.gov.uk/CCI/nugget.asp?ID=1329&Pos=6&ColRank=2&Rank=176>

The government’s recommended level of exercise for adults is 30 minutes of physical activity of at least moderate intensity at least five times per week (see paras. 67–8 below).

⁴⁰ NICE (2006), p. 9.

⁴¹ *Hansard*, House of Commons Written Answers, 16 June 2006, Col. 1534W.

in England, with a substantial loss of incidental exercise. (This has arguably been driven by some of the same lifestyle factors that have affected dietary habits in recent years.) And it is reasonable to see this development as a significant factor in the obesity epidemic.

39. Data from the National Travel Survey show that a substantial increase in car ownership (including households owning two or more cars) and a decline in the proportion of short trips taken have brought considerable reductions in the distances covered on foot and by bicycle.⁴²
40. Declining use of public transport may also be implicated in rising obesity levels. It was suggested to the Joint Select Committee that people who used public transport tended to walk more, as they were not travelling “door-to-door” and tended to walk to and from railway stations and bus stops.⁴³ (Although, conversely, it has been suggested that increased use of public transport, instead of walking and cycling, is implicated in rising obesity levels.)⁴⁴ It has been suggested in the literature that issues associated with personal safety (such as fear of crime and traffic levels) have played a part in reducing levels of physical activity.⁴⁵
41. Declining levels of physical activity in children are indicated by trends in transportation, with more children being driven to and from school than ever before.⁴⁶ There is also evidence of a decline in the number of young people playing sport at school.⁴⁷ It has further been suggested that the rise of sedentary pastimes (television, computing, video games, *etc.*) among children is related to

⁴² *Loc. cit.*; DoH (2005a), p. 5.

⁴³ Written evidence: David Joyner, 6 February 2006

⁴⁴ <http://info.cancerresearchuk.org/healthyliving/obesityandweight/whatcausesobesity/>

⁴⁵ Boehmer *et al.* (2006)

⁴⁶ DETR (2001), p. 6.

⁴⁷ Parliamentary Office of Science and Technology, *Postnote* no. 205, September 2003.

rising obesity.⁴⁸ Here again, concerns about personal safety in public places may have contributed to declining physical activity.⁴⁹

42. Official data suggest that participation in sport and exercise tends to vary by age, sex, social class, education and ethnicity:

- Involvement in physical activity declines with age for both children and adults⁵⁰ (this is clearly illustrated in Figure 2 above).
- Men and boys are more likely to be active than women and girls – there is a marked “gender gap” in all age groups⁵¹ (this also is illustrated in Figure 2 above).
- Men in managerial and professional, and intermediate households report higher participation in sport and exercise than those in other categories.⁵² However, evidence also suggests that, whilst managerial and professional, and intermediate groups are more likely to participate in sport, their total physical activity is actually lower than that of other groups.⁵³
- Low educational attainment is associated with lower levels of physical activity.⁵⁴
- Women of Bangladeshi and Pakistani origin are less likely than the general population to meet the government’s recommended level of physical activity. And both men and women of Bangladeshi and Pakistani origin are more likely than the general population to have low levels of

⁴⁸ “Young couch potatoes risk illness”, *Guardian*, 1 June 2006 (report of a British Dietetic Association survey); *Hansard*, House of Commons Written Answers, 16 June 2006, Col. 1534W.

⁴⁹ Weir *et al.* (2006)

⁵⁰ ONS / HSCIC, Health Survey for England 2004, Table 17: “Health Survey for England 2004: Proportion achieving the physical activity target, 1997, 1998, 2003, 2004, by age and sex”.

⁵¹ *Ibid.*

⁵² <http://www.publications.parliament.uk/pa/cm200405/cmselect/cmcomeds/507/5040520.htm>

⁵³ SEPHO (2006), p. 13.

⁵⁴ <http://www.publications.parliament.uk/pa/cm200405/cmselect/cmcomeds/507/5040520.htm>

physical activity. These trends are likely to be related to socio-economic and cultural factors.⁵⁵

43. The government has conservatively estimated the total cost of physical inactivity in England as being “in the order of £2bn a year” – but believes that a figure as high as £8.2 billion “can be calculated”.⁵⁶ It should be noted that the costs of physical inactivity include more than just the costs of obesity – they also include costs associated with overweight, as well as other conditions related to inactivity. (Conversely, as the Chief Medical Officer pointed out in 2004, the health benefits of physical activity go far beyond the prevention of obesity.)⁵⁷ It should also be noted that it is possible to be physically active and still overweight (if energy intake exceeds energy expenditure) – but this is better for health than being physically inactive and overweight.⁵⁸

44. At one level, obesity is a very simple and straightforward problem, the solutions to which are equally simple and straightforward – it is caused by an imbalance between diet and physical exercise; and it is avoided by restoring an appropriate balance. However, on another level, the issue of obesity is far from simple or straightforward – since trends in the balance between diet and exercise are determined by a complex set of powerful (and sometimes seemingly intractable) economic, social, political, technological, cultural and other forces.⁵⁹

1.6 The prevalence of obesity in Kent

1.6.1 Data from the annual Health Survey for England

45. Data derived from the HSE on prevalence of obesity (BMI ≥ 30) among adults in the former Kent and Medway Strategic Health Authority (SHA) area (using three-year moving averages) are as follows:⁶⁰

⁵⁵ HSCIC (2005), pp. 21–7.

⁵⁶ DCMS / COSU (2002), paras. 2.18–2.22, pp. 46–8.

⁵⁷ DoH (2004a). Cf. DCMS / COSU (2002), paras. 2.13–2.15, pp. 45–6.

⁵⁸ Oral evidence: Dr. Kate Woolf-May, 22 March 2006.

⁵⁹ House of Commons Health Committee (2004), p. 46.

⁶⁰ DoH, “Health Survey for England: Health & lifestyle indicators for Strategic Health Authorities 1994–2002”, table for Kent & Medway.

Table 4

	1994–6	1995–7	1996–8	1997–9	1998– 2000	1999– 2001	2000–02
	%	%	%	%	%	%	%
Men	17.2	19.9	20.1	19.1	20.9	22.0	23.4
Women	18.1	20.1	20.4	20.2	19.1	21.0	22.9
Persons	17.7	20.0	20.3	19.7	20.0	21.5	23.1

46. These data show the former Kent and Medway SHA area had the highest prevalence of obesity of any SHA area in the South East region. Kent and Medway was the only SHA area in the South East to exceed the national average for obesity prevalence in 2000–2; however, the difference was not statistically significant. Prevalence of obesity and overweight combined in the Kent and Medway SHA area was marginally below the national average.⁶¹

1.6.2 Data from the Kent and Medway Health and Lifestyles Survey

47. Both of the Kent and Medway Health and Lifestyles Surveys, conducted by the Centre for Health Service Studies at the University of Kent (in 2001 and in 2005), included questions on height and weight.

48. The 2001 survey found that 11% of those surveyed were obese (BMI 30 – <35) and a further 3.3% were grossly obese (BMI ≥35).⁶²

49. Data from the 2005 survey have been used to generate the following estimates of the prevalence of obesity in Kent and Medway.⁶³

⁶¹ SEPHO (2005), p. 12.

⁶² Palmer (2003), p. 12.

⁶³ Information supplied by Dr. Ann Palmer (Centre for Health Service Studies, University of Kent).

Table 5

	%
Men	14.9
Women	16.5
Persons	15.8

50. It is notable that both sets of data from the Kent and Medway Health and Lifestyles Surveys are significantly discrepant from the figures for the prevalence of obesity in Kent and Medway generated by the HSE (see Table 4 above).

1.6.3 Synthetic estimates of obesity

51. In January 2005, the National Centre for Social Research produced, for the Department of Health (DoH), synthetic (model-based) estimates of obesity prevalence by Primary Care Trust (PCT) area. These estimates are not based on direct measurement of obesity in PCT areas but, rather, give assumed or expected rates of obesity, based on other socio-demographic variables that are believed to correlate with obesity rates (*i.e.* proxy variables).

52. The model-based estimates of obesity prevalence in the former Kent and Medway PCT areas are as follows:⁶⁴

Table 6

PCT area	Expected prevalence of obesity, 2000–02 %
Ashford	22.9

⁶⁴ HSCIC, "Synthetic Estimates of Healthy Lifestyle Behaviours at PCT Level, 2000–2002". These data were created from ward-level synthetic estimates using an aggregation of "best-fit" ward data (PCTs and wards are not coterminous).

Canterbury and Coastal	22.8
Dartford, Gravesham and Swanley	23.3
East Kent Coastal	24.0
Maidstone Weald	22.3
Medway	23.3
Shepway	23.3
South West Kent	19.8
Swale	25.5

53. The model-based estimate of obesity prevalence for the Kent County Council area is 24.4%.⁶⁵

54. The estimates at district/Unitary Authority level for Kent and Medway are as follows:⁶⁶

Table 7

District/UA area	Expected prevalence of obesity, 2000–02 %
Ashford	22.7
Canterbury	22.7
Dartford	22.7
Dover	24.0

⁶⁵ DoH, Health Profile for Kent 2006 (2006).

⁶⁶ DoH, Health Profiles for Kent districts and Medway UA area (2006).

Gravesham	23.4
Maidstone	22.1
Medway	23.2
Sevenoaks	20.3
Shepway	23.1
Swale	24.5
Thanet	23.7
Tonbridge and Malling	22.1
Tunbridge Wells	20.3

55. These are the only data available on obesity at PCT, county and district / UA level. Given that they are speculative in nature, they cannot be treated as a reliable indication of the prevalence of obesity in the populations of these areas.

1.6.4 Other data

56. The Joint Select Committee learned that work was being done in one area – Dartford and Gravesham – to build a dataset on the local prevalence of childhood obesity. This was in order to establish reliable baseline data against which the success of anti-obesity initiatives could be measured. A scheme to gather sample data among children aged 9–10 years had been launched in six local schools. The scheme was entirely confidential and optional. Children’s height and weight were measured and their BMI calculated (from a chart calibrated specially for children) with parents present. The intention was to compare the prevalence of

childhood obesity between deprived and non-deprived areas and to see how rates among boys and girls compared with reported national rates.⁶⁷

57. A government plan to measure children systematically in primary schools at the ages of four and 10 (which the Joint Select Committee welcomes) should enable the generation of very high-quality data on childhood obesity down to the local level.⁶⁸

⁶⁷ Oral evidence: Judith Webb, 8 March 2006 and John Britt, 13 March 2006; “Levels of Overweight and Obese Children in Dartford and Gravesham”, presentation by Moya White (Chief Dietician, Dartford and Gravesham NHS Trust) to Obesity Sub-Committee of the Kent and Medway Public Health Network, 10 May 2006.

⁶⁸ “Obesity tests for four-year-olds”, BBC News Online, 22 May 2006 – <http://news.bbc.co.uk/1/hi/health/5003766.stm>

Chapter 2: Public-health goals

2.1 The scope of public health

58. It is generally accepted that public health is defined as:

*the science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public and private, communities and individuals.*⁶⁹

59. The scope of public health covers a broad spectrum of modes of intervention and practice, which can be categorised as follows:⁷⁰

Table 8

Type of public health intervention	Characteristics
Health protection	Enforced regulation of human activity and the environment
Preventive medicine	Primary clinical prevention – preventing the onset of disease
	Secondary clinical prevention – stalling the progress of disease
	Tertiary clinical prevention – minimising the complications of disease
Health education	Whole-population and group interventions
	Individual interventions
Healthy public policy	Improvement of the conditions under which people live, to address the wider determinants of health
Community empowerment	Facilitating community participation in decision-making

⁶⁹ Wanless (2004), p. 3.

⁷⁰ This table reflects the standard public-health typology, which derives from Holman (1992).

60. It is readily apparent that government, both local and national, has a major role to play in addressing obesity as a public-health issue through the whole range of public-health interventions (in partnership with a diverse group of stakeholders). This has been increasingly recognised in recent years, as the obesity epidemic has become more apparent – as indicated by the setting of targets in this area.

2.2 Central government targets

61. The increasing prevalence of obesity, and the trends in diet and physical activity from which it stems, have been recognised in recent years by national government as cross-departmental priorities.

62. In 2000, the *NHS Plan* committed the government to “local action to tackle obesity and physical inactivity ...”⁷¹ The *NHS Cancer Plan* (2000), the National Service Framework (NSF) for Coronary Heart Disease (2000) and the NSF for Diabetes (2001) all further set out government commitments to action on obesity.

63. The 2001 NAO report, *Tackling Obesity in England*, and the House of Commons Health Committee report on obesity in 2004 both drew particular attention to the scale of the public-health problem now presented by obesity. As such, they underlined the urgent necessity for the government to formulate coherent and overarching policy in this area.

64. In 2004, Sir Derek Wanless’s landmark report on public health bracketed obesity with smoking as one of the two “most important lifestyle determinants of future health”.⁷² The report stated that “an objective should be set to halt the rise in obesity now with a gathering pace of reductions planned for the medium-term”.⁷³

65. A key turning point in government policy on obesity came with publication of the public-health White Paper *Choosing Health: Making healthy choices easier* (2004), which listed obesity as one of six priorities for action. Subsequent government documents – *Delivering Choosing Health* (2005), *Choosing A Better Diet* (2005) and *Choosing Activity* (2005) – have further elaborated policy on

⁷¹ DoH (2000), p. 111.

⁷² Wanless (2004), p. 6.

⁷³ *Ibid.*, p. 8.

improving health and preventing obesity through both better diet and increased levels of physical activity.

66. Targets relating to obesity, and to physical activity, have been set in national Public Service Agreements (PSAs). These are three-year agreements, negotiated between each of the main government Departments and the Treasury, which describe the key improvements that the public can expect from government expenditure. Each PSA sets out a department's high-level aims, priority objectives and key outcome-based performance targets. The following PSAs for 2005–8 (set in July 2004) are relevant to obesity:

Table 9

Department(s)	PSA target
<ul style="list-style-type: none"> • Department for Culture, Media and Sport • Department for Education and Skills 	Enhance the take-up of sporting opportunities by 5 to 16-year-olds so that the percentage of school children in England who spend a minimum of two hours each week on high quality PE [Physical Education] and school sport within and beyond the curriculum increases from 25% in 2002 to 75% by 2006 and to 85% by 2008, and to at least 75% in each School Sport Partnership by 2008.
<ul style="list-style-type: none"> • Department for Culture, Media and Sport / Department for Education and skills • Department of Health 	Halt the year on year increase in obesity among children under 11 by 2010, in the context of a broader strategy to tackle obesity in the population as a whole.
<ul style="list-style-type: none"> • Department for Culture, Media and Sport 	By 2008, increase the take-up of cultural and sporting opportunities by adults and young people aged 16 and above from priority groups, by: <ul style="list-style-type: none"> • Increasing the number who participate in active sports at least twelve times a year by 3%, and increasing the number who engage in at least 30 minutes of moderate intensity level sport, at least three times a week by 3% ...

67. The Chief Medical Officer has recommended (in accordance with internationally accepted guidelines) the following minimum levels of physical activity:⁷⁴

Table 10

Age group	Recommended minimum level of physical activity
Adults	30 minutes of physical activity of at least moderate intensity at least five times per week
Children and young people aged 5–18	one hour per day of physical activity of at least moderate intensity

68. “Moderate intensity” exercise is defined as exercise that results in:

- an increase in breathing rate;
- an increase in heart rate, to the level where the pulse can be felt; and
- feeling warmer, possibly accompanied by sweating on hot or humid days or indoors.⁷⁵

69. The CMO’s exercise recommendation for adults features in a target set in a publication of the Department for Culture, Media and Sport, and the Prime Minister’s Strategy Unit, *Game plan: a strategy for delivering government’s sport and physical activity objectives* (2002). This sets as an objective: “By 2020, 70% of individuals to be undertaking 30 minutes of physical activity 5 days a week” – with an interim target of 50% of individuals by 2011.⁷⁶

⁷⁴ DoH (2004a)

⁷⁵ Sport England (n.d.), p. 24.

⁷⁶ DCMS / COSU (2002), para. 3.20, p. 86

70. Under the National Physical Education, School Sport and Club Links Strategy, there is a long-term ambition, by 2010, to offer all children at least four hours of sport every week made up of:

- at least two hours of high quality PE and sport at schools — with the expectation that this will be delivered totally within the curriculum; and
- an additional 2-3 hours beyond the school day delivered by a range of school, community and club providers.⁷⁷

71. The following key dietary targets relevant to obesity were set out by the DoH in *Choosing a Better Diet* (2005):

- to maintain the average total intake of fat at 35% of food energy;
- to reduce the average total intake of saturated fat to 11% of food energy;
- to increase the average consumption of a variety of fruit and vegetables to at least five portions per day (the “Five-a-Day” campaign);
- to increase the average intake of dietary fibre to 18 grams per day;
- to reduce the average intake of added sugar to 11% of food energy.

2.3 Kent targets

72. Under the Local Government Act 2000, each local authority is required to prepare a Community Strategy to promote the “economic, environmental and social well-being” of the local community. To facilitate the preparation and delivery of Community Strategies, the Act encouraged the formation of Local Strategic Partnerships (LSPs). These are non-statutory, non-executive advisory bodies, matching local-authority boundaries, that aim to bring together the public, private, community and voluntary sectors at the local level. Their formation was only mandatory in areas receiving Neighbourhood Renewal Funding (none of which is

⁷⁷ <http://www.teachernet.gov.uk/teachingandlearning/subjects/pe/nationalstrategy/>

in Kent), but in practice they were formed in most, if not all, areas. A December 2005 consultation document, *Local Strategic Partnerships: Shaping their future*, introduced a template for Sustainable Community Strategies (in line with the UK Sustainable Development Strategy), to be developed out of the Community Strategies required by the 2000 Act.

73. KCC's Community Strategy, prepared through the county-wide LSP (the Kent Partnership), is the *Vision for Kent* (V4K), which sets out goals for the county over the coming two decades. V4K was originally published in 2002, reviewed during 2005–6 and republished in an updated form in April 2006.⁷⁸ The third key theme of V4K, "Improved health, care and well-being", commits KCC and its partners to promoting healthy lifestyles, including in respect of diet and exercise. Short-term priorities include:

- *Address[ing] the wider factors affecting people's health as well as treating the conditions from which they suffer;*
- *Empower[ing] people to make healthier choices that help prevent them from being ill.*⁷⁹

74. The County Council's aspirations for the county over the next four years, as set out in *Towards 2010* (June 2006), include the objective of "Improved health and quality of life" for the county's population. This is to be achieved through "Working with the public, private and voluntary sectors to help people lead healthy lifestyles", including a healthy diet and exercise.⁸⁰

75. Detailed targets are laid down in the Kent Agreement, which is an umbrella agreement incorporating the Kent Local Area Agreement (LAA) and the Second Generation Local Public Service Agreement (LPSA2).⁸¹

76. LAAs are three-year agreements, setting out priorities for a local area, agreed between central government (represented by the Government Office for the

⁷⁸ <http://www.kentpartnership.org.uk/vision-for-kent.asp>

⁷⁹ Kent Partnership (2006), pp. 24–6.

⁸⁰ KCC (2006b), pp. 2 and 16

⁸¹ Oral evidence: Richard Sperry, 14 February 2006.

region concerned) and a local area – represented by local authorities, LSPs and other key local delivery partners. LAAs are based on (Sustainable) Community Strategies and are structured around four themes, one of which is “Healthier communities and older people” (*Choosing Health* envisaged delivery of health objectives as a key role for LAAs).⁸²

77. LPSAs are three-year agreements between county, metropolitan or unitary authorities and central government, setting out specific goals to be achieved as part of public-service improvement. Success in achieving LPSA targets brings a Performance Reward Grant, as well as the opportunity to negotiate certain freedoms from regulation and prescription.

78. The current Kent Agreement covers the period 1 April 2005 to 31 March 2008, and was signed by KCC on behalf of the Kent Partnership. It was also signed by other partners, including Kent’s 12 district councils, on behalf of their respective LSPs.

79. Block 1 of the Kent Agreement covers “Children and young people”; it includes Outcome 1: “To promote the physical, emotional, social and intellectual development of young children so they flourish at home and at school”. The following indicators regarding Outcome 1 relate to obesity (in respect of the Healthy Schools process, January 2006 is effectively the baseline).⁸³

Table 11

Lead partner	KCC Children, Families and Education Directorate (until April 2006, Education and Libraries Directorate)
Other partners	Principal: All maintained, voluntary and private early-years providers within the defined areas. The Pre-School Learning Alliance, Sure Start, Children’s Centres, Early Years Development and Childcare Partnership, Children’s Consortia. Secondary: Multi-agency preventative group overseen by the Children’s

⁸² DoH (2004b), paras. 26–8, p. 84.

⁸³ The Kent Agreement (25 July 2005), pp. 22–3.

	Strategic Board (Children, Families and Education Directorate; Health), with District-based planning and commissioning.		
Indicators	Data source	Lead partner	Other partners
9. An increase of 5% from baseline in the number of mothers breastfeeding at birth, six weeks and seventeen weeks (in respect of Sure Start/Children's Centres); March 2006 = 46.14% at birth, 26.73% at six weeks and 15.95% at 17 weeks (last two figures calculated in respect of those Children's Centres that made a return on the two appropriate measures).	Sure Start Local Programme Areas/ Children's Centres	KCC	Children's Consortia
11. 100% of schools with 20% or more Free School Meal Eligibility to be engaged in the Healthy Schools process by March 2006; January 2006 (Spring Term) = 43%.	National Healthy Schools programme	KCC	PCTs; Kent Public Health Network
12. 50% of all schools to be engaged in becoming Healthy Schools by December 2006; January 2006 (Spring Term) = 30%. All schools to work towards Healthy Schools accreditation by March 2009; January 2006 (Spring Term) = 67%.			

80. Block 3 of the Kent Agreement covers "Healthier Communities and Older People"; it includes Outcome 16: "To improve the health of Kent's residents, and reduce health inequalities by addressing variations in health across the county". The following indicators regarding Outcome 16 relate to obesity (unless otherwise stated, baseline data is for 2004–5, targets are to be achieved by 2007–8 and data given for Year 1 relates to 2005–6):⁸⁴

Table 12

Lead partner	PCTs, with LSPs. Co-ordinating role for the Kent Public Health Network		
Other partners	SHA, KCC, district councils, voluntary and community sector, private sector		
Indicators (Measured countywide)	Data source	Lead partner	Other partners
2. Reduce the risk factors associated with obesity			
2.1 Increase the percentage of patients with Coronary Heart Disease (CHD) whose last blood pressure reading (measured within the last 15 months) is 150/90 or less, from 79.54% to 81.95%; Year 1 = 86.16%.	SHA (monitoring of PCT local delivery plans)	PCTs	LSPs; KCC; district councils
2.2 Increase the percentage of patients with CHD whose last measured cholesterol (measured within the last 15 months) is 5mmol/l or less, from 66.92% to 71.22%; Year 1 = 57%.			
2.3 Reduce the number of people aged 15–75 years old on General Practitioner registers recorded as having a BMI of 30 or greater, from 19.09% to 17.75%; Year 1 = 22.43%.			
2.4 Increase the proportion of people aged 15–75 years old registered with a General Practitioner whose BMI is recorded, from 18.65% to 49.94%; Year 1 = 21.33%.			

⁸⁴ *Ibid.*, pp. 33–4.

6. Help Kent's residents stay healthy			
6.1 Increase the percentage of 5–16-year-olds in schools who participate in an average of two hours' high-quality PE and School Sport per week within and beyond the National Curriculum during one complete school year, from 45% (2004) to 87%; Year 1 = 64%. LPSA2 Target 10.1	Physical Education School Sport and Club Links Survey; Kent PE Conference Survey	KCC Children, Families and Education	Children's consortia
6.2 Increase the percentage of 5–16-year-olds in schools who participate in an average of three hours' high-quality PE and School Sport per week within and beyond the National Curriculum during one complete school year, from 9% (2004) to 19%; Year 1 = 20%. LPSA2 Target 10.2			
6.3 Increase the number of adults participating in at least 30 minutes of moderate intensity sport and physical activity on five or more days each week on average over a year, as measured by questions 44 and 45 of the Kent and Medway Health and Lifestyles Survey, from 23.9% (2005) ⁸⁵ to 27.0% (September 2008). LPSA2 Target 10.3	Kent and Medway Health and Lifestyles Survey	PCTs	Primary care; LSPs

81. At the regional (South East) level, there is a target to increase participation to 50% of the population by 2020, which means increasing the current level of participation by 1%, year-on-year. The national target (as noted above at para. 69), to achieve 70% participation by 2020, with an interim target of 50% by 2011, remains an aspiration in the South East.

⁸⁵ The 2001 Kent and Medway Health and Lifestyles Survey found that 16.7% of respondents were participating in physical activity for 30 minutes, five times a week – information supplied by Dr. Ann Palmer (Centre for Health Service Studies, University of Kent); Palmer (2003), p. 15. A survey of members of KCC's Kent Residents Panel during February–April 2006 found that 20.9% of respondents were active to at least this level – *Opinion* [KCC] no. 5, June 2006, p. 2.

Chapter 3: Partnership working to tackle obesity in Kent

3.1 Planning of the built environment

82. Kent's district councils are the county's statutory local planning authorities. As such, each is required, under the terms of the Planning and Compulsory Purchase Act 2004, to prepare a Local Development Framework (LDF). LDFs set out each authority's policies for meeting the community's economic, environmental and social aims for the future, where this affects the development and use of land. They constitute the "spatial element" of each area's (Sustainable) Community Strategy.

83. KCC is the county's statutory transport authority and, as such, provides transport input on large planning applications. KCC further has statutory responsibility for regeneration, development investment and designated "Growth Areas" in Kent, where substantial new house-building is occurring. "Growth Areas" exist in the Ashford District and along the "Thames Gateway", which includes substantial parts of the Dartford, Gravesham and Swale districts (as well as the Medway Unitary Authority area).

84. The Joint Select Committee heard from Robert Hardy, Assistant Director of KCC's Strategic Planning Directorate (since April 2006, the Environment and Regeneration Directorate), that the Directorate was endeavouring to ensure development plans took full account of the need to facilitate and promote healthy lifestyles.⁸⁶ This entailed close partnership working with developers, and with district authorities in the areas concerned.

85. The Directorate would do all that was possible to improve opportunities for walking and cycling, by building these options in as integral elements of travel-planning for developments, and ensuring that shops, developments and services were placed where they could be easily accessed on foot or bicycle.

86. These objectives have been clearly set out in public statements of KCC policy. The second Local Transport Plan for Kent (LTP2, covering the period 2006–11)

⁸⁶ Oral evidence: Robert Hardy, 8 February 2008.

states that the County Council will “encourage and require safe and secure walking routes to be built into new development”, through the Kent Design Guide (drawn up by the Kent Planning Officers’ Group)⁸⁷ and will encourage “Sustainable patterns of development” that facilitate public transport, walking and cycling.⁸⁸ LTP2 also states that “Existing Supplementary Planning Guidance will be strengthened to ensure that workplace travel plans are built into planning applications for all large or strategically significant developments”.⁸⁹ The October 2001 Walking Strategy, which sits under KCC’s Local Transport Plan, sets as an objective “To ensure developments are ‘pedestrian friendly’”.⁹⁰ The Kent and Medway Structure Plan also makes a number of references to ensuring that developments facilitate public transport, cycling and walking.⁹¹

87. An important means of achieving these objectives is Section 106 of the Town and Country Planning Act 1990. This gives planning authorities the power to oblige developers to incorporate in their plans, and provide funding for, healthy lifestyle features (see Section 7.3 below).

88. The Committee also heard from KCC’s Head of Leisure Services, Chris Hespe, about the involvement of the County Council’s Sports Development Unit in planning for development in the “Thames Gateway” and Ashford areas.⁹² The Unit was endeavouring to ensure, through Section 106 developer contributions, that sports facilities were given sufficient prominence amongst the social infrastructure in these new developments.

89. Mr. Hardy, in his evidence, told the Committee that attempts would also be made to ensure that future developments included access to a choice of fresh food outlets. Some 20% of households in Kent did not have a shop selling fresh fruit and vegetables within 15 minutes’ walk; in future, efforts would be made to ensure that adequate provision was made in developments for such outlets.

⁸⁷ KCC (2006c), para. 6.49. The Kent Design Guide is available online:

<http://www.kent.gov.uk/publications/council-and-democracy/kent-design-guide.htm>

⁸⁸ KCC (2006c), para. 3.39.

⁸⁹ *Ibid.*, para. 6.41. See Section 5.4 below for more on Workplace Travel Plans.

⁹⁰ KCC (2001), Objective 4.

⁹¹ KCC / Medway Council (2006).

90. The Committee heard evidence from Nigel De Wit, Senior Planning Officer at Tonbridge and Malling Borough Council. He explained that the council was looking to re-use “brownfield” sites in locations in proximity to local services, thereby giving people greater opportunity to access these by walking and cycling. And the council had a duty to make provisions for physical activity within the Development Plan Documents. Linked to this was the council’s Open Space Strategy, which involved carrying out an audit of existing provisions looking at, quantity, quality, value and accessibility.

Recommendation 1

All future developments in Kent should be required by planning authorities to make provision for healthy lifestyles – including adequate footpaths and cycle paths, and sports leisure facilities.

3.2 Business and consumer-protection

3.2.1 Food labelling

91. The Joint Select Committee heard evidence from Sue Harvey (Lead Officer for Food and Agriculture, Trading Standards, KCC) regarding the work of Trading Standards.⁹³

92. Trading Standards were responsible for the regulation of food-labelling. Regulations required a product to be labelled with its name, ingredients, storage and cooking instructions. Providing nutritional information was not a legal requirement – unless a product made a specific claim, e.g. that it was “low fat”. Trading Standards did encourage the food industry to be responsible in the way food was labelled and promoted, bearing in mind the national problem with obesity.

⁹² Oral evidence: Chris Hespe, 8 February 2006.

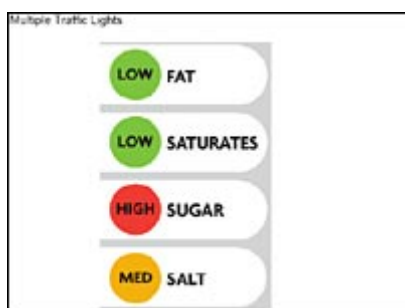
⁹³ Oral evidence: Sue Harvey, 8 February 2006.

93. Trading Standards also monitored food presentation and labelling in restaurants – including examining the validity of claims that a pub or restaurant meal was “low fat” or the “healthy option” compared to other food on offer.

94. The ultimate sanction that Trading Standards had against those who wilfully mislabel food was the power to take them to court. However, this was very expensive and not always a productive use of public funds.

95. The Food Standards Agency (FSA) has recently recommended that food manufacturers should adopt a “traffic light” system of labelling on the front of packaging for food (red for “not many”, amber for “go steady”, and green for “eat as much you like”), to allow people to see “at a glance” which are healthy options. This labelling system is already being used by Sainsbury’s and Waitrose;⁹⁴ Tesco, however, are using their own food-labelling system.⁹⁵

Figure 3



96. The Joint Select Committee heard evidence on the issue of food-labelling from Paul Lincoln, Chief Executive of the National Heart Forum. Mr. Lincoln believed that self-regulation was a flawed concept for a globalised and highly competitive industry working on thin profit margins. He thought that some in the food industry did not want “traffic-light” labelling, as it would mean putting lots of red traffic-light markers on their products, leading to a drop in sales. He felt the only answer was to legislate for a compulsory labelling system.

⁹⁴ <http://www.food.gov.uk/news/newsarchive/2006/mar/signpostnewsmarch>

⁹⁵ “Tesco labels ‘confusing shoppers’”, BBC News online, 10 July 2006 – <http://news.bbc.co.uk/1/hi/uk/5164840.stm>

97. Mr. Lincoln said that it was not clear whether the government had powers under the European single market to act unilaterally at national level as regards introducing a mandatory traffic-light system. However, the EU labelling directive was due to be reviewed in 2007 and the UK government was apparently pushing strongly for the EU labelling review to reflect the need for this sort of labelling.⁹⁶

Recommendation 2

Food manufacturers should adopt a standard system of food-labelling, to enable consumers to make better-informed choices.

3.2.2 Weights and measures

98. Ms. Harvey also told the Joint Select Committee about Trading Standards' responsibility for the regulation of weights and measures. An initiative had been set up to go into General Practitioner (GP) surgeries to check the accuracy of their scales. At the same time, Trading Standards could offer literature on healthy-eating, and on understanding and interpreting food labels. However, the take-up rate for this initiative had been disappointing, with only seven out of 20 surgeries in the Thanet pilot area taking up the invitation.

99. A small credit-card sized leaflet had been produced giving simple nutritional information. This had been promoted by being placed, along with other health literature, in Thanet GPs' surgeries at the time when the scale-checking exercise took place. This gave a platform for doctors to raise dietary issues with patients. Feedback on its usefulness was awaited and it was hoped that this could be rolled out further across the county.⁹⁷

3.2.3 Promotion of fresh local produce

100. Through its Environment and Economy Unit, KCC is a partner in the "Produced in Kent" Consortium, which promotes fresh produce from the county.

⁹⁶ Oral evidence: Paul Lincoln, 22 February 2006.

⁹⁷ Oral evidence: Sue Harvey, 8 February 2006.

Funding sources for the Consortium include the Big Lottery Fund (formerly known as the New Opportunities Fund) and the European Union.⁹⁸

101. Mr. Hardy also told the Committee that his Directorate was involved in promoting local farmers' markets, to avoid areas becoming "food deserts".⁹⁹

3.3 Children and families

102. Under the Children Act 2004, local authorities are required to take the lead in developing a multi-agency Children and Young People's Plan (CYPP), commencing in April 2006. The CYPP is intended to be a high-level strategic document, covering the activities of all publicly-funded agencies that deliver services to children and young people. It covers a period of around three years and includes outcomes under the government's Every Child Matters (ECM) framework (stemming from the Children Act 2004 and the broader reform of services for children and young people).
103. KCC's CYPP for 2006–9 incorporates the key outcomes from the "Children and Young People" block of the Kent Agreement, including Outcome 1: "To promote the physical, emotional, social and intellectual development of young children so they flourish at home and at school". Under the heading "Being Healthy" (which includes "healthy lifestyles"), Priority 4 is to: "With partners ensure that services continue to be developed to improve and promote healthy lifestyles outcomes for Children". One of the Outcomes and Success Criteria for Priority 4 is to achieve a "Reduction in Obesity amongst [children and young people]".
104. Key Action 22, under Priority 4, of Kent's CYPP is to "Undertake projects that reduce child health inequalities and promote social inclusion". A key element of this in Kent, as elsewhere, is central government's Sure Start programme. This initiative has focused on families with children up to the age of four living in the most deprived areas, providing access to family support, advice on nurturing, health services and early learning. Sure Start local programmes were originally set up with a projected lifespan of 10 years, as a means of promoting best

⁹⁸ <http://www.producedinkent.co.uk/>

⁹⁹ Oral evidence: Robert Hardy, 8 February 2008.

practice. However, with the implementation of the national ECM framework, Sure Start programmes should continue as part of the new network of Children's Centres, which it is intended will be present in every area by 2010.

105. Children's Centres are intended to provide flexible multi-agency services for young children and their families – including integrated early learning, care, family support, health services, outreach services, and access to training and employment advice. The Centres are based in the 20% of most disadvantaged wards in England; the majority of Centres have been developed from Sure Start local programmes, Neighbourhood Nurseries and Early Excellence Centres.
106. KCC has been one of the accountable bodies for Sure Start projects in Kent and is the sole accountable body for Children's Centres in the county. There are nine Sure Start centres across the county. Gravesend already has a Children's Centre and 52 more will be established across Kent by March 2008. Each Centre will cater for 800 children aged 0–5. Not all areas of Kent have been covered by Sure Start local programmes – but areas without coverage may instead have a Children's Centre (this is the case in Maidstone, for instance).
107. KCC social workers have been seconded to some Sure Start programmes, and Sure Start has good links to the voluntary sector, for instance with the Council for Voluntary Services' "Home Start" programme.
108. Key Action 23 of Kent's CYPP, under Priority 4, is to: "Promote breastfeeding throughout Sure Start Areas". And one of the Outcomes and Success Criteria is to "Improve breastfeeding rate". The Joint Select Committee heard from Heather Robinson and Kim Broster, of the Gravesend Sure Start centre, that emphasis was placed by the centre on promoting breastfeeding – in light of the evidence that breastfed babies were less likely to become obese.¹⁰⁰ The centre sought to break down embarrassment and inhibitions about breastfeeding through midwife-organised breastfeeding peer support groups and attempted to educate people about the benefits of breastfeeding. Breastfeeding women were also able to have free fruit and vegetables through Sure Start.

¹⁰⁰ Oral evidence: Heather Robinson and Kim Broster, 8 March 2006.

109. The Joint Select Committee was impressed with these initiatives. However, the Committee noted that not all Sure Start local programmes and Children's Centres appeared to be systematically collecting and reporting data on the extent of breastfeeding among their client group. This was regarded as a cause for concern, since it meant that baseline and monitoring data for the Kent Agreement performance indicator regarding breastfeeding was not entirely robust.
110. Ms. Broster said early weaning was discouraged by Sure Start, with parents being advised to wean at six months and not rush to start their child on solid food. Advice on the preparation of fresh food was built into advice on weaning babies, as many young parents lacked knowledge in this respect.

Recommendation 3

- All district councils should include in local guides references to the availability of facilities for breastfeeding.
- All SureStart schemes and Children's Centres should systematically collect and report data on the extent of breastfeeding among their client group.

111. The Committee heard that Sure Start sought to signpost families to low-cost physical activities, such as reduced-rate services for those on benefits provided by local-authority leisure centres.
112. The success of Sure Start was closely monitored in each area (for example, Gravesham had a Data Monitoring Officer). Since June 2006, all monitoring and evaluation information had been passed to KCC. Sure Start local programmes had annual external evaluations. In some instances, the only way of measuring the impact of Sure Start had been to ask parents how they had changed their behaviour as a result of Sure Start. And it was difficult to identify and quantify what changes in behaviour might have happened without Sure Start.
113. Claire Martin (Public Health Specialist with East Kent Coastal PCT) told the Committee that Sure Start had had poor evaluation over its first three years – but it was seeking to embed long-term changes and so short-term evaluation was an

inadequate measure of its success or failure. She also noted that community development projects could not be judged entirely by quantitative outcome measures, as they were seeking to bring about quality-of-life improvements, which could not be measured in a purely quantitative way.¹⁰¹

114. The Committee heard from Cllr. Lee Croxton (Lead Member for Environment, Leisure and Public Space), Cllr. Andrea Webb (Lead Member for Community Health and Wellbeing), Patricia Jefford (Head of Environmental and Public Health) and John Britt (Public Health Manager) about the range of initiatives Gravesham Borough Council had undertaken through its “Health Action Gravesham” regeneration partnership (launched in 1998).¹⁰²
115. Central to these initiatives was the Gr@nd project.¹⁰³ This was set up in 2001 through a joint-funded initiative involving Health Action Gravesham and the National Lottery’s New Opportunities Fund (now known as the Big Lottery Fund). Lottery funding (under the Healthy Living Centres initiative)¹⁰⁴ ended in 2005, but funding was in place allowing the project to continue until 2010. The Gr@nd project involved close partnership working with the Dartford, Gravesham and Swanley PCT, as well as local GPs, schools and Sure Start. Through the project, a number of initiatives had been implemented that contributed to the anti-obesity agenda – notably “Kids Stop GO” and “Don’t Sit, Get Fit!” (DSGF).
116. DSGF promoted healthy eating and physical activity among children aged 5–13 in deprived wards of Dartford and Gravesham. It had begun in 2003, to run for three years in the first instance on a pilot basis, and was funded by the Kent Children’s Fund. (The Children’s Fund is a central-government initiative, funded through the Department for Education and Skills, that funds projects for disadvantaged children aged 5–13.)¹⁰⁵ The Committee heard from Mr. Britt that DSGF was

¹⁰¹ Oral evidence: Claire Martin, 22 March 2006. The National Evaluation of Sure Start programme is being undertaken by a team at Birkbeck, University of London:

<http://www.ness.bbk.ac.uk/>

¹⁰² Oral evidence: Lee Croxton, Andrea Webb, Patricia Jefford and John Britt, 13 March 2006.

¹⁰³ <http://www.gravesham.gov.uk/index.cfm?articleid=684>

¹⁰⁴ On the Healthy Living Centres initiative, see Health Service Circular HSC 1999/008, 15 January 1999.

¹⁰⁵ <http://www.kentchildrensfund.net/>

innovative in actually being designed and led by the children it was seeking to help.¹⁰⁶

117. DSGF employs three full-time workers (two exercise coordinators and a nutritionist).¹⁰⁷ The Committee heard from Judith Webb, Head of Nutrition and Dietetic Services at Darent Valley Hospital (Dartford and Gravesham acute NHS Trust), that DSGF had made 2,000 initial contacts, of which 1,500 were ongoing. Ms Webb said it was planned that DSGF would be continued beyond its initial three-year scope to encompass both a wider age range (covering two age groups: 5–8/9 years and 8/9–14 years) and a wider geographical area.¹⁰⁸

118. As noted above (para. 56), efforts are being made to compile reliable data on the local prevalence of childhood obesity, in order that the project's degree of success can be better judged. The Committee heard that the project had been evaluated by Gravesham Borough Council; it had also been subject to external evaluation as part of a Kent Children's Fund pilot quality assurance programme. Both these evaluations had pointed to positive outcomes.¹⁰⁹

119. A community cooking scheme run through the Gr@nd Project had shown that barriers to better nutrition were not always financial but were often about lack of skills. This scheme had produced a spin-off called "Grow it, Cook it, Eat it", involving the use of allotments (which had the advantage of addressing the issues of diet and physical exercise together).

3.4 Adult Services

120. Written evidence submitted to the Joint Select Committee by Cathi Sacco, Head of Contracting and Quality Assurance for KCC's Adult Services Directorate (until

¹⁰⁶ Oral evidence: John Britt, 13 March 2006.

¹⁰⁷ GOSE / Sport England South East / DoH (2004), p. 16; "Levels of Overweight and Obese Children in Dartford and Gravesham", presentation by Moya White (Chief Dietician, Dartford and Gravesham NHS Trust) to Obesity Sub-Committee of the Kent and Medway Public Health Network, 10 May 2006.

¹⁰⁸ Oral evidence: Judith Webb, 8 March 2006.

¹⁰⁹ Oral evidence: John Britt, 13 March 2006.

April 2006, the Social Services Directorate) detailed the various ways in which issues of physical activity and diet were addressed:¹¹⁰

- All residential and domiciliary care providers must meet minimum nutritional standards laid down by the DoH.
- 84% of older persons residential care homes in Kent meet minimum nutritional standards (in line with the national rating).
- 86% of disability residential homes in Kent meet minimum nutritional standards (the national figure is 85%).
- Community Meals Delivery Service providers must provide healthy options (the National Association of Care Catering sets standards in this regard). However, service users are free to choose their meals and may choose a meal that does not meet NACC standards.
- Residential care providers are required to encourage physical activity on the part of residents.
- The vulnerable adults day service and services provided in the home allow clients to be accompanied and transported to leisure centres, *etc.*
- The Adult Services Directorate has an overall health agenda.
- Possible causes of obesity among service users are addressed as follows:
 - Medical conditions – KCC has taken the lead in Telehealth, to better monitor and manage conditions.
 - Poor eating habits – the Adult Services Directorate successfully opposed cuts to Adult Education classes for people with disabilities.
 - Inability to self-manage – KCC assists service users with equipment that allows them to be mobile and prepare their own food.

¹¹⁰ Written evidence: Cathi Sacco, 4 April 2006.

- Lack of mobility – the Community Support Service and the Brighter Futures Group help individuals to access exercise.
- The Direct Payments scheme allows clients to purchase services for themselves, and there are examples of clients buying classes at leisure centres.

121. KCC has worked in partnership with the “RED” design team from the Design Council on a pilot project, centred on Maidstone’s Park Wood estate (an area of social deprivation), aimed at developing a prototype “co-created” service to encourage physical activity. This has entailed involving local people in forming groups (“Activmobs”) to undertake various kinds of physical activity, with “rewards” for doing so. The project looked at ways of measuring success in order to form the basis for allocating rewards. It was decided that objectively measuring hours of activity or improved levels of fitness would present practical difficulties, and could actually act as a disincentive to participation. Instead it was decided to use self-reported qualitative measures; it was believed that these could still be used to measure success in achieving PSA targets.¹¹¹

122. KCC has agreed to back a social enterprise to promote Activmobs throughout the county by developing the platforms, arranging for discounts as rewards and undertaking marketing. The project’s success will be measured by the number of active participants. It is planned in the first instance to extend the ActivMobs pilot to the following areas:

- Stanhope in Ashford;
- Lydd on Romney Marsh;
- Swanscombe and Northfleet in Gravesend;
- Newington in Thanet; and

¹¹¹ Cottam and Leadbeter (2004); Murray *et al.* (2006), pp. 18–25; Vanstone and Winhall (2006); Jonathan Freedland, "Reform need not mean privatisation if public services are localised", *Guardian*, 17 May 2006; Oral evidence: Richard Sperry, 14 February 2006.

- St Radigunds in Dover.

3.5 Education and learning

3.5.1 National standards for schools

123. *Choosing Health* emphasises the importance of the National Healthy Schools Programme, stating that "The Government has a vision that half of all schools will be healthy schools by 2006, with the rest working towards healthy school status by 2009."¹¹² The White Paper also indicated that the Ofsted school-inspection regime would be used to monitor each school's contribution to the five outcomes underpinning ECM, "with increased emphasis on the health, safety and wellbeing of children and young people".¹¹³
124. As indicated above (at para. 79), the Kent Agreement includes targets in line with this vision. KCC is committed to fulfilling the National Healthy School Standard,¹¹⁴ through the Kent Healthy Schools Programme, and has set targets accordingly.¹¹⁵ Key Action 14 of Kent's CYPP, under Priority 4, reads: "All Kent schools to be engaged in the Healthy Schools initiative by 2009 and to promote the benefits of healthy eating, physical activity and sport to children and families". And one of the Outcomes and Success Criteria is "Targets for schools engagement in Healthy Schools achieved".
125. KCC is also committed to abiding by the National Service Framework for Children, Young People and Maternity Services. Adhering to these national standards entails promoting healthy lifestyles in schools through diet and exercise, in various ways.
126. The Joint Select Committee heard evidence from Carol Healy, KCC's Healthy Schools Programme Manager. Ms Healy explained that she was employed by the Council and worked with the national Healthy Schools programme. She explained

¹¹² DoH (2004b), para. 47, p. 55.

¹¹³ *Ibid.*, para. 51, p. 56.

¹¹⁴ On the Healthy School standard, see: <http://www.wiredforhealth.gov.uk/> ;
<http://www.standards.dfes.gov.uk/sie/si/SfCC/goodpractice/nhss/>

¹¹⁵ <http://www.kenthealthyschools.org/>

that she was also seconded part-time to the DoH, working on the Social Marketing Strategy in relation to obesity (on Social Marketing, see paras. 333–44 below). Her post had been established within KCC in July 2005 as a result of a strategic review of health and education partnerships, aimed at strengthening partnership working. Three PCTs in Kent were currently hosting Healthy Schools Local Co-ordinators, who were driving the Healthy Schools programme in those areas.¹¹⁶

3.5.2 Teaching children about diet and physical activity

127. At Key Stage Two (Years 3 and 4; ages 7–11), in Sc2 (“Life Processes and Living Things”), children learn about the importance of a varied diet and exercise for their own health. The DSGF initiative in Dartford and Gravesham includes a schools-based intervention, whereby sessions are held in local primary schools to teach the Key Stage Two requirements relating to healthy eating and physical activity. A recent independent evaluation has apparently demonstrated the effectiveness of this programme.¹¹⁷
128. Trading Standards and Kent Scientific Services (KSS), in association with the NHS Fruit and Vegetables in Schools Co-ordinator, have run a “Five-a-Day” fun day for children from one school (Kings Hill Primary School) – involving a visit to KSS laboratories. This was a productive exercise, but KSS does not have the capacity to do this on a regular basis.¹¹⁸
129. The Joint Select Committee heard evidence from representatives of the Kent Youth County Council about the lack of teaching around nutrition at secondary-school level. This subject is only taught to school students who are studying for GCSEs in Science or Food Technology, and the Youth County Council representatives felt that this teaching should be more widely disseminated.¹¹⁹

¹¹⁶ Oral evidence: Carol Healy, 8 March 2006.

¹¹⁷ GOSE / Sport England South East / DoH (2004), p. 16; “Levels of Overweight and Obese Children in Dartford and Gravesham”, presentation by Moya White (Chief Dietician, Dartford and Gravesham NHS Trust) to Obesity Sub-Committee of the Kent and Medway Public Health Network, 10 May 2006.

¹¹⁸ Oral evidence: Sue Harvey, 8 February 2006.

¹¹⁹ Oral evidence: Grace Kelley, Rebecca Marshall, Cally Pike and Katie Shore, 13 March 2006.

3.5.3 Physical activity in schools

130. As previously noted, KCC is committed to both PSA and Kent Agreement targets on sport and PE in schools (see para. 79 above). One of the Outcomes and Success Criteria in the Kent CYPP, under Priority 4, is that "All children receive at least 3 hours of high quality PE/Sport". In the *Vision for Kent*, KCC sets as a short-term priority "Developing sport in schools".¹²⁰ And the County Council has undertaken, in *Towards 2010*, to "Create and launch initiatives that facilitate more competitive sport in schools, support after-school sports clubs and sponsor more inter-school competitions and holiday sports programmes".¹²¹ There is also an undertaking to establish the Kent Youth Games on a biennial basis.¹²²
131. The Joint Select Committee took evidence from Peter Cotton and Julia Gillingham from the Meopham School, which has specialist Sports College status. They also spoke for the Youth Sport Trust charity.¹²³
132. Mr. Cotton and Ms. Gillingham explained that the aim of the national Physical Education, School Sport and Club Links (PESSCL) strategy was to improve schoolchildren's behaviour and attitude through sport. (PESSCL is a joint initiative of the Department for Culture, Media and Sport and the Department for Education and Skills, launched in 2002. It aims to implement a national strategy for PE and School Sport.)¹²⁴
133. Mr. Cotton said that school PE lessons alone could not provide enough physical activity to meet the PSA targets. PE was now more of an academic subject than previously, with a requirement for PE lessons to include a proportion of class-time dealing with theory (it was, in fact, possible to do a GCSE in PE at Key Stages 3 and 4). Mr. Cotton said that, in his opinion, PE did not have a high enough profile or sufficient priority in the national curriculum.

¹²⁰ Kent Partnership, *Vision for Kent: Kent people in partnership for a better tomorrow* (version 2; Kent Partnership, April 2006), p. 35.

¹²¹ *Towards 2010* (KCC, June 2006), p. 16.

¹²² *Ibid.*, p. 10.

¹²³ Oral evidence: Peter Cotton and Julia Gillingham, 8 March 2006.

¹²⁴ <http://www.teachernet.gov.uk/teachingandlearning/subjects/pe/nationalstrategy/>

134. Ms. Gillingham said that the government funding allocation to local School Sport Partnerships (SSPs) and PESSCL showed commitment and was a good indication that the success of current schemes would be able to continue into the future. There were 13 SSPs around Kent, and the aim, by September 2006, was that all Kent schools would be in a partnership. The Gravesham SSP was playing a key role in fostering participation in sport and in allowing professional development (to compensate for the lack of an adequate PE element in teacher training).
135. Mr. Cotton and Ms. Gillingham noted that provision of adequate facilities was essential for the development of school sport. In the past, too many school playing fields had been sold off, or significantly reduced in size, for housing development. This point was also made by Helene Raynsford (South East Regional Development Manager for Physical Activity and Health) in her evidence to the Committee.¹²⁵
136. Part of increasing physical activity, in addition to PE lessons, was to encourage playground play – for instance through providing hopscotch grids and basketball hoops in playgrounds.
137. The Committee was contacted by Olive Jerome, a school activities coordinator, who has had great success in getting children physically active at lunchtime. She pointed out that once children reached secondary school they tended to become a lot less physically active and this needed to be addressed, with more posts such as her own.¹²⁶
138. The Committee also heard that KCC's Sports Development Unit had developed a new programme to encourage the use of school sites for out-of-hours sport. So far, 70 schools had benefited.¹²⁷

¹²⁵ Oral evidence: Helene Raynsford, 14 February 2006.

¹²⁶ Information supplied by Olive Jerome (lunchtime activities coordinator, Hartsdown Technology College, Margate).

¹²⁷ Oral evidence: Chris Hesse, 8 February 2006;

http://www.kentsport.org/schools/SchoolSport_SchoolSportPartnerships.cfm

139. Representatives of the Kent Youth County Council highlighted the lack of choice in sports lessons before Year 10. They felt little was achieved by forcing school students to undertake activities that they did not enjoy. Lack of choice in sports kit was also a factor that lessened enjoyment, they thought – it was unfair to be expected to wear T-shirts and shorts outside in the winter months and they would have appreciated the option of wearing tracksuits instead.¹²⁸
140. A pupil survey undertaken by the National Foundation for Educational Research has apparently shown that young people would like more opportunity to undertake individual sports and physical activities, such as running, cycling, swimming and racket sports.¹²⁹
141. The Joint Select Committee noted the report on *Sport in Schools* (2005), which resulted from a topic review carried out by a Select Committee of KCC's Education and Libraries Policy Overview Committee. The report's findings overlap in several respects with evidence that was presented to the obesity topic review Joint Select Committee.¹³⁰

3.5.4 Food in schools

142. As noted above (at para. 34), the poor quality of school catering has been cited as a factor contributing to childhood obesity; and various measures have been taken at national level in recent years to improve school food.
143. *Towards 2010* states that KCC will “Encourage healthy school eating by providing nutritious school lunches through the ‘Healthy Schools’ programme and initiate in a number of schools a pilot of free and nutritious school lunches”.¹³¹
144. The Joint Select Committee heard from Sue Harvey that Trading Standards gave advice on the Kent Healthy Schools programme. Trading Standards also had an impact on pupils' choice of food at school and had used a programme developed

¹²⁸ Oral evidence: Grace Kelley, Rebecca Marshall, Cally Pike and Katie Shore, 13 March 2006.

¹²⁹ Information supplied by Graham Badman (Managing Director of KCC's Children, Families and Education Directorate).

¹³⁰ KCC (2005).

¹³¹ *Towards 2010* (KCC, June 2006), p. 16.

by KSS to enable students to see the salt, fat, vitamin content, *etc.*, of foods chosen on a screen, allowing them to learn about nutrition and choose healthier foods. However, Trading Standards had found that, even when the overall choice of school meals on offer was made healthier, children still tended not to put fruit and vegetables on their plates. It was suggested to the Committee that the answer was to eliminate fatty and salty foods so they could not be selected. This, however, raised a dilemma for school-meals providers, who wanted to prepare and present food that was going to be eaten rather than wasted, and to ensure that pupils ate some form of meal.¹³²

145. The Committee also heard from Ms. Healy, KCC's Healthy Schools Programme Manager, that Kent's schools would receive £3m, over three years, of "Transforming School Meals Grant" funding (popularly known as "Jamie Oliver money") and the Healthy Schools programme would work with KCC Client Services to allocate this money.¹³³

146. Pam Naylor, Food and Health Policy Lead for the South East Public Health Group, explained to the Committee that the national School Fruit and Vegetable Scheme had been set up to give primary-school children aged 4–6 years in state-maintained schools one piece of fresh fruit per day, free of charge. The Scheme had originally aimed to achieve 97% participation with eligible schools, but had managed to exceed this, achieving almost 99% sign-up.¹³⁴

147. The Joint Select Committee heard from representatives of the Kent Youth County Council that they believed the quality of fruit that was made available in schools was poor. One representative stated that fruit was often in a rotting state, consisting of produce that could not otherwise be sold, and that young people would not pay for it. However, members of the Committee were sceptical about this anecdotal evidence – they felt that, while the situation described might once have been the case, the quality of school food had improved greatly.

¹³² Oral evidence: Sue Harvey, 8 February 2006.

¹³³ Oral evidence: Carol Healy, 8 March 2006.

¹³⁴ Oral evidence: Pam Naylor, 14 February 2006.

148. The Youth County Council representatives also felt that school lunches were unappetising and unpopular; and they stated that healthier options were more expensive than less healthy choices.¹³⁵

149. The Committee also received written evidence from Sainsbury's on the work that their two Food Advisers in Kent do with local schools, though initiatives such as the "Feed Me Better" project, "Focus on Food" weeks and "Healthy Eating" weeks.¹³⁶

3.5.5 Extended Schools

150. The Extended Schools concept involves schools providing extended services, including:

- childcare before and after school hours (for instance, through Breakfast Clubs)
- help with parenting and family-support
- school clubs (including sport clubs)
- swift and easy referral to specialist services (including health services)
- sharing of school facilities (including sporting facilities) with other schools and the wider community.¹³⁷

151. The Joint Select Committee heard from Carol Healy that the principle of Extended Schools could be used to provide activities for children and could engage hard-to-reach groups. However, in "school club" situations it was very easy for only a minority of children to be engaged, with the majority not taking up what was on offer. Ms Healy thought it was necessary to look at increasing participation rather than simply providing opportunities.¹³⁸

¹³⁵ Oral evidence: Grace Kelley, Rebecca Marshall, Cally Pike and Katie Shore, 13 March 2006.

¹³⁶ Written evidence: Shirley Waters and Gill Stowe, April 2006.

¹³⁷ <http://www.teachernet.gov.uk/wholeschool/extendedschools/>

¹³⁸ Oral evidence: Carol Healy, 8 March 2006.

152. A potentially useful application of the Extended Schools concept would be to use school facilities to provide classes in cooking and healthy-eating for parents.

3.5.6 School Travel Plans¹³⁹

153. The October 2001 Walking Strategy, which sits under KCC's Local Transport Plan, sets as an Objective "To promote walking as a safer mode of transport to school".¹⁴⁰ One of the Outcomes and Success Criteria in the Kent CYPP, under Priority 4, is an "Increase in proportion of [children and young people] walking or cycling to school". LTP2 highlights the importance of School Travel Plans, as part of the Smarter Choices element of Kent's Integrated Transport Programme, under the Local Transport Plan.¹⁴¹

154. The Joint Select Committee heard evidence from Mr. Hardy about the role of the Strategic Planning Directorate (since April 2006, the Environment and Regeneration Directorate) in formulating School Travel Plans. He said that KCC's School Travel Plans were in accordance with the Department for Transport's broad aim of influencing people towards healthier and more sustainable transport options. Currently, 200 schools in Kent had a Travel Plan and the aim was for all Kent schools to have one by 2010. Funding was available to schools that participated in the initiative. Travel Plans could include:

- walking buses;
- cycle facilities;
- car-sharing; and
- school buses.

155. "Walking Bus" schemes encouraged children to walk to school in a safe, supervised way without each individual parent having to embark on a car journey.

¹³⁹ The themes in this section are covered in much greater detail by the KCC Select Committee report on home-to-school transport – KCC (2006a).

¹⁴⁰ KCC (2001), p. 13.

¹⁴¹ *Local Transport Plan for Kent, 2006–11* (KCC, March 2006) para. 6.40.

These worked best with primary schools, as younger children tended to live in closer proximity to their school.¹⁴²

156. The Kent and Medway Walking Bus Group is a partnership group, with commercial sponsorship, that is seeking to develop a network of walking buses across the geographical county.¹⁴³

3.5.7 Healthcare in schools

157. *Choosing Health* emphasises the key role of school nursing services and envisages “a new and relevant role for school nurses on a wider scale than in recent years”.¹⁴⁴ KCC's Children, Families and Education Directorate informed the Joint Select Committee that a recent study in Chicago had confirmed the important role that school nursing services can play.¹⁴⁵
158. Key Action 19 of Kent's CYPP, under Priority 4, is to: “Further develop the school nursing service in relation to healthy lifestyles and prevention with particularly reference to vulnerable groups”.
159. The issue of school nurses was discussed with the Committee by Dr. Jonathan Sexton, Director of Public Health for Canterbury and Coastal PCT, in respect of a planned under-16s GP referral scheme in his area (see para. 223 below). There were currently not enough school nurses for the scheme. Dr. Sexton stated that, for the additional school nurses required, he estimated that £41,000 would be needed – this would provide additional hours for existing staff and nursing assistants to measure children to allow screening for possible referral. Dr. Sexton explained that, as a rule of thumb, *Choosing Health* allowed for one school nurse per school cluster. In East Kent there were currently just three school nurses.¹⁴⁶

¹⁴² Oral evidence: Robert Hardy, 8 February 2006.

¹⁴³ <http://www.kentwalkingbus.org>

¹⁴⁴ DoH (2004b), paras. 28–9, pp. 48–9.

¹⁴⁵ Information supplied by Graham Badman (Managing Director of KCC's Children, Families and Education Directorate).

¹⁴⁶ Oral evidence: Dr. Jonathan Sexton, 27 March 2006.

160. KCC's Children, Families and Education Directorate is currently negotiating with the School Nursing Service (provided by PCTs) to second school nurses into school clusters. Matched funding has been offered by KCC to any schools that wish to participate. (In the view of the Children, Families and Education Directorate, the figure of £41,000, cited by Dr. Sexton for East Kent, may be an overestimate of the cost.) A process is to be set up whereby clusters can discuss their specification with the School Nursing Service at local level and a specification is then agreed by KCC, releasing its portion of the funding. The School Nursing Service is keen to arrange two-year agreements, but KCC is only able to guarantee funding for 2006–7.¹⁴⁷
161. One way of addressing such issues in future may be through the Children's Trust that is soon to be formed in Kent. Children's Trusts are non-statutory partnerships of local authorities and NHS bodies, the formation of which is encouraged under the Children Act 2004.¹⁴⁸ They will provide a means whereby services for children can be commissioned in partnership. Elements of health commissioning that may be covered by the Kent Children's Trust include School Nursing, Health Promotion for children and young people (both within schools and outside) and co-located health services under the Extended Schools concept.

3.5.8 Adult Education

162. The Adult Education Service in Kent, which is run by KCC, recognises that it has a role to play in promoting healthy eating and physical activity. The Service provides various kinds of classes relevant to obesity through its "Healthy Living" programme of courses, covering both diet and physical activity (including sport, dance and exercise).¹⁴⁹
163. The Adult Education Service also works in partnership with other local organisations and service providers to promote healthier lifestyles. In Gravesham, students that sign up to classes as part of the local GP referral programme (see

¹⁴⁷ Information supplied by Graham Badman (Managing Director of KCC's Children, Families and Education Directorate).

¹⁴⁸ <http://www.everychildmatters.gov.uk/aims/childrenstrusts/faq/>

Section 3.9 below) are entitled to receive up to 40 hours' tuition at 50% of the standard fee.¹⁵⁰

164. The Committee heard in evidence that the East Kent Coastal PCT was working in partnership with the Adult Education Service and that the PCT wished to give a higher profile to this partnership.¹⁵¹

Recommendation 4

Kent County Council's Children, Families and Education Directorate should continue to promote the Healthy Schools programme and the Extended Schools concept – including Breakfast Clubs and use by wider community of school sports facilities.

3.6 Leisure and recreation

3.6.1 Sport

165. *Choosing Health* notes that “Sport and active recreation make a significant contribution towards overall physical activity levels in the population”.¹⁵²
166. In the *Vision for Kent*, KCC commits itself, as a short-term priority, to “Identifying the need for additional sporting facilities, developing sports performance and enhancing coach and club development”.¹⁵³ And, in *Towards 2010*, the County Council undertakes to support, encourage and promote sporting activity in Kent.¹⁵⁴

¹⁴⁹ <http://www.kent.gov.uk/education-and-learning/adult-and-community/courses-and-enrolment/healthy-living.htm>

¹⁵⁰ Written evidence: Lois Reynolds, 13 February 2006.

¹⁵¹ Oral evidence: Claire Martin, 22 March 2006.

¹⁵² DoH (2004b), para. 47, p. 91.

¹⁵³ Kent Partnership, *Vision for Kent: Kent people in partnership for a better tomorrow* (version 2; Kent Partnership, April 2006), p. 35.

¹⁵⁴ *Towards 2010* (KCC, June 2006), p. 10.

167. KCC's Sports Development Unit “develops sport, provides a focus for sports issues and ensures that the best use is made of resources in the County”. It works in partnership with some 600 schools and 15,000 voluntary sports clubs, as well as governing bodies of sport, sports associations, government agencies, local authorities, coaches and performers.¹⁵⁵
168. The Joint Select Committee took evidence about the work of the Unit from KCC’s Head of Leisure Services, Chris Hespe.¹⁵⁶ He explained that the Unit received its core funding from KCC – currently approximately £600,000 per annum. Part of the Unit’s role was to secure funding, from a range of sources, for sport in Kent; in 2006, some £4m had been sourced. Sports development in Kent benefited from the availability of small grants and sponsorship (for example, from Pfizer, Kent Reliance Building Society and Charlton Athletic FC) to facilitate community sport development schemes for disadvantaged children. The Unit had 45 staff in total, made up of 10 KCC full-time equivalent and nine other KCC contracted staff, who were part-funded by KCC, with the remainder being external posts. The Unit had also recently gained a new staff member, part of whose role was to develop and exploit the links between health and sport.
169. Mr. Hespe expressed the view that the healthcare sector should be contributing towards funding for sport, as part of the disease-prevention role of healthcare organisations.
170. Mr. Hespe said that volunteers made a valuable contribution to sports development in Kent – 28% of volunteering was in sport, and the Unit hosted the Kent Sports Volunteers Project, through which 186 volunteers had been found, trained and placed in sport in Kent over the last two years.
171. Under the auspices of the Sports Development Unit, KCC is running the “Kent 2012” campaign, which aims to raise the profile of the 2012 Olympic (and Paralympic) Games and the benefits that they can bring to Kent. Estimated benefits for the county from the Olympics include: greater specialist sports facility development in Kent; increased participation in sport; the placing of sport at the

¹⁵⁵ <http://www.kentsport.org/>

¹⁵⁶ Oral evidence: Chris Hespe, 8 February 2006.

top of the political agenda; and recognition of sport's contribution to health.¹⁵⁷ (The *Vision for Kent* makes reference to the potential benefits of the 2012 Olympics for sport and leisure in the county;¹⁵⁸ and *Towards 2010* commits KCC to supporting Kent sportsmen and sportswomen who wish to compete.)¹⁵⁹

172. Charlton Athletic FC's Community Scheme has implemented an initiative in Dartford and Gravesham through the "Positive Futures" programme, a national sports-based social-inclusion programme managed by the Home Office Drugs Strategy Directorate. Positive Futures operates as a partnership between Sport England,¹⁶⁰ the Football Foundation, the Home Office Drugs Unit and the Youth Justice Board. Its aim is to "use sport to reduce anti-social behaviour, crime and drug use among 10–16 year olds within local neighbourhoods".¹⁶¹

173. Charlton Athletic FC's "Positive Futures" programme in Dartford and Gravesham encompasses the following strands:

- Estates Programmes – five-a-side or coaching sessions for young people in areas where access to facilities or structured sessions is difficult;
- School-Based Programmes – weekly three-hour sessions at secondary schools for disengaged pupils (male and female); these include fitness sessions and games, as well as workshops on topics including crime, drugs and diet.
- Diversionary Programmes – for identified groups of young people that have, for various reasons, come to the attention of the authorities.

¹⁵⁷ http://www.kentsport.org/news_kent_2012.cfm

¹⁵⁸ Kent Partnership, *Vision for Kent: Kent people in partnership for a better tomorrow* (version 2; Kent Partnership, April 2006), pp. 26, 34 and 35.

¹⁵⁹ *Towards 2010* (KCC, June 2006), p. 10.

¹⁶⁰ Sport England is the brand name of the English Sports Council, which distributes money from the National Lottery Sports Fund in England.

¹⁶¹ http://www.cafc.co.uk/Social_inclusion.ink ; http://www.sportengland.org/pf_summary.pdf ; Oral evidence: Dr. Meradin Peachey, 8 March 2006; Alan Dennington, 13 March 2006.

- Girls-Only Football – an initiative to encourage girls to play football.

174. Fifteen full-time staff and 180 part-time coaches are involved in this work. The Positive Futures programme is currently being extended across the whole of Kent, having initially run as six-week pilot in Dartford and Gravesham. The approximate cost of running a scheme across Kent is £900,000. The scheme currently receives £150,000 from KCC and £150,000 from Kent Police.
175. The Committee learned that Charlton Athletic FC had also been involved in the “Kick Start for Life” programme in Canterbury, involving primary-school children up to 11 years old. This programme had commenced in November 2005 and 287 primary school children had taken part. Charlton Athletic FC is also involved in Canterbury in the development of a programme to tackle youth crime and improve the health of young people using football.¹⁶²
176. The Joint Select Committee was very impressed with the Positive Futures initiative and thought that it deserved to be more widely recognised and emulated.
177. The Committee noted that there are other initiatives in other sports to involve young people – girls as well as boys. The Kent Cricket Board Development Office runs schemes including cricket for girls.¹⁶³ The Kent County Rugby Football Union¹⁶⁴ runs Kent Girls Rugby and promotes Tag Rugby (a non-contact version of the game, suitable for young beginners).
178. District councils do much to promote sport in their areas. The Committee heard from Adrian Hickmott and Sarah Knight of Gravesham Borough Council that their authority undertook direct management and contract supervision of a wide range of sport and leisure facilities both indoor and outdoor. In addition, the council organises outdoor events and holiday activities, as well as developing sport through increasing participation, club development and volunteer development. From April 2006 the Council would be moving sports and recreation into its

¹⁶² Oral evidence: Janine Marsh, 27 March 2006.

¹⁶³ http://www.kentsport.org/news_crick6.cfm

¹⁶⁴ <http://www.kent-rugby.co.uk/>

environmental and public health services, emphasising the role of sport in providing social and health benefits.¹⁶⁵

179. David Ford and Janine Marsh of Canterbury City Council explained to the Committee that the City Council had widened the sports development brief to include Health. The emphasis was on partnership working with sports clubs and leisure-service providers, as well as with PCTs and others in the health sector.

180. Ms. Marsh had been appointed as a Sports and Health Manager. The Committee felt that this explicit linkage of the two roles in a single post was an example of good practice that deserved to be copied by other local authorities.

181. The City Council was working in partnership with the East Kent Health Promotion Service (which is supported by all four East Kent PCTs) and Active Life Ltd. (which ran the City's leisure centres). They were promoting sport and other physical activity through the "Get Active: Feel Alive" campaign.

182. The Council was also preparing to take advantage of the fact that the English leg of the Tour de France cycle race was due to end in Canterbury in July 2007. The City Council regarded this as something of a "trial run" for efforts to increase participation in sport around the 2012 London Olympics. The City Council had successfully bid for £140,000 of funding from the East Kent Partnership for the Tour de France and some of this would be used to ensure there was increased and sustained participation.¹⁶⁶

183. As already noted (Section 3.5.5 above), the Extended Schools concept can include the opening up of school sports facilities to use by the wider community. This idea was commended to the Committee as a means of making good-quality sports facilities available to members of the public.¹⁶⁷ The Committee was broadly supportive of this. However, members were mindful of the fact that opening up school facilities might in some circumstances adversely affect the local "sport economy", by taking custom away from local-authority, and other, facilities. This

¹⁶⁵ Oral evidence: Adrian Hickmott and Sarah Knight, 13 March 2006.

¹⁶⁶ Oral evidence: David Ford and Janine Marsh, 27 March 2006.

¹⁶⁷ Oral evidence: Claire Martin, 22 March 2006.

possibility does need to be taken into account where public access to school sport facilities is proposed.

184. All KCC Members have Member Grants of £10,000 each, which they can, and do, use to fund sporting activity in their respective electoral divisions.
185. The Kent Physical Activity Alliance (KPAA) is a body that is working with the South East Physical Activity Co-ordinating Team to implement *MOVE IT!: A Framework for Action on Physical Activity in the South East*, which was published by the Government Office for the South East, Sport England South East and the DoH in 2004.¹⁶⁸
186. The Joint Select Committee was concerned to hear that KPAA was apparently not as strong as it could be. Helene Raynsford (South East Regional Development Manager for Physical Activity and Health) informed the Committee that the establishment of KPAA had been “a struggle”, with sporting bodies reluctant to become involved (although there had been some improvement in partnership working).¹⁶⁹ The Committee felt there was scope here for the development of a joint strategy with KCC’s Sports Development Unit.

Recommendation 5

All local authorities in Kent should:

- support initiatives that encourage young people (including girls) to participate in sport;
- consider appointing Sports and Health Managers, to promote active lives for all the community;
- do as much as possible to capitalise on the public interest generated by the 2012 London Olympics in order to promote wider participation in sport.

¹⁶⁸ Oral evidence: Helene Raynsford and Penny Kurowski, 14 February 2006.

¹⁶⁹ Oral evidence: Helene Raynsford, 14 February 2006.

Recommendation 6

Kent County Council's Sports Development Unit and Public Health Department, and the Kent Physical Activity Alliance must work more closely together to promote physical activity.

3.6.2 Recreational use of the countryside and public spaces

187. V4K notes that:

*While formal provision for leisure activities is important, it is vital that this is not achieved to the exclusion of, or at the expense of, informal leisure activities that do not require special infrastructure or organisation. Simply enjoying a walk in the countryside, kicking a ball about or walking the dog are popular, free and enjoyable activities, requiring only that accessible countryside and open space continues to be there for Kent's residents to enjoy.*¹⁷⁰

188. Accordingly, V4K includes commitments to developing, improving and promoting Kent's Country Parks, Areas of Outstanding Natural Beauty, open access countryside (under the "right to roam" legislation – the Countryside and Rights of Way Act 2000) and Public Rights of Way.¹⁷¹

189. In *Towards 2010*, KCC undertakes to improve access to Public Rights of Way.¹⁷²

190. Kent has the largest Public Rights of Way network of any county in England and Wales – covering some 6,900km.¹⁷³ The Joint Select Committee heard in evidence that no-one in Kent lived more than two miles from a public footpath.¹⁷⁴ KCC has a statutory duty in respect of the maintenance of Public Rights of Way,

¹⁷⁰ Kent Partnership, *Vision for Kent: Kent people in partnership for a better tomorrow* (version 2; Kent Partnership, April 2006), p. 33.

¹⁷¹ *Ibid.*, pp. 26, 35 and 38.

¹⁷² *Towards 2010* (KCC, June 2006), p. 14.

¹⁷³ *Local Transport Plan for Kent, 2006–11* (KCC, March 2006), para. 4.26.

¹⁷⁴ Oral evidence: Robert Hardy, 8 February 2006.

including production of a Rights of Way Improvement Plan;¹⁷⁵ this duty is discharged through the Environment and Regeneration Directorate (until April 2006, the Strategic Planning Directorate).

191. The Joint Select Committee heard from Ian Baugh (KCC's Countryside Access Development and Promotions Manager) that, in addition to fulfilling this statutory duty, KCC did much to promote use and enjoyment of the Public Rights of Way network. This was done through attempting to reach "target markets", using various means. These "markets" included people with disabilities, tourists, walkers and cyclists. Various kinds of promotional materials were used, such as leaflets with suggested walks, an "Explore Kent" calendar, *Kent Trails* magazine (produced twice a year with a print-run of 50,000 copies) and the "Explore Kent" website. Particular effort had gone into the last of these, as it had the potential to reach a very large audience.¹⁷⁶
192. LTP2 commits KCC to improving and developing the county's Public Rights of Way network, in order to maximise its potential as a means of sustainable transport that can bring a whole range of benefits – including improved health and fitness.¹⁷⁷
193. The Environment and Regeneration Directorate also encompasses a number of discretionary (non-statutory) areas of activity that relate to enabling and promoting recreational physical activity – notably the ownership and management of KCC's 22 Country Parks. At Shorne Wood and Trosley Country Parks there are "trim trails", with simple fitness equipment; and consideration is being given to providing similar facilities in other Country Parks.¹⁷⁸ Nordic Walking events have been held in a number of Country Parks, to promote this particular form of exercise.¹⁷⁹

¹⁷⁵ *Local Transport Plan for Kent, 2006–11* (KCC, March 2006), paras. 4.28–9.

¹⁷⁶ Oral evidence: Ian Baugh, 14 February 2006.

¹⁷⁷ *Local Transport Plan for Kent, 2006–11* (KCC, March 2006), ch. 4.

¹⁷⁸ Oral evidence: Dr. Linda Davies and Paul Lonergan, 14 February.

¹⁷⁹ Information supplied by Flavio Walker (Health and Safety Manager, KCC Environment and Regeneration Directorate).

194. Another recreational activity based in the countryside that involves taking exercise is the Green Gyms project, in which members of the public volunteer to undertake conservation work. The Joint Select Committee heard that North West Kent Countryside Partnership, which involved KCC, Dartford Borough Council and others, including the British Trust for Conservation Volunteers, was running a successful Green Gym in the Dartford area. A bid was being made for further funds for two full-time coordinators and consideration was being given to the idea of working with local PCTs to make Green Gyms a form of exercise-on-prescription (see Section 3.9 below regarding prescribed exercise).¹⁸⁰ Green Gyms also operate in other areas, for example Maidstone.¹⁸¹
195. The county's Countryside Projects offer a similar opportunity to be physically active through conservation work.¹⁸²
196. Public parks and other non-rural public space also represent an important resource that can be enjoyed as part of a physically active lifestyle. Relevant to this are a number of outcomes in Block 2 of the Kent Agreement, "Safer and stronger communities", covering issues such as road-safety, crime, perceptions of local drug-use and drug-dealing, anti-social behaviour and "cleaner and greener public spaces".¹⁸³

3.7 Transport, highways and streets

197. KCC's vision for transport to 2025 is set out in LTP2. It includes "developing public transport, walking and cycling", in the interests of both transport planning (reducing congestion and pollution, and facilitating easier commuting) and better public health, including improved levels of fitness.¹⁸⁴ This reflects the priorities for transport laid out in the *Vision for Kent*.¹⁸⁵

¹⁸⁰ Oral evidence: Paul Lonergan, 14 February 2006.

¹⁸¹ Written evidence: David Petford, 1 February 2006.

¹⁸² <http://www.kent.gov.uk/environment/our-environment/natural-environment/countryside/countryside-partnerships.htm>

¹⁸³ The Kent Agreement (25 July 2005), pp. 27–31.

¹⁸⁴ *Local Transport Plan for Kent, 2006–11* (KCC, March 2006), Vision.

¹⁸⁵ Kent Partnership, *Vision for Kent: Kent people in partnership for a better tomorrow* (version 2; Kent Partnership, April 2006), pp. 36–8.

198. Underneath the Local Transport Plan sits a Walking Strategy, which “guides and informs” work on facilitating and promoting walking.¹⁸⁶ This document (published in October 2001) sets out seven objectives, including:¹⁸⁷

- To reduce the vulnerability of pedestrians and promote their safety and security
- To reduce peak period and short distance car journeys, so as to reduce congestion, and pollution and to promote healthy living
- To encourage walking as part of an integrated transport policy
- To promote the benefits of walking

199. Responsibility for achieving these objectives rests with the County Council’s Environment and Regeneration Directorate, which aims to create an infrastructure to allow people to choose healthier transport options if they wish. This is facilitated by the Integrated Transport Programme, which includes:

- Supported Public Transport;
- Smarter Choices Kent (in which travel-planning is used to encourage walking and cycling);
- Small Highways Scheme (which improves the infrastructure for bus-users, walkers and cyclists).¹⁸⁸

200. Cycling is a key part of the County Council’s transport strategy. KCC has direct responsibility for creating and maintaining cycle routes in the county; and LTP2 sets a target of a 38% increase in cycling on 2003–4 levels by 2011. The Plan

¹⁸⁶ *Local Transport Plan for Kent, 2006–11* (KCC, March 2006) para. 6.49.

¹⁸⁷ <http://www.kent.gov.uk/NR/rdonlyres/5BE72B6D-332E-45E2-B52D-320B21CDF73A/642/walkingstrategy.pdf>

¹⁸⁸ Written evidence: David Joyner, 6 February 2006.

includes schemes to improve and expand the cycling network, as well as services for cyclists, in Kent.¹⁸⁹

201. Both School and Workplace Travel Plans form key elements of the Smarter Choices programme – these are dealt with elsewhere in this report.¹⁹⁰
202. KCC also works with partner local authorities in preparing a Green Travel Plan for each district. District councils lead on this work, while KCC contributes a valuable strategic input.¹⁹¹
203. Some district councils have their own local strategies for walking and cycling – such as Tonbridge and Malling Borough Council’s Cycling Strategy, “Putting the Wheels in Motion”, and Canterbury City Council’s joint “Walking and Cycling Strategy”.¹⁹²
204. The Committee heard from Nigel De Wit, Senior Planning Officer at Tonbridge and Malling BC, that an extensive cycle route had already been implemented along the A20 in the Medway Gap Area and the Borough was working in partnership with KCC and Sustrans (the sustainable transport charity).¹⁹³

3.8 Everyday exercise

205. As noted (see para. 38 above) a factor in the rising prevalence of obesity is the loss of incidental exercise in many people’s daily lives. An important aspect of combating obesity is, therefore, the promotion of such “everyday exercise” – as recognised in the Department of Health’s “Small Change, Big Difference” campaign.¹⁹⁴

¹⁸⁹ http://www.kent.gov.uk/static/local-transport-plan/chapter_47.html;
<http://www.sustrans.org.uk/webfiles/county/Kent%20Walking%20and%20Cycling%20policy.pdf>
<http://www.kent.gov.uk/transport>

¹⁹⁰ On School Travel Plans, see Section 3.5.6. On Workplace Travel Plans, see Section 5.4.

¹⁹¹ Oral evidence: Robert Hardy, 8 February 2006.

¹⁹² *Local Transport Plan for Kent, 2006–11* (KCC, March 2006), p. 119.

¹⁹³ Oral evidence: Nigel De Wit, 22 February 2006

¹⁹⁴ “Small changes ‘add years to life’”, BBC News online, 25 April 2006 –
<http://news.bbc.co.uk/1/hi/health/4941910.stm>

206. The Joint Select Committee heard from Richard Spoerry, the Kent Agreement Manager, that a working group from the Kent Agreement team was working on maximising public awareness of exercise opportunities, including ways that people could build exercise into their daily routines. It was important to emphasise that physical activity did not necessarily involve joining a football team or paying for gym membership – activities such as getting off the bus one stop early, undertaking light shopping trips on foot, gardening and housework were all good ways of taking exercise.
207. As already noted, planning of the built environment (Section 3.1 above) and transport planning (Section 3.7 above) have important roles to play in minimising obstacles to, and maximising opportunities for, everyday exercise.

3.9 Primary-care practitioner referral schemes

208. An exercise referral (or exercise-on-prescription) scheme involves a partnership between healthcare professionals and leisure/exercise providers, allowing primary-care practitioners (GPs and others) to help patients access structured physical-activity programmes.
209. In 2001, the DoH published a National Quality Assurance Framework for Exercise Referral Systems. In a foreword, the then Secretary of State for Health wrote: “Referral schemes will form an important element in the delivery of local action plans to increase activity levels, reduce obesity and help tackle chronic disease.”¹⁹⁵
210. The January 2006 White Paper *Our health, our care, our say: a new direction for community services* indicated the government’s support for “Social prescribing”, including exercise-on-prescription projects. The White Paper noted that exercise referral had been established or piloted in a number of areas and had “often been very successful”.¹⁹⁶

¹⁹⁵ <http://www.laterlifetraining.co.uk/documents/NQAFExerciseReferral.pdf>

¹⁹⁶ Department of Health, *Our health, our care, our say: a new direction for community services* (TSO, January 2006; Cm 6737), para. 2.93, p. 51. Cf. *Hansard*, House of Commons Written Answers, 1 March 2006, Cols. 760–1W.

211. Exercise referral featured in the guidance on physical-activity public-health interventions published by the National Institute for Health and Clinical Excellence in March 2006, which indicated the need for more and better evidence regarding the effectiveness of this and other interventions (see Section 8.2 below).¹⁹⁷
212. In April 2006, the DoH issued guidance to GPs, setting out clear care pathways for the care and management of obesity and overweight, and encouraging brief interventions in primary care (the “Your Weight, Your Health” series) – although there is no explicit reference in this to exercise referral.¹⁹⁸
213. It is noteworthy that, whilst the Quality and Outcomes Framework for the GP contract now rewards practices for recording patients’ BMIs as part of routine care, no rewards appear to be attached to the referral of patients to activity / weight-loss programmes.¹⁹⁹
214. The Joint Select Committee was told by Claire Martin (Public Health Specialist with East Kent Coastal PCT) that patients with weight issues should benefit from a scientific and systematic approach to exercise. Referral of patients by GPs to structured exercise programmes, run by properly trained and qualified individuals, allowed patients to access assistance and advice on how to exercise safely and effectively. Structured programmes did not need to be confined to institutions (leisure centres, *etc.*) and could include community-based initiatives, such as Health Walks (which have been established in East Kent, Edenbridge, and Tonbridge and Malling, as part of the national “Walking the Way to Health” programme).²⁰⁰ However, Ms. Martin admitted (referring to the work of Prof. Chris Riddoch) that there was little evidence for the effectiveness of GP referral as an

¹⁹⁷ NICE (2006).

¹⁹⁸

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4134408&chk=Sq/wNd

¹⁹⁹ *Hansard*, House of Lords Written Answers, 16 March 2006, Col. WA255. Eight points, out of a possible total of 1,000, are available for maintaining a practice obesity register by monitoring BMIs in this way.

²⁰⁰ <http://www.whi.org.uk/>

intervention – which she attributed to the lack of funding for programmes to evaluate effectiveness.²⁰¹

215. The Joint Select Committee heard evidence from a number of sources on some of the GP referral schemes currently operating in Kent. Debbie McNamara, Sports Development Officer at Tonbridge and Malling Borough Council, spoke about the highly successful Lifestyle Referral Programme run at the council's main leisure centres, in partnership with local GP practices and South West Kent PCT. The Programme cost approximately £70,000 a year; and, in 2005, it had dealt with over 824 referrals. The Programme was designed to assist patients to take responsibility for their own wellbeing and recuperation through participating in designed exercise programmes while understanding and practising a healthy lifestyle. GPs and other primary-care professionals referred suitable patients to Larkfield Leisure Centre or the Angel Centre at Tonbridge for a fitness appraisal and exercise prescription. A Lifestyle consultant assisted referrals through an exercise programme and encouraged patients to enhance and sustain the quality of their exercise.²⁰²

216. All the staff dealing with GP referrals had a Certificate in GP Referral from either the Institute of Leisure and Amenity Management or the Wrights Foundation – focusing on Adapted Physical Activity for people with significant physical limitations related to chronic disease or disabilities. Three members of staff held a Certificate in Cardiac Rehabilitation (Phase IV), *i.e.* community-based cardiac rehabilitation, from the British Association of Cardiac Rehabilitation. Other sports centre instructors held: Exercise and Fitness qualifications appropriate to dealing with physical activity for apparently healthy people with no more than one risk factor for CHD; or Advanced Instructor qualifications adapted for physical activity for people with minor, stable physical limitations, or one or two CHD risk factors.²⁰³

217. The Committee heard from Mr. Hespe, KCC's Head of Leisure Services, that he thought exercise on prescription schemes had great potential to engage hard-to-

²⁰¹ Oral evidence: Claire Martin, 22 March 2006. See also Martin and Woolf-May (1999).

²⁰² Oral evidence: Debbie McNamara, 22 February 2006

²⁰³ Written evidence: Debbie McNamara, 13 March 2006.

reach groups – but needed to be well-planned and delivered to secure public confidence. He stated that, to successfully deliver exercise on prescription, staff at sports facilities and leisure centres had to have sufficient training and be able to understand the physical needs and limitations of the people referred to them. And there would need to be proper assessment of an individual before committing them to a long-term programme of exercise.²⁰⁴

218. A key component of the DSGF programme in Dartford and Gravesham is a GP referral scheme for overweight and obese children. Under this scheme, children can be referred by a GP or a paediatrician to the DSGF “Active Club”. The Club allows children to receive regular individual consultations and the opportunity to take part in a 12-session programme in which they can learn about healthy eating and physical activity in an enjoyable and friendly environment.²⁰⁵

219. The Committee heard from Judith Webb, Head of Nutrition and Dietetic Services at Darent Valley Hospital (Dartford and Gravesham Acute NHS Trust), that the GP referral component of DSGF had had good outcomes – although the children had not lost weight, they had not gained any.²⁰⁶

220. Rob Swain (Managing Director of Gravesham Community Leisure Ltd.) told the Committee that a referral scheme linked to GPs was being initiated; this was to be a low-risk junior coaching scheme.

221. The GP referral scheme was actually a cardiac scheme. Patients from Darent Valley Hospitals Cardiac Phase 4 unit were referred to leisure centres and were prescribed certain exercises through a Cardio Phase 4 class. This was undertaken by qualified instructors who were already employed by the centres.²⁰⁷

²⁰⁴ Oral evidence: Chris Hespe, 8 February 2006.

²⁰⁵ GOSE / Sport England South East / DoH (2004) p. 16; “Levels of Overweight and Obese Children in Dartford and Gravesham”, presentation by Moya White (Chief Dietician, Dartford and Gravesham NHS Trust) to Obesity Sub-Committee of the Kent and Medway Public Health Network, 10 May 2006; Health Action Dartford / Health Action Gravesend / Kent Children’s Fund (n.d.), p. 5.

²⁰⁶ Oral evidence: Judith Webb, 8 March 2006.

²⁰⁷ Oral evidence: Rob Swain, 13 March 2006.

222. Neil West, Chief Executive of Canterbury's Active Life Leisure Trust, told the Committee that since the City's leisure centres had been transferred from the Council, one of their key objectives had been to increase the adult exercise referral programme by 20% per year – and they had exceeded this target. In the past year, 250 people per week were attending on a referral basis. Patients were referred by GPs, physiotherapists and nurses for a 26-week programme of exercise. Referral was primarily for rehabilitation following strokes and heart attacks. Active Life Leisure Trust only had one member of staff responsible for that programme, namely their Exercise Referral Manager, although they did have trained instructors who had part-time input into the programme. They were finding that they had too many people to cope with on the programme. There were two extremes among the patients: many dropped out during the scheme – but also they had a lot of clients who did not want to leave at the end of the scheme. The scheme was partly funded by the East Kent Health Promotion Service.

223. Mr. West explained that they had an initiative with Whitstable Community College where school nurses referred obese children and that it was now planned to develop this into a wider scheme.²⁰⁸ The Committee heard more about this from Janine Marsh of Canterbury City Council. The plan was to develop an under-16s GP referral scheme that would build on the successful adult GP referral scheme. The under-16s referral scheme would rely on school nurses and GPs referring obese or near-obese children to a general activity programme run by Active Life Leisure Trust Ltd. The activity programme would consist of gentle exercise and would run for seven to eight weeks. This programme would be carried out in leisure centres, to take the young people away from the school setting, and would take place out of school hours. It was hoped that it would also have the added advantage of encouraging the use of sports centres. Ms. Marsh stated that a problem with the planned scheme was the lack of school nurses – there were currently too few to get round to all the schools in the area.²⁰⁹

²⁰⁸ Oral evidence: Neil West, 27 March 2006.

²⁰⁹ Oral evidence: Janine Marsh, 27 March 2006.

224. Other examples of exercise on referral schemes are to be found in Ashford,²¹⁰ Tunbridge Wells²¹¹ and Edenbridge.²¹²

Recommendation 7

All Primary Care Trusts should encourage GPs to prescribe exercise to patients where appropriate. This prescribing should include referral to sports and leisure centres with staff trained to provide specialist services tailored to individuals' clinical needs.

225. The Joint Select Committee also heard evidence from representatives of Slimming World, a commercial organisation that had developed a "Slimming on Referral" programme in partnership with some PCTs. This involved GPs referring patients on to Slimming World groups, whose services were commissioned by the PCT.²¹³

²¹⁰ Written evidence: Angela Hinkley, 13 January 2006.

²¹¹ Oral evidence: Robert Hardy, 8 February 2006.

²¹² Written evidence: Adam Perry, 12 January 2006.

²¹³ Oral evidence: Dr. Jacquie Lavin, S Bartlett and J Jackson, 22 February 2006.

Chapter 4: Strategic leadership

4.1 The NHS

226. The NHS in Kent and Medway obviously has a vital role to play in the fight against obesity, not only by providing appropriate management for overweight and obese patients (assisting weight-loss within primary care and through referral to specialist services), but also in developing preventive strategies through the promotion of healthy lifestyles. The NHS Modernisation Agency, in partnership with the NHS Alliance has produced guidance for PCTs on *Commissioning Obesity Services*, including preventive services, which emphasises the importance of partnership working and the production of local supporting strategies.²¹⁴
227. The Joint Select Committee heard encouraging evidence that PCTs in Kent are developing obesity strategies. There are issues regarding commonality between the obesity strategies, with some variation in the approaches taken in compiling strategies (as well as working to different timetables). However, in East Kent three PCTs have developed common obesity strategies (albeit with different action plans), while all four East Kent PCTs are collaborating through the East Kent Health Promotion Service (which is funded by all the PCTs and managed by East Kent Coastal PCT). The reconfiguration of the nine Kent and Medway PCTs into three (East Kent, West Kent and Medway) from 1 October 2006 will provide an opportunity to address issues around commonality of strategy and approach.²¹⁵
228. Evidence was also presented to the Committee of partnership working at the strategic level between PCTs, local authorities and other bodies. For instance, Dr. Meradin Peachey, Director of Public Health for Dartford, Gravesham and Swanley PCT, explained to the Committee that, while her post was wholly funded by the NHS, appointment to the post was made jointly by the NHS and Gravesham Borough Council.²¹⁶ Also, a public health strategy has been agreed by the

²¹⁴ NHS Modernisation Agency and NHS Alliance (2005).

²¹⁵ "Work on Obesity", presentation by Jo Verrall (Team Manager, East Kent Health Promotion Service) to Obesity Sub-Committee of the Kent and Medway Public Health Network, 10 May 2006.

²¹⁶ Oral evidence: Dr. Meradin Peachey, 8 March 2006.

cabinets of Gravesham BC, Dartford BC, Sevenoaks DC and the Dartford, Gravesham and Swanley PCT, with one of its two targets for the first two years being to reduce childhood obesity.²¹⁷

229. The Kent Public Health Network includes an Obesity Sub-Committee, which works to identify priorities, bring together people from different obesity-related fields, generalise best practice and pull together all the strands in a joined-up approach.²¹⁸ The Sub-Committee appears to function well as a vehicle for networking and exchange of information between the PCTs and other stakeholders. However, the Committee felt that the Sub-Committee did not appear to be playing a leading role in developing a coherent obesity strategy across the county.
230. The Joint Select Committee is concerned at the lack of strategic leadership – and concerned that this agenda may actually go backwards with the reconfiguration of PCTs that is due to take place on 1 October 2006. The Committee felt that KCC itself had an important part to play in this regard.

4.2 KCC Department of Public Health

231. KCC is strongly aware of its role in fostering public health in Kent. The County Council takes seriously its ability to influence, by means of health-promotion, health-related choices that are made by people in the county. For instance, *Towards 2010* promises “a hard-hitting public health campaign targeted at young people to increase awareness and reduce the damaging effects of smoking, obesity, alcohol, drugs and early or unprotected sex”, as part of working towards the goal of “Improved health and quality of life” for the county’s population.²¹⁹
232. The Council is also aware of its role in influencing, as a service-provider the many “wider determinants of health” across the county (such as employment, education, housing and transport) – as detailed elsewhere in this report.

²¹⁷ Oral evidence: Lee Croxton, Andrea Webb and Patricia Jefford, 13 March 2006.

²¹⁸ Oral evidence: Claire Martin, 22 March 2006.

²¹⁹ KCC (2006b), p. 16.

233. KCC is now also moving to take a leading strategic role as regards public health in the county, through its recently established Public Health Department. This is led by Dr. Quentin Sandifer, a Consultant in Public Health, and was jointly set up by KCC and the former Kent and Medway SHA. The Department promotes the health of the population of Kent by:

- giving strategic leadership to the public health community;
- effectively co-ordinating and mobilising the resources of local councils and the NHS.²²⁰

234. The Department has recently issued an Annual Operating Plan, closely linked to the targets set in the Kent Agreement and other strategic documents, including the *Vision for Kent and Towards 2010*. The Department intends to formulate a full joint strategy with the NHS across Kent and Medway once the imminent reorganisation of the NHS has taken place and the arrangements for Public Health within the new PCTs have been clarified. The Strategy will seek to:

- promote knowledge management;
- develop strategies using the Social Marketing model [see paras. 333–44 below];
- formulate health impact assessments; and
- mainstream public-health interventions that are shown to be effective.

235. Specifically as regards obesity and physical activity, the Department of Public Health is developing plans to conduct demonstration projects (*i.e.* projects that will include systematic evaluation of effectiveness) in partnership with the National Social Marketing Centre, the Design Council RED Team (building on the ActivMobs pilot – see paras. 121–2 above) and Charlton Athletic FC’s “Positive Futures” project. In addition, a further demonstration project is planned, involving the development of an online Single Point of Entry Information System. This will allow members of the public to be referred by a primary care practitioner to a

²²⁰ Oral evidence: Dr. Quentin Sandifer and Charlie Manicom, 8 February 2006.

website containing comprehensive information about options for physical activity in their local area. A bid is being submitted to the Big Lottery Fund (formerly known as the New Opportunities Fund) for a substantial sum to underwrite this project.²²¹

4.3 Local Strategic Partnerships

236. The role of LSPs has already been noted (see para. 72 above). The 2004 *Choosing Health* White Paper stated as follows:

*The best Local Strategic Partnerships have been very effective in bringing about real improvement in the health of their communities by facilitating joined-up planning and delivery. Strong leadership through Local Strategic Partnerships, with direct involvement from PCT chief executives and other senior NHS representatives, is often the key to success in a joined-up approach to health improvement.*²²²

237. However, the Joint Select Committee found no evidence that LSPs, as currently constituted, were effective delivery mechanisms regarding the obesity agenda and other health issues. They lack the funding, resources, direction and structures of accountability necessary for this purpose.

238. The Committee received a written submission from an independent consultant, Fiona Gore, who had been working with LSPs on their involvement with the Kent Agreement. She stated that KCC, the former Kent and Medway SHA, and former PCTs had offered support to LSPs in dealing with the implications of the Kent Agreement. However, only four LSPs had shown an interest in this support; and just two had acted on it. Thanet LSP had, with support from the local PCT, considered the local implications of Outcome 16 of the Kent Agreement. And Swale LSP had addressed Outcome 16 through its Health and Well-being Sub-Group, seeking to identify strategic leads for local priorities.²²³

²²¹ Information supplied by Mark Lemon (Strategy Manager, KCC Public Health Department).

²²² DoH (2004b), paras. 24–5, pp. 83–4.

²²³ Written evidence: Peter Jolley, 10 February 2006; Fiona Gore, March 2006.

239. The Committee heard from many witnesses who were involved in very successful partnership work in which LSP involvement had apparently been entirely superfluous. John Britt (Public Health Manager for Gravesham Borough Council), for instance, told the Committee he did not feel the Kent Thameside LSP had been a supportive vehicle in delivering the agenda towards which he had been working on obesity.²²⁴
240. The Committee did, though, note that the role of LSPs may be set to change. Between December 2005 and March 2006, the Office of the Deputy Prime Minister carried out a consultation (as part of the local:vision debate on the future of local government), around the document *Local Strategic Partnerships: Shaping their future*. This indicated that the government envisaged an expanded role for LSPs in future, with active involvement in delivering (Sustainable) Community Strategies through actually taking decisions and commissioning services.
241. The government has recently made clear its commitment to a continuing role for LSPs as “partnerships of partnerships”, bringing together the public, private, voluntary and community sectors to bring about seamlessly joined up delivery of public services. The forthcoming White Paper on local government, due to be published in autumn 2006, will apparently set out what the future role of LSPs is to be.²²⁵

Recommendation 8

In order for Local Strategic Partnerships to play their part in addressing obesity, and other public-health issues, the government must ensure they are properly funded and resourced for this purpose. Local Strategic Partnerships also need more direction and more structures of accountability.

²²⁴ Oral evidence: John Britt, 13 March 2006.

²²⁵ “Shaping the Future of Local Services”, Speech by Phil Woolas MP (Minister of State for Local Government) to the New Local Government Network Conference on Local Strategic Partnerships, 14 June 2006 – <http://www.dclg.gov.uk/index.asp?id=1500839>

Recommendation 9

The production by Kent County Council's Public Health Department of a detailed obesity strategy for the whole of Kent, in collaboration with partners and stakeholders, must take place as soon as possible following the reorganisation of the National Health Service in Kent and Medway.

Chapter 5: Healthier workplaces in Kent

5.1 The role of occupational health

242. Occupational health can be defined in its broadest sense as the promotion and maintenance by an employer of the physical and mental wellbeing of its staff – including the promotion and facilitation of healthy lifestyles.
243. The *Choosing Health* White Paper refers to the role of employers in promoting health within the workplace.²²⁶ The *Vision for Kent* states that it is a short-term priority for health and social care services in Kent to “Promote health through large employers and use employment, commissioning and other working practices to enhance healthy living and wellbeing”.²²⁷
244. The survey of members of the Kent Residents Panel that was commissioned by the Joint Select Committee found that 55% of employed respondents did not consider their employers were helping them to maintain good health and wellbeing. Thirty-eight per cent thought their employers were helping in this way – of whom 73% considered the initiatives sufficient and 20% did not.
245. The initiatives offered were reported as follows:
- health checks (43.3%)
 - healthy canteen menus (42.7%)
 - discounted gym membership (41.3%)
 - organised sport (16.7%)
 - others (22.0%) including:
 - wellbeing programmes (16%)
 - activities (16%)

²²⁶ DoH (2004b), paras. 20–7, pp. 164–6.

- weight loss programmes (10%)

246. Of those offered these initiatives, 72.6% reported that they participated and 27.4% that they did not. Of those that did not participate, 17% gave lack of time as their reason; 14% said that the location was inconvenient; and 14% that they made their own arrangements.²²⁸
247. The Joint Select Committee contacted a range of major employers across Kent to ask what, if any, measures they were taking to promote healthier lifestyles and combat obesity. A significant number did not respond and, of those that did respond, a number reported little activity in this regard. However, the Committee did receive information on a number of worthwhile initiatives, as detailed below.

5.2 Access to sport and exercise facilities

248. Providing free or subsidised gym membership as a staff benefit is an important way that an employer can help and encourage staff to take exercise.
249. The Committee heard from Richard Spoerry, the Kent Agreement Manager, that some employers had previously provided gym facilities or access to clubs, but they had had to reduce or discontinue this provision in recent years to cut their costs. Smaller employers and those no longer able to support their own provision might possibly be able to make use of school facilities through Extended Schools.
250. Elaine Mason, KCC's Staff Care Manager, told the Committee that the County Council itself had negotiated discounted membership of gym clubs for staff around the county through the "Value Plus" Staff Benefits Scheme.²²⁹
251. The Committee was advised in written evidence received from Shepherd Neame, an important employer in Faversham, that the firm offered corporate membership of a local sports facility and a local golf club, which gave reduced rates or free

²²⁷ Kent Partnership (2006), p. 26.

²²⁸ *Opinion* [KCC] no. 5, June 2006, pp. 9–10.

²²⁹ Oral evidence: Elaine Mason, 14 February 2006.

access. The company also supported many sports clubs and fund-raising events such as the *Kent Messenger* sponsored walk.²³⁰

252. The Kent Messenger Group, in written evidence to the Committee, stated that they had arranged a 20% staff discount for the leisure centre across the road from their premises, and that this attracted a lot of interest from staff.²³¹

253. Megger Ltd. reported that they provided corporate membership of the Dover Sports Centre for their staff – however, this had “a limited take-up”.²³²

5.3 Workplace-based physical activity

254. The Joint Select Committee heard evidence Dr. Linda Davies, Chairman of the Wellbeing Group in KCC’s Strategic Planning Directorate (since April 2006, the Environment and Regeneration Directorate) about the work of the Group. Dr. Davies said that:

- staff in the Directorate were encouraged to use the stairs rather than the lift;
- lunchtime walks had been set up;
- two netball teams had been established;
- parties had been held on a Team or Divisional basis that included team games, such as rounders;
- there was a well-supported “squash ladder”;
- lunchtime jogging had been organised;
- and a challenge had been set to walk the equivalent distance “from the North to the South Pole”, where 50 people were supplied with pedometers and encouraged to walk an average of 7,000 steps a day.

²³⁰ Written evidence: J B Neame, 23 March 2006

²³¹ Written evidence: Amanda Watts, 5 April 2006

²³² Written evidence: Stephen Drennan, 20 March 2006

255. Initiatives were usually free to the employee and low-cost to the employer. For example, lunchtime keep-fit sessions run in the cellar of Invicta House at County Hall were run by an employee for 12 to 15 colleagues. There was an issue with lack of facilities: Invicta House only had two showers; and there were no proper changing facilities. This did have an effect on whether people wanted to engage in exercise activities or cycle to work.²³³ The Directorate has apparently also run Nordic Walking events for staff at some of the Country Parks for which it is responsible.²³⁴
256. The Committee was also told by Ms. Mason that the KCC Staff Club had recently arranged pilot Salsa and fitness sessions at lunchtimes in Maidstone.²³⁵ Shepherd Neame stated that they had a company sports and social club that organised sporting activities, including cricket, football and golf tournaments.²³⁶ Saga reported that they held on-site fitness classes for staff.²³⁷

5.4 Travel to work

257. LTP2 includes data showing that 75.7% of all work-related journeys in Kent are made by car, while public transport accounts for 6.8% and bicycle journeys account for just 2.4%. However, 12.7% of work-related journeys in the county are made on foot – involving some 63,952 people (11.3% of the workforce).²³⁸
258. LTP2 highlights the importance of Workplace Travel Plans, as part of the Smarter Choices element of Kent's Integrated Transport Programme, under the Local Transport Plan. These “could cover a single site or a cluster of businesses, for example on a business park”. LTP2 commits KCC to leading by example, “by establishing travel plans at 19 KCC offices with more than 100 staff”, as well as

²³³ Oral evidence: Dr. Linda Davies, 14 February 2006.

²³⁴ Information supplied by Flavio Walker (Health and Safety Manager, KCC Environment and Regeneration Directorate).

²³⁵ Oral evidence: Elaine Mason, 14 February 2006.

²³⁶ Written evidence: J B Neame, 23 March 2006

²³⁷ Written evidence: Natalie Cale, 6 April 2006

²³⁸ KCC (2006c), paras. 2.10–1

“actively promot[ing] workplace travel plans to 146 companies with more than 500 staff (Phase 1) and 325 companies with more than 200 staff (Phase 2)”.²³⁹

259. The Select Committee heard from Robert Hardy, Assistant Director of KCC’s Strategic Planning Directorate (since April 2006, the Environment and Regeneration Directorate) about the application of Travel Plans to large workplaces.²⁴⁰ He pointed out that “Investors in People” included a Green Travel Plan amongst its criteria for accreditation of employers. He said that Green Travel Plans were often easier for private sector employers, rather than local authorities, to run. Such plans were monitored annually by an independent company. One major employer in Kent, Pfizer, was a recognised leader in the field of Workplace Travel Plans. As part of their plan, Pfizer offered bicycle loans, to encourage staff to cycle to work.²⁴¹
260. KCC itself has a well-established travel plan for County Hall in Maidstone.²⁴² The Committee heard from Ms. Mason that KCC was developing its own “Cycle2work for less” scheme, to allow staff to purchase bikes for travel to work at a discounted rate.
261. Written evidence received from Shepherd Neame reported that the company operated a cycle-to-work programme, whereby a bicycle was provided for employees who preferred to cycle to work – and more than 40 employees have taken advantage of this.²⁴³
262. The Committee did hear in evidence from Mr. Spoerry that some employers’ sites did not lend themselves to access by bicycle (or public transport).²⁴⁴

²³⁹ *Ibid.*, para. 6.41.

²⁴⁰ Oral evidence: Robert Hardy, 8 February 2006.

²⁴¹ For more information on Pfizer, see here: <http://www.theclimategroup.org/index.php?pid=720>

²⁴² Written evidence: David Joyner, 6 February 2006.

²⁴³ Written evidence: J B Neame, 23 March 2006.

²⁴⁴ Oral evidence: Richard Spoerry, 14 February 2006.

5.5 Staff catering

263. The Committee heard from Ms. Mason that YES Dining, the catering contractor responsible for running the Crown Restaurant at County Hall, were ensuring that they provided healthy eating options such as fruit, yoghurt and semi-skimmed milk.²⁴⁵
264. Shepherd Neame²⁴⁶ and Saga²⁴⁷ likewise reported that their staff canteens offered a range of healthy options. The Kent Messenger Group reported that the menu options provided by the contractor operating their staff canteen had become healthier recently, in response to requests from staff.²⁴⁸ Megger Ltd. stated that the salads on their canteen menu were “very popular (as are curries and anything with chips)”.²⁴⁹

5.6 Workplace-based health-screening and advice

265. The Committee heard evidence from Elaine Mason and Jeremy Smith (KCC’s Occupational Health Manager) about the “Work and Wellbeing” initiative, which formed part of KCC’s Strategy for Staff. The initiative involved personal Wellbeing Health Checks (including advice on diet and exercise) being offered free to all (non-schools) staff (over a three-year period, in the first instance). To date, 5,000 KCC staff had attended Health Checks. Management information was received on an annual basis from the Health Checks – and the latest report had indicated that KCC staff were 50% below the national average in relation to exercise, with no variation across age groups. There was anecdotal evidence that, in some cases, issues had been picked up at the health check that could be dealt with at an early stage before they had developed into serious conditions that would have led to sickness absence. (These checks are conducted by Health Sure UK, a specialist provider of occupational health services.)²⁵⁰ In addition, various means were used

²⁴⁵ Oral evidence: Elaine Mason, 14 February 2006.

²⁴⁶ Written evidence: J B Neame, 23 March 2006.

²⁴⁷ Written evidence: Natalie Cale, 6 April 2006.

²⁴⁸ Written evidence: Amanda Watts, 5 April 2006.

²⁴⁹ Written evidence: Stephen Drennan, 20 March 2006.

²⁵⁰ <http://www.healthsureuk.com>

to get across to staff information and advice on health and wellbeing, including in relation to diet and exercise.²⁵¹

266. The Committee heard evidence from Paul Smith, Head of the Health Faculty at Kent Police, about the Police Authority's "Healthy Eating and Fitness" promotion. This was an occupational-health initiative in 2005, with the aim of reducing absenteeism by promoting healthy lifestyles among Kent Police's 3,000 officers and 3,200 civilian staff. It was organised in partnership with the British Dietetic Association (BDA) as part of their "W8 Wise @ Work" campaign. A dietician was involved in implementing diet-based workplace initiatives. Other partners, who were involved through the BDA, were Kellogg's and Slimming World.

267. The total cost of the initiative was £13,000, including the dietician's services. It was felt there was a good justification for this expenditure if it helped achieve the Authority's Positive Attendance Management programme target of reducing absence by 25% – which would represent a saving of £82,000.²⁵²

268. Shepherd Neame also reported that they provided an occupational health service for staff, with a professional input.²⁵³ Saga informed the Committee that they provided free medicals for staff, as well as Well Man / Well Woman health-screening and wellbeing workshops. Also, they held an annual Health Week, with exhibitors including Weight Watchers and a local gym.²⁵⁴

5.7 The business case for healthier workplaces

269. It is now widely accepted that there is a compelling business case for occupational health. This case has been clearly set out by the Faculty of Public Health and the Faculty of Occupational Medicine.²⁵⁵

²⁵¹ Oral evidence: Elaine Mason and Jeremy Smith, 14 February 2006.

²⁵² Oral evidence: Paul Smith, 22 February 2006. See also: Kent Police Authority, *Delivering the Vision*, p. 58;

<http://www.personneltoday.com/Articles/Article.aspx?liArticleID=29725&PrinterFriendly=true>

²⁵³ Written evidence: J B Neame, 23 March 2006.

²⁵⁴ Written evidence: Natalie Cale, 6 April 2006.

²⁵⁵ FPH / FOM (2006).

270. The Committee heard from Elaine Mason and Jeremy Smith that there were national statistics to show that workplace health-improvement directly impacted on a reduction in sickness absence. The Society of Chief Personnel Officers Awards this year highlighted wellbeing and demonstrated that looking after staff's health increased business productivity. There were national statistics to show the benefits of corporate fitness and health programmes, with these leading to five days per year less sickness absence per employee. It was essential to develop a response to long-term sickness by dealing with stress and mental-health issues – and exercise and diet could have an impact on this.²⁵⁶

5.8 Setting an example

271. *Choosing Health* states that “corporate social responsibility” in this regard particularly applies to “local government, local NHS and community organisations”, which must operate as “organisations promoting health both as employers and as producers”.²⁵⁷

272. The Committee found little evidence of the NHS locally taking steps in this direction, despite the clear indication in *Choosing Health* that the NHS has a responsibility to promote health not just as a service-provider but also as an employer (and a major one, at that).

273. As regards KCC itself, the County Council is the largest employer in Kent – including school-staff and temporary workers, the authority employs around 44,000 staff. As such, the County Council has a particular opportunity to set an example as a responsible employer, promoting healthy lifestyles amongst its own workforce. As indicated above, KCC has accepted that there is a sound business case for taking this approach and some steps in this direction have already been taken.

274. The Joint Select Committee was particularly impressed with the role played by the Wellbeing Group in KCC's Strategic Planning Directorate (since April 2006, the Environment and Regeneration Directorate). The Committee heard from Dr. Linda

²⁵⁶ Oral evidence: Elaine Mason and Jeremy Smith, 14 February 2006.

²⁵⁷ DoH (2004b), para. 4, p. 78.

Davies, Chairman of the Group, about its work. She explained it consisted of a small number of representatives from all of the divisions of the Directorate. They met six times a year to see what they could do within the Directorate to support people with stress and to alleviate stress by making the workplace more pleasant. Their aim was to provide the opportunity for staff to engage socially and to encourage them to undertake healthy lifestyles.

275. However, it seems that other Directorates within KCC are lagging behind in this regard. Whilst there is a Corporate Wellbeing Group for KCC as a whole, no other Directorate has its own Wellbeing Group.

Recommendation 10

- Kent County Council should seek to set an example of good practice in encouraging and facilitating healthy lifestyles among its workforce.
- The innovative work of the Environment and Regeneration Directorate in this regard should be copied by all KCC Directorates.
- A business case setting out the benefits for employers of this approach should be developed by KCC and shared with other employers in Kent.

Chapter 6: Obstacles to physical activity

6.1 The general population

276. The 2001 Kent and Medway Health and Lifestyles Survey found that reasons given for not taking exercise included the following:

- *lack of leisure time – this was important for men of working age*
- *illness or disability – this was the most common reason given by people aged over 75*
- *lack of incentive – this was important for men aged 45-64 and for women aged 25-44*
- *lack of money*
- *lack of interesting activities*
- *lack of facilities at work and in the community*
- *lack of transport, primarily for people under 25 and those aged 75 and over²⁵⁸*

277. As part of its research, the Joint Select Committee placed a feature in KCC's *Around Kent* magazine, asking members of the public to get in touch, detailing the factors that were obstacles to them getting more physically active; free pedometers were offered as an incentive. A total of 57 individuals responded (mostly members of the public). The following key obstacles to activity emerged from their responses:

- Lack of money (for membership of gyms, sports clubs, dance classes, etc.)
- Lack of time (due to work / commuting and family commitments)
- Need for motivation and incentives

- Lack of suitable facilities
- Lack of childcare
- Lack of information about facilities, places to go walking, *etc.* (compounded by lack of access to the Internet)
- Concerns about personal safety (especially in urban areas)
- Lack of a group with which to walk / exercise
- Concerns about the quality of the environment walking in urban areas (traffic-pollution, graffiti, litter, poorly-maintained pavements)
- Poor maintenance of footpaths
- Lack of women-only sessions at gyms

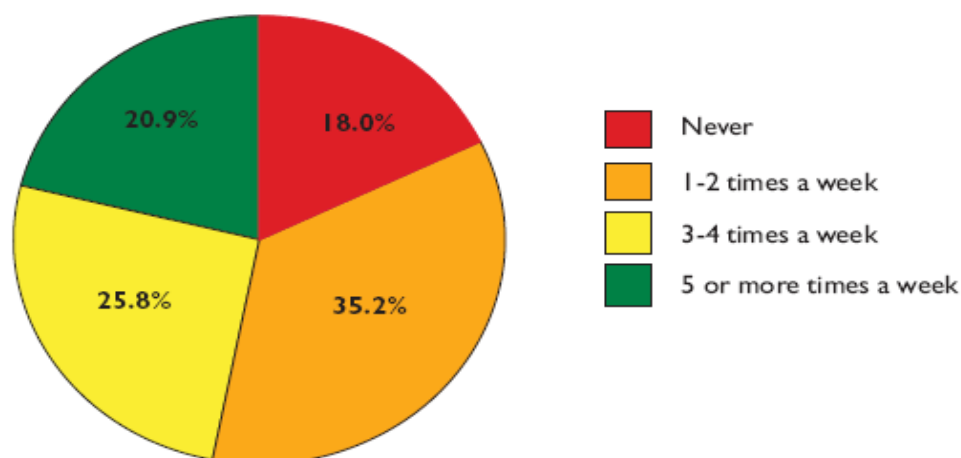
278. The survey of members of the Kent Residents Panel commissioned by the Joint Select Committee found that 79.1% of respondents were not taking 30 minutes of moderately intensive physical exercise the extent recommended by the government, *i.e.* five or more times per week.²⁵⁹ Eighteen per cent of respondents did not take this amount and type of exercise on any occasion in an average week.

²⁵⁸ Palmer (2003), p. 16.

²⁵⁹ A previous Residents Panel survey, in Summer 2004, found 60% of respondents were not active at the level recommended by the government.

Figure 4

Q1 How often do you take part in 30 minutes of moderately intensive physical activity in an average week?



279. A large proportion of respondents (51%) wished to get more physically active. Whilst this group could have included some of those already active to the optimum level, it must have included a significant proportion of those who were insufficiently active. At the same time, a hard core of 8.5% of respondents were not interested in physical activity. Of these, 67% said there was nothing that would encourage them to become active. Others thought they might be encouraged by free or cheaper facilities (11%), better health (8%), more time (6%), more encouragement (6%), and different locations or opening hours for facilities (4%) – the remainder (8%) identified activities that might appeal to them as individuals.

280. Among those who wished to be more physically active, the main obstacles cited were:

- time (53.7%)
- cost (31.7%)
- location of facilities (16.6%)
- lack of available facilities (16.1%)

- childcare arrangements (6.9%)
- others (35.5%) – including:
 - health / disability (47%)
 - laziness / lack of willpower or motivation (17%)
 - age (10%)
 - work (6%)
 - weather (6%)
 - others (19%)

281. Asked about preferred sources of information on physical activity, Panel members responded as follows:

- local newspapers (83.8%)
- GP surgeries (69%)
- leisure centres (49.7%)
- local radio (48.7%)
- council websites (43.6%)
- community centres (42.0%)
- digital television (26.8%)
- specific website (25.4%)
- others (25.4%) – libraries, Parish and village noticeboards, *etc.*

282. Asked about locations for the display of information on healthy lifestyles, respondents replied similarly.²⁶⁰
283. It should be readily apparent that most, if not all, of these perceived obstacles can be (and often are being) addressed by the measures detailed in Chapter 3 above.

6.2 Black and minority ethnic groups

284. As already noted, some black and minority ethnic groups can be more prone to obesity (see para. 20 above) and / or less likely to be physically active than the population as a whole (see para. 42 above). This is likely to be down to a range of genetic, socio-economic and cultural reasons. In addressing the problem of obesity, these issues need to be taken into account in a culturally sensitive and appropriate manner.
285. Jenne Dixit, Black and Minority Ethnic Equality Adviser for Diabetes UK, provided the Joint Select Committee with valuable written evidence in this regard.²⁶¹ She explained that some minority ethnic communities were socially excluded, living in poor conditions, with poor health. She also explained that, in some minority ethnic cultures, being overweight was seen as a sign of prosperity and success, or was associated with beauty. In some cultures the notion of undertaking an activity for the purpose of taking exercise was unknown (apparently in some languages there was no word for “exercise”).
286. Ms. Dixit said that women from some minority ethnic groups did not want to attend leisure centres for cultural reasons. However, women from these communities could be encouraged to undertake other forms of exercise; and it could be explained that attending a leisure centre need not mean wearing clothes that were culturally unacceptable. Women from some minority ethnic groups did not want to out of the house exercising on their own, for cultural reasons – but they could be encouraged to take walks with family, friends and neighbours (“Walks in the Park” had been successful in some areas).

²⁶⁰ *Opinion* [KCC] no. 5, June 2006, *passim*.

²⁶¹ Written evidence: Jenne Dixit, 4 April 2006

287. In other evidence, the Committee heard of initiatives in Gravesham, which has a very significant minority ethnic population (10.9% of the Borough's population).²⁶² These provided positive examples of how the promotion of healthy lifestyles can be undertaken in a way that meets the needs of a diverse community. The Committee noted that Gravesham Borough Council had been awarded Beacon Status in 2005 for its work in Promoting Racial Equality.²⁶³
288. Heather Robinson and Kim Broster, of Gravesham Sure Start, told the Committee that minority ethnic groups in the area displayed specific health problems. They had observed that children from an Asian background actually seemed to have more of a problem with malnourishment and anaemia than with obesity. Health visitors would address these issues by exploring a child's diet with his or her parents.²⁶⁴
289. The Committee heard from Gravesham Borough Council that, through the local Gurdwara (Sikh temple), it had been possible to engage successfully with both men and women from the Sikh community to promote public-health messages about diet and exercise. Among the Muslim community, it had been possible, by arranging a visit to a leisure centre, to allay concerns among Muslim women that attending such a place might not be appropriate to their culture. Having been given this opportunity, a number of Muslim women then continued to attend the women-only exercise classes provided at the centre.²⁶⁵
290. The Joint Select Committee learned from Judith Webb, Head of Nutrition and Dietetic Services at Darent Valley Hospital (Dartford and Gravesham Acute NHS Trust), that, in respect of the DSGF programme in Dartford and Gravesham, 18% of take-up was from minority ethnic groups.²⁶⁶ This figure represents a higher level of ethnic-minority representation than is present in the local population.
291. The Committee also heard from John Britt (Public Health Manager for Gravesham Borough Council) that, in minority ethnic communities, food and nutrition were

²⁶² <http://www.gravesham.gov.uk/index.cfm?articleid=2287>

²⁶³ <http://www.gravesham.gov.uk/index.cfm?articleid=2023>

²⁶⁴ Oral evidence: Heather Robinson and Kim Broster, 8 March 2006.

²⁶⁵ Oral evidence: Lee Croxton, Andrea Webb and Patricia Jefford, 13 March 2006.

closely linked to culture. Consequently, he said, it was necessary to work in culturally appropriate ways – which meant working with the appropriate “opinion formers”, which, in this case, meant those women who influence household practices.²⁶⁷

6.3 People with mental-health issues

292. As indicated already, there are connections between mental-health issues and obesity. Conditions such as depression may be risk-factors for obesity; and weight-gain is a very common side-effect of medications prescribed to people with mental-health issues (see para. 10 above). Conversely, obesity is regarded as having the potential to bring about adverse social and psychological consequences (see para. 26 above). At the same time, regular physical activity is perceived to benefit mental health.²⁶⁸ (Attempts have also been made to link mental health to diet, but the evidence for this seems far from conclusive.)²⁶⁹

293. Janine Marsh referred in her evidence to work that Charlton Athletic FC had done in partnership with the East Kent Health Promotion Service. Mental-health groups had put forward five-a-side football teams to play against the visiting Charlton Athletic team on a “turn-up-and-play” basis; and this had proved to be a very successful initiative.²⁷⁰

6.4 People with disabilities

294. There is some evidence showing that people with disabilities (both physical and intellectual) have a higher risk of obesity than the general population; and that people with disabilities are likely to be less active and less involved in sport than the general population. Whilst there is a lack of research in this area, the available evidence does indicate (according to a memorandum submitted to the Joint

²⁶⁶ Oral evidence: Judith Webb, 8 March 2006.

²⁶⁷ Oral evidence: John Britt, 13 March 2006.

²⁶⁸ <http://www.fitness.gov/mentalhealth.htm>

²⁶⁹ “Mental health link to diet change”, BBC News online, 16 January 2006 – <http://news.bbc.co.uk/1/hi/health/4610070.stm>

²⁷⁰ Oral evidence: Janine Marsh, 27 March 2006.

Select Committee) that “given the right treatment disabled adults can lose weight as effectively as non-disabled groups”.²⁷¹

295. Kent has a Disability Sports Strategy, which aims “to provide a framework of recommendations to develop, expand and establish sporting and recreational opportunities to all disabled people, of whatever age, across Kent, within a four year time scale”.²⁷²
296. Mike Bishop, the Sports Development Manager for Disabled People at the Kent Sports Development Unit, told the Committee about the work that he did to try and overcome barriers to participation in physical activity among people with disabilities.
297. Mr. Bishop said that in Kent and Medway there were two public fitness centres accredited for use by disabled people – at Folkestone and Strood. The Folkestone centre had 29% usage by disabled people. This success was partly down to Shepway District having a dedicated Disability Sports Officer.
298. Another initiative that had been tried was district-based multi-sports clubs, which existed in five districts. The club in Thanet had approximately 300 disabled people as members and some 80–100 disabled young people were able to access a range of sporting facilities through the club in the evenings.
299. Mr. Bishop also referred to the Kent Outdoor Pursuits Disability Project, which focused on trying to develop new opportunities for disabled people in specific sports, including archery, climbing and horse-riding. The project was currently working with 350 people with disabilities. There were also disabled cycling clubs on the coast which could be used by the family and friends of disabled people.

²⁷¹ Rachel Brignall, “Obesity Amongst Disabled People” (memorandum submitted to the Joint Select Committee, March 2006), p. 6. Data from the 2005 Kent and Medway Health and Lifestyles Survey indicate that people with a long-standing illness or disability are more likely to be obese – Information supplied by Dr. Ann Palmer (Centre for Health Service Studies, University of Kent).

²⁷² KCC (n.d.), p. 6.

300. A Kent-based Research Project, “By All Means”, was working with the Countryside Agency to overcome barriers to disabled people enjoying the amenities offered by the countryside.
301. In June 2006 the Kent Disability Youth Games had taken place, involving six competitive and two demonstrative sports and bringing together 350 young people with disabilities from 25 schools.
302. Mr. Bishop stated that much of his work had been focused on special schools, which did long-term sustainable work in relation to physical activity among children with disabilities. However, the Sports Development Unit was now starting to work with those children with disabilities who were in mainstream schools. There was a concern that these children were not being properly involved in school sport.
303. The Committee also heard from Chris Hespe, KCC’s Head of Leisure Services, that the Sports Development Unit manages the County Disability Swimming squads.²⁷³
304. Written evidence received by the Committee from the Avenues Trust, a charity providing services for people with disabilities, reported that, through its Health Action Plan, the trust was trying to promote active lifestyles. One successful measure taken had been the establishment of a football club for service users, Avenues Albion FC.²⁷⁴
305. The Committee received written evidence from Royal British Legion Industries Ltd. at Aylesford, whose workforce includes a number of people with disabilities. As well as providing an occupational-health facility, free of charge, and reductions in gym-membership fees, the company was looking at how it could provide health advice and guidance in formats that would be appropriate for all staff.²⁷⁵

²⁷³ Oral evidence: Chris Hespe, 8 February 2006.

²⁷⁴ Written evidence: Jayne Kilgallen, 31 March 2006.

²⁷⁵ Written evidence: David Jessop, 20 March 2006.

Recommendation 11

All sports and leisure centres should seek to remove perceived barriers to using their services (relating to age, gender, ethnicity, disability, *etc.*), so that they can serve all groups in the community.

Chapter 7: Funding sources

7.1 Choosing Health allocations

306. PCT allocations for 2006–7 include identified funding for delivering objectives set in the 2004 *Choosing Health* White Paper. This funding includes support for "Capacity Expansion" – identified as 14.25% of *Choosing Health* allocations. The Committee heard that an estimated 9% of PCT *Choosing Health* allocations for 2006–7 would be specifically allocated to obesity.²⁷⁶

307. This table shows an indicative amount for *Choosing Health* allocations for 2006–7 in respect of PCTs in the former Kent and Medway SHA area (totalling £4,566,000):

Table 13

	Ashford	Canterbury and Coastal	Dartford, Gravesham & Swanley	East Kent Coastal	Maidstone Weald	Medway	Shepway	South West Kent	Swale
<i>Choosing Health</i> allocation (£000s)	232	387	711	611	698	834	248	519	326
<i>CH</i> allocation as a percentage of all Kent & Medway PCTs' <i>CH</i> allocations	5.1	8.5	15.6	13.4	15.3	18.3	5.4	11.4	7.1
<i>CH</i> allocation as a percentage of PCT's recurrent resource increase	2.3	2.3	3.1	2.2	3.1	2.7	2.2	3.3	2.1

²⁷⁶ Oral evidence: Dr. Quentin Sandifer and Charlie Manicom, 8 February 2006.

308. Three of the former PCTs in Kent and Medway (Maidstone Weald, Medway and South West Kent) apparently received additional sums of £25,000 in 2005–6 to fund their role as “early adopters” of the Health Trainers programme. (This is an initiative, arising from *Choosing Health*, in which people are recruited from within local communities to help individuals adopt healthier lifestyles through setting personal targets.)²⁷⁷ However, it seems that little, if anything, has actually been done in this regard so far.
309. Evidence received by the Joint Select Committee from a number of sources clearly indicated that *Choosing Health* allocations had been appropriated for other purposes in a number of PCTs in Kent, due to financial problems.²⁷⁸ The Committee was disturbed to discover that this money was not ring-fenced. In the current climate of shortfalls and financial instability within the NHS, these funds are almost certain to be used for purposes other than those for which they are intended.
310. Both the Chief Medical Officer²⁷⁹ and the Association of Directors of Public Health²⁸⁰ have made reference to this issue. It was also touched on in the recent view by the National Social Marketing Centre (NSMC) regarding the implementation of a National Social Marketing Strategy for Health (see Section 8.1 below). The review concluded that the DoH should “Ensure PCT funding for health promotion is ring-fenced or subject to separate reporting via local directors of public health”.²⁸¹

²⁷⁷ DoH (2004b), paras. 9–27, pp. 106–12;

<http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060503/text/60503w38.htm> ;

Oral evidence: Helen Flint and Malti Varshney, 22 February 2006;

http://www.kentandmedway.nhs.uk/pdf/structure_and_organisations/Board_papers/SW_kent_PCT/New_december/6_12_fin_sw.pdf

²⁷⁸ Oral evidence: Dr. Meradin Peachey, 8 March 2006; John Britt, 13 March 2006; Lee Croxton, Andrea Webb and Patricia Jefford, 13 March 2006; Claire Martin, 22 March 2006; Dr. Jonathan Sexton, 27 March 2006.

²⁷⁹ “Chief medical officer defends NHS”, BBC News Online, 20 July 2006 –

<http://news.bbc.co.uk/1/hi/health/5201684.stm>

²⁸⁰ “Public health plans ‘in disarray’”, BBC News Online, 12 September 2006 –

<http://news.bbc.co.uk/1/hi/health/5335576.stm>

²⁸¹ NSMC (2006), p. 27.

Recommendation 12

- The money allocated to Primary Care Trusts to fulfil *Choosing Health* objectives should be ring-fenced by the Department of Health
- Kent County Council's NHS Overview and Scrutiny Committee should receive a breakdown of how this money has been spent each year by the PCTs in Kent.

7.2 Section 64 funding

311. Under Section 64 of the Health Services and Public Health Act 1968, the Secretary of State for Health has the power to make grants to voluntary organisations in England whose activities support the DoH's policy priorities. This is done through the Section 64 General Scheme of Grants, which is the DoH's main funding stream for voluntary organisations in the health and social-care sectors. The scheme allots an average of £47,000 to over 300 organisations – a total of £17.2m for projects that promote health and wellbeing.²⁸²

7.3 Section 106 funding

312. As mentioned above (at para. 87), Section 106 of the Town and Country Planning Act 1990 gives LOCAL planning authorities powers in respect of developers that can be used to facilitate healthy lifestyles. The Act allows for the drafting of agreements between a local planning authority and a developer. These agreements impose certain legally-binding planning obligations on the developer, relating to the securing of community infrastructure to meet the needs of residents in new developments and / or to mitigate the impact of new developments upon existing community facilities. Through this means, funding can be secured from developers for the provision of footpaths, cycleways, public open spaces and

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http://www.dh.gov.uk/PublicationsAndStatistics/PressReleases/PressReleasesNotices/fs/en?CONTENT_ID=4135540&chk=HkAz6J

other amenities that contribute to making new developments conducive to healthier lifestyles.²⁸³

7.4 KCC Member Grants

313. As mentioned above (at para. 184), all KCC Members have Member Grants of £10,000, which they can use (subject to agreement from Local Boards) to fund projects relating to the promotion of a healthy diet and physical activity. The Joint Select Committee takes the view that this money might best be used for projects promoting healthy lifestyles if a number of Members in a given area were to pool their Grants, thereby allowing them to be spent on more substantial projects.

7.5 European Union funding

314. The European Union provides funding for a number of projects relevant to obesity, including the “Produced in Kent” Consortium.²⁸⁴

315. However, the Joint Select Committee heard from Colin Maclean, KCC’s Head of External Funding, that future funding potential from the EU was not likely to be high, as the next wave of EU funding would probably not be coming to Britain (or at least not to areas such as Kent).²⁸⁵

316. Funding might be available through the EU’s Interreg IV programme (due to run during 2007–13); but this would require a cross-border (*i.e.* cross-channel) partnership element. A two-year (2005–7) cross-channel healthy schools and communities project is currently running between partners in Kent and the Pas-de-Calais in France. The scheme, entitled Bien-être (“Wellbeing”), is an Interreg IIIa project, with partners including East Kent Coastal Teaching PCT, KCC and schools in the Dover Cluster.²⁸⁶

317. The Government Office for the South East has announced a programme funded by the European Social Fund, “On Your Marks”. This will focus on opening up

²⁸³ http://www.opsi.gov.uk/acts/acts1990/Ukpga_19900008_en_5.htm

²⁸⁴ <http://www.producedinkent.co.uk/>

²⁸⁵ Oral evidence: Colin Maclean, 8 February 2006.

²⁸⁶ <http://www.kent.ac.uk/news/stories/article2006.php?id=bienetregillianvass.txt>

employment, skill development and life long learning opportunities principally within the construction, logistics, and sport and leisure industries, to enable successful delivery of the 2012 Olympics.²⁸⁷

7.6 The National Lottery

318. The Big Lottery Fund (BLF – formerly known as the New Opportunities Fund) programmes covering the period 2006–9 have four outcomes, one of which is to “create healthier and more active people and communities”. One programme is entitled “Well-being (Healthy Lifestyles Initiative)” and has a budget of up to £165 million. The Initiative, which was launched in March 2006, aims to:

- increase participation in physical activity including active travel;
- educate and promote healthy eating within communities;
- develop early intervention approaches to common mental health problems.

The deadline for initial submissions was in July 2006, and the South East Public Health Group has submitted a bid on behalf of interested parties in the region.²⁸⁸

319. Other BLF programmes that could link to the obesity agenda are:

- Children's Play (budget: up to £155 million);
- Community Learning (budget: up to £140 million);
- Environmental (budget: up to £354 million);
- Young People's Fund (budget: up to £100 million – in addition to the £157.5 million already available for the Young people's Fund in England).²⁸⁹

²⁸⁷ Written evidence: Colin Maclean, 8 February 2006;

http://www.lda.gov.uk/upload/pdf/On_Your_Marks_ESF_brochure.pdf

²⁸⁸ <http://www.sepho.org.uk/viewResource.aspx?id=10242>

²⁸⁹ Written evidence: Colin Maclean, 8 February 2006;

320. The Joint Select Committee heard evidence from Sonia Howe, Regional Policy Advisor for the BLF. She described in some detail the various strands of funding that her organisation provided, particularly with reference to the Well-being initiative. The Fund's budget amounted to some £600m–700m annually, of which 60–70% had to be disbursed to voluntary and community organisations. The Fund had spent some £12.5m in Kent on Healthy Living Centres (of which there were 10 in the county), Five-A-Day Coordinators (to promote the “Five-a-Day” campaign on eating fruit and vegetables) and projects under the New Opportunities for PE and Sport (NOPES) scheme. NOPES had spent some £6.6m on schools in Kent, and encouraged dual use of school sports facilities by the wider community outside school hours.²⁹⁰
321. The National Lottery also has an “Awards for All” programme, which gives small grants of between £300 and £10,000 for projects that promote education, the environment and health in local communities.²⁹¹
322. Sport England's Community Investment Programme is a National Lottery-funded programme designed to increase participation in sport and active recreation, in pursuit of goals including the widening of access, and improving health and wellbeing. The programme particularly focuses on areas of multiple deprivation and Sport England target groups – including women and girls, those aged over 45, young people, people with disabilities and members of black and minority ethnic groups. Grants are for sums over £5,000; and both revenue and capital funding are available.²⁹²

7.7 Other sources of funding

323. There is a wide range of other available sources of funding – particularly for sport. KCC's Sports Development Unit “levers funds into Kent sport from trusts, foundations, governing bodies of sport, Sport England, the European Union, the National Lottery and other funding agencies”. The Unit has an online database

<http://www.dsc.org.uk/charityexchange/blf0905.html>

²⁹⁰ Oral evidence: Sonia Howe, 8 February 2006; <http://www.biglotteryfund.org.uk>

²⁹¹ <http://www.awardsforall.org.uk>

²⁹² <http://www.sportengland.org/>

that contains information on more than 100 funding streams, both local and national, that can be accessed through the Sports Development Unit.²⁹³

324. Some district authorities make available grants to fund sport. Tonbridge and Malling Borough Council, for instance, offers grant awards for sports clubs and organisations (for purposes such as the purchase of equipment and the training of coaches) and sums for individuals under a “Sporting Excellence” grant scheme.²⁹⁴
325. The Joint Select Committee heard from Mr. Maclean about the Kent and Medway Funding Fair. He explained that this was held every February and allowed community groups to meet exhibitors from a range of funding providers. There was also a newsletter, “Inside Track”, providing details of current funding opportunities and a diary of deadlines for submitting funding bids.²⁹⁵
326. There is also a “Kent4Community” website, which community groups can use to search for government, Lottery, charitable and other sources of funding.²⁹⁶
327. District councils in Kent also have external funding officers, whose role is to help obtain funding for various community purposes. These officers work together as the Kent External Funding Officers Group.²⁹⁷
328. Neighbourhood funding from central government can be used flexibly to meet a range of community outcomes. The Neighbourhood Renewal Fund has provided £1.9 billion over the period 2001–6 to 88 of the most deprived local-authority areas in England to help improve public services in the most deprived neighbourhoods and narrow the gap with the rest of the country. While none of these areas is in Kent, there are two Neighbourhood Management schemes in the county (Hawkinge in Shepway and Margate in Thanet), for which funding is allocated to address issues relating to quality of life.²⁹⁸

²⁹³ <http://kentsport.org/funding.cfm>

²⁹⁴ <http://www.tmbc.gov.uk/cgi-bin/buildpage.pl?mysql=598>

²⁹⁵ Oral evidence: Colin Maclean, 8 February 2006.

²⁹⁶ <http://www.open4community.info/kent/Default.aspx>

²⁹⁷ Written evidence: Colin Maclean, 8 February 2006

²⁹⁸ Written evidence: Colin Maclean, 8 February 2006; <http://www.neighbourhood.gov.uk>

Chapter 8: Measuring success

8.1 Government policy

329. As noted above, the issue of measuring the success of anti-obesity initiatives has been considered in respect of projects in Dartford and Gravesham (para. 56 above), the ActivMobs pilot in Maidstone (para. 121 above) and Sure Start centres (paras. 112–3 above).
330. In recent years, judging the effectiveness of public-health interventions has become an issue of concern to the government. The second Wanless Report (2004) drew attention to both the inadequacy of data-collection regarding public health in the UK and “the weakness of the evidence base” regarding the effectiveness, and cost-effectiveness, of public-health interventions. The report noted that “Information is particularly scarce on which interventions can help reduce health inequalities due to, say, smoking or obesity, by differentially changing the behaviour of lower socio-economic groups.”
331. Nevertheless, the report went on, “the need for action is too pressing for the lack of a comprehensive evidence base to be used as an excuse for inertia. Instead, current public health policy and practice, which includes a multitude of promising initiatives, should be evaluated as a series of natural experiments.”²⁹⁹
332. The *Choosing Health* White Paper also indicated the need for public health / health promotion interventions to be evidence-based and cost-effective, while announcing a number of measures intended to make this possible.
333. *Choosing Health* referred to the need to acknowledge “the power of ‘social marketing’, marketing tools applied to social good”.³⁰⁰ At the same time, the White Paper gave commitments to implement a new public-health strategy and to “appoint an independent body to implement the strategy on its behalf”.³⁰¹

²⁹⁹ Wanless (2004), p. 107.

³⁰⁰ DoH (2004b), para. 10, p. 21.

³⁰¹ *Ibid.*, para. 13, p. 22.

334. These commitments led to joint work with the National Consumer Council (NCC) on health-related Social Marketing. This was defined by the DoH and NCC as “A systematic process using marketing techniques and approaches to achieve behavioural goals, relevant to improving health and well-being” – measured in terms of realising “specific, achievable and measurable behavioural goals”.³⁰² Subsequently, the National Social Marketing Centre (NSMC) was established by the DoH and the NCC, based at the NCC.

335. The NSMC has recently published a review (commissioned by the DoH), setting out recommendations for how the DoH could develop and implement a National Social Marketing Strategy for Health. The turn to Social Marketing was explained by reference to a realisation that “continuing with existing methods and approaches was not going to deliver the type of impact on key health-related behaviour that was needed”.³⁰³ The recommended strategy, it is stated, would:

- “Put people at the centre of policy thinking”;
- “Apply what works and stop what does not”; and
- involve partnership between the government, individuals, and the private and NGO (non-governmental organisation) sectors.³⁰⁴

336. As part of the review, the NSMC developed a series of Effectiveness Reviews on Social Marketing interventions, including those aimed at increasing physical activity and improving nutrition. The Effectiveness Review on physical activity interventions looked at the following types of intervention (including some interventions targeted at particular segments of the population, such as minority ethnic groups):

- Community interventions
- School-based interventions

³⁰² DoH / NCC (2005).

³⁰³ NSMC (2006), p. 7.

³⁰⁴ *Ibid.*, p. 5.

- Mass media-based intervention
- Interventions in other settings

337. The provisional conclusion of the Effectiveness Review was that:

although [an] increased level of physical activity can be difficult to achieve[,] interventions are successful at changing attitudes and perceptions towards physical activity and that perhaps continued or follow up interventions could build upon this to effect behavioural change.

338. While interventions “appear to have a more limited effect on physiological outcomes such as blood pressure, body mass index and cholesterol”, it was true that “these kinds of outcomes are arguably more difficult to influence, and changes are likely to take a much longer time to occur and be detected”. Furthermore, “physiological outcomes are influenced by other factors in addition to physical activity, including diet and smoking”.³⁰⁵ There appear to be issues regarding how much the studies concerned reveal about Social Marketing, given that the interventions studied also involved conventional health promotion techniques.

339. In Autumn 2006, a government Obesity Social Marketing Campaign is due to be launched, aimed at improving both diet and levels of physical activity; it will be delivered by the DoH with a wide range of partners, including the food and leisure industries.

340. The Joint Select Committee heard evidence from Clive Blair-Stevens, Deputy Director of the NSMC.³⁰⁶ He explained that control-based attempts to change the public’s behaviour were of only limited use. Fear and guilt had only short-term value as motivators and would need to be used alongside other ways of motivating people to change. Social Marketing sought to incentivise some behaviour and disincentivise other behaviour: the challenge was to make healthy

³⁰⁵ National Social Marketing Centre, "NSMC Report 1: A Review of the Effectiveness of Social Marketing Physical Activity Interventions" [Circulation Draft] (March 2006).

³⁰⁶ Oral evidence: Clive Blair-Stevens, 6 February 2006.

choices the most appealing options, while disincentivising other options without resorting to controlling tactics.

341. Social Marketing sought to base health promotion on the public's present behaviour and attitudes – starting from an understanding of the situation and concerns of the “customer”, rather than starting from the health promotion message. Each campaign had to be carefully tailored to the target audience.
342. Mr. Blair-Stevens said that Social Marketing involved exploiting the tricks already familiar to commercial companies. He thought that the public sector needed to engage more closely with the private sector in joint working, accepting that businesses such as fast-food companies had a good understanding of their target group.
343. Social Marketing involved setting definite goals for behaviour-change and having means of measuring progress towards those goals. There was a need to prioritise the finite resources of the NHS and this meant only continuing with campaigns if there was evidence of their effectiveness, as commercial companies did.
344. Evidence given to the Committee by Dr. Jonathan Sexton, Director of Public Health for Canterbury and Coastal PCT, appeared to indicate that enthusiasm for Social Marketing is not universal among public-health professionals. He told the Committee that Social Marketing was an idea that had “suddenly become fashionable” and he indicated a degree of scepticism about its effectiveness.³⁰⁷
345. It does seem that there are inherent problems in attempting to build a convincing evidence base for whole-population and group behaviour-change interventions. It is certainly possible to show changes in disease levels in a population over time, using epidemiological data sets (regularly produced by the Office for National Statistics). And it is possible to map changes in aspects of lifestyle that relate to illness and death in a population, through survey data (such as that provided by the Kent and Medway Health and Lifestyles Survey). However, it is less easy to show conclusively the role played by particular health-promotion interventions in bringing about changes in behaviour in large populations over time (and,

³⁰⁷ Oral evidence: Dr. Jonathan Sexton, 27 March 2006.

consequently, bringing about shifts in patterns of illness and health). The wider social determinants of health and illness are so multi-faceted and complex that they make the tracking of cause and effect extremely problematic.

346. It may, though, be less problematic to measure the effectiveness of individual interventions. Recent work by the National Institute for Health and Clinical Excellence (NICE), arising from commitments in *Choosing Health*, points to the possibility of fruitful research in this area.

8.2 NICE guidance

347. In March 2006, NICE issued physical-activity public-health intervention guidance, covering four common methods used to increase the population's physical activity levels.³⁰⁸

- brief interventions in primary care;
- exercise referral schemes;
- pedometers;
- community-based walking and cycling programmes.

348. NICE's Public Health Interventions Advisory Committee did find that "there is sufficient evidence to recommend the use of brief interventions in primary care". NICE defined "brief interventions" as involving "opportunistic advice, discussion, negotiation or encouragement. They are commonly used in many areas of health promotion, and are delivered by a range of primary and community care professionals. The interventions vary from basic advice to more extended, individually focused attempts to identify and change factors that influence activity levels".

349. NICE stated that "Primary care practitioners should take the opportunity, whenever possible, to identify inactive adults and advise them to aim for 30 minutes of moderate activity on 5 days of the week (or more) ..." NICE also

³⁰⁸ NICE (2006).

recommended that account should be taken of individual patients' "needs, preferences and circumstances".

350. There should be monitoring of "whether or not opportunistic advice is helping to increase the physical activity levels of people from disadvantaged groups, including those with disabilities (and thereby tackling health inequalities)". They should also assess how effective professionals from a range of disciplines are at raising long-term physical activity levels among these groups and "pay particular attention to the needs of hard to reach and disadvantaged communities, including minority ethnic groups, when developing service infrastructures to promote physical activity".
351. Exercise referral, pedometers, and walking and cycling schemes should only be used to promote physical activity as "part of a properly designed and controlled research study to determine effectiveness". (This confirms the information given to the Committee by Claire Martin, Public Health Specialist with East Kent Coastal PCT, about the lack of research on the effectiveness of GP exercise referral – see Section 3.9 above.)
352. Further NICE public health guidance on "the prevention, identification, assessment and management of overweight and obesity in adults and children" is being prepared, with publication due in November 2006.

Recommendation 13

Kent County Council's NHS Overview and Scrutiny Committee should initiate a research programme, in partnership with Canterbury Christ Church University's Department of Sport Science, Tourism and Leisure, to evaluate the effectiveness of brief interventions in primary care in tackling obesity. This should include evaluations of giving patients pedometers, referral to leisure centres and referral to Health Walks.

Appendix 1 – Evidence

Witnesses interviewed at meetings of the Joint Select Committee (evidence published separately as Part III of this report)

Hosted by Kent County Council

Monday 6 February 2006

- Clive Blair-Stevens (Deputy Director, National Social Marketing Centre) – National Consumer Council / Department of Health

Wednesday 8 February 2006

- Dr. Quentin Sandifer (Director, Public Health Department) and Charlie Manicom (Assistant Director, Public Health Department) – National Health Service (Kent and Medway Strategic Health Authority) / Kent County Council
- Colin Maclean (Head of External Funding – Corporate Services Directorate) – Kent County Council
- Sonia Howe (Regional Policy Advisor) – the Big Lottery Fund
- Robert Hardy (Assistant Director of Strategic Planning, Change and Development Division – Strategic Planning Directorate) and Sue Harvey (Lead Officer for Food and Agriculture, Trading Standards Division – Strategic Planning Directorate) – Kent County Council
- Chris Hespe (Head of Leisure Services – Education and Libraries Directorate) – Kent County Council

Tuesday 14 February 2006

- Richard Spoerry (Kent Agreement Manager – Corporate Services Directorate) – Kent County Council
- Pam Naylor (Food and Health Policy Lead for the South East Public Health Group) – Government Office for the South East / Department of Health

- Helene Raynsford (South East Regional Development Manager for Physical Activity and Health) – Sport England / Department of Health
- Dr. Linda Davies (Divisional Director, Environment and Economy, and Chairman of Work and Wellbeing Group – Strategic Planning Directorate), Ian Baugh (Countryside Access Development and Promotions Manager – Strategic Planning Directorate) and Paul Lonergan (Environmental Projects and Promotions Officer – Strategic Planning Directorate) – Kent County Council
- Elaine Mason (Staff Care Manager – Corporate Services Directorate) and Jeremy Smith (Occupational Health Manager – Corporate Services Directorate) – Kent County Council
- Penny Kurowski (Sports Development Manager) – Sport England

Hosted by Tonbridge and Malling Borough Council

Wednesday 22 February 2006

- Jacquie Lavin (Nutritionist and Partnership Manager), Ms. S Bartlett (Local Team Manager) and Ms. J Jackson (Dietician) – Slimming World
- Paul Lincoln (Chief Executive) – National Heart Forum
- Debbie McNamara (Acting Sports Development Officer, Leisure Services Business Unit) – Tonbridge and Malling Borough Council
- Nigel De Wit (Senior Planning Officer) – Tonbridge and Malling Borough Council
- Helen Flint (Locality Manager and Health Promotion Manager, South West Kent Primary Care Trust) and Malti Varshney (*Choosing Health* Liaison Manager, South West Kent Primary Care Trust) – National Health Service
- Paul Smith (Head of Health Faculty) – Kent Police

Hosted by Gravesham Borough Council

Wednesday 8 March 2006

- Dr. Meradin Peachey (Public Health Director, Dartford, Gravesham and Swanley Primary Care Trust) and Judith Webb (Head of Nutrition and Dietetics, Dartford and Gravesham NHS Trust) – National Health Service
- Carol Healy (Kent Healthy Schools Programme Manager – Education and Libraries Directorate) – Kent County Council / Department of Health
- Heather Robinson (Programme Director) and Kim Broster (Health Advisor) – Gravesham Sure Start
- Peter Cotton (Director of Physical Education and Community Sport) and Julia Gillingham (Partnership Development Manager) – Meopham School / Youth Sport Trust

Monday 13 March 2006

- Cllr. Lee Croxton (Lead Member for Environment, Leisure and Public Space), Cllr. Andrea Webb (Lead Member for Community Health and Wellbeing) and Patricia Jefford (Head of Environmental and Public Health) – Gravesham Borough Council
- Adrian Hickmott (Sport Development Officer) and Sarah Knight – Gravesham Borough Council
- Alan Dennington (Dartford / Gravesham Project Officer) – Charlton Athletic Football Club “Positive Futures”
- John Britt (Public Health Manager) – Gravesham Borough Council
- Rob Swain (Managing Director) – Gravesham Community Leisure Ltd.
- Grace Kelley, Rebecca Marshall, Cally Pike and Katie Shore – Kent Youth County Council

Hosted by Canterbury City Council

Wednesday 22 March 2006

- Ms. Claire Martin (Public Health Specialist, East Kent Coastal Primary Care Trust) – National Health Service
- Mike Bishop (Sports Development Manager for Disabled People, Kent Sports Development Unit – Education and Libraries Directorate) – Kent County Council
- Dr. Kate Woolf-May (Research Fellow, Department of Sport Science, Tourism and Leisure) – Canterbury Christ Church University

Monday 27 March 2006

- David Ford (Assistant Head of Cultural Services) and Janine Marsh (Sports and Health Manager) – Canterbury City Council
- Neil West (Chief Executive) – Active Life Leisure Trust
- Dr. Jonathan Sexton (Director of Public Health, Canterbury and Coastal Primary Care Trust) – National Health Service

Sources of written evidence received

- Natalie Cale (Human Resources Manager) – Saga Ltd. (Folkestone)
- Marie Capes (Company Secretary) – WPP (Hythe)
- Claire Cotter (Health Promotion Specialist, South West Kent Primary Care Trust and Maidstone Weald Primary Care Trust) – National Health Service
- Gill Crebbin (Sustainability Coordinator) – Tonbridge and Malling Borough Council
- Jenne Dixit (Black and Minority Ethnic Equality Adviser) – Diabetes UK
- Stephen Drennan (General Manager) – Megger Ltd. (Dover)
- Mr. J F Elliott (Company Secretary) – M P Evans Group plc (Tunbridge Wells)
- Fiona Gore (Independent Consultant)
- Mr. M R Harris (Chief Executive) – Bovis Homes Group plc (New Ash Green)

- Angela Hinkley (Health and Fitness Manager, Stour Centre) – Ashford Borough Council
- Cheryl Ives (Chair) – East Kent Mental Health and Social Care Trust Patient and Public Involvement Forum
- David Jessop (Director of Operations and Human Resources) – Royal British Legion Industries Ltd. (Aylesford)
- Peter Jolley (Head of Community Regeneration) – Swale Borough Council
- David Joyner (Sustainable Transport Manager) – Kent County Council
- Jayne Kilgallen (Director of Operations) – the Avenues Trust (Sidcup)
- Colin Maclean (Head of External Funding – Corporate Services Directorate) – Kent County Council
- Debbie McNamara (Acting Sports Development Officer, Leisure Services Business Unit) – Tonbridge and Malling Borough Council
- Claire Martin (Public Health Specialist, East Kent Coastal Teaching Primary Care Trust) – National Health Service
- Mr. J B Neame (Chief Executive) – Shepherd Neame Ltd. (Faversham)
- Dr. Meradin Peachey (Director of Public Health, Dartford, Gravesham and Swanley Primary Care Trust) – National Health Service
- Adam Perry (Community Development Officer, Sencio Community Leisure) – Sevenoaks District Council
- David Petford (Chief Executive) – Maidstone Borough Council
- Lois Reynolds (Curriculum Manager, Kent Adult Education Service – Education and Libraries Directorate) – Kent County Council
- Dr. John Rodriguez (Director of Public Health, Ashford and Shepway Primary Care Trusts) – National Health Service
- Cathi Sacco (Head of Contracting and Quality Assurance – Adult Services Directorate) – Kent County Council

- Jonathan Sexton (Director of Public Health, Canterbury and Coastal Primary Care Trust) – National Health Service
- Gill Stowe (Food Adviser for West Kent) – Sainsbury's Supermarkets Ltd.
- Shirley Waters (Food Adviser for East Kent) – Sainsbury's Supermarkets Ltd.
- Amanda Watts (Head of Human Resources) – Kent Messenger Group Ltd. (Larkfield)
- Alison Wood (Environmental Education Officer) – Shepway District Council

Other sources of evidence

- Responses from 57 members of the public to a feature in *Around Kent* magazine (issue 19, April–June 2006, p. 21 – “What’s stopping you from getting fit?”), offering a free pedometer (supplied by East Kent Health Walks, supported by the NHS, KCC and Pfizer) for information on obstacles to taking part in physical activity.

Appendix 2 – Glossary

BDA	British Dietetic Association
BLF	Big Lottery Fund
BMI	Body Mass Index
CHD	Coronary Heart Disease
COSU	Cabinet Office Strategy Unit
DfES	Department for Education and Skills
DoH	Department of Health
DCMS	Department for Culture, Media and Sport
DSGF	Don't Sit, Get Fit! (Dartford and Gravesham)
ECM	Every Child Matters
FSA	Food Standards Agency
GP	General Practitioner
HSCIC	Health and Social Care Information Centre
HSE	Health Survey for England
KCC	Kent County Council
KPAA	Kent Physical Activity Alliance
KSS	Kent Scientific Services
LAA	Local Area Agreement
LDF	Local Development Framework
LSP	Local Strategic Partnership
LPSA	Local Public Service Agreement
LPSA2	Second Generation Local Public Service Agreement (Kent)
LTP2	Second Kent Local Transport Plan (2006–11)
NAO	National Audit Office
NFS	National Food Survey
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NOPEs	New Opportunities for PE and Sport (Big Lottery Fund)
Ofsted	Office for Standards in Education
PESSCL	Physical Education, School Sport and Club Links
PCT	Primary Care Trust
PE	Physical Education
PSA	Public Service Agreement

SEPACT	South East Physical Activity Co-ordinating Team
SHA	Strategic Health Authority
SSP	School Sport Partnership
V4K	<i>Vision For Kent</i>
WHO	World Health Organization

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