



What can be learned from the Amsterdam Healthy Weight programme to inform the policy response to obesity in England?

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Contributions

Research for this report was undertaken by SR and AI, guided by CH and RV who reviewed and synthesised findings. Substantial sections of this report are based on a report lead authored by CH and published in 2017 by IPES Food: “What makes Urban Food Policy Happen”. HR contributed as a consultant to the OPRU, commenting on the final paper.

Background

This report is the response to a request made to OPRU on 16 November 2017 by the Department of Health to answer the question: “What can be learned from the Amsterdam Healthy Weight programme to inform the policy response to obesity in England?” The report represents a “rapid response” to answer this question. We have highlighted areas where further exploration of the programme, especially in relation to its evaluation, would be useful but which was outside the scope of the current report given the time available. It is based upon previous investigations of the Amsterdam project undertaken by one of us (CH), telephone discussions with project staff, published information on the project website, and information relating to English cities to inform potential feasibility.

This report is divided into two sections. **Section A** outlines:

1. An overview of the Amsterdam Healthy Weight Programme (AAGG using the Dutch acronym)
2. How the AAGG relates to England’s child obesity strategy
3. The factors that enabled the AAGG’s development
4. Available data on the effects and costs of the programme, including where data are missing

Based on this review, and a distillation of the *transferable active* elements of the AAGG **Section B**, outlines the feasibility of piloting a similar programme in England. Outline feasibility is assessed for the 20 largest cities in England.

Note that this is a rapid response briefing paper, much data on the AAGG were not available (highlighted in the relevant sections) and some publications are only available in Dutch and could not be reviewed in the time available. The section on feasibility for English cities is based on a rapid high-level review of publicly available data.

Section A: Programme review

1. Overview of the AAGG

In 2013, the Amsterdam Healthy Weight Programme (AAGG) was introduced in response to childhood overweight and obesity rates that were substantially above the Netherlands national average; in 2013, 27,000 children in the city were overweight or obese, which constituted 21.0% of under-18s compared to 15.0% nationwide.¹ The prevalence of overweight and obesity in Amsterdam is spread unequally throughout the city and population,² with children of low income and educational status, and those from migrant and minority ethnic backgrounds particularly affected.³ In 2012, 21.8% of children of very low socioeconomic status (SES) were overweight or obese compared to 9.6% of children of very high SES; in terms of ethnic group, 29.9% and 22.9% of Turkish and Moroccan children respectively were overweight or obese compared to 8.7% of Dutch children.³

At the national level policies to address obesity in the Netherlands have included public awareness campaigns, educational initiatives, guidance for a voluntary front-of-pack logo, and a voluntary Healthy School Canteen programme.^{4,5,6} In addition, the Dutch government has promoted the reduction of salt, saturated fats and sugar in food products through a voluntary agreement with the food industry.⁷ A recent evaluation of this programme showed it had been successful for salt but unsuccessful for fats and sugars.⁸

This brief overview of national level action indicates a clear emphasis on education and voluntary measures. In contrast, the AAGG represents a structured, interventionist approach integrated across various departments of local government. A crucial aspect of the AAGG is that it is designed and delivered as an **urban-level policy**. That is, it is managed by a city-level authority, and leverages the powers held by local governments to effect change. Actions that can only be taken at the national level (e.g. marketing regulations) are excluded.

The key objectives of the AAGG are to reduce obesity by enabling children to eat and drink healthy foods, increase their physical activity, and have good quality sleep.¹ The principle running through the programme is that *the healthy choice should be the easy choice*. This concept acknowledges that eliciting behaviour change in a population requires consideration of the complex and multi-factorial determinants of childhood obesity. Consequently, the AAGG seeks to better understand the causes of obesity, including underlying psychological mechanisms, individual lifestyle factors, and living and working conditions, within the context of structural determinants.⁹ The programme seeks to stimulate cultural change by addressing these factors via what the Centre for Social Justice has termed a “whole-systems approach.”¹⁰

Initiation and Implementation

In 2012, the Epidemiology, Health Promotion and Care Innovation (EGZ) department of the Public Health Service of Amsterdam (GGD Amsterdam) analysed their most recent data set on childhood obesity in the city. They found what they considered to be “high levels” of overweight and obesity. 21.0% of under 18 year olds were overweight or obese, with higher prevalence among migrant groups. The GGD showed the data to the Deputy Mayor of Amsterdam responsible for public health, Eric van der Burg. Mr van der Burg (of the liberal-conservative People’s Party for Freedom and Democracy), shocked by what he learned, decided to prioritise the issue of childhood obesity in the city’s public health agenda. The City had the authority to act directly on public health as a result of the decentralisation of public health instituted by the Public Health Act of 2000.

Thereafter began the process of developing the AAGG. Executives governing the city formally committed to the AAGG by the end of 2012. It was implemented in 2013 and reauthorised after the municipal elections in 2015.

The Deputy Mayor stated at the outset that implementation should draw on existing resources from across city departments, to show what could be achieved through cooperation and taking joint responsibility. According to Hawkes and Halliday⁹ (p42) “directors of all departments were instructed to provide the programme manager — who was paid by the Department of Social Development — with any assistance required. An inter-departmental, multi-disciplinary team was assembled which included and joined together representatives from the Departments of Health, Housing and Social Support, Sports, and Work and Income;¹ collaborative working was also cross-sector and included schools, medical professionals, planning bodies, sports organisations, communities, charities, and the business sector.”¹⁰ The “Rainbow Model” of the determinants of health - that healthier behaviour results from a healthier environment - developed by Dahlgren & Whitehead was adopted as the basis of programme design.

The team initiated collaborative working with academics and experts on a range of issues, including the relationship between poverty and obesity, in order to better understand how layers of policy influence childhood weight and lifestyle factors.⁹ Once a model of cooperative and collaborative working had been established, a follow up plan was put in place which, from 2015 onwards, received annual funding of €2.5 million from the city budget, supplemented with short term funding for specific projects from central government totalling approximately €2.8 million per year.⁹

At the outset, the Department of Social Development was given overall responsibility for the programme rather than the Public Health Service, which indicated an appreciation that childhood obesity was not solely a public health issue and that responsibility for tackling the problem should be shared.⁹ In 2015, after the initial strategic phase, the responsibility for coordinating the project was transferred to the Public Health Service owing to their expertise in developing interventions and collecting health indicator data.⁹ An online platform was set up to monitor and provide evidence relating to outcomes; responsive action could then be taken depending on the effectiveness of given interventions. It is not clear which data are collected.

The programme combined long-term and short-term aims and used analogies about running to communicate these. The ultimate aim ('the marathon') was to eradicate childhood obesity over a twenty year period. Shorter aims were also clearly defined; by 2018 (the '5000m') the aim was that all children aged 0-5 years would be a healthy weight; by the halfway point (2023) the aim was that all children aged 0-10 would be a healthy weight; with the final aim (2033) of all under-18s being a healthy weight. The current (2017) mission ('5000m') which aims to be achieved within the current municipal term of office includes organising the city in a 'demonstrably healthy' way, making the heaviest neighbourhoods lighter, reducing the percentage of overweight or obese children in primary schools, and the population as a whole.²

Structure

The AAGG defines itself as having '7 guiding principles' and '10 pillars of action'. According to Hawkes and Halliday⁹ (p44) “some early inspiration was drawn from the French EPODE41 programme, known as JOGG in the Netherlands, a method that mobilizes the whole community in a collective effort to prevent obesity. However the team found that while EPODE is applicable in small communities, it does not provide a practical method for designing and implementing an integrated programme in a metropolitan context.”

Guiding principals

The 7 overarching principles guiding policies and programmes are the following:

- Eradicating overweight and obesity is a long term task that will take a generation
- The programme, actions and activities must be sustainable
- The programme is inclusive of all people and across all policy areas
- Addressing childhood obesity is a matter of shared responsibility
- The approach is evidence-based - ‘learning by doing, doing by learning’
- Choices must be made to focus efforts
- Prevention first, but do not forget children of the present

Ten pillars of action^{1,10}

The 10 pillars of action define the key elements of the AAGG. Notably, each pillar maps to an inter-departmental working party with responsibility for its implementation. The first six are aimed at preventing children from becoming overweight or obese, the seventh pillar is 'curative', and the final three were secondary or facilitative (see Table).^{2,9}

A range of policies have been introduced in response to specific objectives within the ten pillars, although we do not have data on which elements were already in place in Amsterdam and which were newly introduced in the AAGG.

To meet the complex needs of families, every neighbourhood has agreements and collaborative working between paediatricians, GPs, healthcare professionals, parent and child professionals, youth health care nurses, youth counsellors, welfare professionals, and community organisations. Collaborators take a coordinated approach with the aim of boosting family autonomy and self-management.

10 pillars of action of the AAGG	Policies and action:
<p>A. Preventative:</p> <p>1. A 'first 1000 days' approach (from the start of pregnancy until age two)</p> <p>2. Schools approach (including pre-schools and primary schools)</p> <p>3. Neighbourhood and community approach</p> <p>4. Healthy environment approach (healthy urban design, healthy food environment)</p> <p>5. Focus on teens</p> <p>6. Focus on children with special needs</p>	<ul style="list-style-type: none"> • Screening of infants for risk of obesity • Counselling for expectant mothers • Information provided to pregnant women about healthy diets • Mothers supported to breastfeed • Additional support for teenage parents and more deprived mothers • Making primary schools healthier places • Cycle routes have been made safer • After-school activities have been arranged for children • Subsidies for sports club membership for low income families

	<ul style="list-style-type: none"> • Community health ambassadors assigned • Working with supermarkets and local food suppliers to: modify menus and reduce portion sizes; manage stock better; create healthier checkout environments; use traffic-light labelling posters • Banning unhealthy food and drinks sponsorship of city sports events • Reducing the advertising of unhealthy foods in council-owned locations
B. Curative:	
7. Helping children who are overweight or obese to regain a healthier weight	<ul style="list-style-type: none"> • Assigning youth healthcare nurses • Drawing up care plans • Ensuring overweight and obese children receive an appropriate level of care • Communicating behavioural insights
C. Facilitative:	
8. Learning and research approach	
9. Use of digital facilities	
10. Use of communications and methodologies for behavioural insights	<ul style="list-style-type: none"> • Using an evidence-based approach • Observing interventions • Innovating digital tools • Introducing digital health coins • Exploring healthy sleep determinants, and assessing interventions

The first 1000 days

As part of the first 1000 days approach, the AAGG has provided screening of infants for risk of obesity and intensive counselling for expectant mothers deemed to be at an elevated risk. Through a smartphone app which monitors baby development, information has been provided to pregnant women about healthy diets and lifestyles; the AAGG has also supported mothers to breastfeed, although we do not have data on methods used. Medical professionals have helped to customise coaching programmes for future parents, and additional support has been provided for teenage parents and more deprived mothers, including the development of new pregnancy courses. Information has been given to families as to what constitutes a healthy breakfast, how to leave sugar out of their diet, and the importance of eating dinner as a family. Cooking classes have also been provided to teach healthier versions of various dishes; for example, pizzas with a broccoli base and kebabs with lean chicken instead of pork. Again, we do not have detailed data on many of the approaches used.

The schools approach

'Jump in' is a multi-level intervention, incorporating individual, environmental, and policy elements. The intervention began in 2002 at a national level with the primary objective of increasing physical activity and participation in sports but has been expanded in Amsterdam to include a focus on healthy diets.¹¹ In Amsterdam the overarching objective of 'Jump in' is to make primary schools healthier places. To receive 'Jump in' status, schools must fulfil eight requirements related to healthy eating:

- Recognise health as a long term priority
- Nutrition must be taught in class
- Birthday treats brought into school must be healthy (e.g. dried fruit, vegetables or fruit kebabs)
- Only water or milk can be drunk and healthy snacks to be eaten during breaks; fruit juice must not be brought into school
- Meetings must be held with parents to discuss healthy lifestyles

- Extra gym classes must be facilitated by trained teachers, with attention given to children's motor skills and development
- Children must be encouraged to be active when outside
- Appointments must be organised with child health services to measure school children's height and weight; additional appointments to be organised if anything unusual is found

Despite the programme being voluntary, over 100 of Amsterdam's 225 primary schools now participate.¹² Active support and guidance is provided in schools where the average BMI is higher than the national average (152 of the 225 schools, although it is unclear how many of these participate). 'Prevention scans' are carried out to assess schools against the eight requirements and coaches are appointed to work with schools to implement the requirements over a three year period. In some cases, implementation has been achieved in stages if schools chose to adopt a number but not all of the requirements. Advisors would continue to work with the schools to advocate the complete package and only when all eight requirements were met would the school achieve 'Jump in' status.

Since school meals are not provided in Amsterdam, work has been undertaken with parents to encourage them to provide a healthy packed lunch, typically a wholegrain sandwich and a piece of fruit.¹² While many parents reported liking the system, as the rules were simple and it was cheaper than providing pre-prepared snacks,¹² some were reluctant to change their habits. The response to this barrier provided a good illustration of 'learning by doing'; when fruit juice was withdrawn in schools, parents (believing their children were receiving less nutrients) began providing more juice at home, making the policy counterproductive. In response, educational meetings with parents were introduced, which successfully addressed the problem.¹³

Increasing physical activity

A range of policies have been introduced to encourage increased exercise and physical activity. Cycle routes have been made safer as part of a wider plan to make outdoor space more enjoyable, especially for children. After-school activities have been arranged for children, organised jointly by schools and sports clubs. Joining a sports centre has been encouraged and low income families have received additional support, including subsidies for membership. Facilities themselves have been made healthier; for example, by providing a healthier range of snacks. Physically active residents in low income areas have been further encouraged and can apply for subsidies for particular activities, such as healthy cooking classes.

The neighbourhood approach

After analysis of childhood overweight and obesity by area, priority neighbourhoods were identified and assigned a community manager to support the programme. Actions have been customised and localised based on the given area and working partnerships have been established with welfare organisations, civil society, minority ethnic organisations and local shops to promote healthy lifestyles. Over 200 community health ambassadors have also been assigned to initiate and support engagement in their network, provide useful information and support the needs of clients, including those accessing food banks.

Hawkes and Halliday⁹ (p48) discuss one example of a neighbourhood approach where one parent's question relating to activities for Mother's day led to an outpouring of ideas within the neighbourhood meeting in what would later be called an 'oatmeal revolution'. Dozens of women and organisations engaged in healthy and fun activities of preparing oat-based breakfasts and recipes with their children; the recipes were also extended to traditional Ramadan dishes.

Working with local business

The AAGG has also been working with supermarkets and local food suppliers to encourage them to increase the amount of healthy foods in their range. An intervention aimed at local shop and café owners has been piloted which seeks to change buying and eating habits by offering healthy options, modifying menus and

reducing portion sizes. Practical tips have been provided, such as better management of stock, so that offering healthier options does not necessarily equate to a drop in profits.

The AAGG recognised that the food industry was needed to help achieve the programme's goals. A working network was developed between the AAGG, the Amsterdam Health and Technology Institute, the Free University of Amsterdam, and Albert Heijn, the largest supermarket chain in the Netherlands, with 34.1% of the market share.¹⁴ The network has encouraged businesses involved in the production, supply and sales of food to make food products healthier; for example, by making portions smaller and reducing the amount of sugar, fat and salt in products. To be involved in the programme, supermarkets and shops were obliged to meet various requirements, including introducing healthier checkout environments in store and displaying large traffic-light labelling posters in soft and alcoholic drinks aisles; clearer labelling has also been adopted as part of a drive to establish a new common standard with clear guidelines to staying healthy (provided by the Netherlands Nutrition Standard).

Responsible marketing

The City was aware that marketing controls are a national level responsibility. However, they joined forces with the Alliantie Stop Kindermarketing (Alliance Stop Child Marketing), which has established a set of guidelines around appropriate marketing. The engagement stimulated the City to ban unhealthy food and drinks sponsorship of city sports events where more than 25% of audience are children. The Alliance also led a campaign to reduce the advertising of unhealthy foods, such as fries or ice cream, in council-owned locations, including all 58 metro stations around the city; while this latter policy was not a specific output of the programme, it was believed to be facilitated by the city-wide vision of the AAGG.

Digital development

The development of innovative digital tools for use by professionals, parents and children was identified as a key component of the programme. Various digital interventions have been introduced including digital health coins which can be earned by families and exchanged for discounts on health products. An online tool was also introduced - 'The Living and Action Plan', which has been used to set achievable goals for parents and children. Investigation has been conducted to better understand the accessibility of digital marketing for hard to reach groups, research has been carried out to evaluate the content and effectiveness of existing healthy lifestyle apps, and experiments have been undertaken to better understand unconscious interventions and the impact of behavioural 'priming'. At the time of writing, further details of these interventions and their effectiveness are not available.

The curative approach

Overweight and obese children have been assigned a youth healthcare nurse who works as a care manager and draws up a care plan with the child and their family; health insurance companies are required to pay for this care. While care for obese children has historically been a responsibility of health insurers, standards of care were not routinely implemented. The City Council took responsibility along with the health insurer Zilveren Kruis, a key collaborator of the AAGG, to ensure that overweight and obese children would receive an appropriate level of care.

Methodologies for behavioural insights

We identified limited information about activities under this pillar. The recent Centre for Social Justice (CSJ) report¹⁰ suggests that healthcare providers who have a central role in coordinating care between relevant professionals are responsible for gaining and communicating behavioural insights throughout the network. This action plan allows behaviour to be observed and managed, and contributes to the 'learning by doing' approach where interventions are halted or adapted if they are not having the desired effect.

Sleep interventions

Finally, to meet the last of the three overarching objectives of the programme, academic researchers and hospital sleep specialists have been developing a six-step sleep intervention plan for the Healthy Weight Programme. This includes an inventory of sleep behaviour in Amsterdam, an exploration of healthy sleep determinants, an assessment tool, a specifically developed intervention, and an implementation plan for the intervention. As with other elements, we do not have detailed information on the intervention nor its evaluation.

2. How the AAGG compares with England’s child obesity strategy

A review of the activities of the AAGG suggests that it contains no novel individual innovations and that most of the 10 pillars are, to a greater or lesser extent, in play in some local authorities (LAs) in England.

The Table below maps the AAGG pillars to elements of the UK Childhood Obesity Plan. Whilst the AAGG is a city-level activity and the Childhood Obesity Plan focuses predominantly at a structural/national level (e.g. sugar reduction), there are some common elements.

10 pillars of the AAGG	UK Childhood Obesity Plan
A. Preventative:	
1. The first 1000 days approach (from the start of pregnancy until age two)	Healthy Start Scheme
2. Schools approach (including pre-schools and primary schools)	Primary PE & Sport Premium Healthy Schools Rating System School Food Plan Support for Early Years Settings
3. Neighbourhood and community approach	Healthy options in public sector Cycling & Walking Investment Strategy
4. Healthy environment approach (healthy urban design, healthy food environment)	
5. Focus on teens	
6. Focus on children with special needs	
B. Curative:	
7. Helping children who are overweight or obese to regain a healthier weight	Making Every Contact Count
C. Facilitative:	
8. Learning and research approach	
9. Use of digital facilities	Supporting Innovation
10. Use of communications and methodologies for behavioural insights	Behavioural Insights

We note that the majority of the AAGG pillars map to services or programmes currently offered in different LAs in England, although an accurate assessment of this is beyond the scope of this review. For example, the

first 1000 days pillar maps to the routine universal midwifery and health visiting services still offered in most LAs, although these are now under threat in many LAs due to cuts to public health budgets.¹⁵ Other LAs offer specific early years programmes e.g. HENRY (<https://www.henry.org.uk>). Re schools, the NCMP operates in (nearly) all schools in England, with innovative school-based programmes in a number of LAs integrating the NCMP into activity programmes and family weight management programmes. Regarding the curative pillar, many LAs continue to offer family weight management clinical programmes, although these are also under threat. In terms of taking a learning approach, a number of LAs link with academic networks (e.g. NIHR CLAHRCs) in planning and evaluating their childhood obesity work.

We note that work with teenagers or with children with specific needs does not appear to map strongly to work in England.

3. Enablers of the development of the AAGG

Here we summarize the factors that underpinned the successful development of the AAGG. This information builds on previous published work on the AAGG undertaken by CH,⁹ which concluded that the development of AAGG was successful as a result of *how* it was developed and the structures put into place for implementation.

We outline seven components of the strategy that appear to have contributed to how it has been able to operate - essentially the 'enablers' of the AAGG. These are:

1. Strong vertical leadership
2. A collaborative, cross-departmental approach
3. Strategic use of power and influence
4. Clear parameters and expectations
5. An academically rigorous basis for action
6. A culture of reviewing, monitoring, and reflective action
7. A creative approach to addressing barriers

Under each component below is a description of the actions that demonstrate the enabler in practice and an explanation of what effect it has on the strategy's **operation** and **output**.

1. Strong vertical leadership

This was actioned in two main ways:

- Deputy Mayor Eric Van de Burgh demonstrated strong leadership, individually championing the AAGG and securing commitment from the rest of the council. The *effect* was to provide the impetus to overcome obstacles and see the programme to fruition.
- Management of the AAGG was initially placed in the Department for Social Development, taking it out of the remit of Public Health, a statement that obesity was an issue that extended beyond public health and should concern everyone. The *effect* was to pave the way for leadership and commitment from across the city.

2. Emphasis on a collaborative, cross-departmental approach

This was actioned in three main ways:

- Each aspect of the AAGG (the 10 pillars) is led by a cross-department working group, demonstrating strong horizontal leadership. This has three *effects*: all departments felt they were working towards the same goal and had joint responsibility for the AAGG's success; conflicts could be resolved at a high level; and the strategy could impact all the structures which shape risk of obesity simultaneously rather than only one or two.

- Collaboration rather than funding was prioritised – the first iteration of the strategy focused on building collaboration and commitment using existing resources rather than seeking additional funds. From 2015 funding was secured based on established priorities. The *effect* was to show that effective action is possible without significant extra funding, which enabled strong collaboration to be fostered independent of funding cycles. Where funding has been secured there has been a clear and specific use for it.
- There have been efforts to create strategies to combat interdepartmental conflict. At the start of the development of the AAGG tensions existed between different departments of the council. Instead of being ignored, these were addressed by bringing departments together to collaborate on small, tangible projects. Once a successful working model had been established and all departments recognised their role in contributing to obesity prevention, a process for interdepartmental collaboration was established. The *effect* of recognising tensions rather than ignoring them has provided an opportunity to move forward productively.

3. Strategic use of power and influence

This was actioned in three main ways:

- The Council was pragmatic about using its existing powers to drive action. Rather than concentrate on issues the city of Amsterdam has little control over (such as marketing or recipe formulation), the AAGG prioritises issues that local government has the power to address. The *effect* has been to focus time and energy on areas where tangible action is possible.
- Rather than seek broad industry engagement, the AAGG has chosen only to engage with those industry partners who are likely to make concrete efforts towards obesity reduction. The *effect* has been that the AAGG has not had to alter its priorities to accommodate industries that do not share a genuine commitment to preventing obesity, and time and energy can be spent engaging with partners who will be able to contribute to the goals of the AAGG.
- Although it is an Amsterdam-wide strategy, the AAGG has focused particularly on the communities considered to be most affected by obesity. The *effect* of this targeted approach has been that more resources can be focused where they can have the greatest impact and inequalities in obesity are reduced rather than widened.

4. Clear parameters and expectations

There is a recognition that eradicating child obesity is a long term project. However, to ensure there is continued buy-in, and to mitigate against the disruption caused by electoral cycles, the AAGG has established shorter term goals along the way (see programme description). The potential *effect* is if it can be demonstrated that the milestone goals are being achieved this may encourage continued buy-in from different sectors and across election cycles. This will then facilitate the achievement of the AAGG's long-term goal.

5. Academically rigorous basis for action

Several academics have been involved with the development of the AAGG from the outset, ensuring that strategy is built on a significant body of research and its underlying assumptions and theoretical basis are academically rigorous. The *effect* has been to lend the programme authority, and increase the likelihood that AAGG actions will achieve their intended outcomes.

6. Monitoring, reviewing, and reflective action

This has been actioned in three main ways:

- An in-house team regularly collects data on overweight/ obesity rates amongst children. The *effect* has been to make data is available with which to measure whether the strategy is reaching its targeted goals.

- An in house team constantly examines the impact each aspect of strategy is having and the results are fed in to adaptations to the AAGG, which is considered a work in progress. The *effect* of this 'learning by doing' method means that efforts are not wasted on programmes that are not having the desired outcomes, and any unintended consequences can be addressed.
- Regular community engagement explore how programmes are working in practice and enables the council to respond to community needs and perceptions. The *effect* has been that when strategies are not having their intended outcomes community engagement can help what barriers exist. Additionally individuals are more likely to engage if they feel their felt needs are being addressed.

7. A creative approach to addressing barriers

Where there have been obstacles, the AAGG has employed experimental approaches to overcome them. The *effect* has been that a route has been found round a number of barriers through the use of experimental methods (e.g., when efforts to engage industry were proving challenging, a strong business case for engagement was developed and this helped to bring industry members on board).

4. Effects and costs of the programme

Costs

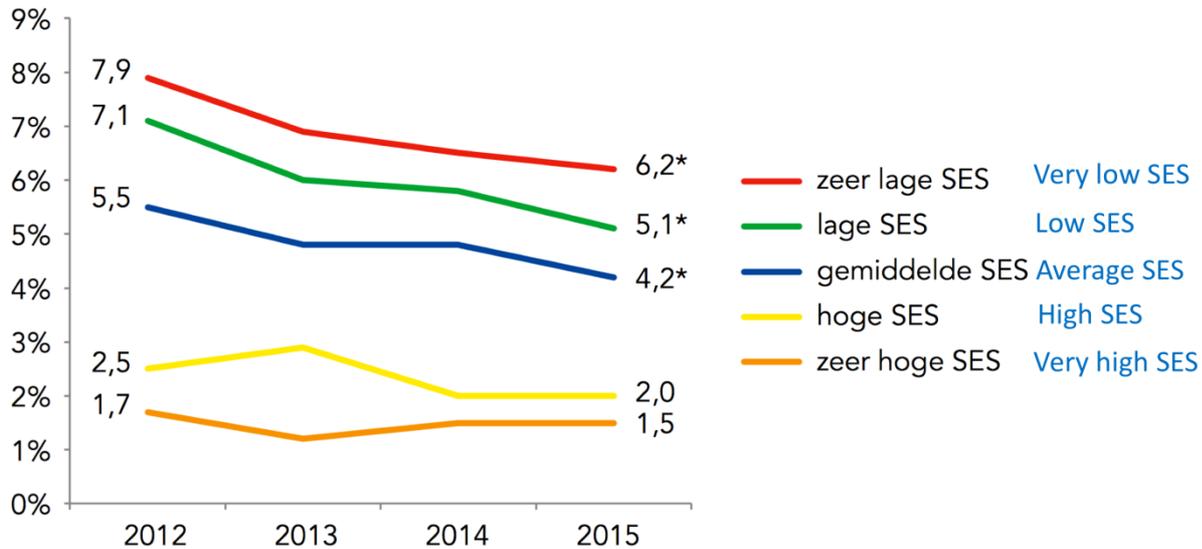
Between 2012 -2015 no additional budget was allocated to the programme. In 2015 annual funding of €2.5 million was assigned to the AAGG out of the city budget. This represents around 0.04% of Amsterdam's total annual budget of €6.3 billion. This has been supplemented by additional funds of around €2.81 million from the national government, mostly consisting of short-term funding for specific projects or objectives.

Outcomes and effectiveness

There are no direct evaluations of the effect of the programme on obesity prevalence in Amsterdam. However, the Public Health Service of Amsterdam monitors obesity prevalence. Between 2012 and 2015 obesity prevalence fell from approximately 8% to just over 6% in the most deprived group of children 0-18 years. The prevalence of combined overweight and obesity amongst children 0-18 years in Amsterdam fell from 21% to 18.5% over the same period; in absolute terms this represented a fall from 27,000 to 24,500 children with overweight/obesity, despite an additional 5,000 children in Amsterdam in this period.¹⁶

Figure: Trends in the prevalence of obesity by socioeconomic status (SES) for 5-10 year olds in Amsterdam (2012-2015). We understand that SES is defined by parental occupation although this needs confirmation.

Trend in de prevalentie van obesitas naar SES voor 5- en 10-jarigen (periode 2012-2015)



Source: Amsterdam Healthy Weight Programme: Outcome Monitor 2017
amsterdam.nl/aanpakgezondgewicht

This is a large effect when compared with the very small annual changes seen in English LAs in NCMP data, and also one that appears to be concentrated amongst the most deprived, with more affluent groups experiencing less decline.

There are however a number of issues with these data.

1. Absence of peer-reviewed outcome data

First, there are no peer-reviewed outcome data published from the AAGG, nor has there been an evaluation by an organisation independent or semi-independent from the Public Health Service. It was made clear to us that the publically available data showing an impact of the AAGG on obesity prevalence are based upon routine measurements of children that are considered largely accurate, with analysis undertaken by the city Public Health Service. However there hasn't been a detailed academic analysis of the data (personal communication, Prof. Jaap Seidell, Vrije University, Amsterdam).

2. Lack of detail

No data are publicly available on the sample sizes for the BMI trend analysis shown above, nor the sample sizes within the various SES bands. These data are needed to enable a critical appraisal of the trend data. The trends shown cannot therefore be assumed to be entirely reliable. However, the sample sizes are undoubtedly large. There are approximately 27,000 children and young people under 18 years in Amsterdam, who are weighed and measured approximately 13 times by the municipal system between birth and 18 years (address by Deputy Mayor Eric van der Burg, Portcullis House, London, 7 December 2017).

3. Causality cannot be established

It is not possible to directly attribute the presented falls in obesity prevalence to the AAGG. There may have been shifts in other factors linked with obesity that have contributed to the fall in obesity, such as shifts in the socioeconomic make up of city districts (e.g. 'gentrification'), shifts in ethnicity in districts over time or the effects of other policies or programmes (e.g. the national JOGG programme (Jongeren Op Gezond

Gewicht, translated as Young People at a Healthy Weight; www.jogg.nl). Those within the AAGG programme recognise that the available outcome data are insufficient to prove that the decline is the direct result of the programme, though as noted above, it is believed to indicate the programme is “promising” given that rates of decline are more rapid than the rest of the Netherlands.

Unanswered questions

In the month available for this report, we have not been able to identify sufficient detail on each of the activities under the 10 pillars of action. However we welcome clarification regarding these data. Further detailed work would be needed to fully understand the theoretical underpinning of interventions and methods used, e.g. for promotion of breastfeeding or for family education, and to understand to what extent these differ from methods used in the UK.

Community engagement is an essential part of the programme. However, more details are needed as to the level to which children, young people and families are actively involved, and how.

The limitations relating to data are as noted above. The extent to which data on the impact of the programme on elements other than childhood BMI are available is uncertain.

Section B: Feasibility of implementing an AAGG style programme in England

A full assessment of the feasibility of implementation of the AAGG is beyond the scope of this rapid response briefing paper. We restrict our analysis to i) the identification of key factors likely to influence feasibility; and ii) to illustrating potential English cities where, *prima facie*, feasibility of implementation could be investigated further. The 20 largest English cities are considered in this feasibility assessment and presented in Table x. Feasibility was considered according to three sets of factors: i) demographic, ii) *transferable active* elements based on learning from the AAGG, iii) political and community interest in obesity.

i) Demographics

Feasibility assessment commenced by identifying three demographic factors that we believe are relevant to pilot site selection. Data were obtained on the following three demographic indicators.

Size: It is possible that the success of the AAGG may have some relationship to city size i.e. that the size of Amsterdam (820,000 population) allows a balance between action at scale and the ability to influence industry (requiring a larger metropolis) on the one hand, with the coherence and responsiveness potentially available in smaller cities on the other. There is no clear evidence to support this, however we suggest that it is likely that a city size roughly comparable to Amsterdam might be the most feasible in which to pilot the AAGG.

Childhood obesity prevalence: Feasibility is likely to be higher in cities with a higher prevalence of childhood overweight and obesity and where this is seen as a problem. Note that the prevalence of childhood overweight and obesity in Amsterdam for ≤ 18 year olds is around 18%, compared to a national average for the Netherlands of around 13%.

Deprivation: A key feature of the AAGG has been its proportionate universalism approach, with a focus on more deprived communities. We suggest that a city with significant levels of deprivation would therefore be appropriate.

ii) Potential to implement 'active transferable' elements

The review of the AAGG in section A of this report provides detail on both the *what* and the *how* of the programme. We believe that whilst collective approaches to community obesity prevention have been tried elsewhere, it appears that it is the 'how' rather than the 'what' that has made the AAGG programme a case study of international interest, particularly how it was politically led.¹⁰ Through a synthesis of the information in Section A, we have distilled seven *transferable active* elements that underpin the programme. We suggest that a city's capacity to integrate these elements has important implications for feasibility. We have therefore developed a further set of indicators based on these seven elements.

1. Strong political and personal commitment by senior city politician; the CSJ report¹⁰ also identified political leadership as the key 'ingredient' driving the success of the AAGG.
2. Long term vision, understanding that it is not an overnight process
3. Multiple actions taken throughout government not only within public health sector; all departments are required to contribute through their policies
4. Combination of government led approach - setting top down standards - with community engagement - engagement and listening to the community; engage with them to solve the problems
5. Norm and values used: a shared belief is that obesity in children is unhealthy and it needs to be addressed. Everyone is responsible for taking action; belief that change can happen.
6. Meet people where they are: starting points are the deprived neighbourhoods (targeting)
7. Learning approach mentality: solid evaluation and monitoring is important - "learning by doing"

For this briefing paper, we could only comment on the potential ability to implement key active factors from a review of i) the political form of the city LA, using the presence of an elected mayor as a proxy for the potential for strong political leadership; and ii) a rapid review of LA policies and programmes relating to obesity and key issues such as healthy food and physical activity. The latter included an assessment of evidence of academic collaborations with LAs relevant to a capacity to monitor impacts of programmes. Note that these data are very high-level, using data available on the internet (see Appendix 1 for sources) as proxies for a range of important factors, and we recognise that this approach may miss some childhood obesity policies and programmes that do not have a web presence.

iii) Political and community interest in obesity

Priority given to obesity prevention: Feasibility is likely to be greater in cities with a history of according high priority to childhood obesity prevention. Additionally, we noted that it is likely that the long cultural history of public health activism in Amsterdam is relevant to the apparent success of the AAGG. We therefore note whether city and civil society efforts are already prioritising obesity prevention.

Limitations of feasibility assessment

We note a number of limitations to this feasibility assessment. As regards the *transferable active elements*, the degree to which these elements are transferrable to cities in England is unclear, however, and requires more analysis to assess the transferability of the programme. Amsterdam also presents a specific context which is likely to influence what is transferable. Notably:

- Political leadership of the AAGG came from a charismatic and powerful deputy Mayor who i) helped initiate the project and has an enduring personal commitment to it; ii) enabled the project through his personal influence, his simultaneously holding key city portfolios (e.g. health plus others e.g.

sport); and iii) enabled the project to obtain significant funding. The extent to which this could be replicated by LA political leaders, e.g. Mayors/Metro Mayors, in England is unclear.

- Amsterdam has a very well-established culture of community action, particularly relating to children and health; e.g. the School Gardens have been part of city life for over 90 years. Those involved with the AAGG note that Amsterdam has a very different cultural history to other large Dutch cities, e.g. Rotterdam, and acknowledge that it is unclear how transferrable the programme would be to other Dutch cities let alone cities outside the Netherlands.

Lastly, a city's prior work on obesity prevention may both facilitate and hinder a pilot. It could be argued that English cities with a history of giving priority to childhood obesity prevention are likely to have a high degree of prevention activity already underway, and that this may interfere with any piloting of an AAGG-like programme. However as noted above it would be important for an AAGG-like pilot to embrace and synergise with current activities.

Feasibility by city

Using these considerations, we illustrate how England's 20 largest cities map to these feasibility factors. Online searches were undertaken using City Council and LA public health web pages. For the childhood obesity focus markers, specific search terms were used for the various measures (e.g. 'obesity plan' or 'childhood obesity steering group'). For the transferable and feasibility elements, key terms were searched (e.g. obesity and healthy weight) and results were ordered for relevance. Search results relating to current policies and practice (including webpages, published documents, reports, presentations and meeting records) were reviewed for relevant text. Positive or affirmative judgements were given where policies and actions corresponded to the given element (for examples of relevant text, see Appendix 1). The sustainable cities webpage was used and general web searches were carried out to supplement these searches for each city in order to ascertain the level and nature of community action. Note we excluded London from this exercise due to its very large size (>8 million) and complex health and political landscape.

We summarize these in the Table below. The Table shows:

- A. Demographic, childhood obesity prevalence and governance data
- B. Evidence for an LA focus on childhood obesity
 - a. LA has a childhood obesity plan, and date of last update
 - b. clear engagement with measurement through the National Child Measurement Programme (NCMP)
 - c. Obesity is listed as a Public Health priority
 - d. Obesity is listed as a Joint Strategic Needs Assessment (JSNA) priority
 - e. Presence of a Childhood Obesity Steering Group
 - f. City is signed up to Sustainable Cities
- C. Evidence that the 7 potentially transferrable 'Active elements' of the AAGG are operating in the LA
- D. Evidence for other feasibility elements
 - i. undertaking a cross-departmental approach
 - ii. civil society engagement in childhood obesity prevention
 - iii. academic collaboration
 - iv. capacity to monitor

Where data are unavailable for section B, we show a '?'. For sections C and D we only show where we found evidence to support the presence of the element.

Data shown in the Table suggest that larger cities with the greatest evidence for potential feasibility according to these criteria include Birmingham and Bristol. Leeds, Manchester and Liverpool also have available evidence in a number of domains. Note that few smaller cities have a mayor or metro mayor. Amongst the smaller cities, Brighton and Southampton appear to have the greatest evidence for potential feasibility.

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Population rank	City (UK)	Population			Childhood overweight/obesity		Governance		Childhood obesity focus markers							Transferrable active elements relevant to AAGG						Other feasibility elements							
		ONS mid-2016	% of LSOAs in top IMD decile	% black & minority ethnicity	% Ov+Ob 4-5s	% Ov+Ob 10-11s	IMB / UA / MD	Elected mayor	Signed to Sustainable Cities	Council Obesity plan	Plan last updated	NCMP engagement	Obesity: PH priority	Obesity: JSNA theme	CO steering group	Political commitment	Long term vision	City level action	Top down + community	Norms/values	Targeting deprivation	Learning approach	Horizontal/cross-department approach	Civil society /organisations	Academic collaboration	Capacity to monitor			
1	Birmingham	1,124,569	39.6%	42.1%	23.8%	39.9%	MB	Y (WM)	P	P	2017	P	P	P	P	P		P	P		P	P	P	P	P	P	P	P	P
2	Leeds	781,743	21.8%	14.9%	21.4%	35.4%	MB	N	P	P	2017	P	?	?	?	P	P	P					P	P		P	P		
3	Sheffield	575,424	23.5%	16.3%	22.3%	34.3%	MB	Y	P	P	2014	?	?	?	?			P						P				P	
4	Bradford	534,279	32.6%	32.6%	21.1%	36.4%	MB	N	P	?	2011	?	P	?	?			P											
5	Manchester	541,263	40.8%	33.4%	24.9%	40.2%	MB	Y (GM)	P	?	?	?	P	P	?		P	P				P						P	
6	Liverpool	484,578	45.0%	11.1%	25.6%	39.8%	MB	Y	P	P	2014	?	?	P	?			P									P		
7	Bristol (UA)	454,213	16.0%	16.0%	22.9%	35.6%	UA	Y	P	P	2017	P	P	P	P	P	P	P			P		P	P	P	P	P	P	
8	Leicester (UA)	348,343	24.0%	49.5%	20.4%	37.3%	UA	Y	P	P	2016	?	P	P	?	P	P	P			P				P				
9	Wakefield	336,834	14.4%	4.6%	22.0%	35.6%	MB	N	O	P	2016	?	?	P	?														
10	Coventry	352,911	18.5%	26.2%	22.4%	37.5%	MB	N	O	P	2017	P	P	P	?		P	P								P			
11	Nottingham (UA)	325,282	33.5%	28.5%	25.5%	37.0%	UA	N	O	P	2011	P	P	P	?	P	P	P			P	P				P			
12	Newcastle u Tyne	296,478	22.3%	14.5%	24.1%	38.8%	MD	N	P	P	2014	?	?	?	?			P			P		P	P		P	P		
13	Sunderland	277,962	19.5%	4.1%	23.9%	39.8%	MB	N	O	P	2015	?	P	P	?			P											
14	Brighton (UA)	289,229	10.3%	10.9%	19.8%	26.1%	UA	N	P	P	2015	P	P	P	?	P	P	P	P	P			P	P		P	P		
15	Hull (UA)	260,240	45.2%	5.9%	27.9%	37.4%	UA	N	P	P	2014	P	?	P	?														
16	Plymouth (UA)	264,199	16.8%	3.9%	24.6%	29.6%	UA	N	P	?	?	P	?	P	?										P	P			
17	Wolverhampton	256,621	25.9%	32.0%	25.3%	40.3%	MB	Y	O	P	2014	P	P	P	?														
18	Stoke (UA)	253,226	30.2%	11.4%	26.3%	37.8%	UA	N	P	P	2015	P	P	P	?		P	P	P					P	P				
19	Derby (UA)	256,233	18.5%	19.7%	21.7%	36.7%	UA	N	O	?	?	?	?	P	?														
20	Southampton(UA)	254,275	12.8%	14.1%	22.2%	36.7%	UA	N	O	P	2016	P	?	P	?		P	P	P		P	P		P	P		P	P	

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Table Notes:

Abbreviations

MB: Metropolitan Borough; UA: Unitary Authority; MD: Metropolitan District

WM: West Midlands; GM: Greater Manchester

CO: Childhood obesity

Table data sources: Data for population are taken from the Office for National Statistics (ONS). Childhood overweight/obesity prevalence data are taken from the NCMP. Data for Childhood obesity focus markers were taken from LA public health websites. Data for Transferrable active elements (TE) were taken from LA public health websites, Director of Public Health reports and public health publications. Key feasibility elements were taken from all of the above together with community action and individual project webpages.

Conclusions and recommendations

There is understandably a great deal of interest in the AAGG and its potential for application to cities in the UK.

The programme appears to have some success in reducing childhood obesity, although a peer-reviewed analysis has not been published and changes in obesity cannot be causally attributed to the programme.

The AAGG is made up of a combination of activities that are predominantly evidence-based and are recognised elements of many childhood obesity prevention programmes. Many, if not all, of these are already in place in many places in the UK, although levels of integration of activities differ. The 'how' of the programme in terms of enabling, embedding and operation appear to be more important than the 'what' of individual activities. We have identified key enablers and 'active learnings' that early studies indicate may be responsible for the programme's success. These include but go beyond political leadership and adequate funding.

We suggest that the programme merits closer investigation to clarify activities and data, along with investigation of transferability of how actions were designed and of the structures through which they were implemented. Greater detail than has been possible in this brief report should be obtained before piloting can be considered. Piloting in England would best be undertaken in a small number of carefully selected sites, with additional work needed to understand feasibility and complementarity with local work. The focus of piloting should be on the AAGG overall programme coordination and leadership, cross-city action, community engagement, and their policy enablers, rather than implementation of a series of actions drawn from individual AAGG elements. It will be important to give any such pilots a fair chance of success by ensuring adequate funding, over a sufficiently long time frame, with an appropriate integrated evaluation.

Appendix 1 - transferable and feasibility elements - data sources

Birmingham		
Element	Relevant text	Sources
TE: Political commitment	The Birmingham Food Council will oversee and report on the coordination of actions to deliver priorities.	https://www.birmingham.gov.uk/info/50120/public_health/1337/jsna_themes/8
TE: City level action	Birmingham Food Council CIC was established in March 2014, with grant funding from Birmingham Public Health. Its work is guided by the Birmingham Food Charter which aims to improve the health of Birmingham’s residents, its economy and its environmental sustainability.	http://www.birminghamfoodcouncil.org/wp-content/uploads/2015/01/Food-and-the-city-economy_InterimReport_Dec2014.pdf
TE: top down + community	The Birmingham Food Charter is a high level statement of a vision and the key priorities to deliver that vision.	http://sustainablefoodcities.org/findacity/cityinformation/userid/27
TE: Targeting deprivation	We have set up and are leading a project to scope a city-wide strategic response to the challenges presented by food poverty, notably emergency food provision (e.g. through food banks) in partnership with the Ashram Housing Association and the Trussell Trust.	http://sustainablefoodcities.org/findacity/cityinformation/userid/27
TE: Learning approach	Evidence-based means to help all citizens eat healthily.	http://www.birminghamfoodcouncil.org/wp-content/uploads/2014/08/BirminghamFoodCharter_Summer2014.pdf
Horizontal/cross-department approach	We will encourage entrepreneurial engagement in the local food industry. There are clear tensions between the political desire to attract investment to the local food industry through initiatives such as the Food Hub zone and to support local businesses and the health and social issues caused by obesity and increasing levels of food poverty and poor enforcement of food standards in Birmingham.	http://www.birminghamfoodcouncil.org/wp-content/uploads/2015/01/Food-and-the-city-economy_InterimReport_Dec2014.pdf
Civil society/organisations	Schools are working on FoodforLife partnership. Birmingham Open Spaces Forum supports food growing initiatives in a variety of open spaces across the city. Birmingham is part of Food Smart Cities (Universities West Midlands Collaboration: establishing the “food-smart City” concept). FoodNet has been operating in Birmingham since 2000, promoting food skills and knowledge.	http://sustainablefoodcities.org/findacity/cityinformation/userid/27
Academic collaboration	International Panel of Experts have research and/or professional experience relevant to our work.	http://www.birminghamfoodcouncil.org/about/who-we-are/panel-of-experts/

Leeds		
Element	Relevant text	Sources
TE: Political commitment	2017/18 priorities. We will continue to implement the Leeds Child Healthy Weight Plan with actions for 2017/18 including: increasing the availability for HENRY (Health Exercise and Nutrition in the Really Young) Group and one-to-one support for parents in the early years; HAPPY – a new intervention to tackle maternal obesity; and the Healthy Start in Childcare initiative.	http://www.leeds.gov.uk/docs/Best%20Council%20Plan%202017-18.pdf
TE: Long term vision	20 objectives for 2020 (including obesity levels at age 11).	http://www.leeds.gov.uk/phrc/Documents/Childhood%20obesity%20forum%2024%20Sep%202013.pdf

TE: City level action	Leeds Food Partnership (LFP) was established by Feed Leeds, Leeds City Council, and food organisations across Leeds to promote a new strategic approach to sustainable, healthy and affordable food in the city.	http://sustainablefoodcities.org/findacity/cityinformation/userid/31
Horizontal/cross-department approach	Building on the range of council and partnership strategies in place and in development, the update sets out interconnected priority areas of work that, taken together, will deliver better outcomes for everyone in Leeds:	http://www.leeds.gov.uk/docs/Best%20Council%20Plan%202017-18.pdf
Civil society/organisations	'Feed Leeds'. Food Officer also appointed through Sustainable Food Cities.	https://oneyouleeds.co.uk/eat-well/

Sheffield		
Element	Relevant text	Sources
TE: City level action	The diversity of both long established and newly emerging food and drink related activities taking place across Sheffield is entering an exciting new phase of development. The Sheffield Food Strategy 2014-17 set out what Sheffield City Council and partners aimed to do between 2014-17 to improve the local food system.	https://www.sheffield.gov.uk/content/sheffield/home/schools-childcare/healthy-early-years.html
Civil society/organisations	A willingness to share learning on food policy with other UK cities and make positive change happen is increasingly apparent in the Council and other key city institutions.	http://sustainablefoodcities.org/findacity/cityinformation/userid/387
Capacity to monitor	Measure - develop a set of indicators that will help measure the positive impacts of implementing the food plan and guide future direction (Oct 17 onwards)	http://sustainablefoodcities.org/findacity/cityinformation/userid/387

Bradford		
Element	Relevant text	Sources
TE: City level action	Cook and eat programmes are running in a range of community venues across the district. Bradford's Food Strategy is coordinated by Bradford Council, working with a range of partner organisations. The Strategy aims to strengthen local food networks in ways that promote environmental sustainability, food security, social equity, economic prosperity, fair trading and the health and well-being of all residents.	https://www.bradford.gov.uk/health/improve-your-health/healthy-eating/ http://sustainablefoodcities.org/findacity/cityinformation/userid/20

Manchester		
Element	Relevant text	Sources
TE: Long term vision	We will strengthen our input to the Reducing Childhood Obesity in Manchester (RCOM) programme to ensure that there is a co-ordinated approach across all partner agencies and clear milestones for improvement over the medium to long term.	http://www.manchester.gov.uk/downloads/download/6794/public_health_annual_report_2016-2017
TE: City level action	Food Futures is a city-wide strategy and programme to improve the health and sustainability of food in Manchester. It is coordinated by Public Health Manchester based within Manchester City Council.	http://sustainablefoodcities.org/findacity/cityinformation/userid/46
TE: Learning approach	To make a meaningful difference and reduce avoidable inequalities in health, we need to tackle not just the	https://www.gmcvo.org.uk/sites/gmcvo.org.uk/files/Mapping%20Food%20Poverty

	health problems but the determinants of those problems (the 'causes of the causes').	%20and%20Food%20Deserts%20in%20Gr eater%20Manchesterv6.pdf
Civil society/ organisation	A new Manchester Food Board has been established, involving a range of cross sector partners, to lead on the Manchester Food Board priorities and drive forward activity for the City	http://www.manchester.gov.uk/meetings/meeting/1917/council
Capacity to monitor	We have expertise in sourcing, analysing and synthesising the data, information and evidence required to understand the needs of the population, and we redesign, monitor and evaluate locally commissioned services. We also support teams and organisations to access and contribute to the local and national evidence base and help to translate this knowledge into actions that will improve the health and wellbeing of Manchester residents.	http://www.manchester.gov.uk/downloads/download/6794/public_health_annual_report_2016-2017

Liverpool		
Element	Relevant text	Sources
TE: City level action	The Liverpool Food People is a network of food growers, composters, buyers, cooks and eaters passionate about a positive healthy food culture for Liverpool. The LFP is third sector led, with members currently hailing from Food for Thought; healthy school meals caterer; Fareshare Merseyside; Health Equality Group (Heart of Mersey); Faiths4Change and arts and health enterprise Squash Nutrition with support from NHS Liverpool CCG, and Liverpool City Council.	http://www.sustainablefoodcities.org/findacity/cityinformation/userid/44
Civil society/ organisation	Food for Thought (Merseyside) Ltd. is a unique 'not for profit' healthy school meals caterer. It is a company owned and managed by its partner schools with any surplus created being re-invested in our local community schools.	http://www.foodforthoughtliverpool.co.uk/ http://fareshare.org.uk/fareshare-centres/merseyside/

Bristol (UA)		
Element	Relevant text	Sources
TE: Political commitment	Public Health Bristol: Vision and Priorities 2017 to 2019 - Develop a city wide all age approach to healthy weight including sugar smart.	https://www.bristol.gov.uk/documents/20182/848009/Public+health+vision+2017+to+2019/e8e8ab69-ca50-4eab-85d4-2753cf1255d6
TE: Long term vision	Acknowledgement that 'Long term sustainable change will only be achieved by the active engagement of schools, communities, families and individuals'.	https://www.bristol.gov.uk/documents/20182/1655362/Healthy+Weight+-+Children+%26+Young+People+-+JSNA
TE: City level action	The Bristol Food Policy Council is a partnership of community, public and private organisations representing the interests of the whole food sector, including the long-established Bristol Food Network.	http://sustainablefoodcities.org/findacity/cityinformation/userid/36
TE: top down + community	Bristol City Council and NHS Bristol, working in partnership with business and charities involved with processing, growing, distributing and selling food. This includes waste management – whole system approach.	https://www.bristol.gov.uk/documents/20182/32619/Who-feeds-Bristol-report.pdf
TE: Targeting deprivation	Reducing health inequalities as part of the healthy weight strategic plan. What Does the Evidence Tell Us about food Poverty:?	https://www.bristol.gov.uk/social-care-health/get-involved-in-the-great-weight-debate

		http://bristolfoodpolicycouncil.org/food-poverty-what-does-the-evidence-tell-us/
Horizontal/cross-department approach	The Food Policy Council has adopted a whole systems framework in its approach to changing the food culture in the city, beginning with baseline research into our current food system – the ‘Who Feeds Bristol?’ report.	http://sustainablefoodcities.org/findacity/cityinformation/userid/36
Civil society/organisations	We’re inviting citizens, businesses, schools and organisations across the city to help us develop and implement a new Healthy Weight Strategic Plan.	https://www.bristol.gov.uk/social-care-health/get-involved-in-the-great-weight-debate
Academic collaboration	Food and planning developmental review.	http://bristolfoodpolicycouncil.org/wp-content/uploads/2014/07/WHO-Food-and-Planning-Review-BCC-040614.pdf
Capacity to monitor	In 2013, the Good Food Plan for Bristol was launched. This sets out 8 themes for changing the food system. The Bristol Food Policy Council, established in 2011, will measure progress towards achieving changes.	http://bristolfoodpolicycouncil.org/what-do-we-know-about-the-state-of-good-food-in-bristol/

Leicester (UA)		
Element	Relevant text	Sources
TE: Political commitment	Leicester's Food Plan marks the start of a long term programme to make Leicester a healthy and sustainable food city.	https://www.leicester.gov.uk/your-council/policies-plans-and-strategies/environment-and-sustainability/leicesters-food-plan/
TE: Long term vision	The Food Plan sets out 10 long term ambitions in an updated Food & Drink Charter.	http://sustainablefoodcities.org/findacity/cityinformation/userid/21
TE: City level action	Support for at least nine more community food and horticulture projects. At least 3900m ² of new allotments. Help for families, children’s centres, nurseries and schools including healthy nutrition and cooking skills sessions. Support for food businesses looking at the health and sustainability of the food we buy.	https://www.leicester.gov.uk/media/178765/leicesters-food-plan-2014-16.pdf
TE: top down + community	The plan has been developed by the city’s Food Plan Board – a partnership between the City Council, the voluntary and community sector and the business community, chaired by the Deputy City Mayor.	http://sustainablefoodcities.org/findacity/cityinformation/userid/21
TE: Targeting deprivation	In Leicester we know there are important challenges including: Unacceptable levels of food poverty.	https://www.leicester.gov.uk/your-council/policies-plans-and-strategies/environment-and-sustainability/leicesters-food-plan/
Civil society/organisations	Saffron Acres Project; Eat Better, Start Better; Indoor Market redevelopment; Community Harvest Whetstone Over 20 community projects are supported by the Council’s Parks Service; Leicestershire Food Links; other projects include FareShare Leicester, Fairtrade City.	http://sustainablefoodcities.org/findacity/cityinformation/userid/21

Wakefield

Coventry		
Element	Relevant text	Sources
TE: City level action	Coventry City Council is committed to working to combat the issue of childhood obesity and encouraging healthy eating for families to help reduce health inequalities in the city.	http://www.coventry.gov.uk/news/article/1997/change4life_hits_the_road_in_coventry_to_help_families_be_food_smart

TE: top down + community	Public services like the City Council, the Clinical Commissioning Group and others commission a whole range of organisations which serve food to children and families – often those at greatest need.	file://ad.ucl.ac.uk/home9/sejjsr9/Documents/Shape Up annual report Public Health low res .pdf
Civil society/ organisations	The response needs to be multi-faceted from changing the environment via policy to make healthy eating and physical activity a more natural choice in Coventry, through to the individual support that children who are obese need (and all the levels in between). This needs a multi-agency response	http://www.coventry.gov.uk/downloads/file/17699/childhood_obesity

Nottingham (UA)		
Element	Relevant text	Sources
TE: Political commitment	It is appropriately ambitious, putting the health of every citizen at the centre. If we achieve our objectives, we will have every right to feel proud of Nottingham as a healthy place to live. Achieving our targets could save 280 lives by 2020, as well as bringing wider health benefits to the people of Nottingham.	http://www.nottinghamcity.nhs.uk/images/stories/docs/PubHealthdocs/final_merged_healthy_weight_strategy_with_appendices1.pdf
TE: Long term vision	Healthy Weight Strategy for Nottingham 2011-2020:	
TE: City level action	Tackle the ‘obesity promoting’ environments in which our citizens live, play, learn and work. The Nottingham Plan is the City’s Sustainable Communities Strategy which provides the overarching vision and direction for all the City’s public strategies and plans.	
TE: top down + community	This strategy takes into account the local leadership and action and builds on the Nottingham City child obesity strategy.	
TE: Targeting deprivation	Social issues are important determinants of obesity in children and adults. Addressing deprivation through broad action across the One Nottingham Partnership will improve health, including healthy weight. Economic factors can influence an individual’s ability to choose a diet that is lower in fats and sugars and access opportunities to be physically active.	
TE: Learning approach	An Evidence Based Approach: The evidence is very clear that policies aimed solely at individuals will be inadequate and that simply increasing the number or type of small-scale interventions will not be sufficient to reverse the trend. We need significant effective action to prevent obesity at a population level targeting elements of the obesogenic environment as well as improving nutrition and physical activity in individuals.	
Civil society/ organisations	Interventions are broken down into universal (policy, transport and built environment etc.), targeted (working with at risk groups), and specialist (mainly curative for overweight and obese children and adults).	

Newcastle upon Tyne		
Element	Relevant text	Sources

TE: City level action	Over the next three years the council will be working with Food Nation and schools, charities and restaurants to transform access to local, affordable and sustainable food for people across the city.	https://www.newcastle.gov.uk/health-and-social-care/health-and-wellbeing/healthy-eating
TE: Targeting deprivation	We will continue to convene a cross-sector food poverty working group to develop solutions to the root causes of food poverty and in so doing, reduce the demand for emergency food aid.	http://sustainablefoodcities.org/findacity/cityinformation/userid/41
Horizontal/cross-department approach	Our main programme of work for 2016 and into 2017 is to build a representative, influential partnership, capable of determining its own longer-term future. The development of a city wide food partnership is intended to support a coordinated approach to everything that Newcastle can do in relation to food; an enabling environment for creating a healthier food culture.	http://sustainablefoodcities.org/findacity/cityinformation/userid/41
Civil society/organisations	Food Newcastle is an independent non-profit leading a movement of organisations and individuals demanding a healthier food culture in Newcastle upon Tyne.	http://www.foodnewcastle.org/

Sunderland		
Element	Relevant text	Sources
TE: City level action	At Sunderland City Council, we work closely with a number of organisations including Sunderland Clinical Commissioning Group, NHS and Public Health England to deliver high quality services and programmes that are tuned to the specific needs of our communities. It's also our job to promote healthy living, to tackle health inequalities, and to put plans in place so that everyone has the knowledge they need to help themselves stay healthy.	https://www.sunderland.gov.uk/article/13873/Our-responsibility-for-Public-Health

Brighton (UA)		
Element	Relevant text	Sources
TE: Political commitment	The Health & Wellbeing Board (HWB) is a partnership body bringing together councillors and senior council officers, NHS commissioners and local people which oversees the strategy for public health in Brighton & Hove.	https://www.brighton-hove.gov.uk/content/health/public-health-brighton-hove
TE: Long term vision	Long term aim of the 'Healthy Weight Programme Board' is to develop a whole systems approach to healthy weight for people in Brighton & Hove. the new weight management services will take a life course approach; that is, intervening across the life course and at specific times where there may be specific opportunities to influence behaviour	https://present.brighton-hove.gov.uk/Uploaded/C00000826/M00006663/AI00057392/\$20170703120453_011883_0046856_WeightManagementTier2procurementHWBB11072017.docxA.ps.pdf
TE: City level action	In 2012, the Brighton & Hove Food Partnership launched the city's second food strategy which sets out how collectively as a city we will achieve a vision of a healthy, sustainable and fair food system for Brighton & Hove.	http://sustainablefoodcities.org/findacity/cityinformation/userid/45
TE: top down + community	Brighton & Hove City Council Public Health Commissioner: Brighton & Hove we're working hard with our partners such as Brighton & Hove Food Partnership, Albion in the Community and GPs to help and to provide advice for	https://www.brighton-hove.gov.uk/content/health/public-health-brighton-hove

	people who are overweight on how to stay within healthy limits. Key factors in helping stay within healthy weights include healthy eating and regular exercise so we proactively work as a city on both important areas.	
TE: Norms/values /culture	The city celebrates a cut in child obesity; Brighton & Hove City Council is now in the top 10% of local authorities nationally for tackling child obesity. Statistics from Public Health England show that Brighton & Hove has the lowest figure in the South East at 49.2% of adults overweight or obese	https://www.brighton-hove.gov.uk/content/press-release/city-celebrates-another-cut-child-obesity
TE: Targeting deprivation	We offer food poverty awareness training and have developed resources and advice for front line workers and people directly experiencing food poverty.	http://sustainablefoodcities.org/findacity/cityinformation/userid/45
Horizontal/cross-department approach	The Brighton & Hove Food Partnership brings together community organisations, statutory agencies, local businesses and individual residents in a city-wide, strategic approach to food.	http://sustainablefoodcities.org/findacity/cityinformation/userid/45
Civil society/ organisations	Brighton & Hove is hosting the first city-wide initiative in the UK over the devastating harm caused by overconsumption of sugar as part of a drive to help reduce obesity.	https://www.brighton-hove.gov.uk/content/press-release/brighton-hove-first-uk-city-tackle-sugar-addiction-and-unveils-brand-new-city

Kingston upon Hull (UA)

Plymouth (UA)		
Element	Relevant text	Sources
Horizontal/cross-department approach	Food Plymouth CIC is a strong cross-sector collaborative partnership of public, private, community and voluntary sector organisations. Stakeholders across the city have been working to develop the partnership and delivery since 2010, to increase local and sustainable food in the city, through the vision of the Plymouth Food Charter and Action Plan.	http://sustainablefoodcities.org/findacity/cityinformation/userid/16
Civil society/ organisations	Good food is vital to the quality of peoples' lives in Plymouth. By promoting healthy and sustainable food as part of a thriving food economy, the Plymouth Food Charter aims to improve health and wellbeing for all and to create a more connected, resilient and sustainable City.	http://www.foodplymouth.org/

Wolverhampton

Stoke-on-Trent (UA)		
Element	Relevant text	Sources
TE: Long term vision	Stoke-on-Trent Healthy Weight Strategy 2016-2019 - to make a healthy weight the norm across all ages in Stoke-on-Trent.	https://www.stoke.gov.uk/site/scripts/google_results.php?q=obesity
TE: City level action	Good Food Stoke-on-Trent is a partnership of community, public, private and business sectors to drive action on food issues in the city. The group will meet four times a year to share successes, discuss challenges and work in	http://sustainablefoodcities.org/findacity/cityinformation/userid/463

	collaboration to identify new opportunities to add value to the sustainable food agenda in Stoke-on-Trent.	
TE: top down + community	The North Staffordshire Community Food Network contributes to Good Food Stoke-on-Trent by bringing together groups in co-operation on issues and celebrations focused on food. This includes sustainability and security of food supply, food poverty, food waste and health and welfare. The network aims to provide an inclusive network which challenges, informs and celebrates the contribution that the community makes to the sustainable food future of North Staffordshire.	http://sustainablefoodcities.org/findacity/cityinformation/userid/463
Horizontal /cross-department approach	Create healthy weight neighbourhoods and towns; building public health considerations into planning policies, decisions and programmes will ensure that the built and green environment of Stoke-on-Trent encourages and enables residents to maintain a healthy weight.	https://www.stoke.gov.uk/site/scripts/google_results.php?q=obesity
Civil society/ organisations	Stoke-on-Trent City Council commissions and supports a number of healthy eating campaigns: The Cook and Eat programme; The local Food for Life programme; The Council has also produced a Stoke Sustainable Food City film.	http://sustainablefoodcities.org/findacity/cityinformation/userid/463

Derby (UA)

Southampton (UA)		
Element	Relevant text	Sources
TE: Long term vision	Healthy Early Years delivered by Southampton City Council and Solent NHS Trust was award winning in 2017 for long term work to curb the increase in the number of children that are overweight or obese. Southampton City Council is working alongside partners to create health promoting environments in the city, through settings such as early years, schools, businesses, parks and open spaces.	http://www.southampton.gov.uk/news/article.aspx?id=tcm:63-396577
TE: City level action	Being a healthy weight is key to a child's well-being Southampton City Council has key objective of creating a healthy city for children and young people.	http://www.southampton.gov.uk/health-social-care/children/healthy-weight/
TE: top down + community	Obesity is included as a key theme in the Taking Responsibility for Health JSNA. Southampton Healthy Living can provide you with the support and motivation needed to make healthier choices through one to one and group support. You can find out more on the My Weigh page or access Self Help apps which you can use yourself to help manage your weight.	http://www.southampton.gov.uk/health-social-care/children/healthy-weight/ https://www.southamptonhealthyliving.org.uk/
TE: Targeting deprivation	Health inequalities are largely preventable. Not only is there a strong social justice case for addressing health inequalities, there is also a pressing economic case. Action on health inequalities requires action across all the social determinants of health, including education, occupation, income, home and community.	http://www.publichealth.southampton.gov.uk/healthintelligence/phar/phar2014/inequalities.aspx?tab=tcm:62-372367

TE: Learning approach	In order to improve the health of the population we serve, we use data and information from a range of sources, including hospitals, births and death information, commissioned services' performance data, and public surveys.	http://www.southampton.gov.uk/contact-us/privacy-cookies/public-health-privacy-statement.aspx
Horizontal/cross-department approach	Schools, businesses, workplaces, the public sector, charities, parents and families can all play a part in championing healthy food and physical activity.	http://www.southampton.gov.uk/health-social-care/children/healthy-weight/
Civil society/organisations	Various local services and organisations are provided which relate to specific need; categorised by early years, schools, adults.	http://www.publichealth.southampton.gov.uk/healthintelligence/jsna/takingres_obesity.aspx?tab=tcm:62-353502

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