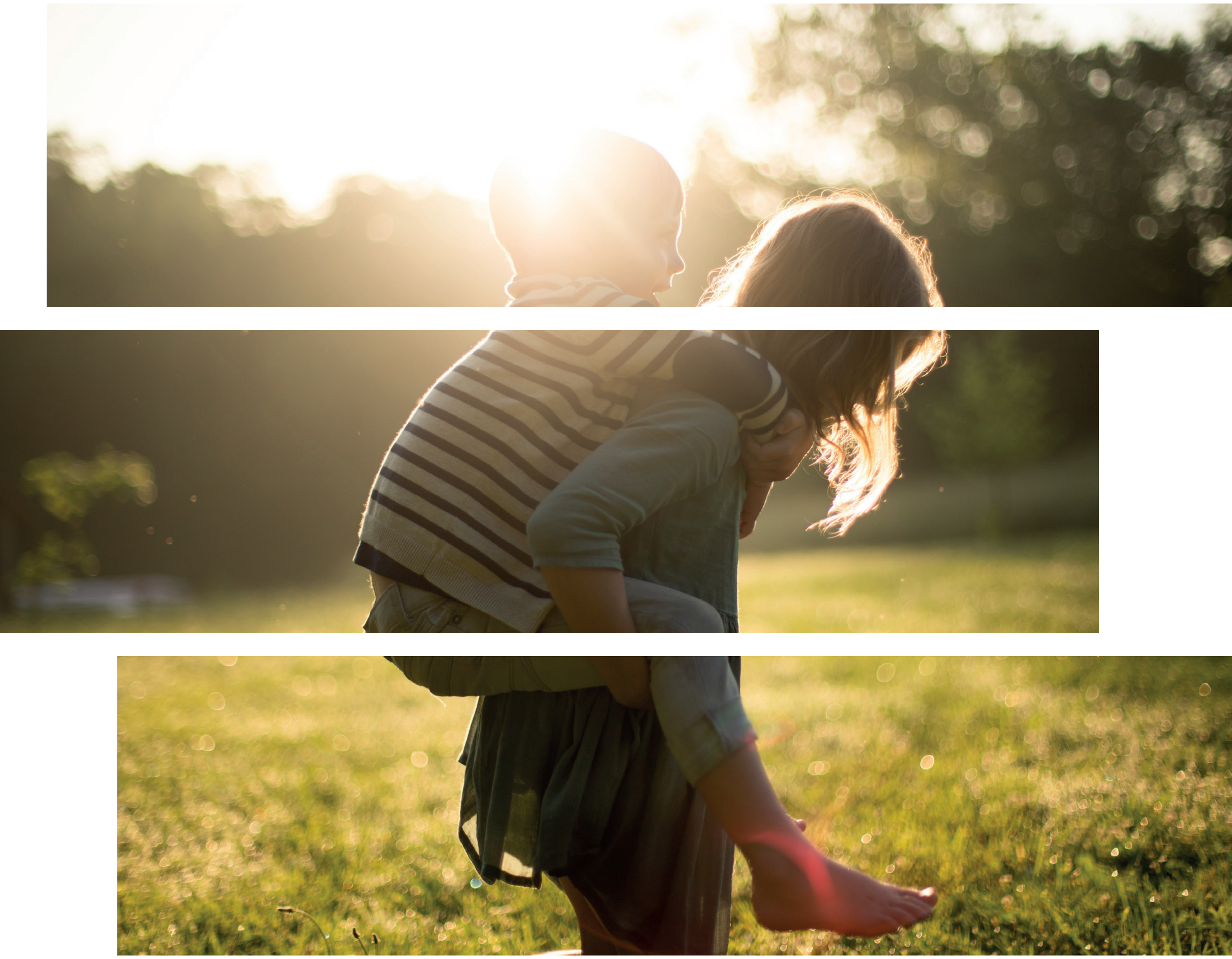
LONDON CHILDHOOD OBESITY TASKFORCE ENGAGEMENT WITH CHILDREN AND YOUTH

EVIDENCE IN SUPPORT OF CALLS TO ACTION



LONDON'S CHILD OBESITY TASKFORCE

SUPPORTED BY
MAYOR OF LONDON

GUY'S & ST THOMAS' CHARITY

Public Health England

ADPH London

ALDCS
Association of London Directors of Children's Services

The London Child Obesity Taskforce was established in 2018 as part of the Mayor's commitment to address child obesity. Find out more at www.london.gov.uk/what-we-do/health/londons-child-obesity-taskforce or email childobesitytaskforce@london.gov.uk

AMBITION 1: END CHILD POVERTY IN LONDON

Action: *We call on the Mayor to lead a drive to significantly increase the number of employers becoming London Living Wage accredited, and the UK Treasury to devolve power to the Mayor to set a legal minimum wage for London*	
Rationale	Child poverty is rising in London. This includes both relative and absolute poverty (rates measured before or after housing costs). Across the past decade, the income of less well-off families has been hit by severe real-terms cuts in benefit levels and by higher housing costs, while being constrained by limited opportunities to improve earnings from work. Accordingly, despite rises in overall incomes, increasingly more children are living in poverty then at the start of the decade. After accounting for the costs of housing, poverty rates in London are highest of anywhere in the UK. **37% of London's children live in poverty** after accounting for housing costs [End child poverty. 2019]. Rates of childhood obesity in London is strongly socioeconomically patterned: 10-11-year-old children living in the top 10% of deprivation are twice as likely to experience overweight and obesity than those in the bottom 10% [NHS. 2018]. Most health behaviours that contribute to excess weight are driven by socioeconomic resources. For example the primary concern of parents from low-income communities in London is dealing with the cost of food and needing to manage on a restricted budget [Harvey. 2014]. Parents consistently report differences between how they would like to feed their children and the reality of what they are able to do. Beyond specific monetary amounts other factors including parental time constraints, often from working long hours, results in a reliance on quick meals and dinners. Patterns of where food and takeaways are purchased is heavily influenced by routines [Patterson et al. 2012]. Given the strong link between socioeconomic resources and health behaviours, alongside rising levels of child poverty, the obesity gap is widening between advantaged and disadvantaged populations. Within addressing basic income levels, many of London's families will continue to face substantial barriers to health behaviours including purchasing healthy food and accessing opportunities for children to be physically active.
Supporting evidence	London's living wage is an hourly rate of pay (currently set at £10.55) that reflects the high rate of living in the capital and gives a worker and their family enough to afford the essentials. Calculated by the Centre for Research in Social Policy at Loughborough University, the pay rate reflects the minimum money needed to lead a basic life. In addition to the clear benefit to individuals and families, businesses that pay the living wage see reduced absenteeism and sick leave, find it easier to recruit and retain staff, see a huge boost to staff morale and productivity and see improved brand awareness [Living Wage Foundation. 2018].

Action: *We call on the Department of Health and Social Care and Alexandra Rose Charity to work with Public Health England, boroughs and retailers to review existing food voucher schemes and trial improved ways to design and deliver them so they work better for London's families.*

Rationale	Food poverty is defined as the inability to obtain healthy affordable food. While there are a wide array of reasons of why families experience food poverty, the central root cause is money. More than two fifths (39%) of families on low-incomes in London worry about running out of money for food [GLA. 2013]. More than half (52%) of households in the UK spend less on food then the minimum needed set to achieve a nutritious socially acceptable diet. Recent evidence indicates substantially more severe food insecurity in certain boroughs of London. 81% of parents (in a study conducted in the London Borough of Lambeth) report not having enough to eat, being worried about food sufficiency and running out of food before there was money to buy more [Harvey. 2014]. Ever family interviewed reported being unable to afford balanced, healthy meals for their family. When faced with food insecurity, fruit, vegetable and meat intake tends to be curtailed, with UK families switching to more calorie dense food of poorer nutritional quality and processed foods [Institute for Fiscal Studies. 2013]. In parallel, reliance on takeaways increases in times of food insecurity: in a study with young people 11-15 years of age living in food insecure homes in Lambeth, South London, adolescents from ten of the fourteen families (71%) described regularly having takeaway meals from local food shops, typically "chicken and chips" [Harvey. 2014]. Across London and the UK families with low-income have the lowest intake of fruits and vegetables [ARC. 2014]. These trends of eating behaviours contribute to excess weight and obesity.
Supporting evidence	**Healthy Start programme food vouchers:** Healthy Start is UK's food welfare scheme for pregnant women and young children in low-income families. An evaluation of Healthy Start Food Vouchers across the UK demonstrated that the vouchers increased the quantity and range of fruits and vegetables used, improved the quality of family diets and established good habits for the future. [McFadden et al. 2014]. There is a need for work to increase uptake – in some areas only 55% of eligible families receiving the Vouchers use them. Qualitative research has demonstrated some vulnerable groups are unable to access the scheme, there is stigma associated to their use and a need for better integration with retailers for ease of acceptance of the vouchers [Lucas et al. 2015].
Supporting evidence (continued)	**Alexandra Rose Charity, Rose Vouchers:** aim to promote healthy eating and combat food poverty by giving families vouchers that can be redeemed for fresh fruit and vegetables at local markets. The Rose Voucher scheme aims to add further value to those already entitled to use the Healthy Start Scheme. The business exchange set up encourages the maintenance of local markets as important sources of healthy low cost food. Of the families accessing Rose Vouchers: 95% report increases in fruit and vegetable consumption; 75% a decrease in consumption of takeaways and convenience foods; 65% more meals cooked from scratch and 95% report improved health and well-being [Lambeth project final evaluation].

AMBITION 2: SUPPORT WOMEN TO BREASTFEED FOR LONGER

Action: *We call on the London boroughs and voluntary sector organisations to initiate and scale up peer-to-peer support networks and trial incentives with academic partners to help mothers feel more supported to breastfeed for longer, and in more places.*

Rationale	Evidence demonstrates that breastfeeding is protective against childhood obesity: this has been revealed in two large reviews and meta-analyses [Yan et al. 2014, Horta et al. 2013]. The relationship between breastfeeding and childhood obesity is dose dependent: infants who are breastfed have a reduced risk of being overweight in the first year of life, and the protective association is stronger with longer and more exclusive breastfeeding [Azad et al. 2018. Paediatrics]. This established association needs to be accompanied by the disclaimer that as with any behaviour that is strongly socioeconomically patterned it is challenging to disentangle the results from confounding . Breastfeeding initiation rates across the UK are 83%. However, rates drop off drastically from here: mothers exclusively breastfeeding at 10 days is 46% and by six months less then 1% [NHS Infant Feeding Survey]. Rates of breastfeeding at 10 days is associated with higher income professions, living in less deprived areas, increasing maternal age and increasing levels of maternal education [Rayfield et al. 2015]. Breastfeeding rates at 6-8 weeks is on average 42.7% across England, with wide variance in rates between Boroughs in London: from 29.6% in Redbridge to 93.4% in Tower Hamlets (PHE, 2018/19). Rates have been illustrated to be strongly influenced by sociodemographic and equity characteristics across London (PHE. 2013).

Supporting evidence	**Peer to peer support networks for breastfeeding:** A Cochrane review of additional support (provided by professionals, peer supporters, or both) based on 57 trials, including 37 from high income countries found that any extra support (irrespective of provider) had a positive effect on breastfeeding duration rates [Renfrew et al. 2012]. A recent Cochrane review reported similar findings [McFadden et al. 2017]. Interventions tended to be more effective when delivered in areas with higher background initiation rates, delivered faceĐtoĐface, offered proactively, offered on an on-going basis, and when tailored to the needs of the target population [Renfrew et al. 2012]. **NCT Breastfeeding Peer Support Project:** This was a three-year funded programme for to set up, train, and use, peer supporters to improve breastfeeding rates. The pilot evaluation of mothers' experiences of peer support illustrates the value of community breastfeeding support. The mothers very much appreciated being part of a supportive community group and liked the informal non-directive style of the NCT-trained peer supporters. Through the support of peers, the mothers felt more confident about breastfeeding and less vulnerable to self-doubt and being undermined by other people. This study and accompanying evaluation recommended that the NCT should roll-out the partnership model of breastfeeding peer support training as a core activity, ensure peer support schemes are organised as part of a coordinated programme for breastfeeding and have a paid local coordinator in each area. It is recommended that priority be given to setting up programmes in inner-city areas, urban and rural areas where the NCT has traditionally not had a high profile so as to reach a more diverse range of parents and respond to health and social needs [Muller et al. 2009]. Financial incentives for breastfeeding: **Nourishing Start for Health:** was a large cluster randomized controlled trial conducted across 92 electoral wards in England (included over 10 000 mother-infant pairs) testing the effect of financial incentive on breastfeeding rates 6 to 8 weeks post-partum. The financial incentive was £40 at five set times from birth to 6 months. When analysed this worked [Relton et al. 2018]. The scheme was tested in areas with low breastfeeding rates, the trial found a significant increase in breastfeeding rates in areas where offered. Mothers breastfeed for longer and reported feeling rewarded for breastfeeding.

Supporting evidence (continued)	**Qualitative evaluations regarding financial incentives for breastfeeding** illustrate generally positive response from participants – women felt valued for the effort involved in breastfeeding. The vouchers were frequently described as a reward, a bonus and something to look forward to, and helping women keep going with their breastfeeding. They were often perceived as compensation for the difficulties women encountered during breastfeeding [Johnson et al. 2017].
Action: *We call on the NHS, the London boroughs and Public Health England to collect and analyse robust breastfeeding data at ten days and six-to-eight weeks, to explore how mothers can be more supported to breastfeed for longer.*	
Rationale	As outlined above, breastfeeding rates in UK mothers drop drastically in the first weeks of an infant's life. While 83% of mothers initiate breastfeeding, this drops to 46% at 10 days and less then 1% at 6-months. Data revealing that breastfeeding rates are strongly shaped by socio-demographic factors (Breastfeeding at 10 days is associated with higher income professions, living in less deprived areas, increasing maternal age and increasing levels of maternal education [Rayfield et al. 2015]) illustrate an evident need to provide support to less advantaged London mothers to increase rates of breastfeeding. Data illustrating that rates at 6-8 weeks vary drastically rates between London Boroughs (ranging from 29.6% in Redbridge to 93.4% in Tower Hamlets [PHE, 2018/19]) reveals a need to better understand when these differences emerge and manifest. Collecting data at 10 days will enable the Taskforce to gain a greater understanding of when differences emerge and how they are patterned between groups, to better design and target support.
Supporting evidence	Systematic review of breastfeeding trials (N=195) indicates that interventions should be delivered in a combination of settings by involving health systems, home and family and the community environment concurrently. [Sinha et al. 2015]. • Findings of this recent review of the effect of 195 interventions of breastfeeding revealed for early initiation, counselling or educational interventions delivered at home and community were found to be the most powerful intervention (85% increase) and were identified that these should receive the highest priority. o Counselling when provided as a single intervention in the community environment was also effective but had a lower impact on breastfeeding initiation.

Supporting evidence (continued)	• Similar to earlier findings [Ingram et al. 2010], counselling by health staff only at home had a non-significant effect on breastfeeding initiation. This suggests that in addition to educating the mother, increasing awareness in the whole community is an essential component of an effective strategy. • For promotion of exclusive breastfeeding, counselling or education in the health system and community is likely to be the most powerful (increase by 152%) among the examined interventions. The individual interventions i.e. counselling at health systems or community when examined separately had a significant but lower impact on exclusive breastfeeding rates, but the combination had a synergistic effect. This finding is confirmed in another review [Haroon et al. 2013].

AMBITION 3: SKILL UP EARLY YEARS PROFESSIONALS

Action: *We call on the NHS, Health Education England, the Mayor and the London boroughs to provide a core training programme for the early years workforce and NHS staff who engage with young children and their parents.*	
Rationale	Staff and teachers in early year settings play a key role in the implementation of interventions targeted at changing behaviours in children and adolescents and are a central, regular, influence on the daily lives of young children and their parents. For example, in the context of physical activity behaviour, studies have shown that individual teachers in child care centres determine daily schedules and ultimately make the decision whether to take the children outdoors, while also serving as gatekeepers to the playground. A study of this illustrated that children can have very different activity experiences within the same facility (with the same environment and policies) based on the beliefs, creativity and level of engagement of their teacher (Copeland et al. 2012). Reviews of multi-behaviour obesity prevention interventions have illustrated that training and support for teachers to implement health promotion strategies is a promising strategy and needed strategy to maximise intervention effectiveness and a key to behaviour change success (Waters et al. 2011).
Supporting evidence	Evidence generated from individual trials illustrates the influential and effective role the training of early years staff can have on effectively changing the health behaviours of children. This includes across: **Physical activity:** • Goldfield et al. (2012): the trial of a physical activity intervention in child care centres in Canada illustrated the importance of engaging both the director and the teachers, demonstrating that they act as gatekeepers to children's health. It was recommended that interventions should focus on teacher knowledge and skills as potential targets for improvement to drive positive impacts on health behaviours in young children. • Mehtala et al. 2014: this review examined socioecological approaches to physical activity interventions in childcare. Of all the trials included the review the use of in-service teacher training as an intervention strategy was particularly effective (compared to the wide array of other strategies employed). **Nutrition:** • Nathan et al. (2011): an Australian trial of a nutrition intervention (the adoption of a fruit and vegetable break) was 2.2 times higher for children in early years schools that had teachers trained in the program, its' rationale, objectives and implementation, compared with those in settings without the training. • Ward et al. (2016): this cross-sectional study illustrated that childcare educators act as central role models for healthy eating behaviours amongst young children and influence the quality of children's dietary intake at lunch in childcare centres. **Both physical activity and nutrition:** • De Groot et al. (2010): evaluation of the Romp & Chomp community wide obesity prevention intervention made multiple recommendations which addressed community-level intervention on obesity. It recommended that key emphasis be placed on building capacity and strong leadership within the community, alongside early years care and education. The researchers emphasised focusing on professional development regarding 'healthy lifestyles' through teacher training is particularly needed. • Ratanachu-ek et al. (2008): this trial tested the effect of teachers' education and training on the prevalence of overweight and obesity in Thailand. The findings illustrated that the prevalence of overweight decreased significantly over a period of 3 years in the schools that received teachers' education and training.

Action: *We call on the Mayor, Public Health England and the London boroughs to implement food training and require qualifications for all early years settings with caterers and chefs..*	
Rationale	By the time UK children enter primary school at age four over one fifth are already overweight or obese (NCMP. 2017). Regular fruit and vegetable consumption at this young age supports healthy weight development (Gardner et al. 2009) and encourages a taste for healthy food in the long term (Carruth et al. 1998). Given that the majority of infants and young children in London attend early years and eat a meal while in attendance, there is significant opportunity to influence a large proportion of their daily energy intake through consumption of healthier school food. Pre-school nurseries and care facilities stand out in systematic literature reviews looking across multiple settings in a child's day which the potential to impact children's health behaviours (Osei-Assibey et al. 2013). The provision of food in nurseries is linked to their consumption (Ball et al. 2008). Beyond supporting parents in encouraging healthy eating, nurseries can support in the introduction of different foods and reducing fussy eating (Carruth et al. 1998). Other more structural level factors need to also be extensively considered within approaches enacted by the Taskforce. Systematic literature reviews of globally aggregated evidence has illustrated that school food environment policies can improve dietary behaviours (Micha et al. 2018). However, as outlined by the UK's School Food Trust's theoretical framework a substantial number of people and factors are involved in promoting healthier eating of foods in educational settings. For sustained long term change it is likely numerous of these factors and levers need to change. For example, recent evidence of UK nurseries illustrated that nurseries farthest from a supermarket were significantly less likely to serve fruits and vegetables (Burgoine et al. 2017). However, we know that chefs and caterers are strong influences within the broader system. Studies of school meal provision in the UK have illustrated that caterers play a central role in the promotion and provision of healthy food. Caterers particularly influence the quantity and types of foods offered to attendees which can be altered to promote healthy eating behaviours within a school catering context (Day et al. 2015).
Supporting evidence	Emerging trials have demonstrated that professionally trained chefs with a goal of improving the taste of healthy meals can significantly increase fruit and vegetable consumption. The findings of these studies highlight the importance of focusing on the palatability of school meals (Cohen et al. 2015). This evidence is the strongest yet and followed a pilot study that found that students exposed to chef-enhanced meals selected more whole grains and consumed more vegetables compared with students in control schools (Cohen et al. 2012).

AMBITION 4: USE CHILD MEASUREMENT TO BETTER SUPPORT PARENTS

Action: *We call on the London boroughs to work with the NHS, children, parents, and teachers to co-produce guidance on how to make the National Child Measurement Programme more supportive for London's families.* **Action:** *We call on each London borough to work with Public Health England, the NHS and community groups to communicate the results of the National Child Measurement Programme to parents in a way that makes them feel confident that their child will receive the support they need.*	
Rationale	The National Child Measurement Programme (NCMP) was launched in 2005 across the UK to monitor rates of childhood obesity. Since 2008, parents have been provided with feedback regarding their child's weight status and information on the health risks associated with being overweight, most often in written format. The aim of this feedback is to help parents understand their child's health status, support and encourage behaviour change, and provide a mechanism for direct engagement with families with overweight children. Feedback letters follow a standardised template that can be adapted by public health staff involved in the delivery of the NCMP. A template letter and operational guidance is available. Parents of children identified as overweight (> 91st percentile) or obese (> 98th percentile) are typically advised to contact a health professional for further advice (although the exact approach taken differs by school). Evidence however indicates that few parents take up the current limited offers of support (Falconer et al. 2014). There is substantial, emerging, evidence illustrating that this current feedback system is not enacting positive behaviour change and that current reporting system can be stigmatizing for parents. The current approach does not provide parents with support to enact changes in their child's day to positively impact behaviour and obesity outcomes. This change proposed by the Taskforce support's prior calls for an overhaul of the letters.

Supporting evidence	Concerns have been raised that given the cultural sensitivities around weight, the NCMP program it could lead to adverse psychological consequences and distress through 'labelling' a child as overweight with the potential of inducing risky unhealthy weight behaviours (Ikeda et al. 2006). Evidence and qualitative research indicates that the letter can be stigmatizing for parents who have reported to feel targeted as caregivers. This has led to family and peers collaborating in the dismissal of the overweight feedback (Gainsbury & Dowling. 2018). Qualitative studies illustrate that parents who receive NCMP written feedback often disregard the results (Syrad et al. 2014). The feedback was considered less credible by parents because it did not consider the individual child's lifestyle. This evidence that written feedback does not necessarily translate into concern for health or behaviour change, is consistent with previous weight feedback research. Many parents conceptualised child health in terms of diet, activity level and wellÐbeing, and felt that, because their child ate healthily, and was happy and physically active, this meant that all was well. Given that parents have previously been found to overÐestimate the healthiness of their child's diet and how physically active they are, this illustrates the importance that parents are reliably informed as to where improvements in their child's lifestyle could be made. The findings from this study suggest that letters home to parents should emphasise the importance of activity and a healthy diet rather than focusing solely on weight or BMI centiles to effectively engage parents and guardians. Other evidence supports this illustrating that at present the impact of weight feedback through the NCMP programme on behaviour change is limited (Falconer et al. 2014). These findings suggest that further work is needed to identify ways to more effectively communicate health information to parents and to identify what information and support may encourage parents in making and maintaining lifestyle changes for their child. The study conducted a pre-post survey of parents before and after children participated in the NCMP programme. Following the NCMP letter parent-reported changes in lifestyle behaviours among children were minimal. There was some suggestion that weight feedback had a greater impact upon changing parental recognition of the health risks associated with child overweight in non-white ethnic groups.

Supporting evidence (continued)	The Royal Society of Public Health conducted research illustrating that only 1/5 of parents find the letter useful and have called for the letter to be the beginning of a dialogue with parents. The RSPH has called for the following changes: 1) for parents of children who are obese to be contacted by telephone prior to being sent the letter; 2) support in the form of either healthy food vouchers or access to after-school activity clubs to incentivise healthier eating and exercise habits for those children who are overweight and 3) better integration of the Child Measurement Programme with other public health initiatives, such as Change4Life. Co-production refers to a collaborative process where healthcare providers work with healthcare users to shape health services with the intention of better designing them (Durose et al. 2011). Unlike other forms of engagement co-production builds on a child's interests, knowledge, experience, skills and support networks. Co-production emphasises doing thinks 'with children' as opposed to doing things 'to children' or 'for children'. Co-production leads to a multitude of benefits including a better service (less stigma, a more attractive service to children and parents), improved engagement and community relations (stronger mutual support systems and care in the community) and growing social networks (NEF. 2009). Co-production between all stakeholders in building an NCMP toolkit, given the particular need for sensitivities surrounding the issue, will benefit from each of these factors outlined.

AMBITION 5: ENSURE ALL NURSERIES AND SCHOOLS ARE ENABLING HEALTH FOR LIFE

Action: *We call on 'ambassador' nurseries and schools, supported by the Association of Directors of Public Health for London, to build capacity for comprehensive and bold change across London by establishing peer networks with headteachers, governors and school food providers.*
Action: *We call on Ofsted to include in all its reports and its inspections framework a stronger emphasis on the provision of, and education quality about, healthy diets, water and activity when evaluating education, child development and overall effectiveness of early years settings and schools.*

Rationale	Ofsted is the Office for Standards in Education, Children's Services and Skills. Ofsted's function is 'to inspect and regulate services that care for children and young people, and services providing education and skills for learners of all ages'. It carries out inspections and visits leading to published reports; it then shares best practice and monitors improvement, with the goal of achieving excellence in education and care. The outcomes of Ofsted inspections often have high-stakes implications. Favourable judgements for schools can open up opportunities to become a school sponsor or teaching school, or for school leaders to take up national or local system leadership roles. Unfavourable judgements can lead to intervention, academisation or school closure. Due to the implications of evaluations for funding and sustainability, schools take meeting the set evaluation criteria very seriously. Thus, the incorporation of wellbeing outcomes has the potential to mandate and drive change in schools. This proposed action follows changes announced this Jan 2019 by Ofsted that for the first time include criteria beyond direct academic outcomes, including consideration of the quality of education. This added component of the inspection looks at how providers are deciding what to teach and why, how well they are doing it and whether it is leading to strong outcomes for young people. It also is adding a new inspection area, 'personal development', which rates how a school prepares pupils for life in modern Britain. These changes which are the first major shifts to look beyond academic outcomes provide good momentum for the further incorporation of well-being and health outcomes as proposed by the Taskforce.
Supporting evidence	Any additional changes in Ofsted evaluations need to ensure to consider the risk of differential effectiveness. Prior evidence has raised questions regarding Ofsted's evaluative approach, including evidence that the evaluation can widen inequalities. A report by Huchinson. 2016 investigated this and illustrated that: • There is a systematic negative correlation between school intakes with more disadvantaged children, or more children with low prior attainment, and with favourable Ofsted judgements. • Secondary schools with up to 5 per cent of pupils eligible for free school meals (FSM) are over three times as likely to be rated 'outstanding' as schools with at least 23 per cent FSM (48 per cent vs. 14 per cent 'outstanding'). Those secondary schools with the most FSM pupils are much more likely to be rated 'inadequate' than those with the fewest (15 per cent vs. 1 per cent). • "notable proportions of 'good' and 'outstanding' schools are not down-graded ", even when their performance deteriorates substantially. Conversely, the "most deprived schools are systematically more likely to be down-graded than the least disadvantaged" – this has further detrimental effects as the very schools that need the most help are further harmed by inaccurate and biased Ofsted reports subsequently makes the recruitment and retention of teachers even more difficult. Furthermore, as those heads chosen to become system leaders come from the most advantaged schools their advice to the poorest schools is often not what is needed/helpful. To enable sustained change and leadership for well-being and health outcomes as outlined above, **peer-to-peer networks** will be used. There are multiple examples of schools in London already actively taking action on childhood obesity irrespective of its inclusion in the Ofsted criteria. Schools with already established success in taking action on childhood obesity have significant knowledge, successes, failures to share with other schools across London as changes to prioritize well-being start and are built on. This includes a wide range of stakeholders ranging from the headteacher to the governors and school food providers.

Supporting evidence (continued)	One such example is **Charlton Primary School**, who has enacted a variety of actions which include: • School has a garden that students help take care of – this includes chickens and bee hives. Students are free to spend time in the garden as they like and have regular opportunities to learn how these ingredients are incorporated into the foods they eat. • Beyond this, students get to regularly use garden ingredients in the school's teaching kitchen where they learn to bake and cook. o Cooking is commonly combined with math and language curriculum. o Parents say this cooking program has made a huge difference on their children's consumption patterns. Their children are now interested in cooking, they get excited about being able to see where the ingredients come from (E.g. collecting eggs for bread or picking herbs for cooking) and are less picky eaters (the excitement of eating their own cooking with a range of tastes has extended to eating different foods at home). • Students participate in all stages of the lunchtime feeding process – including a rotation of students that get to serve as waiters to the rest of the students. • The school kitchen and cooks are constantly trying out new low sugar low salt recipes and testing how students enjoy them. • The school tuck shop which is open after school serves these products. It is a big hit with both children and families. • The school offers Physical education classes in the morning which parents and children can attend together. • There is a wide range of after school clubs that parents use as they are comparably far cheaper than community alternatives. • The multitude of actions and success at a school and community level have come through extensive action and work by multiple stakeholders at the school. There are clear lessons and knowledge that can be shared with other schools invested in taking action to make their school setting healthier. The multitude of actions and success at a school and community level have come through extensive action and work by multiple stakeholders at the school. There are clear lessons and knowledge that can be shared with other schools invested in taking action to make their school setting healthier.

AMBITION 6: MAKE FREE 'LONDON WATER'[1] AVAILABLE EVERYWHERE

Action: *We call on the Mayor, water companies and the advertising industry to incentivise children to drink water by reframing London's free drinking water as a 'London Water' brand, co-designed with London's children.* **Action:** *We call on the Mayor, the food service industry, schools and public institutions to scale up and extend existing initiatives to make London Water widely, freely and conspicuously available from public drinking fountains, all restaurants and public buildings, and in 'water only' schools.*	
Rationale	Children in London consume large amounts of sugar sweetened beverages. A study conducted in London revealed that 47% of 13-15 year olds consume a sugar sweetened beverage at least once per day (Shareck et al. 2018). Consumption of sugar sweetened beverages is higher in children from disadvantaged and minority ethnic groups. At present, soft drink consumption increases with age, providing 7%, 10%, 22% of daily energy from free sugars from age groups 1.5-3 years, 4-10 years and 11-18 years respectively. These rates are well above the government guidance of 5% (PHE. 2018). In adolescence almost a quarter of sugar consumed by teenagers comes from sugary drinks (Sustain. 2019). Water consumption helps to reduce the consumption of sugar-sweetened beverages and thus is outlined in many paediatric obesity prevention and treatment guidelines. Higher levels of water consumption also have independent effects on reducing energy expenditure (Dubnov-Raz et al. 2011), with low levels of water consumption established in certain populations to be associated with obesity and lower success in weight reduction efforts. Longitudinal evidence indicates that increased water consumption in childhood might reduce the risk for excessive weight gain in the long term (Muckelbauer et al. 2014). Given the negative health consequences of both excessive consumption of sugar sweetened beverages and low levels of hydration, there is clear positive benefit to the promotion of water drinking across London. Structural barriers exist to the consumption of water in urban settings illustrating a need to address accessibility and for action beyond individual behavioural messages. A recent randomised controlled trial of behavioural advice to increase habitual water intake in an adolescent population revealed that environmental barriers presented significant barriers to adherence due to a lack of convenient places to drink water from a fountain or refill a water bottle outside school or home setting (Wong et al. 2017).

[1] Working brand title.

Rationale (continued)	There is additionally strong environmental rationale for this investment. In the UK the consumption of bottled water has doubled with 13 million plastic bottles used in the UK every year (Sustain. 2019). While it is positive that this increase in bottled water partially comes from rising knowledge and interest of the need to provide healthier alternatives to sugary drinks there are significant detrimental environmental impacts. Public drinking fountains have both strong environmental and health wins. The case for it is especially strong in the UK given that we have some of the highest quality water in the world (Sustain. 2019).
Supporting evidence	There is strong public benefits for this investment and public focus. Recent UK research illustrates that 78% of people would like greater availability of free tap water in public spaces (Keep Britain Tidy and BRITA. 2018). There is strong evidence that greater availability of drinking water facilities would increase uptake of reusable water bottles across the UK with 69% of respondents indicating this would make them 'a bit more' or 'a lot more' likely to use a reusable water bottle when out in the city. This is a significant increase from prior years. Modelling studies have illustrated clear public health benefit to increased consumption of water consumption in children and adolescents – particularly in light of high sugar-sweetened beverage consumption. An analysis in the US illustrated that when holding fast food and other beverage consumption constant but substituting sugar sweetened beverages with water would result in an average reduction of 235 kcal per day in children and adolescents (Wang et al. 2009). Over time this amount would have a significant impact on weight and health outcomes on a population level. Evaluations of water drinking interventions have illustrated the need to consider study designs that overcome the environmental barriers associated with the provision and/or accessibility of potable water such as placement of 'water jets' (electrically cooled, large clear jugs with a push lever for fast dispensing) in school cafeterias to increase access to drinking water (Schwartz et al. 2016). Overall there is a strong case that the access and promotion of water fountains in schools increases water consumption, with specific trials showing an effect on children's weight and evaluations creating a strong cost-benefit case.

AMBITION 7: CREATE MORE ACTIVE, PLAYFUL STREETS AND PUBLIC SPACES

Action: *We call on the Mayor, London boroughs, housing associations, landowners and developers to dramatically increase timed closures of streets to motor traffic and other public-realm improvements that reduce traffic and support children's health, wellbeing and mobility.* **Action:** *We call on the Mayor and the London boroughs to make children's health, wellbeing and mobility required criteria for public funding and authorisation of regeneration and transport schemes.*	
Rationale	Data reveals that only 11.8 % of 15-year-olds in London are physically active for at least one hour per day (Hammersmith and Fulham have the lowest levels of physical inactivity, with only 9.3% meeting international recommendations) (PHE England 2018 Physical Activity Data and Indicator). Education, household income and local deprivation are all independently and strongly associated with physical inactivity. One way of increasing levels of physical activity is through encouraging active transport (children walking, biking, scootering etc. to school). 'School Streets' are timed street closures at the start and end of the day to remove danger and encourage walking and cycling. It was initially introduced by transport planners in Reading, Netherlands, but is widening use with recent momentum in London.

Evidence of effectiveness	Evaluations are emerging from pilots across various local authorities in London creating a strong case for effectiveness of school streets. Evaluations from both Camden and Hackney revealed school street pilots resulted in: • Lower vehicle volumes on school streets. • A greater number of children walking to school on a regular basis. • Children being driven to school had decreased. • High levels of compliance with the street closures. • Improved perceptions around feelings of safety, motorist compliance, and inconvenience associated with the restrictions from children and parents. • Improvement of air quality around schools. There appears to be momentum in London surrounding the enactment of school streets with enthusiasm from schools, Local Authorities and parents. **The Camden Healthy Schools Project** (funded by the TFL Future Streets Incubator Fund) provides a case study of the implementation and testing process. The school streets project was implemented following a public consultation process revealing 80% positive responses and support from the community. Signage closed the road up to the schools with bollards ensuring compliance. Outcomes: surveys indicated that driving to school fell dramatically following the street closure despite the closure only being in a 200m radius around the schools. Evaluations illustrated that the air quality on the street outside the schools significantly improved. The positive improvement on the number of children taking forms of active travel are suggested to be the largest impact on reducing driving trips across and in comparison to other schemes enacted by the local authority. Boroughs enacting school streets: Following two consultations in January/February Hackney is introducing two new school streets from spring 2019. They have piloted five and have one permanent thus far. Mayor of Hackney revealed ambition of another 12 school streets by 2022. Additional school streets are being added in across other London Boroughs including Southwark, Hackney, Camden, Dulwich, Islington, Croydon, Haringey. To achieve sustained change on a population wide scale, systems for funding, design and maintenance need to recognise the importance and prioritise children's well-being. If all funding schemes across London take a child's lens in how funding and support this will have positive benefit.

AMBITION 8: STOP UNHEALTHY MARKETING THAT INFLUENCES WHAT CHILDREN EAT

Action: *We call on the Mayor, Transport for London, London boroughs, sport clubs, stadia and leisure centres to extend the advertising restrictions on the TfL estate – initially to all outdoor public spaces in London, sports stadia and leisure facilities, and then beyond.*	
Rationale	There is a growing body of evidence that the more children are exposed to advertising for less healthy foods, whether on TV, on the internet, or via outdoor advertising, the higher the risk of increasing their consumption of those foods and of becoming overweight or obese. A report published in 2018 by Cancer Research UK found young people who recalled seeing junk food adverts every day were more than twice as likely to be obese (CRUK. 2018). The same study found 87% of young people found adverts for high fat, salt and sugar products appealing, with three-quarters tempted to eat a product after seeing such an advert. Recent research from the Institute for Fiscal Studies found that 50% of all TV ads seen by children (4-15 years of age) are for products high in HFSS (Institute for Fiscal Studies. 2018). Based on these findings, alongside other emerging evidence, from Feb 2019, Transport for London (TfL) banned junk food advertising. Food and drink brands, restaurants, takeaways and delivery services are only able to place adverts which promote their healthier products, rather than simply publicising their brands. The restrictions apply across TfL's advertising estate, this includes Underground, TfL Rail, Buses, Overground, Docklands Light Railway, roads (e.g. adverts on roundabouts and bus stops owned by TfL), River Services, Tram, Emirates Air Line, Victoria Coach Station, Dial-a-Ride and Taxi and private hire.
Evidence of effectiveness	Strong behavioural evidence is support by public support for action on restricting food advertisements. A study of public opinion leading into the ad ban revealed overwhelming public support with 82% of Londoners backing a full junk food advertising ban (TFL. 2018).

Evidence of effectiveness (continued)	In London, overall restrictions do not apply to sports stadia and leisure facilities. There is however significant reason to do so. A recent study revealed that 76% of food products shown in ads promoting a sports organization sponsorship are unhealthy and that 52.4% of beverages shown in sports sponsorship ads are sugar-sweetened (Bragg et al. 2018). There is recent momentum and action for the Taskforce to endorse and build off of. In 2018, Healthy Stadia and Sustain, the charity behind SUGAR SMART, drafted an open letter addressed to the FA, the Premier League and DDCMS, along with the other Home Nations FA's, asking them to reconsider future partnerships with companies promoting HFSS products, in particular the increasing prevalence of 'sports' drinks and 'energy' drinks partnering with football stakeholders. The letter was supported by hundreds of fans and members of the public, and over 60 experts in the field from clinical research, sustainability, local public health leads, oral health and from within sport itself (Healthier Stadia Organisation). Other cities globally which have successfully reversed childhood obesity rates have also enacted similar measures in sports stadia. The City of Amsterdam introduced a ban on adverts for unhealthy foods in sports stadium as part of its whole systems approach. The complex systems approach has seen child obesity fall by 12% overall and by 18% among the most deprived children since 2012 (AHWP.2019).
Action: *We call on the Consumer Goods Forum and shops and supermarkets to extend industry trials on healthier retailing to stop displaying unhealthy foods at the height of a small child's eyes or hands and work with academic partners to evaluate impact.*	
Rationale	Qualitative studies exploring shoppers' experiences grocery shopping in low-income neighbourhoods, identify poor placement and promotion of healthy items as potential barriers to purchasing these items (Zachary et al. 2013). The opposite is true for unhealthy processed foods which are often put in accessible, visible locations within a grocery store. In addition to these factors children play a significant role in food purchasing choices. Children exert significant influence on caregivers' purchasing decisions, and use this influence to promote specific grocery items (Powell et al. 2011). Other studies suggest that children influence purchasing more directly in the store, through requests and nagging for specific items (Henry et al. 2011). Characteristics of products influence what children are drawn to (often those marketed to children with bright colours, familiar cartoon characters, etc).

Evidence of effectiveness	Moving junk food out of children's reach and making healthier foods appear more enticing to children can enable healthier choices within a food purchasing setting (Wingert et al. 2014). This study (conducted in a low-income neighbourhood in Baltimore) illustrated that creating opportunities for children to interact with healthier foods may increase health purchasing by leading children to request healthier foods and allow them to try new products that their caregivers would not otherwise risk purchasing. Children in stores tend to request unhealthy items that they see throughout the store while shopping with their caregivers. Although some parents use strategies to mitigate the influence of children's requests, many parents give into requests in order to appease their children and prevent them from throwing tantrums. Across the evidence base there are not yet extensive trials evaluate the overall effectiveness and impacts of moving HFSS Foods off of shelves specifically at the height of a small child. Thus, within action by the Taskforce more broader efforts to encourage healthy consumption within retail settings should be considered. Emerging evidence reveals support for changes: **At the checkout:** Recent evidence from an evaluation at supermarkets in the UK demonstrated significantly reduced purchasing of common, less-healthy, checkout foods (sugary confectionary, chocolate and potato crisps) when a store had introduced a policy to place healthier items in checkouts (Eklerskov et al. 2018). **In serving sizes:** A recent evaluation from northern England worked with a wholesale provider to assess the acceptability of an intervention to promote smaller portions in Fish & Chip shops. Following the intervention which reduced portion sizes 7 of 12 shops reported increased sales of the smaller portion meals and of the customers surveyed 28% were unaware of the availability of smaller portion meals; 20% had bought smaller portion meals; and 46% of those who had not bought these meals were interested to try them in the future. This trial suggested that the sale of smaller meals is viable from both a business owner and customer perspective. **Systematic review:** Evidence of grocery store trials more broadly illustrates interventions that manipulate price, suggest swaps and manipulate item availability have an impact on purchasing of healthy foods and could play a role in public health strategies to improve health (Hartmann-Boyce et al. 2018). Positional promotions of unhealthy products within supermarkets have result in increased purchasing for children and young people (Cairns. 2015). Other trials and studies are currently being conducted to evaluate these influences across retail settings more extensively.

AMBITION 9: TRANSFORM FAST-FOOD BUSINESSES

Action: *We call on* ***takeaway and fast-food businesses*** *to restrict the sale of unhealthy items at times when unaccompanied children and young people are likely to visit.*

Rationale	Fast food outlets and QSRs play a significant, centre role in children and adolescent's food consumption in London. The number of QSRs in London is continuously increasing. The number of takeaways in London increased from 4,100 in 2010 to 8,273 in 2018. This is 61 takeaways per 100,000 of the population. Around four fifths of QSRs in London are independent outlets (Allegra. 2013). The number of QSR's children and adolescents have access to varies substantially by Borough. Newham for example, one of the three most deprived boroughs in London, has over 258 hot food takeaway outlets, of which 28% are fried chicken shops (Shift. 2017). There is significantly higher availability of QSRs within deprived boroughs across London (PHE. 2017). Qualitative studies have illustrated that the proliferation of fast food outlets, particularly the low cost, around schools and their homes consistently interferes and inhibits their efforts to get their children eat healthily (Rawlins. 2013). Beyond the high concentration and accessibility of QSRs in London, the marketing strategies of QSRs are particularly influential and often target children. A visible marketing strategy across high streets are discounted Kids meals, commonly priced and available between £1 – 1.50 (Shift. 2017).
Evidence of effectiveness	Generally, the evidence base indicates that restaurant or QSR based interventions have the potential to promote healthier purchasing and improve the nutrients consumed by children. A recent trial of 'healthier' children's meal options within a restaurant setting illustrated short term effectiveness (Ayala et al. 2017). As far as we are aware there are no trials up until this point to test the effectiveness of menu offers at specific times in a QSR setting. We do know that children and adolescents are highly influenced by the takeaway outlets within the area surrounding a school. The availability of fast food and takeaways on the way to school contributes to patterns of consumption in London children and adolescents. Students consistently cite buying take aways from fast food outlets and shops on the way to and from school. Thus targeting meal offerings directly in the times at which school ends in London has the potential to impact positive change (Pearce et al. 2009; Caraher et al. 2014).

Action: *We call on the London boroughs and the Mayor to step up support to small takeaway and fast-food businesses to enable them to become Healthy Catering Commitment accredited and to identify and trial tangible incentives to encourage them all to do so, with academic partners to evaluate impact.*

Rationale	The HCC aims to encourage businesses in the catering trade to reduce the levels of saturated fat, salt and sugar in foods, offer healthier options and/or smaller portions, and adopt healthier cooking and preparation practices by using the 'small changes make a big difference' principle. It also aims to raise awareness of the importance of providing healthier food choices and ideally lead to changes in consumption behaviour (London Gov. 2019). The Healthy Catering Commitment scheme is designed to be relatively easy for all types of catering establishments, including fast-food outlets, to sign up to, thereby encouraging take-up and providing a means of engaging businesses in the healthier catering agenda.
Evidence of effectiveness	The scheme currently operates across 24 London boroughs and is support by the Mayor of London. The maps included in this Sustain report outline participation across Boroughs in London (Sustain). As illustrated, there has not been uptake across all Boroughs in London and wide variation between establishments within each Borough. The establishment of clear rewards for those meeting the criteria will be helpful for pushing from establishments to sign up and work to provide healthier options.

AMBITION 10: FUND GOOD-FOOD INNOVATION AND HARNESS THE POWER OF INVESTMENT

Action: *We call on investment funders, the Mayor, London boroughs, established businesses and Guy's and St Thomas' Charity to support the development of a 'good food' investment fund.* **Action:** *We call on the Mayor to support the responsible investment case for solutions to unhealthy weight in childhood and encourage institutional investors to join the ShareAction Healthy Markets coalition.*	
Rationale	A large, and growing, proportion of children and families in London are living below the poverty line without access to healthy and nutritious food on a daily basis. The Good Food Investment Fund will help the Taskforce respond to this problem through a financing opportunity. An investment fund will provide support to private businesses working to establish products and outlets that provide London's children with access to healthier food options on a daily basis. Financing will prioritise companies with a focus on affordability and accessibility of healthy foods within deprived communities in London. Contributing to innovation within the sector will help to transform to food environments in communities across London. Analyses illustrate an array of benefits and public costs through financing and investment in healthy foods (UCSUSA. 2013). A Charter of Principles will enable the Taskforce to ensure and encourage common objectives and priorities of all participating businesses in the prioritisation of children's health and well-being.
Evidence of effectiveness	The positive impacts and potential of financing to drive innovation in healthy food production can be seen by looking at examples from other cities. Some of these include: **Michigan Good Food Fund:** is a $30 million public-private partnership loan fund that provides financing to good food enterprises working to increase access to affordable, healthy food in low-income and underserved communities in Michigan. The fund is focused and committed to support projects across the entirety of the food chain. Including businesses that grow, process, distribute, and sell healthy food. The fund provides flexible, patient capital to good food enterprises that would often overlooked by traditional banks. Lending is strengthened by business assistance to help entrepreneurs grow their ventures and prepare for financing. Impact: The fund (established in 2013) has invested more than $11 in goof food enterprises, supported 47 businesses with financing and assistance and created/retained 390 jobs across the state food value chain. **The New York City FRESH program (Food Retail Expansion to Support Health):** aims to provide nutritious, affordable, fresh food options in underserved communities with zoning and financial incentives to eligible store operators and developers. The program is administered by the New York City Industrial Development Agency (NYCIDA) and the New York City Department of City Planning (DCP), with support from the Department of Mental Health and Hygiene and Mayor's Office of Food Policy. **Impact:** Since its launch, over 20 projects have been approved and more than half have completed their construction and are open to the public. These supermarkets are expected to provide approximately 730,000 square feet of new or renovated space, are estimated to retain more than 600 jobs and create over nearly 1,000 new jobs, and represent an investment of approximately $100 million across the city. Stores opened across NYC with the fund can be seen on the city map here.