Walsall Council

Public Health Walsall 2015 Healthy Weight and Physical Activity Needs Assessment

This needs assessment is part of the Walsall Joint Strategic Needs Assessment process

Contents

Acknowledgements

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Glossary

The table below defines terms included within this HW & PANA:

BME	black and minority ethnic
BMI	Body Mass Index
CCG	Clinical Commissioning Group
CQUIN	Commissioning for quality and innovation
CYPB	Children and Young People's Board
IMD	Index of Multiple Deprivation
JSNA	Joint Strategic Needs Assessment
MBC	Metropolitan Borough Council
NCMP	National Child Measurement Programme
NICE	National Institute for Health and Clinical Excellence
WHT	Walsall Healthcare Trust

Message from DPH

BW to complete

Executive Summary

Obesity and physical inactivity remains a challenge in Walsall, in line with national trends; Walsall's population continues to become increasingly overweight and obese. With 24% (854) of Walsall's Reception children being overweight or very overweight and 40% (1,275) of Year 6 children also overweight or very overweight in 2013/14 and almost 70%, 2012 of the adult population classed as overweight or obese. Obesity and physical inactivity is associated with many chronic diseases including diabetes, coronary heart disease and some cancers. Obesity threatens the health and well-being of individuals and places a burden on public resources in terms of

health costs, on employers through lost productivity and on families because of the increasing burden of long-term chronic disability.[1] Without action obesity related diseases in Walsall will cost £82.5 million by 2015. Wider total costs to society (such as loss of productivity) of overweight and obesity are estimated to reach £49.9 billion by 2015.[1]

Just over half (50.8%) of the adult population take no part in any physical activity (i.e. not achieving 30 minutes of exercise on any day during the week). It is estimated that the consequences of physical inactivity in the Walsall population cost the local economy £33m per year[2] through increased sickness absence, reduced productivity and increased cost to individuals and for their carers.

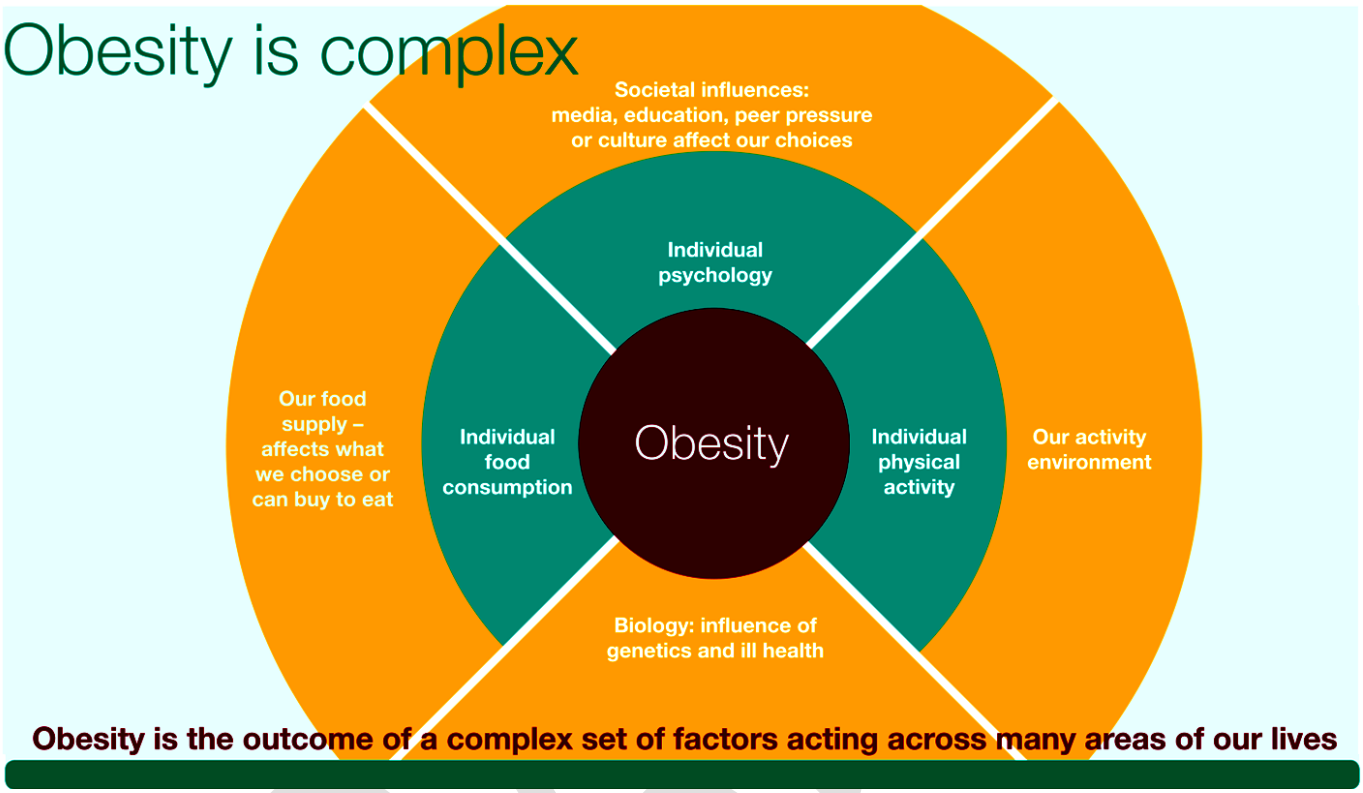
Obesity

Obesity is the outcome of a complex set of factors acting across many areas of our life. The Foresight report (2007) refers to a 'complex web of societal and biological factors that have in recent decades, exposed our inherent human vulnerability to weight gain' demonstrated in Figure 1 below;

[1] Butland B, Jebb S, Kopelman P, et al. Tackling obesities: future choices – project report (2nd Ed). London: Foresight Programme of the Government Office for Science, 2007.

2 Walsall Joint Strategic Needs Assessment: 2013

Figure 1 Factors influencing obesity



Obesity does not affect all groups equally and is associated with many indicators of socioeconomic status, with higher levels of obesity found among more deprived groups. Local data shows the obesity prevalence in Reception children increases significantly from 2.7% to 11.4% as the socio economic deprivation increases. Similarly the obesity prevalence in Year 6 children increases significantly from 17.4% to 26% as the socio economic deprivation increases.

In adults the association is stronger in women than men. Nationally the prevalence of obesity in women falls from 31% in the lowest income quintile to 19% in the highest income quintile. [3]

Some black and minority ethnic (BME) groups are also more at risk of becoming obese. In Walsall Black (16.5%) and mixed race children (13.6%) are significantly more likely to be obese than Asian (9.2%) and White children (10.0%) in Reception. Similarly Black children (19.4%) are significantly more likely to be overweight than Asian (14.0%) and White children (14.3%) in year 6.

[3] *Healthy Survey for England 2012*

In adults nationally the prevalence of obesity is higher among women of Black Caribbean (25.5%), Black African (31.6%), and Pakistani ethnicities (26.2%), compared to the other ethnic groups with Bangladeshi men having the lowest prevalence(11.5%).

People with disabilities are also more at risk of becoming obese. Analysis of combined data from the Health Survey for England (HSE) 2006–2010 shows that children aged 2–15 with a limiting long-term illness (LLTI) are approximately 35% more likely to be obese than children without a LLTI.[4]

Data from the Health Survey for England (HSE) show that obesity rates among adults with a long-term limiting illness or disability (LLTI) are 57% higher than adults without a LLTI.[5] Over 80% of people with a serious mental illness are overweight or obese[6] and according to a study conducted by Luppino, (2010), depressed persons had a 58% increased risk of becoming obese.[7]

Diet

It is widely recognised that lifestyle factors such as poor diet lead to poor health outcomes and cause increased prevalence of obesity, disease, disability and premature death. Local data from the 'YOW' Survey (2013) highlighted that only 36% of children claimed to eat something at breakfast, lunch and dinner every day. 11% of young people never eat breakfast with significantly less girls (40%) eating breakfast every day compared to 58% of boys. Just 14% of young people consume their recommended '5 a day'.

Poor diet is linked to social deprivation, residents in the more affluent areas of the borough are more likely to consume the recommended '5 a day' target, semi-skimmed milk, meat and fish than residents living in the deprived wards. Similar to young people, 12% of Walsall's residents consume their recommended '5 a day'. Only 7% of Black and minority ethnic residents consume their recommended '5 a day' compared to 12% of White residents. The consumption of foods high in fat and sugar are highest amongst the unemployed (59%) and BME groups (43%).

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[4] Gatineau M. Obesity and disability: children and young people. Oxford: Public Health England Obesity Knowledge and Intelligence, 2014.

5 Gatineau, M, Hancock C, Dent, M. Adult disability and obesity. Oxford: National Obesity Observatory, 2013.

[6] National Institute of Mental Health (2013) NIH Study Shows People with Serious Mental Illnesses Can Lose Weight, March 21, 2013

[7] Luppino, F. et al (2010) Overweight, obesity, and depression: a systematic review and meta-analysis of longitudinal studies. Archives of General Psychiatry 2010;67(3):220-9.

Physical activity

Similar to obesity there are clear and significant health inequalities in relation to physical inactivity according to income, gender, age, ethnicity and disability.[8]

Some BME groups are less active than the general population. Only 11% / 26% of Bangladeshi women and men are sufficiently active for good health, compared with 25% / 37% of the general population.[9]

Boys are more active than girls and girls are more likely than boys to reduce their activity levels as they move from childhood to adolescence. Men are more active than women in virtually every age group, with 6 in 10 women not participating in sport or physical activity[10].

People with disabilities are less likely to be physically active. Only 1 in 4 people with learning difficulties take part in physical activity each month, compared to over half of people without a disability.[11]

Recommendations

A number of recommendations have been identified through this needs assessment based on evidence, evaluation, need and consultation. These have been listed below in 5 themes these will be prioritized in Walsall's Healthy Weight and Physical Activity Strategy:

Children: healthy growth and healthy weight

- Evaluate Maternal and Early Years Programme including model of delivery, referral pathway and data collection to ensure the programme remains cost effective with the greatest impact.

8Start Active, Stay Active : A report on physical activity for health from the four home countries' Chief Medical Officers: 2011

[9] Joint Health Surveys Unit (2006). Health Survey for England 2004: Health of Ethnic Minorities. The Information Centre: Leeds.

[10] Active People Survey 2007.

[11] Sport England Active People Survey December 2013 (sport once a month, any sport, any duration)

- Ensure that GPs, midwives and Health Visitors work with other partners to support women to enter their pregnancy a healthy weight.

- Support Early Years settings such as nurseries and Childrens Centres in promoting healthy eating and physical activity.

- Ensure children's weight management and healthy eating programmes specifications identify and target high risks groups e.g. Black children, boys, children with disabilities and living in the local quintiles 1-3.

- Using the obesity RAG rated Primary School data to target schools within the top 30 for Food Dudes Programmes.

- Redesign the local Healthy Schools Award to offer schools a package of tailor made services and offer advice on support on how to utilize the school sport premium effectively.

- Continue to work with and develop referral pathways from primary and secondary care to the children's weight management programmes.

- Review existing databases within WHT and CCG to enable communication between both systems to ensure GP's can identify very overweight children identified through the NCMP to offer lifestyle advice/ support and refer appropriately to local weight management programmes.

- Replicate the holistic approach delivered by the Way4forward team and diabetic team in other paediatrics clinics within WHT.

Promoting healthier Food Choices

- Support and offer training to caterers and teachers to achieve new mandatory food school standards and increase the quality, take-up and economic viability of school meals.

- Support schemes like the Food for Life Partnership programme in secondary schools to increase school meal take up.

- Encourage schools to grow their own fresh produce where possible or engage with community allotments.

- Work with local retailers, farmers markets and allotments and support innovative schemes to supply more fresh food to 'food deserts'.

- Explore the 'social supermarket' model. Currently being pioneered in South Yorkshire. Social supermarkets allow people on low incomes to register and shop for heavily discounted food which has been gathered from manufacturers' surplus produce. Once registered, they also receive a 'hand up' through help with debt problems, budgeting support and the skills required for work. The option of buying food at a greatly reduced price can help free up monies to cover other household essentials.

- Encourage development of delivery services and box schemes targeting those people who have decreased access to fresh, healthy and affordable food.

- Use branding such as 'Change 4 life' to promote healthy food sales and dietary knowledge in the local area.

- Work with stores/ Cafes/ parks located close to schools / nurseries participating in 'Food Dudes' to develop relations with a view to using the branding in house on fresh fruit and vegetables and other healthy foods.

- Support local Food banks to offer healthy foods and offering dietary knowledge and healthy recipes.

- Engage and support employers to offer healthy options in vending machines through the workplace wellbeing charter.

- Establish a programme of health impact assessment (HIA) training for public health teams, planning officers, and others.
- Agree a process with the planning team for incorporating HIAs in the planning process.
- Utilize community infrastructure levy money to support the development of infrastructure within the community for example safer road schemes or park improvements.

Building physical activity into our lives

- Ensure that all physical activity specifications identify and target high risk groups' e.g. Residents in quintiles 1-3, Bangladeshi population, adults with disabilities, adolescent girls and older people.

- Need to develop a consistent approach to monitoring levels of sustained participation across all commissioned services and build a stronger evidence base to ensure programmes are evidence led.

- In order to make the most of Walsall's Green Spaces there is a need for collaboration across a number of sectors, including Parks and Green Spaces, Public Health, CCGs, Sustainable Travel, Rights of Way, Canals and River Trust and Education.

- Identify strategic green spaces across the borough to which resources are prioritised ensuring they meet certain criteria which will ultimately encourage more physical activity and address some of the barriers identified in the consultation. For example, good and safe access, signage, safe and maintained equipment, conservation of natural features and well maintained walking routes. Green spaces should be selected based on access to areas of increased health inequality, size, type, quality existing infrastructures (e.g. play facilities) and the potential for them to be used as active travel corridors.

- To develop links between education and green spaces through improving schools knowledge of local green spaces and teachers confidence in delivering outdoor learning.

- Increase the promotion of green spaces as a means to take part in recreational walking, active travel corridors and structured physical activities.

- Programmes should be designed and only resourced when plans for on-going sustainability are in place. This will include building partnerships with the voluntary sector and increasing the number of volunteer led programmes such as walking schemes and conservation groups.

- Further consultation with the public may be required to identify need, particularly to those hard to reach groups. National research suggests that BME, people living in urban deprived areas, people from D and E socio economic groups, people aged over 65 and people with disabilities visit green spaces far less frequently. Many of these groups are likely to benefit the most from engaging with green spaces.[1] Tailored programme design is particularly important in engaging hard to reach groups. Programmes that are delivered without a clear focus on equity may even increase health inequality.

Creating incentives for better health

- Expand on the healthy workplace programme targeting companies with employees in greatest need e.g. small companies employing manual labour.

- Walsall MBC to adopt the Workplace Wellbeing Charter which is approved by Public Health England and includes physical activity, diet and weight management.

- Provide a reduced package of support (including physical activity) to other workplaces that are not included in the healthy workplace programme. Examples include reduced cost lunch time/ after work activities and improved information on local physical activity provision.

- Roll out the health Switch Award targeting the most deprived wards and takeaways in close proximity to Primary and Secondary Schools.

Personalised support for overweight and obese individuals.

- Ensure all adult weight management specifications identify and target high risks groups e.g. Black Caribbean, Black African and Pakistani ethnicities, people with mental health conditions and adults in quintiles 1-3.

In order to reduce the population burden of overweight and obesity and increase physical activity levels, whilst also reducing the gradient of inequalities in health, there must be a balance between a universal approach and targeting high risk groups, including those who are already overweight, obese and inactive. Meeting the demand for treatment of people with existing weight problems has been a higher short term priority in recent years. As budgets become increasingly tighter we need to realign budgets to commission additional early year's interventions and to focus on improving upstream universal approaches for a wider, longer term impact. With key partners we need to facilitate healthy personal choices for Walsall residents and reduce barriers to physical activity in the community.

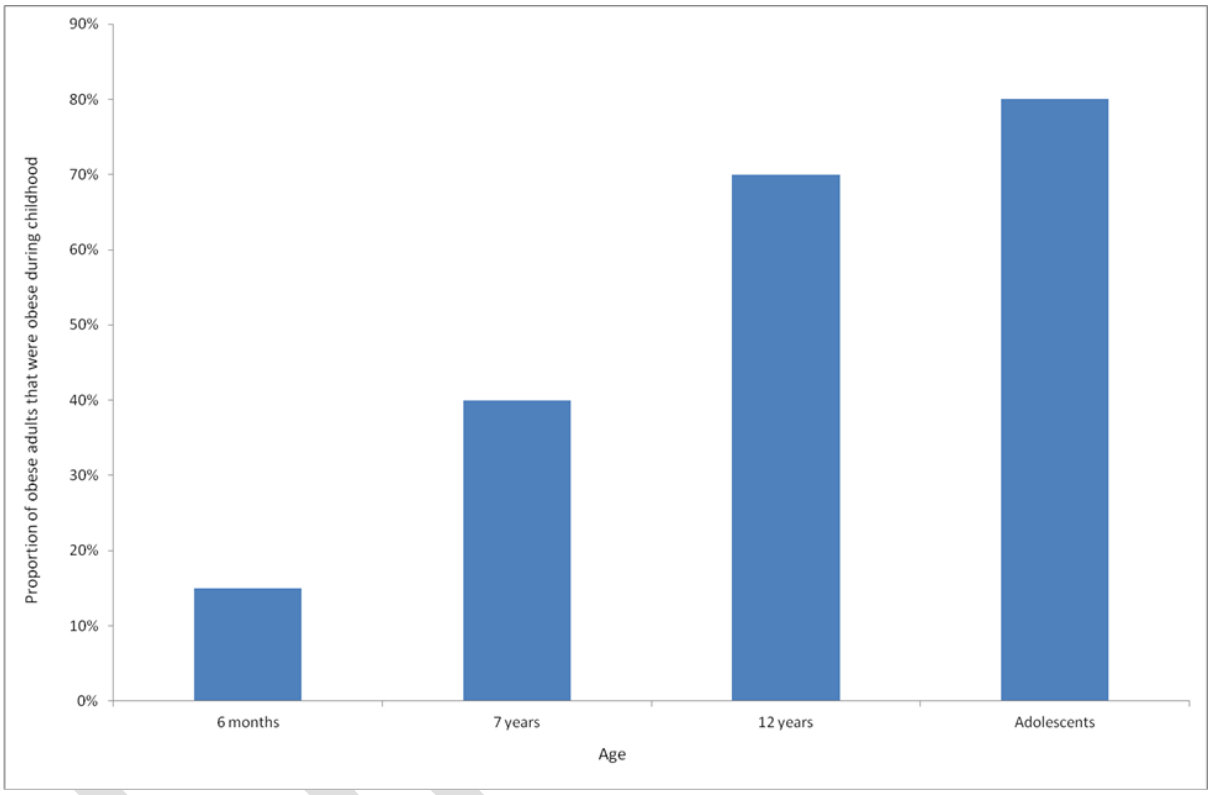
Reducing obesity and increasing physical activity in Walsall will not be achieved through 'health' alone and a society wide approach is needed with collaboration and involvement from all local government departments, the third and private sector are essential to achieve this.

Strategic Context

Public Health's Healthy Weight Needs Assessment aims to collate data, identify evidence based practice and offer recommendations to support Walsall's Healthy Weight Strategy and inform commissioning and provision of services across Walsall. It aims to provide robust evidence and recommended solutions to tackle the wider determinants of obesity, for example, the obesogenic environment.

Obesity is a significant issue for Walsall as our population, in line with national trends, continues to become increasingly overweight and obese. The most important consequence of childhood obesity is its persistence into adulthood (*Figure 2*) and the early appearance of obesity-related disorders such as hypertension, coronary heart disease, type 2 diabetes and some cancers. Figure 2 highlights the importance of delivering early interventions and focus on improving up stream universal approaches.

Figure 2: Adult to Child Predictive Value



More immediate issues for overweight and obese children include a significant impact on their social and psychological well being; many children develop a negative self –image and low self-esteem. They are also at a higher risk of bullying and depression.

The current economic climate poses challenges for all residents and organisations within the borough. Public Health recognises the importance of getting maximum value for money by using evidenced based methods, and that prevention is more cost-effective than cure. However, this must be balanced with the need to reduce health inequalities and provide services for those who are already overweight and obese. Where possible, win-win solutions will be found; for example encouraging walking and cycling will reduce traffic congestion and carbon emissions as well as producing health benefits. This was the foundation for Walsall's Healthy Weight Strategy 2011 – 2014.

In the UK, it is estimated that overweight, obesity and related morbidity cost the NHS £4.2 billion in 2007 and these costs are predicted to reach £9.7 billion by 2050. It is estimated without action obesity related diseases in Walsall will cost £82.5 million by 2015. Wider total costs to society (such as loss of productivity) of overweight and obesity are estimated to reach £49.9 billion by 2015.[12]

It is estimated that the consequences of physical inactivity in the Walsall population cost the local economy £33m per year[13] through increased sickness absence, reduced productivity and increased cost to individuals and for their carers. An inactive person spends 37% more days in hospital and visits the doctor 5.5% more often[14]. Physical activity levels, especially participation in sporting activities will also impact on the economic profile of Walsall. According to the Inter Departmental Business Register Walsall in 2013 had 55 sport related businesses employing 1.6% (compared to 2.1% nationally) of the local working population. This has reduced from 3.1% in 2011.

12 Butland B, Jebb S, Kopelman P, et al. Foresight report: Tacking obesities: future choices - project report. London: Government Office for Science, 2007.

13 Walsall Joint Strategic Needs Assessment: 2013

14 Sari N. Physical inactivity and its impact on healthcare utilization. Health Econ 2009, 18:885–901.

The Public Health Outcomes Framework 'Healthy lives, healthy people: Improving outcomes and supporting transparency' 15 sets outs a vision, desired outcomes and indicators for Public Health to help protect and improve the public. Indicators relating to healthy weight and physical activity include;

- Percentage of all mothers who breastfeed their babies within the first 48hrs after delivery.
- Percentage of all infants due a 6-8 week check who are totally or partially breastfeeding.
- Percentage of children aged 4-5 (Reception Year) classified as overweight or obese.
- Percentage of children aged 10-11 (Year 6) classified as overweight and obese
- Percentage of adults classified as overweight and obese.
- Percentage of adults achieving at least 150 minutes of physical activity per week in accordance with the UK CMO physical activity guidelines.
- Percentage of adults that are classified as 'inactive'.
- Percentage of people using outdoor space for exercise/ health reasons.

Reducing obesity and increasing physical activity in Walsall will not be achieved through 'health' alone and a society wide approach is needed with collaboration and involvement from all local government departments, the third and private sector are essential to achieve this. Obesity and physical activity has been highlighted as a priority in several local documents and strategies including the Walsall's JSNA, Health and Wellbeing Strategy, CYPB Action Plan and CCG's 5 year plan.

To reflect the vision laid out in the *Walsall's Healthy Weight Strategy* 2011-14 this needs assessments focuses on five themes:

Children: healthy growth and healthy weight

Promoting healthier food choices

Building physical activity into our lives

Creating incentives for better health

Personalised support for overweight and obese individuals

[15] *'Healthy lives, healthy people: improving outcomes and supporting transparency': A public health outcomes framework for England, 2013-2016*

Classification of Weight

Overweight describes a condition in which excess body fat has accumulated to an extent that health may be impaired.

BMI is used to measure childhood obesity for children aged 2 years and over. Children are classed as overweight or obese when their BMI is compared to a reference population which takes into account their sex and age. This is extremely important as BMI in children varies with both age and sex, therefore fixed BMI cut offs cannot be used for children, like they can in adults.
This is a confusing issue as various reference populations and thresholds exist. The main four which are used are:

1. International Obesity Task Force (IOTF) thresholds
2. WHO 2007 Growth Reference for 5-19 year olds
3. UK1990 Population Thresholds (85th and 95th)
4. UK 1990 Clinical Thresholds (91st and 98th)

A review of BMI thresholds was published in April 2012 and is a joint position statement by the Scientific Advisory Committee on Nutrition (SCAN) and the Royal College of Paediatrics and Child Health (RCPCH). [16]They considered and disregarded other approaches, and focused on the UK 1990 Population and Clinical thresholds as the most appropriate.

They concluded that there is no reason to select one set of thresholds over another for use in all situations. Each threshold has a separate, discrete purpose. Using the 91st/98th centiles only for both clinical and population surveillance may not capture all those at risk of overweight. However, only using the 85th/95th centiles would result in more children being identified for intervention than necessary and the 85th/95th centiles do not appear on growth charts used in practice and may make observations and monitoring difficult.

They recommend the following descriptors to be used and that the DH should move towards a single set of thresholds within 2 years:

Purpose	**Clinical management and planning individual-based interventions**			**Population surveillance and planning population-based interventions**		
Thresholds	**Centile**	**Current descriptor**	**Revised descriptor**	**Centile**	**Current descriptor**	**Revised descriptor**
	91st	Overweight	Overweight	85th	Overweight	At high risk of overweight
	98th	Obesity	Clinical obesity	95th	Obesity	At high risk of obesity

LMSgrowth Software

[16] *Consideration of issues around the use of BMI centile thresholds for defining underweight, overweight and obesity in children aged 2-18 years in the UK. SCAN and RCPCH. April 2012*

Professor Tim Cole developed the LMS method for constructing age-related reference ranges such as growth charts. The LMS method was used to develop the British 1990 growth reference, which was the official UK growth reference from 1996 to 2009.

UK-WHO growth charts for children from birth to 4 years are used by GPs, pediatricians and parents across the UK to assess the growth of infants and children and are included in the Personal Child Health Record (the 'red book') given to every child born in the UK.[17]

The National Child Measurement Programme (NCMP) follows NICE guidance in recommending that the UK1990 growth reference is used. In practice, clinicians in the NHS use UK 1990 (or UK/WHO for 2-4 year olds). International Obesity Taskforce (IOTF) cut offs tend to be used in research. The debate over which cut offs to use for adults has also lead to the need to consider changes for cut offs for children, but currently there is insufficient evidence and UK90 cut offs are to be used for all children.[18]

Weight in adults is commonly defined by Body Mass Index (BMI), which is calculated by dividing an individual's weight in kilograms by the square of their height in metres (kg/m2). In addition to BMI, waist circumference may be used in people with a BMI less than 35 to assess health risks.

Figure 3 World Health Organisation classification of weight in adults

Classification	BMI (kg/m2)
Underweight	<18.5
Normal range	18.5 – 24.9
Overweight	25 – 29.9
Obesity class I	30 – 34.9
Obesity class II	35 – 39.9
Obesity class III	40+

It is now generally accepted that South Asian populations are at greater risk of ill health at lower BMI levels than White populations. A lower threshold of 23 kg/m² for classification as overweight in British South Asians has been recommended by the World Health Organisation. Due to continuing debate about the validity of BMI in different ethnic groups, the National Institute for Health and Clinical Excellence

[17] *http://www.ucl.ac.uk/ich/research-ich/mrc-cech/research/studies/LMS-method*

[18] *Obesity and Ethnicity, January 2011, National Obesity Observatory. http://www.noo.org.uk/NOO_pub/briefing_papers*

(NICE) continues to advise that the same thresholds should be used for all ethnic groups in the UK.

For both adults and children the debate continues in regards to the use of current BMI cut offs for non-white ethnic groups. Despite growing evidence, there is a lack of universal agreement in relation to reduced BMI cut offs for certain ethnic groups, however, the decision in Walsall for adults is to follow the guidance from the Scottish Intercollegiate Guidelines Network (SIGN) and use lower the cut offs for the South Asian population to 23 kg/m2 and 27.5 kg/m2 for overweight and obesity respectively. NICE Guidance in July 2013 suggested that the evidence confirms that these groups are at an equivalent risk of diabetes, other health conditions or mortality at a lower BMI than the white European population. But it was not sufficient to make recommendations on the use of new BMI and waist circumference thresholds to classify whether members of these groups are overweight or obese.

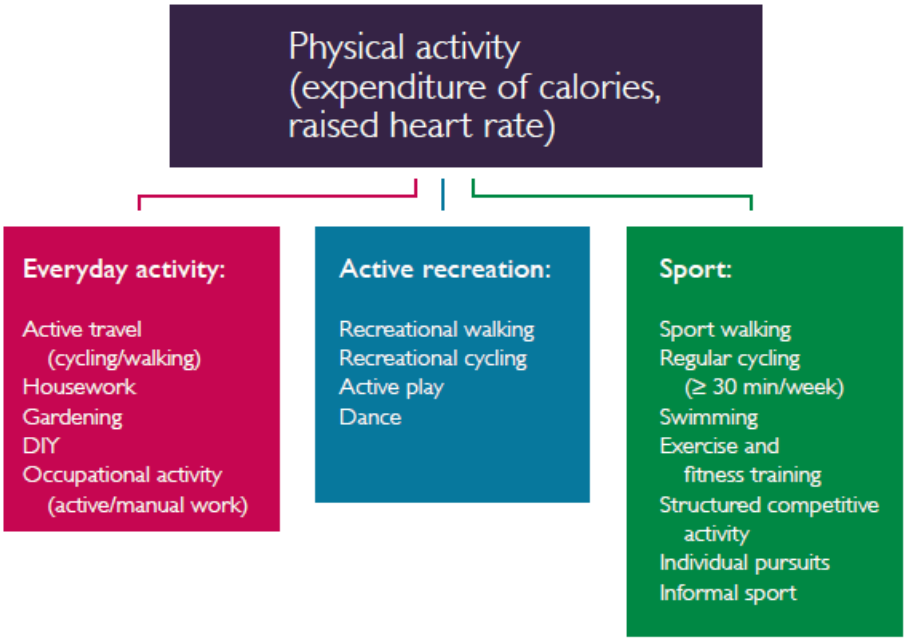
Definition of Physical Activity

"Any force exerted by skeletal muscle that results in energy expenditure above resting level".

Physical activity includes all forms of activity, such as everyday walking or cycling to get from A to B, active play, work-related activity, active recreation (such as working out in a gym), dancing, gardening or playing active games, as well as organised and competitive sport.[19]

[19] *Start Active, Stay Active : A report on physical activity for health from the four home countries' Chief Medical Officers: 2011*

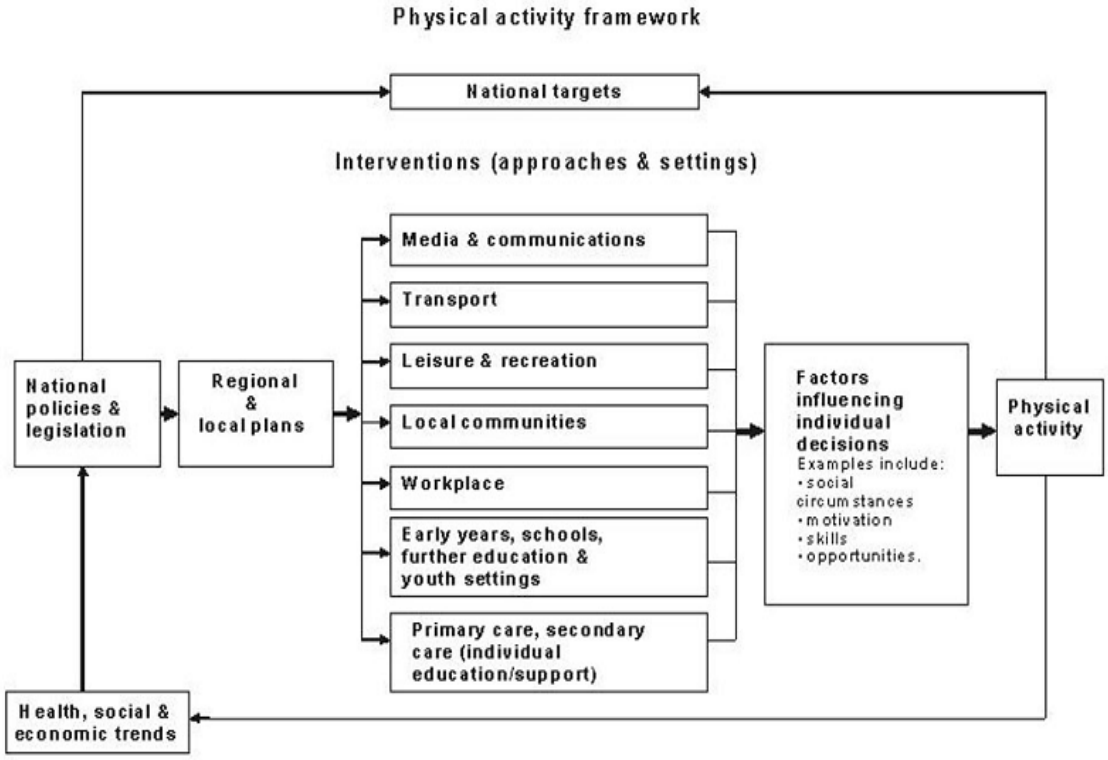
Figure 4: Different types of physical activity



With this in mind, along with an aim to develop a well rounded physical activity and healthy weight strategy this needs assessment takes a holistic approach to assessing the need of physical activity provision in Walsall including information from a variety of settings including leisure and recreational activity, active travel, recreation within green spaces, schools and workplaces. See *Figure 5* below[20].

[20] *NICE Guidance Physical Activity and the Environment; 2008*

Figure 5: Physical activity framework



Consequences of excess weight and inactivity

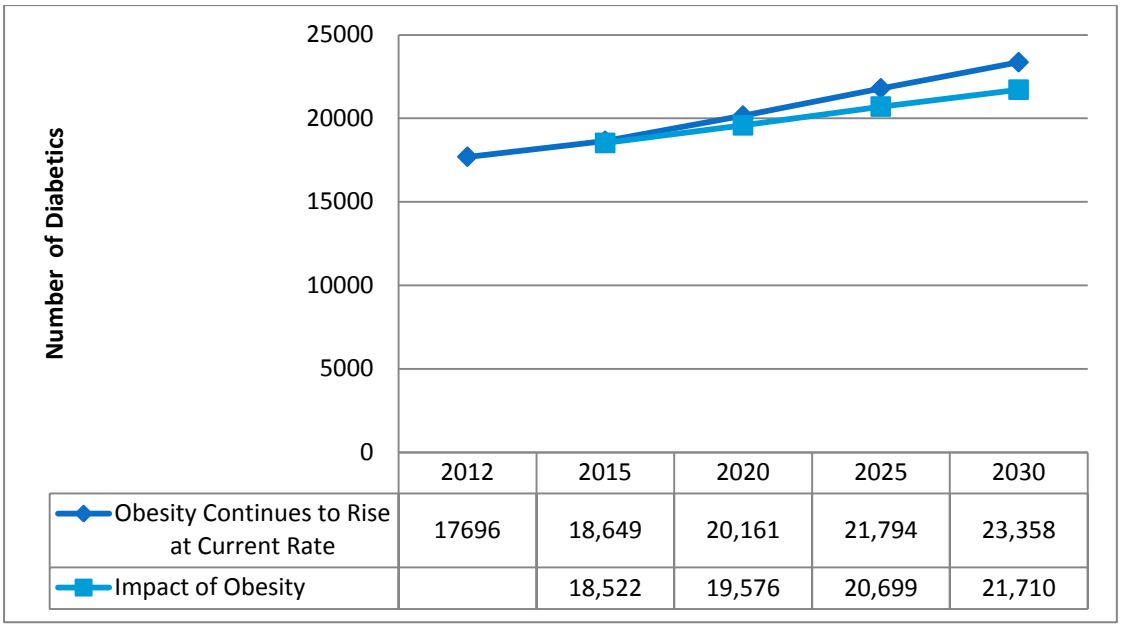
24% (2013/14) of Walsall's Reception children are overweight or very overweight and 40% of Year 6 children are also overweight or very overweight. Overweight and obesity in childhood and adolescence have adverse consequences on premature mortality and physical morbidity in adulthood[21]. The strongest predictor of childhood obesity is parental obesity (a mixture of nature and nurture) and children who are obese are more likely to grow up to be obese adults, therefore a vicious circle is created. More immediate issues for overweight children are social and psychological, including stigma, bullying, low self-esteem and depression. Children

[21] *Reilly JJ, Kelly J. Long-term impact of overweight and obesity in childhood and adolescence on morbidity and premature mortality in adulthood: systematic review. Int J Obes (Lond). 2011 Jul; 35(7):891-8.*

identify very overweight children as being less popular and see fat-related teasing and bullying as commonplace[22].

Adult obesity is associated with many chronic diseases including diabetes, coronary heart disease and some cancers. It is estimated that 12,000 cases of cancer a year in the UK are due to obesity[23]. Obese adults are five times more likely to be diagnosed with diabetes than adults of a healthy weight. In England 90% of adults with type 2 diabetes are overweight or obese.[24] In Walsall the diabetes prevalence 8.30% is higher than the England average of 6%. If obesity levels in Walsall could be maintained at 2010 levels there would be 585 fewer Diabetics by 2020. This is shown in *Figure 6* below. By 2030 a static prevalence of obesity would mean an estimated 1648 fewer people with Diabetes.

Figure 6 Estimated Impact of increasing prevalence of obesity on diabetes prevalence in Walsall



	2012	2015	2020	2025	2030
Obesity Continues to Rise at Current Rate	17696	18,649	20,161	21,794	23,358
Impact of Obesity		18,522	19,576	20,699	21,710

[22] *Rees R., Oliver K., Woodman J. & Thomas J. Children's views about obesity, body size, shape and weight: a systematic review. 2009. EPPI- Centre, Social Science Research Unit, Institute of Education, University of London, London.*

[23] *Bhaskaran K, et al. (2014). Body-mass index and risk of 22 specific cancers: a population-based cohort study of 5·24 million UK adults, The Lancet, DOI: 10.1016/S0140-6736(14)60892-8*

[24] *'Adult Obesity and Type 2 diabetes': Public Health England, July 2014.*

Other health problems associated with adult obesity are listed in the table below;

Figure 7 Health problems associated with obesity

Large increase in risk	Moderate increase in risk	Slight increase in risk
Type 2 Diabetes Gallbladder disease Abnormal lipids e.g. high cholesterol Insulin resistance Sleep Apnoea (breathing problems during sleep)	Coronary Heart Disease High blood pressure Osteoarthritis (wear and tear arthritis) High uric acid levels and gout	Some cancers (including breast and bowel cancers) Reproductive hormone abnormalities Polycystic ovary syndrome Impaired fertility Low back pain

Source: World Health Organisation

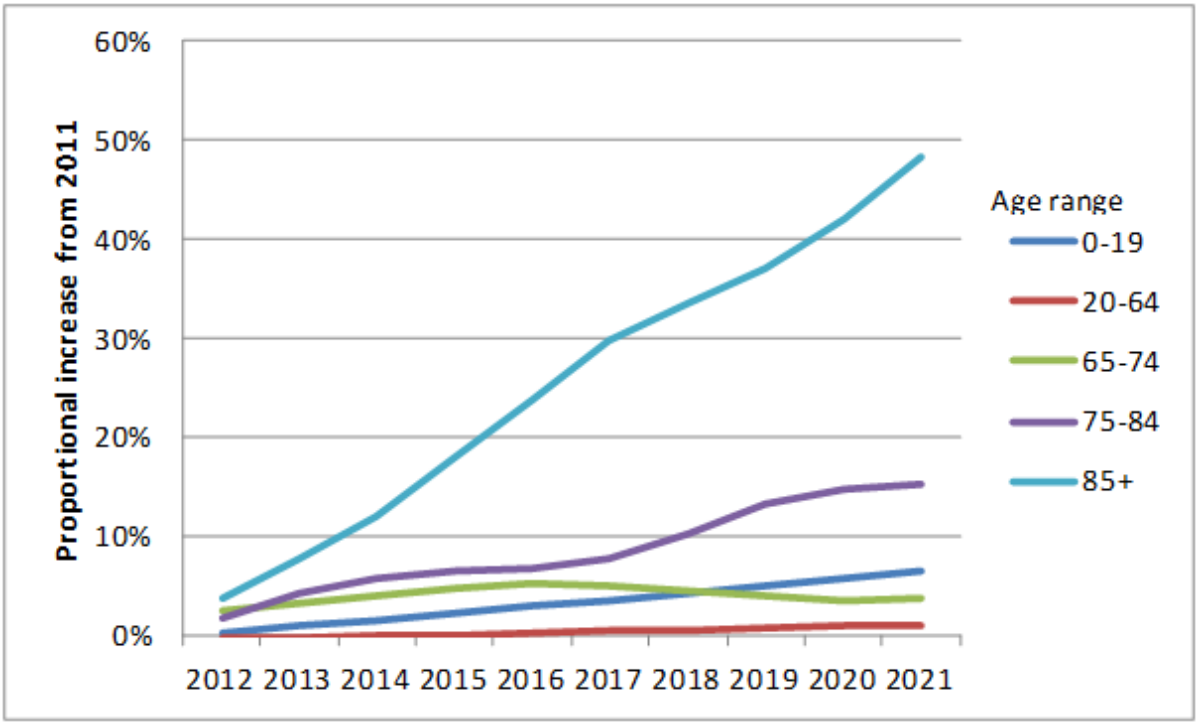
Similar to obesity, physical inactivity is associated with many chronic diseases and is responsible for 10.5% of heart disease cases, 13% of type 2 diabetes cases, around 18% of cases of colon and breast cancer and 17% of premature deaths in the UK [25].

Introduction to Walsall

Walsall's overall population is predicted to increase over the next 10 years by 5.1% from 270,900 in 2012 to 284,700 in 2022. In addition to this, Walsall's older population (those aged 65 and above) is also predicted to increase by 13.8%, with the number of people 85 years and older increasing from 47,200 in 2012 to 53,700 in 2022 (see Figure 8 below). Planning to meet the needs of a growing number of older people must be incorporated within key strategic priorities in Walsall.

[25] *Lee I-M, Shiroma EJ, Lobelo F, Puska P, Blair SN, Katzmarzyk PT, Lancet Physical Activity Series Working Group. Effect of physical inactivity on major non-communicable diseases worldwide: an analysis of burden of disease and life expectancy. Lancet 2012,* ***380****:219–229.*

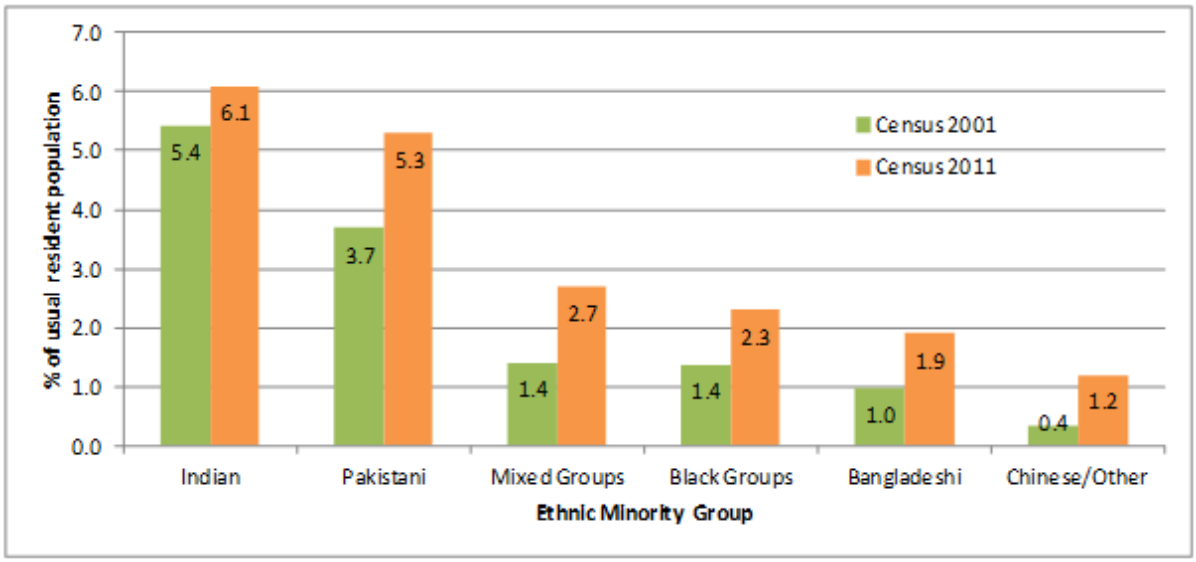
Figure 8: Walsall population projections, by age 2011-2021



Source: Office for National Statistic (ONS)

Walsall also has a culturally-mixed population. People of Indian, Pakistani and Bangladeshi background form the largest minority ethnic groups in Walsall. The number of Non-UK Born residents in Walsall has increased by 3.7% (or 9,859 people) between the 2001 and 2011 censuses (see figure 5). Walsall now has a small Eastern European population who make up about 1% of the area residents (2,681 people in total). Access and the appropriate provision of services depend upon a well-informed understanding of the specific needs of these different communities.

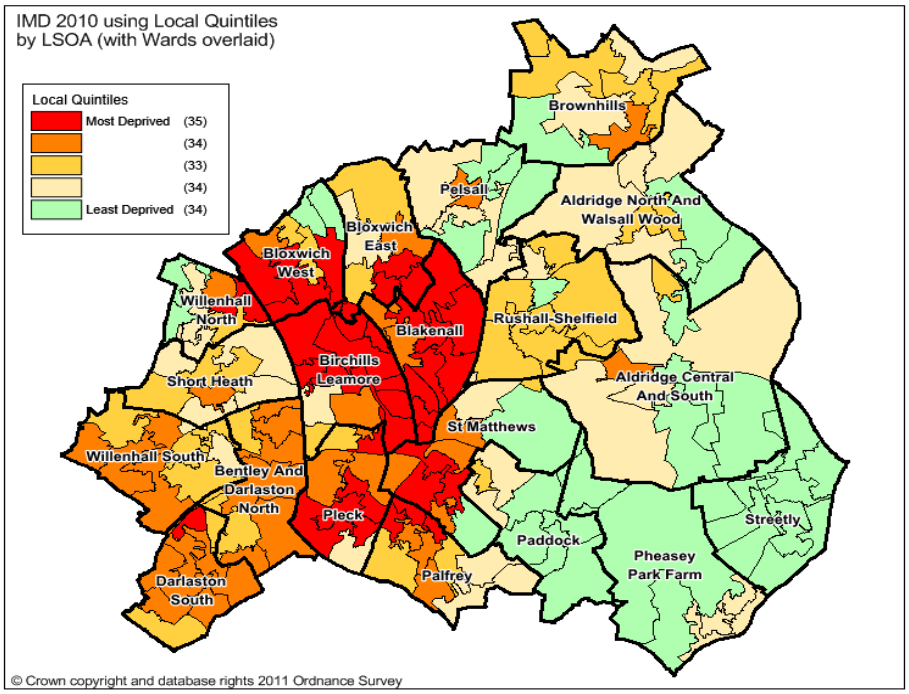
Figure 9: Minority ethnic group trends in Walsall 2001-2011



Source: ONS

In 2010, Walsall was ranked as the 30th most deprived of the 326 Local Authorities in England. This position has worsened since the last data release in 2007, where Walsall ranked 45th out of 354. The borough fares particularly badly in terms of education, income and employment deprivation. Central and western parts of the borough are typically more deprived than the east.

Figure 10: Walsall LSOA deprivation using Local Quintiles



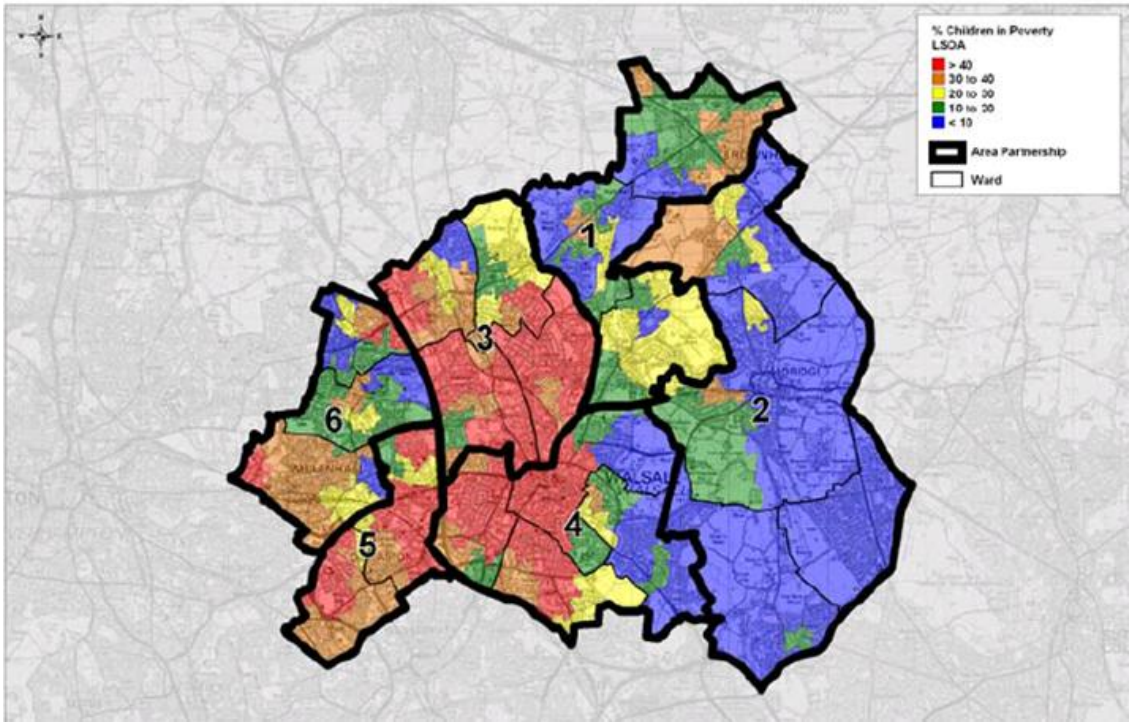
Source: Department for Communities and Local Government

114,800 (44.6%) of Walsall's total population (2010 mid-year estimates) live within the most deprived quintiles compared to 30,400 (11.8%) living in the least. Looking specifically by age, 28,100 (52.3%) of 0 to 15 year olds live within the most deprived quintiles in Walsall and 16,100 (35.5%) of over 65's. This compares to 5,000 (9.2%) of 0 to 15 year olds living within the least deprived quintiles in Walsall and 7,000 (15.6%) of over 65's.

- 7,042 (7.0%) lone parent households with dependent children[26] in Walsall, compared to 6.5% nationally.
- Blakenall has the highest proportion (12.6%) of lone parent households with dependent children compared to Streetly which has the lowest proportion (2.5%) in Walsall.
- 32,701 (32.3%) households with dependent children of all ages in Walsall which is higher than the nationally (29.5%).
- Palfrey has the highest proportion (41.5%) of households with dependent children and Aldridge Central and South have the lowest (26.0%).

Walsall ranks 47th out of 354 councils on the Income Deprivation Affecting Children Index (IDACI), falling within the 20% most deprived in England. Over a quarter of children live in poverty (26.9%) (IDACI 2007) and there is a clear east/west divide in the levels of deprivation (see Figure 11 below).

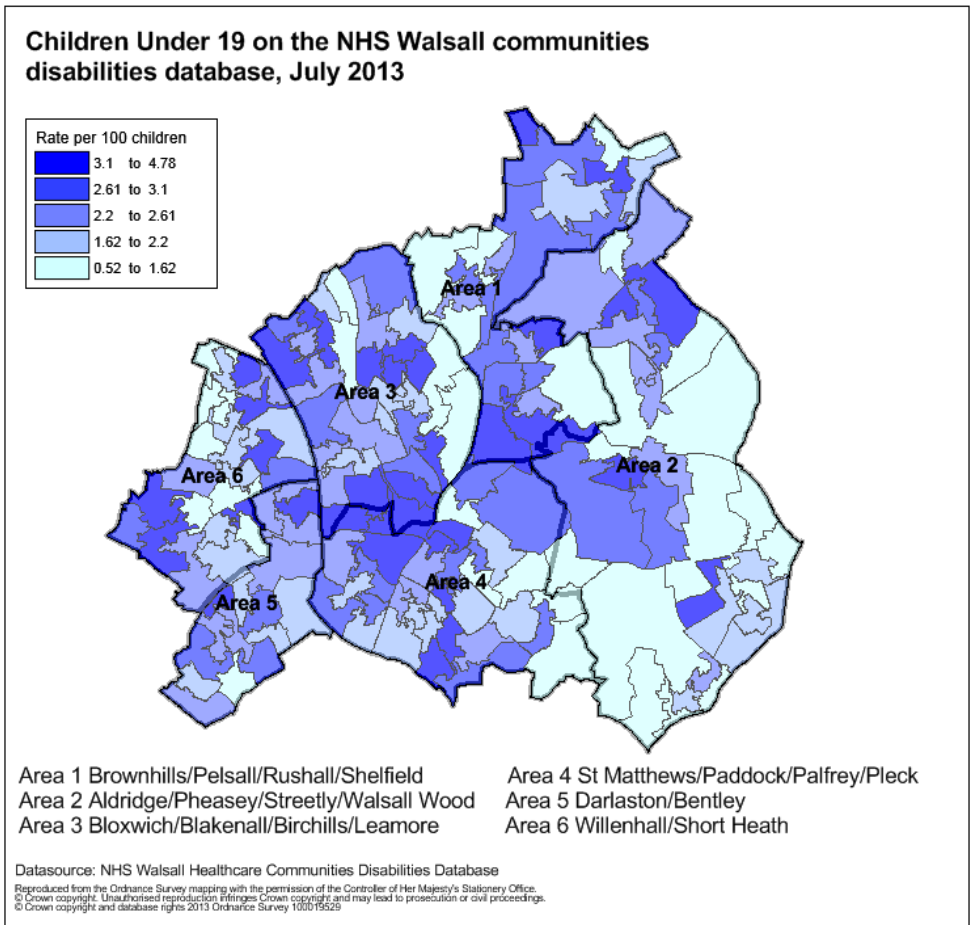
Figure 11: Map of % of children in poverty shown by Lower Super Output Area (LSOA)



[26] *A dependent child is a person in a household aged 0 to 15 (whether or not in a family) or a person aged 16-18 who is a full time student in a family with parent(s)*

- Palfrey and Birchills-Leamore accounted for 61.4% of the increase in the number of children in poverty in the borough as a whole. Adding Pleck and St. Matthews takes the increase up to 91.5%.
- Using this measure, almost 30% of children in Walsall were affected by deprivation in 2007 which amounts to about 16,000 children.
- 1,500 children with a disability[27], ranging from physical disabilities, cognition and learning behaviour, emotional and social to language/communication.

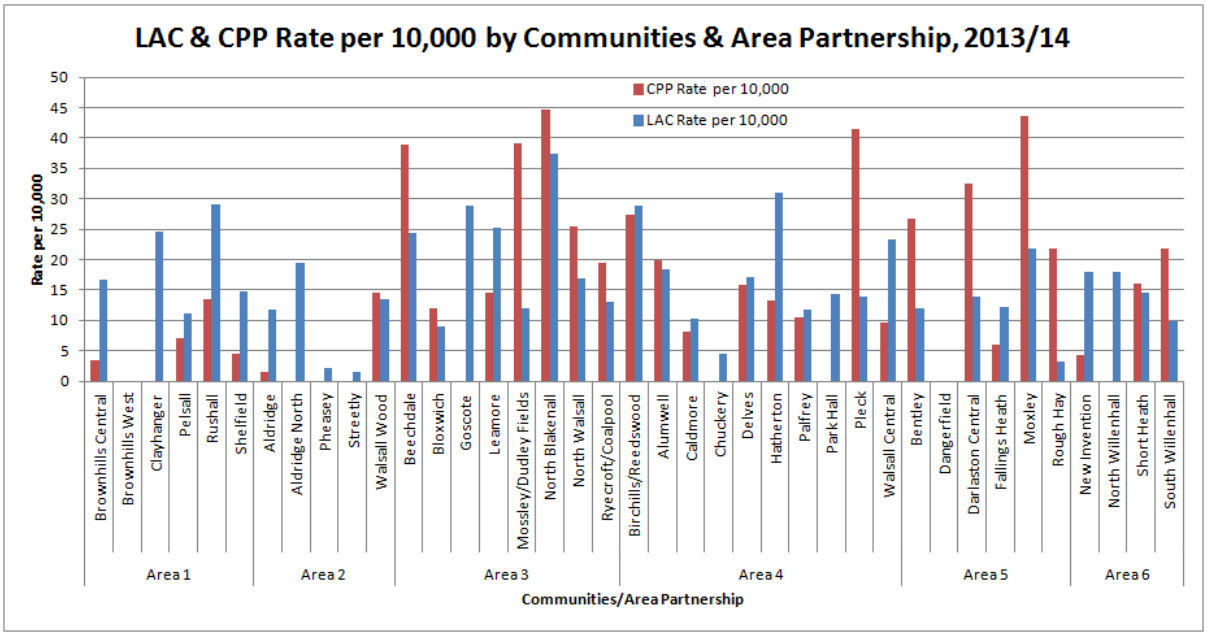
Figure 12: Children under 19 on the NHS Walsall communities' disabilities database, July 2013



[27] *Walsall Community Health Database*

In July 2014 there was an estimated 365 children subject to child protection and up to 625 children in the care of the local authority. Number varies widely across Walsall with a strong correlation with deprivation.

Figure 13: Ward & Area Partnership rates of looked after children (LAC) and children with protection plans (CPP), Walsall 2013/14

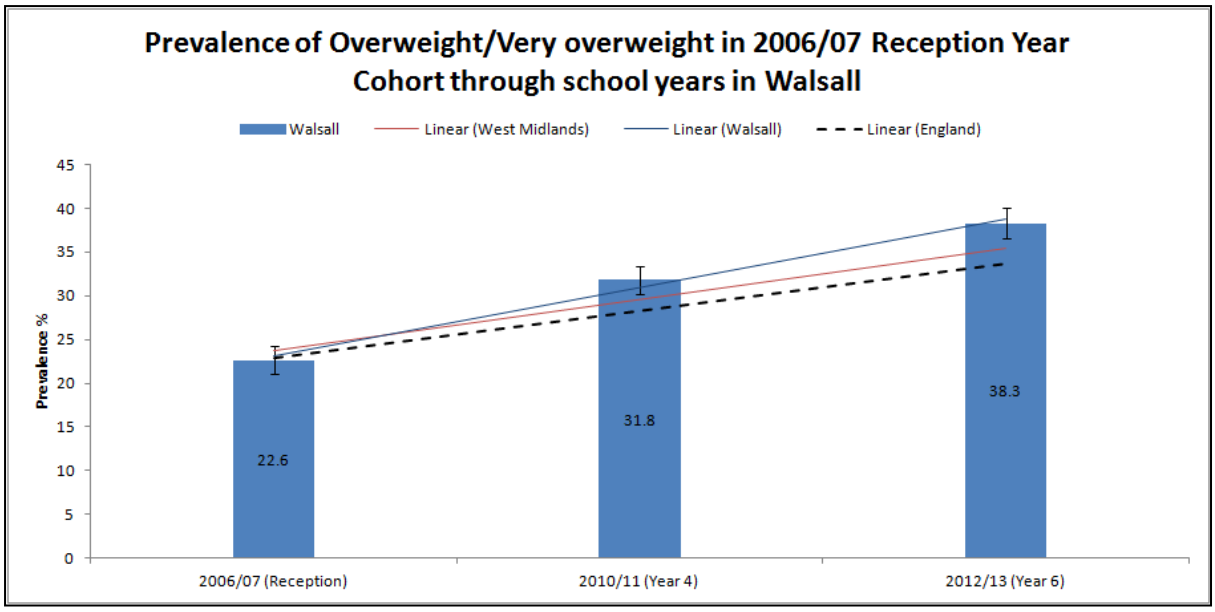


Childhood Obesity in Walsall

The National Child Measurement Programme

The National Child Measurement Programme (NCMP) is a mandatory annual programme which measures the height and weight of children in Reception (age 4-5 years) and Year 6 (age 10-11 years) within state maintained schools in England. In addition to the required measurements Walsall also measures children in Year 4 (age 8-9 years) and Year 10 (age 14-15 years) providing robust data on childhood obesity.

Figure 14: Overweight/obese from 2006/07 (Reception Year) to 2012/13 (Year 6) for Walsall compared with West Midlands and England



Caveat: The number of participating children in reception year (2,843), year 4 (3,083) and year 6 (3,043) for Walsall is different and therefore direct comparison between each year needs to consider this factor.

The proportion of overweight and very overweight children in Walsall has increased between reception year (22.6%), Year 4 (31.8 %) and Year 6 (38.3%). Walsall reception year 2006/07 had a lower prevalence of overweight and very overweight children compared with regional (23.7%) and national averages (22.9%), however this has changed in Year 4 and by Year 6, Walsall is significantly higher than regional (35.5%) and national averages(33.7%).

A Masters in Public Health Dissertation (MPH) titled 'A retrospective cohort analysis to determine the relationship between weight status of reception age children in Walsall, West Midlands and weight status at year 4' was conducted on reception children measured in 2006/07 and their year 4 measurements from 2010/11. The method, findings and conclusion are highlighted below[28;]

Purpose: Primarily, to investigate if weight status at reception in Walsall is a determinant of weight status at year 4.

Methods: The study was a retrospective cohort analysis using secondary data from 2406 matched records from the National Child Measurement Programme

[28] *'A retrospective cohort analysis to determine the relationship between weight status of reception age children in Walsall, West Midlands and weight status at year 4.' Tracy Thompson. November 2012*

forReception and Year 4. Age, weight and height were used to determine body mass index (BMI) and BMI SD score, and weight status based on the 85th centile. Mean (sd) or median (range) were obtained. Gender, ethnicity and Indices of Multiple Deprivation (IMD) were described using frequency and percentage. Paired t-test was used to compare BMI SD scores at reception and year 4. Multi-linear and logistic regressions were used to predict BMI SD Score and weight status at year 4, respectively.

Results: At reception, mean age of the children (48.6%, girls; 51.4%, boys) was 5.1 (sd 0.36) years, weight 19.6 (sd 3.3) kg, height 1.1 (sd 0.05) m, BMI SD score 0.27 (sd 1.15), and 545 (22.6%) were classed overweight or obese. BMI SD score increased by 0.2 (sd 0.86) ($p < 0.001$) at year 4, and 739 (30.7%) were classed overweight or obese. Height and weight at reception significantly predicted BMI SD Score at year 4 (R^2 0.53; p=<0.0001) and the odds ratio obese or overweight in Year 4 was 16.1 (CI = 12.727 – 20.289) ($p < 0.001$) if overweight or obese at Reception. Ethnicity 'Other' was significant.

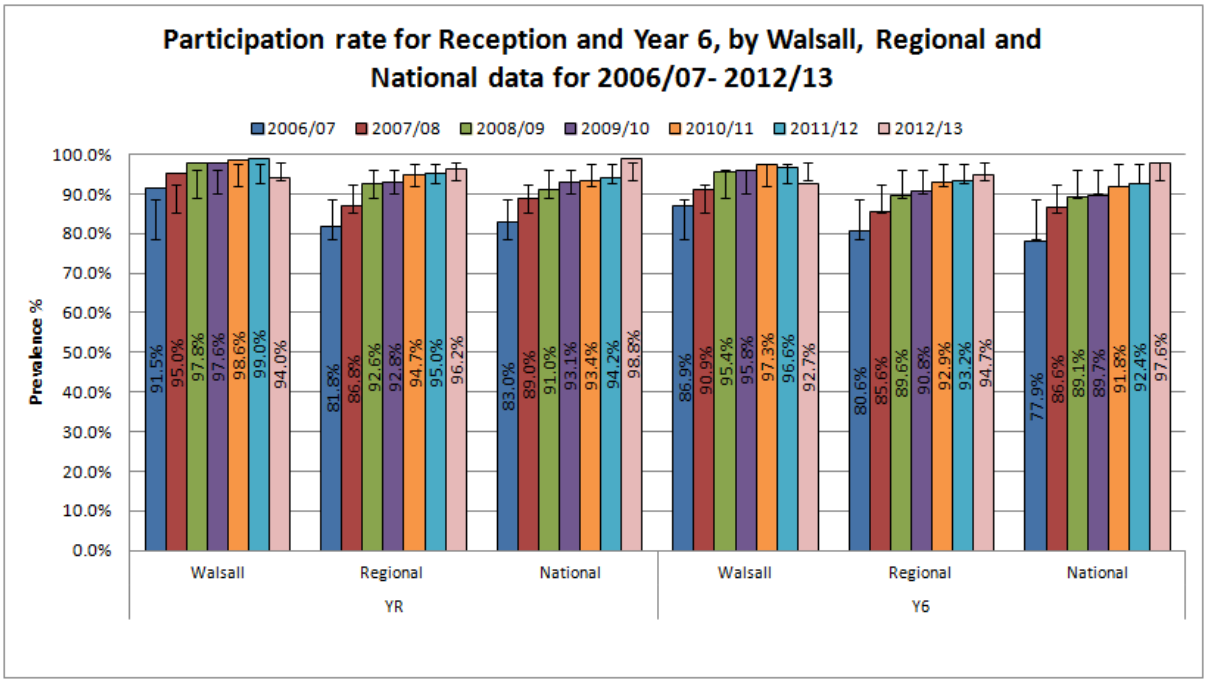
Conclusion: Height and weight from reception aged children are highly significant predictors of BMI SD scores at year 4. Weight status at reception is a strong predictor of weight status in year 4. Early intervention is imperative to prevent obesity in later childhood although more research is needed to consider the impacts of other risk factors for obesity.

Three year Data: 2008/09 to 2010/11

Public Health holds comprehensive datasets on children's BMI, measured as part of the NCMP, since 2005. The last three years of data have been analysed together instead of using single year data alone.

Participation

Figure 15: Participation rates for Reception and Year 6, by Walsall from 2006/07 – 2012/13



**As the participation rate has increased again in 2011/12, and the regional variation has decreased, it was considered unnecessary to repeat the analysis this year. We will continue to monitor this in the future. Taken from the NCMP report
A confidence interval indicates the likely error around estimates that has been calculated from the measurements based on a sample of the population. This indicates the range within which the true values for the population are expected to lie. The 95% confidence intervals are used throughout the report.
The participation rate is the percentage of pupils eligible in state schools in each year group for whom valid measurements were recorded. In 2009/10, all PCTs were working towards a national target of achieving at least an 85% participation rate in reception and year 6.

Key findings:

- Reception and year 6 participation rates continue to supersede the Black Country, Regional and National rates.
- Participation rates for Reception (98.6%) have increased by 1% from 2009/10.
- Participation rates for Year 6 (97.3%) have increased by 1.5% from 2009/10.

Prevalence

Figure 16: Prevalence of underweight, healthy weight, overweight and obese children by school year and sex, Walsall, 2011/12 to 2013/14

Numbers/Percentages

		Underweight	Underweight	Healthy weight	Healthy weight	Overweight	Overweight	Obese	Obese	Overweight and Obese combined		Number Measured
	Girls	49	1.0%	3900	76.7%	586	11.5%	553	10.9%	1139	22.4%	5088
	Boys	97	1.8%	3952	73.3%	717	13.3%	624	11.6%	1341	24.9%	5390
Reception	**Both**	**146**	**1.4%**	**7852**	**74.9%**	**1303**	**12.4%**	**1177**	**11.2%**	**2480**	**23.7%**	**10478**
	Girls	61	1.3%	3099	65.4%	651	13.7%	927	19.6%	1578	33.3%	4738
	Boys	46	0.9%	3225	65.0%	653	13.2%	1039	20.9%	1692	34.1%	4963
Year 4	**Both**	**107**	**1.1%**	**6324**	**65.2%**	**1304**	**13.4%**	**1966**	**20.3%**	**3270**	**33.7%**	**9701**
	Girls	87	1.9%	2755	61.1%	707	15.7%	957	21.2%	1664	36.9%	4506
	Boys	79	1.7%	2750	57.9%	699	14.7%	1218	25.7%	1917	40.4%	4746
Year 6	**Both**	**166**	**1.8%**	**5505**	**59.5%**	**1406**	**15.2%**	**2175**	**23.5%**	**3581**	**38.7%**	**9252**
	Girls	30	1.5%	1225	61.1%	321	16.0%	428	21.4%	749	37.4%	2004
	Boys	43	1.9%	1415	63.7%	315	14.2%	448	20.2%	763	34.4%	2221
Year 10	**Both**	**73**	**1.7%**	**2640**	**62.5%**	**636**	**15.1%**	**876**	**20.7%**	**1512**	**35.8%**	**4225**
Grand Total		492	1.5%	22321	66.3%	4649	13.8%	6194	18.4%	10843	32.2%	33656

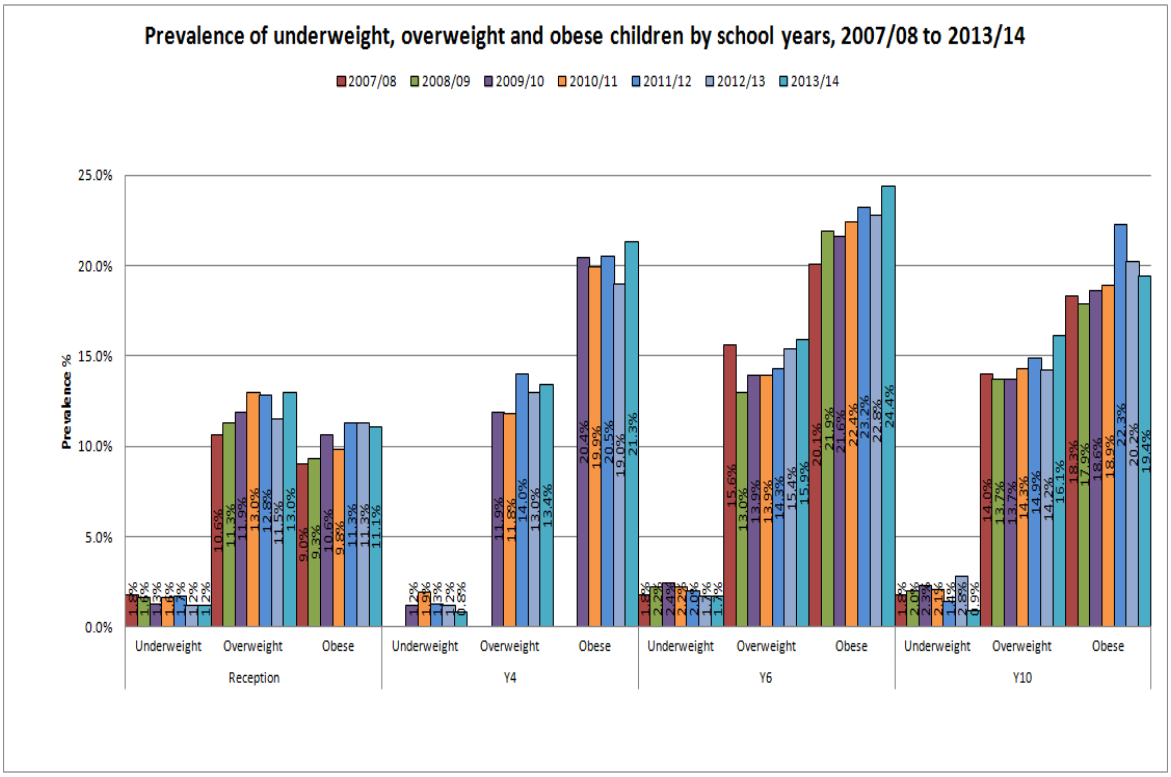
Source: NCMP Dataset 11/12-13/14

Key Findings:

- In reception, nearly a quarter (23.7%) of the children measured was either overweight or obese over a three year period. In year 6, the rate was more than one in three (38.7%).
- The proportion of obese children in year 6 (23.5%) more than doubles that of reception year (11.2%).
- The percentage of overweight children was higher in year 6 (15.2%) than in year 4 (13.4%) and reception year (12.4%).
- The overall prevalence of underweight children was higher in year 6 and year 10 (1.8% and 1.7% respectively) than reception (1.4%) and year 4 (1.1%).

Prevalence – Trends

Figure 17: shows the prevalence of underweight, overweight and obese children by school year for 2007/08 to 2012/13

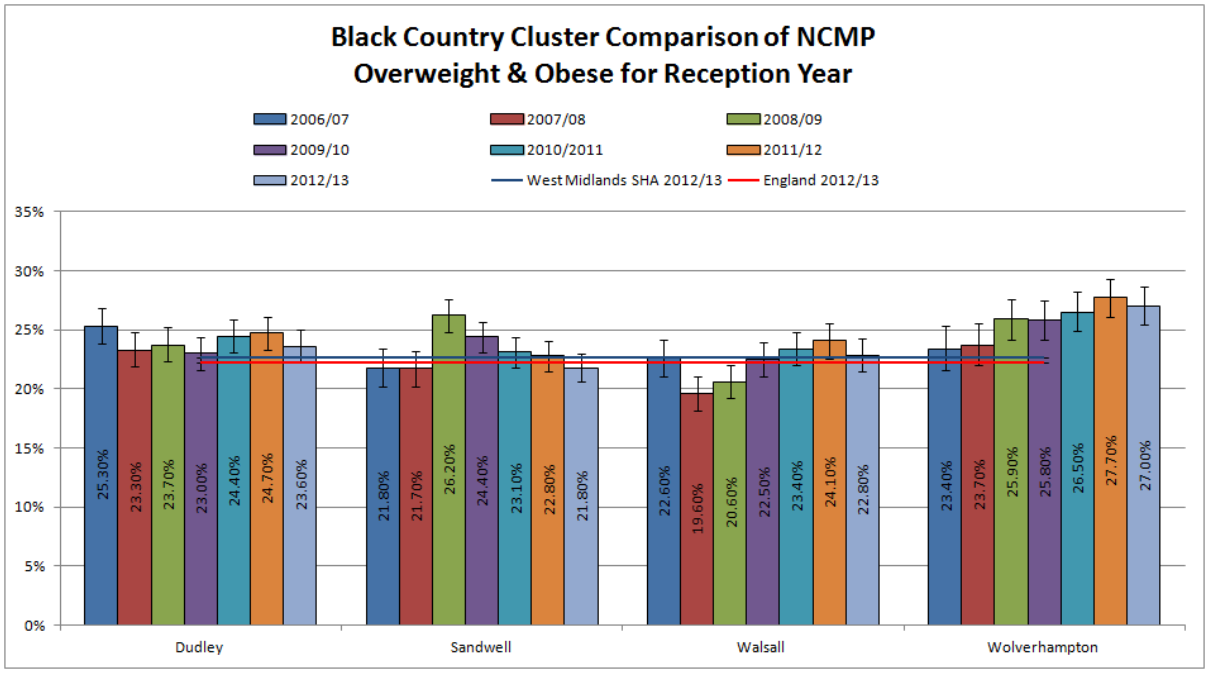


Key findings:

- In reception, the proportion of obese children (11.1%) has increased from 9.0% over the 7 year period but has shown small decline in last 2 years; however the overweight children (13%) has increased in 2013/14.
- In year 6, the proportion of obese children (24.4%) has increased over the 7 years compared to 2007/08 when the corresponding figure was 20.1%. The proportion of overweight children (15.9%) had increased from 15.6% over the 6 years.
- In Year 4, the proportion of obese children (21.3%) increased slightly over the 4 year period compared to 2009/10 (20.4%).
- In year 10, the proportion of obese children (19.4%) has increased slightly over the 6 years compared to 2007/08 (18.3%), however there has decrease since 2011/12.

Further analysis of the prevalence of underweight, overweight, and obese children in Reception and year 6 can be found in Appendix 1

Figure 18: Black Country Cluster comparisons of NCMP data for overweight and obese Children in Reception.

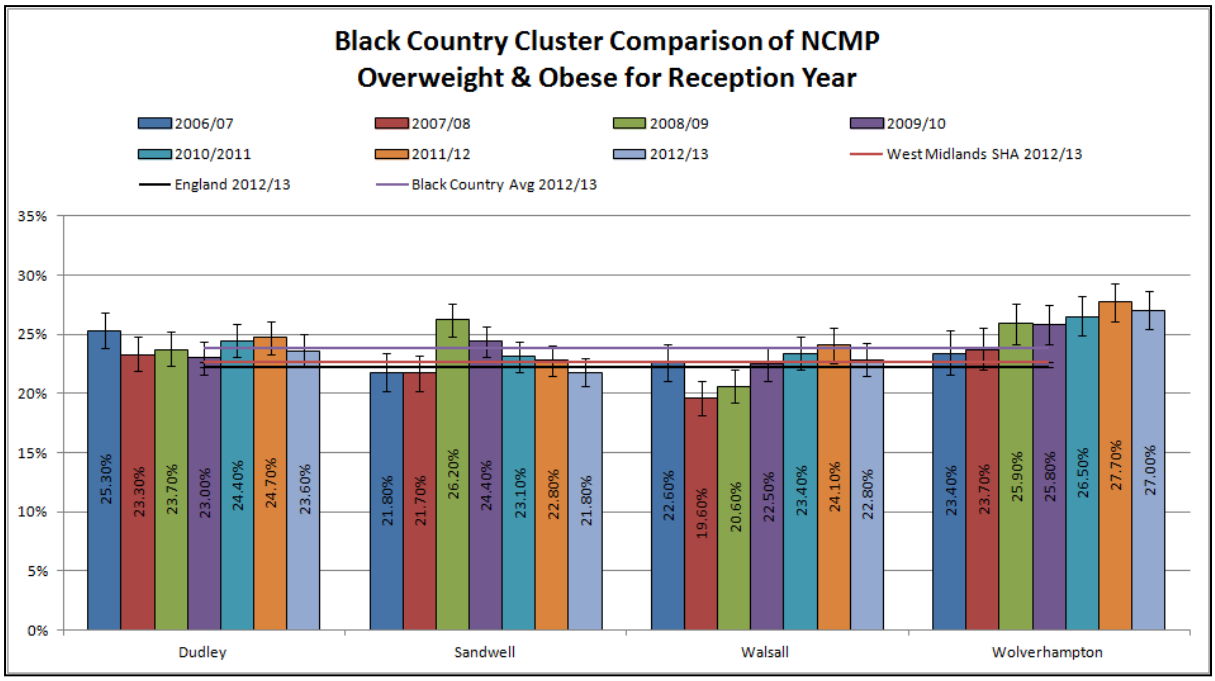


Key Findings:

- From 2006/07 to 2012/13 Walsall's overweight and obesity prevalence for Reception are the lower than of all neighbouring Local Authorities (LA) in the Black Country with the exception of Sandwell's 2012/13 levels.

- Walsall's overweight and obesity prevalence for Reception (22.8%) in 2012/13 is lower than Dudley (23.6%) and Wolverhampton (27%) but slightly higher than Sandwell (21.8%).

Figure 19: Black Country Cluster comparisons of NCMP data for overweight and obese Children in Year 6.



Key Findings:

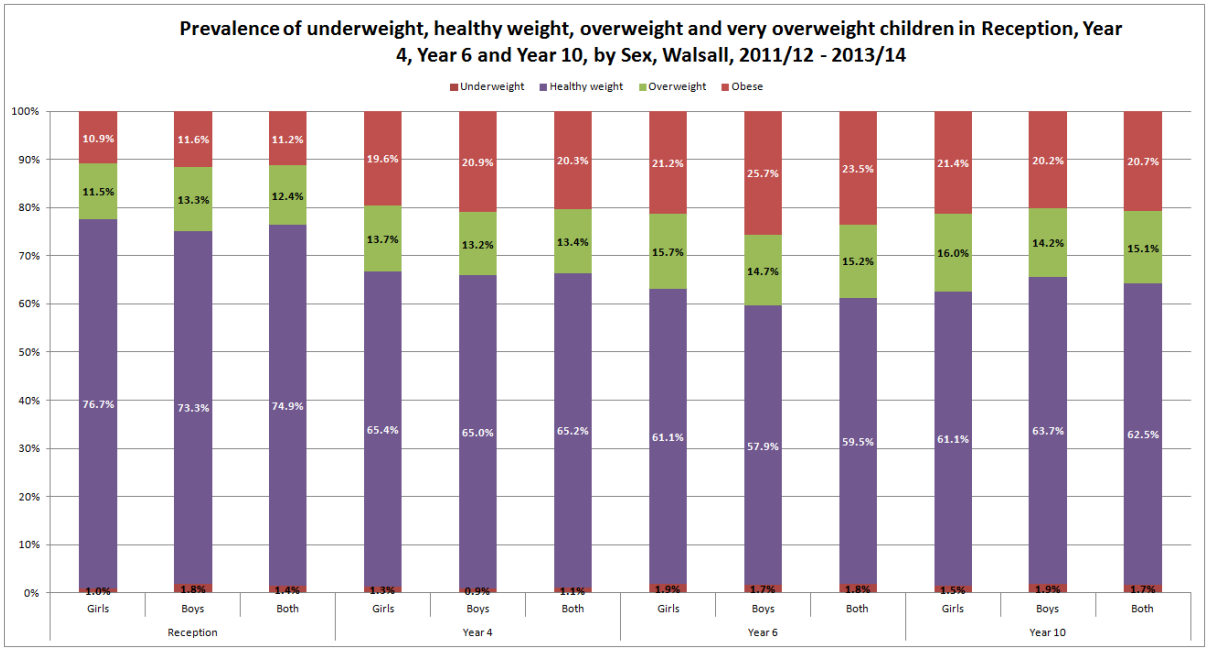
- The Black Country's overweight and obesity prevalence including Walsall's for Year 6 remains higher than the regional and national average.

- Walsall's overweight and obesity levels for year 6 over the 5 year period remain lower than all Black Country cluster LA in 2012/13 except for Dudley.

- Walsall's overweight and obesity prevalence for year 6 (38.3%) in 2012/13 is lower than Sandwell (40.5%), Wolverhampton (40.6%) but higher than Dudley (37.1%).

Gender

Figure 20: Prevalence of underweight, healthy weight, overweight and obese by gender in Walsall for 2010/11-2012/13.



Key findings:

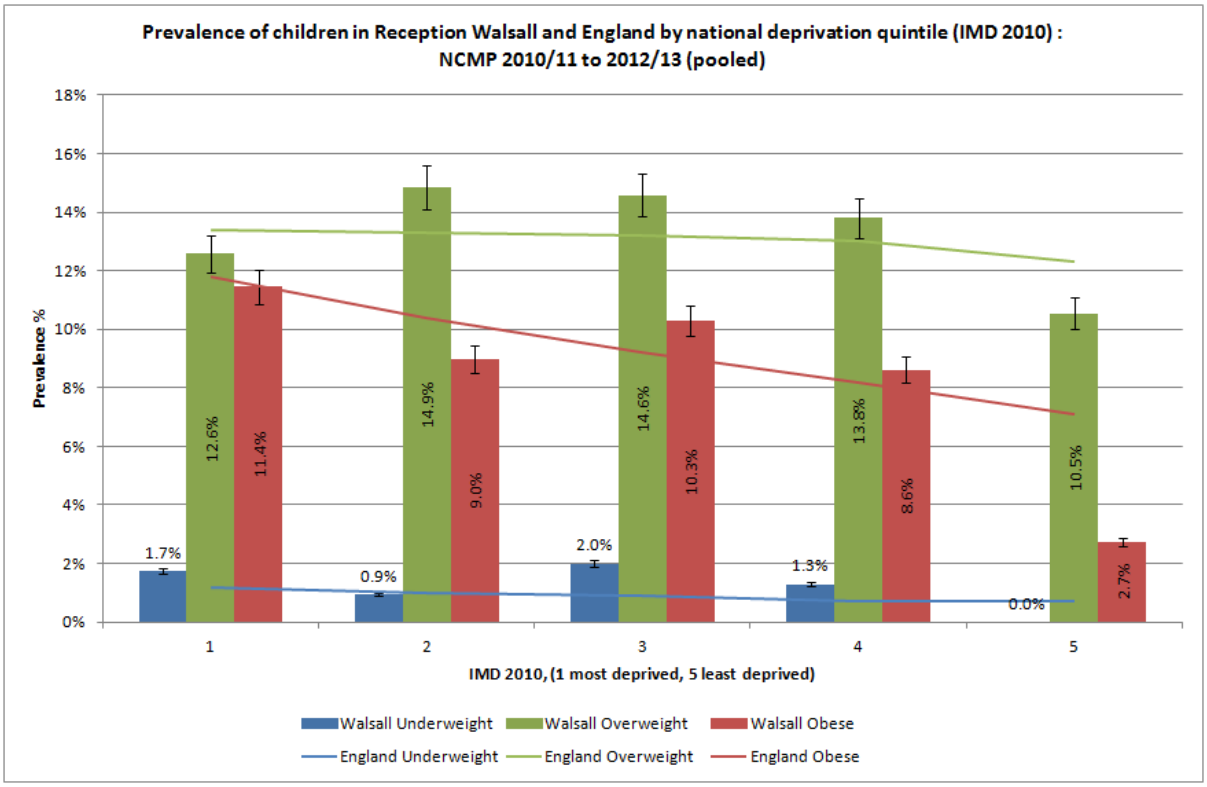
- The prevalence of obesity is higher in boys than in girls in all age groups except in Year 10.
- The prevalence of obesity between reception and year 6 more than doubles, this is similar for boys and girls, with the largest increase in boys (11.6% to 25.7%).
- In reception and year 10, slightly more boys were underweight than girls, whereas in year 4 and year 6 the opposite is true.

Deprivation

Obesity is associated with social and economic deprivation; there is a particularly strong gradient nationally in children, with increased deprivation being associated with increased obesity[29].

To analyse the relationship between deprivation as measured by the 2010 Index of Multiple Deprivation (IMD) and the prevalence of underweight, overweight and obese reception, year 6 and year 10 children, records have been placed into one of five equal sized groups based on the IMD score of the child's home address. The prevalence of underweight, overweight and obese children in reception (where 1 is the most deprived) is shown below in Figure 21.

Figure 21: Prevalence of underweight, overweight and obese children in Year Reception by national deprivation quintile from 2009/10 – 2012/13.

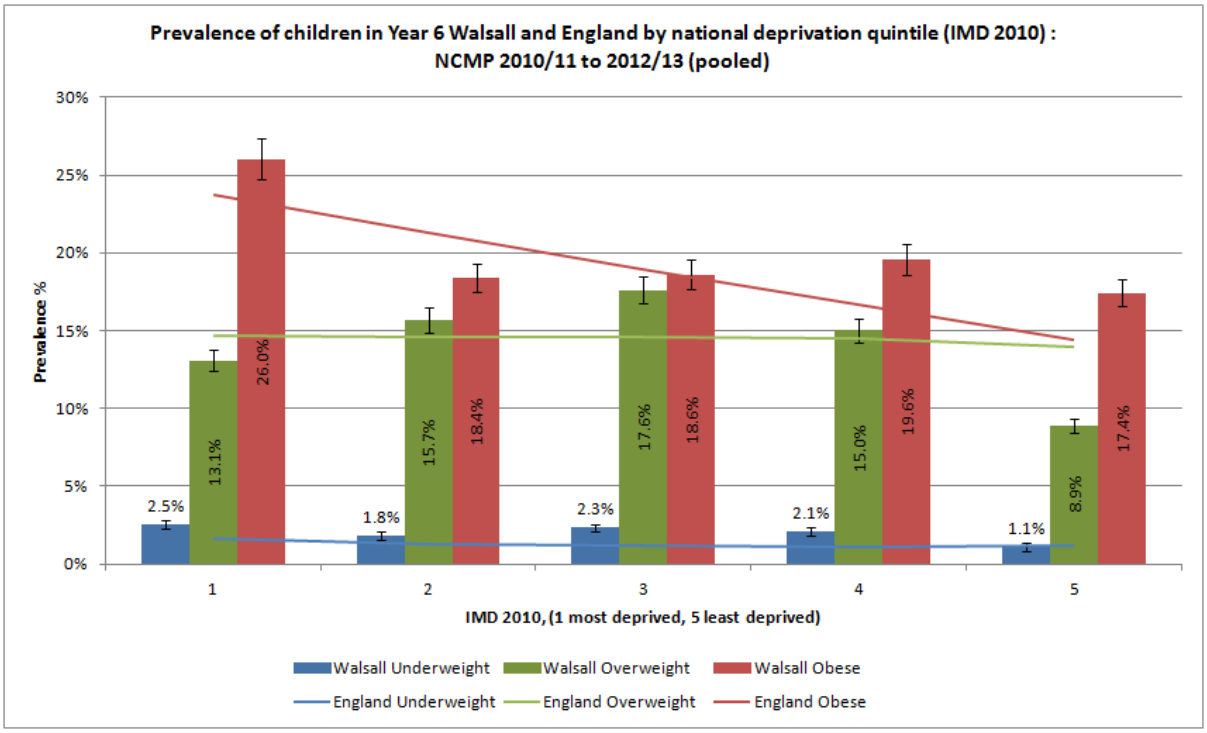


[29] *Child Obesity and Socioeconomic Status. NOO Data Factsheet. December 2011. http://www.noo.org.uk/NOO_pub/Key_data (last accessed 19/09/12)*

Key Findings

- A link exists between deprivation (as measured by the 2010 IMD Score) and childhood obesity in Reception. Obesity prevalence increases significantly from 2.7% to 11.4% as the socio economic deprivation increases.
- Overweight prevalence is less significant, with children with an IMD score of 3 having a higher prevalence of 14.0% compared to those from most deprived (12.6%).
- There is also a positive association between underweight and deprivation.

Figure 22: Prevalence of underweight, overweight and obese children in Year 6 by national deprivation quintile from 2009/10 – 2012/13.



Key Findings:

- A link exists between deprivation (as measured by the 2010 IMD Score) and childhood obesity in Year 6. Obesity prevalence increases significantly from 17.4% to 26% as the socio economic deprivation increases.
- Walsall children with an IMD score of 5 (least deprived) still have higher prevalence of obesity than nationally.
- Overweight prevalence is less significant in relation to deprivation, with children with an IMD score of 3 having a higher prevalence of 17.6% compared to those from most deprived (13.1%).

Ethnicity

The NCMP are required to collect ethnicity data of all the children participating in the programme. Utilising classified codes from the Department of Education's and the NHS, the codes were grouped into seven categories for analysis.

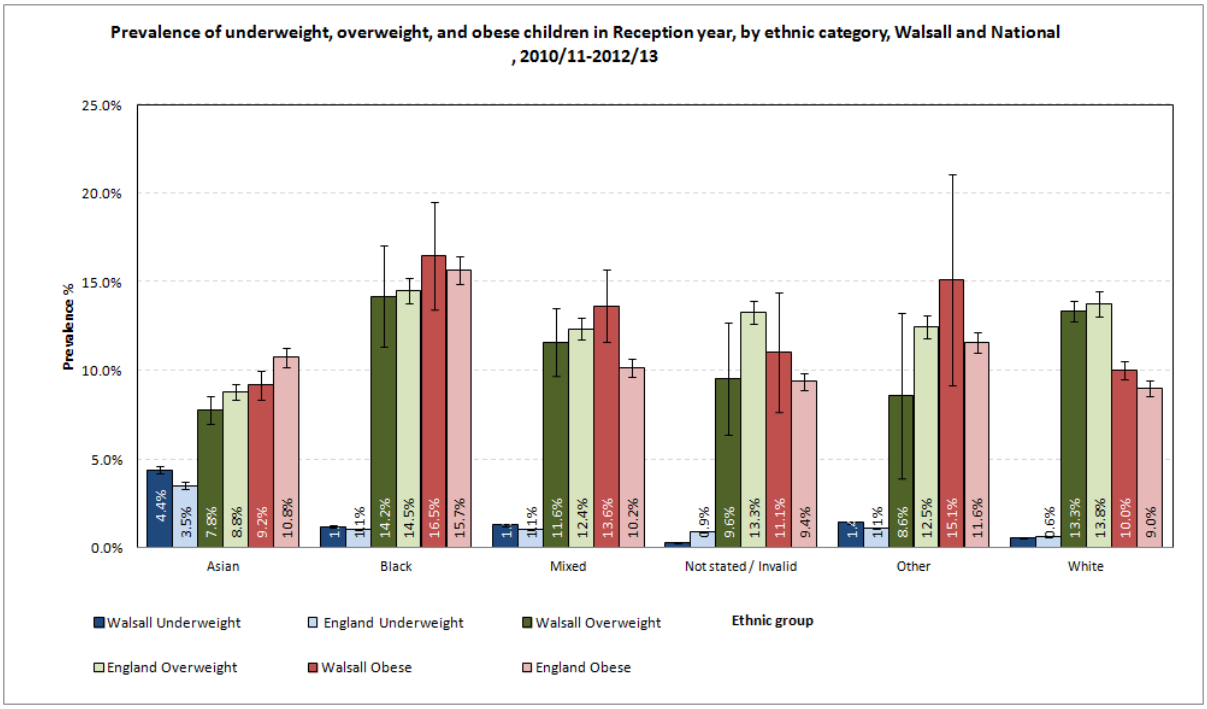
Of the 34,468 children measured over the 3 year programme for the reception, year 4, year 6 and year 10 groups, 98% of the records had a valid ethnic code.

The six ethnic categories used for analysis have been derived by combing the following NHS ethnic categories:

- *White: White British, White Irish, White Any other White background*
- *Mixed: Mixed White and Black Caribbean, Mixed White and Black African, Mixed White and Asian, Mixed any other Mixed background.*
- *Asian or Asian British: Asian and Asian British Indian, Asian and Asian British Pakistani, Asian and Asian British Bangladeshi, Asian and Asian British any other Asian background.*
- *Black or Black British: Black or Black British Caribbean, Black or Black British African, Black or Black British Any other black background:*
- *Chinese and other ethnic Group: Chinese, any other ethnic groups:*
- *No Information: Not stated or no data.*

Of the 10,388 reception children measured over the 3 year programme for the reception groups, 99% of the records had a valid ethnic code similar to the National rate of 99%.

Figure 23: Prevalence of underweight, overweight and obese children by ethnic category for Reception year.

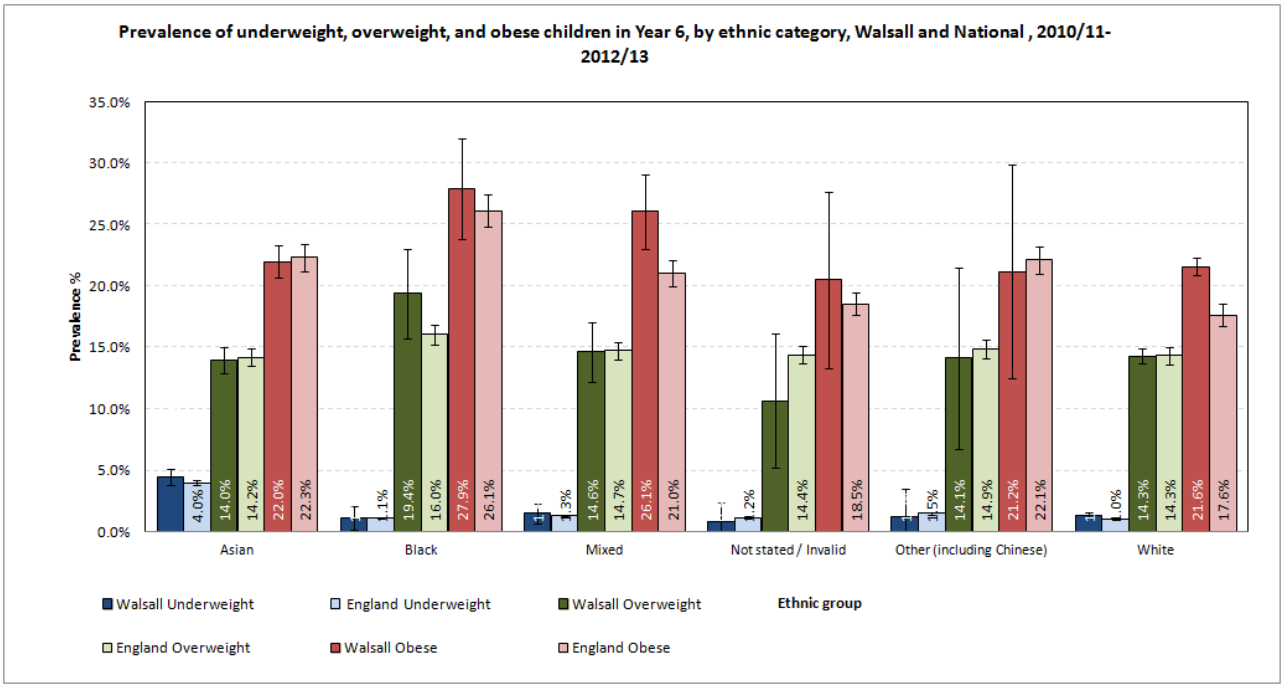


Key Findings:

- Asian children in Walsall are most likely to be underweight (4.4%) in reception and is higher than the national average (3.5%)
- Black (16.5%) and mixed children (13.6%) are significantly more likely to be obese than Asian (9.2%) and white children (10.0%) in Walsall.
- Reception white (13.3%) and Black children (14.2%) are significantly more likely to be overweight than Asian children (7.8%) in Walsall which is comparable to national figures.

Of the 9,237 year 6 children measured over the 3 year programme for the reception groups, 99.9% of the records had a valid ethnic code similar to the National rate of 99%.

Figure 24: Prevalence of underweight, overweight and obese children by ethnic category for year 6



Key findings:

- Asian children in Walsall are most likely to be underweight (4.5%) in Year 6.
- Black children (19.4%) are significantly more likely to be overweight than Asian (14.0%) and White children (14.3%) in year 6.
- Black (27.9%) and mixed children (26.1%) are significantly more likely to be obese than white children (21.6%) in year 6.

Disabilities and Special Educational Needs

Analysis of combined data from the Health Survey for England (HSE) 2006–2010 shows that children aged 2–15 with a limiting long-term illness (LLTI) are approximately 35% more likely to be obese than children without a LLTI.[30]

Current NCMP Guidance[31] states that measurements in special schools should be 'encouraged' but offers no further guidance on this. In Walsall, only children with a physical or learning disability and a known long term condition are weighed and measured by the Children's Community Nursing Services.

Caution needs to be taken when assessing BMI in children with special needs. Some conditions affect growth and it may not be appropriate to use the UK1990 reference data for this population. For example, short stature is a characteristic of Down syndrome and there is a high prevalence of overweight and obesity amongst people with Down syndrome. The Royal College and Paediatrics and Child Health (RCPCH) and the Down Syndrome Medical Interest Group (DSMIG) have produced growth charts with a specific BMI conversion for use within this population.[32] This should also be considered for any children with SEN who attend mainstream schools and are measured.

Area Partnership Analysis

Walsall's Area Partnerships bring together local people, Council and partner services and the community and voluntary sector to make Walsall a place where residents can live, work and play. There are six Area Partnerships in the borough; each has a dedicated Area Manager to facilitate local partnership working and each has an Area Community Plan to tackle the key issues and priorities in the locality. There are 39 communities within these Area Partnerships.

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[30] *Gatineau M. Obesity and disability: children and young people. Oxford: Public Health England Obesity Knowledge and Intelligence, 2014.*

[31] *National Child Measurement Programme 2012/13 Guidance, DH*

[32] *THE 2011 DSMIG/RCPCH GROWTH CHARTS FOR CHILDREN WITH DOWN SYNDROME FACT SHEET. RCPCH/DSMIG Down syndrome growth chart steering group. May 2012*

Figure 25: Prevalence of overweight and very overweight children in Reception by communities from 2011/12 to 2013/14

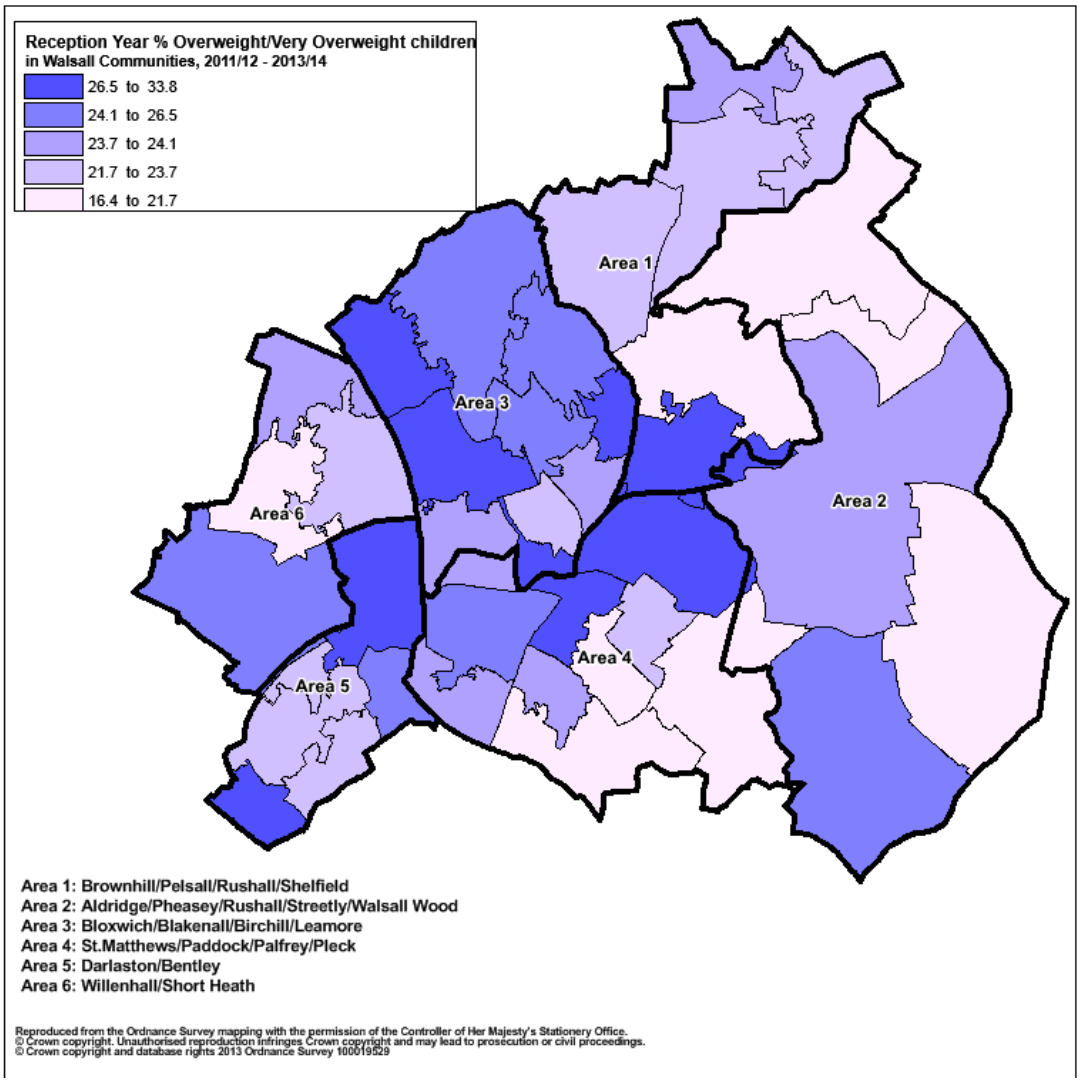
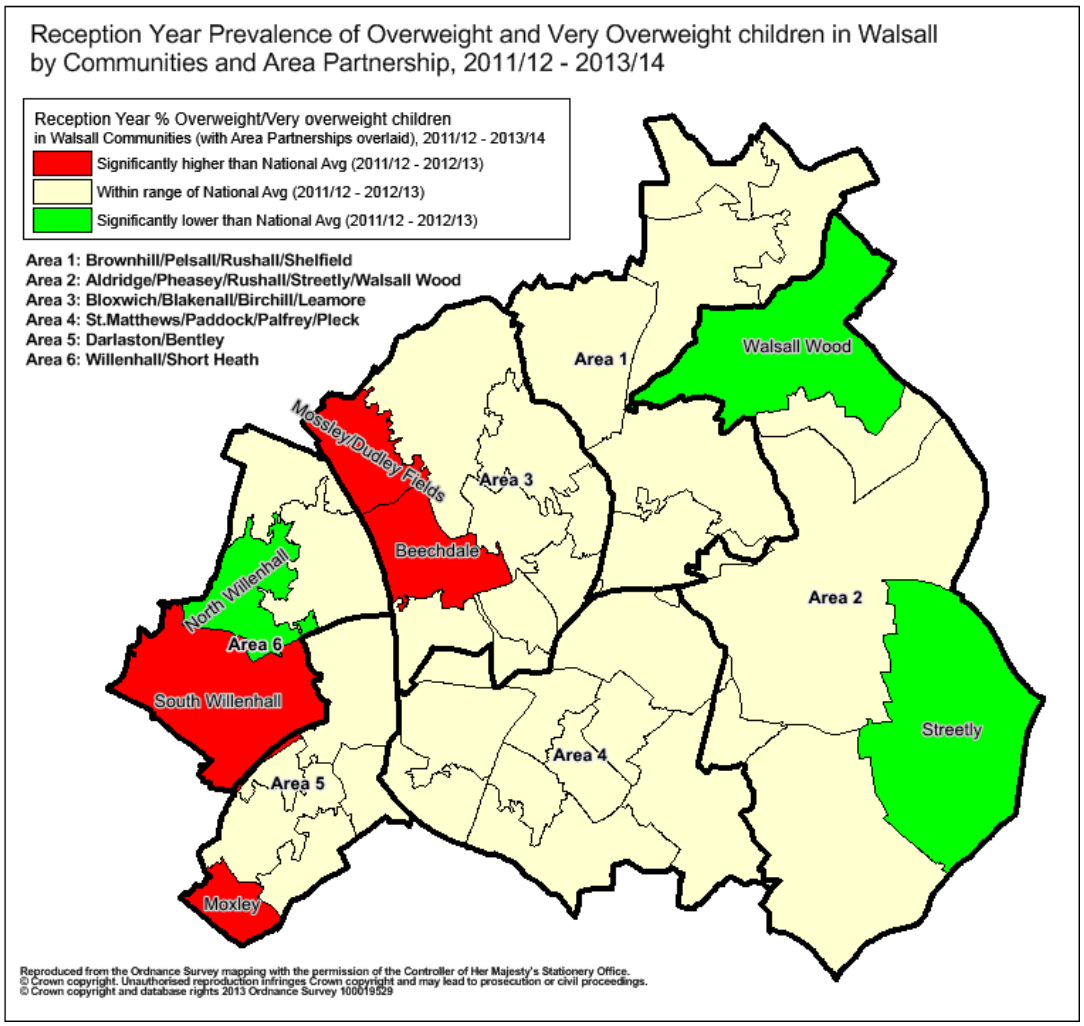


Figure 26: Prevalence of overweight and obese children in Reception by communities and Area Partnerships for 2011/12 to 2013/14



Key Findings:

- All Walsall communities are mainly within range or higher than the national average (22.4%) excluding North Willenhall, Walsall Wood and Streetly.
- Moxley (33.7%) and Goscote (31.3%) communities within the Darlaston/Bentley and Bloxwich/Blakenall/Birchill/Leamore area partnerships respectively have the highest overweight and obesity rates in the borough compared to Streetly (17.5 %) and North Willenhall (16.5%) with the lowest rates.
- Within the area partnerships, 17 out of the 39 (44%) communities have lower overweight and obese rates in reception than the overall Walsall average (23.6%).

Further analysis of the prevalence of obese and healthy weight children in Reception by communities from 2009/10 to 2011/12 can be found in Appendix 2

Figure 27: Prevalence of overweight and obese children in Year 6 by communities from 2011/12 to 2013/14

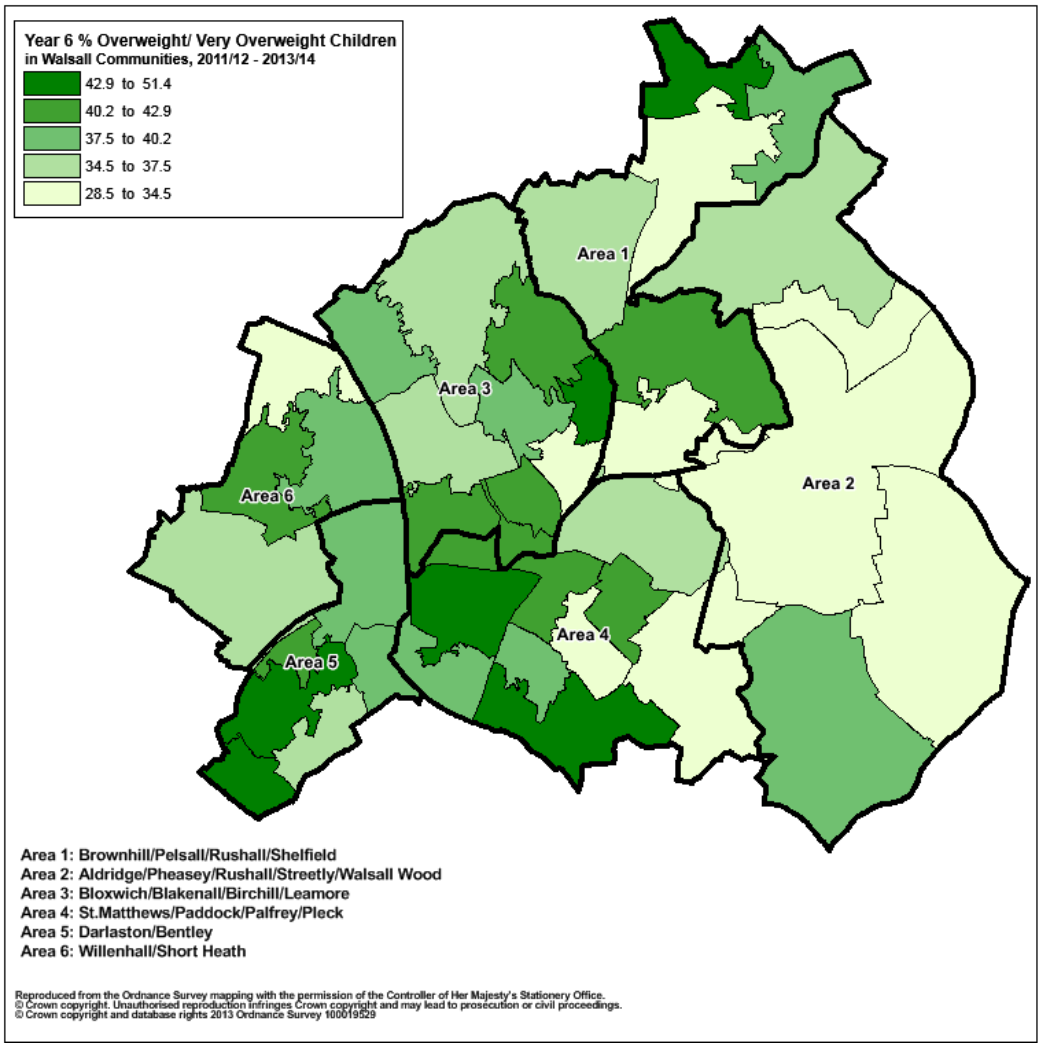
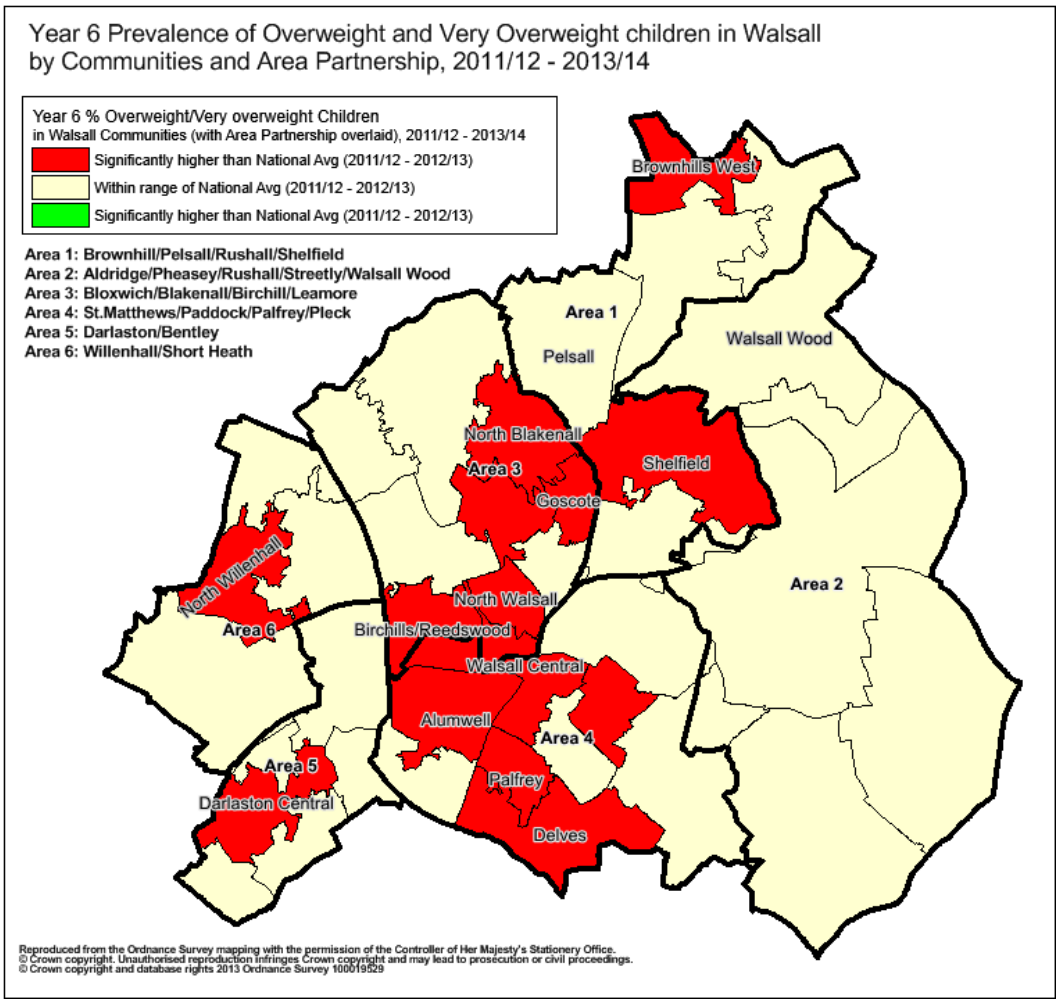


Figure 28: Prevalence of overweight and obese children in Year 6 by communities and Area Partnerships for 2011/12- 2013/14



Key Findings:

- Overweight and obesity rates in year 6 are higher in the most deprived wards in the west of the borough.
- Alumwell (46.8%) and Delves (46.1%) within the St.Matthews/Paddock/Palfrey/Pleck area partnership have the highest overweight and obese rates in the borough compared to Aldridge North (29%) and Caldmore (28.6%) with the lowest.
- Within the area partnerships, 19 out of the 39 (49%) communities have lower overweight and obese rates in Year 6 than the overall Walsall (38.4%) average.

Further analysis of the prevalence of obese and healthy weight children in Year 6 by communities from 2009/10 to 2011/12 can be found in Appendix 3.

Mosaic

Mosaic is a household classification tool, which provides detailed understanding of the location demographics, lifestyles and behaviours of citizens. One of the key strengths of the tool is that it provides an understanding of how individuals think and behave and how to communicate successfully with these population groups.

Using the tool, the population is classified into the following groups based upon postcode: **A – Residents of isolated rural communities**
B – Residents of small and mid-sized towns with strong local roots
C – Wealthy people living in the most sought after neighbourhoods
D – Successful professionals living in suburban or semi-rural homes
E – Middle income families living in moderate suburban semis
F – Couples with young children in comfortable modern housing
G – Young well-educated city dwellers
H – Couples and young singles in small modern starter homes
I – Lower income workers in urban terraces in often diverse areas
J – Owner occupiers in older-style housing in ex-industrial areas
K – Residents with sufficient incomes in right-to-buy-social housing
L – Active elderly people living in pleasant retirement locations.
M – Elderly people reliant on state support
N – Young people renting flats in high density social housing
O – Families in low-rise social housing with high levels of benefit need.
U - Unclassified

The 2013/14 NCMP overweight and very overweight data for Walsall is predominantly classified as group "K", which is defined as

"Residents with sufficient incomes in right-to-buy-social housing"

Many of Group 'K' live on former council estates, ones which were comparatively well built and pleasantly laid out and where a large proportion of properties have been purchased under right-to-buy legislation.
Some residents continue to rent from their local council but a large number now own their own homes. Some of the owner-occupiers will have been former tenants who exercised their right-to-buy whilst others will have bought freeholds from former council tenants. People therefore live in communities with a fair mix of incomes but where there is relatively little threat from anti-social elements.

Sector Types

The above groups can also be subdivided into public sector types, which helps describe the population in more detail. The top 5 in this list are as follows:

Ranking/ Sector type	Population %	Description of Sector Type
1 –K50	18.1%	Older families in low value housing in traditional industrial areas
2-O69	10.7%	Vulnerable young parents needing substantial state support
3-I42	9.3%	South Asian communities experiencing social deprivation
4-O67	6.4 %	Older tenants on low rise social housing estates where jobs are scarce
5-J45	5.5%	Low income communities reliant on low skill industrial jobs

For each of the 5 sector types above a description of their health characteristics of the population can be found in Appendix 4

Utilizing the data collected through the NCMP and analyzed by Public Health intelligence team a table highlighting a RAG rating Primary schools against Walsall, Regional and National average to identify those schools significantly higher to enable us to target schools appropriately.

Recommendations:

1) *Formulate a healthy weight/ physical activity marketing campaign using the mosaic information to communicate and engage effectively with the top 5 public sector types.*

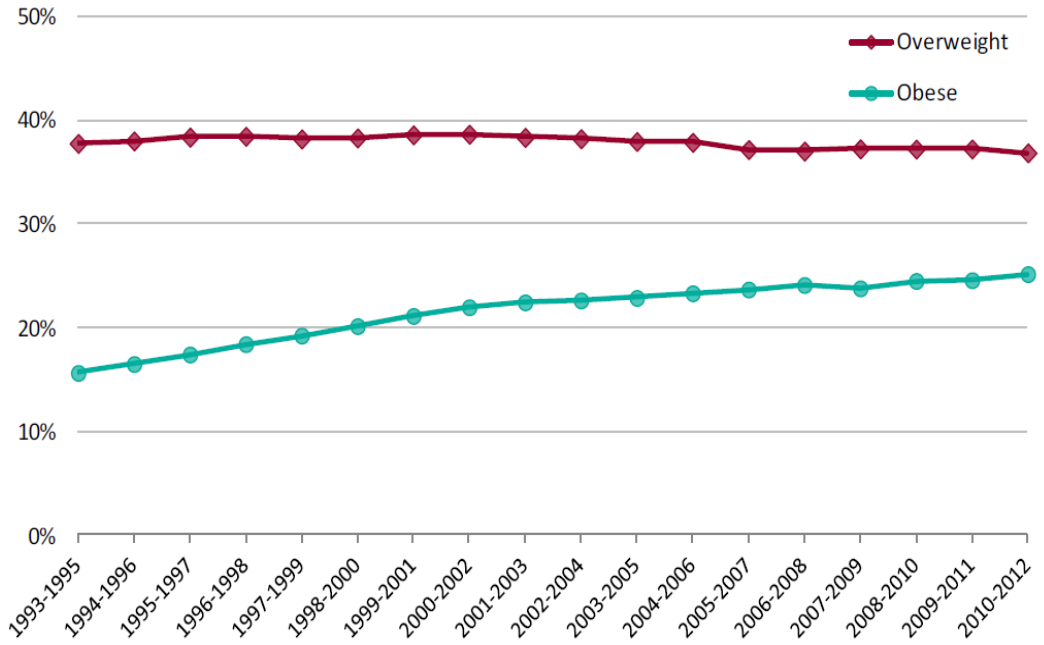
2) *Share profile data with providers to ensure engagement and recruitment onto family weight management programmes.*

Adult Obesity in Walsall

The Health Survey for England estimated in 2012, 62% of adults were overweight or obese[33].

Figure 29: National prevalence of overweight and obesity among adults (aged 16 and over), 3-year moving averages, 1993 to 2012below shows the prevalence of adult obesity continues to rise and has increased from 15% in 1993 to 25% in 2012. The prevalence of overweight has remained broadly stable during this time at 37-39%.

Figure 29: National prevalence of overweight and obesity among adults (aged 16 and over), 3-year moving averages, 1993 to 2012



Source: Health Survey for England

Future projections[34] do not indicate any flattening out of the current rising obesity trend in adults. By 2020 for men aged 20-65, projections signal a clear decline in the prevalence of healthy weight accompanied by significant increases in the prevalence of obesity and severe obesity. For women there is also a projected rise in obesity

[33] http://www.hscic.gov.uk/catalougue/PUB13218

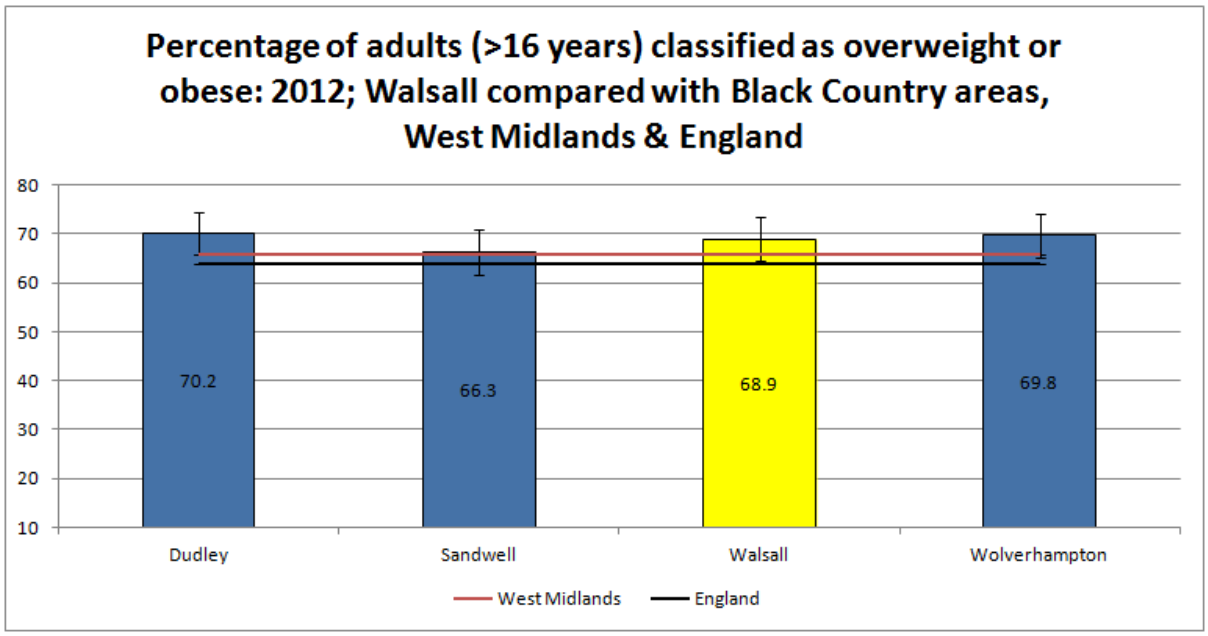
[34] Brown M, Byatt T, Marsh T, McPherson K (2010) A prediction of Obesity Trends for Adults and their associated diseases: Analysis from the Health Survey for England 1993 – 2007. Report. London; National Heart Forum

and severe obesity but to a lesser extent than for men. This is the opposite of the current situation where severe obesity is more common in women than in men.

The Health Survey data for England offers national statistics on adult obesity so local figures are more difficult to determine. To analyse data at a more local level we have analysed data from the Active People's Survey this data estimated in 2012 that adult overweight and obesity prevalence was slightly higher than HSE at 63.8%.

Figure 30 below compares Walsall's prevalence of overweight and obesity to our Black Country neighbours, regionally and nationally.

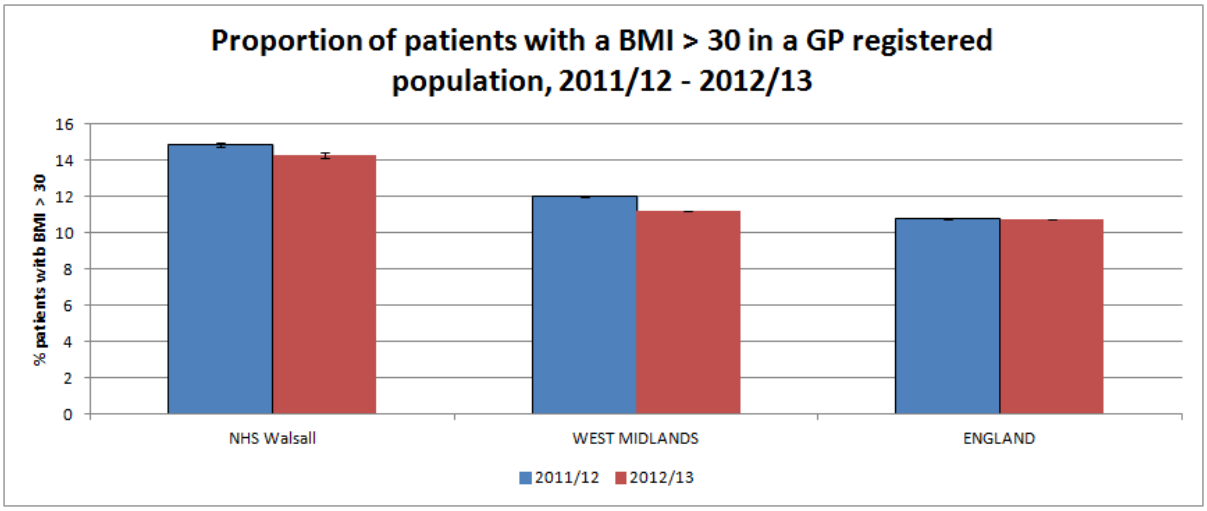
Figure 30: Prevalence of overweight and obese Adults in Walsall, Black Country areas, West Midlands and England, 2012



Datasource: Active People Survey, Sport England

In Walsall, the prevalence of overweight and obese adults are higher than the regional average (65.7%) and statistically significant higher than the national average (63.8%); however amongst the Black Country cluster Walsall has a lower prevalence than all except Sandwell.

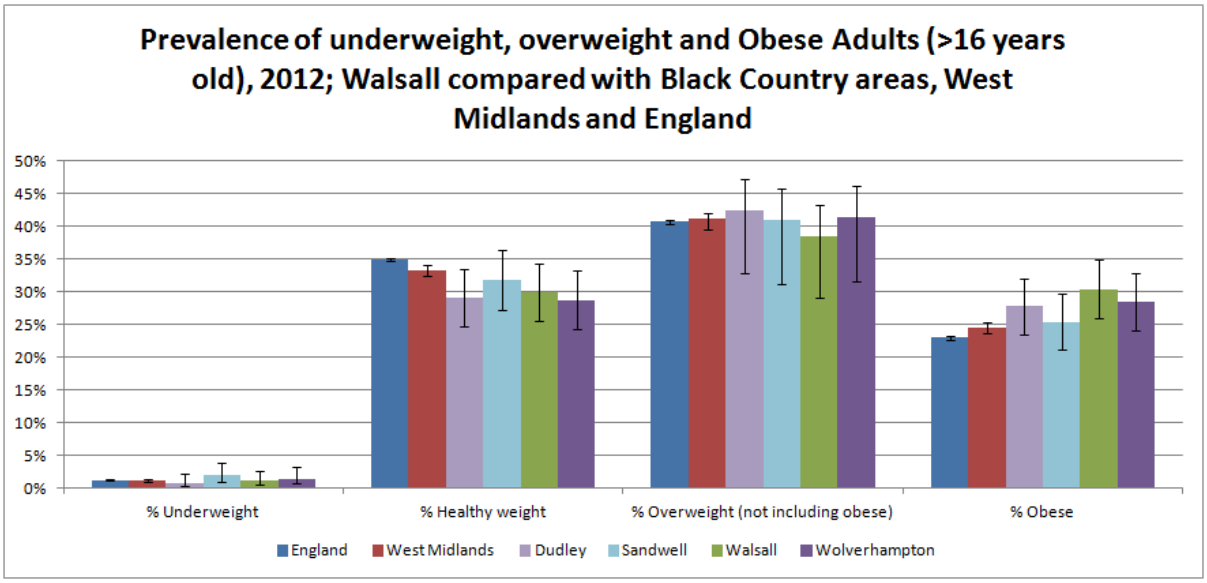
Figure 31: Proportion of patients with a BMI > 30 on GP practice obesity register, 2011/12 – 2012/13



Datasource: Quality and Outcomes Framework, QMAS database

In 2012/13, the proportion of GP registered patients with BMI > 30 in Walsall (14.3%) was significantly higher than the regional (11.2%) and national average (10.7%) however there seems to have been a significant decrease between 2011/12 and 2012/13 in Walsall which was also reflected in regional and national averages. The above data measure only patient's registered with a GP with a chronic illness and therefore is not reliable data in relation to the whole population and Walsall's obesity prevalence as highlighted above is likely to be much higher.

Figure 32: Prevalence of underweight, overweight and obese Adults in Walsall, Black Country areas, West Midlands and England, 2012



Datasource: Active People Survey

Key points:

- The prevalence of healthy weight adults in Walsall is lower than regional and national averages, however compared with the Black Country cluster Walsall is higher than all except Sandwell.
- Walsall has the lowest prevalence of overweight adults compared with Black Country cluster, regional and national averages.
- The decrease levels of overweight adults in Walsall is mainly due to the higher prevalence of obese classified adults as shown in Figure 32, Walsall has the highest prevalence of obese adults in black country cluster and is significantly higher than the regional and national averages

Gender

Figure 33 provides a national breakdown of weight status in recent years, based on Health Survey for England (HSE) data. It shows that in 2012 around 62% of adults were overweight or obese (BMI ≥25kg/m2); this equates to 57% of women and 67% of men. Men and women have a similar prevalence of obesity (25%), but men are more likely to be overweight (32% for women and 42% for men). The adult prevalence of severe obesity (obesity III: BMI ≥40kg/m2) is 2.4%, and the prevalence of underweight is 1.8%.

Figure 33: National weight status among adults (aged 16 and over)

		Underweight	Healthy weight	Overweight	Obese
2010 (%)	Men	1.3	30.9	41.6	26.2
	Women	1.9	40.4	31.7	26.1
	Adults	1.6	35.6	36.7	26.1
2011 (%)	Men	1.4	33.6	41.4	23.6
	Women	2.2	39.4	32.5	25.9
	Adults	1.8	36.5	36.9	24.8
2012 (%)	Men	1.3	32.1	42.2	24.4
	Women	2.3	40.6	32.1	25.1
	Adults	1.8	36.4	37.1	24.7

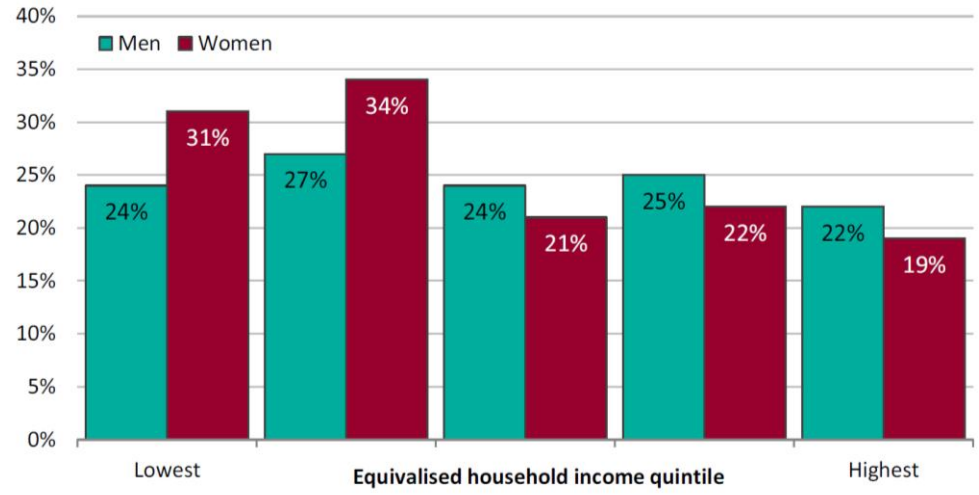
Source: Health Survey for England

Deprivation

As highlighted earlier, obesity is associated with social and economic deprivation and there is a particularly strong gradient nationally in children and women, where increasing deprivation is associated with increasing obesity.

Figure 34 shows the prevalence of obesity by equivalised household income quintile. Women living in lower income households are more likely to be obese: obesity prevalence falls from 31% in the lowest income quintile to 19% in the highest income quintile. There is no clear pattern for men.

Figure 34: National prevalence of obesity (age standardized) in adults (aged 16 and over) by equivalised household income quintile, 2012



Source: Health Survey for England

Ethnicity

Figure 35 shows a variation in prevalence of obesity by ethnic group and between sexes within ethnic groups. Prevalence of obesity is higher in women compared to men for Black African and Pakistani ethnic groups. Prevalence of obesity is higher among women of Black Caribbean, Black African, and Pakistani ethnicities, compared to the other ethnic groups.

This data has been age standardised to adjust for the different average age by ethnic group.

However, there is ongoing debate as to whether the current criteria for defining obesity in both adults and children are appropriate for non-European populations. BMI is not always an accurate predictor of body fat or fat distribution in individuals. Research has shown that for the same BMI, people of African ethnicity are likely to carry less fat and people of South Asian ethnicity more fat than the general population. This indicates that current BMI thresholds may overestimate obesity among Africans and underestimate obesity in South Asians. Using adjusted thresholds for these ethnic groups could improve obesity estimates.

Figure 35: National prevalence of obesity in adults (aged 16 and over) by ethnic group and sex, 2006-2010

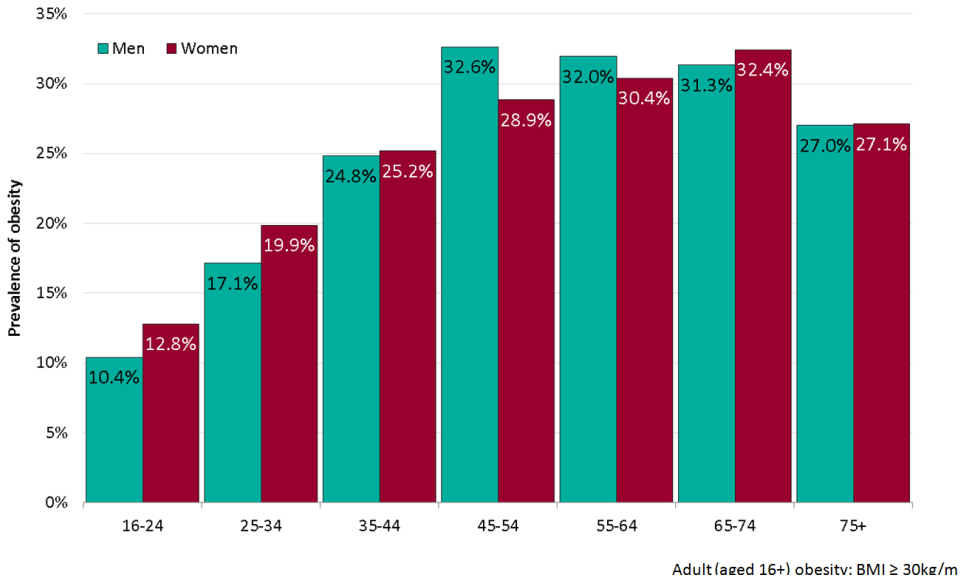
Source: Health Survey for England 2006-2010

Age

The prevalence of obesity increases with age. Prevalence of overweight and obesity is lowest in the 16–24 years age group and appears to increase with age (in the age range 16 to 74 years), but then decreases above age 75 years.

When broken down by age group, differences in obesity prevalence by sex are most noticeable in the 16-24 years, 25-34 years. Here obesity prevalence is higher for women than for men. However between the ages of 45 and 64 years obesity prevalence appears to be higher among men than women.

Figure 36: National adult obesity by age



Source: Health Survey for England 2011-2013

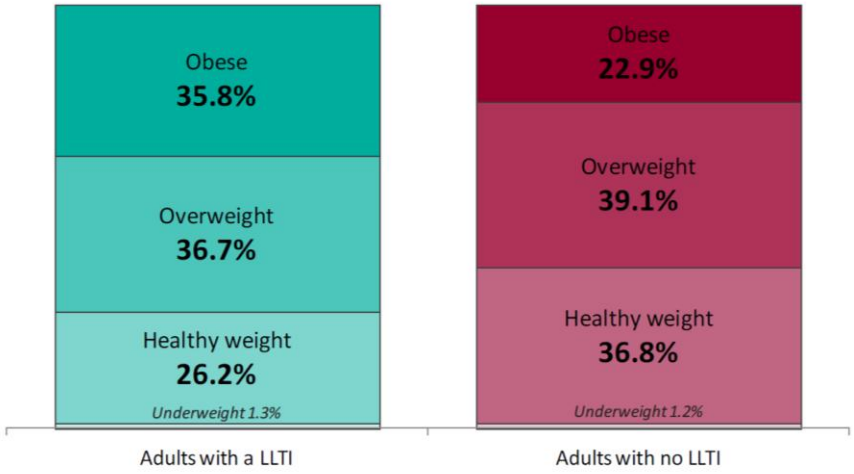
Disabilities and Special Educational Needs

Data from the Health Survey for England (HSE) show that obesity rates among adults with a long-term limiting illness or disability (LLTI) are 57% higher than adults without a LLTI.[35] Among adults with a LLTI, 35.8% are obese (

Figure 37) compared to 22.9% of adults without a LLTI. These figures are very similar to those found in the United States.[36]

[35] Gatineau, M, Hancock C, Dent, M. Adult disability and obesity. Oxford: National Obesity Observatory, 2013.
[36]Centers for Disease Contol. Overweight and obesity among people with learning disabilities. 2010; Available from: http://www.cdc.gov/ncbddd/disabilityandhealth/documents/obesityfactsheet2010.pdf.

Figure 37: BMI category for adults (aged 18+) with and without a long-term illness or disability (LLTI) in England.



Source: Health Survey for England. Combined data from 2006–2010

Mental Health

Over 80% of people with a serious mental illness are overweight or obese[37]. Furthermore, in a study conducted by Luppino, (2010), depressed persons had a 58% increased risk of becoming obese[,38] and this risk increases with age.[39] Although obesity is such a significant concern amongst people experiencing mental illness the attention paid to it does not reflect need.[40]

37 National Institute of Mental Health (2013) NIH Study Shows People with Serious Mental Illnesses Can Lose Weight, March 21, 2013
38 Luppino, F. et al (2010) Overweight, obesity, and depression: a systematic review and meta-analysis of longitudinal studies. Archives of General Psychiatry 2010;67(3):220-9.
39Kivimaki, M. et al (2009) Association between common mental disorder and obesity over the adult life course, British Journal of Psychiatry, 195(2), August 2009, pp.149-155
40 Royal College of Psychiatrists (2010) No health without public mental health: The case for action, , London N Engl J Med. 2013 Apr 25;368(17):1594-602.

Recommendations

Based on national and local healthy weight data target the development of adult weight management opportunities in the following areas and groups;

1) *Women of Black Caribbean, Black African, and Pakistani ethnicities.*
2) *Individuals with disabilities including mental health*
3) *Individuals with life-limiting illness.*
4) *Older adults*
5) *Residents in the local quintiles 1-3*

Diet and Nutrition

It is widely recognised that lifestyle factors such as poor diet lead to poor health outcomes and cause increased prevalence of obesity, disease, disability and premature death.

Our diets can also affect how we concentrate, behave and perform. Research carried out by the School Food Trust in primary and secondary schools, following improvements in the nutritional quality of schools meals showed pupils were more alert and over 3 times more likely to be 'on-task' working in the classroom after lunch[41]. Furthermore post evaluation (2 years) of the improved school meals by Jamie Oliver in Greenwich South- East London showed significantly better SAT results than matched schools in neighbouring boroughs[42].

[41] *www.schoolfoodtrust.org.uk*

[42] *Belot M, James J 2009 healthy School Meals and Educational Outcomes. London; Institute for Social and Economic Research*

Children

The annual 'Tellus' survey previously provided evidence on what around 2,000 children and young people experienced in their lives; how that changed over time and how it compares with other areas. It was a powerful source of information, however it is no longer available and although ongoing consultations and other ad hoc sources are conducted, the 'voice' of children and young people was greatly diminished.

In 2013 Walsall Council developed and launched the Youth of Walsall (YOW) Survey, an anonymous online survey for secondary school children in Walsall. The questionnaire was developed and designed in partnership with colleagues in the police and public health as well as children and young people themselves.

Between October 2013 and May 2014 the questionnaire was administered online (Snap 11 Survey) as part of a lesson in schools and took on average about 34 minutes to complete. The questionnaire consisted of mainly closed, tick box options and space for comments where appropriate. The subject areas covered 14 key themes, including Activities, Exercise and Health.

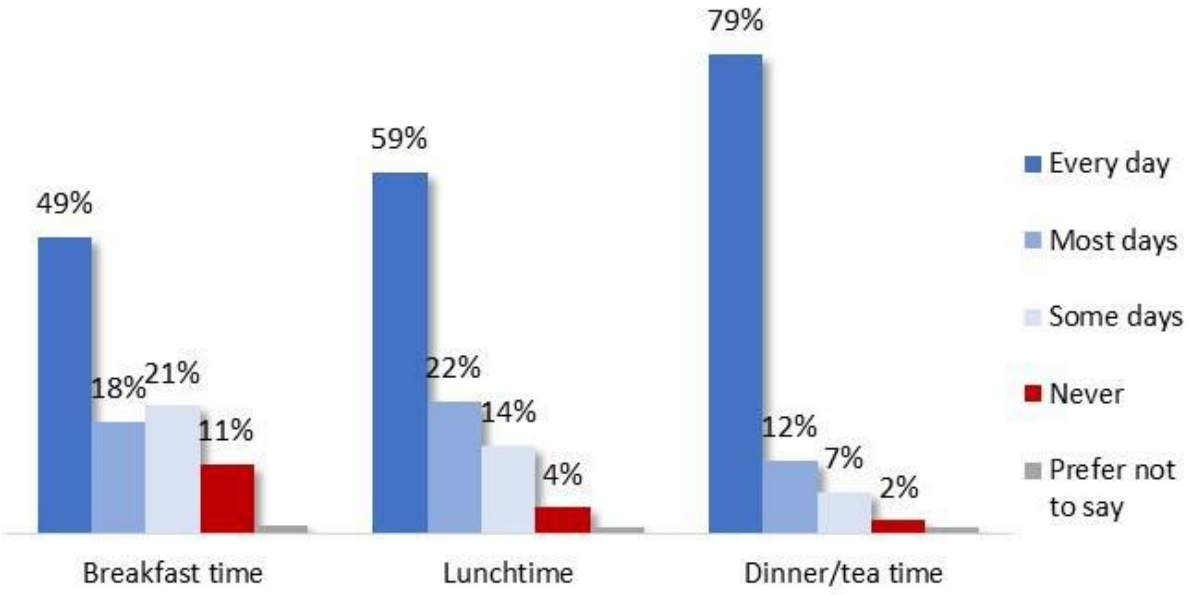
25 schools were invited to take part, with the majority of responses coming from 6 schools. In terms of overall participation, **3482** young people completed the survey (some only completed it partially). The age of respondents ranges from 10 to 19. Of the schools in Walsall that were invited to take part, not all took the opportunity, so the results are not wholly representative of the wider population. Results are more heavily skewed towards those living in the certain areas of the borough, especially Walsall North and Walsall South.

The following data relating to children's diet in Walsall was captured in the survey and summarized below:

Young people were asked how often they eat something at meal times throughout the day. Dinner/tea time is the meal the majority of young people eat every day (79%). This falls to 59% claiming that they eat something at lunchtime every day and just 49% who say they eat breakfast every day (

Figure 38).

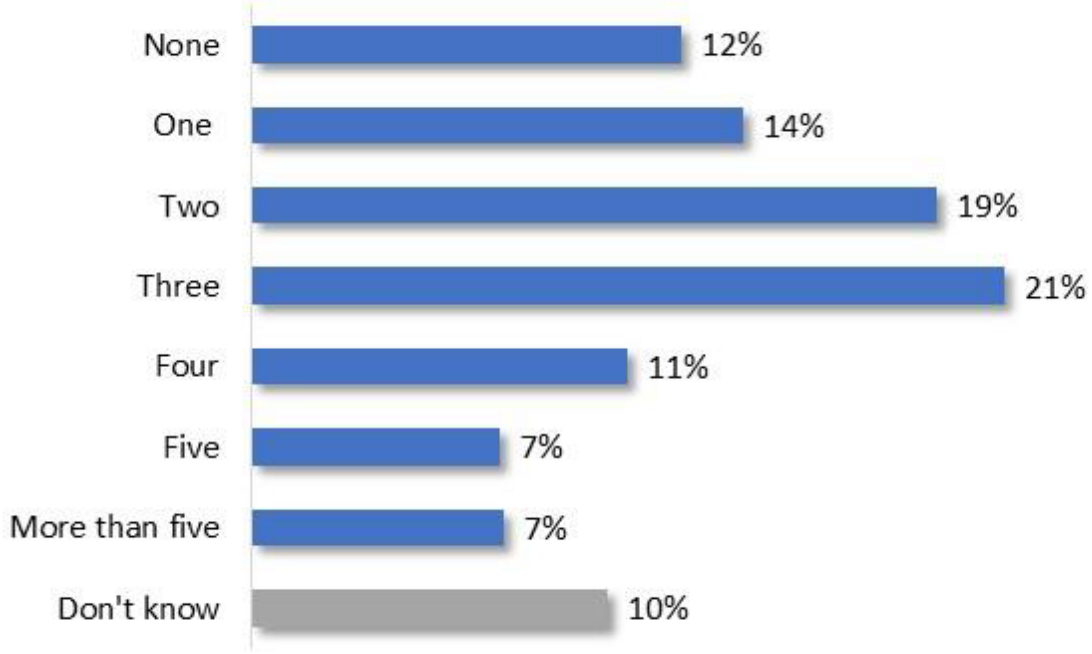
Figure 38 frequencies of children eating at meal times



Key Findings:

- Across all three meals just 36% of young people claim to eat something at breakfast time, lunchtime, and dinner/tea time **every day.**
- Of those who claim to never eat something at meal times throughout the day, over one in ten young people (11%) claim to never eat breakfast. This falls to 4% never eating anything at lunchtime and 2% never eating at dinner/tea time.
- Young people claim to eat breakfast less frequently than the other key meals of the day. Significantly fewer girls (40%) eat breakfast everyday compared with boys (58%).

Figure 39 Fruit and vegetable consumption in children



Key Findings:

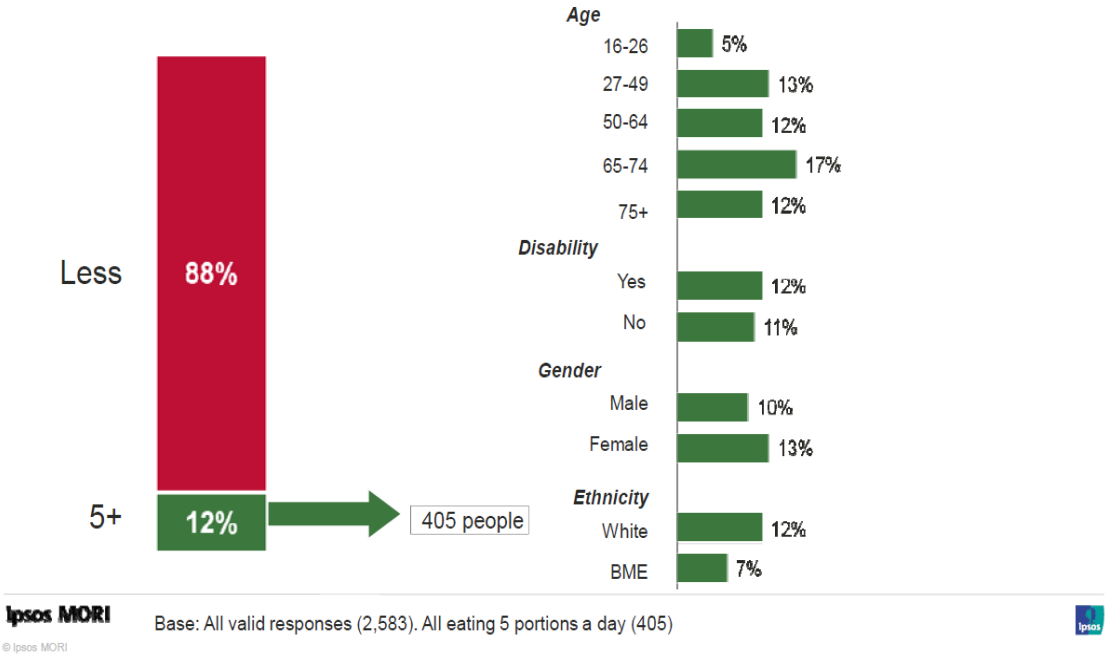
- Just 14% of young people are meeting the national recommendation of '5 a day' fruit and vegetable portions.
- Most young people (40%) claim to have had two or three portions of fruit and vegetables the day prior to taking this survey. Over one in ten young people (12%) had no fruit or vegetables whilst 7% are at the other extreme and claim they have had five or more portions.
- Significantly more boys (9%) claim to have had five or more portions of fruit or vegetables compared with girls (6%).

Adults

Between February and May 2012, Ipsos MORI was commissioned through the Local Authority and NHS Walsall to carry out a postal lifestyle survey in Walsall. The 'Your Place, Your Well-being Walsall Lifestyle Survey' was conducted among 3,224 adults aged 16 years plus. Data was collected in relation to diet and is summarised below;

The proportion of Walsall residents consuming their '5 a day' target of fresh fruit or vegetables is around 1 in ten (12%)[43] this is lower than the national average of 27%.[44]

Figure 40: A demographic breakdown of Walsall residents who consume the recommended '5 a day' 2012.



Key Findings

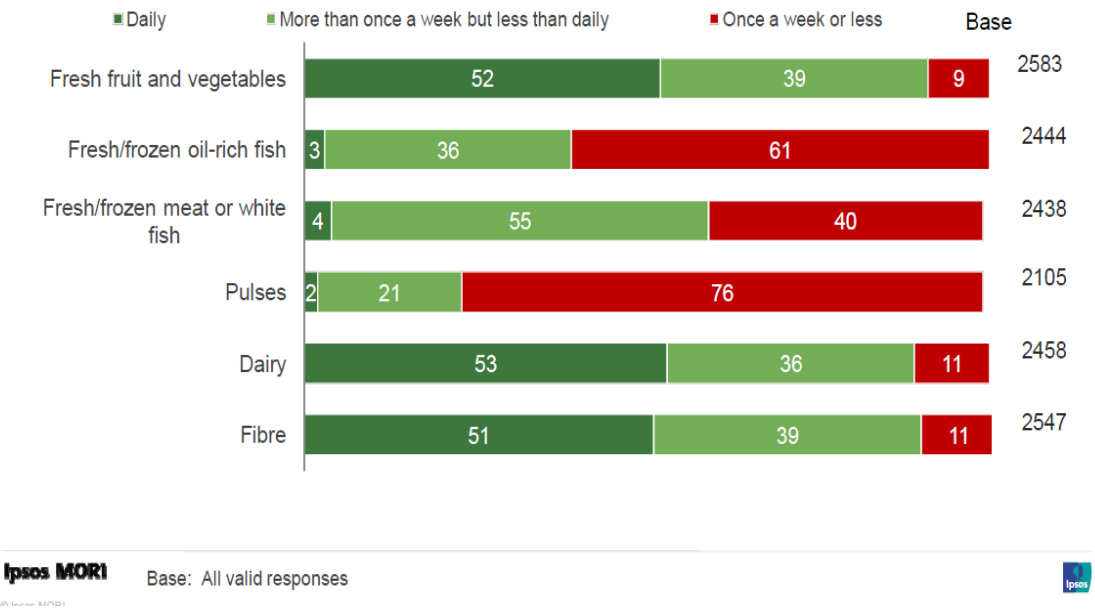
- Locally more women (13%) consume '5 a day' compared to men (10%) this is similar nationally trends 29% of women consume '5 a day' compared to 24% of men.

[43] *Your Place, Your Well-being Walsall Lifestyle Survey 2012, Ipsos MORI commissioned by Walsall MBC and NHS Walsall*

[44] *Health Survey for England 2012*

- The younger age group 16-26yrs are less likely to consume '5 a day' compared to older residents (5% vs. 17% of those aged 65-74 and 12% of those aged 75+).
- Only 7% of Black and minority ethnic residents consumed their recommended '5 a day' compared to 12% of White residents.

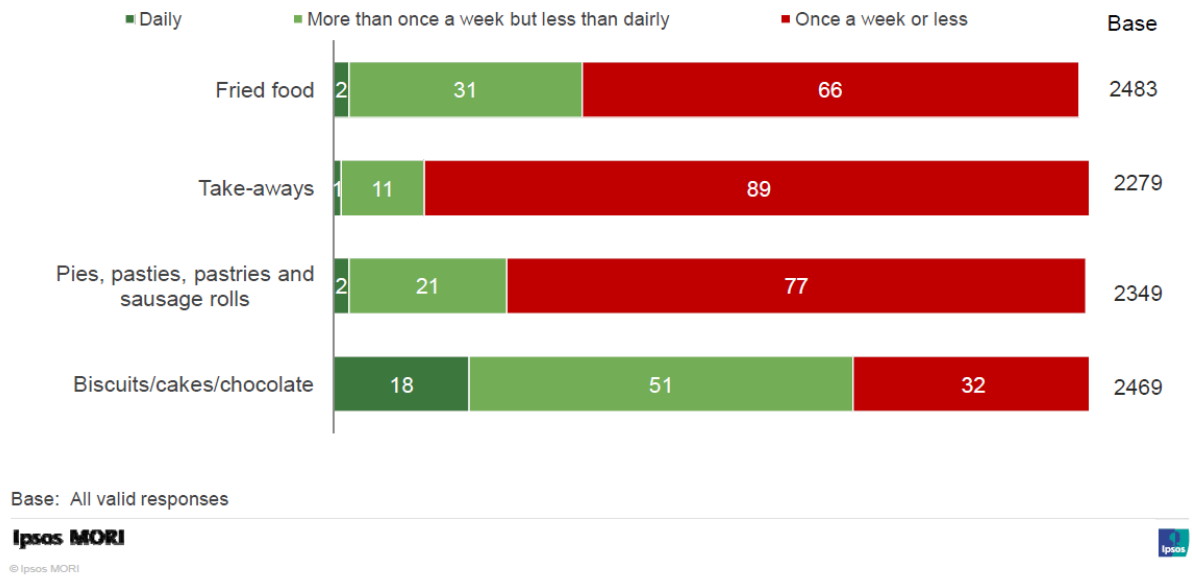
Figure 41: Consumption of foods low in fat and sugar by Walsall residents.



Key Findings

- 61% of Walsall residents eat less than the recommended one portion of oily fish (140g) per week.
- Poor diet is linked to social deprivation, residents in the more affluent areas of the borough are more likely to consume the recommended '5 a day' target, drink semi- skimmed milk, eat meat and white fish than residents living in the deprived wards.

Figure 42: Consumption of foods high in fat and sugar by Walsall residents



Key Findings

- 33% of residents consume fried foods more than once a week and this is highest among the unemployed (59%) and BME (43%) residents.
- One in four residents (23%) consume pies, pasties and a pastry more than once a week and this is higher among men (28%) than women (19%).
- 11% of residents eat take-aways more than once a week and again this is higher among men (15%) than women (7%).
- 24% of BME residents consume more take- away's (see *Figure 67* on more information relating to fast food outlets) once a week compared to White residents (9%).

The data presented above in relation to diet are self-reported figures. Self-report data should be used with caution as people may over or under report consumption of

certain foods possibly through a desire to show socially desirable behaviour. Also, there may be inaccuracies in people's recall of what they have consumed in a 24-hour period and there is the potential for confusion or misunderstanding about portion size and content of foods.

Recommendations

Based on national and local diet and nutritional data target the development of healthy eating opportunities in the following areas and groups;

- *Local quintiles 1-3*
- *Adult Men*
- *BME groups*
- *Children and younger adults age group 16-26yrs*

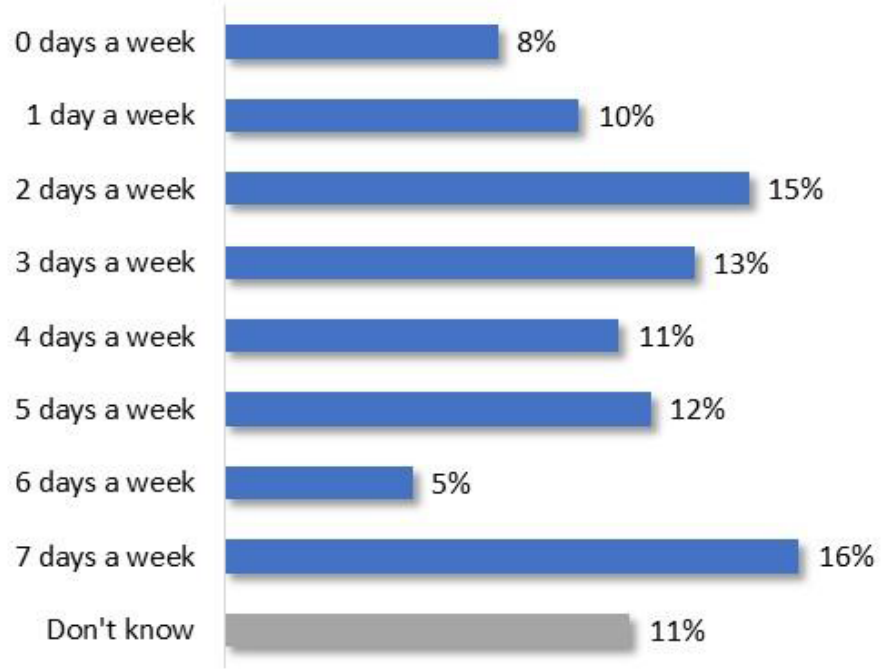
Levels of Physical Activity in Walsall

Children

Further data from the Youth of Walsall (YOW) Survey relating to physical activity in children is summarized in this chapter.

Children were asked how often they exercise Figure 43 shows that exercising for over an hour seven days a week is the most selected by young people (16%); significantly more boys than girls claim this (20% and 12% respectively). Similarly, 15% claim they exercise two days a week for at least an hour.

Figure 43: Exercise frequency

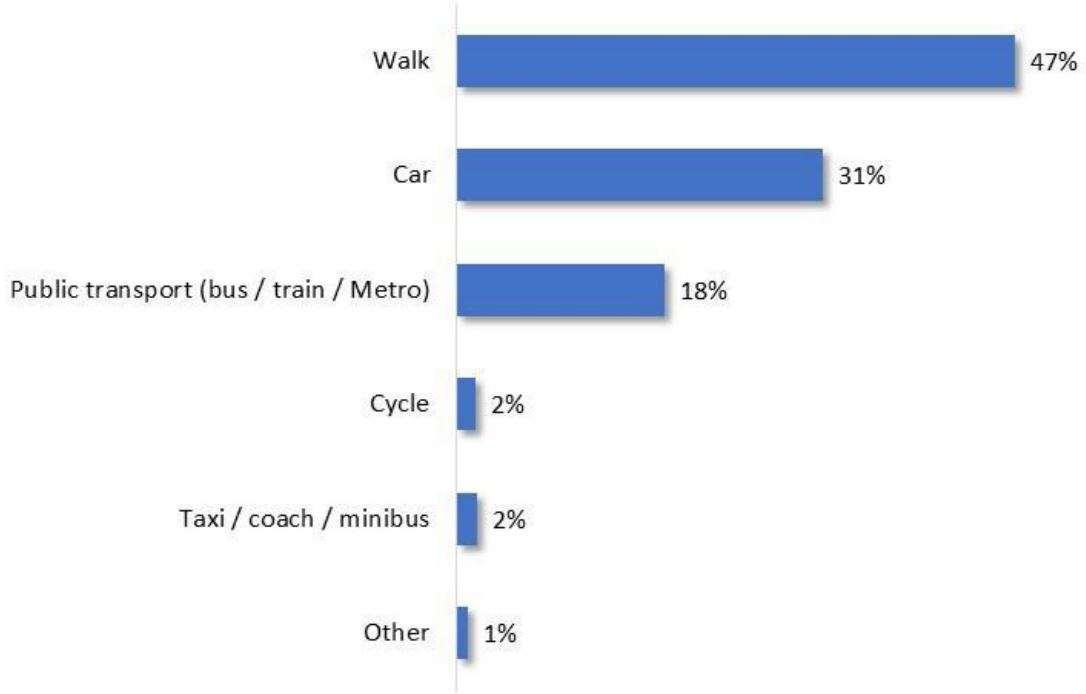


However, 8% of young people claim they do not exercise for at least one hour a week. Significantly more young people in Year 12 and 13 (15%) exercise zero days a week compared with those in Years 9 to 11 (8%) and Years 7 and 8 (6%). These young people are those who claim to be significantly hungrier due to a lack of food at home and also say they go to bed feeling hungry. They are also significantly more likely to engage in smoking. Interestingly, these are also the young people who say that they feel unsafe at home, at school and outside within the local area during the day; and who say they feel worried or anxious 'all of the time'.

Young people were asked how much time they spend sitting down on a typical Saturday. 1863 young people gave their estimate on this, working out at an average of **6** hours.

Children were asked their mode of transport to school in the morning highlighted below in *Figure 44*.

Figure 44: Transport to school in the morning

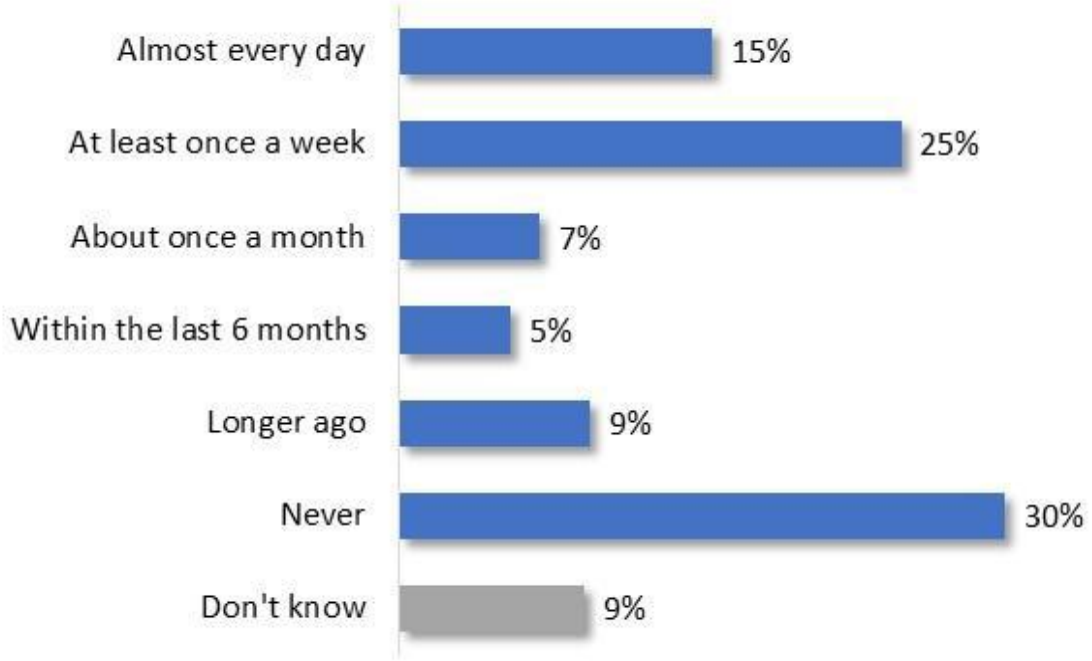


Key Findings:

- Walking was reported as the favoured mode of transport to school- 47% compared to cycling where only 2% reported cycling to school (See page 119 for more information on active travel).

- Significantly more young people in Years 12 and 13 (56%) say they walk to school/sixth form compared with those in Years 7 and 8 (44%).

Figure 45 School activities participation frequency



Key Findings:

- Significantly more boys compared with girls take part in school activities almost every day (18% and 13% respectively). Significantly more young people in Years 7 and 8 take part in activities at least once a week (30%) compared with those in Years 9 to 11 (20%) and Years 12 and 13 (18%). One hypothesis for this is that those who are younger have more time to take part in school activities compared to those who are studying for their GCSEs and A-levels.

- Of those that claim they never take part in school activities, there is no significant differences between perceptions of activities available at their school (i.e. those who think there is a good mix versus those who don't). This suggests it is not the availability of activities that stops young people participating in school activities but that there are other contributing factors.

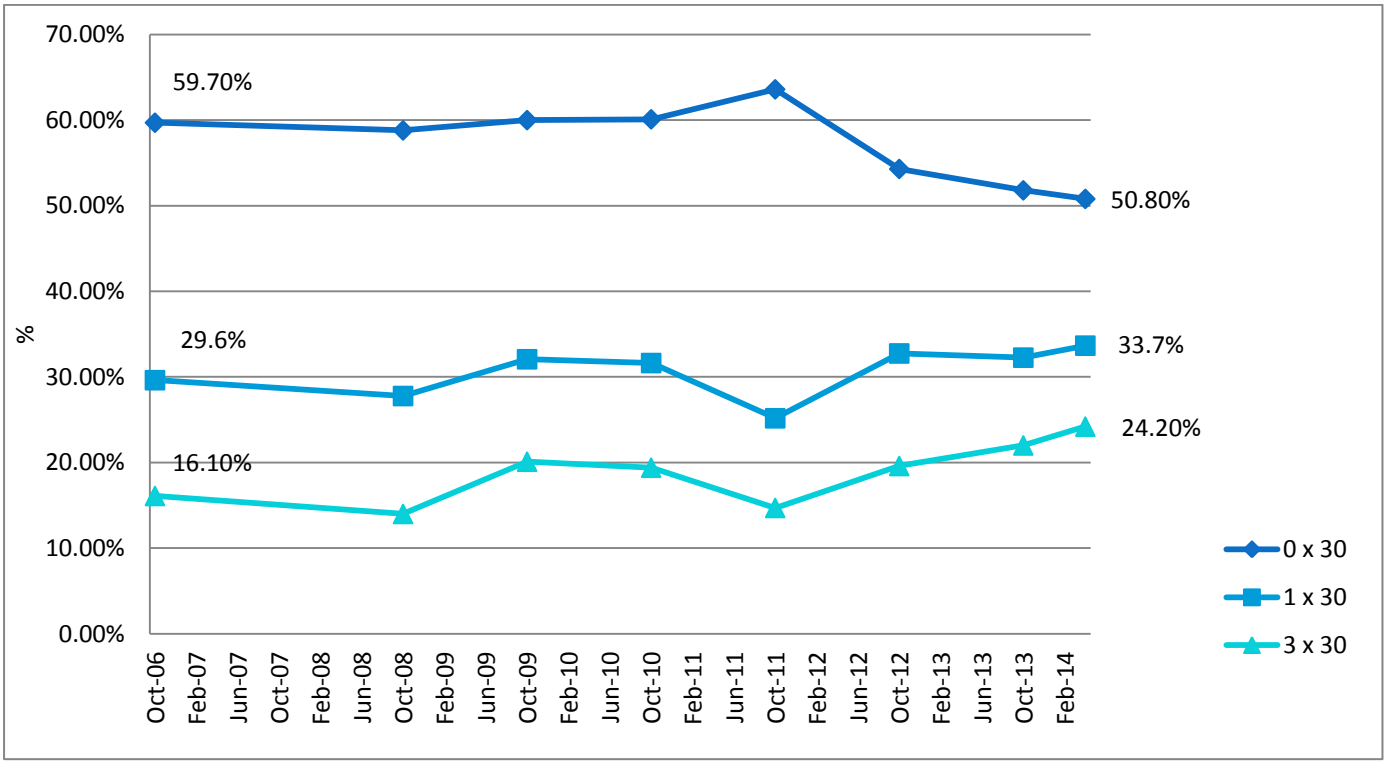
- Demographically, significantly more girls say they never take part in school activities compared with boys (36% and 23% respectively). Significantly more young people in Years 12 and 13 say they never take part in school activities (42%) compared with those in Years 7 and 8 (22%). Non-participators in school activities are also significantly more likely to be non-white (35%) compared with white (25%). 66% of those that took part in activities participated in Sports, Athletics, Fitness or Swimming.

Adults

Walsall's population has been extremely inactive, however over recent years the number of individuals taking part in no physical activity has started to decline. Since 2006 the number of adults taking part in no activity (i.e. not achieving 30 minutes of exercise on any day during the week) has actually reduced by nearly 9% - an equivalent of nearly 18,000 adults (See

Figure *46* below). At the same time participation in 1 x 30 and 3 x 30 minutes has increased by 3.6% (7,209) and 8.1% (16,200) respectively. Walsall's participation in 3 x 30 minutes is still below the national average but the gap is now only 1% compared to 5.5% in 2006. This increase in participation now puts Walsall above the West Midlands average

Figure 46 Active people participation in Walsall Oct 06- Present.



Definitions of Sport England's Active People Indicators

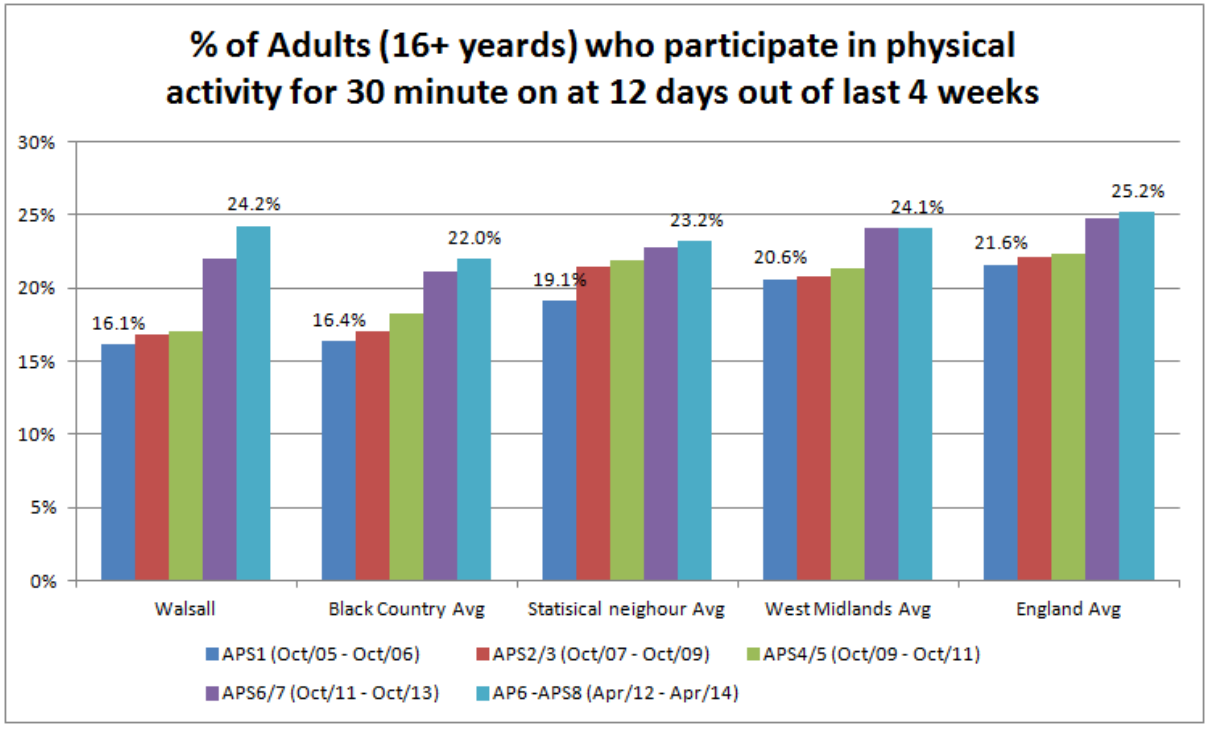
0 x 30 minutes - The proportion of respondents that did not participate in sport and active recreation, at moderate intensity, for at least 30 minutes on any days in the last 4 weeks.

1x30 minutes (16 years and over) - The sports participation indicator measures the number of people aged 16 and over participating in at least 30 minutes of sport at moderate intensity at least once a week.

It does not include recreational walking or infrequent recreational cycling but does include cycling if done at least once a week at moderate intensity and for at least30 minutes. It also includes more intense/strenuous walking activities such as power walking, hill trekking, cliff walking and gorge walking

3 x 30 minutes - The percentage of the adult (age 16 and over) population in a local area who participate in sport and active recreation, at moderate intensity, for at least 30 minutes on at least 12 days out of the last 4 weeks (equivalent to 30 minutes on 3 or more days a week).

Figure 47: shows the percentage of adults who participate in sport and active recreation, Oct/05 – Apr/14



Data source: Active People Survey

Key Findings:

- The percentages of adults participate in sport and active recreation in Walsall is higher than our statistical neighbour's average and only slightly below England average.
- In comparison to the Black Country cluster, Walsall has higher percentages of active adults. There has been significant increase between APS6/7 and AP6-APS8, which is only replicated by one other area (Sandwell).

Similar to obesity there are clear and significant health inequalities in relation to physical inactivity according to income, gender, age, ethnicity and disability.[45]

Gender

Men are more active than women in virtually every age group, with 6 in 10 women not participating in sport or physical activity[46].

Boys are more active than girls and girls are more likely than boys to reduce their activity levels as they move from childhood to adolescence.

Between 2008 and 2012, inactivity in boys rose by 7% and in girls by 2%, and the proportion of those reaching the healthy recommended levels of activity fell by 7% for boys and 3% for girls.[47]

Deprivation

Utilising Sport England's Market Segmentation profiles Figure 48 below shows a breakdown of predicted participation in 0 x 30minutes of physical activity/ week across Lower Super Output Areas across Walsall. The map clearly shows an east/

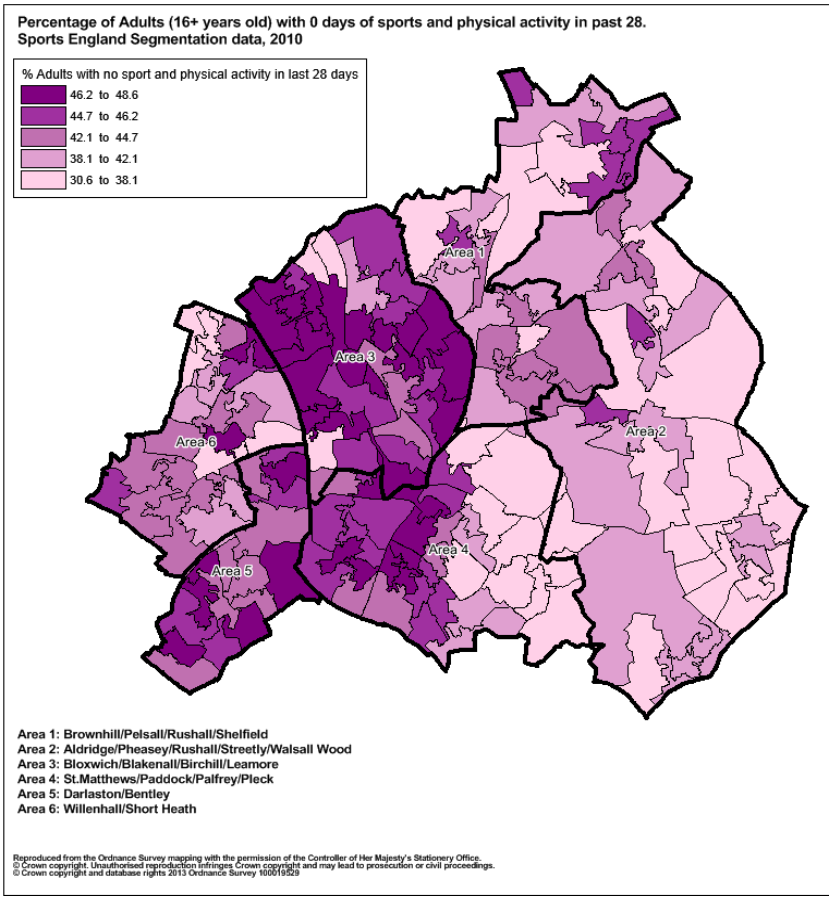
[45] *Start Active, Stay Active : A report on physical activity for health from the four home countries' Chief Medical Officers: 2011*

[46] *Active People Survey 2007.*

[47] *Start Active, Stay Active : A report on physical activity for health from the four home countries' Chief Medical Officers: 2011*

west divides with particularly high levels of inactivity in Area 3, Area 4 (west) and Area 5.

Figure 48: Percentage of adults with zero days of sports and physical activity in past 28 days, 2010



Datasource: Sports England Segmentation

Age

Physical activity declines with age to the extent that by 75 years only 1 in 10 men and 1 in 20 women are sufficiently active for good health.[48]

Ethnicity

Only 11% / 26% of Bangladeshi women and men are sufficiently active for good health, compared with 25% / 37% of the general population.[49]

[48] *Health Survey for England, 2012*

Disabilities and Special Educational Needs

Disabled people are half as likely as non-disabled people to be active. Only 1 in 4 people with learning difficulties take part in physical activity each month, compared to over half of people without a disability.[50]

Recommendations

Based on national and local physical activity data target the development of physical activity opportunities as follows;

1) *Area 3 (Bloxwich/ Blakenall/ Birchills/ Leamore), Area 4 (St Matthews/ Palfrey/ Pleck/ Paddock), Area 5 (Darlaston and Bentley), and Area 6 (Willenhall and Short Heath)*
2) *Older Adults (50+)*
3) *Adult Females,*
4) *Young People, especially adolescent girls*
5) *Individuals employed in Employed within NS Sec 3 (Intermediate Occupations – e.g. clerical and administrative occupations) , NS Sec 4 (Small Employers and Account Workers) and NS SEC5,6,7,8 (Lower supervisory and technical occupations, Semi-routine occupations, Routine occupations, Never worked and long-term unemployed)*
6) *Bangladeshi Population*
7) *Individuals with disabilities or life-limiting illness.*
8) *Inactive*

[49] *Joint Health Surveys Unit (2006). Health Survey for England 2004: Health of Ethnic Minorities. The Information Centre: Leeds.*

[50] *Sport England Active People Survey December 2013 (sport once a month, any sport, any duration)*

Evidence Base

There is a wealth of evidence supporting action to reduce overweight and obesity. Similarly there is a large amount of evidence to support increasing physical activity regardless of weight.

Lifestyle change resulting in modest weight loss helps to reduce the risk of developing a range of diseases including cancer, and helps people with pre-existing medical conditions to bring their condition under control (see *Figure 49* below for examples).

Figure 49: Health benefits of weight loss

Condition	***Weight loss***	***Effect***
High blood pressure	*10kg*	*10mmHg decrease systolic, 20mmHg decrease diastolic blood pressure*
Type 2 diabetes	*10-20%*	*Up to 3 years improved blood sugar control*
High cholesterol	*10kg*	*10% fall in total cholesterol levels*
Obesity related cancer	*0.5–9.0 kg*	*Decrease of 40–50% in deaths from obesity-related cancers*

Source: University of Birmingham Healthcare Needs Assessment: Obesity

The Scottish Intercollegiate Guidelines Network – Management of Obesity (February 2010) recommends patients with a BMI 25-35 Kg/m² should aim to lose 5-10% weight loss and patients with a BMI > 35 should aim to lose 15-20% weight loss to improve co morbidity.

Lifestyle intervention with modest weight loss of 5 to 10% reduces progression to diabetes by up to 58% over 4 years (Knowler et al, 2002 and J Tuomilehto et al, 2001). Overall, moderate obesity (BMI 30-35 kg/m^2) was found to reduce life expectancy (the average number of years an individual of a given age is expected to live, if current mortality rates continue to apply) by an average of three years, while morbid obesity (BMI 40-50 kg/ kg/m^2) reduces life expectancy by eight to ten years. This eight to ten year loss of life is equivalent to the effects of lifelong smoking.

These are the estimated effects of becoming obese by middle age. The effects on life expectancy of becoming obese in childhood have not yet been precisely estimated[51].

Patients from certain ethnic groups (e.g. South Asians) are more susceptible to the metabolic effects of obesity and related co morbidity is likely to present at lower BMI cut-off points than in individuals of European extraction (SIGN Guidelines for the Management of Obesity).

The health benefits of a physically active lifestyle are also well documented and there is a large amount of evidence to suggest that increasing physical activity, regardless of weight, can reduce the risk of Coronary Heart Disease, Stroke and Diabetes by up to 50% (see Figure 50 below) and increase your life span by 3-5 years. Physical activity is also associated with reduced risk of depression, anxiety and dementia.

Figure 50: Health benefits of physical activity[52]

Condition	***Risk Reduction***	***Strength of evidence***
All cause mortality	*20-35%*	*Strong*
Type 2 diabetes	*35-50%*	*Strong*
Coronary Heart Disease and stroke	*20-30%*	*Strong*
Colon Cancer	*30-50%*	*Strong*
Breast Cancer	*20%*	*Strong*
Hip Fracture	*36-68%*	*Moderate*
Depression	*20-30%*	*Strong*

[51] *Briefing Note: obesity and life expectancy, NOO, August 2010*

[52] *Wen CP, Wu XF. Stressing harms of physical inactivity to promote exercise. Lancet 2012,* ***380****:192–193.*

Alzheimer's disease	*40-45%*	*Moderate*

NICE has a suit of guidance relating to healthy weight and physical activity. This provides an evidence based approach to developing and commissioning services effectively. These include;

1) *Weight management before, during and after pregnancy*
2) *Obesity – working with local communities*
3) *Assessing body mass index and waist circumference thresholds for intervening to prevent ill health and premature death among adults from black, Asian and other minority ethnic groups in the UK*
4) *Managing overweight and obesity among children and young people: lifestyle weight management services*
5) *Managing overweight and obesity in adults – lifestyle weight management services*
6) *Physical activity: brief advice for adults in primary care*
7) *Behaviour change: the principles for effective interventions*
8) *Physical activity and the environment*
9) *Promoting physical activity in the workplace*
10) *Promoting physical activity for children and young people*
11) *Walking and cycling: local measures to promote walking and cycling as forms of travel or recreation*
12) *Physical activity: brief advice for adults in primary care*

These are considered and inform all healthy weight and physical activity service specifications commissioned through Public Health.

The UK Chief Medical Officer's recommend that adults should accumulate at least 150 minutes of moderate physical activity such as walking every week, and those children should be active for at least an hour every day. The CMOs also recommend that we should minimize the amount of time spent being sedentary[53]. Below are the recommended physical activity levels by age;

[53] *Department of Health. Start Active, Stay Active: A Report on Physical Activity from the Four Home Countries' Chief Medical Officers [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127931] (Department of Health, 2011).*

Physical Activity recommendations for health[54]

Under 5s – Infants who are not yet walking

1) Physical activity should be encouraged from birth, particularly through floor-based play and water-based activities in safe environments.

2) All under 5s should minimise the amount of time spent being sedentary (being restrained or sitting) for extended periods (except time spent sleeping).

Examples of physical activity that meet the guidelines

- 'Tummy time' – this includes any time spent on the stomach including rolling and playing on the floor
- Reaching for and grasping objects, pulling, pushing and playing with other people
- 'Parent and baby' swim sessions

Minimising sedentary behaviour is also important for health and development and may include:

- Reducing time spent in infant carriers or seats
- Reducing time spent in walking aids or baby bouncers (these limit free movement)
- Reducing time spent in front of TV or other screens

Under 5s – Infants who are capable of walking

1) Children of pre-school age who are capable of walking unaided should be physically active daily for at least 180 minutes (3 hours), spread throughout the day.*

2) All under 5s should minimise the amount of time spent being sedentary (being restrained or sitting) for extended periods (except time spent sleeping).

* Most UK pre-school children currently spend 120–150 minutes a day in physical activity, so achieving this guideline would mean adding another 30–60 minutes per day.

Physical activity is likely to occur mainly through unstructured active play but may also include more structured activities. Activities can be of any intensity (light or more energetic) and may include:

[54] *UK physical activity guidelines: Department of Health: 2011*

- Activities which involve movements of all the major muscle groups, i.e. the legs, buttocks, shoulders and arms, and movement of the trunk from one place to another
- Energetic play, e.g. climbing frame or riding a bike
- More energetic bouts of activity, e.g. running and chasing games
- Walking/skipping to shops, a friend's home, a park or to and from a school

Minimising sedentary behaviour may include:

- Reducing time spent watching TV, using the computer or playing video games
- Reducing time spent in a pushchair or car seat – this can also help to break up long periods of sedentary behaviour

Children and Young People (5 -18)

1) All children and young people should engage in moderate to vigorous intensity physical activity for at least 60 minutes and up to several hours every day.
2) Vigorous intensity activities, including those that strengthen muscle and bone, should be incorporated at least three days a week.
3) All children and young people should minimise the amount of time spent being sedentary (sitting) for extended periods.

Moderate intensity physical activities will cause children to get warmer and breathe harder and their hearts to beat faster, but they should still be able to carry on a conversation. Examples include:

- Bike riding
- Playground activities

Vigorous intensity physical activities will cause children to get warmer and breathe much harder and their hearts to beat rapidly, making it more difficult to carry on a conversation.

Examples include:

- Fast running
- Sports such as swimming or football

Physical activities that strengthen muscle and bone involve using body weight or working against a resistance. Examples include:

- Swinging on playground equipment
- Hopping and skipping
- Sports such as gymnastics or tennis

Minimising sedentary behaviour may include:

- Reducing time spent watching TV, using the computer or playing video games

- Breaking up sedentary time such as swapping a long bus or car journey for walking part of the way

Adults (19 – 64)

1. Adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least 5 days a week.
2. Alternatively, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or combinations of moderate and vigorous intensity activity.
3. Adults should also undertake physical activity to improve muscle strength on at least two days a week.
4. All adults should minimise the amount of time spent being sedentary (sitting) for extended periods.

Moderate intensity physical activities will cause adults to get warmer and breathe harder and their hearts to beat faster, but they should still be able to carry on a conversation. Examples include:

- Brisk walking
- Cycling

Vigorous intensity physical activities will cause adults to get warmer and breathe much harder and their hearts to beat rapidly, making it more difficult to carry on a conversation. Examples include:

- Running
- Sports such as swimming or football

Physical activities that strengthen muscles involve using body weight or working against a resistance. This should involve using all the major muscle groups. Examples include:

- Exercising with weights
- Carrying or moving heavy loads such as groceries

Minimising sedentary behaviour may include:

- Reducing time spent watching TV, using the computer or playing video games
- Taking regular breaks at work
- Breaking up sedentary time such as swapping a long bus or car journey for walking part of the way

Older Adults (65+ Years)

Older adults who participate in any amount of physical activity gain some health benefits, including maintenance of good physical and cognitive function. Some physical activity is better than none, and more physical activity provides greater health benefits. There is strong evidence that group or individual physical activity programmes significantly reduce the rate of falls (by up to 54%) and risk of falls. These programmes can be delivered at home or in community settings. High intensity programmes are better than low intensity ones.

The need for a range of 'maintenance' or follow-on activities in the community is also supported by the physical activity guidelines for older adults, which recommend activities to improve muscle strength and balance on two or more days per week for all adults over 65.

2. Older adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least 5 days a week.

3. For those who are already regularly active at moderate intensity, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or a combination of moderate and vigorous activity.

4. Older adults should also undertake physical activity to improve muscle strength on at least two days a week.

5. Older adults at risk of falls should incorporate physical activity to improve balance and co-ordination on at least two days a week.

6. All older adults should minimise the amount of time spent being sedentary (sitting) for extended periods.

Moderate intensity physical activities will cause older adults to get warmer and breathe harder and their hearts to beat faster, but they should still be able to carry on a conversation. Examples include:

- Brisk walking
- Ballroom dancing

Vigorous intensity physical activities will cause older adults to get warmer and breathe much harder and their hearts to beat rapidly, making it more difficult to carry on a conversation. Examples include:

- Climbing stairs
- Running

Physical activities that strengthen muscles involve using body weight or working against a resistance. This should involve using all the major muscle groups. Examples include:

- Carrying or moving heavy loads such as groceries
- Activities that involve stepping and jumping such as dancing
- Chair aerobics

Activities to improve balance and co-ordination may include:

- Tai chi
- Yoga

Minimising sedentary behaviour may include:

- Reducing time spent watching TV
- Taking regular walk breaks around the garden or street
- Breaking up sedentary time such as swapping a long bus or car journey for walking part of the way

All of the above guidance is considered and reflected in all weight management and physical activity service specifications. Standard Evaluation Frameworks[55] exist for weight management, physical activity and dietary interventions that are also incorporated into Walsall's service specification ensuring all programmes are evaluated thoroughly.

Children: healthy growth and healthy weight

In order to tackle the rising prevalence of obesity in Walsall it's imperative to focus on children particularly in the early years. As highlighted earlier the most important consequence of childhood obesity is its persistence into adulthood. Early interventions during pregnancy and ongoing support in the early years are fundamental to the long term health of the child. Prevention of obesity and promotion of physical activity in the early years is vitally important for improving health, reducing health inequalities and promoting educational engagement and attainment at all ages.

[55] *http://www.noo.org.uk/core/frameworks*

Maternal and Early Years Service (MAEYS)

This service is commissioned through Public Health and its primary aim is to minimise weight gain during pregnancy targeting pregnant women with a BMI ≥30. The programme also offers advice on diet, physical activity, breast feeding and weaning.

Being overweight or obese in pregnancy can increase the risk of complications with extremely obese women being 5 times more likely to have high blood pressure, 9 times more likely to have newly diagnosed diabetes and almost 4 times more likely to be admitted to an intensive care unit

In 2013-14, 410 referrals were made to this programme an increase of 124 referrals from the previous year. Of those referrals only 26% (106) accepted the programme. The main reason for this low uptake is due to inaccurate contact details being taken and missing information at the point of referral. Measures have been put in place since July 2014 to rectify this and should be reflected in 2014/15 once participants have completed phase 2 of the programme. A CQUIN was set in place in April 2014 with WHT to measure referrals from maternity to lifestyle programmes. This showed that 83 (78%) patients completed the pregnancy phase 1 of the programme and 94% (82) of clients lost weight, remained the same weight or gained weight within the 10kg range recommended by NICE. Only 49% (54) of clients completed the post natal phase 2 of the programme and 39% (21) of those clients lost weight. Of those clients completing phase 2, 40% (16) initiated breast feeding. In phase 2 of the programme the number of infants introduced to solids at the 21-25 weeks was 85% (29) and the number of infants introduced to solids after 25 weeks as per national guidance was 9% (3).

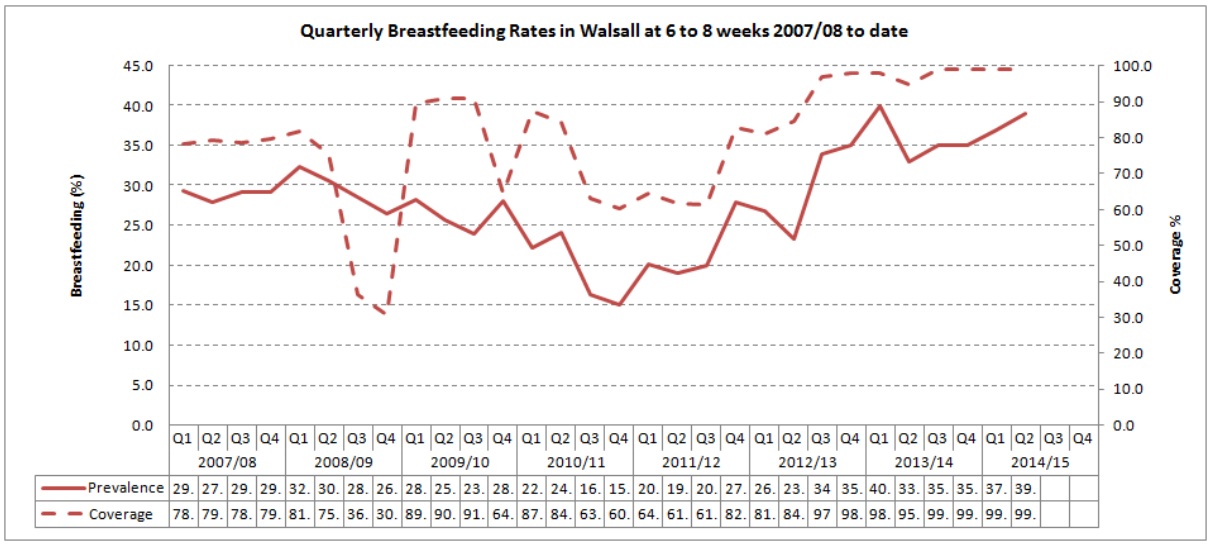
Recommendations

1) *Continue to develop referral pathways from maternity to the Maternal and Early Years Programme identifying all pregnant women with a BMI of 30 and ensuring data collected is accurate.*
2) *Review service specification and database to ensure information collected captures relevant data to facilitate a robust evaluation.*
3) *Review model of delivery and evaluate programme to ensure the programme remains cost effective.*
4) *GPs, midwives and health visitors to support women in entering their pregnancy a healthy weight.*

Breastfeeding

Breastfeeding provides short and long term health benefits for a mother and her baby, including reducing obesity in childhood and adolescence.

Figure 51: Breastfeeding Rates in Walsall at 6 to 8 weeks, 2007/08 to date



Source: Walsall Healthcare Trust

Trends in breastfeeding rates at 6-8 weeks have increased since 2013/14. Figures peaked in Q1 of 2013/14 at 40% and were at their lowest during Q4 of 2010/11 at 15.1%.

Coverage (recorded breastfeeding status at 6-8 week check) has been erratic with a low of 30.6% during Q4 of 2008/09 and highs of 90.9 during Q2 of 2009/10. More recent data recorded within the Public Health Contract Monitoring Scorecard has shown an increase from 81% Q1 2012/13 to 99% coverage at Q2 2014/15.

Health Visiting

The 26 months check carried out by health visitors offers us the first opportunity to check a child's weight status.

In a child over 2 years of age, the BMI centile is a better indicator of overweight or underweight than the weight centile alone.[56] UK-WHO Growth charts were introduced in May 2009 to measure height and weight in children aged 0-4 years. The new charts will have an impact on the interpretation of weight patterns in children. After the age of 6 months, roughly twice as many children will be above the 98th centile for weight compared with the UK 1990 charts, and only about 1 in 200 children will be below the 2nd centile .Therefore, more children should be assessed as being 'overweight' than in previous years, due to these new charts.

Health Visitor numbers have increased in Walsall and now meet our trajectory. The Government is committed to boosting the number of health visitors in England by 4,200 by 2015 and outlined a new service vision. [57]This includes restabilising the Health Visitor as the key professional in public health delivery and leading the 'Healthy Child Programme 0-5'. They have a unique role offering a universal service to all children under 5 and so are in a key position to monitor the weight status of every child and offer support The 2 year to 2.5 year check is to be a mandated service when health visiting moves to Local Authority commissioning in October 2015.

[56] *Using the new UK–World Health Organization 0–4 years growth charts: Information for healthcare professionals about the use and interpretation of growth charts, Department of Health*

[57] *Health Visitor Implementation Plan 2011–15, A Call to Action (February 2011)*

Healthy Start

Woman who are pregnant or families with a children under four years of age and are on certain benefits qualify for Healthy Start. All pregnant women under the age of 18 qualify - whether or not they are on benefits. Families who qualify for Healthy Start receive vouchers to spend on milk, plain fresh and frozen fruit and vegetables and infant formula milk. Pregnant women receive one voucher each week in the amounts of £3.10. Mother's receive two vouchers each week (£6.20) for babies under one year and from children aged from one to four years one voucher per week (£3.10).

Figure 52: Healthy Start National and Regional data 2014/15

Area	Entitled	Eligible	Take Up by LA	Eligible Children	Eligible Mothers	Drops claimed	Tablets claimed	Potential no. of drops	Potential no. of tablets	% drop uptake
East Midlands	31,951	42,376	73.64%	31,951	12,316	4,936	1,950	207,682	80,054	2.2
East of England	33,173	47,600	69.21%	33,173	11,841	6,910	3,051	215,625	76,967	2.7
London	61,068	85,810	70.91%	61,068	20,793	10,506	4,855	396,942	135,155	2.1
North East	25,752	31,987	79.89%	25,752	10,135	421	204	167,388	65,878	0.1
North West	59,314	77,836	74.61%	59,314	22,901	5,993	3,215	385,541	148,857	1.8
South East	42,447	61,786	67.76%	42,447	13,710	2,525	981	243,984	89,115	1.0
South West	29,548	41,033	69.94%	27,823	10,340	2,051	2,476	180,850	67,210	1.5
West Midlands	49,574	64,623	75.14%	49,574	19,212	10,223	5,394	322,231	124,878	3.0
Yorkshire and Humber	46,262	59,814	75.97%	46,262	18,502	4,806	5,410	300,703	120,263	1.4

Figure 53: Healthy Start Regional and Local data 2014/15

Area	HS Take Up %	% drop uptake	% tablet uptake
Birmingham	78.1	5.45	5.73
Coventry	77.7	4.6	5.98
Dudley	76.7	1.06	1.85
Sandwell	77.3	0	0
Shropshire UA	72.2	4.53	11.96
Solihull	72.6	10.17	15.02
Staffordshire	69.9	0.09	0.04
Stoke-on-Trent	77.5	0	0
Telford and Wrekin	78.3	4.67	18.67
Walsall	77.8	2.28	2.59
Warwickshire	69.4	2.73	3.69
Wolverhampton	77.8	3.41	3.89
Worcestershire	71.4	0	0

Figure *53* highlights that 78% of women exchange their healthy start vouchers for milk, fruit; vegetables and formula milk in Walsall higher the national average 73% and regional average 75%.

Healthy Start Vitamin uptake in women and babies is however low and work is in place to increase this.

Food Dudes Nursery Settings

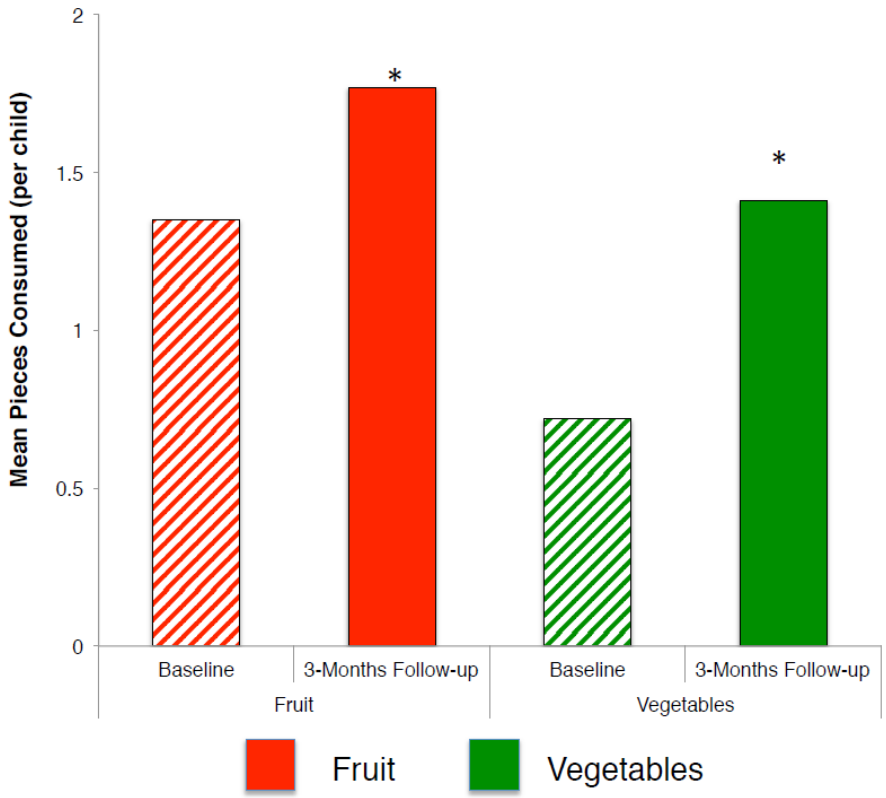
Following the success of the Food Dudes programme in Primary Schools in Walsall in 2011, a nursery programme was piloted in 2012 based on the same principles as the Primary School programme designed to increase the fruit and vegetable consumption in 2 to 5 year old children.

It applies leading behavioural science and fun activities to improve children's eating habits using 3 key psychological principles (role modelling, rewards and repeated tasting). In the first phase of the Programme, lasting 20 days, children are presented with four different fruit and vegetable pairs and encouraged through peer modelling, songs, stickers and small prizes to taste / consume these foods. In the second phase of the Programme, nursery teachers organise weekly "picnics" where children are asked to bring fruit and vegetables from home and are encouraged to eat them. Children having eaten their fruit and vegetables are then rewarded with small prizes!

51 Nursery settings (2411 children) have participated in the Food Dudes Early Years programme in the 2013-14 academic year. Results highlighted that on average 86% of children consumed fruit and 74% consumed vegetables.

Figure 54 shows Food Dudes nurseries increased their consumption of fruit by 31% and their vegetable consumption by 96% following completion of the programme

Figure 54: Mean pieces consumed per child by the Food Dudes Nurseries 2013-14.

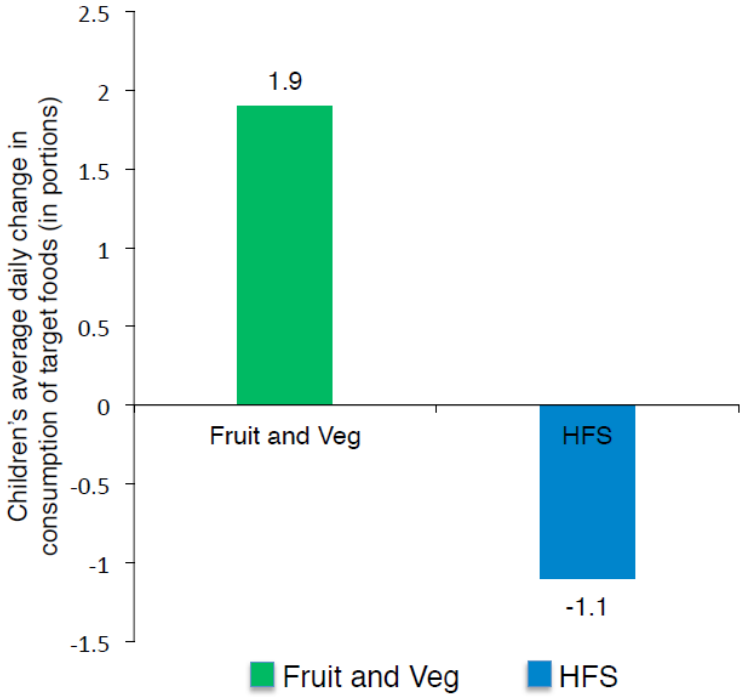


* The Increase from the baseline to the follow up data was significant increases with good effect sizes.

At home 91% of parents had reported an increase in their child's fruit and vegetable consumption by 1.9 portions a day. They also reported their child's consumption of foods high in fat a sugar had decreased by –1.1 portions a day at home (

Figure 55).

Figure 55: Average number of extra or reduced portions of fruit & vegetables, and foods high in fat and sugar (HFS) by children at home 2013-14.



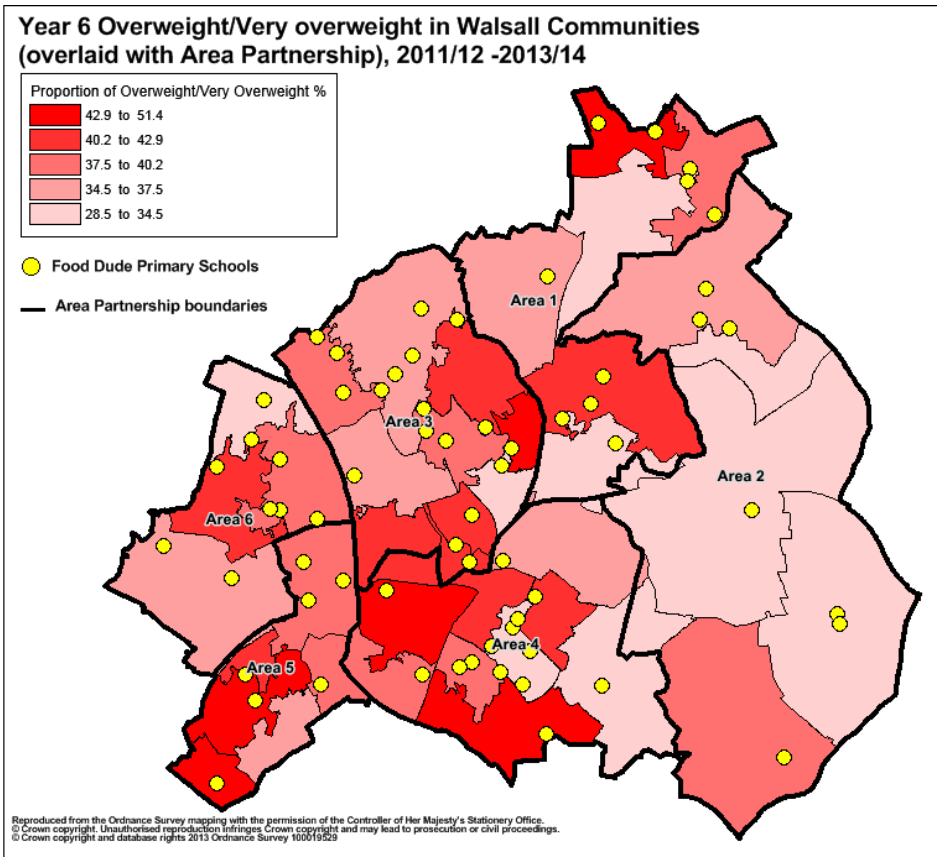
School Health

There is now a named school nurse for every secondary school and cluster of primary schools who is in a position to monitor children as they attend for regular school health interventions such as screening or health promotion sessions. They can also offer support to school staff around particular weight management concerns a pathway is being developed to increase referrals into Fun 4 Life and Make it Count.

Food Dudes in Primary Schools

Food Dudes is commissioned through Public Health and is a unique award –winning approach to healthy eating for children that combine leading behavioural science techniques with fun activities to encourage children to increase their consumption of fruit and vegetables and the reduction of unhealthy snacks. It is currently offered to all Primary Schools and in 2013/14, 64 (17,549 children) Primary Schools including 2 special schools enrolled in the Food Dudes programmes. Figure *56* below shows the location of the Food Dudes schools across the borough overlaid on Year 6 overweight and very overweight data for 2011/12-2013/14.

Figure 56: Food Dudes Schools overlaid on Year 6 overweight and very overweight in Walsall 2011/12-2013/14



Food Dudes is delivered through 2 programmes in Primary schools. The initial programme offered to schools is called *Food Dudes Full Force programme* and all classes take part in the programme and is broken down into 2 phases described below;

Intensive Phase: The first 16 days

• Each day, children watch movies or receive emails from the Food Dudes, who are healthy eating superheroes in battle with General Junk and the Junk Punks.
• Children earn prizes for tasting and eating both a portion of fruit and vegetables (F&V).
• Children are provided with 4 different pairs of F&V over the 16 days.
• Home packs encourage increase in fruit and vegetable consumption away from school.

Maintenance Phase: The rest of the academic year

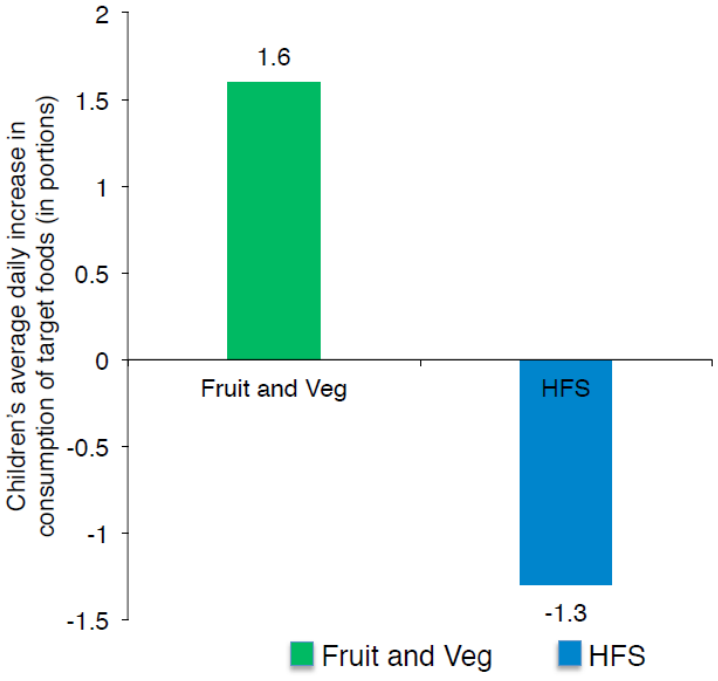
• Children are given orange and green boxes in which they can bring fruit and vegetables to school. They are encouraged to try and eat F&V at lunchtime.
• The Food Dudes Dining Experience starts in the dining hall.

• Packed lunch and school meal children earn ticks on their Food Dudes cards whenever they eat a portion of F&V to progress through levels and earn prizes. The second programme is called the Next Generation which is implemented each year thereafter with the new reception class intake participating in the Intensive Phase and the whole school continuing to take part in the Maintenance Phase.

Online data indicated by the end of the intensive phase of the Full Force Programme indicated that 93% of children ate the fruit provided and 89% ate the vegetables provided. On average children had consumed an extra 1.6 extra portions of fruit and vegetable a day. They had also reduced their consumption of foods high in fat and sugar by 1.3 portions e.g. crisps and chocolate (

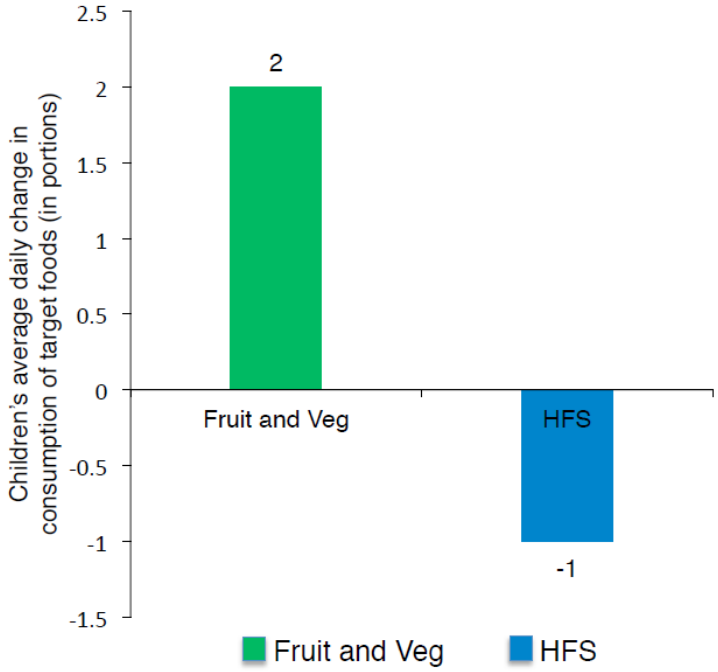
Figure 57).

Figure 57: Average number of extra or reduced portions of fruit, vegetables, and foods high in fat and sugar (HFS) consumed by children 2013-14.



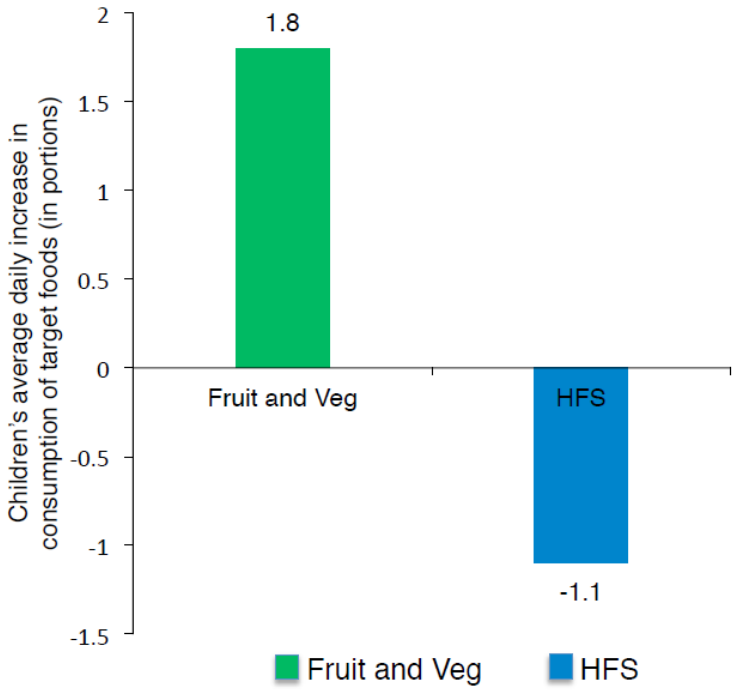
At home 90% of parents had reported an increase in their child's fruit and vegetable consumption by 2 portions a day. They also reported their child's consumption of foods high in fat a sugar had decreased by -1 portion a day at home.

Figure 58: Average number of extra or reduced portions of fruit & vegetables, and foods high in fat and sugar (HFS) consumed by children 2013-14.



The programme also had an influence on the whole family at home with parents reporting that family members had increased their consumption of fruit and vegetables by 1.8 portions per day. Family members had also reduced their consumption of foods high in fat a sugar by -1.1 portions per day.

Figure 59: Average number of extra or reduced portions of fruit, vegetables, and foods high in fat and sugar (HFS) consumed by family members 2013-14.



Healthy Schools Programme

The national local healthy schools initiative ceased in a 2010 and a local healthy schools initiative was developed with a bronze, silver and gold standards. Standards were developed relating to healthy weight, sexual health and teenage pregnancy, emotional health and drugs alcohol and tobacco. All primary schools had achieved bronze apart from one, 23 are working towards silver and 1 school is working towards gold.

Public Health is currently reviewing and remodelling the healthy schools model looking at current models national and consulting with schools to ascertain what support they would like in relation to health.

Family Weight Management Programmes

Make it Count

Make It Count (MIC) was locally developed in 2008/09 by NHS Walsall Community Health and commissioned by Public Health in response to an identified need through the NCMP data for obese and overweight children <8 years of age.

Make It Count
Children with BMI > 91st percentile aged 4-7 year or >85th centile and 'at risk' of obesity e.g. parents overweight, children who would benefit from being more physically active – perhaps identified through schools etc
12 week program based in schools or community
1 x 1 hour session per week for the children
At least one parent/carer required to attend two sessions over the programme and 1 x 1 hour physical activity session with their child per week
Commissioned places: 550 children per year

The programmes run during school time with the teachers and teaching assistant support or as an after school club with parents and school volunteers supporting the programme. Each week children and their families take part in 60 minutes of fun physical activity through a variety of games developing their knowledge of healthy and unhealthy food choices through an interactive approach. Children have a week by week folder of information about healthy living including activities for the home such as colouring sheets and word searches related to healthy lifestyles and physical activity.

Throughout the programme parents are encouraged to engage with the programme and become practically involved with their children and act as an active role model. The parents will also get the opportunity to gain tips about preparing healthy meals and how to reduce salt, sugar and fat during family engagement cook and eat style sessions.

Please see Appendix 4 for the Make it Count Pathways

Make it Count Programme	**Numbers and %**

Number of children accessed the programme	586
Number of children identified as overweight/ very overweight	*210 (36%)*
Number of overweight/ very overweight children that reduced or maintained their weight	210 (36%)
Number of parents who accessed the programme	*371*
Number of children identified as at risk of becoming overweight	*194 (33%)*
Number of children deemed as low risk or no known risks of becoming overweight.	*184 (31%)*
Number of children from local quintiles 1-3	515 (88%)
Number of children from BME groups	176 (35%0

Referrals generated from the NCMP feedback letters to parents remain low, parents of younger children (Reception children age 4-7 years in response to NCMP letters) do not recognise obesity as an issue as they believe it is 'puppy fat' or 'they will grow out of it'. Research also suggests that half of parents do not recognise that their child as overweight or obese.[58]

With this in mind the 'Make it Count' Programme was redesigned to enable the programme to be delivered to the whole school to engage as many overweight and very overweight children as possible.

Fun4Life

[58] Lundahl A, Kidwell KM, Nelson TD. Parental underestimates of child weight: a meta-analysis. Pediatrics 2014;133:e689–703.

Fun4life is a 12 week education and physical activity programme. Its aim is to prevent young people and their families to make healthy and balanced choices by increasing their physical activity levels and having the knowledge to make suitable food choices.

Fun4Life

Children with BMI > 91st percentile aged 8 - 15 years.

12 week community based programme. 1 x 2.5 hour session per week.

At least one parent/carer required to attend sessions with their child.

Commissioned places: 180 children per year

Fun 4 Life Programme	**Numbers / %**
Number of children accessed the programme	111
Number of overweight/ very overweight children that reduced or maintained their weight	91%
Number of children from local quintiles 1-3	70%
Number of children from BME groups	40%
Percentage of children that complete F4L are followed at 12 months	76%

In order to engage and increase referrals from secondary care a member of the Way4ward team now attends the diabetes clinics twice a week working with teenagers with diabetes who are currently going through transition into adult services.

The addition of an Active Lifestyle Officer to the diabetic team has enabled a more holistic approach for all diabetes patients. Each patient is offered advice and help regarding their physical activity levels and where appropriate controlling their weight.

The regular attendance with the hospital clinics has the advantage for the Active Lifestyle Officer to track the patients on a regular basis not only height, weight but also to map this against the management of their long term condition. The Active Lifestyle Officer has also become a part of other activities that operate with the

young people with diabetes including attendance on their weekend camps and also provision of a more local holiday club that took place for the first time during the half term holidays (October 2014) at Darlaston Town Hall.

Recommendations

1) *Continue to support the importance of breastfeeding and offer support to those groups least likely to breastfeed.*

2) *Increase the number of eligible women and babies who receive Healthy Start vitamins.*
3) *Continue to engage and commission healthy eating interventions like Food Dudes in special schools*

4) *Ensure children's weight management programmes specifications identify and target high risks groups e.g. Black children, boys and children living in the local quintiles 1-3.*

5) Allocate resources to commission more early years interventions.

6) Using the obesity RAG rated Primary School data target schools within the top 30 for Food Dudes Programmes.

7) Redesign the local Healthy Schools Award to offer schools a package of tailor made services and offer advice on support on how to utilize school sport premium effectively.

8) Ensure that investigation into why a child is underweight is undertaken

9) *Continue to work with and develop referral pathways from primary and secondary care to the children's weight management programmes.*

Underweight Services

The prevalence of underweight amongst YR, Y4 and Y6 children in Walsall is approximately 1.5%. Each year, approximately 135 parents of primary age children (3 year groups) receive a letter via the NCMP stating their child is underweight. There are several reasons for poor weight gain e.g. poor diet, fussy eating, genetics,

other illnesses e.g. autism. One of the reasons for poor weight gain can also be neglect and therefore would be a safeguarding issue.

Currently, where there is a concern (e.g. by GP, School Health Nurse) about a child being underweight in Walsall, these are referred to the dietetics department at Walsall Manor Hospital. Parents of underweight children are not currently proactively contacted following an NCMP letter and if any parents contact the services following the check in school and subsequent letter, they are referred to the dieticians via a referral letter.

Overall, this is a very small number of children per year and the service wouldn't have capacity to see all underweight children if they were referred. However, should there be a triage service for these children, the dieticians at Walsall Manor Hospital would be able to agree to see these children and monitor referrals.

Eating Disorders

Eating disorders refer to a group of conditions defined by abnormal eating habits that may involve either insufficient or excessive food intake to the detriment of an individual's physical and mental health.

Promoting healthier Food Choices

Food in Schools

A child having a daily school lunch will eat nearly 20% of their meals in a year, at school. Therefore school food can limit a child's exposure to sugary, fatty foods, providing a more nutrient-dense foods rather than energy dense options. Good dietary habits developed at school are more likely to be continued into adulthood. A whole-school approach to healthy school meals, universally implemented for all pupils, has shown improvements in academic attainment at key stages 1 and 2, especially for pupils with lower prior attainment[59].

From September 2014 all children in reception, year 1 and year 2 in state-funded schools in England will receive free school meals. The government made this decision after a recommendation in the School Food Plan.

Also as part of the School Food Plan from January 2015, a revised set of standards become statutory for food served in maintained schools and some academies and

[59] *Kitchen S, Tanner E, Brown V, Payne C, Crawford C, Dearden L, Greaves E and Purdon S (2013) Evaluation of the Free School Meals Pilot Impact Report, Prepared by National Centre for Social Research for DfE. London: DfE*

free schools. These standards will make it easier for school cooks to create imaginative, flexible and nutritious menus so that pupils eat healthily at school[60].

The new regulations include that;

- Every meal should include one or more portions of vegetables,
- At least three different fruits and three different vegetables made available each week
- The amount of added sugars or honey in drinks to be restricted to 5 percent.

In addition there have also been amendments to;

- The supply of milk at lunchtimes (page 7)
- Fruit Juice / combination drinks (including maximum serving size) (page 8)
- Sugar content in fruit juice (page 8)
- Food available other than lunchtime

These standards will be monitored as part of OFSTEAD inspections.

The School Food Trust provides annual results regarding school meals across the country.[61]

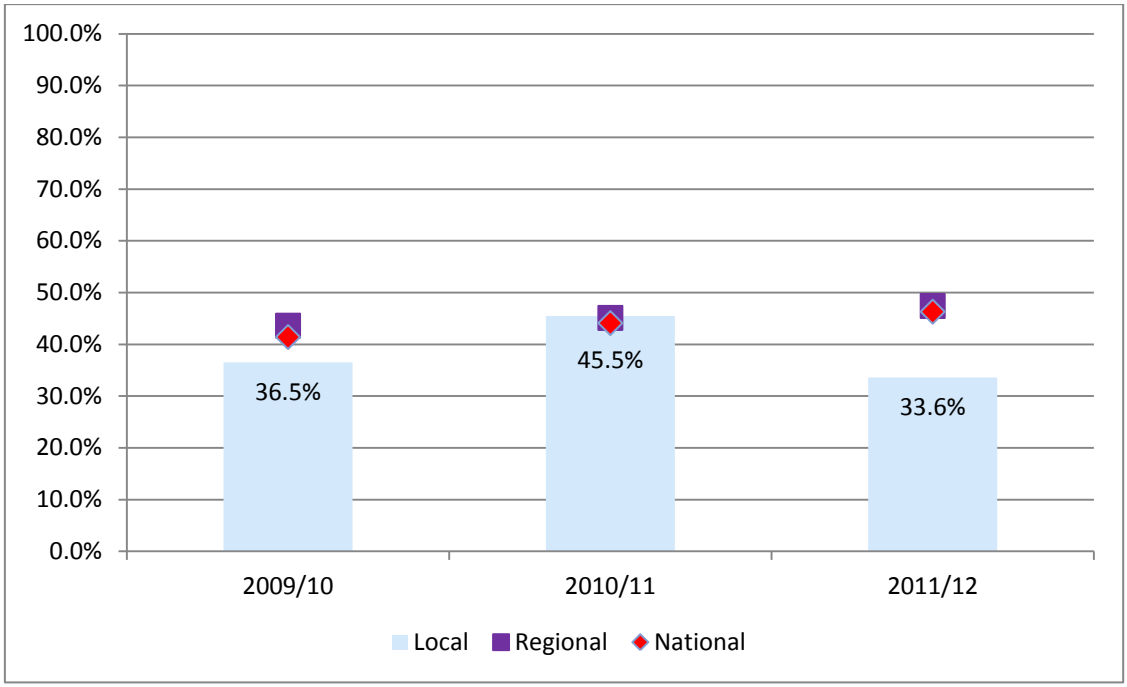
Figure 60: Primary and Special School Meal Take Up and coverage from 2009-2012

Primary	2009/10		2010/11		2011/12	
	Take Up	Coverage	Take Up	Coverage	Take Up	Coverage
Local	36.5%	91.3%	45.5%	90.2%	33.6%	78.5%
Regional	43.6%	93.9%	45.1%	93%	47.4%	90.4%
National	41.4%	94.2%	44.1%	78.4%	46.3%	60.8%

[60] *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/320697/Government_Response_-_Revised_Standards_for_School_Food_Consultation_FINAL.pdf*

[61] *School Food Trust: Statistical Release Take up of School Lunches in England 2010-11 and School Food Trust: Sixth Annual Survey of Take up of School Lunches in England 2010-11*

Figure 61: School lunch take up at Primary and Special schools



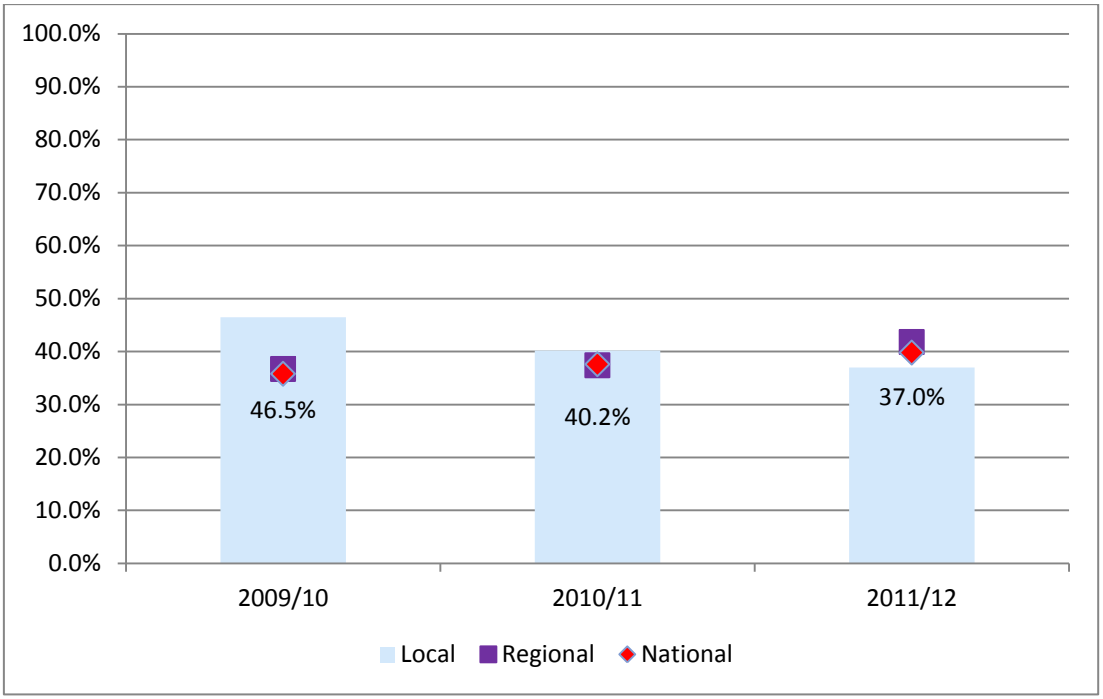
Key Findings:

- The national average take up of school lunches in 2011-2012 was 46.3% in primary schools, an increase of 2.2 percentage points compared with 2010-2011. Although the national coverage in 2011-12 has fallen to 60.8% from 78.4% in 2010-11.
- Locally take up of school meals in Primary schools was significantly lower than national take up 33.6% compared to 46.3% and regional take up 47.4%. Coverage has fallen from 78.5% in 2011-12 compare to 90.2% in 2010-11.
- Walsall's take up of school meals in Primary schools has significantly dropped from 2010-11 (45.5%) compared to 2011-12 (33.6%).

Figure 62: Secondary School Meal Take Up and coverage from 2009-2012

Secondary	2009/10		2010/11		2011/12	
	Take Up	Coverage	Take Up	Coverage	Take Up	Coverage
Local	46.5%	36.8%	40.2%	31.6%	37.0%	50.0%
Regional	35.7%	82.7%	37.4%	64.3%	41.8%	61.8%
National	35.8%	80.3%%	37.6%	54.2%	39.8%	38.0%

Figure 63: School lunch take up at Secondary schools



Key Findings:

- Nationally take up of school meals in Secondary schools was 39.8%, an increase of 2.2 percentage points compared with 2010-2011. Although the national coverage in 2011-12 has fallen to 38% from 54.2% in 2010-11.
- The take up of school meals in secondary schools has fallen significantly

In order to maintain the benefits available to children from regular school meals throughout the holidays when eating might become more erratic in certain families; Holiday Kitchens are to be introduced in Walsall offering children and their families an opportunity to come together for food and physical activity during the holiday. This will begin at Christmas 2016 run by Accord Housing

Improving School Meal Take Up

The School Food Trust produced 'six staples' which they suggest are needed to keep school meal uptake increasing. These are:

1. Enough time for lunch: no one likes to be rushed
2. Decent dining rooms: what's most important to kids is not what they eat, but where they eat
3. Freshly cooked food: the way food is prepared is linked to take up
4. A 'stay on site' policy

Polling for the Trust suggests that 90% of parents think schools should adopt a stay-on-site policy at lunchtime, with 67% agreeing that children would eat more healthily if they weren't allowed to leave school at lunch. It can help make sure that children don't turn up late in the afternoons, and allows teachers to focus on behaviour in school rather than outside. Stay on site can also ease tensions with residents living near school and cut littering.

5. Cooking in the curriculum: learning to cook and understand food is too valuable to be an 'optional extra' or 'nice to have'.
6. Affordable prices: keeping school meals affordable for parents is essential if we want more children to benefit from them.

Recommendations

1) Support caterers and schools to achieve new mandatory food school standards and increase the quality, take-up and economic viability of school meals.

2) Improving schools meals by offering training to catering staff to include portion control and the dining experience.

3) Encourage schools to offer breakfast clubs

4) Support schemes like the Food for Life Partnership programme in secondary schools to increase school meal take up.

5) Encourage schools to grow their own fresh produce where possible or engage with community allotments.

Vending Machines

It is well recognised that fatty and sugary food and drinks should only be an occasional part of our diet. However, vending machines offering and advertising these products to children at places that they go to be active do not reinforce this. We should be using this opportunity to promote healthy eating, complementing the message of the importance of exercise and a healthy weight, rather than opposing this. The British Heart Foundation looked at the food available in vending machines in leisure centres and found that the average calorie content was 203kcal, which would require a 7 year old to swim for 88 minutes, or an 11 year old to do 44 minutes of football.[62]

[62] *British Heart Foundation. A fit choice: A campaign report on the provision of children's food in leisure venues. London. British Heart Foundation 2009*

The Department of Health West Midlands Obesity Update Bulletin in 2008 included a Leisure Centre Food and Drink Survey which found that within the 89 snack vending machines in leisure centres, only 25 healthy snacks were available. Healthy drink availability was slightly better; 106 drinks available from 180 cold drink vending machines. They recommended that healthier options should be available in all vending machines and that all drink vending machines should offer plain or sparkling water, 100% fruit juice or milk based drinks with less than 5% sugar.[63]

In schools there are set standards for all food provided, including that from vending machines. These are set by Department for Children, Schools and Families and then delivered by the Schools Food Trust which includes vending machines. As recommended by the British Heart Foundation, these same standards could be used to assess the nutritional quality of food going into vending machines in public buildings and workplaces for example leisure centres Local Authority buildings and hospitals.

Food Deserts

In 2011, Public Health, in partnership with the Darlaston and Bentley Area Partnership conducted a mapping exercise to establish areas of Bentley and Darlaston where there may be 'food deserts'. A food desert is an area where people have inadequate access to fresh fruit and vegetables. For the purpose of the project, a food desert was any area outside a 10 minute walk of a fresh fruit and vegetable supplier.

100% of the Darlaston population lived within a 10 min walk of any shop selling fresh fruit or veg. However, when variety was taken into account (a 'good range' was defined as more than five varieties of fruit and more than five varieties of veg), this dropped to 82%.[64]

Figure 64: Number and % of population living within any shops selling fresh fruit and vegetables

Number of persons			
5 mins	10 mins	15 mins	20 mins

Percentage of Darlaston Population			
5 mins	10 mins	15 mins	20 mins

[63] *Department of Health West Midlands. 2008. Obesity Update Bulletin (online). Available at: http://www.foodwm.org.uk/resources/Bulletin_200807.doc. (Accessed 22/8/11)*

[64] *Do Food Deserts Exist in Walsall? A Study of Access to Retailers of Fruit and Vegetables in Darlaston. Elizabeth Sherwin. Public Health. NHS Walsall. December 2011*

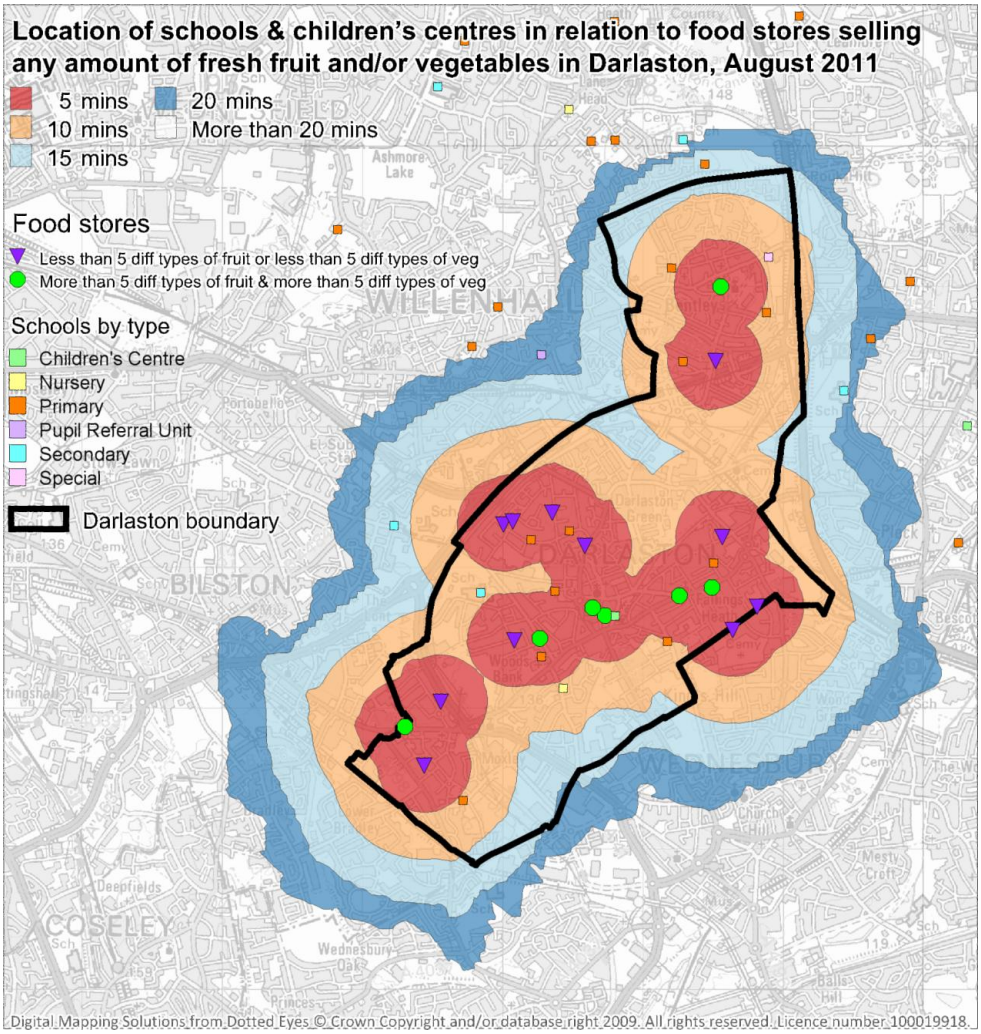
19,995	25,907	25,907	25,907		77	100	100	100

Figure 65: Number and % of population living within shops selling a good range of fresh fruit and vegetables

Number of persons			
5 mins	10 mins	15 mins	20 mins
10,685	21,155	25,907	25,907

Percentage of Darlaston Population			
5 mins	10 mins	15 mins	20 mins
41	82	100	100

Figure 66: Location of schools and children centres in relation to food stores selling any amount of fresh fruit and vegetables



Key Findings:

- 4 primary schools were within a five minute walk of a shop selling a good range of fresh fruit and vegetables
- All 10 primary schools were within a ten minute walk of a shop selling a good range of fresh fruit and vegetables
- One nursery was just outside the five minute walk-zone from a shop selling fresh fruit and vegetables
- The one secondary school was also just outside the five minute radius
- There was one children's centre and this was within very close proximity of a shop selling a good range of fruit and vegetables

Recommendations

1) Work with local retailers, farmers markets and allotments and support innovative schemes to supply more fresh food to 'food deserts'.

2) Explore the 'social supermarket' model. Currently being pioneered in South Yorkshire. Social supermarkets allow people on low incomes to register and shop for heavily discounted food which has been gathered from manufacturers' surplus produce. Once registered, they also receive a 'hand up' through help with debt problems, budgeting support and the skills required for work. The option of buying food at a greatly reduced price can help free up monies to cover other household essentials.

3) Encourage development of delivery services and box schemes targeting those people who have decreased access to fresh, healthy and affordable food.

4) Use branding such as 'Change 4 life' to promote healthy food sales and dietary knowledge in the local area.

5) Work with stores/ Cafes located close to schools / nurseries participating in 'Food Dudes' to develop relations with a view to using the branding in house on fresh fruit and vegetables and other healthy foods.

6) Support local Food banks to offer healthy foods and offering dietary knowledge and healthy recipes.

7) Engage and support employers to offer healthy options in vending machines through the workplace wellbeing charter.

Fast Food Outlets

The National Planning Policy Framework (NPPF) outlines that local planning authorities have a responsibility to promote healthy communities. Local plans should "take account of and support local strategies to improve health, social and cultural wellbeing for all"[65].

The NPPF also gives clear advice that local planning authorities should "work with public health leads and organisations to understand and take account of the health status and needs of the local population… including expected changes, and any information about relevant barriers to improving health and wellbeing".

A number of local authorities have drawn up supplementary planning documents (SPDs) to restrict the development of new fast food premises near schools. However, it is recognised that due to consultation and other procedures, these can take a long time to prepare and agree. SPDs must also relate to a policy in the local plan, so the priority is to make sure the issue is addressed within the local plan in the first place.

Sandwell Council adopted an SPD for hot food takeaways in 2012, including a 400m exclusion zone around secondary schools, and tests for over-concentration, clustering and environmental impact. In one appeal there was little support from the school affected or secondary evidence, so the application was approved. Council officers reported they have since made efforts to work more closely with public health colleagues and to engage with schools on the issue.

All subsequent appeals to the Planning Inspectorate, including one within 400m of a secondary school, have been dismissed, so the SPD appears to have been effective.[65]

A 2008 report from the Nutrition Policy Unit of London Metropolitan University[66] found that food outlets in close proximity to and surrounding schools were an obstacle to secondary school children eating healthily, with many shops offering child-sized portions at child-sized prices. Research into the link between food availability and obesity is still relatively undeveloped although a US study has found evidence of

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[65] *Public Health England. Obesity and the environment briefing: regulating the growth of fast food outlets. March 2014.*

66 The School Fringe: What pupils buy and eat from shops surrounding secondary schools. Sarah Sinclair and Jack Winkler. Nutrition Policy Unit. London Metropolitan University, July 2008

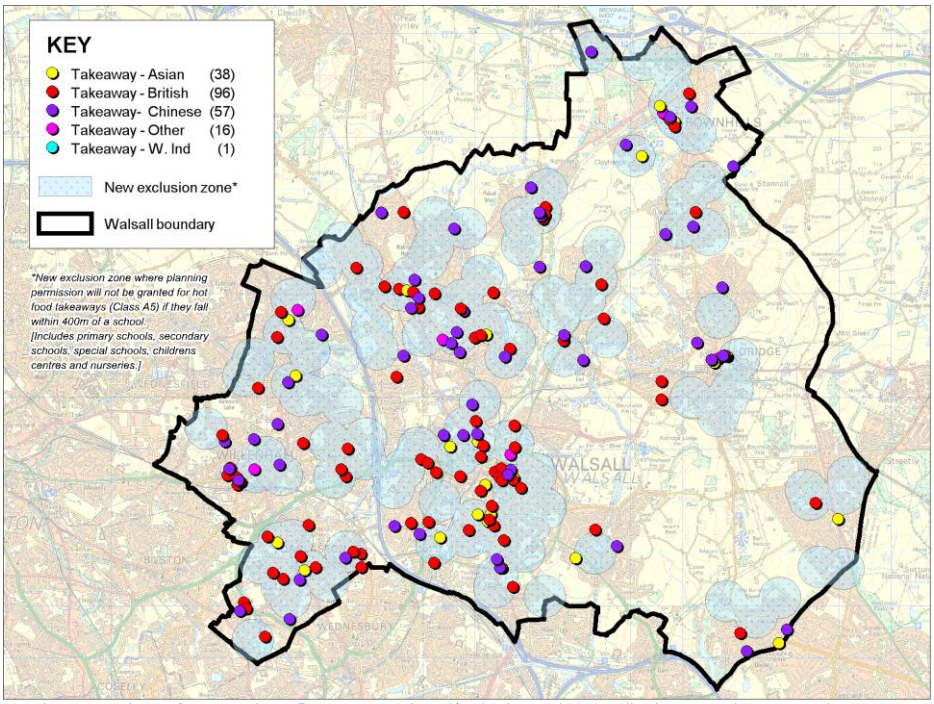
elevated levels of obesity in communities with high concentrations of fast food outlets[67].

Takeaways within walking distance of schools are contributing to the obesogenic environment children in Walsall face every day. Four hundred metres is deemed to be an acceptable measurement for the distance children may walk out of school to buy lunch. Currently in Walsall, Trading Standards have a condition that street traders are not allowed to park within 200m of a school entrance or of another trader of the same type this does not include the town centre.

Barking and Dagenham's supplementary planning document 'Saturation Point' was used as a guide to map takeaways in Walsall and an exclusion zone of 400m was set around each school (primary, secondary and special) and children's centre in Walsall.

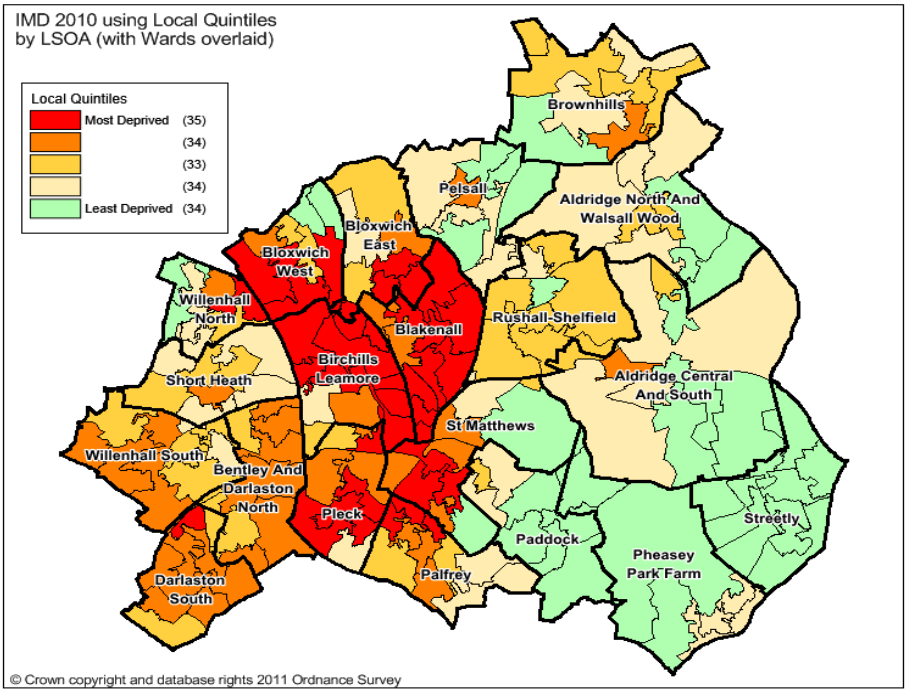
Figure 67 below shows that a large percentage of takeaways in Walsall are within 400m of a school or children's centre in Walsall.

Figure 67: Map of Takeaways in Walsall with 400m exclusion zones highlighted



67 Zenk SN, Schulz AJ, Odoms-Young AM. How neighborhood environments contribute to obesity. The American journal of nursing. 2009 Jul;109(7):61-4.

Figure 68: Walsall LSOA deprivation using Local Quintiles



Source: Department for Communities and Local Government

Furthermore comparing Figure 67 and

Figure ***68*** highlights that the majority of takeaways are situated in the west of the borough in the areas of high deprivation. Similar work carried out nationally by PHE's obesity knowledge and information team (formerly the National Obesity Observatory) produced a briefing paper on fast food outlets. This shows the density of outlets varies between 15 and 172 per 100,000 populations. This data shows a strong association between deprivation and the density of fast food outlets, with more deprived areas having a higher proportion of fast food outlets per head of population than others.

Recommendations

1) *Establish a programme of health impact assessment (HIA) training for public health teams, planning officers, and others.*

2) *Agree a process with the planning team for incorporating HIAs in the planning process.*

3) *Utilize community infrastructure levy money to support the development of infrastructure within the community for example safer road schemes or park improvements.*

Building physical activity into our lives

It is important for people to be active throughout their lives. Physical activity is central to a baby's normal growth and development. This continues through school, and into adulthood and older years. Being physically active can bring substantial benefits including improvements to mental health, reduced risk of disease such as diabetes and ultimately reduced risk of a premature death.

Public Health commission a number of physical activity programmes/ initiatives that are evaluated below:

Time 2 Change Programme

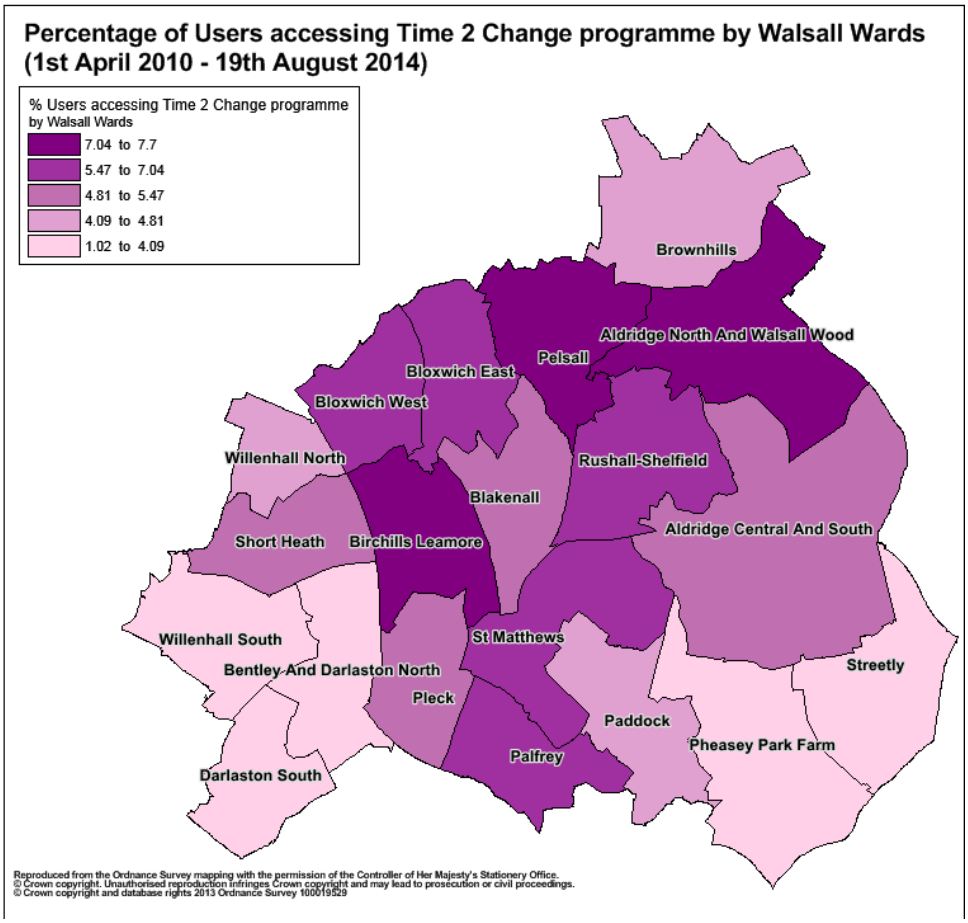
One to one exercise advice and support service for individuals who need to increase their levels of physical activity or suffer with medical conditions.

Figure ***69*** highlights a number of outcomes from the programme for 2013-14.

Figure 69: Time 2 Change key performance indicators 2013/14

Participants	Changes in PA Levels	Reduction BMI	Quintiles (1-3)	% Male	%BME	18-35	36-50	50+
594	79%	71%	54%	37%	27%	26%	55%	19%

Figure 70: Percentage of users accessing the Time 2 Change programme by Ward 2010-14



Key Findings:

- Aldridge North and Walsall Wood, Birchills leamore and Pelsall have highest percentage of users.

- The service has less engagement with residents in west of the borough, especially some areas of increased deprivation such as Willenhall and Darlaston.

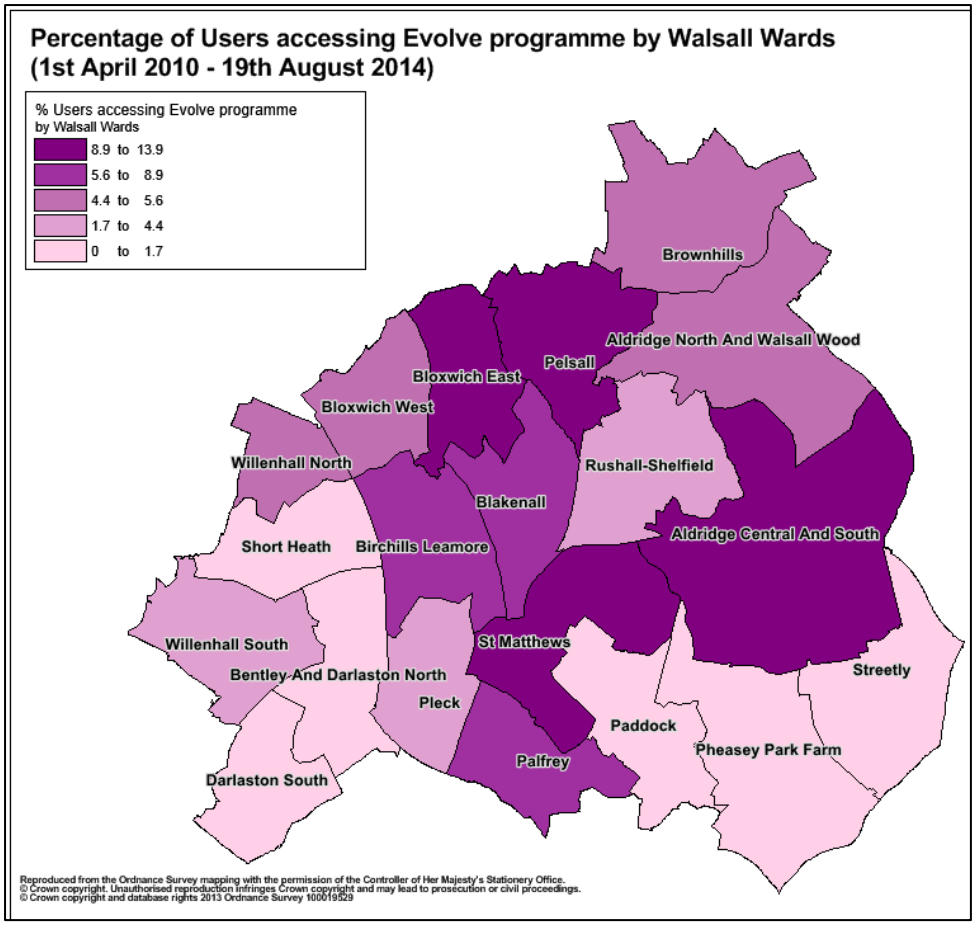
Evolve Programme

Evolve aims to help individuals lose weight through leading a healthier and active lifestyle. Evolve is a 12 week programme designed to give individuals the necessary tools to be able to make small realistic changes which can be maintained to lead a lifelong healthy lifestyle. *Figure 71* highlights a number of outcomes from the programme for 2013-14.

Figure 71: Evolve programme key performance indicators 2013-14

Programmes	Participants	Attendances	Changes in PA Levels	Reduction BMI	Quintiles (1-3)	% Male	% BME	18-35
12	**89**	**862**	**79%**	**71%**	**54%**	**37%**	**6%**	**26%**

Figure 72: Percentage of users accessing the Evolve Programme by Ward 2010-14



Key Findings:

- Aldridge Central and South, Bloxwich East, Palfrey and Pelsall wards have the highest proportion of users acccessing the programme (43.9%).
- The service has less engagement with residents in west of the borough, especially some areas of increased deprivation such as Willenhall and Darlaston.
- Average number of attendances/ person is 9.7 which is high retention for a 12 week programme.

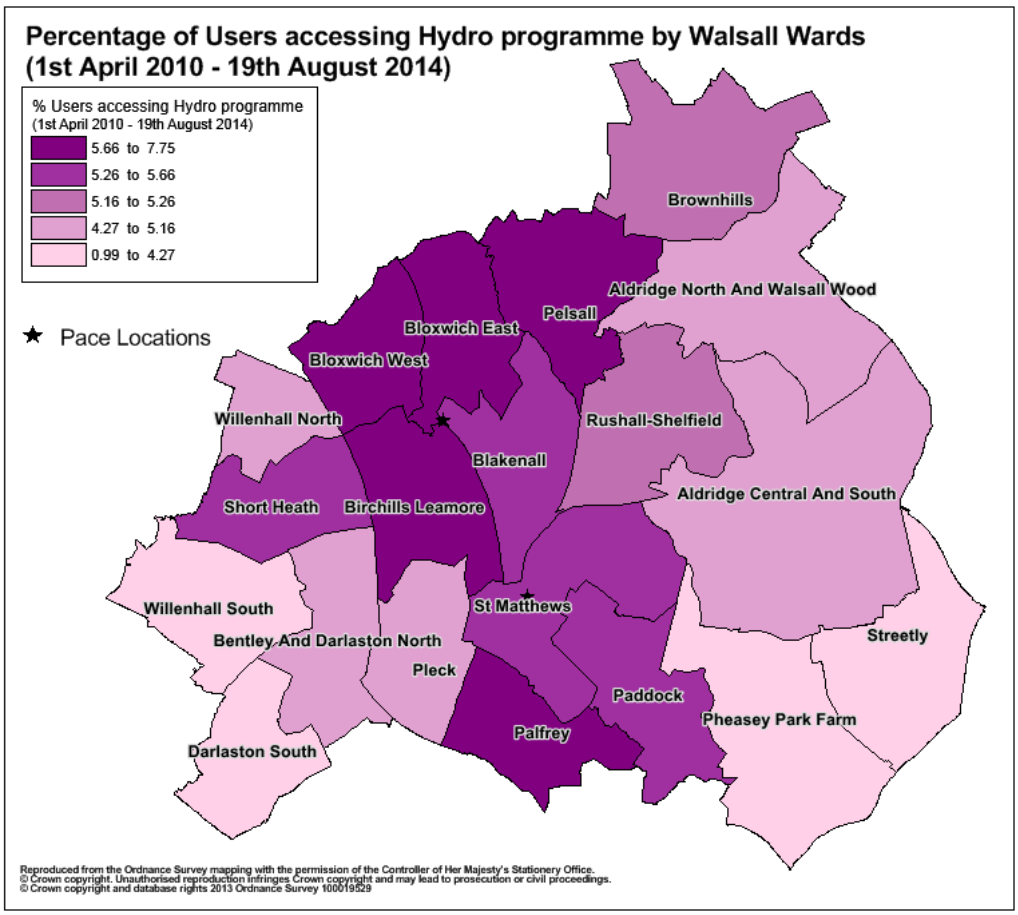
Hydrotherapy Programme

Community Hydrotherapy sessions offer tailored water based exercise programmes for individuals with musculo-skeletal conditions, such as osteo-arthris. *Figure 73* highlights a number of outcomes from the programme for 2013-14.

Figure 73: Hydrotherapy programme key performance indicators 2013-14

Participants	*Attendances*	*Increase in PA Levels*	*Quintiles (1-3)*	*% Male*	*% BME*	*18-35*	*36-50*	*50+*
539	*5791*	*72%*	*49%*	*42%*	*9%*	*16%*	*37%*	*47%*

Figure 74: Percentage of users accessing the hydrotherapy programme by Ward 2010-14



Key findings:

- Bloxwich East, Bloxwich West, Birchills leamore, Palfrey and Pelsall wards have highest proportion of users accessing the programme (29.8%).
- The programme has increased engagement with residents within the catchment area of the 2 venues – i.e. Gala Baths (Central) and Bloxwich Leisure Centre. The sessions are restricted due to the need for an accessible swimming pool, however Darlaston Swimming pool may provide an option for increasing participation in the respective catchment.
- The programme engages with a high number of particpants.

Falls Prevention Services

Community Falls and Balance is an evidence based programme that includes training elements that support the client's individual needs in improving functional fitness and reduction in the risk of falls. These include the main contributors to falls prevention; strength, balance co-ordination, flexibility and posture. The programme also includes bone leading activities to improve bone density contributing to reducing

the risk of future fracture. These elements are also supported by aerobic training in order to improve general health and to reduce the risk of CHD and related conditions.

The FaME (Falls Management Exercise) study demonstrated significant reduction in falls risk and lower mortality and morbidity at 3 year follow up when compared to (randomised) control groups. The most effective component of a multifactorial intervention is therapeutic exercise, as balance impairment and muscle weakness caused by ageing and disuse, are the commonest modifiable risk factors for falls.

Falls prevention programmes have been proven to be extremely effective in reducing falls. They therefore play an important role in reducing the financial burden on the NHS and adult social care services by preventing fractures, avoidable hospital admissions and the need for long term residential and nursing care.

Following a multifactorial risk assessment, it is crucial that those at risk of falls are offered a range of interventions, including medication reviews and home safety or hazard assessments.

The falls prevention service is currently being re-procured and therefore a specification has been developed through a separate piece of work and consultation exercise.

Commissioned Universal Provision

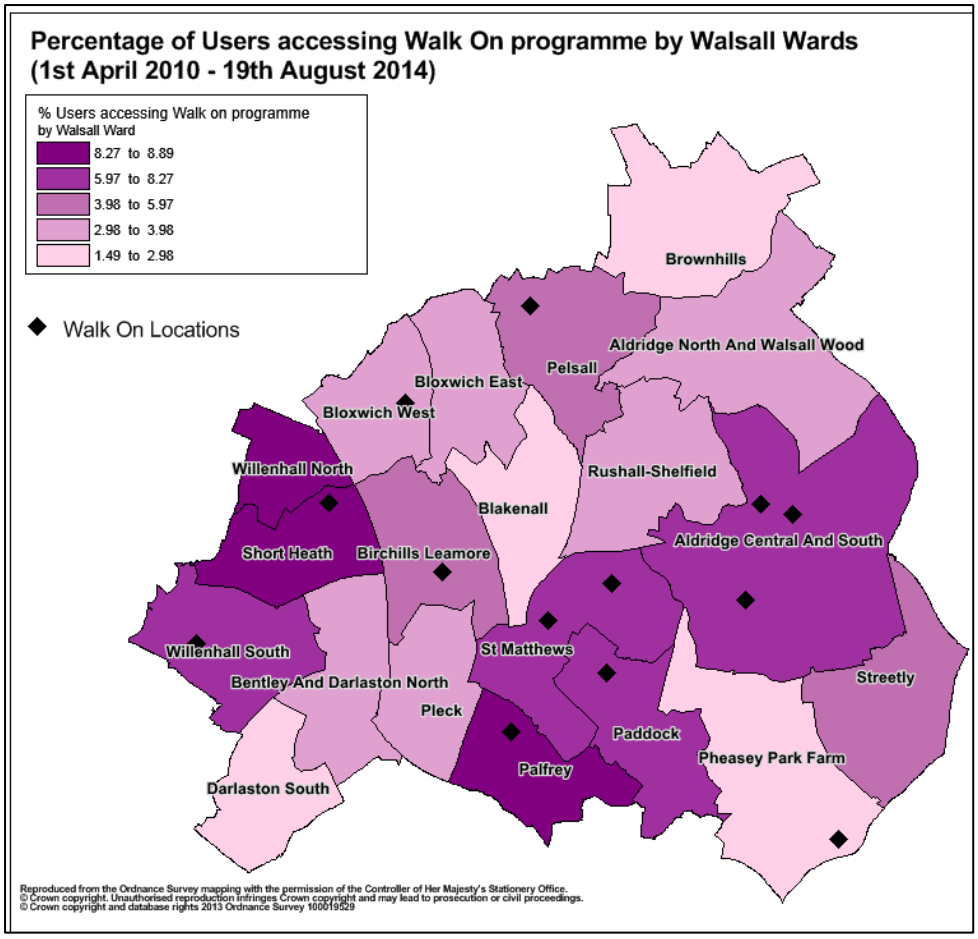
Walk on programme

Walk On is a nationally accredited weekly programme of free health walks held in parks and countryside spaces across the borough. The weekly programme provides a range of walks varying in length and terrain with distances from approximately one mile up to about six miles. Walks are led by volunteer walk leaders who have completed the Volunteer Health Walk Leader training course that is provided by Natural England. *Figure 75* highlights a number of outcomes from the programme for 2013-14.

Figure 75: Walk on programme key performance indicators 2013-14

Participants	*Attendances*	*Increase in PA Levels*	*Quintiles (1-3)*	*% Male*	*% BME*	*18-35*	*36-50*	*50+*
422	*9702*	*77%*	*50%*	*43%*	*6%*	*5%*	*13%*	*82%*

Figure 76: % of users accessing the Walk On programme by Ward 201-14



Key Findings:

- Palfrey, Short Health and Willenhall North wards have the highest proportion of users accessing the programme (26%).
- The programme engages with a high proportion of older people.
- The programme engages with low percentage of BME compared to borough profile.
- Provision is limited within Darlaston, Pleck and Blakenall leading to reduced number of participants from these areas.

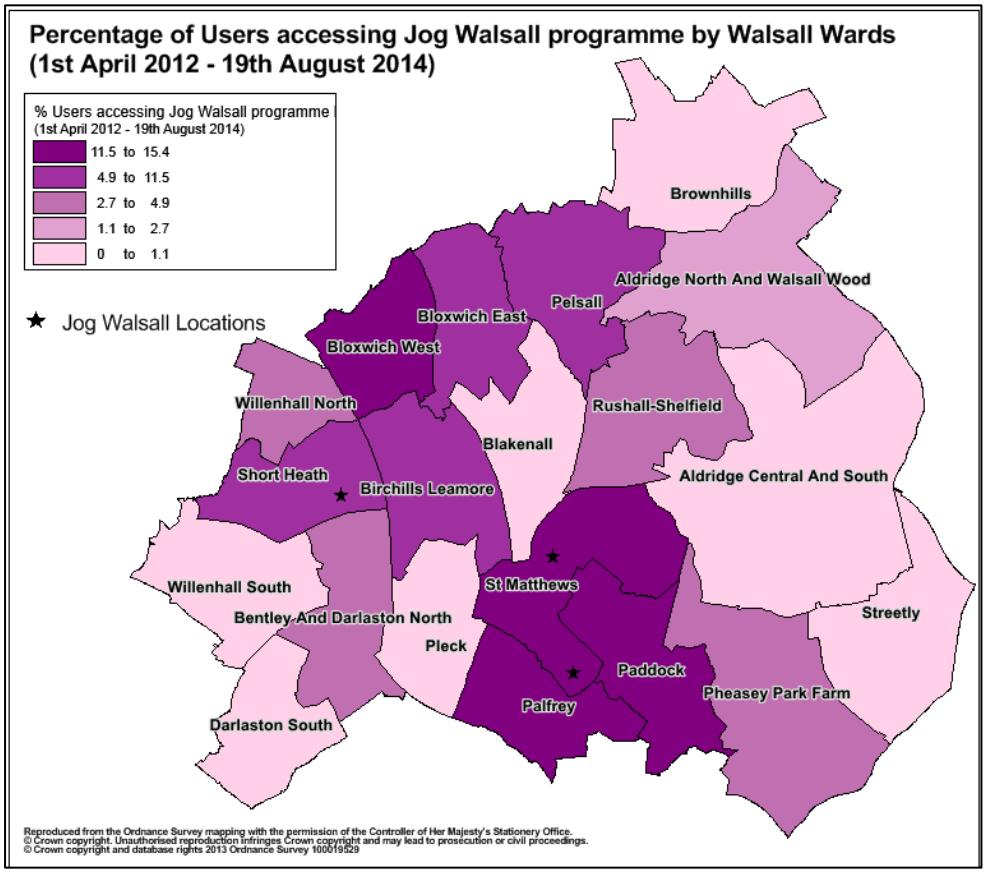
Jog Walsall Programme

The following table highlights a number of outcomes from the programme for 2013-14.

Figure 77: Jog Walsall Programme key performance indicators 2013-14

Participants	*Attendances*	*Increase in PA Levels*	*Quintiles (1-3)*	*% Male*	*% BME*	*18-35*	*36-50*	*50+*
1185	*8924*	*74%*	*27%*	*64%*	*15%*	*35%*	*51%*	*14%*

Figure 78: Percentage of users accessing Jog Walsall programmes by Ward 2012-14



Key Findings:

- Bloxwich West, Paddock, Palfrey and St. Matthews wards have the highest proportion of users accessing the programme (52.2%).
- Large number of participants take part in the weekly "Parkrun" which is a 5km timed run.

- Participation is low in some of the more deprived areas of the borough, including Blakenall, Pleck, Willenhall and Darlaston. This is likely to be due to the venues in which they take place.

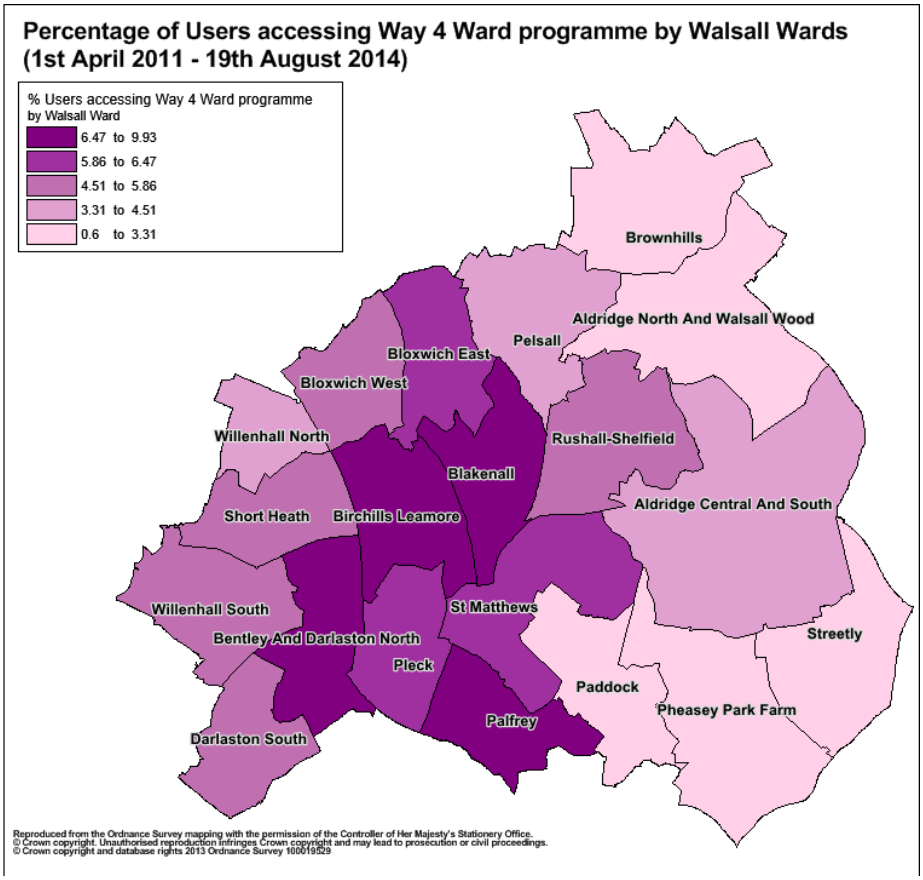
Way 4ward Programme

One to one exercise advice and support service for young people who need to increase their levels of physical activity or improve management of their weight. The following table highlights a number of outcomes from the programme for 2013-14.

Figure 79: Way 4ward Programme key performance indicators 2013-14

Participants	*Increase in PA Levels*	*Quintiles (1-3)*	*% Male*	*% BME*	*8-11*	*12-16*
197	*88%*	*65%*	*49%*	*44%*	*5%*	*13%*

Figure 80: Percentage of users accessing Way4 Ward programmes by Ward 2012-14



Key Finidngs:

- Blakenall, Bentley and Darlaston North, Birchills leamore and Palfrey wards have the highest proportion of user accessing the programme (26.8%).
- Increased engagement with participants living on the west the borough, hence majority are from quintiles 1-3.
- Very high percentage of BME engagement (44%), well above borough profile (19%).
- Low overall number of participants.

Walsall Health Care Trust Free Physical Activity Sessions

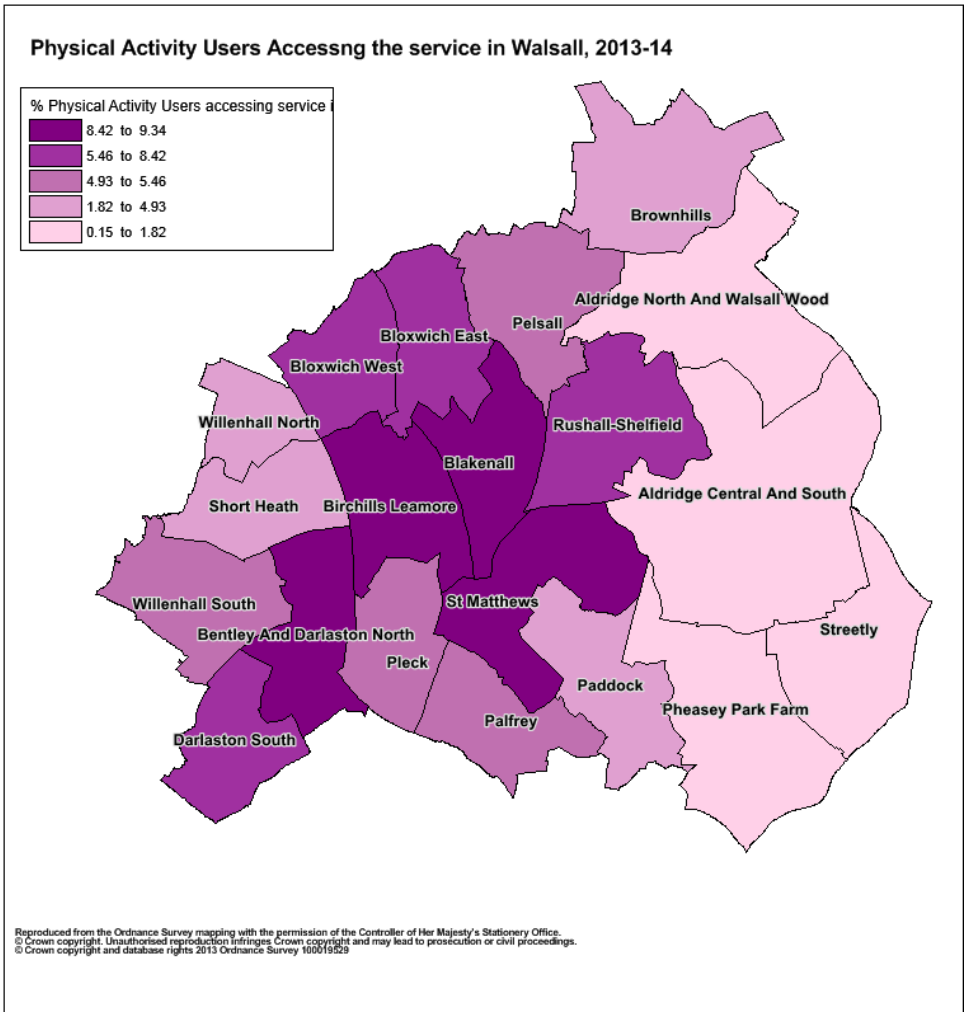
Walsall Health Care Trust Physical Activity Team has developed a wide range of activity sessions for all ages and levels of fitness, from gentle aerobics and family

dance to circuit training and the sessions are available at different venues across the borough. The following table highlights a number of outcomes from the programme for 2013-14.

Figure 81: WHT Physical activity sessions key performance indicators

Participants	*Quintiles (1-3)*	*% Male*	*% BME*	*16-35*	*36-50*	*51+*
651	*68%*	*9%*	*29%*	*38%*	*20%*	*42%*

Figure 82: Percentage of users accessing WHT physical activity sessions by Ward 2013-14



Key Findings:

- Due to the structure (free access) of the programme there is limited room for development of the service to enable an increase in particpants.
- Increased enagement with BME and local quintiles 1- 3.
- Increased engagement across Bloxwich, Blakenall, Birchills, St Matthews, Bentley and Darlaston North.
- Reduced engagement on Willenhall, Pleck and Palfrey.

Recommendations

1) *Target more deprived areas of the borough, quintiles 1-3.*
2) *Target BME groups.*
3) *Need to develop a consistent approach to monitoring levels of sustained participation across all commissioned services. Sustained participation will have greater impact on an individual's health.*

Active travel

Active travel to and from school could provide an excellent opportunity to increase activity levels in children. Getting one more person to walk or cycle to school could pay back between £768 or £539 in terms of NHS savings, productivity improvements and reductions in air pollution and congestion. [68]

In addition, active travel to school is repetitive and can become habitual, creating good habits for the future. Active travel to school with parents can also play an important role in reducing car journeys and is positive role-modelling for children.

The A*Stars programme focuses on empowering schools to embed safer and sustainable travel on all school journeys. It differs from other programmes in its innovative approach to engage with all sectors of the school community to bring about a cultural change where walking and cycling are the norm.

[68] *Public Health England. Local action on health inequalities: Understanding the economics of investments in the social determinants of health. Health Equity Briefing 9: September 2014.*

The number of primary schools engaged in the A*STARS programme over the last 2 academic years has continued to increase from 16 (2012/13) to 56 (2014/15) Primary Schools.

The programme offers bikeability training to all A*Stars schools currently 523 children in year 5/6 have been trained in Primary schools. A*Stars schools have shown cycling rates of 2.7%, an increase of 0.4% from the previous year this is fhigher than the national average rate for primary schools at 1% (2013). Currently 2,800 children have participated in pedestrian or bikeability training.

The A*Stars team offer support and resources to national and local campaigns including Walk to School Month. In October 2014 campaign, 41 (73%) schools participated with an estimated 65,000 active journey made in that month

A*Stars is currently piloting a similar porgramme in 4 secondary schools.

Physical Activity in schools

Black Country School Sport Premium Report

This report details the findings of the insight research carried out by Walsall Council and its associated partners on behalf of the Black Country Consortiums BeActive Partnership “Primary School Sport Premium Local Intelligence and Advocacy Project”. The insight work was commissioned in order to understand how Primary Schools in the Black Country are deploying their share of Primary School Sport Premium. It was designed to identify what is on offer locally (through NGBs, private providers, YST etc.), identify key issues, and concerns to shape the design of future advice and guidance required to provide additional support to those schools who want or need it.

Primary School Sport Premium (Premium) The government has provided additional funding of £150 million per annum for academic years 2013 to 2014 and 2014 to 2015 to improve provision of physical education (PE) and sport in primary schools. This funding - provided jointly by the Departments for Education, Health and Culture, Media and Sport - will be allocated to primary school Head teachers. This funding is ring-fenced and therefore can only be spent on provision of PE and sport in schools. In Walsall, this translates into £800,000 per year for Walsall Schools to improve provision of PE and Sport in Primary Schools.

The report is covered under ministerial privilege so limited information is provided in this needs assessment. In summary, the report identifies a number issues and the need for increased school engagement, increased uptake in the school games, improved support to schools, a coherent, quality and effective CPD offer, good

practice guidance including minimum operating standards and a qualifications framework for different models of coaching and teaching delivery.

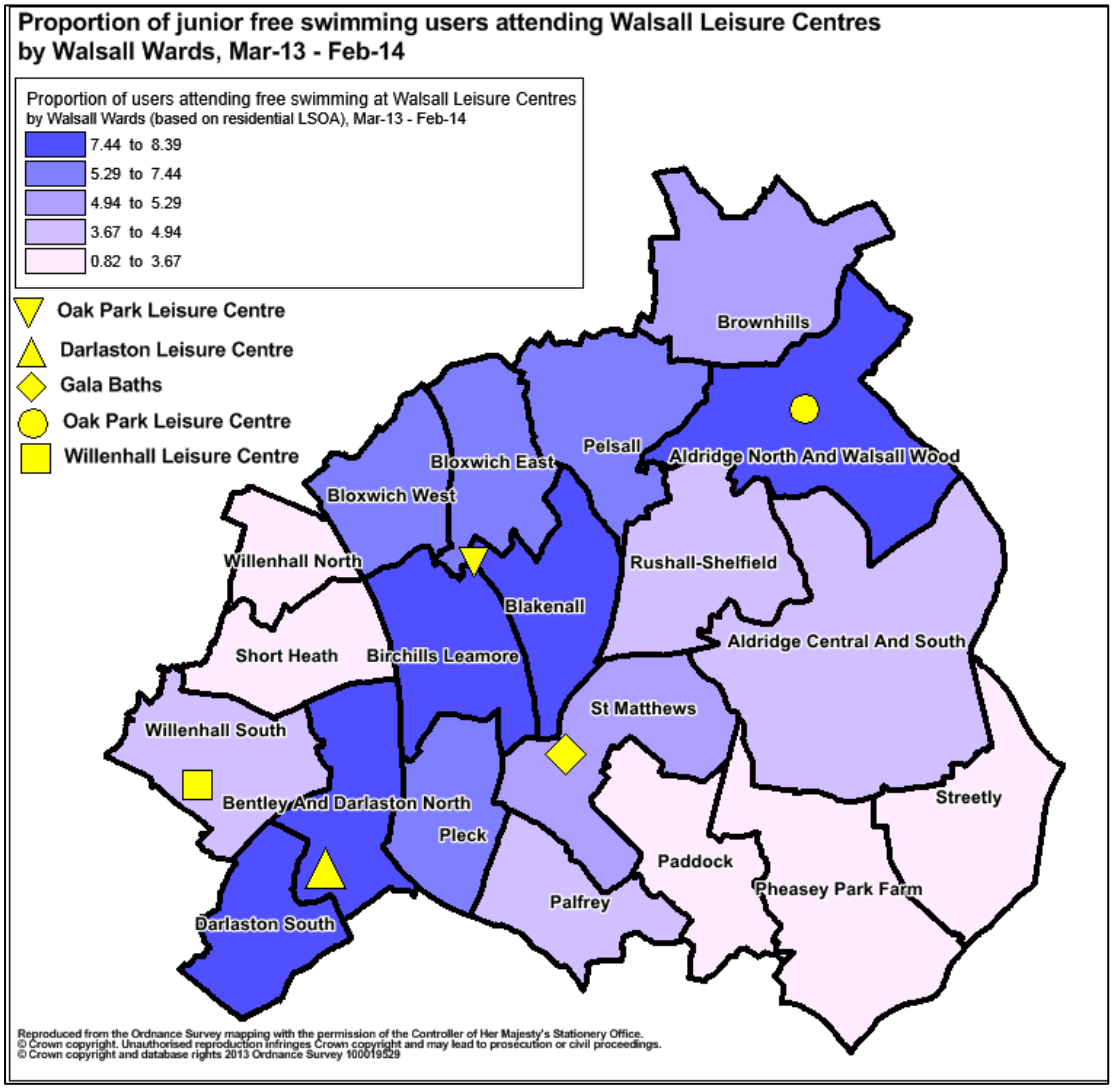
Active clubs

Active Clubs is a National programme designed to encourage more children and young people to take part in physical activity, particularly during out of school hours and particularly those who are inactive. Out of school care settings have an important role to play in encouraging more children and young people to be active.

To ensure active clubs are sustainable and can be delivered in school settings but outside of curriculum time e.g. breakfast clubs, after school clubs, playground activities the physical activty team offer freee training to suitable candidates including those whose job remit requires the promotion or support of physical activity for children and young people within the community or school. Currently 44 volunteers a have been trained who are working in 18 primary schools.

Walsall Housing Group also supports this initiative by engaging volunteers within the community and setting up active clubs outside school curriculum time. Of the 15 people who received training 7 are continuing to deliver an Active Clubs session in after school or community based session.

Figure 83 Free Swimming (under 16yrs)

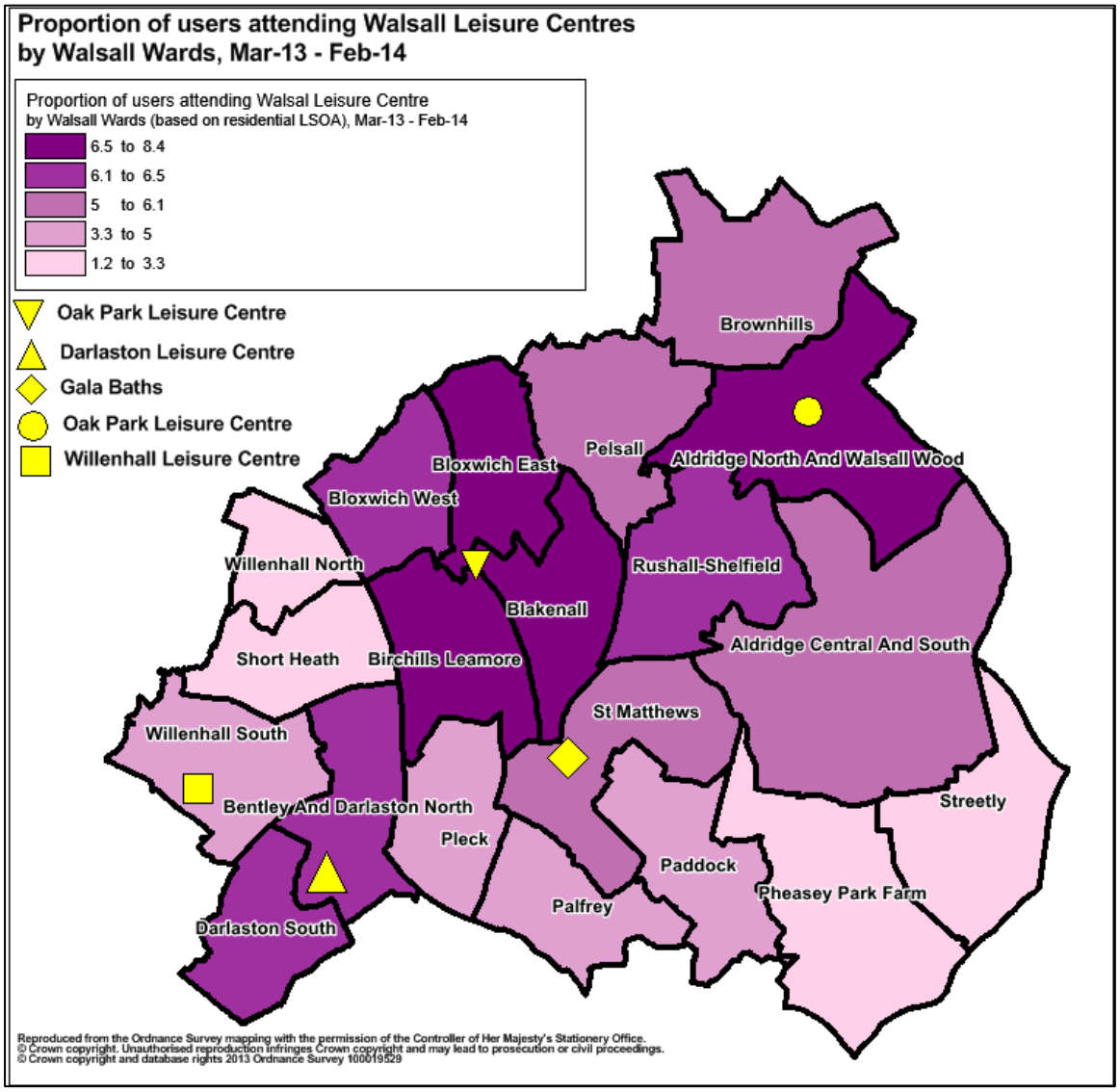


Key Findings

- 87.1% of all users were from national quintile 1-3 and 72.1% using the local quintiles.
- 20.3 % of users were outside of area, with Darlaston centre showing greatest proportion of out of area users (36.8%).
- North Walsall Area partnership has greatest proportion of users (26.4%).

Further analysis of the junior free swimming in Walsall can be found in appendix 7.

Figure 84: Proportion of users attending Walsall Leisure Centres by Ward 2013/14



Key Findings

- 26939 users attended one of four leisure centres in Walsall during the last 12 months (Mar-13 – Feb-14).
- 66% of all users were from national quintile 1-3 and 52.5% using the local quintiles.
- 19.3% of all users were outside of Walsall.

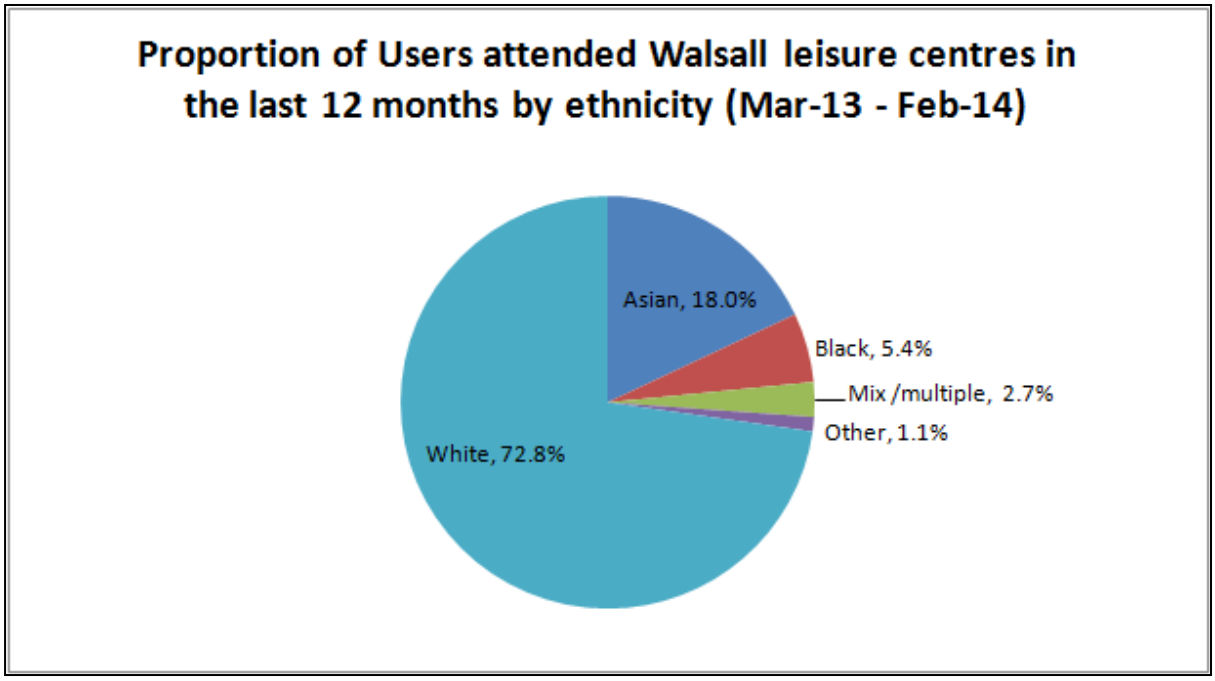
Further analysis of the Walsall leisure centres usage can be found in appendix 8.

The following table below highlights the demographic data on the number of users accessing Walsall's leisure centres from 2013/14.

Figure 85: Demographic breakdown of users in the last 12 months

	Users attended at least once in last 12 months					
	Male		Female		Persons	
Age Group	Number of Users	%	Number of Users	%	Number of Users	%
0-15	7765	60.2%	7584	50.6%	15349	55.1%
16-34	1878	14.6%	3132	20.9%	5010	18.0%
35-64	2324	18.0%	3287	21.9%	5611	20.1%
65+	931	7.2%	977	6.5%	1908	6.8%
Total	12898		14980		27878	

Figure 86: Ethnic breakdown of Leisure centre users 2013/14



Key Findings

- Users excluded from this data include; those not registered with the centres (casual pay as you go adult swimmers), group or club bookings, all school children attending as part of lessons and classes.
- Due to the high uptake of the junior free swimming, which requires registration, these junior customers are disproportionately highly represented in the sample.

- Bloxwich Leisure Centre and Gala Baths engage most participants from the most deprived wards, local quintiles 1-3.
- Access from the BME community is representative of the borough.

Green Spaces

Safe, clean spaces encourage people to walk more and therefore offer significant health benefits. Parks and green spaces offer places for sport, recreation and relaxation, benefiting physical health and mental wellbeing. There is even evidence that access to good quality local spaces can help people live longer and green spaces can provide solutions to redress worsening public health.[69]

Green spaces can also bring significant community benefits as places to play, encouraging neighbourliness and social inclusion and as a venue for events that bring people together.[70] Research demonstrates that disadvantaged people who live in areas with large amounts of green space may be more likely to use their local green spaces and be more physically active, thus experiencing better health outcomes than those of a similar level of disadvantage for who such easy access to good quality green space is much less [71]. Evidence shows that children living near green spaces are less likely to experience an increase in body mass index (BMI) over time.[72] Therefore increasing the amount and quality of green space can be part of a low cost package to address health inequalities, improve health outcomes and deliver other benefits[73].

Networks of linked green spaces and green corridors can encourage cycling, active travel and subsequently lower dependency on the car, reducing levels of traffic. Walsall is particularly well served by green corridors with Walsall Arboretum extending from Walsall Town Centre to wider countryside and the canal network providing important routes for people and wildlife. Green space also provides an ideal opportunity for recreational walking and provision of low cost physical activity programmes, such as led walks and jogs.

The distribution of green space is uneven with some wards having much less access to green space than the Borough average. These wards, many of which are in the west of the Borough have less green space and that provided is typically of lower quality than other areas of the Borough despite broadly equal levels of capital

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[69] *Sustainable Development Commission (2008) – Health, Place and Nature: How Outdoor Environments Influence Health and Wellbeing – A Knowledge Base*

[70] *Your Parks, The Benefits of Parks and Green Space*

[71] *Pretty et al (2005) The Mental and Physical Health Outcomes of green exercise. Int J Environ Health Res 15:319-37*

[72] *Pretty et al (2005) The Mental and Physical Health Outcomes of green exercise. Int J Environ Health Res 15:319-37*

[73] *UCL Institute of Health Equity (2014) Natural Solutions for Tackling Health Inequalities*

resource and revenue funding. Other areas experience limited access to specific types of green space, be that allotment provision or access to natural and semi-natural green space.

Not all green space within the borough are freely accessible, many have some form of access restriction. Of the total 535 green spaces 315 (58.9%), have unrestricted access 46 (8.6%) limited access and 174 (32.5%) are not accessible. The table and map below shows a detailed analysis at Partnership Area level of unrestricted green space.[74]

	Amount of Unrestricted Green Space (Ha)	***Amount of Unrestricted Green Space (Ha)***	***Population of Area Partnership***	***Amount of Unrestricted Green Space (Ha) per 1000 population***
1	*Brownhills/Pelsall/Rushall/Shelfield*	*310.50*	*35,939*	*8.64*
3	*Bloxwich/Blakenall/Birchills/Leamore*	*265.58*	*51,506*	*5.16*
	Borough Total	***1,257.60***	***253,499***	***4.96***
6	*Willenhall/Short Heath*	*170.44*	*38,438*	*4.43*
5	*Darlaston/Bentley*	*111.07*	*25,555*	*4.35*
2	*Aldridge/Streetly/Pheasey/Walsall Wood*	*206.72*	*49,579*	*4.17*
4	*St Matthew's/Paddock/Palfrey/Pl*	*193.26*	*53,456*	*3.62*

[74] *Walsall Green Space Strategy (2012 -17)*

	eck			

Brownhills/ Pelsall/ Rushall/ Shelfield and Bloxwich/ Blakenall/ Birchills/ Leamore Area Partnership have more unrestricted green space than both the borough average and the other 4 partnership areas. However, this area partnership analysis masks more local variation in the amount of green space. Whilst Brownhills/ Pelsall/ Rushall/ Shelfield Area Partnership has the greatest amount of unrestricted and over 74% more green space than the borough average the wards of Rushall, Shelfield and Pelsall have much less accessible green space than the borough average. Similarly, within Bloxwich/ Blakenall/ Birchills/ Leamore Area Partnership the wards of Bloxwich east and Birchills Leamore have less unrestricted space than the borough average.

Natural England Accessible Natural Green Space (ANGSt) standard

The provision of natural green space has been compared against the Natural England Accessible Natural Green Space (ANGSt) standard. The ANGSt standard includes the following standards against which an assessment has been made;

- No person should live more than 300m from their nearest area of natural green space of at least 2 ha in size
- There should be at least one accessible 20ha site within 2km from home

Walsall does not achieve this part of the ANGSt standard since there are large areas of the borough with no access to Natural and Semi-natural green space, particularly the south of the borough.

Local Programmes Utilising Green Space

A number of programmes/ facilities designed to increase physical activity have been rolled out within Walsall's Green Spaces. These have included led Walks and Jogs, Outdoor Gyms, development of new play areas and multi-use games area. Some of these programmes, such as the Walk On Scheme (see earlier in the document), have demonstrated a positive impact on levels of physical activity, however others are difficult to quantify because monitoring frameworks were not built in during the programmes/ facilities initial development.

Allotments and Community Gardens

There are currently 39 allotment sites in the borough which provides opportunities for physical activity and local food production. The distribution of these spaces varies significantly with 13 allotment sites in St Matthews/ Paddock/ Palfrey/ Pleck Area Partnership and just 2 in Aldridge/ Streetly/ Pheasey/ Walsall Wood. The draft Allotment Strategy suggests a catchment of 2 kilometres for allotment provision with a standard of all residents having access within this distance. Generally the current

level of provision is adequate against this standard with the exception of parts of Aldridge Central and South, Eastern Streetly and parts of Brownhills. The allotment strategy has recommends that consideration is given to creating new allotments and community gardening provision in areas of deficiency.

Recommendations

1) *In order to make the most of Walsall's Green Spaces there is a need for collaboration across a number of sectors, including Parks and Green Spaces, Public Health, CCGs, Sustainable Travel, Rights of Way, Canals and River Trust and Education.*

2) *Identify strategic green spaces across the borough to which resources are prioritised ensuring they meet certain criteria which will ultimately encourage more physical activity and address some of the barriers identified in the consultation. For example, good and safe access, signage, safe and maintained equipment, conservation of natural features and well maintained walking routes. Green spaces should be selected based on access to areas of increased health inequality, size, type, quality existing infrastructures (e.g. play facilities) and the potential for them to be used as active travel corridors.*

"Surveys show that it's the quality not just the quantity of public parks and spaces that makes people want to walk more"[1]

3) *To develop links between education and green spaces through improving schools knowledge of local green spaces and teachers confidence in delivering outdoor learning. As a result, children will become more aware of local provision and familiar with it as a safe place to take part in structured physical activity or as a means for active travel.*

   "Increasing engagement with the natural environment through the education system can therefore produce a number of beneficial outcomes, such as increase levels of physical activity, helping to tackle childhood obesity and greater wellbeing and potentially improving mental health"[1]

   To ensure engagement of residents takes place across the life-course programmes need to be designed with different age groups in mind. As well as education this will also require partnership working across a number of other sectors such as local employers and health and social care.

4) *A need for increased promotion of green spaces as a means to take part in recreational walking, active travel corridors and structured physical activities. This could include improving signage of walking routes, on-line access to recreational walking routes and trails and roll out of the new Groundmiles app in partnership with BUPA which is designed to encourage independent walking.*

5) *Programmes should be designed and only resourced when plans for on-going sustainability are in place. This will include building partnerships with the voluntary sector and increasing the number of volunteer led programmes such as walking schemes and conservation groups.*

6) *Build a stronger evidence base to ensure programmes are evidence led. In order to demonstrate the health/ physical activity impact of green space based programmes there is a need to create some consistent measures that ensure collection of both qualitative and quantitative data. These should be integrated with programme/ schemes during the initial stages of design and development*

7) *Further consultation with the public may be required to identify need, particularly to those hard to reach groups. National research suggests that BME, people living in urban deprived areas, people from D and E socio economic groups, people aged over 65 and people with disabilities visit green spaces far less frequently. Many of these groups are likely to benefit the most from engaging with green spaces.[1] Tailored programme design is particularly important in engaging hard to reach groups. Programmes that are delivered without a clear focus on equity may even increase health inequality.*

Sustainable Travel

There is huge potential for increasing the number of journeys taken by bicycle. Currently, these trips make up just 2% of all journeys in Britain[75].Twenty percent of all trips made cover less than 1 mile – and just over half of all car journeys cover less than 5 miles). Although most children can cycle, only 2% of trips to school are made by bike[76].

Walsall's cycle network is designed to allow the vast majority of cycle trips to be made on safer routes which are as convenient as they would be by car. This is being achieved by developing safer links between Walsall Town Centre and the five district centres of Willenhall, Bloxwich, Brownhills, Darlaston and Aldridge.

National Cycle Network Route 5

Implemented around 1990-2000, a major artery of Walsall's cycle network is National Cycle Route 5 which runs the entire length of the borough linking Walsall to Brownhills in the north and Sandwell in the south. Between the Sandwell boundary

[75] *National Travel Survey 2012*

[76] *Taking part: The national survey of culture, leisure and sport. Adult and child report 2009/2010.*

and Walsall Town Centre, the route utilises mainly quiet side roads before joining the disused railway line to the north of Walsall up to Pelsall. At Pelsall, the route again uses quiet side roads to link to the canal and then, a right of way takes the route across Brownhills Common, before exiting the Borough in to Chasewater. The route utilises a good variety of infrastructure, each with their own benefits and disbenefits. The on-street sections provide connectivity but are sometimes a little stop-start. The off-road sections are more continuous but can feel more remote.

Walsall to Willenhall Route

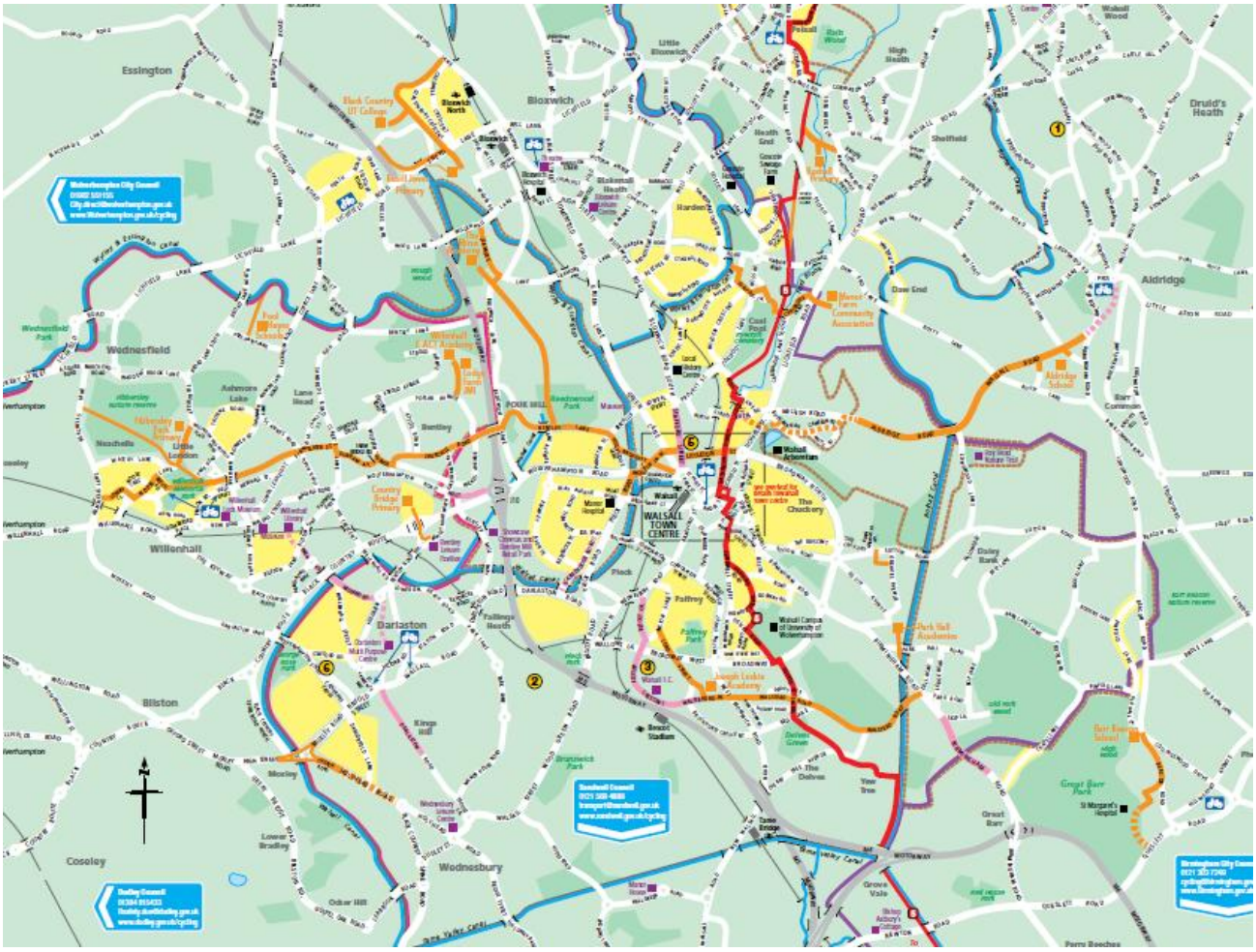
The Walsall to Willenhall route was implemented in the 1990's and mainly utilises quiet side roads (as an alternative to crossing M6, junction 10). Near Willenhall, the route joins a disused railway line and into Willenhall Memorial Park before crossing the border into Wolverhampton.

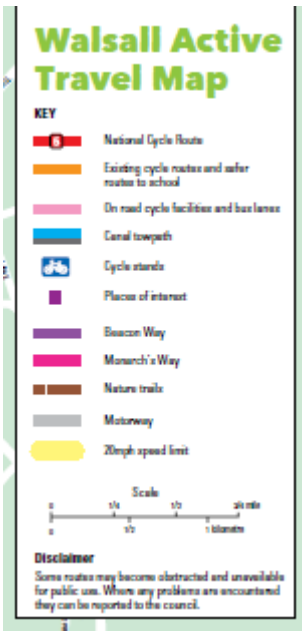
Walsall to Aldridge Route

The Walsall to Aldridge route is predominantly shared-use footway. Linking from National Cycle Route 5 on back roads on the edge of Walsall Town Centre, the scenery then changes to an 'inter-urban' environment and the cycle route takes the form of a shared-use footway alongside an A-road. This is how it stays for the remainder of the route, with links off to the Rushall Canal and Aldridge Science College

These three routes form the "hub and spoke" foundations of the cycle network. The network is a mixture of on-road and off-road routes, which utilises Walsall's abundance of canals and disused railway lines where appropriate. The remainder of the canal network further complements these promoted routes, increasing the potential for traffic-free travel.

Figure 87: Walsall active travel map



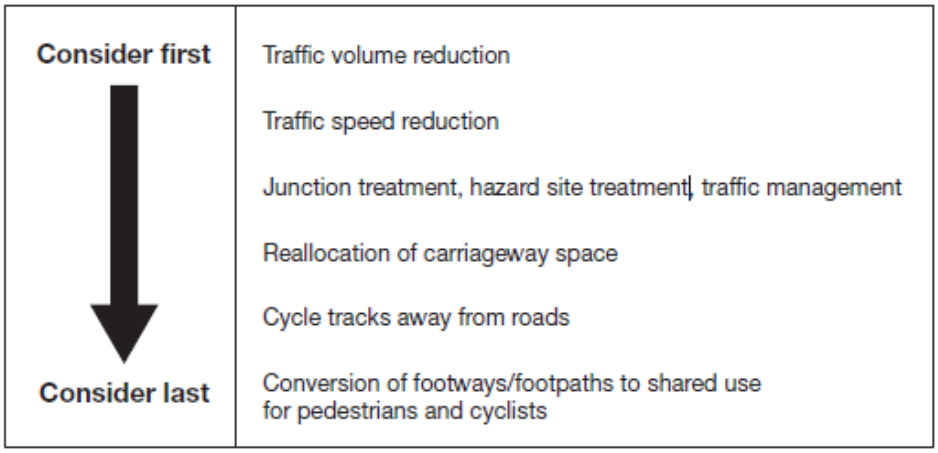


Recommendations

1) *Continued development of cycle network and identification of routes should be prioritised based on;*

    - *Number of casualties/ fatalities*
    - *Existing cycle flow*
    - *Links to existing cycle network*
    - *Links to areas of greatest deprivation*
    - *Access to partnership funding*

2) *Cycle network development will include the following[1];*



3) *Further roll out of the A-Stars programme to encourage an increase in safe active travel by Walsall school children and young people.*

4) *Increase car speed restrictions particularly around schools.*

Creating incentives for better health

Opportunities for a healthy diet and activity are appealing. The instant gratification of unhealthy lifestyle is replaced by rewards and incentives linked to healthy choices.

A number of interventions locally and nationally have utilized social marketing techniques and incentives, financial or otherwise, to make healthy choices more appealing.

Healthy Workplaces

Two thirds of adults in Walsall are in employment and spend a high proportion of their waking hours in the workplace. The workplace offers great scope for targeting messages and initiatives about healthy living – with potential impact on both employees and their families. There is a need to go beyond essential compliance with health and safety legislation and promote health and well-being more generally but especially physical activity.

Employers have a huge amount to gain from having a physically active workforce: lower rates of sickness absence, fewer retirements on health grounds and more productive teams. Workplace physical activity programmes have demonstrated reduced absenteeism by up to 20% and evidence has demonstrated that physically active workers take 27% fewer sick days[77].

132,000 people are in employment within Walsall and increasing access to physical activity provision and normalising being active as part of their everyday life is likely to have a substantial impact on overall physical activity levels across the borough.

Public Health England (PHE) has developed a national framework for the Workplace Wellbeing Charter, a locally delivered award system to encourage employers to create a health enhancing workplace. The Charter supports the delivery of Public Health Responsibility Deal pledges at an individual business level, promoting specific evidence based action on a range of issues including physical activity, leadership and policy, healthy eating, emotional wellbeing and smoking cessation. This builds on local Charters that are already successfully in place in Liverpool, London, the North East and Manchester to create a coherent national approach that supports small, medium and large businesses to take action.[78]

A healthy workplace programme is already in place which currently works across 50 businesses within the borough.

The Health Switch Awards

In partnership with Environmental Health a Health Switch Award has been developed incorporating a bronze, silver and gold standard for hot food takeaways businesses looking at simple ways to offer healthier food choices to Walsall residents. Hot food takeaways can make a significant contribution towards improving their customers overall diet and health through making simple changes to their menu, ingredients and how they prepare and cook the food they sell. The award

[77] *NICE Guidance Physical activity : Public Health Briefing 3; 2012*

[78] *Public Health England (2014) Everybody Active Everyday*

scheme is aimed at small independent run businesses where changes can be made quickly and easily and the potential for change is the greatest. Currently 2 businesses have achieved the silver standard in the Health Switch Award

Recommendations

- *Expand on the healthy workplace programme targeting companies with employees in greatest need e.g. small companies employing manual labor. Adopt the Workplace Wellbeing Charter which is approved by Public Health England and includes physical activity as one of its key elements.*
- *Provide a reduced package of support (including physical activity) to other workplaces that are not included in the healthy workplace programme. Examples include reduced cost lunch time/ after work activities and improved information on local physical activity provision.*
- *Roll out the Health Switch Award targeting the most deprived wards and takeaways in close proximity to Primary and Secondary Schools.*

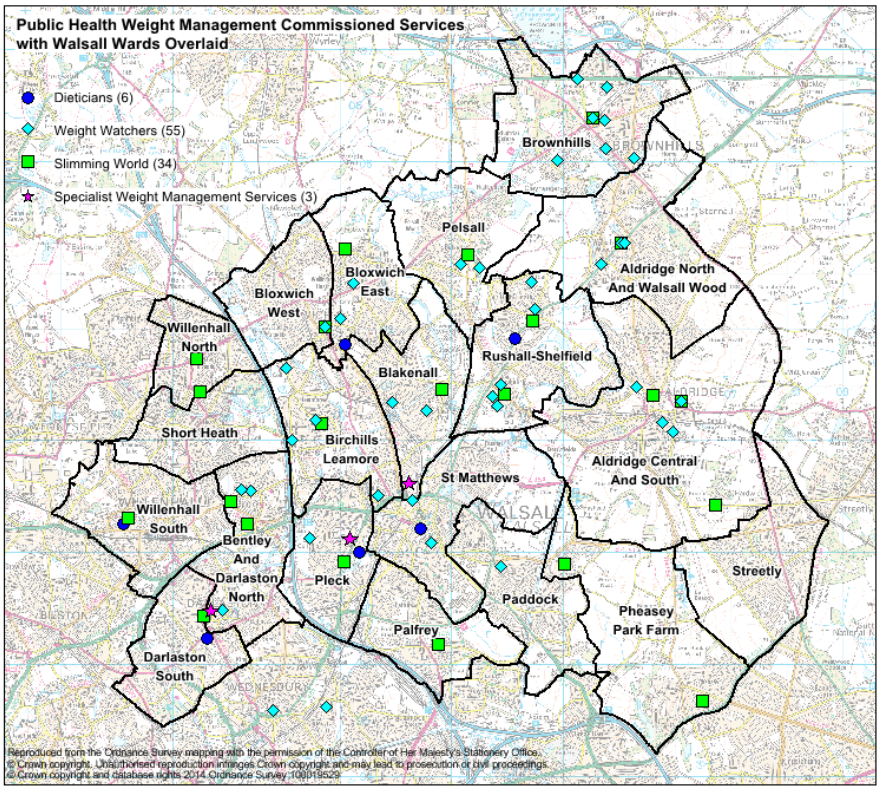
Personalised support for overweight and obese individuals.

Offering tailored support to those that are overweight or obese is also important to reduce the risk of ill health and premature death. Over 2,500 overweight or obese patients access the Adult Obesity Pathway annually. The pathway consists of various weight management programmes delivered through different models including one to one's, groups and online. Lower tiers of the Adult Obesity Pathway are supported through the Health trainer service where patients motivation and readiness to change is assessed and offered additional support where needed.

Figure *88* below highlights where the Public Health commissioned weight management services are located across the borough to assess coverage and accessibility to WM services. The map highlights that the specialist weight

management services are located in the South, South West of the borough and there is no provision in the North.

Figure 88: Commissioned adult weight management services by Public Health



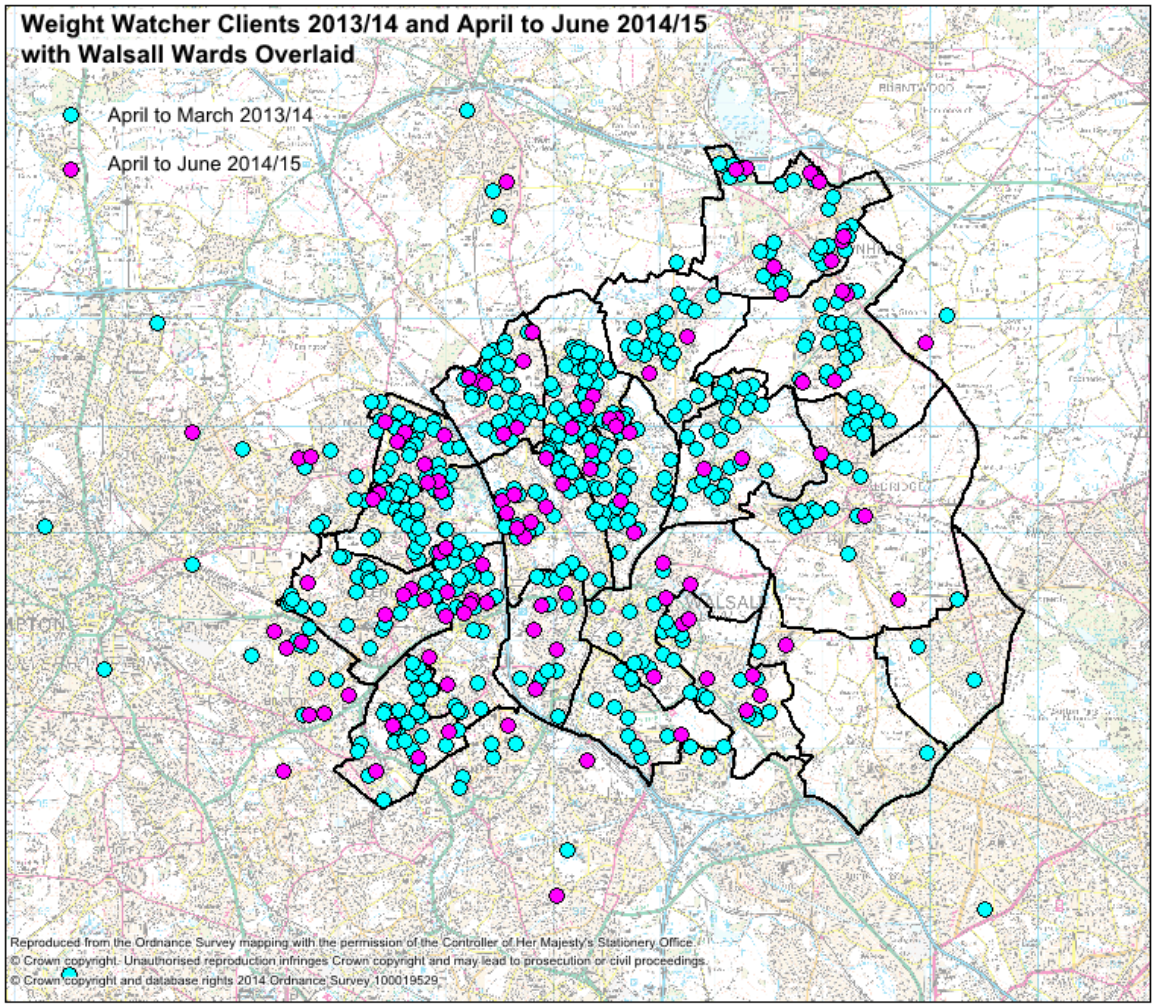
The weight management programmes commissioned through Public Health are evaluated below.

Weight Watchers

In April 2013 to March 2014, 888 clients accessed Weight Watchers of which 65% (454) completed the 12 week programme and 35% (242) lapsed. Of those patients who completed the programme 44% achieved their 5 % weight loss as recommended by NICE guidance.

Data collected and analysed from the commercial weight management programme Weight Watchers in tier 2 shows that most participants accessing these groups are living in the deprived wards mainly in the West of the borough this is shown in Figure 89 below.

Figure 89: Weight Watchers Clients 2013/14 and April to June 2014/15



Those highlighted outside the borough may be working in Walsall who also have access to the commercial weight management programmes.

Key Findings:

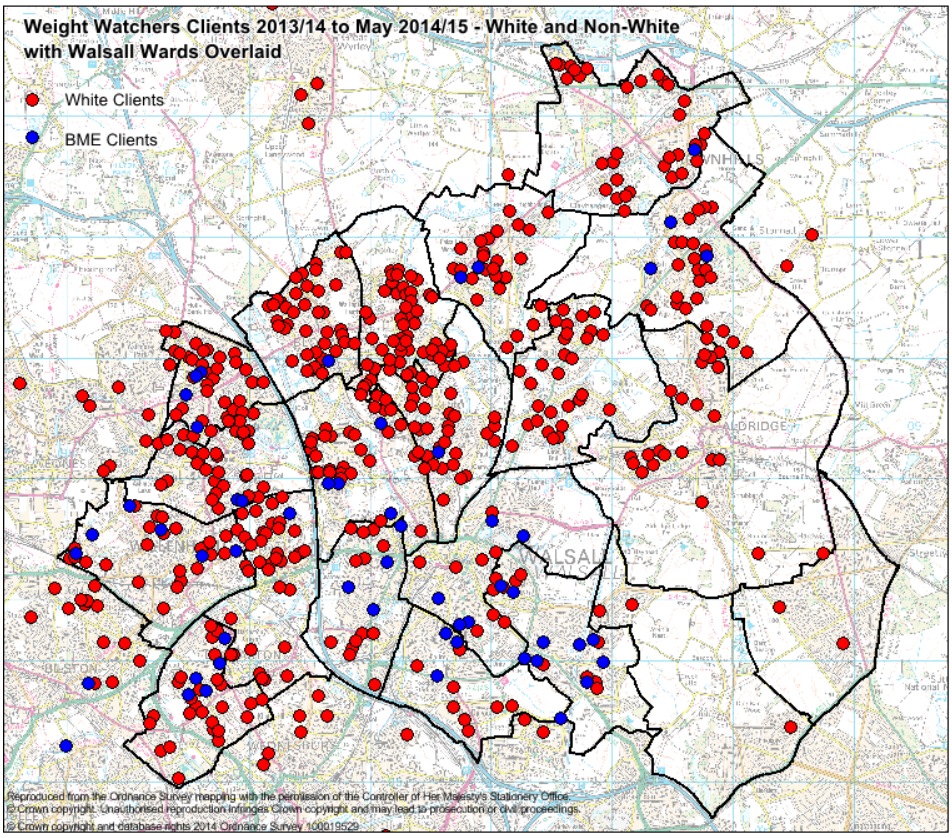
- Most clients were from Bloxwich East (95 clients) ranked the 4th most deprived ward in the borough, Birchills Leamore (75 clients) ranked 2nd most deprived and Bloxwich West (73 clients) ranked 10th most deprived[79].
- The least clients were from Streetly (2 clients) ranked 20th the least deprived ward in the borough, Pheasey Farm (4 clients) ranked 19th the second least deprived ward and Palfrey (20 clients) the 5th deprived ward.

[79] ***Source:*** *English Indices of Deprivation, Department for Communities and Local Government 2010*

- Weight Watchers are mainly accessed by Walsall's white population (92%) compared to the BME community (8%- see

- Figure 90 below) which would account for the low access from Palfrey which has the highest % of BME in the borough.
- The service is mainly accessed by women 92% (887) compared to 8% (82) of men.

Figure 90: Weight Watchers Clients 2013/14 to May 2014/15 by ethnicity

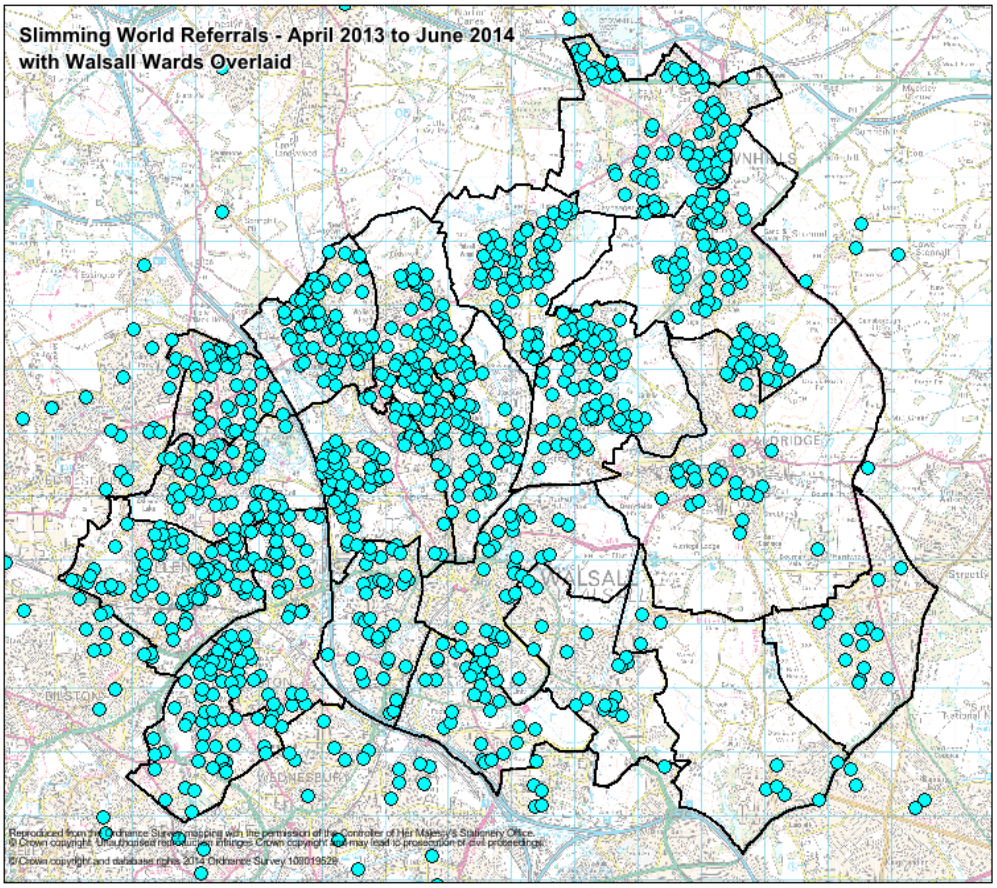


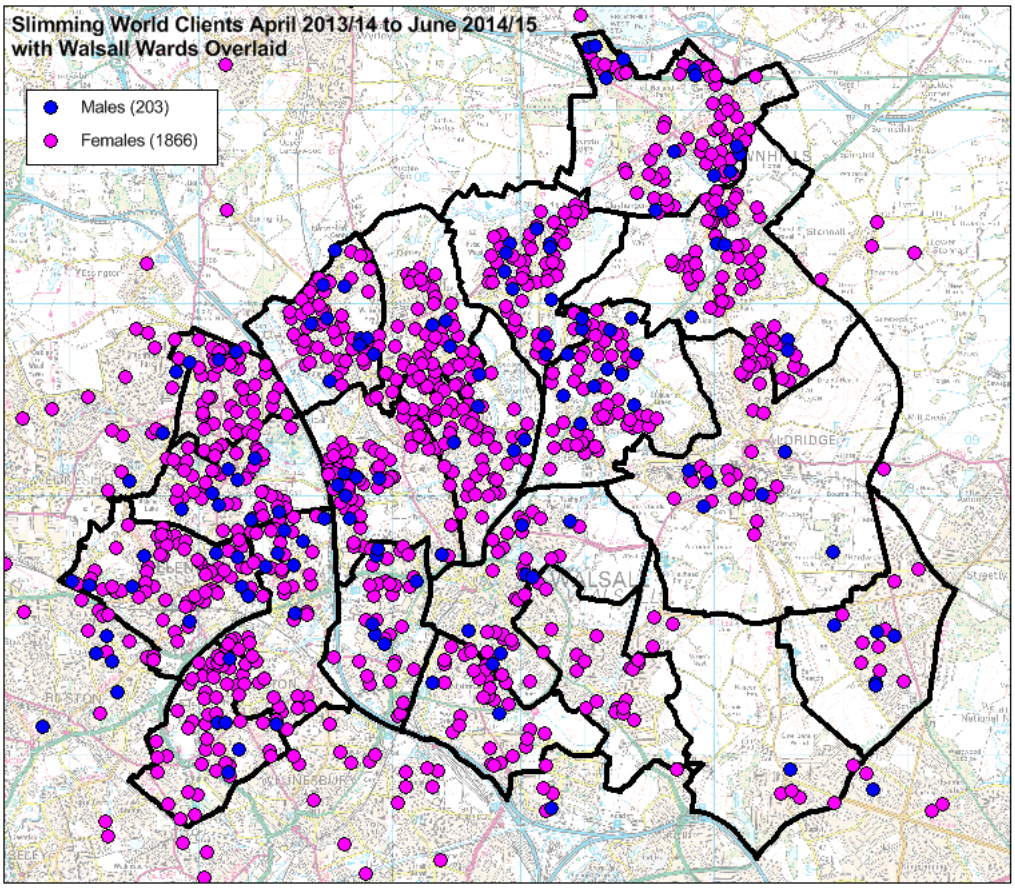
Slimming World

In April 2013 to March 2014, 1756 clients accessed Slimming World of which 66% (1101) completed the 12 week programme and 35% (568) lapsed. Of those patients who completed the programme 44% achieved their 5 % weight loss as recommended by NICE guidance. These findings are very similar to the Weight Watchers data but with a larger cohort.

Data analysed shows that most participants accessing these groups are living in the deprived wards mainly in the West of the borough this is shown in *Figure 91* below.

Figure 91: Slimming World Referrals April 2013/14 to June 2014/15





Key Findings:

- Most clients were from Brownhills (144) ranked 11th most deprived ward, Pelsall (138) ranked 16th most deprived ward and Bentley and Darlaston North (129) 7th most deprived ward in the borough.
- The least clients were from Pheasey Farm (14 clients) ranked 19th the second least deprived ward, Streetly (2 clients) ranked 20th the least deprived ward and Paddock (29) 18th the third least deprived ward in the borough.
- Similar to Weight Watchers, Slimming World is also predominantly accessed by women 90% (1590) compared to 10% (166) of men.
- 34% of the men accessing this service achieved 5 % weight loss compared to 27% of women achieved 5% weight loss.

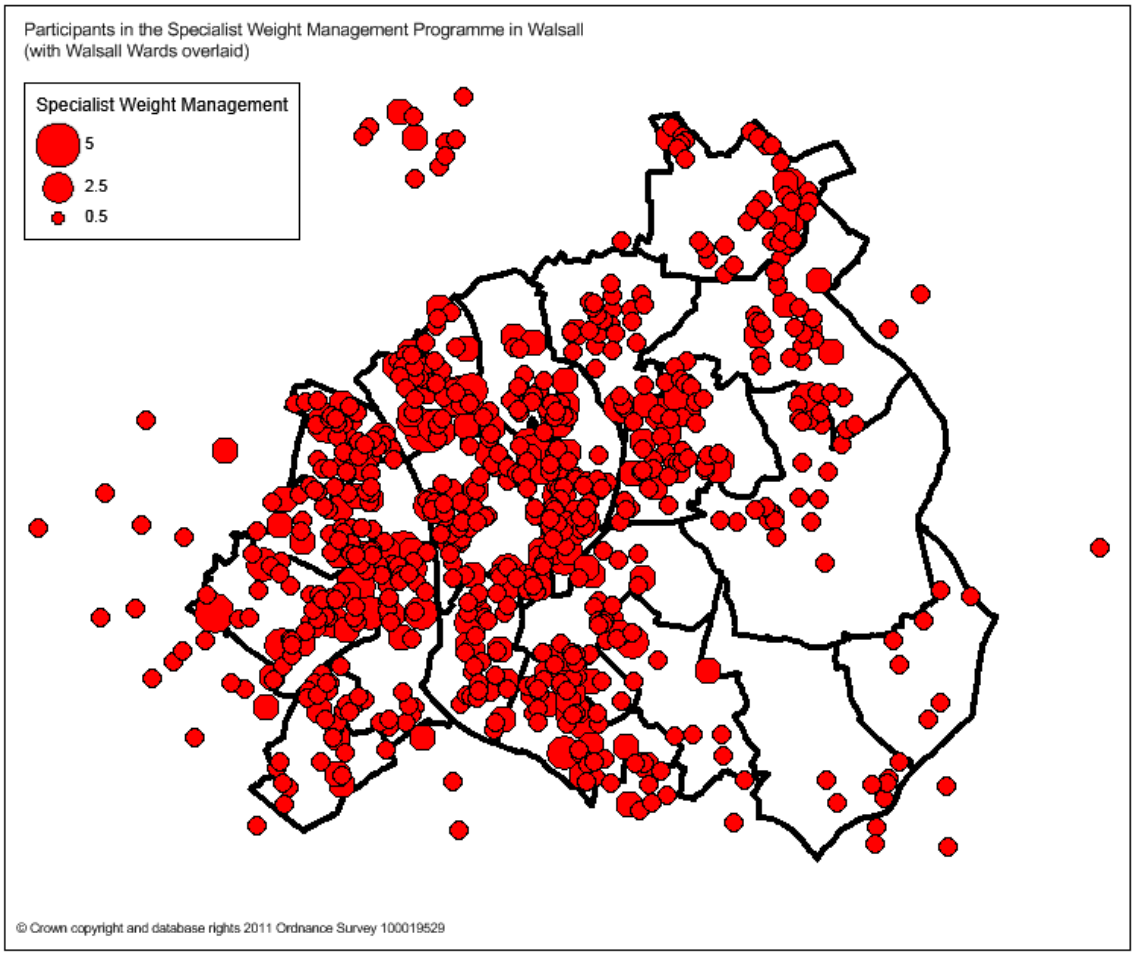
Specialist Weight Management Services

159 accessed the Specialist weight management programme in 2013/14 of which 99 (62%) completed the 24 week programme delivered through a multidisciplinary team and 60 (38%) lapsed. Of those who completed the programme 44 (44%) achieved

5% weight loss and 13 (13%) achieved 10% weight loss. These figures drops to 28% achieving 5% weight loss and 8% achieving 10% weight loss when lapsed clients are in included.

Figure 92 below highlights that a high proportion of the participants accessing the specialist weight management service live on the West of the Borough in the deprived wards.

Figure 92: Participants in the specialist weight management service from 2008-Febuary 2014



Weight management Drugs

Orlistat is the only weight management drug licensed in the UK recommended by NICE. Orlistat is recommended for adults with the following criteria as part of a weight management plan;

- a BMI of 28 kg/m2 or more with associated risk factors
- a BMI of 30 kg/m2 or more

NICE recommends withdrawing drug treatment in people who have not reached their weight loss goals. Rates of weight loss may be slower in people with type 2 diabetes, so less strict goals than those for people without diabetes may be appropriate. Agree the goals with the person and review them regularly. Continue Orlistat therapy beyond 3 months only if the person has lost at least 5% of their initial body weight since starting drug treatment.

Almost 3,000 prescriptions were written in Walsall in the 2014/15 financial year costing £80,871 this would equate to around 500 patients taking Orlistat.

Recommendations

- *Procure adult weight management programmes to ensure services target the high risk groups and become more efficient.*
  - *Local quintiles 1-3*
  - *Adult Men*
  - *BME groups*

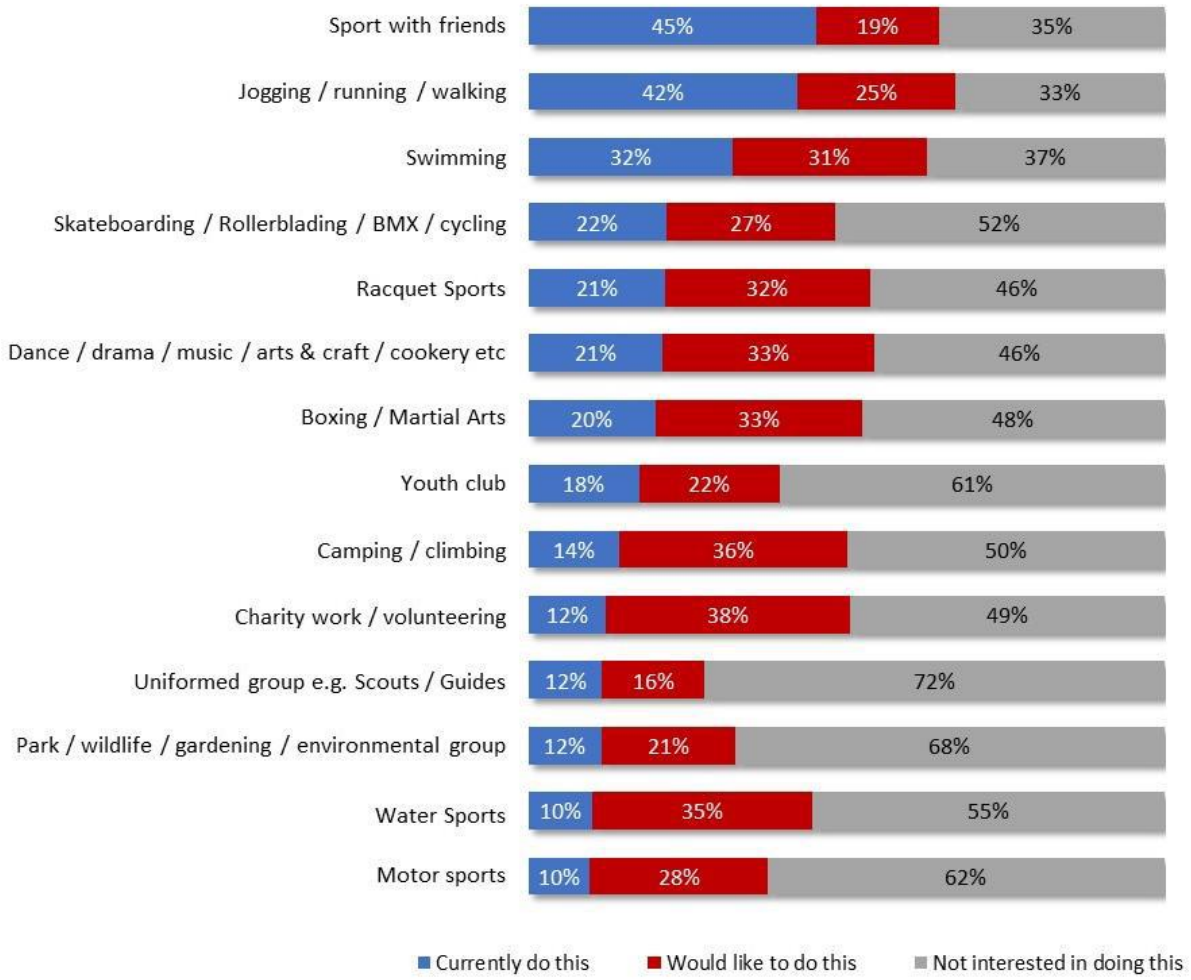
Consultation

Consultation with the public and key stake holders on weight management, diet and physical activity was undertaken through various methods including surveys, questionnaires, focus groups and market days.

Through the Youth of Walsall (YOW) Survey young people were also asked which activities they currently participate in outside of school, and which they have an interest in pursuing highlighted below in .

Figure 93.

Figure 93 Activities participated in outside of school



Key Findings:

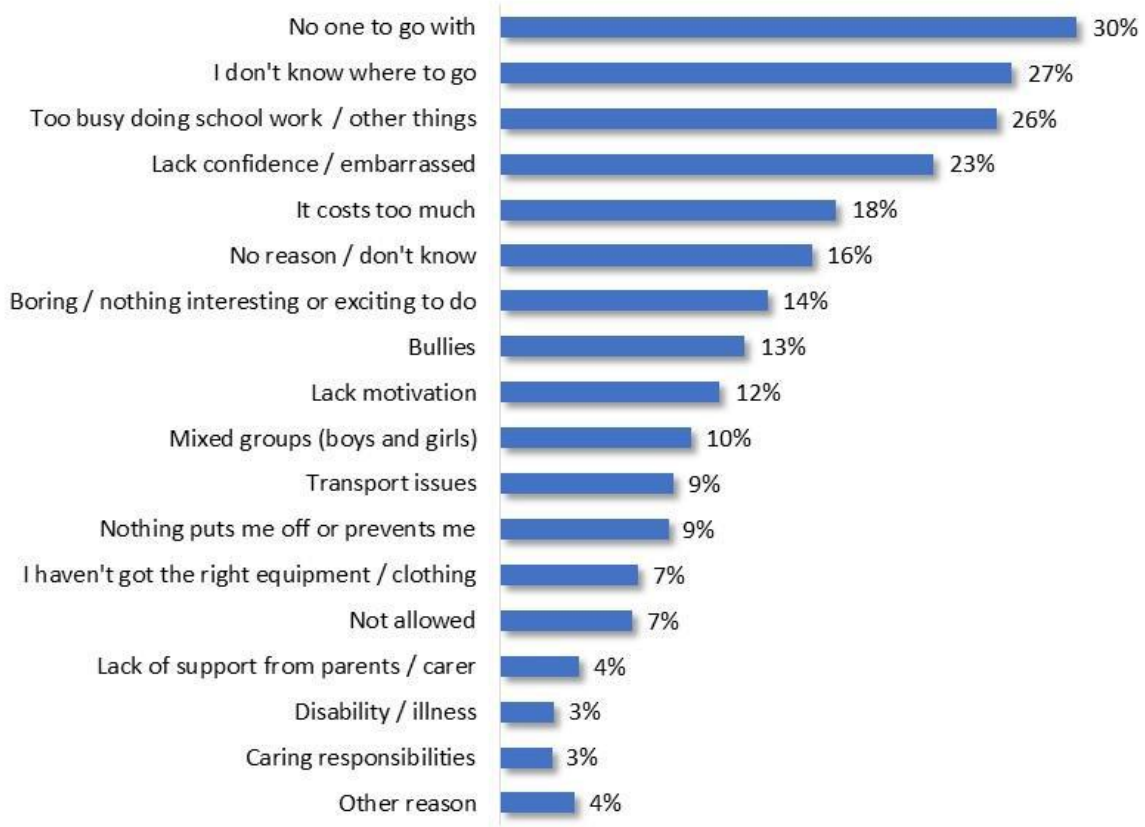
- The most popular sport that young people say they are currently participating in is sport with friends, for example football in the park, with 45% claiming they engage with this already. Similarly, 42% claim to jog/run/walk in their spare time. Conversely, just one in ten young people are currently involved in water sports and motor sports, which is likely to be attributable to the more challenging access to activities such as these.
- Young people are most likely to claim they would like to take part in charity work/volunteering (38% interested in this).

- Uniformed groups such as Scouts and Guides is the activity almost three quarters of young people (72%) are not interested in being involved with, followed by nature-based activities such as park/gardening/environmental group, with 68% expressing disinterest in this.

- Of those young people who currently take part in sport with friends outside of school, significantly more of these are boys (63% boys 29% girls). There are no significant differences between Year groups, suggesting taking part in sport with friends remains consistent with age. Those who are engaging in jogging demonstrate a similar profile, with significantly greater uptake amongst boys (48% boys, 37% girls), and no different across Year groups.

When young people were asked what puts them off taking part in activities outside of school (Figure 94) most claim that they have no one to go with (30%).

Figure 94: Barriers to participation in extra-curricular activities amongst Young People

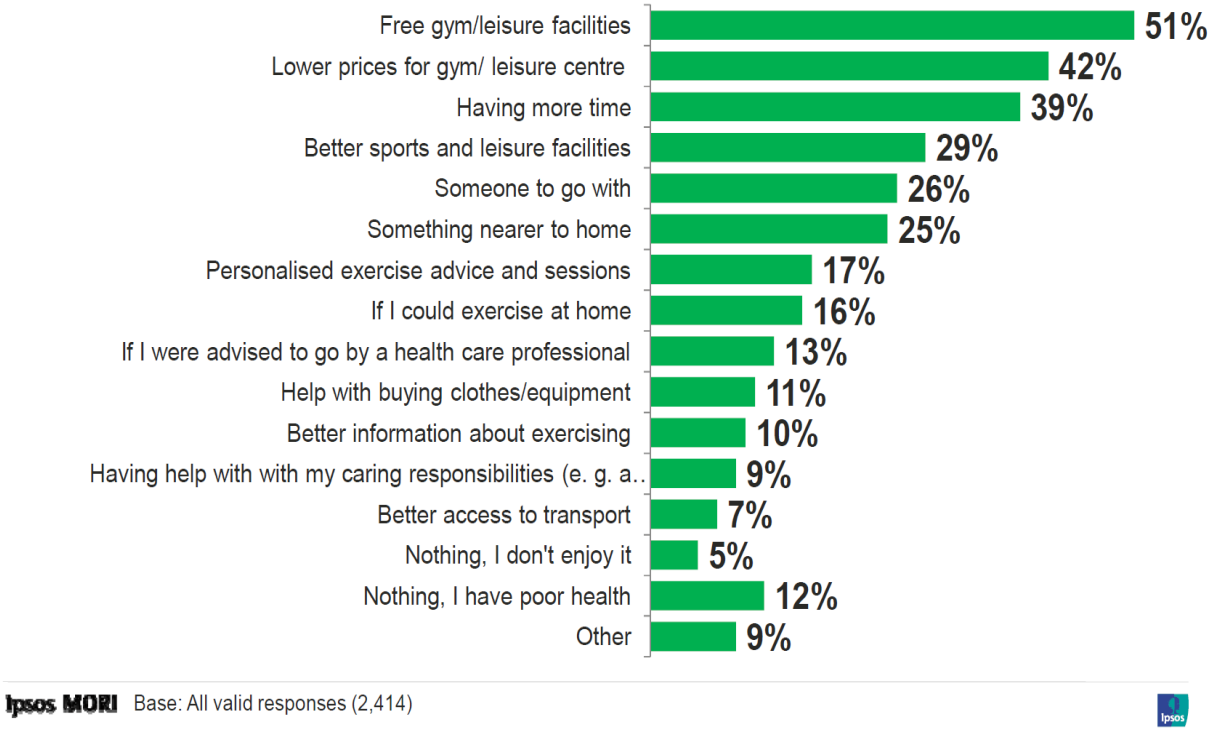


Key Findings:

- Over one quarter claim they don't know where to go or are too busy to take part (27% and 26% respectively). 23% of young people claim they lack confidence or are embarrassed; which is a perception held significantly more amongst girls compared with boys (33% and 12% respectively).
- Significantly more young people in Years 12 and 13 (30%) and Years 9,10, and 11 (26%) lack confidence compared with those in Years 7 and 8 (18%) suggesting that confidence could decrease with age.
- Just 9% of young people claim there is nothing that prevents them taking part in activities and 7% state that they are not allowed.

Through the 'Your Place, Your Well-being Walsall Lifestyle Survey' (2012) Walsall residents were asked what would help or encourage them to be more physically active (***Error! Not a valid bookmark self-reference.***).

Figure 95: factors that would encourage Walsall residents to be more physically active



Key Findings:

- Three in five residents (59%) state at least one form of cost reduction as a way to encourage them to be more physically active; free access to a gym or leisure centre (51%) was the most popular, followed by lower prices for gyms and leisure centres (42%).

- Other major sources of encouragement not related to cost – chosen by more than a quarter of residents - are more time (39%) and better sports and facilities (29%), having an exercise buddy or company (26%) and having something to do nearer their home (25%).

- Cost- related factors were cited more frequently by young people: 84% of 16-26 year olds and 74% of 27-49 year olds, compared with 59% overall.

- Cost-related factors were also most frequently cited by BME residents (76% vs. 56% of White people) and those with children in the household (79% vs. 52% of without children).

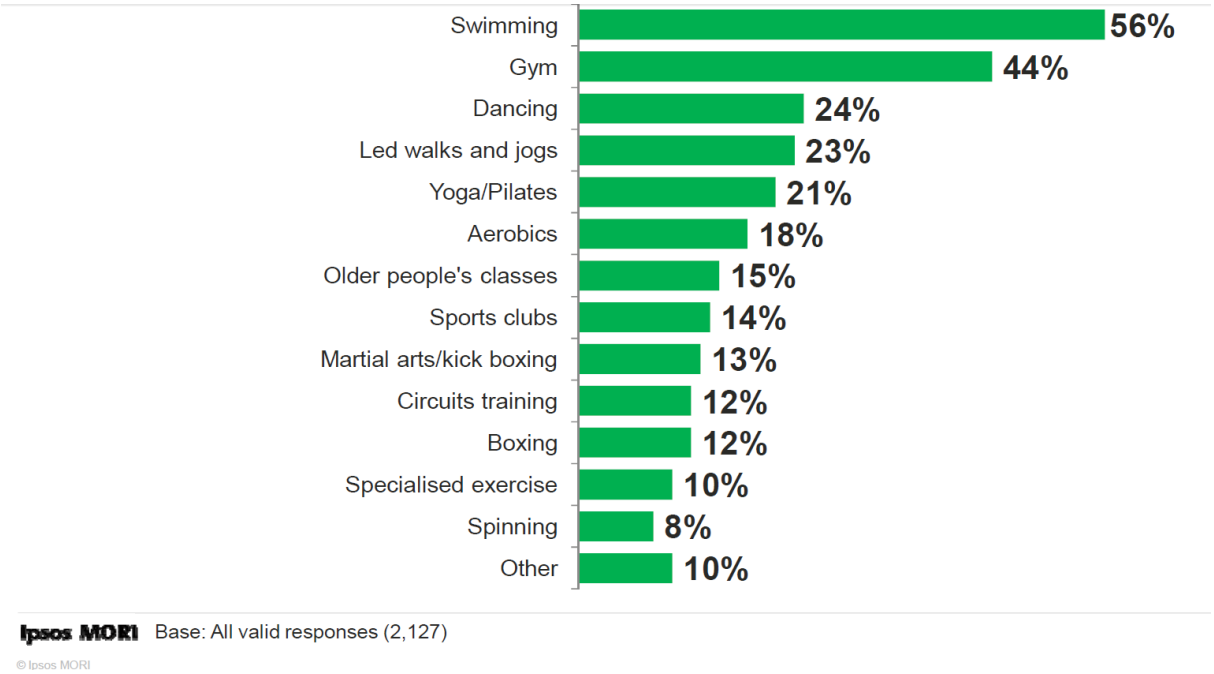
- It is also noticeable that cost is cited as a factor in South Walsall (66% but rising to 75% in the ward of Palfrey), and those dissatisfied with health services (73%).

- Concerns about cost do not, however, rise significantly by IMD quintile but both the unemployed (82%) and working residents (72%) are significantly more likely than the average to mention cost reasons. This may be a result of age, working residents and the unemployed are almost all under 65, and younger people are the more likely to mention problems with cost.

Residents were also asked what physical activities they would be interested in participating in or doing more of, see

Figure 96 below.

Figure 96: Physical activities Walsall residents are most interested in participating in.



Key Findings:

- Younger residents aged 16-26 have the widest interests; over half (56%) identify four or more activities they would be interested in. By contrast, three in ten (30%) residents express interest in only one form of activity and this proportion increases with age, with 48% of 65-74 year olds and 68% of those aged 75+ mentioning only one item. Furthermore, younger people aged 16-49 are more likely than those older than 50 to express an interest in almost all the types of activity. Adults aged 50+ are more likely to choose specialized activities (17% vs. 10% overall) and older people's classes (36% vs. 15% overall).

- Compared with men, women are more interested in aerobics (27% vs. 8%), dancing (38% vs. 9%) and yoga/pilates (30% vs. 12%). Men are more interested than women in boxing (15% vs. 10%), martial arts (17% vs. 10%), circuit training (15% vs. 8%), sports clubs (21% vs. 9%) and the gym (51% vs. 39%).

A survey was carried out in 2011 to identify community needs regarding green spaces in Walsall. This included a questionnaire sent to a random sample of 10,000 households which generated 1,258 responses and an on-line survey targeted at children and young people and promoted through schools.

The main reasons for using green spaces were cited as follows;

Figure 97: Main reasons for use of green spaces (adults)

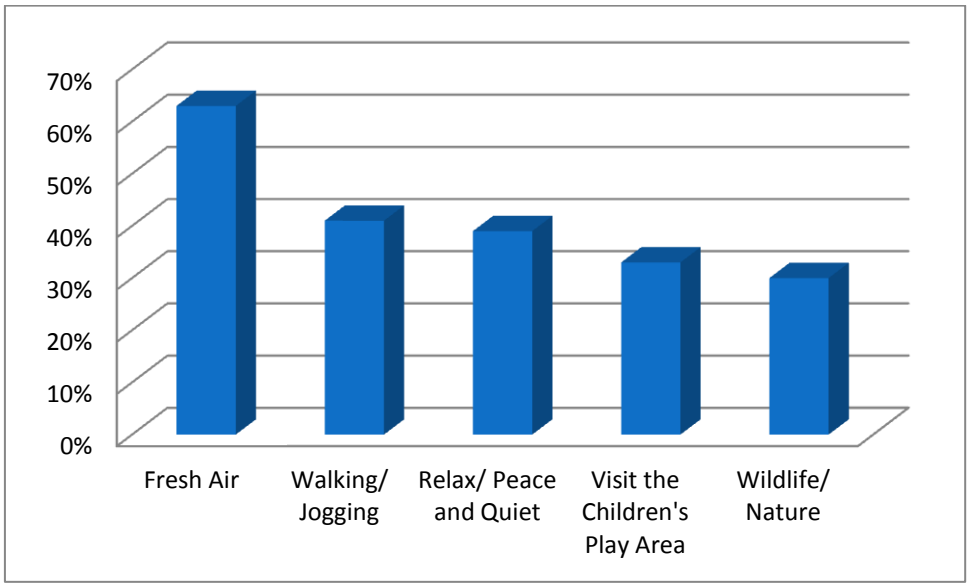
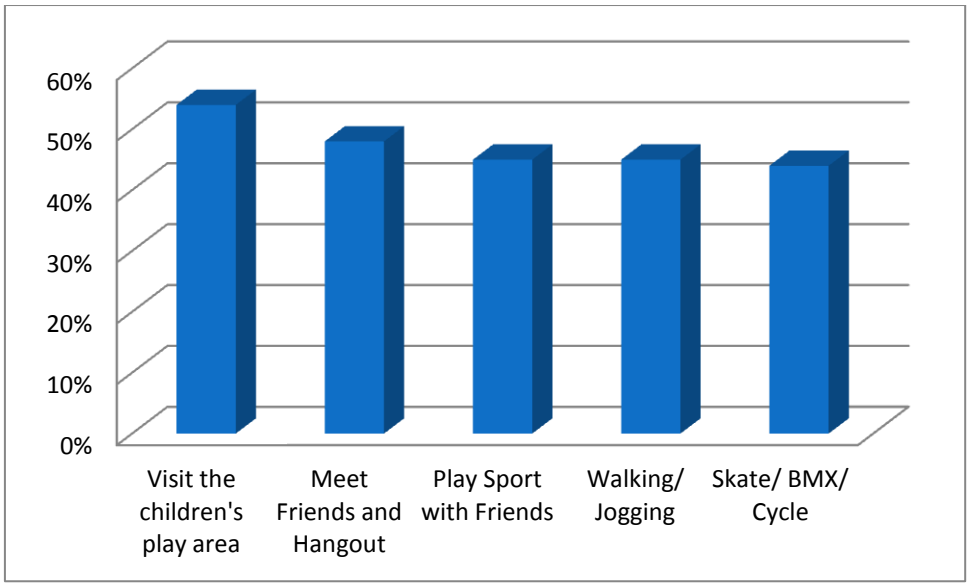


Figure 98: Main reasons for use of green spaces (children and young people)



The above highlights that physical activity is already a key reason for adults and children visiting green spaces in Walsall – with both using green spaces for walking and jogging, and children using it to play sport and visit the play area.

Highlighted below are the various reasons cited by children and adults why they don't use green spaces;

Figure 99: Barriers to use in green spaces (adults)

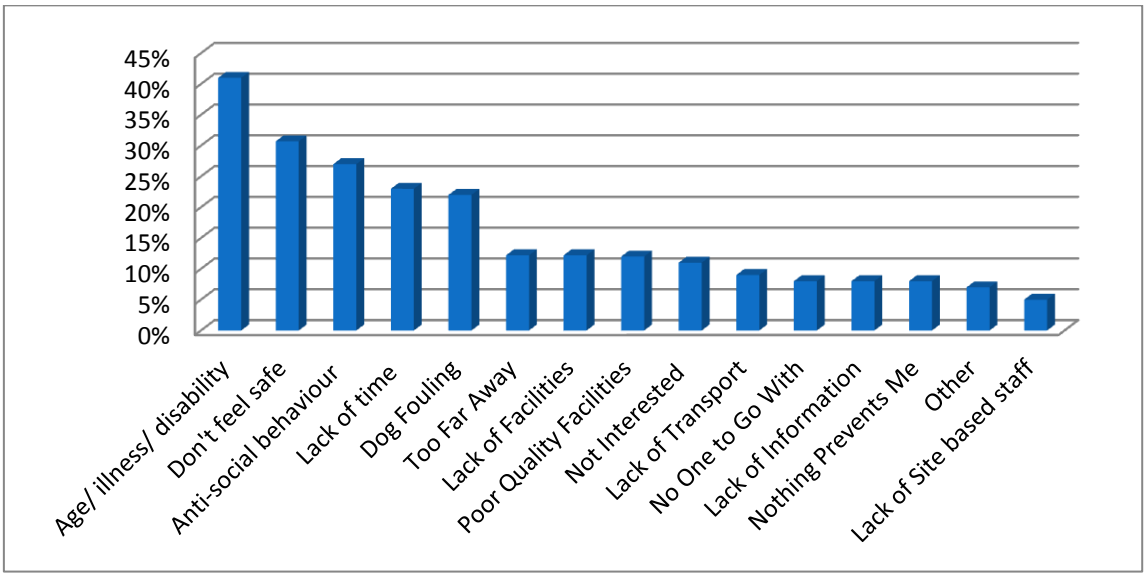
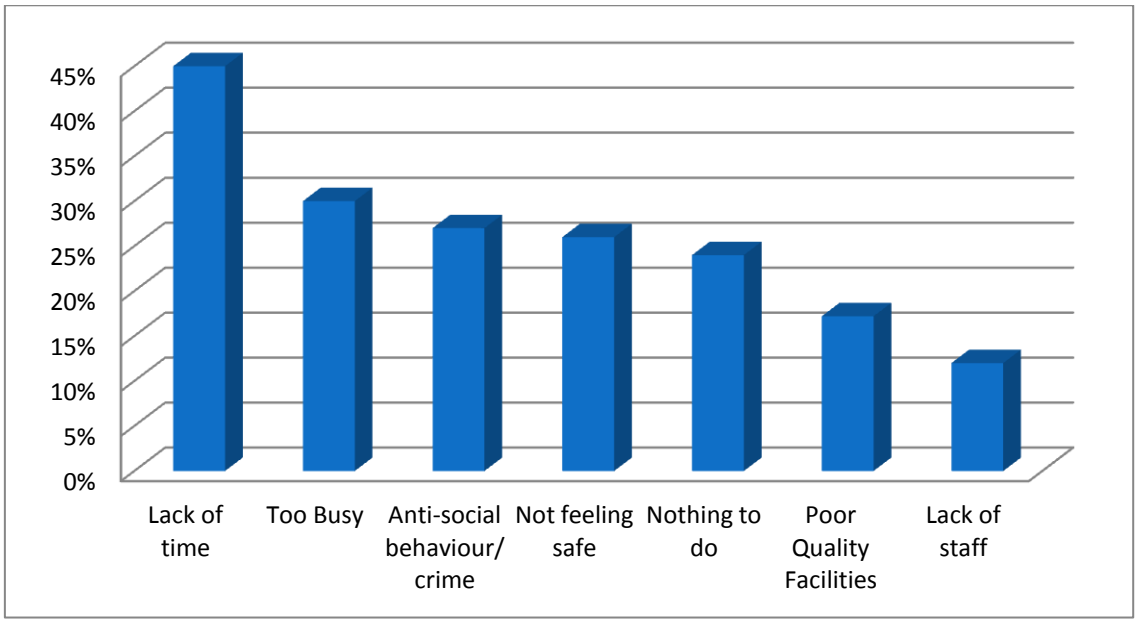


Figure 100: Barriers to use in green spaces (children and young people)



Adult Weight management Services

Consultation on remodelling the adult healthy weight/ physical activity services with the public through focus groups and questionnaire also took place in December 2014

The overall Opinion was respondents generally support this proposal.

- Budget booklet respondents to the Budget booklet fully support and or with concerns and amendments 80% (base 34)
- Feedback from additional survey research showed that, overall, 72% (base 25) of respondents expressed a wish to make some savings as detailed within the Public
- Health proposals. Streamlining and combining health and wellbeing services across related Public Health programmes was suggested.
- Focus group responses were consistent with the survey responses.

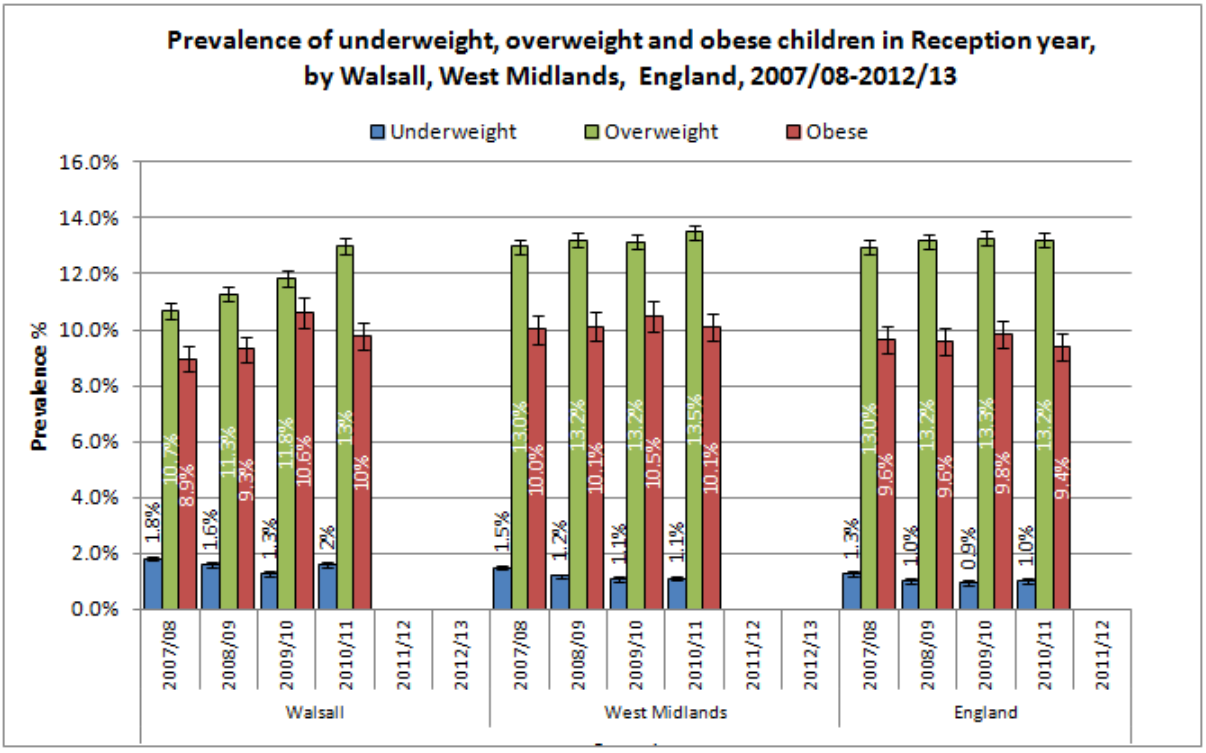
Key issues for consideration across all consultation activity including any concerns / amendments / alternatives expressed.

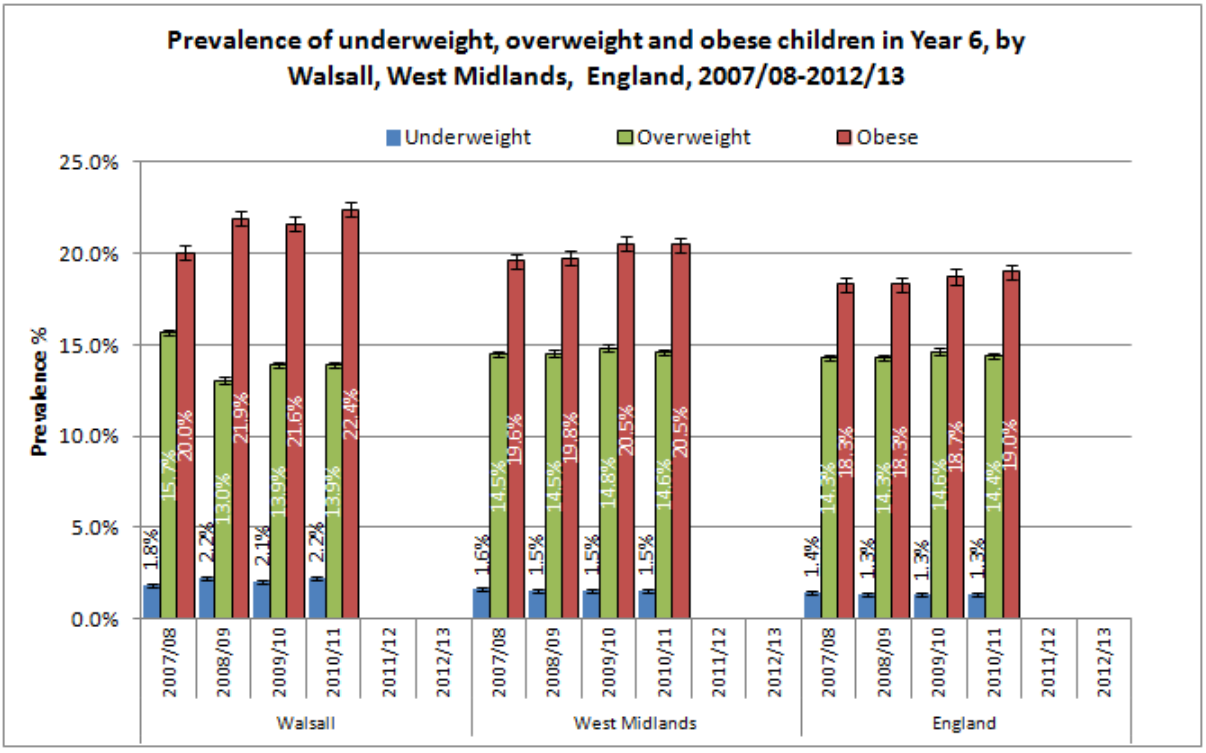
The summary of the feedback is that, whilst concerns have been expressed, the impact of the proposed cuts will be mitigated by the remodelling of the service. Common suggestions for alternatives to the savings are:

- Suggestions to stop this service or for money to come from GP's.
- People should take responsibility for their own health or incentives to be healthy.
- Engage with external services to deliver in a different way.

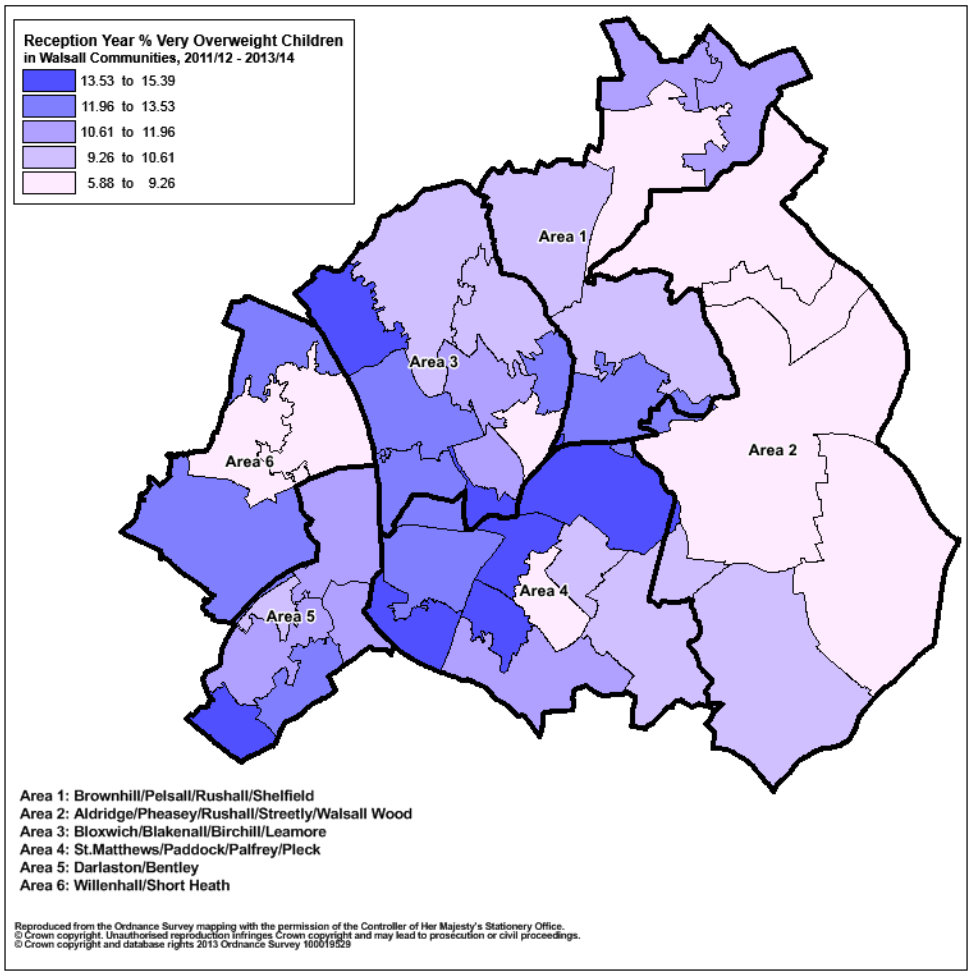
Appendices

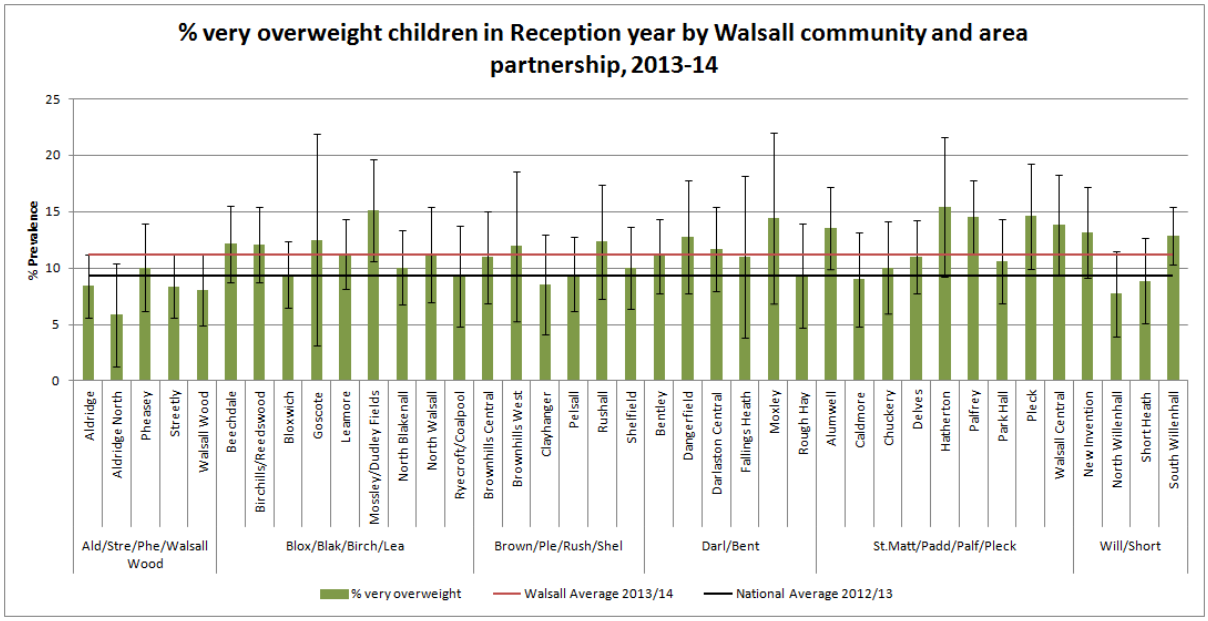
Appendix 1: Prevalence – Walsall, Regional and National Trends



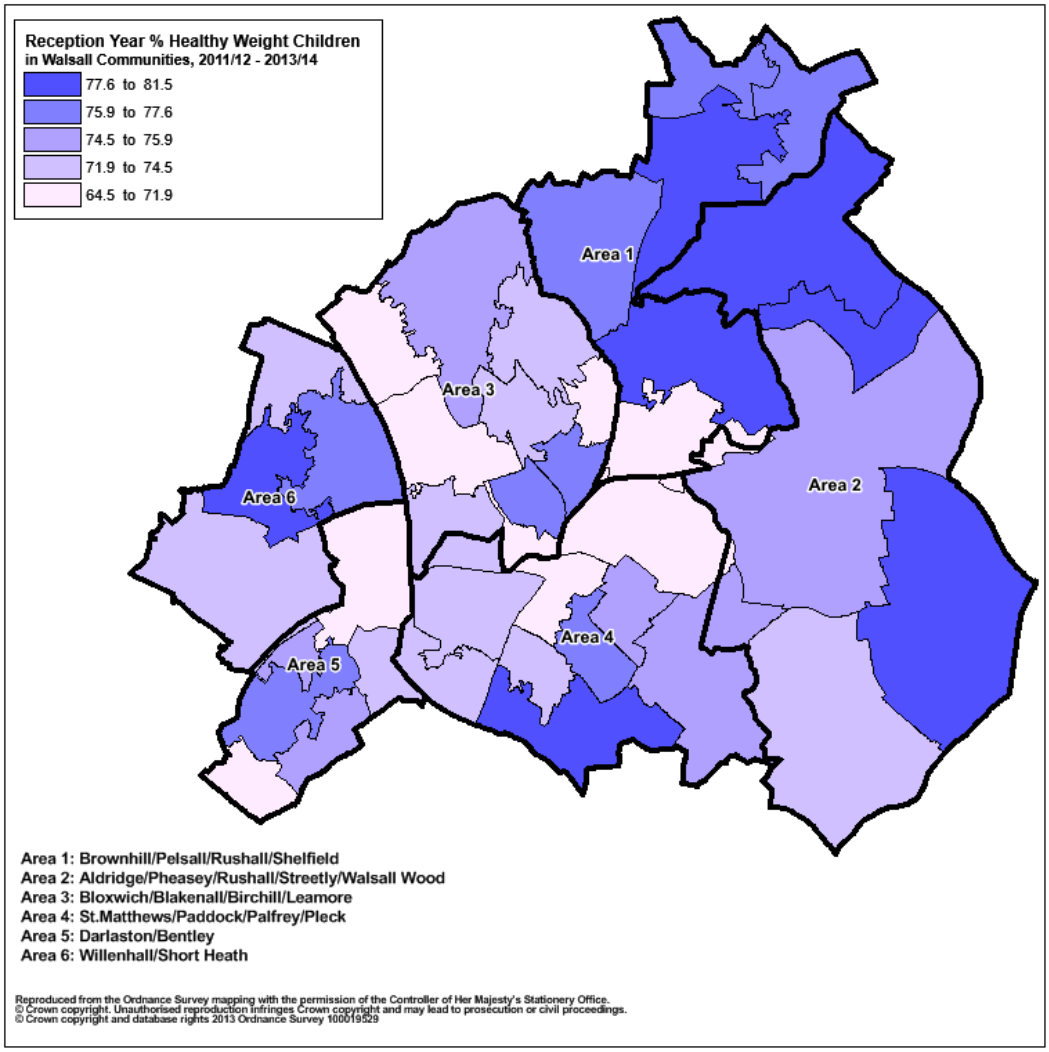


Appendix 2: Reception Year Obesity prevalence by Walsall Communities and Area Partnership

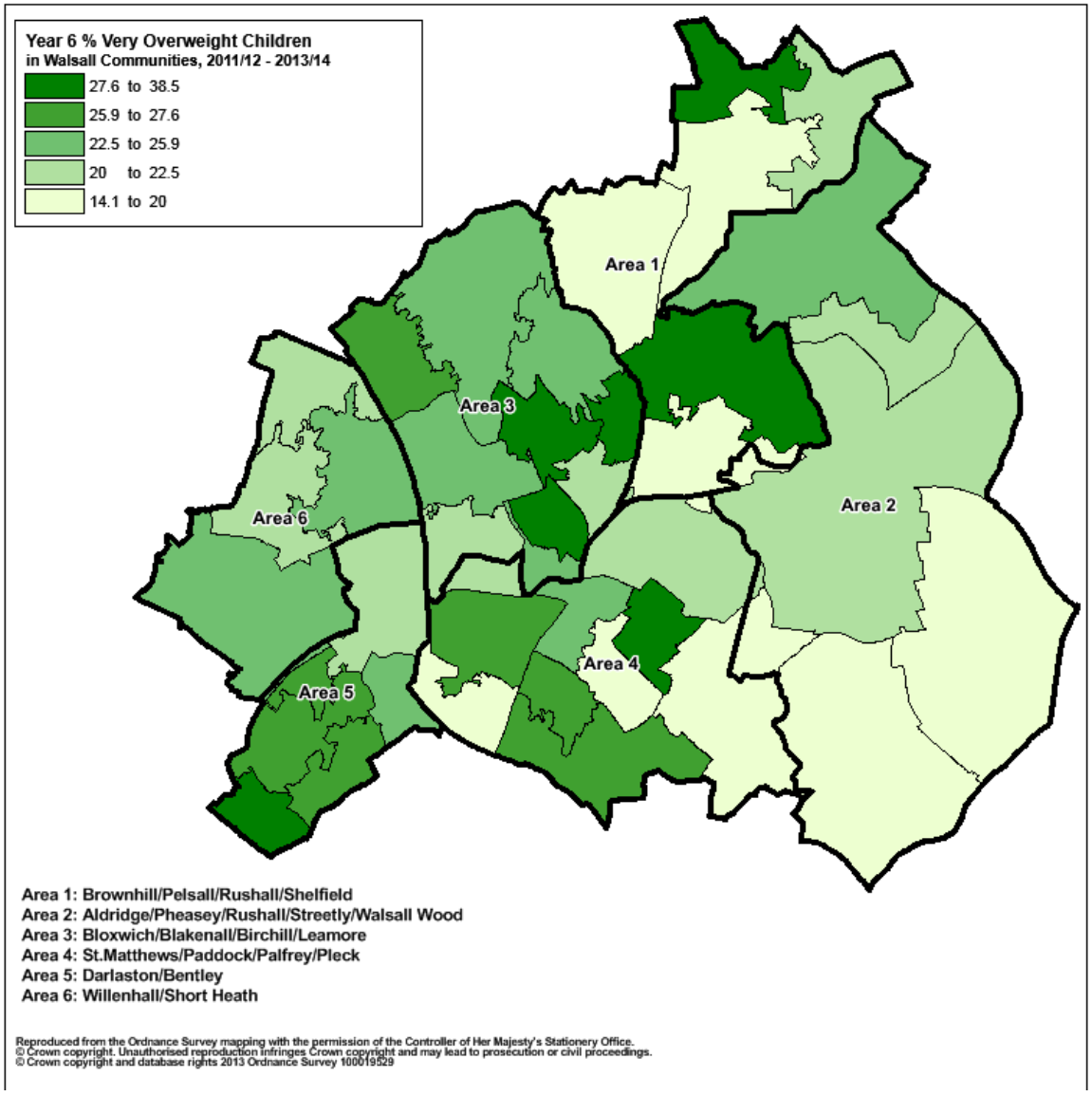




Reception Year Healthy Weight by Walsall Communities



Appendix 3: Year 6 Obesity by Walsall Communities and Area Partnership


Year 6 % Very Overweight Children
in Walsall Communities, 2011/12 - 2013/14
27.6 to 38.5
25.9 to 27.6
22.5 to 25.9
20 to 22.5
14.1 to 20
Area 1
Area 2
Area 3
Area 4
Area 5
Area 6
Area 1: Brownhill/Pelsall/Rushall/Shelfield
Area 2: Aldridge/Pheasey/Rushall/Streetly/Walsall Wood
Area 3: Bloxwich/Blakenall/Birchill/Leamore
Area 4: St.Matthews/Paddock/Palfrey/Pleck
Area 5: Darlaston/Bentley
Area 6: Willenhall/Short Heath
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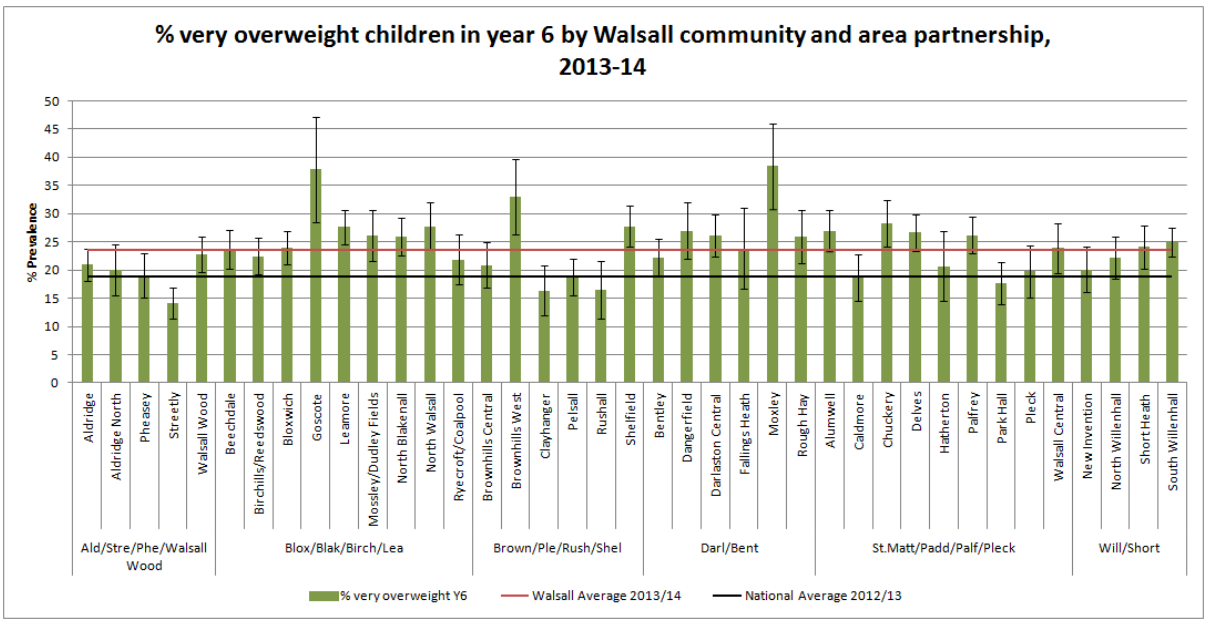
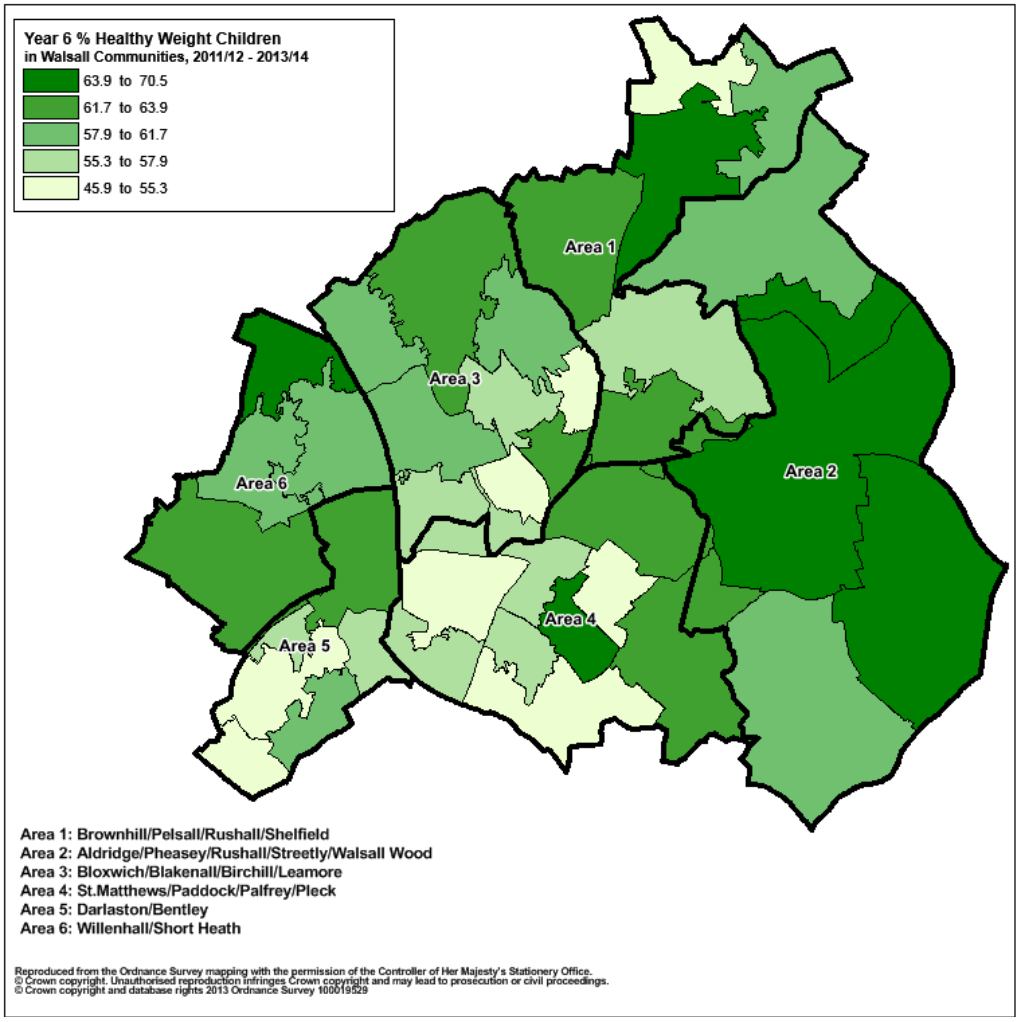

% very overweight children in year 6 by Walsall community and area partnership, 2013-14
% Prevalence
50
45
40
35
30
25
20
15
10
5
0
Aldridge
Aldridge North
Pheasey
Streetly
Walsall Wood
Beechdale
Birchills/Reedswood
Bloxwich
Goscote
Leamore
Mossley/Dudley Fields
North Blakenall
North Walsall
Ryecroft/Coalpool
Brownhills Central
Brownhills West
Clayhanger
Pelsall
Rushall
Shelfield
Bentley
Dangerfield
Darlaston Central
Fallings Heath
Moxley
Rough Hay
Alumwell
Caldmore
Chuckery
Delves
Hatherton
Palfrey
Park Hall
Pleck
Walsall Central
New Invention
North Willenhall
Short Heath
South Willenhall
Ald/Stre/Phe/Walsall Wood
Blox/Blak/Birch/Lea
Brown/Ple/Rush/Shel
Darl/Bent
St.Matt/Padd/Palf/Pleck
Will/Short
% very overweight Y6
Walsall Average 2013/14
National Average 2012/13

Year 6 Healthy Weight by Walsall Communities



Appendix 4: Mosaic

Sector Types – Detail

Sector Rank 1 (public sector type K50)
Older families in low value housing in traditional industrial areas

This Type contains many older people living on moderate incomes in better council estates or in areas of better quality, privately owned older terraced housing. Many of these people have been or are still employed in the manufacturing industry, but demand for their craft skills is now less than it used to be and many have had to be adaptable in finding employment in new service jobs. Residents tend to be conservative in their social attitudes and are careful with their money.

Sector Rank 2 (public sector type O69)
Vulnerable young parents needing substantial state support

This Type has a high concentration of young parents with pre-school age children who have been given priority for social housing and live in some of the least desirable council estates. Many of the country's most vulnerable young children live in these neighbourhoods. These neighbourhoods are found mostly on estates of low rise, terraced or semi-detached housing, often located at some distance from the inner areas of medium sized and large cities in all regions of the country. Very few tenants have exercised their right-to-buy.
Former middle aged and older tenants on these estates have often successfully applied for transfers to homes in “better” estates, leaving accommodation available for younger people in most desperate need of social housing. This results in neighbourhoods with very high proportions of homes with no-one in regular employment, as well as large numbers of children in single parent families. Many of these homes are occupied by young people who have been raised in homes which have relied on welfare benefits rather than employment income for multiple generations. Likewise there are many homes where adults come from families with no experience of stable adult relationships.

Though not all residents experience social deprivation, so many do that what is considered normal is often very different to that considered normal by the population of the wider community

Sector Rank 3 (public sector type I42)
South Asian communities experiencing social deprivation

This Type has a high concentration of recent migrants from South Asia who are a distinctively young population. People of Pakistani and Bangladeshi origin are particularly likely to live in these neighbourhoods, although they do also contain significant populations of Sikh and Hindu Indian origin.

The nature of the South Asian extended family, coupled with the problems new arrivals have in finding accommodation results in large number of young children living in overcrowded conditions in the poorest quality older terraced housing.

The standard of educational attainment is particularly low as many of these residents have difficulty in their use of English language, as a result of which it is often difficult for them to obtain employment other than in menial tasks which do not require them to interact to a significant degree with the host population. A high proportion of residents are self-employed, many in the retail trade and those members are economically successful often continue to live in the local community.

The minority groups who live in these neighbourhoods often have distinctive health profiles, diabetes being a condition which particularly common. The number of children per family is significantly above the national average as some young women are expected to marry relatively early due to cultural customs.

Sector Rank 4 (public sector type O67)
Older tenants on low rise social housing estates where jobs are scarce

This Type is characterised by people of older working age in low rise municipal housing, and mostly living on benefits or incomes little higher than the minimum wage. Most of the population is white. These neighbourhoods are most common in cities which are in long term decline. High proportions of this Type are found in Liverpool, Hull, Middlesbrough and Merthyr Tydfil. Long term unemployment and industrial sickness are endemic. The estates in which the population lives were mostly built by local authorities in the 1960s and 1970s as part of ambitious schemes to house victims of slum clearance. Former residents of older terraced houses, no longer considered fit for habitation, were moved to new communities in green field settings on the edge of the city. The displacement of working class communities often caused considerable damage to residents' family and social support networks, and the alienating effect this has had on a minority of residents has led to persistent problems of anti-social behaviour among their children. As a result, these areas have become the refuge of large families, single parents and households where no-one is in employment. Right to buy legislation has had relatively little effect on tenure patterns on these estates. Few tenants could afford mortgage payments and those who could preferred, if possible, to invest in a property on “better” estates. A distinctive feature of these neighbourhoods is the almost total absence of people who run their own businesses, however small.

Sector Rank 5 (public sector type J45)
Low income communities reliant on low skill industrial jobs

This Type consists of areas of older housing, mostly owner-occupied, with many residents working in poorly paid blue collar jobs in local manufacturing industry. Typically in their late thirties and early forties, these people live in pleasant and quite spacious older terraces in industrial regions of the country such as South Wales, South Yorkshire, Derbyshire and Nottinghamshire.

Many of the communities have had to adapt to the decline of traditional manufacturing industry and to re-invent themselves in a post-industrial age. Key advantages they have over larger cities are the industry and adaptability of their labour force and the low cost of property. Not least on account of the fact they are often set in areas of low landscape value, planners have encouraged the development of new housing estates on cheap land. This has had the effect of keeping house prices within levels that manual workers have, until recently, still been able to afford. Indeed these are among the most affordable neighbourhoods in which to buy a house.

Despite the decline of many established employers, these are neighbourhoods which experience relatively low levels of unemployment.

Appendix 5: Exergaming and Wii Fit

'Exergaming' is a phenomenon that has boomed in recent years with the release of physically interactive, motion-sensitive gaming systems, such as the Nintendo Wii ™. Other companies have followed suit, and recently, two further games consoles have been released.

The Nintendo Wii and Wii Fit have been taken up by a number of organisations promoting children's healthy weight in Walsall, with the understanding that they contribute towards the daily exercise quota. However, little is known regarding the exact effect of the Wii, an important question, given that much has been queried regarding the trend for exergaming, and it's supplantation of 'real' exercise.

Children play computer games at an estimated 3-7 sessions/week at 1.9 hours per session. In a society where children increasingly spend time in front of television screens as opposed to engagement in physical activity, the incorporation of a form of exercise into this time could be beneficial in addressing the issue of childhood obesity in Walsall, where almost one-third of children over the age of 9 fall into the 'overweight' or 'obese' categories.

There are a limited collection of descriptive studies investigating the effect of exergaming in children and adolescents. Most studies looked at small cohorts, limiting their effect by power.

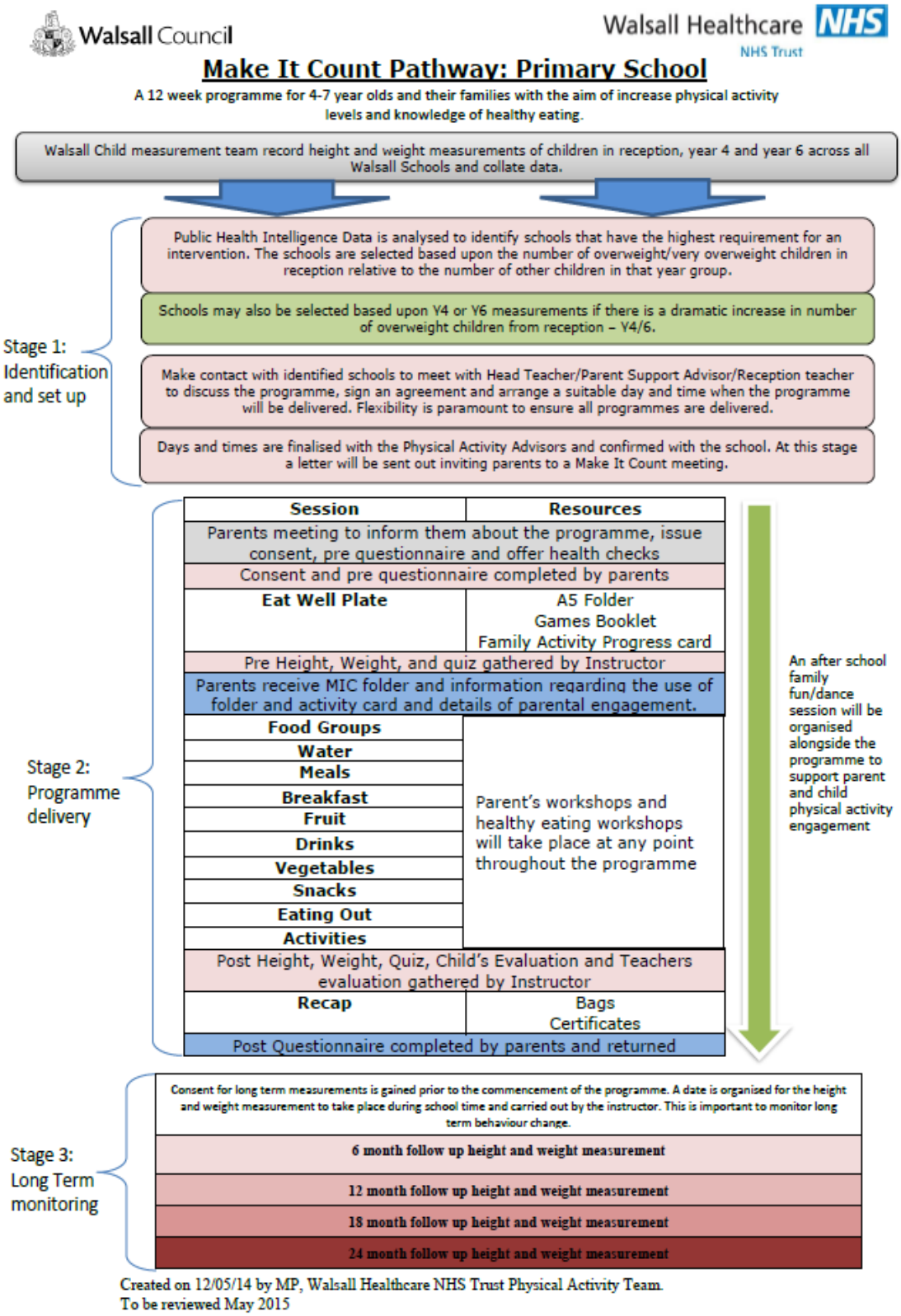
Studies examining exergames assessed Wii games, including Wii Sports and Wii Fit. The reported energy expenditure associated with these activities was variable; between 250-750 kJ hour (1 kilocalorie (kcal) = 4.184 kilojoules (kJ)). All studies identified a statistically significant increase in energy expenditure by 2-3 times and can increase in the level of total body movement compared with sedentary activities, such as watching television and traditional games consoles. A study focusing on the Wii Fit, demonstrated similar results, but also showed that enjoyment for Wii Fit muscle conditioning, yoga, balance and aerobic programmes was greater than enjoyment for hand-held games consoles and treadmill walking.

Within Wii Sports, games such as boxing and tennis were found to be the most effective in increasing levels of energy expenditure. Boxing has been shown to be equivalent to a brisk walk (5.7km hour^{-1}).

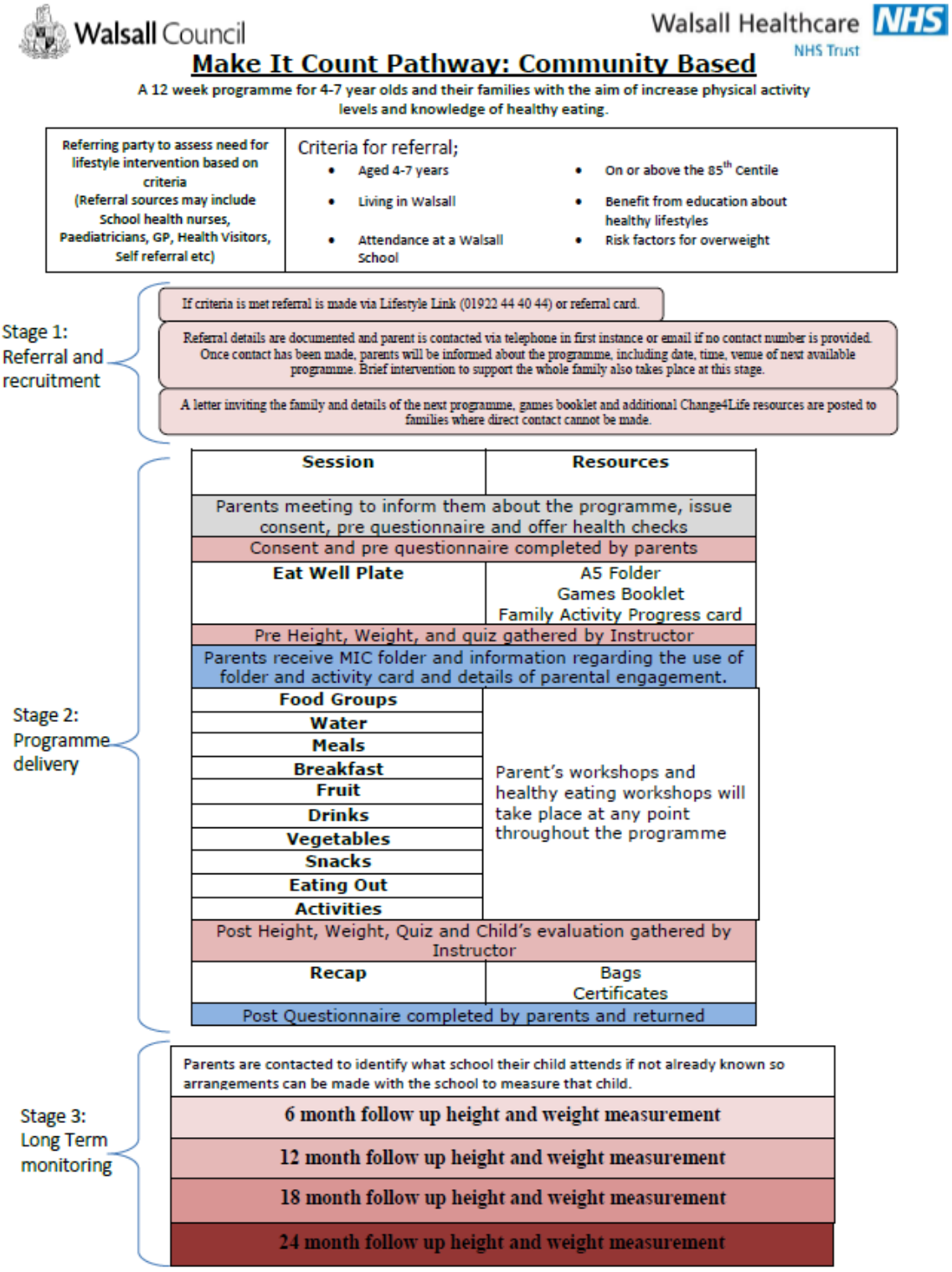
Evidence demonstrates that although Wii games significantly increase total body movement and energy expenditure compared with sedentary computer games and watching television, they are not suitable to replace traditional forms of exercise. Recommended physical activity for children as highlighted above is at least 60 minutes of moderate to vigorous exercise per day. The mild-moderate intensity of Wii games means they cannot be used as an alternative to exercise; one study suggested that active gaming would increase total energy expenditure by less than 2%.

The evidence available is currently very limited. Gaming sessions, outside of the laboratory environment in these studies were conducted, may vary greatly and larger cohorts need to be recruited to enable more reliable conclusions.

Appendix 6: Make it Count Pathway in School



Make it Count Pathway: Community Based



Walsall Council

Walsall Healthcare NHS Trust

Make It Count Pathway: Community Based

A 12 week programme for 4-7 year olds and their families with the aim of increase physical activity levels and knowledge of healthy eating.

Referring party to assess need for lifestyle intervention based on criteria (Referral sources may include School health nurses, Paediatricians, GP, Health Visitors, Self referral etc)	Criteria for referral; • Aged 4-7 years • Living in Walsall • Attendance at a Walsall School • On or above the 85th Centile • Benefit from education about healthy lifestyles • Risk factors for overweight

Stage 1: Referral and recruitment

If criteria is met referral is made via Lifestyle Link (01922 44 40 44) or referral card.

Referral details are documented and parent is contacted via telephone in first instance or email if no contact number is provided. Once contact has been made, parents will be informed about the programme, including date, time, venue of next available programme. Brief intervention to support the whole family also takes place at this stage.

A letter inviting the family and details of the next programme, games booklet and additional Change4Life resources are posted to families where direct contact cannot be made.

Stage 2: Programme delivery

Session	Resources
Parents meeting to inform them about the programme, issue consent, pre questionnaire and offer health checks	
Consent and pre questionnaire completed by parents	
Eat Well Plate	A5 Folder Games Booklet Family Activity Progress card
Pre Height, Weight, and quiz gathered by Instructor	
Parents receive MIC folder and information regarding the use of folder and activity card and details of parental engagement.	
Food Groups	Parent's workshops and healthy eating workshops will take place at any point throughout the programme
Water	
Meals	
Breakfast	
Fruit	
Drinks	
Vegetables	
Snacks	
Eating Out	
Activities	
Post Height, Weight, Quiz and Child's evaluation gathered by Instructor	
Recap	Bags Certificates
Post Questionnaire completed by parents and returned	

Stage 3: Long Term monitoring

Parents are contacted to identify what school their child attends if not already known so arrangements can be made with the school to measure that child.

6 month follow up height and weight measurement

12 month follow up height and weight measurement

18 month follow up height and weight measurement

24 month follow up height and weight measurement

Created on 12/05/14 by MP, Walsall Healthcare NHS Trust Physical Activity Team.
To be reviewed May 2015

Appendix 7: Free swimming under 16's

			March 2013 - February 2014					
Indicator #	**Indicator description**		**Bloxwich**	**Darlaston**	**Oak Park**	**Gala Baths**	**Willehall**	**Overall**
1	Total number of users		2456	3113	2082	2549	214	10415
2	Proportion of users from national quintiles	1	68.2%	71.4%	16.3%	64.3%	41.5%	56.0%
		2	13.0%	16.7%	41.2%	15.6%	37.2%	21.3%
		3	9.6%	8.6%	12.2%	8.3%	18.6%	9.8%
		4	3.6%	1.5%	13.9%	6.3%	0.5%	6.0%
		5	5.6%	1.8%	16.4%	5.5%	2.1%	7.0%
3	Proportion of users from local quintiles	1	46.8%	13.9%	4.0%	34.8%	5.3%	25.6%
		2	18.2%	48.6%	6.2%	25.4%	31.4%	24.9%
		3	13.7%	23.4%	35.8%	14.4%	40.4%	21.6%
		4	12.6%	10.9%	27.8%	15.2%	20.2%	16.4%
		5	8.8%	3.2%	26.2%	10.2%	2.7%	11.5%
4	Proportion of invalidated postcodes		0.3%	0.3%	1.1%	0.6%	0.9%	0.6%
5	Proportion of Outside of area users		11.2%	36.8%	13.0%	15.7%	12.1%	20.3%
6	Proportion of users from Walsall		88.8%	63.2%	87.0%	84.3%	87.9%	79.7%
7	Aldridge Central & South	WALSALL WARDS	1.5%	0.3%	14.6%	2.9%	0.0%	4.4%
	Aldridge North & Walsall Wood		1.7%	0.3%	29.9%	1.4%	1.6%	7.4%
	Bentley & Darlaston North		1.7%	25.0%	0.1%	3.5%	9.0%	7.5%
	Birchills Leamore		15.5%	2.6%	0.7%	8.6%	3.7%	7.1%
	Blakenall		19.2%	0.7%	2.0%	9.4%	0.5%	8.1%
	Bloxwich East		17.5%	0.6%	1.8%	2.7%	1.1%	5.8%
	Bloxwich West		15.9%	1.3%	1.3%	2.0%	0.5%	5.3%
	Brownhills		1.9%	0.3%	19.7%	0.9%	1.6%	5.1%
	Darlaston South		0.4%	36.0%	0.0%	1.3%	1.1%	9.0%
	Paddock		1.2%	2.1%	1.3%	9.8%	0.0%	3.6%
	Palfrey		1.4%	4.0%	0.3%	11.3%	0.0%	4.3%
	Pelsall		7.2%	0.8%	8.3%	2.6%	5.9%	4.7%
	Pheasey Park Farm		0.6%	0.1%	1.0%	1.8%	0.0%	0.9%
	Pleck		1.8%	6.5%	0.4%	15.1%	0.5%	6.0%
	Rushall-Shelfield		3.9%	0.5%	12.6%	3.9%	4.8%	5.0%
	Short Heath		2.3%	6.7%	0.1%	2.1%	18.6%	3.2%
	St Matthew's		1.4%	1.4%	1.6%	16.1%	0.5%	5.2%
	Streetly		0.0%	0.1%	3.6%	0.6%	0.0%	1.0%
	Willenhall North		3.9%	3.4%	0.7%	1.8%	6.9%	2.6%
	Willenhall South		1.1%	7.7%	0.2%	2.2%	43.6%	3.7%
8	AP1 - Brownhills, Pelsall, Rushall, Shelfield	Area Partnership	12.9%	1.5%	40.7%	7.4%	12.2%	14.8%
	AP2 - Aldridge & Beacon		3.9%	0.7%	49.1%	6.7%	1.6%	13.7%
	AP3 - North Walsall		68.0%	5.2%	5.7%	22.7%	5.9%	26.4%
	AP4 - Walsall South		5.8%	14.0%	3.5%	52.3%	1.1%	19.2%
	AP5 - Darlaston & Bentley		2.1%	61.0%	0.1%	4.8%	10.1%	16.5%
	AP6 - Willenhall & Short Heath		7.3%	17.7%	0.9%	6.1%	69.1%	9.5%

Appendix 8: Walsall leisure centre usage

			Walsall Centres					
Indicator #	Indicator description		Bloxwich	Darlaston	Gala Bath	Oak Park	Multi Centre	Walsall Overall
1	Total number of users		4579	5169	4532	4766	7893	26939
2	Proportion of users from national quintiles	1	53.9%	39.1%	44.2%	13.3%	43.2%	39.1%
		2	12.5%	9.7%	14.7%	34.6%	18.2%	17.9%
		3	10.0%	5.6%	8.1%	12.5%	8.9%	9.0%
		4	4.1%	0.7%	7.2%	13.5%	5.4%	6.0%
		5	7.0%	1.0%	8.7%	13.1%	6.3%	7.0%
3	Proportion of users from local quintiles	1	35.1%	6.7%	23.8%	3.4%	21.5%	18.1%
		2	15.2%	26.7%	17.2%	5.6%	17.7%	16.8%
		3	13.7%	14.4%	12.7%	29.1%	17.7%	17.6%
		4	12.7%	6.6%	14.8%	25.8%	14.7%	14.8%
		5	10.8%	1.7%	14.4%	23.0%	10.4%	11.7%
4	Proportion of invalidated postcodes		0.6%	0.3%	0.4%	0.7%	0.4%	6.4%
5	Proportion of Outside of area users		12.5%	34.9%	17.2%	13.0%	7.9%	19.3%
6	Proportion of users from Walsall		87.5%	56.1%	82.8%	87.0%	82.0%	79.0%
7	Aldridge Central & South	WALSALL WARDS	1.1%	0.1%	3.6%	13.1%	5.3%	5.0%
	Aldridge North & Walsall Wood		1.5%	0.4%	2.1%	28.3%	7.2%	8.4%
	Bentley & Darlaston North		1.5%	26.9%	2.5%	0.1%	5.4%	6.1%
	Birchills Leamore		13.1%	2.4%	7.2%	1.0%	7.9%	6.7%
	Blakenall		15.4%	0.4%	7.4%	1.6%	8.1%	7.0%
	Bloxwich East		18.3%	0.5%	3.5%	2.1%	6.5%	6.5%
	Bloxwich West		17.5%	0.9%	3.2%	1.2%	6.2%	6.1%
	Brownhills		1.9%	0.1%	1.3%	17.5%	6.5%	6.0%
	Darlaston South		0.2%	33.8%	0.9%	0.2%	5.2%	6.4%
	Paddock		1.4%	1.4%	11.8%	1.1%	3.1%	3.7%
	Palfrey		0.7%	2.6%	9.0%	0.3%	3.8%	3.3%
	Pelsall		8.6%	0.3%	4.5%	10.2%	5.0%	6.0%
	Pheasey Park Farm		0.5%	0.2%	2.9%	1.1%	1.2%	1.2%
	Pleck		1.5%	5.4%	10.3%	0.4%	5.5%	4.6%
	Rushall-Shelfield		3.5%	0.3%	5.0%	14.2%	6.4%	6.3%
	Short Heath		3.1%	7.4%	2.6%	0.5%	3.1%	3.1%
	St Matthew's		2.0%	0.9%	17.2%	2.1%	5.8%	5.7%
	Streetly		0.4%	0.1%	1.0%	3.4%	1.6%	1.4%
	Willenhall North		6.1%	4.2%	1.9%	0.6%	3.3%	3.2%
	Willenhall South		1.8%	11.5%	2.2%	1.1%	2.9%	3.4%
8	AP1 - Brownhills, Pelsall, Rushall, Shelfield	Area Partnership	14.0%	0.8%	10.8%	41.9%	17.9%	12.8%
	AP2 - Aldridge & Beacon		3.5%	0.9%	9.5%	45.8%	15.3%	11.4%
	AP3 - North Walsall		64.3%	4.2%	21.3%	5.9%	28.7%	17.6%
	AP4 - Walsall South		5.6%	10.3%	48.3%	3.9%	18.2%	11.7%
	AP5 - Darlaston & Bentley		1.6%	60.7%	3.4%	0.3%	10.7%	9.2%
	AP6 - Willenhall & Short Heath		11.0%	23.2%	6.7%	2.2%	9.3%	6.8%