MIDDLESBROUGH COUNCIL

Final Report of the People Scrutiny Panel

HEALTHY PLACEMAKING WITH A FOCUS ON CHILDHOOD OBESITY

CONTENTS

THE AIMS OF THE SCRUTINY REVIEW

1. The aims of the review are to:

    - Understand the current issues and prevalence of childhood obesity in Middlesbrough, including local trends and variations.
    - Examine the role of healthy placemaking in creating environments that support healthier food choices, active lifestyles and overall wellbeing.
    - Identify evidence-based recommendations on how healthy placemaking and partnership working can be embedded more effectively into local policy, strategy and delivery.

2. The review also aims to assist the Local Authority in achieving the following priorities from the Council Plan 2024-2027:

    - **A Healthy Place -** Improve life chances of our residents by responding to health inequalities.
    - **A Healthy Place -** Promote inclusivity for all.

TERMS OF REFERENCE

3. The Terms of Reference for the Scrutiny Panel's review, are as follows:

    A. Establish an understanding of childhood obesity in Middlesbrough, including current prevalence rates, trends over time, variation by ward or demographic group and links to deprivation, ethnicity, and other social determinants.

    B. Identify the key aspects of healthy placemaking and assess current and planned activity within Middlesbrough, such as public health, planning, transport and environment matters.

    C. Examine how partnership working contributes to the current reduction of childhood obesity and identify how this could be further developed by considering areas of best practice.

    D. Explore how healthy placemaking can be embedded more effectively into local council policies and strategies.

BACKGROUND INFORMATION

4. Childhood obesity remains one of the most significant public health challenges in England, contributing to preventable disease, reduced quality of life and widening health inequalities. National surveillance shows that excess weight in childhood has remained persistently high. The Health Survey for England 2022 reported that around one in seven children (15%) aged 2-15 were living with obesity (Health Survey for England 2022, Part 2 – NHS England). This national pattern is reflected locally. Middlesbrough consistently records prevalence rates above both the North East and England averages and obesity remains more concentrated in the town's more deprived wards.

5. According to the NHS, "the term obese describes a person who has excess body fat", which can lead to a range of health problems such as type 2 diabetes, asthma and high blood pressure (NHS, 2024). Children who are overweight or obese are more likely to remain so into adulthood, increasing their risk of developing long-term health conditions and experiencing poorer mental

wellbeing. The causes of obesity are complex and influenced not only by individual behaviours but also by wider social, economic and environmental factors. The financial impact is also significant: the NHS spends around £6.5 billion per year on treating obesity-related ill health across all age groups in England. In response, national bodies continue to introduce targeted services designed to support children, young people and families to achieve a healthier weight and improve their health.

6. Recognising the multifaceted nature of obesity, national guidance such as Public Health England's Whole Systems Approach to Obesity (2019) emphasises the need for a coordinated approach to achieving a healthy weight, one that brings together planning, transport, education, public health and community partners to support environments that enable and encourage healthier lifestyles. Central to this is the concept of healthy placemaking, described by the World Health Organisation as 'health setting'. When talking about healthy placemaking, the World Health Organisation describes the term as "the place or social context in which people engage in daily activities in which environmental, organisational and personal factors interact to affect health and wellbeing"

7. This review examines how healthy placemaking principles can be embedded more effectively across Middlesbrough's local policies, planning processes and partnership arrangements. Tackling childhood obesity requires a coordinated, system-wide approach that brings together the built environment, transport and infrastructure, public health programmes and engagement with schools and communities. Local Authorities play a crucial role in shaping the conditions that support healthy weight, for example through integrating health considerations into planning and regeneration schemes, designing neighbourhoods that encourage walking and cycling, promoting active travel routes to schools and influencing local food environments and through partnership working and policy. Middlesbrough Council already undertakes a range of initiatives in these areas, but there is an ongoing need to strengthen how these efforts connect and complement one another. This review therefore aims to identify opportunities to enhance integration and embed healthy placemaking principles across all aspects of local policy, helping to create environments where children can lead healthier, more active lives.

SUMMARY OF EVIDENCE:

Term of Reference A - Establish an understanding of childhood obesity in Middlesbrough, including current prevalence rates, trends over time, variation by ward or demographic group and links to deprivation, ethnicity, and other social determinants

8. The National Child Measurement Programme (NCMP) records the height and weight of children in Reception (ages 4-5) and Year 6 (aged 10-11), in order to monitor patterns of overweight and obesity across England. Unlike adult measures, childhood Body Mass Index (BMI) classifications are based on age and sex specific growth references, which allow each child's measurement to be compared with expected population norms (A simple guide to classifying body mass index in Children, June 2011).

9. At the 8 September 2025 Panel meeting, Members received an overview of Middlesbrough's most recent NCMP data (2023/24). The figures show that 13.8% of Reception-age children in Middlesbrough were living with obesity or severe obesity, compared with 10.8% in the North East and 9.6% nationally. By Year 6, prevalence rose to 25.6%, slightly above the North East average of 24.5% and notably higher than the England rate of 22.1%.

10. Adult obesity levels in Middlesbrough remain significantly above national levels. In 2023/24, 71.4% of adults were overweight or obese, compared with 64.5% across England.

Indicator	Middlesbrough Value	North East Value	England Value	England Worst
Overweight (including obesity) prevalence in adults, (using adjusted self-reported height and weight) (18+ yrs)	71.4%	70.4%	64.5%	77.2%
Obesity prevalence in adults, (using adjusted self-reported height and weight) (18+ yrs)	35.3%	32.5%	26.5%	38.8%

Department of Health and Social Care – Public Health Profiles – Obesity, Health and Nutrition

Links to Deprivation

11. National data shows a strong socioeconomic gradient: obesity among Reception-aged children in the most deprived areas of England (12.9%) is more than double that in the least deprived areas (6.0%). Among Year 6 pupils, the gap widens further, 29.2% compared with 13.0% in the least deprived areas (NHS England, 2024)

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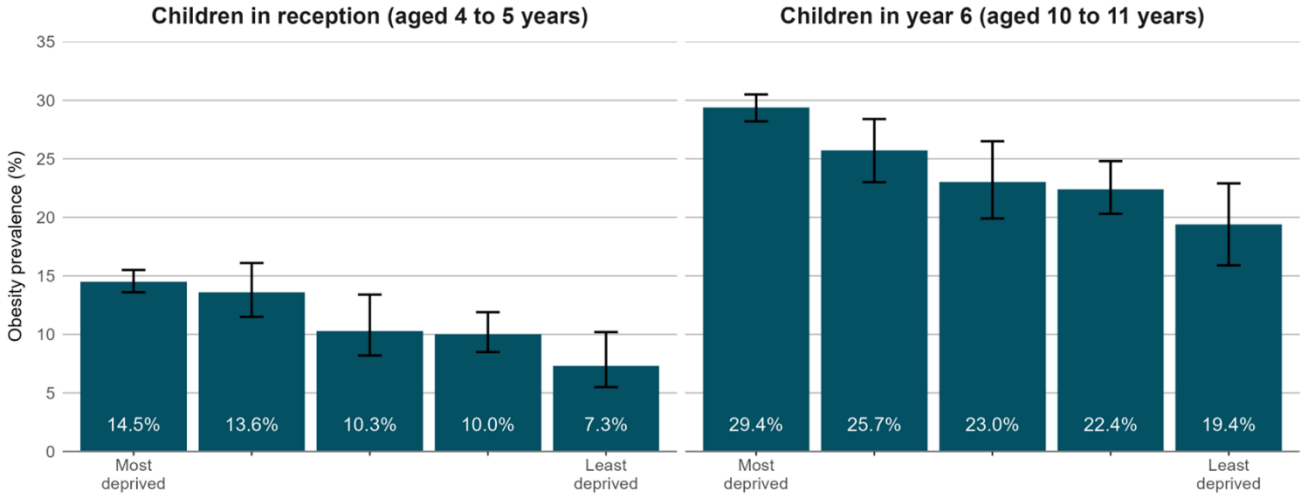
12. The pattern in Middlesbrough mirrors this national trend.
    - Reception: 14.5% of children in the most deprived wards were classed as obese, compared with 7.3% in the least deprived wards.
    - Year 6: 29.4% in the most deprived wards, compared with 19.4% in the least deprived wards.



Ward Level Variation and Deprivation

13. To explore this inequality in more depth, Members received ward-level NCMP data (combined 2021/22-2023/24) presented at the 8 September 2025 Panel meeting. The data, which is illustrated in the bar charts below, shows obesity prevalence among Reception and Year 6 pupils across Middlesbrough's wards, alongside their respective deprivation quintiles.

14. The charts clearly demonstrate that the highest levels of childhood obesity are concentrated in wards within the most deprived quintile (quintile 1), while the lowest rates are consistently found in the least deprived areas (quintile 5).

Reception (Ages 4-5)

15. Obesity levels in Reception vary considerably by ward. Some of the highest rates are seen in the most deprived areas including, North Ormesby (35.3%), Berwick Hills and Pallister (31.5%) and Brambles and Thorntree (31.1%). In contrast, quintile 5 wards such as Nunthorpe (16.9%) and Marton West (20.4%) report far lower rates. This illustrates that inequalities in healthy weight are already evident by school entry age.

Year 6 (Ages 10-11)

16. By Year 6, the gap widens further. All quintile 1 wards record obesity levels above 40%, with the highest observed in Ayresome (48.4%), Brambles and Thorntree (47.6%) and Longlands and Beechwood (47.0%). The only exception within quintile 1 is North Ormesby (36.3%), identified by Members as an outlier.

17. Following further discussion with officers, members noted that North Ormesby's lower-than-expected Year 6 obesity prevalence, when compared with its Reception figures, may be influenced by changes in the ward's population composition rather than reflecting a true cohort trend. Officers highlighted that North Ormesby has a greater migrant population than neighbouring wards - 75.8% of residents are UK-born (compared with 95.4% in Brambles and Thorntree), despite both wards having almost identical proportions of children aged 5–9 (8.1% and 8.2% respectively). This suggests that the composition of the group measured at Year 6 is unlikely to be the same as the cohort measured at Reception.

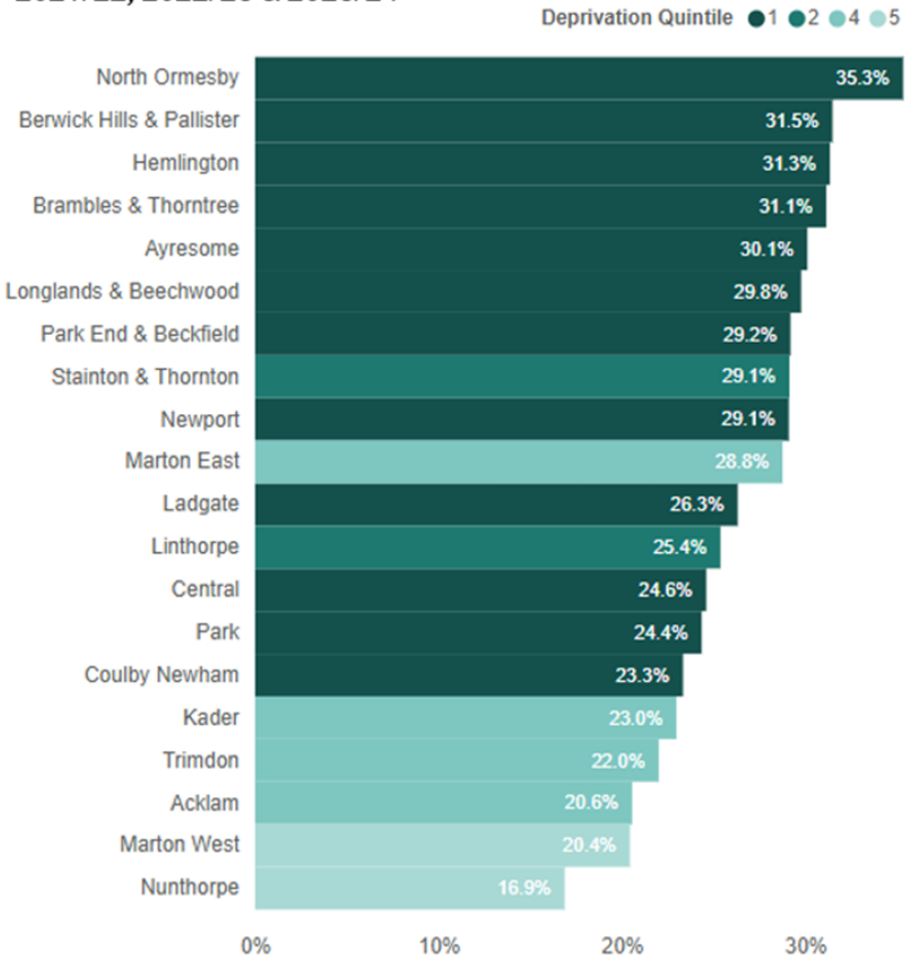
18. Members also recognised that part of the observed pattern may be an artefact of data collection processes, including coverage and participation differences at ward level. Overall, the discussion reinforced the importance of interpreting ward-level obesity data with an understanding of local demographic change, population churn and possible measurement effects.

19. At the opposite end of the scale, quintile 5 wards again show the lowest prevalence: Nunthorpe (25.9%) and Marton West (30.0%).

20. The ward-level data reinforces the strong relationship between deprivation and childhood obesity in Middlesbrough. The fact that differences are evident from Reception and become more pronounced by Year 6, indicates that inequalities accumulate through childhood. The accompanying bar charts provide a visual representation of these patterns and clearly demonstrate the extent of variation across Middlesbrough's communities.

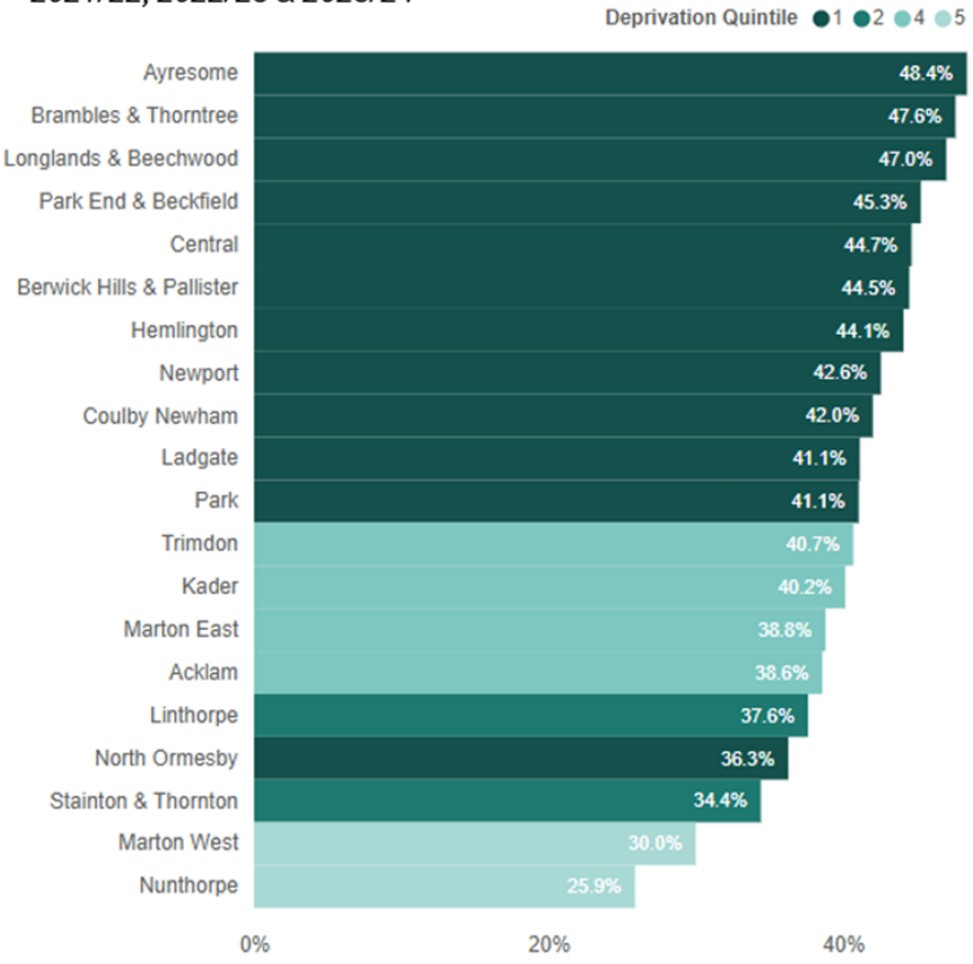
Reception - Overweight & Obese Pupils (%)

2021/22, 2022/23 & 2023/24



Year 6 - Overweight & Obese Pupils (%)

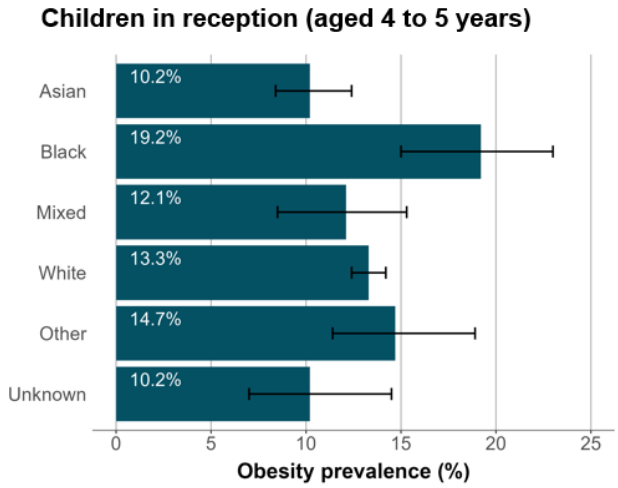
2021/22, 2022/23 & 2023/24

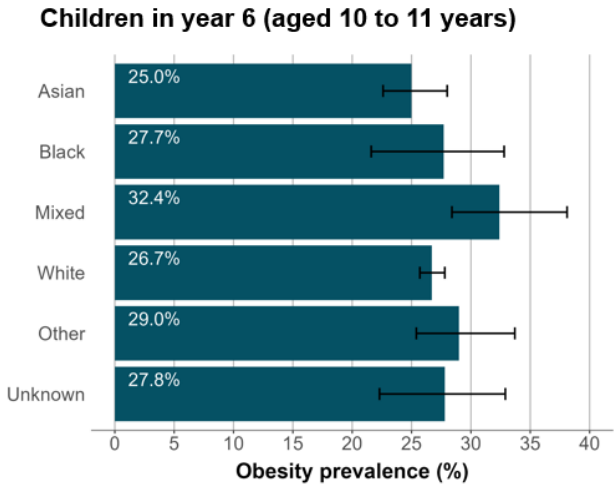


NCMP annual report for England, NHS England Digital

Obesity Prevalence by Ethnic Group in Middlesbrough

21. The National Child Measurement Programme data also highlights variation in obesity prevalence between different ethnic groups. The following charts illustrate the percentage of children living with obesity in Middlesbrough by ethnic group, for both Reception and Year 6.





NCMP 2024/25 Data

22. During the course of the review, the most recent NCMP results for 2024/25 were published on 4 November 2025. These figures show a slight increase in prevalence compared with the previous year. In Middlesbrough:
    - 14.3% of Reception-age were classed as obese (up from 13.8% in 2023/24)
    - 25.9% of Year 6 children classed as obese (up from 25.6% in 2023/24)

23. Although these changes are small, the overall pattern remains consistent with previous years and Middlesbrough is placed among the highest prevalence rates nationally.

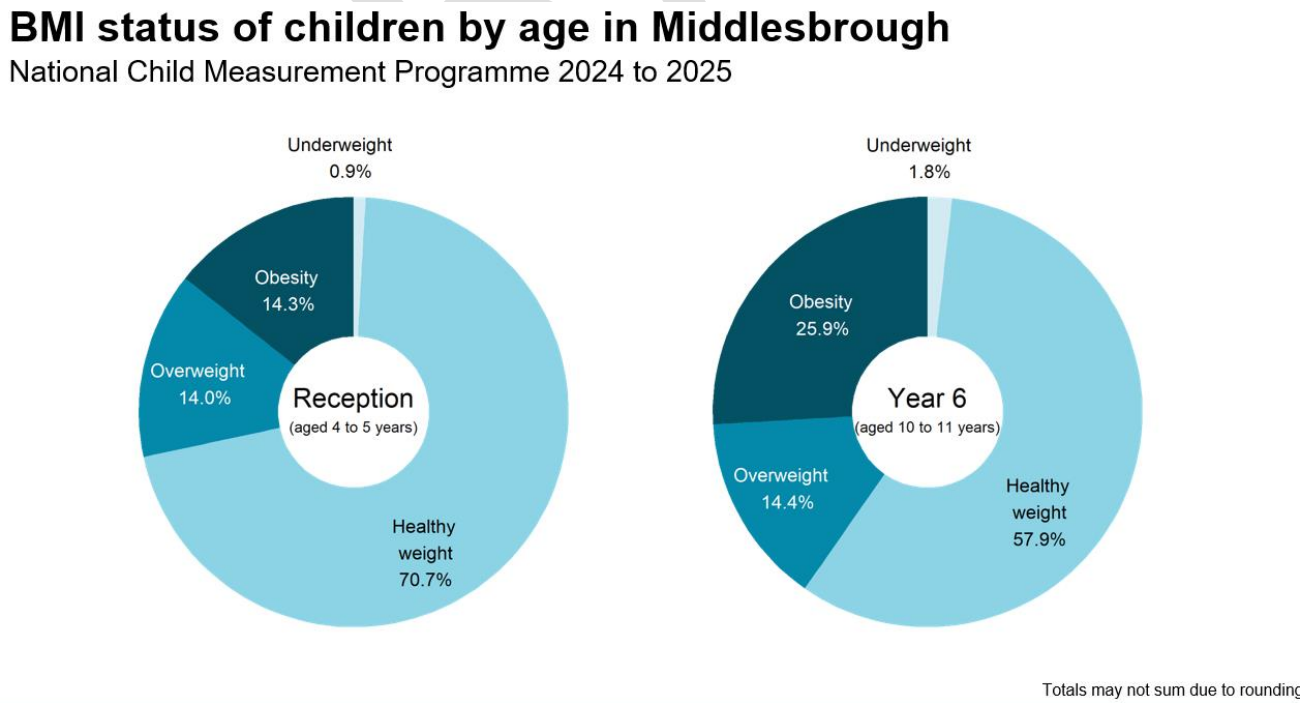


Table One – 2024/25 Obesity Prevalence

Indicator	Middlesbrough Value	England Value
Single year prevalence data for children in reception, age 4 to 5 years 2024/25		
Reception prevalence of underweight	0.9%	1.1%
Reception prevalence of healthy weight	70.7%	75.4%
Reception prevalence of overweight	14.0%	13.0%
Reception prevalence of overweight (including obesity)	28.4%	23.5%
Reception prevalence of obesity (including severe obesity)	14.3%	10.5%
Reception prevalence of severe obesity	4.5%	2.9%
Single year prevalence data for children in year 6, age 10 to 11 years		
Year 6 prevalence of underweight	1.0%	1.6%
Year 6 prevalence of healthy weight	57.9%	62.2%
Year 6 prevalence of overweight	14.4%	13.9%
Year 6 prevalence of overweight (including obesity)	40.3%	36.2%
Year 6 prevalence of obesity (including severe obesity)	25.9%	22.2%
Year 6 prevalence of severe obesity	8.4%	5.6%
Five-year prevalence for local authority inequalities data 2020/21-2024/25		
Reception prevalence of obesity (including severe obesity), 5 years data combined	13.6%	9.8%
Year 6 prevalence of obesity (including severe obesity), 5 years data combined	27.2%	22.3%

Department of Health and Social Care – Public Health Profiles – Obesity, Health and Nutrition

Obesity, physical activity and nutrition - Data | Fingertips | Department of Health and Social Care

24. This evidence demonstrates that childhood obesity in Middlesbrough emerges early in life and is strongly associated with deprivation. This provides the context for the Panel's subsequent consideration of healthy placemaking, partnership working and system-wide prevention approaches.

Term of Reference B – Identify the key aspects of healthy placemaking and assess current and planned activity within Middlesbrough, such as public health, planning, transport and environment matters.

25. Healthy placemaking brings together the physical environment, local policy and service delivery to create places that support and enable healthier behaviours as part of everyday life. It recognises that health outcomes are shaped not only by individual choice, but also by wider factors such as urban design, transport systems and food environments. As part of this review, the Panel considered how healthy placemaking principles are currently embedded across key

Council functions, including public health, planning and transport and infrastructure. Each of these areas are considered below.

Public Health

26. In February 2024, Middlesbrough Council adopted the Healthy Weight Declaration (HWD) in recognition of the scale and complexity of obesity and the need for a coordinated, long-term response. The Declaration represents a town-wide commitment to supporting residents to achieve and maintain a healthy weight, with Public Health providing strategic leadership and coordination across the Council and wider system, underpinned by collaboration across Council departments and with external partners.

27. Officers advised the Panel that the HWD contains sixteen core commitments, designed to embed healthy weight considerations across policy development, decision-making and service delivery. These commitments are grouped under four overarching themes: strategic and system leadership; commercial determinants; health-promoting environments and organisational and cultural change. Taken together, the commitments provide a practical framework through which Public Health can influence multiple Council functions and partner organisations, addressing the wider environmental, social and economic factors that influence diet, physical activity and health outcomes.

28. Members were advised that the HWD supports a whole-system approach, recognising that progress in reducing obesity rates is gradual and that sustained action is required over time. Public Health officers emphasised the importance of maintaining confidence in the direction of travel, even where measurable population-level change may not be immediately apparent, particularly given the strong association between obesity and deprivation.

29. In addition to the HWD, the Panel heard about a range of public health activity supporting healthy placemaking and influencing the local environment in which people live, work and learn. This included work to support the implementation of government advertising restrictions, collaboration with the Council's marketing and communications teams to ensure appropriate messaging across Council websites, and initiatives such as the Eat Well Awards, breastfeeding promotion campaigns and Holiday Activity and Food programmes (HAF). These activities were presented as complementary to policy and planning interventions, reinforcing healthier choices across the life course.

Planning

30. The Panel received evidence from the Strategic Policy Manager (Planning) and the Creating Active and Healthy Spaces Lead (Public Health South Tees) on the role of the planning system in shaping healthier environments.

31. At the outset of the discussion, Members were introduced to the role of the hybrid public health-planning post 'Creating Active and Healthy Spaces Lead', and its importance in delivering healthier places. Officers explained that the role acts as a bridge between public health and planning, supporting a shared understanding of how the built environment influences long-term health outcomes. Members were advised that national evidence recognises that while healthcare services are vital, the places in which people live, work and move can have a greater long-term impact on health, particularly in addressing inequalities.

32. Officers highlighted the value of hybrid roles is reflected in national policy, including the NHS 10-Year Plan and the revised National Planning Policy Framework, which emphasise the need to embed health considerations into decision-making about place. Hybrid posts support planners and public health professionals to work to a common language and shared objectives, improving the use of health evidence in Local Plans, planning applications and design reviews.

33. Members heard that, in practice, these hybrid roles help to strengthen the planning process by embedding health and equity considerations at the earliest stages of development, rather than treating them as a 'tick-box' requirement. The roles support more robust and consistent use of Health Impact Assessments, provide clearer health guidance to developers, and to improve engagement with communities and elected Members. This helps to ensure local priorities inform placemaking decisions and supports the delivery of greener, heathier and more equitable environments.

34. Members were provided with an overview of national policy legislation, the National Planning Policy Framework (NPPF) and associated design and practice guidance. Officers highlighted specific NPPF paragraphs (including paragraphs 96(c) 97, 103 and 109 (e) and (f) which place clear emphasis on creating healthy, safe, inclusive and accessible places.

35. Members were informed that Middlesbrough's Local Plan, which is presently under examination, integrates health considerations throughout its policies. This alignment supports the Council Plan priority of creating a healthy place and links closely with the Joint Health and Wellbeing Strategy and the Joint Strategic Needs Assessment, particularly in relation to promoting wellbeing and reducing health inequalities.

Health Impact Assessments (HIAs)

36. A key feature of Middlesbrough's approach is the use of Health Impact Assessments (HIAs) within the planning process. Officers advised that only around 30% of planning authorities nationally routinely use HIAs and that Middlesbrough's approach represents good practice.

37. HIAs are used as a practical tool to assess the potential health and wellbeing impacts of major developments, informing decisions on design, layout and access. Examples include encouraging the development of usable green space, supporting opportunities for food growing and ensuring proximity to key amenities such as supermarkets within an 800-metre walking distance.

38. To illustrate how healthy placemaking principles are applied in practice, Members were provided with an example of the newly developed Stainsby residential estate, which was highlighted as an example of good practice in creating a healthier community through design.

39. Members noted that the Stainsby development demonstrates how the built environment can actively support healthier behaviours, particularly through the provision of connected and accessible walking routes, green corridors and safe links between homes, open space and local amenities. The masterplanning approach prioritised permeability, legibility and active travel, helping to make walking a realistic and attractive option for everyday journeys.

40. The Panel also noted that health considerations had been embedded at the design stage, including access to open green space, opportunities for informal physical activity and food and nutrition considerations, as reflected through the use of Health Impact Assessment principles. Members welcomed this as an early example of how early collaboration between planning, public health and developers can result in environments that support long-term wellbeing and contribute to the creation of a sustainable, healthy place.

Hot Food Takeaway Policy

41. Members received further evidence on the Council's approach to managing the concentration and location of hot food takeaways.

42. Middlesbrough Council formally adopted the Interim Hot Food Takeaway (HFT) Policy in July 2019, with an amended version adopted in March 2020. The policy applies to hot food takeaways (A5 use class) and sets thresholds to limit over-concentration, protect primary

shopping frontages and restrict new takeaways within a 400-metre walking distance of secondary schools. Hot food takeaways are also not permitted outside of defined centres.

43. Members were advised that since the introduction of the policy, the number of applications has reduced and refusal rates have increased, suggesting a deterrent effect:
    - August 2015 – July 2019: 26 applications, 5 refused (19%)
    - August 2019 – July 2023: 18 applications, 10 refused (55%)

44. Officers explained that while existing outlets remain, the policy provides a robust framework for resisting new proposals in sensitive locations and supports wider healthy placemaking objectives. Progress is monitored through planning performance data, benchmarking against national good practice and ongoing assessment of planning decisions.

Transport and Infrastructure

45. The Panel received a presentation from the Head of Transport and Infrastructure and the Principal Planning Transport Officer on how transport policy, infrastructure investment and education programmes contribute to healthy placemaking. This included data on travel modes, travel to school patterns, road safety and an overview of key strategies and investment programmes aimed at supporting active and sustainable travel.

46. Members noted that Middlesbrough experienced high levels of childhood obesity and physical inactivity, despite low levels of car ownership with 33.1% of households having no car or van and short averages distances between home and school. Officers advised that 46% of children currently walk to school, with this figure having declined in recent years. This prompted concern among Members, particularly given the role that walking to school plays in supporting physical daily activity and reducing congestion at school gates.

47. Following the meeting, Members requested further information on vehicle ownership, broken down by ward. Census 2021 data, presented in the table below, shows that car ownership levels do not directly correlate with obesity prevalence. In fact, wards with higher obesity levels generally recorded lower levels of vehicle ownership, reflecting wider patterns of deprivation rather than transport access alone.

Ward	**% households without cars/vans**
Marton West	9.7
Nunthorpe/Marton East	10.1
Trimdon	12.6
Kader	15.1
Linthorpe	21
Coulby	24
Stainton/Hemlington	26.7
Easterside	31.9
Linthorpe East	32.1
Newport	33.5
Park	36.6
Berwick Hills	43.8
Beechwood	45.2
Thorntree	47
North Ormesby and Brambles	55
Central	55.8
Ayresome	62.4

48. Members discussed that while lower car ownership may result in higher levels of walking for everyday journeys such as travel to school, higher levels of car ownership, often associated with greater household income, may also enable access to a wider range of opportunities that support more active lifestyles. This includes the ability to travel to organised sports, leisure centres, swimming pools and green spaces as well as the financial capacity to afford sports clubs, classes and gym memberships. Members noted that these factors are less accessible to families experiencing deprivation and that this further reinforced the complexity of the issue and the influence of broader social and economic determinants of health.

49. While recognising that patterns of travel are influenced by a range of wider factors, the Panel noted that the Council already delivers a comprehensive programme of education and infrastructure initiatives to encourage safer and more active travel to school. These included Balancability training (74 places), Bikeability provision for Year 3 (1057 places) and Year 5/6 pupils (1,529 places) alongside school assemblies, Dr Bike/Fix-It sessions, guided rides and the installation of secure cycle parking. Officers emphasised that achieving a sustained shift away from car use at the school gate would require behavioural change, supported by clear communication and increased parental confidence, particularly around addressing perceptions around journey distance and safety.

50. Members also discussed the role of cycling infrastructure, including dedicated cycling lanes, in supporting active travel. Officers acknowledged that high-quality, well-connected infrastructure is an important enabling factor for cycling but emphasised that infrastructure alone insufficient to drive sustained behaviour change. Evidence presented to the Panel highlighted that perceptions of safety, confidence, convenience and cultural norms all strongly influence whether residents choose to cycle. Members therefore noted that cycle infrastructure is most effective when delivered as part of a joined-up approach, alongside education, engagement and supportive local environments.

51. The Panel acknowledged that improving active travel uptake is a long-term endeavour and forms a key component of a whole-system approach to healthy placemaking.

Term of Reference C – Examine how partnership working contributes to the current reduction of childhood obesity and identify how this could be further developed by considering areas of best practice.

52. Reducing childhood obesity was consistently described to the Panel as a complex, long-term challenge that cannot be addressed by any single organisation or service in isolation. Evidence presented throughout the review highlighted the importance of partnership working at local, regional and national levels to influence the wider determinants of health, including physical activity, food environments and education.

Cross-Council Partnership Working

53. Public Health officers explained that partnership working is embedded not only through collaboration with external organisations, but also through influencing decision-making across Middlesbrough Council. Public health expertise is integrated within core Council functions through Service Level Agreements (SLAs), enabling health considerations to be incorporated at the earliest stages of policy development, service planning and delivery.

54. This includes close collaboration with Planning, Transport and Infrastructure, Children's Services and Education, supporting a joined-up approach to healthy placemaking, active travel, food environments and school-based initiatives. Members heard that this internal partnership working is particularly important where decisions taken in one service area may have significant downstream impacts on health outcomes.

55. Strengthening cross-departmental working was identified as central to embedding a whole-system approach, ensuring that responsibility for reducing childhood obesity is shared and that health considerations are consistently reflected in Council decision-making.

Unhealthy Commodity Industries (UCIs)

56. The Panel was informed about Unhealthy Commodity Industries (UCIs), defined as profit-driven commercial sectors whose products are associated with significant adverse health outcomes. Examples discussed included tobacco, alcohol, gambling, certain food and beverage products and fossil fuels.

57. Officers explained that the products and practices of these industries are linked to a range of non-communicable diseases, including cancer, cardiovascular disease, stroke, poor mental health and overweight and obesity. Members were advised that non-communicable diseases account for a significant proportion of deaths and ill-health nationally and contribute to widening health inequalities.

58. Members heard that UCIs often influence behaviour through targeted advertising, marketing strategies and approaches that shift responsibility onto individuals rather than addressing wider commercial and environmental drivers of health. Examples relevant to local government were highlighted, including industry-funded training opportunities, sponsorship arrangements and grants to voluntary and community organisations.

59. Officers emphasised that addressing these influences requires coordinated partnership working across Council departments, supported by clear governance arrangements. This was considered important to ensure a consistent, transparent approach to engagement with UCIs and to support decision-making that aligns with public health priorities and the Healthy Weight Declaration.

External Partnerships and Programme Delivery

60. The Panel's meetings considered a range of external partnerships that support healthy behaviours among children and young people.

You've Got This (Sport England)

61. At the meeting on 8 September 2025, Members heard from a representative of You've Got This (Sport England), who outlined the purpose, scope and delivery of the programme. You've Got This is a Sport England-supported Local Delivery Pilot, one of a small number of place-based partnerships across England designed to explore innovative ways of increasing physical activity levels at a population scale and making "active lives a way of life". The programme was established in 2018 and focusses on addressing physical inactivity not simply as an individual behaviour change issue, but as a systemic challenge requiring insight-led, whole systems action across partners and communities. Locally it operates through wide partnership involving public health, local authorities, community organisations and sport providers to create activities, gather insight and support residents to become and stay more active.

62. Members were advised that the programme has a particular emphasis on insight and learning, identifying barriers to activity and testing approaches that work in a local context. Evidence highlighted the value of national partners working alongside local services and schools to deliver consistent messaging and accessible opportunities for participation.

Bring It On Boro – Holiday Activities and Food (HAF) Programme

63. Members also received detailed evidence on Bring It On Boro, Middlesbrough's Holiday Activities and Food (HAF) programme, delivered during 2024/25 for children and young people eligible for benefit-related free school meals and other vulnerable groups. Members reviewed the annual report 2024/2025 which outlined the scale and structure of delivery across the three

main holiday periods (Easter, Summer and Christmas) and demonstrated strong partnership working between Council, voluntary and community organisations and external providers.

64. The HAF programme aims to provide free, accessible activities alongside healthy food, promoting positive holiday experiences while addressing food insecurity, inactivity and social isolation. Its objectives include encouraging children to eat healthily, be physically active, take part in engaging and enriching activities, improve knowledge of health and nutrition, and enhance resilience, wellbeing and social connections.

65. Evidence presented to the Panel highlighted key outcomes from 2024/25, including:
    - The equivalent of six weeks of face-to-face provision across Easter, Summer and Christmas holidays.
    - Activities delivered during the programme that combine healthy meals with sport, creative experiences and opportunities for social engagement, reinforcing both physical and emotional wellbeing.

66. Members noted that delivery was aligned with national HAF standards which require provision to include a combination of healthy food, physical activity and enriching experiences, supporting children to maintain positive routines and connections outside of the school environment.

67. Members acknowledged that the HAF programme contributes to broader healthy placemaking by:
    - Providing structured opportunities for physical activity during school holidays, reinforcing daily activity habits.
    - Supporting social inclusion and wellbeing, particularly for families facing socioeconomic barriers.
    - Strengthening local partnerships, as delivery relies on community organisations, schools and voluntary groups working together to reach eligible children.

68. The programme was recognised as an example of how partnership working, blending national funding streams with local delivery expertise and community networks, can provide meaningful health-related outcomes in the short term while contributing to longer-term ambitions to reduce inequalities and foster healthier lifestyles.

<u>Schools and Early Years Partnerships</u>

69. Members discussed the importance of schools and early years settings as key partners in addressing childhood obesity. Evidence was provided on initiatives including the Eat Well Schools Award, which is available to all primary, secondary and special schools, both maintained and academies.

70. The Eat Well Schools Award is available to all schools in Middlesbrough. To achieve the award, schools are expected to serve healthy food and teach children about healthy and sustainable food. Achieving the award evidences that schools:
    - provide meals which meet the government's school food standards (which is a legal requirement for schools)
    - teach children about the importance of healthy eating
    - support children to make healthy choices
    - support and promote breastfeeding
    - contribute to the changes needed to promote healthy weight and prevent obesity in the area

71. Members expressed interest in the role of schools in shaping food environments and healthy behaviours and noted the importance of continued engagement between Public Health,

education services and school leadership to promote consistent standards and share good practice.

72. The Panel also heard about wider initiatives such as Creating Active Schools, a programme piloted in Bradford, which supports schools to embed physical activity across the whole school day, including within lessons, playtimes, travel to and from school and wider school culture. The programme focuses on long-term behaviour change, supporting schools to create environments where being active becomes a normal and inclusive part of everyday life rather than an additional activity. Members noted the relevance of this approach for Middlesbrough, particularly in areas of higher deprivation where opportunities for physical activity outside of school may be more limited and recognised the potential value of learning from this best practice to inform future local delivery.

Behaviour Change and Cultural Factors

73. Throughout the review, Members emphasised that improving childhood obesity outcomes requires more than infrastructure and programme delivery alone. Officers highlighted the importance of addressing behavioural, cultural, social and environmental factors that influence everyday choices.

74. Members heard examples of long-term, system-wide approaches, including the London Borough of Waltham Forest, where sustained investment in active travel infrastructure combined with strong community engagement had successfully increased walking and cycling levels. Officers advised that such change takes time, persistence and confidence that interventions are having an impact, even where results may not be immediately visible.

75. The Panel recognised that partnership working is essential to tackling childhood obesity and that there are no quick or simple solutions. Members acknowledged that progress requires long-term commitment, shared responsibility and alignment across organisations, sectors and communities.

76. The evidence reinforced the importance of coordinated governance, whole-system thinking and sustained collaboration to support meaningful and lasting change

Term of Reference D – Explore how healthy placemaking can be embedded more effectively into local council policies and strategies

77. Throughout the review, the Panel consistently heard that tackling childhood obesity through healthy placemaking requires sustained leadership, clear governance and a whole-system approach embedded across Council policy, strategy and decision-making. Members recognised that there are no quick wins, and that meaningful change will take time, particularly in a context of high deprivation and widening health inequalities.

78. The Panel noted positively that Public Health is already embedded within core Council functions through Service Level Agreements (SLAs), enabling health considerations to inform policy development, commissioning and operational decision-making at an early stage. This approach was viewed as a strong foundation for embedding healthy placemaking more consistently across the organisation. Members agreed that further strengthening and formalising these arrangements would support a shared responsibility for health outcomes across departments, including Planning, Transport and Infrastructure, Education and Children's Services.

79. Evidence presented to the Panel highlighted the added value of specialist hybrid roles, such as the Creating Active and Healthy Spaces Lead, in bridging public health and planning functions. Members were particularly impressed by how this role supports the integration of

health evidence into spatial planning, the use of Health Impact Assessments and the consistent application of healthy placemaking principles. The Panel recognised the importance of maintaining and future-proofing this role, with clear links to wider Council teams, to ensure continuity, influence and accountability over the long term.

80. The Panel also considered how the Healthy Weight Declaration (HWD) provides a clear, evidence-based framework to support embedding healthy placemaking across Council activity. Members welcomed the HWD as a mechanism for driving leadership, aligning policies and influencing organisational culture, and noted the importance of using it as a living framework rather than a standalone commitment. The Panel agreed that ongoing senior leadership ownership and regular monitoring of progress against the Declaration's commitments would be essential to sustaining momentum and delivering long-term impact.

81. In exploring how healthy placemaking could be strengthened further, Members discussed the influence of Unhealthy Commodity Industries (UCIs) and the importance of a coordinated, transparent approach to engagement with commercial partners. Building on existing cross-Council working and SLAs, the Panel identified an opportunity to use these established governance structures to support a consistent approach to UCIs, ensuring that decisions relating to procurement, sponsorship, grants and partnerships align with public health priorities and the Council's wider commitment to reducing health inequalities.

82. Members were clear that healthy placemaking should not be interpreted solely as the delivery of physical infrastructure, such as cycle routes or highways schemes. While the built environment plays a critical role, evidence presented to the Panel demonstrated that health outcomes are also shaped by behavioural, social, cultural and economic factors, including parental confidence, perceptions of safety, food environments and, critically, levels of deprivation. The Panel noted that Middlesbrough's high levels of childhood obesity cannot be separated from the wider context of poverty and inequality, and that healthy placemaking must therefore address both place-based and socio-economic influences.

83. The Panel recognised that the Council does not have direct control over all factors affecting healthy weight, including national policy decisions, commercial behaviours and wider funding constraints facing local government. Members were clear that the focus of this review, and the recommendations arising from it, relate to areas within the Council's influence, including policy alignment, planning decisions, commissioning, partnership working and the effective use of existing resources. In this context, healthy placemaking was viewed as a long-term, cumulative endeavour, requiring sustained commitment and organisational alignment rather than short-term or isolated interventions.

CONCLUSIONS

84. Based on the evidence provided throughout the investigation, the Adult Social Care and Health Scrutiny Panel concluded that:
    - Childhood obesity remains a significant public health challenge in Middlesbrough, with 2024/25 NCMP data showing that 14.3% of Reception children and 25.9% of Year 6 children are living with obesity.
    - There is a strong and persistent relationship between childhood obesity and deprivation in Middlesbrough, with the highest prevalence rates overwhelmingly concentrated in wards within the most deprived quintiles. The Panel agreed that, without addressing the wider determinants of health and adopting a whole-system approach, progress is likely to remain uneven.
    - Healthy placemaking has an important role to play in tackling childhood obesity, particularly through shaping the built environment, food environments and opportunities for physical activity. The Panel noted positively that health considerations are increasingly being embedded into planning, transport and policy decision-making.

- Officers demonstrated strong commitment to this agenda, and the Panel was particularly encouraged by the development of the Creating Active and Healthy Spaces Lead role, recognising it as a promising model for sustained cross-departmental collaboration and leadership.

85. The Panel acknowledged that there are no 'quick wins' in addressing childhood obesity; meaningful change will require sustained leadership, partnership working and a long-term commitment before measurable improvements are seen. However, the Panel agreed that laying the foundations now—through coordinated, place-based action—will support long-term progress and help create the conditions for healthier futures for Middlesbrough's children and families.

RECOMMENDATIONS

86. The Adult Social Care and Health Scrutiny Panel recommends to the Executive that:

A. The Council should strengthen visible leadership on healthy weight by ensuring LMT members sponsor and champion Healthy Weight Declaration commitments. A written progress update should be provided to the ASC and Health Scrutiny Panel within 12 months.

B. The Council should build on the existing Public Health Service Level Agreements to formalise shared responsibility across all departments, ensuring health and equity considerations are applied in all decision making. A progress update should be provided to the ASC and Health Scrutiny Panel within 6 months.

C. A review of the implementation of the Council's Advertising Policy should be undertaken to ensure it aligns with the emerging national restrictions on the promotion of unhealthy products, a progress update should be provided to the ASC and Health Scrutiny Panel within 12 months.

D. A cross-departmental Steering Group should be established, supported by the Leadership Management Team, to review how the Council currently interacts with Unhealthy Commodity Industries (UCIs) through contracts, grants, sponsorships etc. The Steering Group should undertake a 12-month audit and provide guidance to ensure consistent decision-making aligns with public health aims. Progress should be reported back to the ASC and Health Scrutiny Panel by April 2027.

E. Public Health and Children's Services should work jointly to increase the number of Middlesbrough schools participating in the Eat Well Schools Award, with a particular focus on schools located in the wards with the highest childhood obesity prevalence. A progress update should be reported back to the ASC and Health Scrutiny Panel by April 2027.

F. The Council should continue to invest in safe, well-connected walking and cycling infrastructure, with a focus on improving access, safety and connectivity between homes, schools, green spaces and local amenities, particularly in more deprived areas. Progress should be aligned with existing transport programmes and reported to the ASC and Health Scrutiny Panel within 12 months.

G. Transport and Infrastructure should support school-led development of Active Travel to School Action Plans, identifying a small number of priority schools using relevant indicators (e.g. obesity prevalence, school gate congestion and existing active travel rates). As part of this work, the service should engage directly with all parts of the school community including pupils, parents/carers, staff and governors, to understand the key barriers to walking and cycling. The findings should then be used to shape tailored interventions for

each school and progress reported back to the ASC and Health Scrutiny Panel within 12 months.

H. Opportunities should be sought to extend the Creating Active Schools model to enable more schools in Middlesbrough to develop their own whole school programmes to increasing physical activity, working alongside the Eat well Schools programme to improve food quality and choices, particularly around schools with high levels of obesity and deprivation. Relevant indicators should be used to measure progress, such as activity monitors, and the findings reported back to the ASC and Health Scrutiny Panel in 12 months.

I. The Council should maintain and, for as long as necessary, future-proof the strategic Creating Active and Healthy Spaces Lead role and the companion operational role of Healthy Placemaking Officer. It should also pilot the use of Health Impact Assessments (HIAs) ahead of adoption of the Local Plan. The Local Plan will require that HIAs are prepared for all residential developments of 100 or more dwellings, with other major developments screened on a case-by-case basis to determine whether an HIA is required. Going forward, outcomes should be monitored annually through KPIs, with the first summary report, produced during this transitional period, presented within 12 months to the ASC and Health Scrutiny Panel.

J. Regular assurance should be provided to the ASC and Health Scrutiny Panel by reporting on a six-monthly basis, the number and location of hot food takeaways in the town. This should include new applications, refusals, closures, retrospective planning applications and related enforcement.

K. The Council should continue to advocate to Government, for increased support to reduce child poverty in Middlesbrough, recognising its significant impact on childhood obesity and wider health inequalities.

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Dr David McAleavey, Creating Active and Heathy Spaces Lead, Middlesbrough Council

ACRONYMS

88. A-Z listing of common acronyms used in the report:

BMI	Body Mass Index
FSM	Free School Meals
HAF	Holiday Activities and Food
HIA	Health Impact Assessment
HFT	Hot Food Takeaway
HWD	Healthy Weight Declaration

NCMP	National Child Measurement Programme
NHS	National Health Service
NPPF	National Planning Policy Framework
SLA	Service Level Agreement
UCI	Unhealthy Commodity Industry

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