**From:** Graham Gibbens, Cabinet Member for Adult Social Care and Public Health

Andrew Scott-Clark, Director of Public Health

**To:** Health Reform and Public Health Cabinet Committee

**Date:** 15 January 2019

**Subject:** **Childhood Obesity**

**Classification:** Unrestricted

**Previous Pathway:** This is the first committee to consider this report

**Future Pathway:** None

**Electoral Division:** All


**Summary:**

This report gives an overview of childhood obesity in Kent, the services available to support families and areas of consideration for future action.

Childhood obesity is a major public health challenge, it has a wide-ranging impact on health and wellbeing throughout the life course.The National Child Measurement Programme in 2017/18 in Kent found that 12.4% of reception aged children to be overweight and 8.3% to be obese, the figures were 14.4% and 18.8% for Year 6 children respectively. Living in a deprived area, being male, being from a Black, Minority, Ethnic (BME) group or living in an urban area were factors associated with greater levels of obesity. Inequalities in weight status by socio-economic deprivation status have increased over time.

Healthy lifestyle messages are delivered by health visiting, school health and early help services. Services to provide support to children who are already overweight or obese, are provided by the school health service and some districts. There are challenges to deliver services consistently across the County related to engaging with families and delivering outcomes. There are no services in Kent to support children who are obese with complex needs, which is a clinical service which the NHS has responsibility for providing.

A full needs assessment will be published in the new year and contain expanded recommendations for future action.

**Recommendation:** The Health Reform and Public Health Cabinet Committee is asked to:-

**COMMENT** on and **ENDORSE** the contents of the report, especially the profile of childhood obesity in Kent and the service offer currently available; and

**AGREE** that a further paper be submitted to the Health Reform and Public Health Cabinet Committee on effective and systematic joint working between agencies, including children's centres, in order to tackle obesity.

## 1.0. Introduction

1.1 Kent County Council (KCC) Public Health has a responsibility to deliver improved health and wellbeing and reduce inequalities for Children and Young People living in Kent.

1.2 This paper presents a profile of childhood obesity in Kent and the services provided to prevent children becoming an unhealthy weight and to support those who are already overweight or obese.

1.3 Childhood obesity is a major public health challenge, it has a wide-ranging impact on health and wellbeing. Children who are obese are more likely to have asthma and other respiratory problems, skin infections, type 2 diabetes and some cancers. Obesity in childhood is also linked to psychological disorders including poor self-esteem, eating disorders and anxiety. In the longer-term obese children are more likely to be obese in adulthood, carrying with them the increased risk of disease, disability and premature mortality.

1.4 The causes of childhood obesity are complex, they include biology and individual behaviour but this is set within cultural, social and economic environment in which we live. Our environment provides us with access to cheap energy dense foods and less active ways of living[1]. Eating healthily and being active are not the most accessible ways for people to live their lives. Only focussing on changing individual behaviour is unlikely to lead to any large reduction in the prevalence of obesity. This was reflected in Making Obesity Everyone's Business – A Whole Systems Approach to Obesity (2017)[2]**.** This report highlighted the importance of local authorities adopting a Whole Systems Approach to tackling obesity. Referring to the Obesity Systems Map, the report argues that the complexity of the obesity issue makes it a difficult problem to tackle one component at a time.

1.5 Poor diet and low levels of physical activity are the primary causal factors for childhood excess weight. The low levels of physical activity exacerbate the problems of poor diet and nutrition. The amount of sugar that children consume on a daily basis is a major contributing factor to gaining weight. The environments that children are raised in is a main risk factor for childhood obesity, children who live in family where at least one parent or carer is obese are at increased risk of becoming obese themselves. [3] The recently published 2016 Health Survey for England data found that 28% of children of an obese mother were also obese, compared with 8% of children whose mother was not overweight or obese. Similarly, 24% of children of an obese father were also obese, compared with 9% of children where the father was not overweight or

[1]Government Office for Science. (2007) *Tackling Obesities: Future Choices-Summary of Key Messages*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/287943/07-1469x-tackling-obesities-future-choices-summary.pdf [Accessed 10 December 2018]

[2] Local Government Association. (2017) *Making obesity everybody's business, A whole systems approach to obesity.* Available at: https://local.gov.uk/sites/default/files/documents/15.6%20Obesity-05.pdf. [Accessed 10 December 2018]

[3] PHE (2015) Childhood obesity: applying All Our Health. Available at: https://www.gov.uk/government/publications/childhood-obesity-applying-all-our-health/childhood-obesity-applying-all-our-health. [Accessed 10 December 2018].

obese.[4]

1.6 The Government have published a two-part childhood obesity plan of action, with the aim of significantly reducing England's rate of childhood obesity in the next 10 years.[5][6] The first part focused on working with industry to cut the amount of sugar in food and drinks and to get more primary school children to eat healthily and stay active. This included the introduction of a soft drinks levy, taking 20% of sugar in products by 2020, and introducing a new nutrient profile labelling system. The impact of the plan is not known yet, however the goal to reduce sugar in products by 5% in one year was not achieved. The second part of the plan published in 2018 reaffirmed the previous goal and included plans for calorie reduction programme with industry and a consultation regarding advertising and promotion of unhealthy foods.

## 2.0. Childhood obesity in Kent

2.1 Nationally, the prevalence of overweight and obesity among children (2-15), as measured by the Health Survey for England, has increased from 25.0% in 1995 to 33.4% in 2005 and the trend has been stable since.

2.2 The National Child Measurement Programme (NCMP) in 2017/18 found 12.4% of reception aged children in Kent (aged 4-5) to be overweight and 8.3% to be obese. This is lower than England as a whole (12.8% and 9.5%), but similar to the South East (12.4% and 8.2%).[7] The percentage of reception year pupils classified as overweight or obese (20.7%) ranks 4th amongst the 16 statistical neighbours (Appendix 1 Table 1).

2.3 In 2017/18, 14.4% and 18.8% of Year Six pupils (aged 10 to 11) were classified in Kent as overweight or obese respectively. Overweight levels were similar to England (14.2%) and obesity levels were lower (20.1%); they were higher than the South East (13.6 and 17,3%). The percentage of Year 6 pupils classified as overweight or obese (33.2%) ranks 15th amongst the 16 statistical neighbours (Appendix 1 Table 2).

2.4 The NCMP figures have consistently identified an increase in the percentage of children who are overweight or obese from Year R to Year 6. A report by Public Health England tracking children's weight status from Year R to Year 6 in four local authorities attributed the doubling in obesity rates to the numbers of children in Year R who are overweight and at a healthy weight who become obese by Year 6, 43% and 8%

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[4]NHS Digital. (2018) *Health survey reveals association between parent and child obesity*. Available at https://digital.nhs.uk/news-and-events/latest-news/health-survey-reveals-association-between-parent-and-child-obesity. Accessed[19 December 2018].

[5]HM Government (2016) *Childhood obesity: a plan for action.* Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/546588/Childhood_obesity_2016__2__acc.pdf. Accessed [10 December 2018].

[6] HM Government (2018) *Childhood obesity: a plan for action part two*. Available at https://www.gov.uk/government/publications/childhood-obesity-a-plan-for-action-chapter-2. Accessed [10 December 2018].

[7] KPHO (2018) *National Child Measurement Programme Data release 2017/18.* Available at: https://www.kpho.org.uk/__data/assets/pdf_file/0003/88167/NCMP-2017-18-Data-Report-Accessible-version_FINAL.pdf. Accessed [10 December 2018].

respectively. Only a small number of children with excess weight will return to a healthy weight by Year Six, around 27% of overweight and 10% of obese children.[8]

2.5 The overall trend in the prevalence of overweight, obesity and excess weight (overweight or obese) amongst Year R and Year 6 pupils in Kent between 2010/11 and 2017/18 was stable.

2.6 In 2017/18, for the majority of Districts, the proportion of Year R children with excess weight was similar to Kent. In Dartford, Dover and Swale the prevalence is higher than Kent and the South East figures. In Maidstone, Tonbridge and Malling and Tunbridge Wells the prevalence is lower than Kent, the South East and England as a whole.

2.7 For Year 6 children in Sevenoaks, Tonbridge and Malling and Tunbridge Wells the prevalence of excess weight was lower than Kent and England. Sevenoaks and Tunbridge Wells were also lower than the South East. Dartford, Gravesham and Thanet had a higher prevalence of excess weight than for Kent, the South East and England. Further details about districts can be found at (Appendix 1 Table 3).

2.8 In Year 6, boys in Kent are slightly more obese than girls (21% boys vs 17% of girls).

2.9 In both Year R and Year 6, children living in the most deprived areas in Kent are more likely to be obese (26%) than those living in the least deprived areas (12%). The gap is largest in Year 6 (14.1%), there is evidence of this gap increasing, the gap was only 6.6% in 2008/09.

2.10 In year 6, children of Black or Asian ethnic origin are more likely to be obese than their white classmates, 18% of White pupils are obese compared to 29% of Black pupils and 24% of Asian Pupils. This association is likely to be confounded by the impact of deprivation on obesity, as deprived urban areas in England tend to have a higher proportion of individuals from non-White ethnic groups.[9]

## 3.0. Service Provision

3.1 Services are provided at a universal and targeted level. In the early years, Universal healthy weight messages and interventions for 0-5s are provided by the Health Visiting Service and Children's Centres. The Health visiting service provides the infant feeding support service, this service contributes to the prevention of obesity, as breastfeeding is known to be protective for the child. The service gives healthy lifestyle advice messages given at the five mandated contacts and at other opportunities, including when the child is weighed.

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[8] PHE (2018) Changes in the weight status of children between the first and final years of primary school. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/609093/NCMP_tracking_report.pdf. [Accessed 10 December 2018]

[9]KPHO (2018) *Inequalities in Obesity & Excess Weight in Childhood. NCMP: Kent – 2017/18 update*. Available at: https://www.kpho.org.uk/__data/assets/pdf_file/0009/88371/NCMP-Equity-201718.pdf. Accessed [10 December 2018].

Delaying introducing solid food until 6 months and introducing food using appropriate portion sizes and healthy foods are key interventions to prevent obesity. Open access "introducing solid food" sessions are held in every district delivered by the health visiting service in partnership with children's centres.

3.2 The health visiting service also provide a brief targeted intervention for those children at an unhealthy weight using a healthy weight discussion tool. This has been trialled to enable the health visiting service to carry out brief interventions with families to identify where changes could be made and to provide follow up. There have been challenges in embedding this in the service and it is currently been reviewed. There are no further targeted intervention for 0-5 year olds where an issue is already presenting. There is developing evidence around the HENRY programme, a targeted parenting programme focused on developing health lifestyles, and this has been used on a small scale in Kent. Further work needs to be undertaken to embed the healthy weight tool and develop a targeted 0-5 offer to enable children to be at a healthy weight by the time they start primary school.

3.3 At primary school age, the school health service offers support to schools to promote healthy school environments and increase children's knowledge about healthy lifestyles. This is supported by messaging from the children's centres and youth hubs. The school health service also delivers a targeted 1:1 package of care with families where children are already overweight or obese, using goal setting techniques to change behaviours. This is offered to children identified through the NCMP programme and through professional or self-referral. Despite the offer, there is very low take up. Further work is being undertaken to understand how to better engage families in the offer and the programme is being evaluated.

3.4 NICE guidance compliant family weight management services were until recently provided across Kent for those children with who are overweight or obese. In 2017/18, Tier 2 family lifestyle weight management services had 120 engagers. The percentage completing was 83.3%, achieving the target of 60%. 75% of the child completers reduced or maintained their BMI z-score status. These services struggled to engage families, as a result, currently, only Maidstone, Dartford and Gravesham Districts have an offer for families. Tunbridge Wells, Tonbridge and Malling and Sevenoaks Districts provide a service on a 1:1 basis when they receive a referral. There is no offer in East Kent apart from the School Health package of care. The reduction of family weight management services is reported nationally with local authorities facing reducing public health budgets choosing not to fund family weight management services where they struggle to engage families or show good outcomes.

3.5 In response to this issue, a trial is currently being run to create a hybrid service combining the school health public health 1:1 package of care and the family weight management intervention in Dartford and Gravesham. This will utilise existing resources, to see whether using a combined approach of the District and school health services will increase engagement. As well as providing the intervention, it will be embedded through a partnership approach with a limited number of schools. This will run from January 2019 -July 2020 and is being evaluated by the University of Kent. This evaluation will inform the future

commissioning plans.

3.6 The School Health Service also provides support for whole school approach in secondary schools. A package of care is currently being developed for this aged group, to include emotional health element and a digital element. The service will engage with young people for 1:1 support if they are referred.

3.7 Tier 3 weight management services are the responsibility of the CCGs. These provide more intensive interventions by multidisciplinary teams for those children who are obese or severely obese with complex needs. There are no tier 3 services provided in the Kent.

3.8 PHE provide health lifestyle messaging for children and young people through the Change4Life initiative. It aims to reduce adult and childhood obesity simultaneously by making health a family issue. The Change4Life Sugar Smart campaign which launched in 2016 aimed to engage families to reduce the amount of sugar they consume. The campaign has been promoted widely by early help, health visiting and children's centres. District Councils have also promoted the campaign.

3.9 Across Kent, there were nearly 1,800 registrations to the Sugar Smart campaigns in 2016, this is in the context of a target population of 111,200 families with the youngest child under 10 years of age. Equating to 1.6% for Kent, this was higher than the national figure for registrations as a percentage of target families (See Appendix 1, Table 4).

3.10 A new Change4Life Sugar Smart campaign will be launched in January 2019 and KCC will be working with partners to promote the messages and gain wide engagement across the County.

## 4.0. Oral Health and Obesity

4.1 Oral Health has a major influence on eating, drinking, speaking and quality of life. The most prevalent oral disease is decay; it is preventable and shares common cause with obesity, poor diet with high sugar intake. More deprived areas have greater disease burdens and treatment needs.

4.2 In areas of greater deprivation in Kent there are poorer dental access rates, greater decay rates, greater numbers of General Anaesthesia (GA) extractions and obesity levels. Gross dental decay in Kent's 5-year olds exist at the highest levels in Gravesham (24.1%) and Maidstone (21.8%), which are higher than the national average (20.0%). Such disease is often managed as GA extractions; the most common age group being 5-9-year olds, with the highest GA access rates in the county due to caries in Dartford (0.8%), Gravesham (0.8%) and Ashford (0.8%), which are equal to the national average (0.8%).[10] Reception children in Dartford (10.8%), Gravesham (10.9%) and Swale (9.8%) have

[10] Public Health England (2017). *National Dental Epidemiology Programme of 5 year old children*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/708157/NDEP_for_England_oral_health_survey_5yr_2017_report.pdf [Accessed on 21/11/18].

greater obesity levels than the national average (9.5%).[11] There are unsurprisingly given the common cause, correlations between poor oral health and obesity for children by district.

4.3 Dental services are commissioned by NHS England, however Local Authorities (LA) have a responsibility for oral health promotion and preventing escalation in oral health needs. The existing barriers in dental service uptake result in reduced opportunities for key health communication to prevent common risks impacting obesity and oral health: only half of Kent's 0-17-year olds (52.4%) saw a dentist in the past 12 months with the lowest rate of 44.5% in Thanet. This is compared to the English average of 58.6%.[12]

4.4 Local Authority support in increasing access to dental services and promoting oral health within existing social & health services (Children Centres, GPs, Pharmacies), can reduce obesity and dental decay risk factors. The British Society of Paediatric Dentists (BSPD)'s Dental Check by 1 campaign promotes dental attendance by the age of one. Posters promoting the campaign are in local children's centres and Health Visitors promote accessing the dentist at each mandated check. It is planned to further embed this campaign in Kent, through further promotion and to provide a consistent suite of oral health promotion materials using the soon to be published PHE documentation. The work outlined above to improve diet and reduce sugar intake will also have an impact on the rates of poor oral health.

4.5 It is also planned to work with dentists in those areas with the greatest levels of decay to link with Children's centres to provide positive messaging, encourage attendance at Dentists and increase access to fluoride varnishing which is available to children aged 3 and above. Through a combination of upstream and downstream interventions to 'put the mouth back in the body', a positive environment can be created to provide patients with the tools to improve their health, and barriers to accessing health services can be diminished.

4.6 A further paper on oral health will be submitted to the next cabinet committee in March 2019.

## 5.0. Next Steps

5.1 KCC Public Health is currently working on the implementation of the new draft guidance on the use of a Whole Systems Approach to obesity with partners from PHE and Leeds Beckett University. This approach will work on smaller geographical areas to bring together stakeholders to develop a shared understanding of the local causes of obesity, identify assets and opportunities to mitigate these and develop local action plans using the joint resources available across the partnerships. This is at an early stage as it will be challenging to

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[11] Kent Public Health Observatory (2018). *National Child Measurement Programme*. Available at: https://www.kpho.org.uk/__data/assets/pdf_file/0003/88167/NCMP-2017-18-Data-Report-Accessible-version_FINAL.pdf [Accessed on 05/12/18]

[12] NHS Digital (2018). Dental Activity in Local Authorities. Available at: https://app.powerbi.com/view?r=eyJrIjoiYTRlMzJiYTEtMTgwMi00ZTdiLTgzMWUtZGM5Y2NmMTI5MGE4IiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9 [Accessed on 21/11/18]

implement this approach in such a large geographical area and complicated health economy.

5.2 Further work is being undertaken to embed the healthy weight discussion tool in health visitor conversations with families with children under 5. Opportunities will be explored to develop targeted approaches to support where children are identified at being at an unhealthy weight.

5.3 The evaluation of the trial partnership service between the School Health Service and Dartford and Gravesham districts will be considered and used to inform the targeted service for children of primary school age who are already overweight or obese. An adolescent package of care for healthy weight will be developed by the School Health Service in the first quarter of the new year.

5.4 The East Kent Districts have identified obesity as a cross District priority. KCC Public Health are supporting the districts to develop local action plans.

5.5 A full needs assessment for obesity across the life course will be published in the new year.

5.6 The programme of work to improve oral health for children under 5 will be implemented by the end of March 2018 and the learning used to support a County wide approach. An update on this will feature in the oral health paper to be submitted to the March Cabinet Committee.

5.7 The issue of childhood obesity is being considered by the Joint Health and Wellbeing Board and the STP Prevention Workstream. This is within the context of the planned whole systems obesity work and to consider the provision of targeted and specialist services including tier 3.

## 6.0. Recommendation:

The Health Reform and Public Health Cabinet Committee is asked to:-

**COMMENT** on and **ENDORSE** the contents of the report, especially the profile of childhood obesity in Kent and the service offer currently available; and

**AGREE** that a further paper be submitted to the Health Reform and Public Health Cabinet Committee on effective and systematic joint working between agencies, including children’s centres, in order to tackle obesity.

## 7.0. Background Documents

See attached documents.

## 8.0. Contact Details

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**Appendix 1 - Data Tables**

**Key:**

**RAG Ratings**

| | |
|---|---|
| (g) GREEN | Higher |
| (a) AMBER | Similar |
| (r) RED | Lower |

**Trend significance**

| | |
|---|---|
| ⇧ | increasing |
| ⇩ | decreasing |
| ⇔ | remained the same |

**Table 1**

| Percentage of reception year pupils classified as overweight or obese | | | | | | |
|---|---|---|---|---|---|---|
| | 2010/11 | 2016/17 | 2017/18 | Difference from 2016/17* | Trend since 2010/11 significance** | Nearest neighbour rank*** |
| Kent | 3,500<br>23.0 (a) | 4,300<br>24.4 (r) | 3,400<br>20.7 (g) | - 3.7 | ⇔ | 4th |
| National | 22.6 | 22.6 | 22.4 | - 0.2 | ⇔ | |

**Table 2**

| Percentage of year six pupils classified as overweight or obese | | | | | | |
|---|---|---|---|---|---|---|
| | 2010/11 | 2016/17 | 2017/18 | Difference from 2016/17* | Trend since 2010/11 significance** | Nearest neighbour rank*** |
| Kent | 4,700<br>33.3 (a) | 5,100<br>32.8 (g) | 5,400<br>33.2 (g) | + 0.4 | ⇔ | 15th |
| National | 33.4 | 34.2 | 34.3 | + 0.1 | ⇔ | |

Table 3

| Percentage of reception year pupils classified as overweight or obese | | | | | | |
|---|---|---|---|---|---|---|
| | 2010/11 | 2016/17 | 2017/18 | Difference from 2016/17* | Trend since 2010/11 significance** | Nearest neighbour rank*** |
| Ashford | 270<br>21.1 (a) | 400<br>25.7 (a) | 310<br>21.0 (a) | - 4.7 | ⇔ | 7th |
| Canterbury | 290<br>20.9 (a) | 290<br>19.5 (g) | 270<br>20.2 (a) | + 0.7 | ⇔ | 3rd |
| Dartford | 270<br>23.9 (a) | 370<br>24.9 (a) | 320<br>23.3 (r) | - 1.6 | ⇔ | 11th |
| Dover | 230<br>23.2 (a) | 300<br>25.6 (a) | 270<br>23.5 (r) | - 2.1 | ⇔ | 6th |
| Folkestone & Hythe | 230<br>22.2 (a) | 280<br>24.8 (a) | 250<br>22.9 (a) | - 1.9 | ⇔ | 8th |
| Gravesham | 290<br>24.2 (a) | 390<br>28.0 (r) | 280<br>21.8 (a) | - 6.1 | ⇔ | 5th |
| Maidstone | 350<br>22.7 (a) | 470<br>23.9 (a) | 330<br>17.5 (g) | - 6.4 | ⇔ | 2nd |
| Sevenoaks | 240<br>20.5 (g) | 340<br>25.5 (a) | 230<br>19.0 (g) | - 6.4 | ⇔ | 10th |
| Swale | 330<br>22.4 (a) | 380<br>21.0 (g) | 400<br>23.8 (r) | + 2.9 | ⇔ | 7th |
| Thanet | 330<br>23.0 (a) | 430<br>26.7 (r) | 330<br>22.2 (a) | - 4.5 | ⇔ | 2nd |
| Tonbridge & Malling | 380<br>29.1 (r) | 350<br>23.5 (a) | 240<br>16.6 (g) | - 6.9 | ⇩ | 2nd |
| Tunbridge Wells | 260<br>23.0 (a) | 310<br>25.0 (a) | 170<br>16.4 (g) | - 8.5 | ⇩ | 1st |
| Kent | 23.0 | 24.4 | 20.7 | - 3.7 | ⇔ | |

| Percentage of year six pupils classified as overweight or obese | | | | | | |
|---|---|---|---|---|---|---|
| | 2010/11 | 2016/17 | 2017/18 | Difference from 2016/17* | Trend since 2010/11 significance** | Nearest neighbour rank*** |
| Ashford | 430<br>34.6 (a) | 440<br>32.2 (a) | 450<br>32.0 (a) | - 0.2 | ⇔ | 9th |
| Canterbury | 330<br>28.1 (g) | 430<br>31.4 (a) | 440<br>32.2 (a) | + 0.7 | ⇔ | 7th |
| Dartford | 370<br>36.5 (r) | 440<br>36.9 (r) | 490<br>38.0 (r) | + 1.1 | ⇔ | 16th |
| Dover | 370<br>36.8 (r) | 360<br>34.6 (a) | 390<br>34.9 (a) | + 0.3 | ⇔ | 10th |
| Folkestone & Hythe | 370<br>35.3 (a) | 380<br>35.9 (r) | 350<br>32.8 (a) | - 3.2 | ⇔ | 6th |
| Gravesham | 370<br>33.5 (a) | 470<br>38.3 (r) | 490<br>37.5 (r) | - 0.9 | ⇧ | 15th |
| Maidstone | 500<br>32.1 (a) | 510<br>31.7 (a) | 570<br>32.8 (a) | + 1.2 | ⇔ | 14th |
| Sevenoaks | 310<br>30.7 (a) | 330<br>27.8 (g) | 340<br>27.6 (g) | - 0.2 | ⇩ | 10th |
| Swale | 450<br>31.5 (a) | 500<br>32.6 (a) | 570<br>35.2 (a) | + 2.6 | ⇔ | 12th |
| Thanet | 490<br>35.9 (a) | 560<br>37.1 (r) | 570<br>38.6 (r) | + 1.5 | ⇧ | 16th |
| Tonbridge & Malling | 400<br>33.1 (a) | 390<br>29.1 (g) | 420<br>29.1 (g) | 0.0 | ⇩ | 9th |
| Tunbridge Wells | 310<br>31.7 (a) | 280<br>26.1 (g) | 320<br>26.9 (g) | + 0.9 | ⇩ | 5th |
| Kent | 33.3 | 32.8 | 33.2 | + 0.4 | ⇔ | |

Table 4

| Change4Life Sugar Smart 2016 | | |
|---|---|---|
| Key Indicator | Kent | National |
| No. total registrations | 1,800 | 58,000 |
| Registrations as a percentage of families with youngest child aged under 10 | 1.6% (g) | 1.4% |
| No. total individuals sent at least one email | 4,200 | 138,900 |
| One email opened as a percentage of individuals | 3,600<br>84.3% (a) | 117,800<br>84.8% |
| Three emails opened as a percentage of individuals | 1,700<br>40.6% (a) | 55,700<br>40.1% |
| Percentage of individuals clicking on at least one content link | 1,000<br>23.1% (a) | 31,200<br>22.4% |