Essex County Council

Essex County Council Health Overview and Scrutiny Committee

Scrutiny Review: Tackling Childhood Obesity

March 2007

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Acknowledgements

The Chairman and Members of the review panel would like to thank the many people whose contributions made this report possible:

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County Council; Alison Woolnough, Community Health Co-ordinator, Colchester Borough Council;

Particular thanks must also be given to Dr Pam Hall, East of England Strategic Health Authority and Steve Leverett, Essex County Council who provided invaluable help and advice throughout the review as well as to the Centre for Public Scrutiny who provided the funding that allowed us to complete this review and to Canterbury Christ Church University for their work.

Finally, we would like to thank all those who attended our stakeholder workshop in September 2006 and all those young people who took part in our survey.

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Executive Summary

The Essex Health Overview and Scrutiny Committee has recently undertaken a review of partnership working to tackle childhood obesity. This is a key local priority, represented in the Essex Local Area Agreement and is also a national and international concern.

Stories about an epidemic of childhood obesity are hard to avoid. The newspapers and television schedules seem to have an almost constant supply of stories about overweight children, school meals and unhealthy lifestyles. Tackling obesity is an international problem and in England the Department of Health recognised it as a priority in the 2004 Public Health White Paper, Choosing Health.

Nationally, the National Health Survey data informed the recent report Obesity Among Children Under 11[1] which found the numbers of obese children aged 2-10 had risen from 9.9% to 13.7%. Among older children aged 8 to 10, this had risen from 11.2% in 1995 to 16.5% in 2003. In 2006 each PCT was asked to record the height and weight of reception class (4/5 year olds) and year 6 (10/11 year olds) children to provide more accurate monitoring data. Essex figures suggest a child obesity prevalence rate of about 11% for both of these age ranges combined.[2]

Children who are obese are more likely to become obese adults and therefore at greater risk of developing a number of related illnesses such as Type 2 Diabetes or Heart Disease. The Wanless Report estimated that obesity directly costs the NHS approximately £1 billion a year and the UK economy a further £3.5 billion in indirect costs[3]. If Essex is in line with national averages, this would mean a cost to the NHS in Essex (including Southend and Thurrock) of around £32.5 million each year and a further £110 million cost to the economy through, for example, days of work lost through obesity related illness. If current trends continue, these costs will continue to rise. Preventing or tackling childhood obesity could help reduce the numbers of obese adults, improve people's quality of life and reduce the burden of related diseases on NHS and social care budgets and the wider economy.

The review looked at national and international evidence of what works in tackling childhood obesity and at what is happening locally. This work included discussions with frontline workers and a questionnaire sent to young people.

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[1] Jotangia, Moody, Stamatakis and Wardle, Obesity in Children Under 11. www.dh.gov.uk/assetRoot/04/10/94/10/04109410.pdf

[2] See table on P.28 of this report for the proportion of obese children in each PCT area as measured.

[3] Derek Wanless. Securing our future. Taking a long term view. April 2002. www.hm-treasury.gov.uk/consultations_and_legislation/wanless/consult_wanless_final.cfm

Key Findings

A number of key findings have emerged from the review. The views of those working to tackle childhood obesity, and of young people, have been essential in shaping these findings. Findings include:

- The recent reorganisation of Essex PCTs and the financial difficulties in some parts of the Essex NHS has put NHS engagement and delivery at risk. It is hoped the recent East of England Strategic Health Authority letter setting out tackling childhood obesity as a key priority will help sustain NHS involvement.[4]
- Approaches to child health are most likely to be successful if they are holistic, designed for children and involving families.
- There should be action beyond school age children, with early years interventions central to local obesity strategies.
- Partnership arrangements in Essex are very complex and need to be clarified. It is hoped the Local Area Agreement, Children and Young People's Plan, and the Children's Trust Approach will help ensure strong partnerships with effective accountability frameworks.
- Information sharing is patchy.
- Data collection for monitoring child obesity needs to be improved.
- More consideration needs to be given to evaluating the outcome of interventions.
- There are many examples of good practice that should be shared across the County. Some of these are highlighted in this report.

[4] Letter from Paul Cosford, Regional Director of Public Health, East of England Strategic Health Authority, to Joanna Killian, Chief Executive of Essex County Council. Sent: 15th November 2006.

Key Recommendations

The table below sets out the Panel's recommendations. It proposes who should lead for delivering each recommendation and which partners would need to be involved to ensure success.

	Lead Responsibility	Monitoring arrangements	Locality Group Managers	Schools	Primary Care Trusts	Essex County Council	District/Borough Councils	Children and Young People's Strategic Partnerships (CYPSPs)
Holistic approach to child health								
Clearly identify roles of local partners.	CYPSPs	To be confirmed						✓
Further develop multi-disciplinary teams.	To be confirmed	To be confirmed	✓	✓	✓	✓	✓	✓
Ensure obesity strategies include interventions for pre-school children.		To be confirmed	✓		✓		✓	✓
Physical activity								
Ensure all partners are engaged in developing Play Strategies.	District/ Borough Council		✓	✓	✓	✓	✓	✓
Engage young people in developing opportunities for physical activity.	To be confirmed	To be confirmed	✓	✓			✓	✓
Schools should consider "quick wins" like PE homework.	Schools	To be confirmed		✓				
Social marketing								
Support Essex Obesity Alliance social marketing plans.	Essex Obesity Alliance	To be confirmed	✓	✓	✓	✓	✓	✓
Healthy schools and school food								
Engage children in developing healthy school meals.	Schools	To be confirmed		✓				
Increase roll out and support for healthy schools.		To be confirmed		✓	✓	✓		
Provide support and advice on self-catering.	Education Authority	To be confirmed		✓		✓		
Schools should consider "quick wins".	Schools	To be confirmed		✓				
Partnership arrangements								
Partner organisations	All	To be	✓	✓	✓	✓	✓	✓

	Lead Responsibility	Monitoring arrangements	Locality Group Managers	Schools	Primary Care Trusts	Essex County Council	District/Borough Councils	Children and Young People's Strategic Partnerships (CYPSPs)
should ensure engagement of children and young people and their families.	organisations	confirmed						
Professionals need to be clear which local partners are involved in tackling childhood obesity and about their respective roles.	CYPSPs	To be confirmed	✓	✓	✓	✓	✓	✓
Children and Young People's Strategic Partnerships should develop clarity about local accountability and ensure there is a local named lead for childhood obesity.	CYPSPs	To be confirmed						✓
Local partners should engage with the Essex Obesity Alliance.	All partners, with Essex Obesity Alliance	To be confirmed	✓	✓	✓	✓	✓	✓
Data and measuring outcomes								
PCTs should work closely with schools to improve data collection and monitoring in 2007 and beyond.	PCTs	To be confirmed		✓	✓	✓		
Undertake more assessment of the impact of interventions by following up children, where possible, to establish if lifestyle changes continue after an intervention.	All organisations	To be confirmed	✓	✓	✓	✓	✓	✓
Clinical services								
Continue to develop local Care Pathways based on local and national good practice.	PCTs	To be confirmed			✓		✓	✓
Additional areas for development								
Develop training and/or information for staff	PCTs	To be confirmed			✓	✓		

	Lead Responsibility	Monitoring arrangements	Locality Group Managers	Schools	Primary Care Trusts	Essex County Council	District/Borough Councils	Children and Young People's Strategic Partnerships (CYPSPs)
working with children to enable them to identify a child who is obese or overweight and when action may be necessary.								
Ensure that new PCT structures enable good practice to be spread across areas and strengthen their public health role.	PCTs	To be confirmed			✓			

Please note that other partners may need to be involved as appropriate. For example, acute trusts will be involved in developing care pathways and the community and voluntary sector will be involved in implementing many recommendations.

Monitoring arrangements will be confirmed when we have received formal responses to this report from NHS and other key partners. It is proposed that the LAA obesity lead, via the Essex Obesity Alliance, and the Children and Young People's Strategic Partnerships take the lead in monitoring implementation of the recommendations.

1 Introduction

Essex County Council's Health Overview and Scrutiny Committee has recently completed a review looking at work in Essex to tackle childhood obesity. This report sets out the background to this work and the key findings and recommendations of the review panel. Further information on some key issues is included in the appendices at the back of the report.

1.1 Childhood Obesity – why is it important?

It seems barely a day goes by without another news headline or television programme drawing attention to the issue of childhood obesity. Just one week in November 2006 saw wide media coverage, including:

- Coverage of school meals;
- Proposals for a junk food advertising ban on children's television programmes;
- The National Institute for Clinical and Health Excellence (NICE) announcing that in extreme circumstances surgery will be an option for obese children; and
- Numerous television programmes aimed at reducing the weight of obese children.

Obesity is a topic of international concern, with the World Health Organisation (WHO) identifying obesity as an epidemic requiring urgent public health action[5]. Children who are obese are more likely to become obese adults and therefore at greater risk of a number of related illnesses including Type 2 diabetes and coronary heart disease. The Wanless Report (an assessment of the future resource requirements of the NHS) estimated that obesity directly costs the NHS approximately £1 billion a year and the UK economy a further £3.5 billion in indirect costs[6]. If Essex is in line with national averages, this would mean a cost to the NHS in Essex (including Southend and Thurrock) of around £32.5 million each year and a further £110 million cost to the economy through, for example, days of work lost through obesity related illness. If current trends continue this figure will continue to rise. Preventing or tackling childhood obesity could help reduce the numbers of obese adults, improve people's quality of life and reduce the burden of related diseases on NHS and social care budgets and the wider economy.

Nationally, the National Health Survey for England data informed the recent report Obesity Among Children Under 11[7] which reported that the prevalence

[5] See: World Health Organisation Obesity an Epidemic., Geneva 2000. www.emro.who.int/nutrition/PDF/Obestity_Epidemic.pdf

[6] Derek Wanless. Securing our future. Taking a long term view. April 2002 . www.hm-treasury.gov.uk/consultations_and_legislation/wanless/consult_wanless_final.cfm

[7] Jotangia, Moody, Stamatakis and Wardle, Obesity in Children Under 11. www.dh.gov.uk/assetRoot/04/10/94/10/04109410.pdf

of obesity in children aged 2-10 had risen from 9.9% to 13.7%. Among older children aged 8 to 10, this had risen from 11.2% in 1995 to 16.5% in 2003.

In 2006 each PCT was asked to record the height and weight of reception class (4/5 year olds) and year 6 (10/11 year olds) children to provide local baseline data. Essex figures suggest a childhood obesity prevalence of about 11%. However, as we shall see below there are some concerns that this data may not be representative of children in Essex.

Childhood obesity has been recognised as a major public health problem by the Department of Health. This has been reflected in the Essex Local Area Agreement, which seeks to achieve the joint Department of Health, Department for Education and Skills and Department for Culture, Media and Sports national target a year early and:

- Halt the increase in obesity in Essex in children 5-10 by 2009.

1.2 What is Childhood Obesity?

Experts seem to agree that childhood obesity has increased and that it is a cause for concern. However, there is some dispute about how it should be defined. Body Mass Index (BMI) is commonly used as an indicator of the level of overweight or obesity[8] and as an indicator of associated health risks. The BMI is calculated from an individual’s weight (in kilograms) divided by their height (in metres) squared. In adults, a BMI of 25.3-kg/m2, signifies overweight and >30kg/m2 signifies obesity; overweight and obesity are associated with an increased risk of poor health.

It is not so clear that it is a useful measure in children. In children the “normal” ratio of weight to height changes as a child grows and no simple calculation can define overweight or obesity. Reference charts have been created giving BMI thresholds for overweight and obesity for boys and girls for each year of age. These reference curves are based on data from several British studies published between 1978 and 1990.

1.3 What causes childhood obesity?

Obesity is the result of a long term imbalance between energy intake and energy output, that is, it develops slowly when a child is not using as much energy as they are consuming.

Changing lifestyles are typically blamed for the rise in childhood obesity, particularly a dramatic reduction in physical activity amongst children since the 1970s. It is estimated that between 1995 and 2004 the proportion of children

[8] There are arguments that other measures provide a more accurate indicator of obesity and increased risk of associated health impacts, for example waist circumference or waist to hip ratio.

aged 2-15 who were obese rose from 11 to 19 per cent among boys and from 12 to 18 percent among girls[9].

Health Survey for England data showed the percentage of children aged 2 to 10 who were overweight (including those who were obese) rose from 22.7% in 1995 to 27.7% in 2003 (see Figure 1).

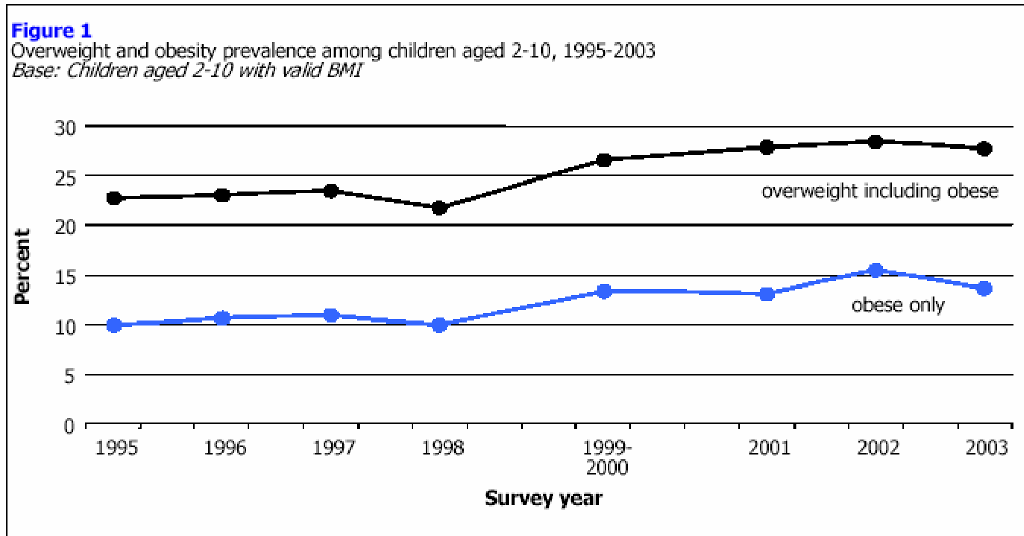
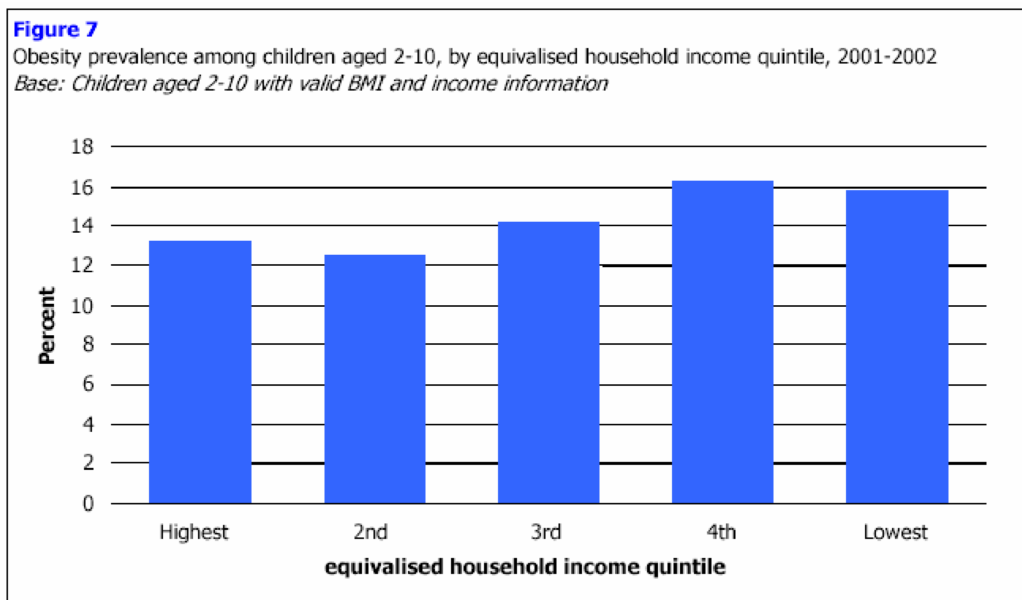


Figure 1: Overweight and obesity prevalence in children aged 2-10, 1995-2003[10]

The prevalence of obesity was higher in children living within households with the lowest levels of household income compared with children from households with the highest levels of household income (15.8% compared with 13.3%, see Figure 2 below).



[9] See Eastern England Public Health Observatory at www.erpho.org.uk/topics/Child_Health/Topicchildhoodobesity.aspx

[10] Jotangia, Moody, Statamakis and Wardle, Obesity in Children Under 11. www.dh.gov.uk/assetRoot/04/10/94/10/04109410.pdf

Figure 2: Obesity prevalence by household income[11]

The same pattern was evident within different levels of area deprivation. Prevalence of obesity was 5 percentage points higher among children living within the most deprived areas (16.4%) than the least deprived areas (11.2%).

Deprivation is correlated with poor health outcomes generally and there are concerns that ill health can lead to unemployment and low levels of aspiration and self esteem. Obesity affects some children in all areas but some focused work may be needed to target those areas of greatest need.

19.8% of children living in households where both parents were either overweight or obese were themselves obese compared with 6.7% of children living in households where neither parents were overweight or obese and 8.4% of children living in households where one of the two parents was overweight or obese (see Figure 3).

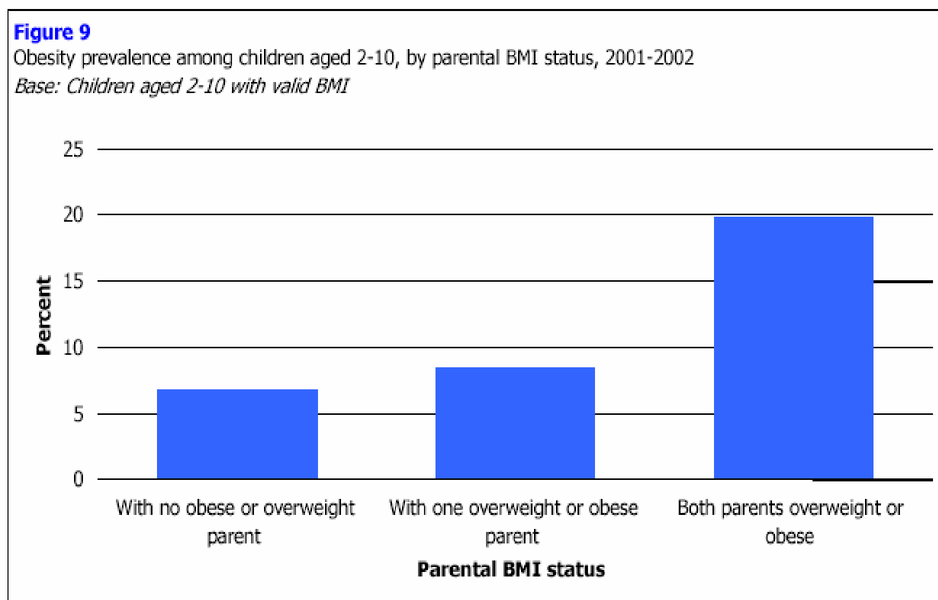


Figure 3: Obesity prevalence by parental BMI status

Obesity levels tended to rise as reported physical activity levels fell (see Figure 4).

[11] As above.

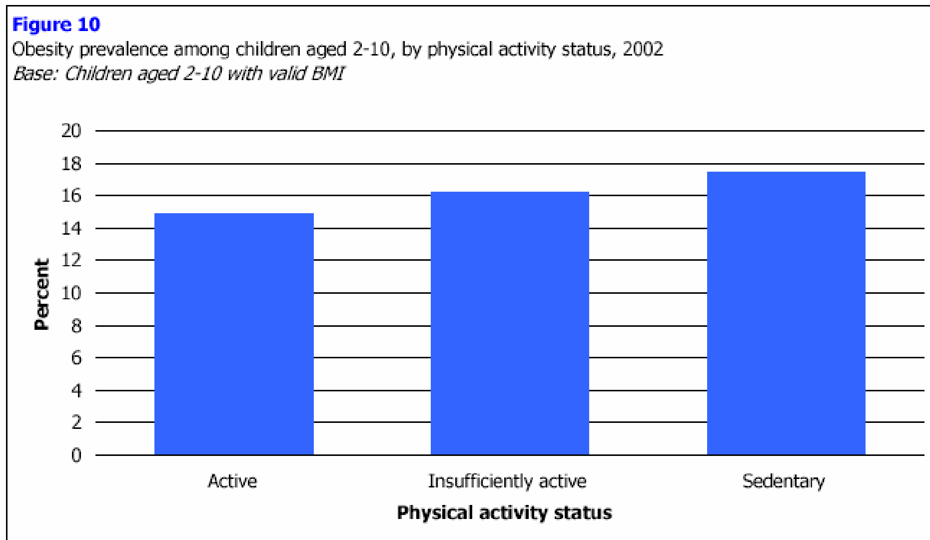


Figure 4: Obesity prevalence by physical activity status[12]

1.4 Tackling Childhood Obesity – what works?

There is limited evidence about which practical interventions work in tackling childhood obesity. This does not mean that interventions are unsuccessful but that more work needs to be done to determine the impact they have. In 2006 a joint report from the Audit Commission, Healthcare Commission and National Audit Office found there to be evidence of effectiveness:

> "to support the use of multi-faceted school-based interventions to reduce obesity and overweight in school children, particularly girls. These interventions included: nutrition education, physical activity promotion, reduction in sedentary behaviour, behavioural therapy, teacher training, curricular material, and modification of school meals and tuck shops"[13].

The report also found limited evidence of effectiveness:

> "to support school-based health promotion (classroom curriculum to reduce television, videotape and video game use) for the prevention of obesity and overweight in children.
>
> that family-based behaviour modification programmes (family therapy in addition to diet education, regular visits to a paediatrician and encouragement to exercise) impede weight gain in obese children"[14].

There was a lack of evidence of effectiveness:

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[12] As above.
[13] National Audit Commission, the Healthcare Commission and the National Audit Office 2006 Tackling Childhood Obesity – first steps. p.27
[14] As above.

> "for school-based physical activity programmes led by specialist staff or classroom teachers for the prevention of obesity and overweight in children.
>
> that family-based health promotion interventions impact on obesity and overweight. These interventions focused on dietary and general health education and increased activity, and involved sustained contact with children and parents"[15].

The Audit Commission identified 5 key programmes that contribute to reducing childhood obesity:

- School Meals
- School Sports Strategy
- Healthy Schools Programme
- Play
- Obesity Campaign (the planned national social marketing campaign)[16]

We considered all of these programmes, and more, in the course of this review, looking at how programmes are being implemented across Essex.

1.5 Objectives of this scrutiny review

The aim of this review was to determine the extent to which pre-adolescent childhood obesity is being tackled in Essex. The review also sought to look at whether, and to what extent, outcomes of interventions are being measured and with what success. Children aged 0-13 (or up to Year 8) were chosen as the focus of the study.

Key objectives were:

- To investigate what resources are currently committed to reducing childhood obesity in Essex.

- To investigate how these resources are being used, by individual agencies and collectively.

- To identify any gaps and/or overlaps in resource use.

- To investigate how outcomes have been defined, how and to what extent are they being measured and with what results.

- To make recommendations for improving partnership working to tackle childhood obesity in Essex.

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[15] As above.
[16] The National Audit Commission, the Healthcare Commission and the National Audit Office (2006) Tackling Childhood Obesity – first steps. p.10

1.5.1 Some limitations

We have faced some limitations in achieving these objectives, particularly in terms of measuring resources. It has been difficult to establish the resources committed to tackling childhood obesity for many reasons, including:

- **Identifying interventions** – the size of Essex and the number of organisations involved has meant we have not been able to capture information about all relevant schemes and interventions. For example, we have limited information about activity in the Community and Voluntary sector, although we know that groups such as Scouts or Guides will engage children in physical activity. Similarly, information about private sports or dance classes has not been obtained although we recognise the value these classes can have.

- **Constant change** - the period of this review has been one of constant change with NHS restructuring and financial constraints and new guidance and initiatives announced nationally and locally. This means that interventions and initiatives have not been constant and it has been difficult to keep a record of all changes across the County.

- **Identifying resources** - it has not been possible to develop an accurate picture of the resources committed to tackling childhood obesity. This is partly because, tackling obesity forms only part of the objectives of a given intervention, or only a part of the mainstream work of schools and other organisations. This difficulty has been reflected in work on the Essex Local Area Agreement where it has been difficult to establish the total resources allocated to deliver a reduction in obesity (i.e. aligned funding).

These limitations mean that, whilst we have investigated the resources being used to tackle childhood obesity and identified some gaps, the review has not entirely met the first three objectives of the review.

There are a number of important areas that contribute to preventing and tackling childhood obesity that have largely been outside the scope of this review. These include:

- **Planning and infrastructure** – the Panel recognises the importance of planning and infrastructure and welcomes the introduction of Health Impact Assessment through the Essex Local Area Agreement and recognises that this will have an impact on the health of local people.

- **Transport** – e.g. walking and cycling opportunities and access to facilities such as leisure centres.

- **Industry** – businesses such as supermarkets and food industry advertising have an impact on children's diet and activity. The Panel would encourage partners to engage with local businesses in addressing childhood obesity.

2 Our Approach

A variety of approaches were used in undertaking this review, reflecting the complexity of the issue. We carried out a literature review of national and international information about childhood obesity and interventions intended to reduce the burden. Colleagues across the County from schools, the NHS, District Councils and the County Council helped us to understand what action is taking place across Essex. Many of these partners were able to attend witness sessions, which enabled Members to hear their experience first hand. This work was supplemented by more detailed work in two areas of Essex:

- Epping Forest and Harlow; and
- Colchester

This work enabled us to look in some detail at partnership arrangements and interventions in these areas and this has helped inform our findings and recommendations. Canterbury Christ Church University College will be producing a report on the action learning element of the work with Colchester and Epping Forest which will help inform future scrutiny reviews.

Members of the Panel carried out visits to local schools and to projects funded through the Centre for Public Scrutiny contribution to this project. This provided an opportunity to see how initiatives work in practice and to engage with children.

A stakeholder workshop was held on 18 September 2006 and attended by over 70 people from across Essex working to tackle childhood obesity. These included School Nurses, School Sports Co-ordinators, Children's Commissioners, Dietitians, Public Health Specialists and many others. We were delighted to also be able to welcome colleagues from Southend and Thurrock as working in partnership with them will become even more important in light of NHS reconfiguration. This event enabled the Panel to test their key findings, which were recognised by attendees as reflecting local experience. It was also an opportunity to begin to develop recommendations.

Members of the Young Essex Assembly and other young people were invited to complete a short questionnaire that asked them their views on childhood obesity and how it could be addressed. There were 73 respondents and their views have been invaluable in writing this report.

3 Our key findings

3.1 NHS context

It is important to stress that tackling childhood obesity in Essex will require a partnership approach involving many organisations including local government, the voluntary and community sector, businesses, schools and the NHS. Many witnesses and contributors spoke of the importance of recent NHS changes and for this reason these are dealt with in this separate section.

Over the period of the review, NHS management in Essex was restructured and the whole of the NHS was subject to tough new financial controls to reduce a net Essex deficit. This has had a damaging effect on the project and on work to tackle childhood obesity. Indeed public health work generally appears to have been the victim of the financial situation with national "Choosing Health" money being redirected to help achieve cost savings targets.

Restructuring Primary Care Trusts (PCTs) has seen the 13 PCTs covering the old Essex Strategic Health Authority area merging into 5 organisations that, unlike other parts of the country, are not co-terminous with Local Authority boundaries. This presents a number of challenges for future partnership working, particularly in the south of the County where the South East and South West PCTs will each cover parts of the Essex County Council administrative area as well as one of the two Unitary Authorities.

The bulk of the research for this report was carried out before the move to 5 PCTs. Throughout the report references are made to the old PCTs unless the information referred to was obtained after 1 October 2006 and it was not clear that it was referring only to an old PCT area.

Figure 5 below shows local government and new PCT boundaries.

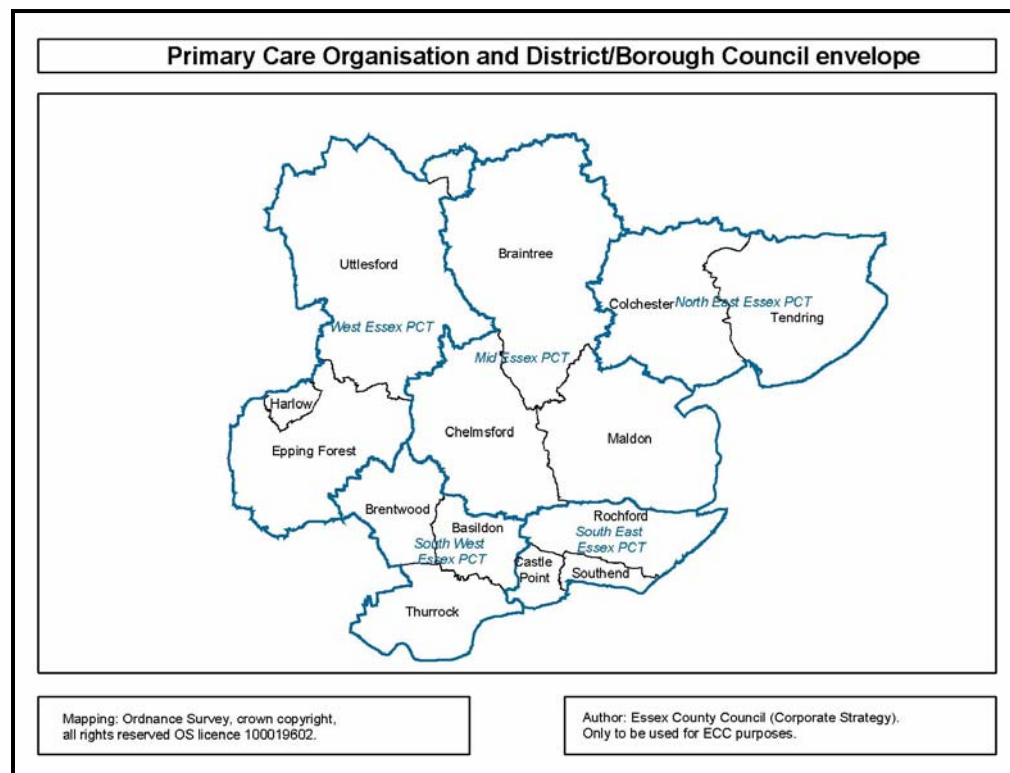

Figure 5: Essex Primary Care Trusts and District/Borough Council boundaries

There are many other changes underway in the NHS that may impact on work in this area. These include:

- A stronger commissioning/provider split that is likely to affect public health work;
- Practice Based Commissioning; and
- NICE guidelines on interventions to tackle childhood obesity which have recently been published.

It is not yet clear how these changes will affect work to tackle childhood obesity but it seems certain they will have some impact and that the strength of local partnerships and strategies will be tested by them, and will influence the implementation of the NICE guidance.

You will see throughout this report that, although important, the NHS is only one of many partners contributing to work to tackle childhood obesity. Indeed, when it comes to prevention, or tackling obesity when there is no need for clinical intervention, it is other partners who can, and frequently do, deliver many effective interventions from ensuring access to healthy food and opportunities for physical activity. This can be seen in the examples of good practice that we have included here.

The Panel hopes that the current changes in the NHS will not have a negative impact on the provision of specialist clinical services for obese children who need to access them or on the NHS contributions to non-clinical interventions. It hopes that through effective partnership working, and in particular the focus on delivering the LAA, that the role of partner organisations will be recognised and strengthened to ensure effective work to tackle the problem of childhood obesity.

3.2 Holistic approach to child health

Many witnesses and contacts spoke with passion about the importance of looking at the whole child and taking a holistic approach to their health. They recognised that obesity is one of many health issues that could be effectively tackled by taking a holistic approach to child health and giving children and families the tools to choose a healthy lifestyle. These tools include self-confidence, motivation and assertiveness.

Witnesses also spoke of the need for prevention rather than cure. That is, encouraging healthy eating and physical activity in all children as a way of preventing obesity. Many schemes highlighted throughout this report adopt this approach, from healthy school meals through to Chelmsford's open access play schemes. The Panel recognise the importance of school sport, healthy eating, family-based interventions, interventions with pre-school children and their families and providing opportunities for play. It has not been possible to do justice here to the range of schemes in place across Essex or to the vast provision of activities through local sports and youth clubs and organisations such as the Scouts.

The importance of early years interventions was also stressed by witnesses. For example, the importance of breastfeeding to child health is recognised in a government target for PCTs to increase uptake of breastfeeding by 2% year on year. Health visitors and midwives have access to families and can address questions of diet and activity for the whole family as well as the individual child.

The children's well-being agenda in Essex is continuing to develop. Under the umbrella of the Children's Trust Approach, the local Children and Young People's Strategic Partnerships (CYPSPs), Local Delivery Groups (LDGs) and multi agency teams, are providing the basis for more holistic approaches to child health. See Appendix 1 for further details of the children's agenda in Essex.

Good practice example: Mid Essex multidisciplinary children's teams and early interventions

In Mid Essex there are now multidisciplinary teams of Health Visitors and School Nurses who are part of Local Delivery Groups. These teams enable a continuity of care for children and their families, from home to school, and should mean more consistent personal plans. The teams also assist in streamlining interventions during the early years and beyond. For instance, weaning advice is now provided earlier in a child's life so parents can understand when and how to introduce weaning to improve the nutrition that a child receives. This can delay weaning and increase the numbers of mothers who continue to breastfeed.

From Pat Jackson, Children's Services Manager, Mid Essex PCT

Good practice example: Snack Attack

Colchester PCT and Colchester Sure Start (Ormiston Trust) have worked together to promote healthy eating in local pre-school groups. A small amount of funding is given to groups to provide and implement healthy eating menus, and a *Snack Attack* certificate is awarded to groups who have successfully implemented them. Many of these groups now choose to continue the initiative adjusting their charging policy accordingly.

From Jeannie May and Beryl Taplow, Ormiston Trust, Colchester

Recommendations

Local Children and Young People's Strategic Partnerships should identify clearly the roles of different partners in delivering child health improvements.

Further develop local multi-disciplinary teams which can engage with families.

Ensure that local obesity strategies include interventions focussed on pre-school children (e.g. Health visitors, Sure Start, promoting breastfeeding).

3.2.1 Physical activity

Opportunities for physical activity are central to tackling childhood obesity. School sports schemes and local sports partnerships have a key role to play in ensuring access to sport and opportunities for physical activity.

Access to play (see below) is also central to tackling obesity through encouraging physical activity. This has been recognised by the Department of Health and the National Institute for Health and Clinical Excellence (NICE)[17].

We asked young people if they thought there were enough opportunities for physical activity in their area. We used a questionnaire distributed through the Young Essex Assembly and the Essex Youth Service and had 73 responses. Whilst most respondents said that there were enough opportunities for physical activity, almost a third of respondents to our questionnaire thought more were needed. A small number (4 respondents) thought cheaper facilities were needed whereas others wanted a broader range of activities such as dancing, girls' football, netball and more gyms and swimming pools.

Good practice example: Chelmsford open access play schemes

Chelmsford Borough Council runs a variety of free access play activities during the school spring and summer holiday periods. These activities commonly include arts, crafts, sports and games as well as the opportunity to play freely under safe adult supervision.

One aspect of this provision has been the "Playground Play" project. This consists of short supervised play provision within neighbourhood equipped play areas, of which there are in excess of 100 within the Borough. As well as providing some supervised activity at the time they are staffed, Playground Play has introduced many children (and their families) to outdoor play provision which is available at all times within their locality. Many children have no interest in competitive sport, but can enjoy healthy outdoor exercise from the use of such play facilities.

From David Archer, Chelmsford Borough Council

[17] Children's Play Information Service Factsheet: Play and Health. www.ncb.org.uk/dotpdf/open%20access%20-%20phase%201%20only/factsheet_playhealth_cpis_2006.pdf

Recommendations

Ensure all partners, including Parish Councils and the Voluntary and Community sector, are engaged in developing local District Play Strategies.

Engage young people in developing local opportunities for physical activity.

Schools should consider if there are potential "quick wins", such as PE homework.

3.2.2 Social marketing

Social marketing has also been identified as an important tool that can help combat some of the messages children receive about, say, diet, through traditional product marketing. The use of social marketing techniques was promoted in the 2004 White Paper 'Choosing Health'[18]. Further work on Social Marketing by the National Consumer Council (NCC) followed. [19]

Social marketing is:

> 'the systematic application of marketing concepts and techniques to achieve specific behavioural goals, for a social or public good'[20]

There are some good examples of how social marketing has been used to achieve health outcomes in other countries, including Australia and the United States[21]. In the UK, this approach has been largely neglected until now.

The Department of Health is engaged in a cross-Public Sector study of the application of social marketing to health and one of its pilot themes is on tackling childhood obesity. Within this work, analysis of the behaviours and assumptions which lead to obesity has been undertaken.[22] It is now being developed further, including through a group of Primary Care Trusts and other organisations who are seeking to impact on childhood obesity. The National

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[18] Department of Health. Chosing Health. www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4094550&chk=aN5C or
See page 24 for a brief discussion of Social Marketing
[19] National Consumer Council. Its our health! Realising the potential of effective social marketing. 2006, www.ncc.org.uk/social-mktg.pdf
[20] Quote from: French, Blair-Stevens (2006) in the document 'Its our health!' given above.
[21] National Consumer Council. Its our health! Realising the potential of effective social marketing. 2006, www.ncc.org.uk/social-mktg.pdf
[22] Department of Health Case study. A Social Marketing Approach to Childhood Obesity. http://engage.comms.gov.uk/webfiles/Case%20studies/Case%20Study%20-%20DH%20Child%20obesity.pdf

Consumer Council is also developing a toolkit to enable professionals to use social marketing interventions.[23]

A national social marketing campaign will be starting in 2007 and is expected to run for 10 years, with the first 3 years focusing on children between 2 and 10 years old.[24]

Recommendation

Local partners should participate in the Essex Obesity Alliance's plans to build on national social marketing campaigns, ensuring consistent messages are promoted locally.

3.2.3 Healthy Schools and the provision of food in schools

Most children spend a large amount of time in schools. This is a key setting for learning, physical activity and meals. Many schools in Essex are working towards 'Healthy Schools' accreditation (see Appendix 4 for more information, including the role of Healthy School Co-ordinators and Links Co-ordinators), and we would like to see the benefits of this approach in all schools in the County. As part of this study a few County Councillors visited primary and secondary schools to hear children's first hand accounts of their experience of eating and physical education in school. The children met said that they enjoyed the better food choices now available and 'agreed with the limit on chips only once a week'[25].

Over half the young people who responded to our short questionnaire (41 out of 73) thought that less healthy options such as chips should be restricted in school meals with a further 2 respondents saying that they should "maybe" or "sometimes" be restricted.

[23] From discussion with Chris Holmes at the Department of Health (DH). 26th September 2006.
[24] Brief details of this can be found at: Department of Health. Delivering the PSA. www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Obesity/ObesityArticle/fs/en?CONTENT_ID=4133952&chk=woBw3G
[25] From discussion between Cllr Julie Young and children at the Sir Charles Lucas Arts College, Colchester.

Good practice example: Cornelius Vermuyden School

In becoming a healthier school, a Deputy Head and the Catering Manager at the Cornelius Vermuyden School on Canvey Island are working together to develop a culture of healthy eating. The school uses its own garden to supply some of the food for school lunches, which are prepared in-house. Children's eating habits are monitored by a swipe card system, which will enable the school to see if its healthy eating strategy is working. The Catering Manager is on hand at parents' evenings to discuss what specific children eat, if parents require discussion. The school recognises that children may be tempted to go outside the school at lunchtimes to buy junk food, but seeks prevention of this by improving its own healthy eating offer.

From presentation by Rob Cawley, Deputy Headteacher

The provision of food in schools is an important issue for those concerned with tackling childhood obesity, and for those interested in child health generally. It has been a topic of national concern with Jamie Oliver's campaign to improve the quality of school lunches and now with new national guidance in place.[26] There have been news reports that, nationally, uptake of school meals has fallen significantly since the introduction of new standards in September 2006. We are not aware of the figures for schools in Essex but would expect individual schools to monitor this and take steps to encourage children and young people to select healthy school lunches.

The way in which school meals are provided is also changing, with many schools in Essex turning to in house provision of meals. However, we heard from witnesses and contacts that more support would be welcomed by schools in developing capacity for in-house provision and that networks of schools reflecting Local Delivery Group areas may help schools develop in this area. (See Appendix 5 for further discussion on Food in Schools).

Good practice example: North Essex Schools Catering Consortium

The North Essex Schools Catering Consortium prepares all its food in-house and has its own Catering Manager. The schools are aiming to provide good and locally produced food, using techniques that do not remove the nutritional value from food. The pace of changing to better and better food is partly determined by bringing children and their parents on board so that they become used to new flavours and appreciate the value of good fresh food. The morale amongst catering staff is better, as they feel to be more a part of the school rather than the 'heater uppers' of a large supplier.

From discussion with Jason Walmsley, Catering Manager.

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[26] See the following link for the latest national guidance:
http://www.schoolfoodtrust.org.uk/UploadDocs/Library/Documents/School-food-trust.pdf

Nationally and locally attention is beginning to spread to encouraging healthier lunchboxes for children who bring their own meals to school. Indeed, the Department of Health is expected to produce guidance on this shortly.

Good practice example: Epping Forest Healthy School Lunchboxes Scheme

Lunchboxes are an important aspect of food and drink provision in schools. With the implementation of healthier school food underway, it is important to support parents and children in putting together a healthy packed lunch. School nurses from Epping Forest and Harlow identified local schools that wished to do some healthy packed lunchbox promotion. The school nurses worked in partnership with many of the local primary schools, to put on demonstrations and workshop sessions for both parents and children. These sessions involved providing ideas, suggestions and support. The children and parents got to make their own lunches and taste a variety of foods. Empowering them to prepare and enjoy healthy food was integral to the project. For example in one school, the children and parents made up some healthy lunchboxes, which the children had for lunch, in school, the following day.

From discussion with Helen Dear, West Essex PCT

Recommendations

Engage children in developing healthy school meals.

Increase the roll out of Healthy Schools and ensure adequate support is provided.

Provide improved advice and support to schools on self-catering, with a corresponding willingness of schools to combine to deliver self-catering. This should include advice on food supply chains.

Schools should consider if there are potential "quick wins", such as healthy vending machines and improved access to drinking water.

3.3 Partnership arrangements

There is a complex range of agencies and partnerships that seek to impact on childhood obesity and child health in Essex (see Appendix 3). These include:

- School Sports Partnerships and Sports Colleges (See good practice example below)
- Play Partnerships, including the development of Play Strategies
- Other Partnerships

- Essex Obesity Alliance
- Community development initiatives, often led by the District Council and tackling a range of issues related to deprivation
- Transport Strategies
- Local Development Plans
- Cleaner, Safer and Greener Community Plans

The Audit Commission has mapped the key agencies involved in tackling child obesity and their work demonstrates the complex arrangements in place nationally and locally. Figure 6 below shows these agencies.

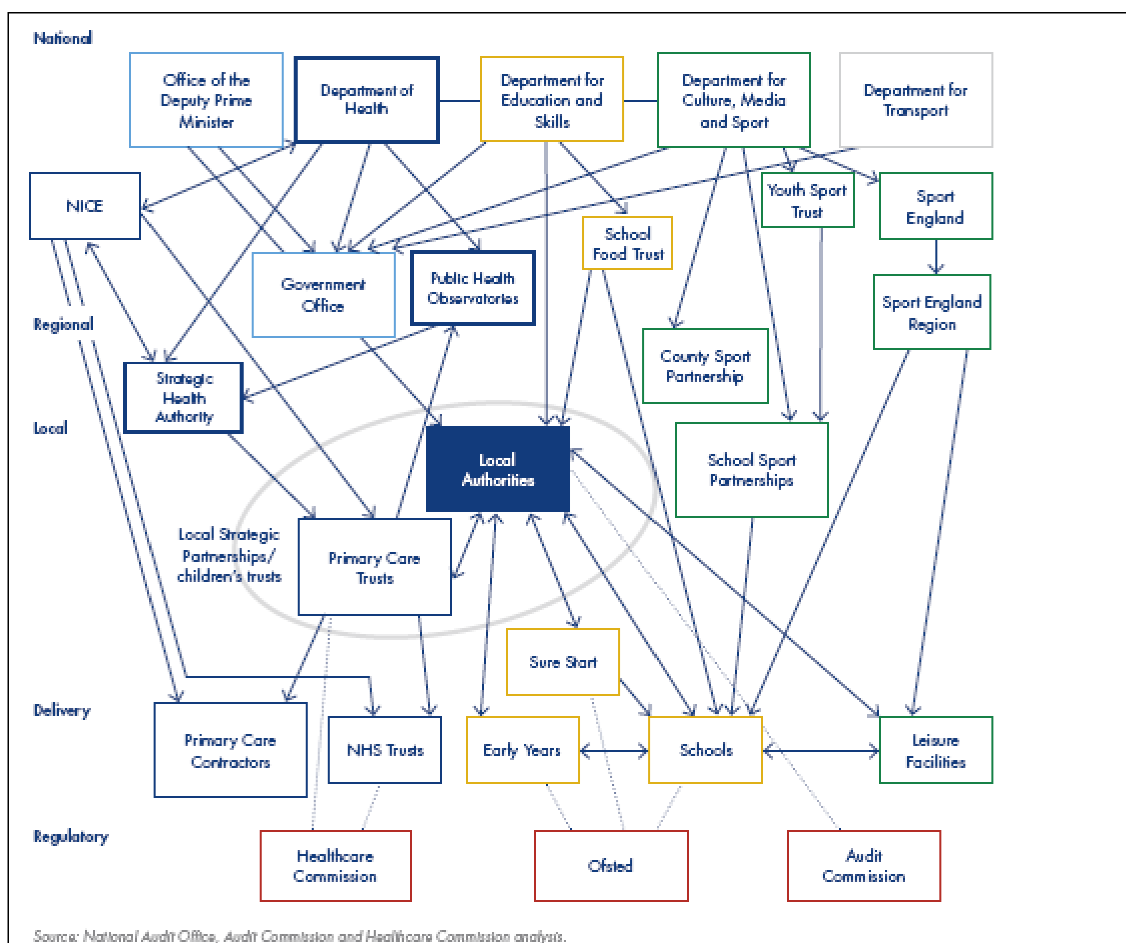

Figure 6: The current delivery chain for child obesity

The Panel noted that partnership working was often ad hoc, with activities happening because of the work of dedicated individuals rather than effective structures. There was also concern that roles and responsibilities were not always clear and that not all relevant partners were sufficiently engaged.

The Panel also heard that information sharing between agencies was not always effective, sometimes because agencies were not working together and sometimes because information systems were not compatible.

It is hoped the Local Area Agreement (LAA), the Children and Young People's Plan, the Children's Trust Approach, and the local Children and Young People's Strategic Partnerships, will help ensure strong partnerships and effective accountability frameworks. The LAA obesity lead will have a key role in ensuring progress is made towards the 2009 target.

The Essex Obesity Alliance is seeking to promote actions across Essex that will support delivery of the LAA and contribute to tackling childhood obesity, for example:

- Health Equity Audits of access to food and opportunities for physical activity;
- Health Impact Assessments; and
- Sharing good practice.

This work will only be successful if local partners are committed to delivery. The Panel would encourage local partners to participate in the Essex Obesity Alliance, and where appropriate contribute to delivery of its action plan.

There are some excellent examples of successful partnerships across the County and unfortunately we cannot include them all in this report. Two examples of partnerships focused on sports are included below.

Good practice example: Sports Partnerships in Epping Forest

There is a very strong partnership at Epping Forest to promote physical education, sport and leisure activity. Much of this activity has focused on the School Sports Partnership where there is a joint officer post between the District Council and Sports Partnership based at the Davenant School. The joint post helps partners to co-ordinate bidding and share facilities. It improves communication between partners so that effective schemes can be developed. A number of schemes have been developed that tackle obesity.

From presentation by Julie Chandler, Epping Forest District Council

Colchester United Sports Community Trust

This is the 'community arm' of the Colchester United Football Club, which is working closely with local agencies to tackle issues of health and fitness. At present it has a range of initiatives including one situated at their centre in Shrub End that provides an activity programme for babies and mums. This is part funded by Sport England. The Trust is also targeting children aged 3 and 4 to improve their co-ordination skills, to support their future participation in sports.

From discussion with Steve Bradshaw. Further details available at: http://www.cucst.org.uk/

A particularly good example of community engagement which demonstrates their Healthy Living Approach is given by what was Maldon and South Chelmsford PCT.

Maldon and South Chelmsford PCT, Approaches to promoting Healthy Living

Maldon and South Chelmsford PCT developed some excellent approaches to promoting Healthy Living including tackling obesity, which seek to generate substantial community and family involvement. For instance, during 'Obesity Week', a banner was erected over Maldon's High Street, visible to all, saying 'What are you weighting for'. A figure from 18th century Maldon, "the fat man of Maldon" also walked through the town. Schools and health professionals were engaged in related events to generate both awareness and ideas.

From discussion with Sarah Southerby and Jackie Tosic, Mid Essex PCT

It has not always been clear to what extent children and families have been engaged as partners in developing services and strategies to tackle childhood obesity. We are aware that many schools have involved children and young people in developing healthy school meals and ensuring that the food is appealing to pupils. However, the Panel recognises that engagement with children has been limited. Indeed, the extent to which the Panel had engaged with children and young people was a concern and the Panel has taken steps to ensure some engagement through school visits, visits to projects in Epping Forest and Colchester and a questionnaire to young people.

Recommendations

Partner organisations should ensure the engagement of children and young people and their families.

Professionals need to be clear which local partners are involved in tackling childhood obesity and be clear about their respective roles.

Children and Young People's Strategic Partnerships should develop clarity about local accountability and ensure there is a local named lead for childhood obesity.

Local partners should engage with the Essex Obesity Alliance.

3.4 Data and measuring outcomes

We have already identified information sharing between partners as an area where further development could improve service delivery. We also found difficulties with collecting data and measuring the impact of interventions. Throughout the course of the review there was no baseline data on levels of childhood obesity in Essex. Partners were planning and delivering services on the basis of synthetic estimates and were anticipating the completion of local data collection. Unfortunately, as mentioned above, there have been some problems with this data, and with the national database. About 70% of children were measured in Reception year and year 6, and the prevalence of obesity was about 13%. The coverage of each year group of children ranged from 0% to 99%.

Prevalence rates are shown in figure 8 below. (Please note the figure for Basildon PCT reflects local data analysis following concerns that the Department of Health figure was too low).

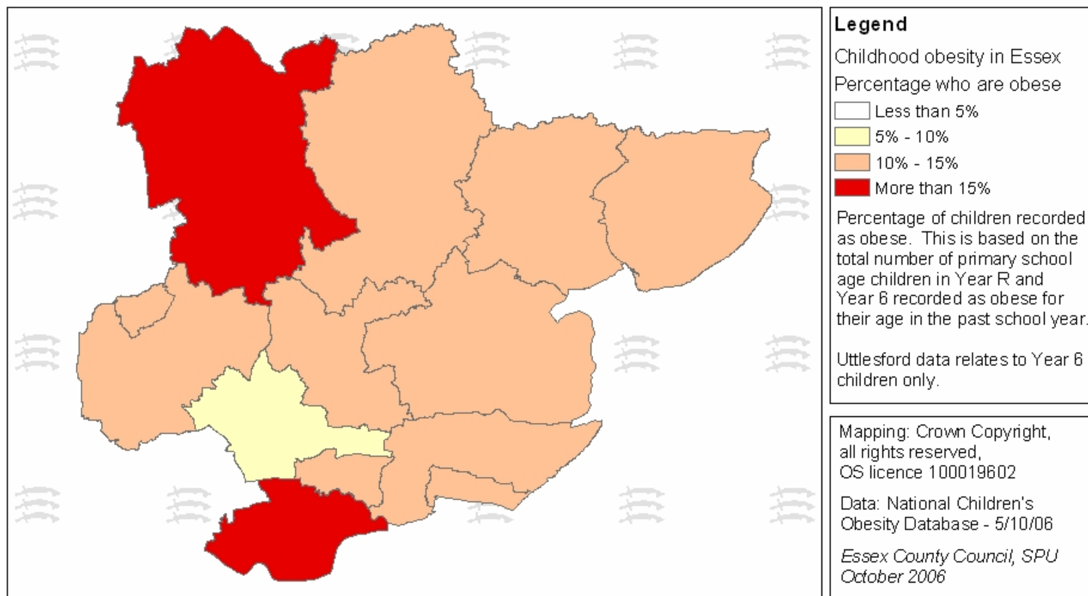

Figure 8: Obesity prevalence as indicated by 2006 monitoring of height and weight in Reception and Year 6 children.

There are concerns about how representative the data is, given that children or their parents can opt out of being measured. Anecdotal evidence suggests that in some schools this was a problem with larger children in Year 6. The figure for Uttlesford is misleading because the PCT did not record the height and weight of reception class children. This can be seen in figure 9 below which shows the percentage of eligible children whose weight was recorded.

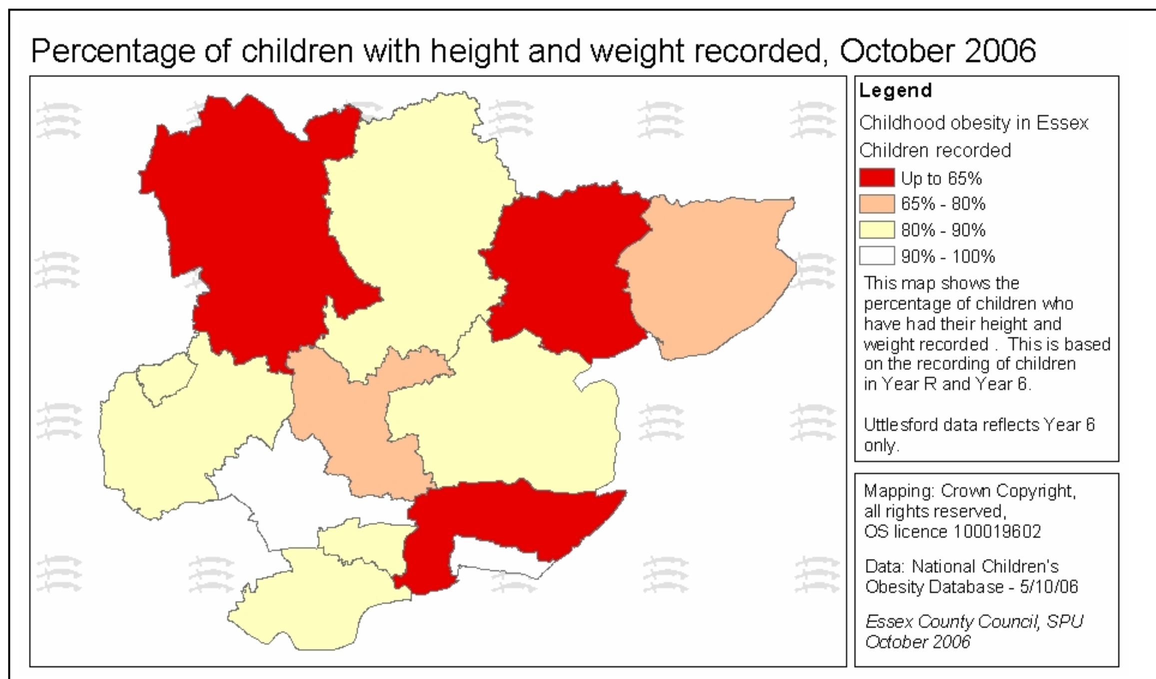

Figure 9: Percentage of children with height and weight recorded during 2006 monitoring of height and weight in Reception and Year 6 children.

It should also be noted that there have been a number of concerns raised by health professionals about the ethics of measuring children's weight, the local arrangements for measurement and the accuracy of the data collected given children's ability to opt out. Appendix 6 sets out these concerns in more detail. However, it is widely acknowledged that, even though figures may underestimate the problem, this data is the best that is available and should enable a more accurate understanding of the extent of childhood obesity in Essex and prove a useful tool for planning interventions.

Case study: Measuring BMI at Harlow

The measurement of the prevalence of obesity in chidren is critical to assessing the performance of our efforts to tackle childhood obesity. Measuring height and weight should be done sensitively to preserve the dignity of the individual, and can also be an opportunity to improve care. All PCTs are faced with this problem. In Harlow there are plans to arrange meetings between groups of parents of obese children and Paediatric Consultants, in order to discuss their children's options.

From discussion with Hayley Freethy, School Nurse, West Essex PCT

The availability of baseline data and future monitoring of levels of obesity may help with assessing the impact of interventions. Whilst the Panel recognise the difficulty in measuring the ongoing impact of many public health interventions, particularly those taking a holistic approach to child health, it was concerned that measurement of the outcomes and impacts of interventions was very limited. There were some notable exceptions, for example a number of projects in Tendring and Colchester have been subject to evaluation by the University of Essex.

Case study: Evaluation of Exercise Referral.

Tendring PCT has been working with Essex University to undertake a limited evaluation of an exercise referral scheme. The scheme includes exercise and discussion with families of overweight and obese children aged 10-15. Children are tested with accelerometers to measure their movement both before and after their participation. Children's understanding of the importance of exercise increases, and so does their co-ordination. Colchester PCT, which works closely with Tendring PCT, will also be learning from and perhaps adapting the scheme.

From discussion with Chris French, North East Essex PCT

Recommendations

PCTs should work closely with schools to improve data collection and monitoring in 2007 and beyond.

Undertake more assessment of the impact of interventions by following up children, where possible, to establish if lifestyle changes continue after an intervention.

3.5 Clinical services

The majority of services which are likely to help tackle childhood obesity are mainstream interventions focussing on prevention, that is, on healthy lifestyles for all children. However, in some cases there is a need for NHS intervention when a child's current or future health are at risk. Approaches to referring children are ad hoc but there are some excellent schemes in place.

Case Study: Use of MEND (Mind Exercise Nutrition – Do It!) in Uttlesford

The MEND programme is a nationally developed and evaluated programme, which is being applied in Uttlesford. The programme is one of few family-based and evaluated interventions. It is run specifically for obese children and their families. It uses cognitive behavioural therapies 'to reveal practical ways to remove unhealthy food triggers'. Some of the health professionals we have talked to referred to MEND as the 'gold standard' of interventions.

From discussion with Gaynor Bradley, Uttlesford District Council and from the MEND website at: www.mendprogramme.com

There is some excellent work underway developing care pathways using the DoH model. There are few simple definitions of care pathways[27], but basically they cover the stages of care that a patient group requires for the achievement of best outcomes, and are often represented by a flow chart. These stages are based on agreements between professionals such as GPs and Paediatric Specialist Dietitians. Care pathways should include non clinical interventions such as exercise schemes. See Appendix 2 for more detail.

[27] See definitions provided by the NHS National Library for Health at: www.library.nhs.uk/pathways/Page.aspx?pagename=ICPS#what

Case study: Mid Essex Care Pathways

A Consultant Community Paediatrician has been developing a Care Pathway in conjunction with consultant colleagues at Mid Essex Hospitals Trust and also with staff working in schools, including School Nurses. Although it has not been fully implemented it did provide a context for considering assessment and referral in relation to children's specific needs, including for instance to Primary Care Mental Health Workers. This pathway also assisted in understanding where there were gaps in provision.

This pathway will be integrated with the example provided by the Department of Health[28]

From discussion with Dr Lily Murtaza, Consultant Community Paediatrician, Mid Essex PCT.

Recommendation

Continue to develop local care pathways based on local and national good practice.

3.6 Additional areas for development

One additional area of concern is the extent to which those working with children have the knowledge and skills to address childhood obesity. A survey carried out by Colchester Borough Council found that most staff, whether Teachers, School Nurses or other professionals, felt they did not have the skills to help, or refer for help, a child that they felt, was obese. Many staff did not recognise obesity as a local problem in contrast to the high prevalence identified through local monitoring.

Another key area identified by stakeholders is school nursing. School nurses are seen as an essential part of child health services and there are concerns that there is wide variation across the County both in terms of the numbers of Nurses available and the services they provide. The current NHS financial situation also raises concerns that school nursing posts will be cut or frozen. The Panel hopes that the new PCTs will enable services to improve across the County, spreading good practice.

[28] The Department of Health pathway can be found at: www.dh.gov.uk/assetRoot/04/13/44/13/04134413.pdf

Recommendations

Develop training and/or information for staff working with children to enable them to identify a child who is obese or overweight and when action may be necessary[29].

Ensure that new PCT structures enable good practice to be spread across areas and strengthen their public health role.

4 Conclusion

The Panel recognises that there are many challenges for partnerships across Essex, as nationally, in delivering work to halt the rise of childhood obesity.

The Essex Local Area Agreement and newly constituted PCTs offer opportunities to bring new partners together to ensure effective work in this area. The Panel hopes that these opportunities are taken and that the recommendations contained within this report are implemented and contribute to local success in tackling child obesity.

[29] Further information on available training could be available from the East of England Public Health Group or the Department of Health.

Appendix 1: Developments in the Children's Agenda in Essex

Services for children are important in tackling childhood obesity and there are many planned changes underway in Essex. Chief among these are:

- The recent appointment of Locality Group Managers who will assist local Children and Young People's Strategic Partnerships in commissioning services based on evidence of local need. There will be 5 Locality Group Managers in Essex.

- The development of the Children's Trust approach and Children and Young People's Strategic Partnerships (CYPSPs) working closely with Local Strategic Partnerships (LSPs), which will bring all agencies together to produce and implement children's strategies across Essex.

- The development of Local Delivery Groups, which bring Extended Schools and Children's Centres together. These provide resources for the use of local communities, and are a location where professionals, children and their families, and communities come together. There are 25 Local Delivery Groups in Essex. In some areas, Local Delivery Groups are more developed than others and provide the main hub of services for children. In other areas some services like Health Visitors are based around General Practices.

Within this structure the following will help in tackling obesity.

Responding to evidence of local need

It is envisaged that BMI data, for schools, communities and areas, when looked at in relation to the extent of other local issues such as bullying, will help partners identify the relative priority for different interventions. In the context of each school, this might mean enhancing plans for groups of children with obesity e.g. for instance, emphasis in the PSHE curriculum or the introduction of a more effective exercise referral scheme. The importance given to obesity will depend on its seriousness relative to other issues.

Having a direct indicator like BMI will also help professionals to understand how obesity relates to 'synthetic' measures like indexes of deprivation[30]. There should be a greater understanding of the factors that contribute to obesity and help professionals to decide what should be done.

Working within Local Delivery Groups: Teams and roles

The development of multi disciplinary teams of Health Visitors and School Nurses allows continuity of provision between home and school, and also for

[30] From discussion with: Steve Leverett, Head of Partnerships, Essex County Council.

interventions to be delivered more efficiently. This is happening in Braintree, Witham and Halstead PCT and also Tendring PCT[31]. These teams may also further allow for a co-ordinated approach to applying public health interventions. The School Nurse Practice Development Resource Pack (March 2006)[32] outlines new roles envisaged for School Nurses to do just this[33]: Key roles include:

- Developing Personal Health Guides for children
- Analysing Public Health Issues within schools
- Supporting interventions in teams, according to needs.

The development of these roles will be particularly important for tackling obesity in children, but success will be dependent on the availability of staff with the necessary competences.

These teams are also part of a wider grouping of professionals that will provide for the early intervention and swift referral of children. This will be made possible by using the Common Assessment Framework to identify the needs of an individual child and to make sure that the appropriate professional engages with the child. It should provide an effective framework whereby the combination of issues that 'vulnerable' children have, and who may be obese, can best be dealt with by the team. Effective teamwork and roles at this stage giving early intervention also become the foundation for the development of appropriate Care Pathways that relate to the child's individual needs.

In East Basildon, the Local Delivery Group, initially through the Extended School, has developed 'Team Around the Child'. This has now been expanded to work around the Children's Centres within the Local Delivery Group.[34]

The pattern and pacing of development within areas of Essex toward this organisation is substantially different, but the main structuring principle of effective services around the child appears to be key to all. At the same time, whilst it will be important to bring teams of professionals together within Local Delivery Groups, it will be perhaps important to maintain some of the aspects of positive engagement with communities and parents, fostered under Sure Start.[35]

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[31] From discussions with Pat Jackson, Children's Services Manager, Braintree Witham and Halstead PCT and with Denise Peggs, Childrens Service's Manager, Tendring PCT.
[32] Available at: http://www.dh.gov.uk/assetRoot/04/13/20/70/04132070.pdf
[33] The White Paper Choosing Health, also highlights this aspect of School Nurses and Health Visitors roles.
[34] From discussion with: Kerry de Jager, Extended Schools Co-ordinator (East Basildon Local Delivery Group)
[35] From discussion with Jeannie May, Ormiston Trust, Colchester

Appendix 2: Care Pathways

There are few simple definitions of Care Pathways[36], but basically they cover the stages of care that a patient group requires for the achievement of best outcomes, and are often represented by a flow chart. These stages are based on agreements between professionals and they should be based on an evidence of what works. When Care Pathways are applied they can become the basis of testing interventions and varying practice to improve services further. They can achieve this when they become what are called 'Integrated Care Pathways'. This is when each of the stages in the pathway is monitored for variations in practice and outcomes.

The Department of Health Childhood Obesity Care Pathway

The model pathway suggested by the Department of Health, [37] is backed by a brief guide to health practitioners on 'Raising the issue of Weight' with children and their families[38]. This is also supported by a 'Why Weight Matters' card[39]. The model also relates to NICE guidelines[40] which identify acceptable interventions given the present evidence base. The pathway emphasises non-clinical interventions such as healthy eating, physical activity, and brief behavioural advice.

Particularly important aspects of the childhood obesity Care Pathway include:

- In 'raising the issue', parental awareness of their children's obesity is critical, with professionals requiring a careful approach that encourages participation.
- 'Readiness to change' is key, with interventions not recommended unless the child and family are ready to change. If there is no basic readiness to change, any intervention, such as a considered exercise referral scheme, may diminish a child's self esteem and impair future efforts to lose weight. 'The main goal in managing overweight and obese children is sustainable lifestyle within the family'[41]
- Behaviour Therapy[42] is best delivered by a specialist but non-specialists can also provide 'brief behavioural advice'. Self monitoring of activity and eating is important for children over 12.

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[36] See definitions provided by the NHS National Library for Health at: http://www.library.nhs.uk/pathways/Page.aspx?pagename=ICPS#what
[37] This is available at: http://www.dh.gov.uk/assetRoot/04/13/44/13/04134413.pdf
[38] This is available at: http://www.dh.gov.uk/assetRoot/04/13/45/44/04134544.pdf
[39] This is available at: http://www.dh.gov.uk/assetRoot/04/13/44/16/04134416.pdf
[40] These have recently been consulted on and are available at: http://www.nice.org.uk/page.aspx?o=296567
[41] Taken from Obesity Care Pathway booklet (Nov 2005): http://www.dh.gov.uk/assetRoot/04/12/40/98/04124098.pdf
[42] Behaviour Therapy has been defined as: 'A form of psychotherapy which seeks to improve the way a person feels by changing what they do.' Royal College of Pscyhiatrists at http://www.rcpsych.ac.uk/mentalhealthinformation/definitions/typesoftherapyandtreatment.aspx

- Assessment of weight comes at the start and includes looking for co-morbidity(ies), and underlying causes.

Discussion

The success of primary universal interventions in the school or community, will reduce the number and amount of later and more costly and more invasive clinical interventions. If these stages are not successful, and the condition is judged to be serious, then NICE guidelines now allow the consideration of the use of drugs for young people, perhaps even at the higher end of the age range for this study (Age 13). In cases when there is a significant risk of 'co-morbidity', surgery can be considered.[43]

By introducing the possibility of these interventions, there is a risk that the problem of obesity is wrongly assumed to have an easily available surgical solution. A careful balance of interventions is required, with recognition that obesity is primarily a social issue and not a medical one. Responsibility should rest with families and their children.

Pathway Development in Essex

There has been very little pathway development or thinking in Essex, but some of it is very good. To date, health practitioners have tended to refer on the basis of what they know to be available and this practice persists without any Care Pathway planning. Making effective referrals from whatever source has to be welcomed. For instance, General Practices might refer children when they see them on the basis of co-morbidity dependent on their ability to assess a condition and their understanding of what acute care clinicians offer. This allows practices to refer, for instance, children with Type-2 Diabetes, a condition that is occurring more and more, given the increasing prevalence of obesity.

Some effective pathway development has been undertaken in Mid Essex[44], which predates the DH model. In this draft pathway:

- The School Nurse team provides the initial assessment, and refers to a local Community Paediatrician, if particular indicators are present.
- The Community Paediatrician then assesses further and can then refer back to a School Nurse team to refer to a specific local programme[45] or

[43] A 'co-morbidity' is simply another condition that exists at the same time, in this case, associated with the condition of obesity. Co-morbities include aspects of the Metabolic Syndrome, Respiratory problems, Endocrine problems, Diabetes, Coronary Heart Disease (CHD), Sleep Apnoea, and high blood pressure. Underlying causes include: Hypothyroidism, Cushings Syndrome, Growth Hormone Deficiency and Prader – Willi syndrome.

[44] Devised by Dr Lily Murtaza (Community Consultant Paediatrician)

[45] In the case of Chelmsford, this could be the 'Junior Live Life Programme'. This is a local educational scheme, which aims to raise the activity level and nutritional awareness of children aged 6-11 years'. Available at: www.chelmsford.gov.uk/index.cfm?articleid=9482 Clearly, the ability to refer depends on availability of appropriate services to refer to.

to the hospital Paediatrician, or again if indicated, Mental Health Primary Care Workers[46].

The advantage of this pathway includes the provision for the assessment and treating in the primary/community sphere, therefore limiting the need for secondary interventions, or even from an acute hospital to a more specialist centre. Development of this pathway is on hold given the development of multi disciplinary teams in Mid Essex and the release of the Department of Health model discussed above.

[46] Primary Mental Health Workers are now in place as part of a tier 2 Child and Adolescent Mental Health Service (CAMHS), and a service review is looking at the role and function of this tier.

Appendix 3: Developments in other Partnerships in Essex

The pattern of partnership in Essex and nationally is complicated. The National Audit Office, Healthcare Commission, and Audit Commission's report, 'Tackling Childhood Obesity – First Steps' (Feb 2006) [47], graphically describes the complexity in the 'delivery chain' that should deliver on the national Public Sector Agreement Target[48]. The report says that, given the complexity, there is: 'little evidence as yet that these interventions are sufficient to achieve the target '.

This appendix focuses on where local partners have significant policy leverage to impact on obesity, omitting issues such as the activities of the Food Standards Agency to improve nutrition labelling, which tends to be done at a national level. Again, 'Tackling Childhood Obesity – First Step' is a good guide to these issues. This appendix also excludes children's partnerships and work around Healthy Schools, which are discussed in other appendices.

To complicate matters further, changes to the NHS in Essex mean new PCT boundaries cut across existing partnerships and local authority boundaries and work will be needed to ensure that effective partnerships with health continue.

Partnerships

Schools Sports Partnerships

These are the essential building block in the development of sport in the County[49]. Within Essex there are 11 School Sports Partnerships, which include Sports Colleges (sports focused secondary schools) at the hub, and include other secondary schools in the area and also primary schools. They are significantly driven by the objective: to enhance the take up of sporting opportunities by 5-16 year olds by increasing the percentage of school children who spend a minimum of 2 hours each week on high quality PE and

[47] The report is available at: (http://www.nao.org.uk/publications/nao_reports/05-06/0506801.pdf). The report, although critical of the complexity of the delivery chain, and therefore critical of Central Government, is presently the best text to understand how partnerships operate for those wishing to understand the wider picture. Page 10 of the NAO report usefully describes key delivery programmes. Page 19 shows national funding allocations. Certain aspects are out of date and this report updates them where they are material in relation to changes in Essex.

[48] See page 24 of this report for a picture of the interrelationship of partners at the national level.

[49] The context within which Schools Sports Partnerships operate is given in the document: 'Learning through PE and Sport. An update on the national PE, School Sport and Club Links Strategy'. Department for Education and Science. October 2004. School Sports Partnerships seek core funds from the Youth Sport Trust and work closely with Sport England through the activities of Sport Essex

school sport within and beyond the curriculum from 25% in 2002 to 75% by 2006 and 85% by 2008.

They receive a core grant from the DfES and have core staff of Partnership Development Managers and School Sports Co-ordinators. As well as co-ordinating activity, these staff bid for more resources from Sport England, the Big Lottery Fund etc, and ideally work with partners in District Councils and Extended Schools Co-ordinators to do so[50]. They also seek to increase the numbers of non-school sports clubs that provide real sporting activities that also can contribute to achieving the 2 hours target.

Sports Colleges can also provide leadership within their partnership by providing a positive culture of pastoral care that emphasises teamwork in relation to fitness. They also have a major collaborative research role across Essex and also look into ways to improve the uptake of sport in Essex[51]

Play Strategies

The Big Lottery Fund (BLF) Play Initiative is open to all authorities in England. There is just over £3 million available to Essex over three years to create and improve play opportunities for children and young people. Each District Council is responsible for its own play strategy. Children, young people and families are part of the consultation and development of the strategies. The Children's Fund Essex Programme Manager is co-ordinating an Essex wide approach to the writing of these strategies including managing a large consultation/participation arts and drama project with children in schools across Essex. Essex districts are working towards the September 2007 deadline to produce a strategy. The strategy will outline how the BLF monies will be spent in the locality. Each District has set up a Play Partnership, usually a sub group of the CYPSP, which has strategic and operational partners from the Voluntary, Community, Private and Statutory sectors involved in play. This Play Partnership will write the Play Strategy.

Play Strategies provide the impetus for joint working with the community and others. Parish Councils (which can bid for funding from the Big Lottery Play Innovation Fund) are involved in the Play Partnerships.

There is much growing evidence of how play can support children's physical health.[52] For example, research done by Mackett[53] showed the following:

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[50] Epping Forest provides an example of a joint post of a School Sports Co-ordinator, working in the Schools Sports Partnership and for the Leisure Section of the Epping Forest District Council. This is discussed on page 23 of this report.
[51] From Paul Farmer, Sports Director, Gt Baddow Sports College, witness session (July 7th 2006).
[52] See factsheet by the Children's Play Information Service, National Children's Bureau at:: http://www.ncb.org.uk/dotpdf/open%20access%20-%20phase%201%20only/factsheet_playhealth_cpis_2006.pdf
[53] Mackett R, 2004 'Making children's lives more active'. London: Centre for Transport Studies, University College London.

1. The best free-time exercise was shown to be walking and playing informal ball games.
2. Children got more exercise from outdoor play than they did from clubs and formal structured sports activities.
3. Children who walked to their leisure activities and school were more energetic when they got there.

In order to be effective, children and young people's opportunities to play needs to be considered when developing any strategy that involves the community.

Other Partnerships and strategies

These include:

- Community development initiatives, often led by the District Council and tackling a range of issues related to deprivation including obesity. There is some very good joint work between PCTs and District Councils across the County. There is a very close relationship in this aspect between Colchester PCT and Colchester Borough Council, and also between Basildon PCT and Basildon District Council.
- Transport Strategies and component Road/Pedestrian/Cycle Access hierarchy strategies and policies. These exist at both the County Council and District Council level, and can influence access to facilities and also affect the priority given to walking or cycling. They also include Travel to School Plans which can play a key role in promoting travel to school by developing safe routes to school, walking buses, and modifying a school's local transport infrastructure. Funds are available for this.[54]
- Local Development Plans. These focus on the spatial aspects of District areas and so directly influence the 'day to day' decisions on the siting and planning for resources including open spaces, leisure facilities and retail development. They are an important part of providing a vision for an area and relate closely to Community Strategies written by Local Strategic Partnerships. In writing Local Development Plans, Local Authorities must involve the community.[55]
- Local efforts and partnerships to achieve Cleaner, Safer and Greener Communities. There are a whole range of powers and responsibilities relating to issues that help to reduce crime, and to create cleaner and greener environments that are conducive to improving access to

[54] Schools should contact Jenna Morgan, School's Travel Plan Co-ordinator, Essex County Council. By 2010, all schools will require to have School Travel Plans that encourage walking or cycling to school or travel by bus, rather than door to door car transport. For ideas for schools to seek funding and develop projects, see also: 'A safer journey to school. A guide to school travel plans'. Department for Transport, at: http://www.dft.gov.uk/stellent/groups/dft_susttravel/documents/page/dft_susttravel_504076-14.hcsp

[55] See the following link for a brief description of who decides what: http://www.direct.gov.uk/HomeAndCommunity/Planning/ThePlanningSystem/PlanningSystemArticles/fs/en?CONTENT_ID=10022600&chk=nEKnv0

physical activities.[56] Again, these aspects should relate to developments in the Local Strategic Partnership.

The circumstances, resources and bidding opportunities will be different for all areas, but as partners begin to understand needs in relation to obesity they should also be aware, in their own specific case, of how they best can respond to local opportunities and barriers in order to tackle childhood obesity.

The LAA will need to have links to the wider objectives in these plans so that childhood obesity is tackled and not compromised.

[56] See: http://www.cleanersafergreener.gov.uk/en/1/csgc.html

Appendix 4: Healthy Schools

The National Healthy Schools Status[57] is made up of 4 key themes, each with specific criteria that all schools should seek to achieve. The Government wants every school to be working towards achieving national Healthy School Status by 2009, and 50% must achieve the standard by December 2006.

The four themes are:

- **Personal, social and health education**, including sex and relationship education and drug education. This includes:
    - Uses the PSHE Framework to deliver a planned programme. Involves professionals from appropriate agencies to create specialist teams to support delivery. Has arrangements in place to refer to specialist services who can give advice. Uses local data and information to inform activities and support national priorities such as reducing teenage pregnancies, sexually transmitted infections and drug/alcohol misuse.

- **Healthy Eating**
  This includes:
    - Identifies members of the senior management team to oversee all aspects of food in school. Has a whole-school food policy (and developed through consultation through school councils, etc). Ensures that healthier food and drink are available and promoted and are nutritious and healthy. Monitors menus to inform policy development. Has opportunities for pupils to learn about food. Has access to water.

- **Physical Activity**
  This includes:
    - Leadership, with a clear policy developed through consultation, and ensures a minimum 2 hours of structured physical activity each week to all of its pupils in or outside the school curriculum. Provides opportunities for all to participate, consulting with and identifying barrier to participation. Involves school sports co-ordinators and other community resources. Encourages walking and cycling to school under a School Travel Plan,

- **Emotional Health and well being, including bullying.**
  This includes:
    - Identifies vulnerable individuals and groups and establishes appropriate strategies to support them and their families. Leadership in the emotional health and well-being of the school. A planned curriculum for pupils to understand and explore

[57] The National Healthy Schools Status – A guide for schools is available at: http://www.wiredforhealth.gov.uk/PDF/NHSS_A_Guide_for_Schools_10_05.pdf

feelings. Has a confidential pastoral system, and a clear and supported policy on bullying.

Evidence needs to be collated to support the case for the achievement of Healthy Schools Status.

Practice in Essex

It is clear that schools need to completely own the Healthy Schools Status and that this should be a whole school policy[58]. The first point of contact for schools is with Healthy School Co-ordinators within schools who provide advice to help schools achieve the status. There are 10 link advisors across Essex and these are jointly funded by Essex County Council and the PCTs. These help to further good practice.

Other professionals and strategies contribute to the achievement of the themes.

In relation to childhood obesity these include:

- Under the first theme (PSHE), the collection of BMI data should help schools to inform priorities.
- Under the third theme (Physical Activity), a minimum of 2 hours a week PE is supported by the Schools Sports Partnerships. School Travel Plan staff also support the adoption of Travel Plans.

Also, the development of Local Delivery Groups and related developments like Team Around the Child will enable schools to identify vulnerable individuals and establish support for their families. (Fourth theme)

Progress in Essex

Many schools in Essex are achieving great things. This study has heard about 3 schools in particular but there are many success stories.

- Cornelius Vermuyden (described on page 22)
- Great Baddow Sports College (described briefly in the context of Sports Partnerships in Appendix 3)
- Others
  - Great Easton Primary School. According to Helen Thorne, Link Advisor for Uttlesford, the school has 'excellent quality food, unprocessed and locally sourced'. The school is visited by a wide range of schools to share good practice. As for the PE and sports agenda, the school introduced 'enrichment afternoons' 4 years ago, to expand the range of opportunities available for children. Parents are involved in the delivery of some activities

[58] The whole school approach is described on P.5 of: The National Healthy Schools Status – A guide for schools is available at: http://www.wiredforhealth.gov.uk/PDF/NHSS_A_Guide_for_Schools_10_05.pdf.

e.g. rugby and yoga. There has also been a walking bus, which is in its 5th year.

What these three schools perhaps have is real senior management commitment backing a Healthy Schools ethos, which is conveyed to communities and pupils.

The table below describes what is happening across Essex[59].
In the table, the intermediate and advanced designation refers to the old Essex Healthy Schools Standard.
Schools that are already advanced can assume Healthy School Status until summer 2007 only. They then fall back on whether they have been accredited in the National Healthy School Standard.
The table indicates that there is a lot of work to do with regard to accreditation to get a true picture, and also that across Essex a lot of schools are likely to be in the early stages of achieving the Healthy School Status. In July 2006 Nick Boddington [60] indicated that 522 schools are engaged in the local programme, with over 100 joining in the summer. The numbers of schools that have achieved either intermediate or advanced status at that stage were particularly low in Harlow.

PCT	Total number of Schools	Number of Schools which achieved advanced award	Number of Schools which achieved intermediate award
Basildon	48	6	17
BBW	56	11	22
Chelmsford	58	9	13
Colchester	83	6	26
CPR	65	13	37
Epping Forest	47	1	10
Harlow	44	2	2
Maldon	33	3	15
Tendring	48	3	20
Uttlesford	37	3	18
BWH	67	4	17
Southend	46	1	11

[59] Table supplied by Tim Hull (Chair of the Essex and Southend Healthy Schools Partnership) July 14th 2006.
[60] Witness session (7th July 2006)

Challenges

- In many cases, it is difficult to get senior teacher buy in to the Healthy School Status and for the whole school agenda to be achieved. Given the many challenges that schools face there is a risk that Healthy Schools may be perceived to be a 'tick-box' exercise. The prospect of 'Sustainable Schools' is now on the horizon, and an integrated approach needs to be achieved.

- The development of PSHE is likely to be a major sticking point given the demands on curriculum time. Citizenship has now become a compulsory subject, which may force other elements of the PSHE curriculum off the timetable.

- It is not clear what will happen when most schools achieve the status. Nick Boddington[61] has suggested that 'Lead Healthy Schools' would be established in the future.

[61] Witness session (7th July 2006)

Appendix 5: Food in schools

The benefit of fresher and healthier food for children has long been recognised.

There is a great deal of change in this agenda given changes in the rules for provision in schools (See: School Food Trust – a guide to introducing the Government's new food based standards for school lunches)[62], and also the announcement of the extension of 'transitional' funding from the Government that will now end in 2011. (These funds were previously due to end in 2008)

Essex schools face particular challenges given the fact that there are no central contracts between commercial catering companies and the Local Authority and all schools are responsible for their own catering arrangements[63]. This has presented a very mixed pattern of provision, with some schools doing their own in-house catering and others contracting from commercial catering companies. This is brought out in the following table[64]:

Commercial/In house and other mixes in Essex.	Number of Schools
Commercial Catering Companies (Including Sandwich Providers)	253
In house-provision	207
Other (Including another school, neighbouring LA caterer, or other)	73

December 2005.

The recent response to these challenges from the Essex and Southend Healthy Schools Partnership and the Essex School Meals Support Group, has been to appoint a Schools Catering Advisor, to be employed by Essex County Council, and who will be responsible for the development of area Catering/Craft Managers and overseeing the use of Government Transition Funds to better stimulate the better provision of food. Behind this move is a broad philosophy that food is better and fresher when it is provided in-house. There is also likely to be action to look at developing local supply chains. This will perhaps be valuable to schools if they seek to become Sustainable Schools.

A main part of the challenge is for schools to recognise the value of doing their own in-house provision and perhaps work in clusters. Sources of profitability such as 'unhealthy' vending machines are no longer available,

[62] See document at: http://www.schoolfoodtrust.org.uk/UploadDocs/Library/Documents/School-food-trust.pdf

[63] Most funds are delegated directly to schools from the Government, apart from Transition Funds, which the County Council distributes on the basis of criteria designed to stimulate the provision of better food.

[64] Information from the table has been provided by Sue Hudson (CSN). This was from a survey commissioned from East Anglia Food Link by Essex County Council, for consideration by Essex and Southend Healthy Schools and the Essex School Meals Support Group. The survey generated a response rate from Essex Schools of 90%.

and, if a school is to benefit, the pace of change needs to bring children and their parents on board, possibly to acquire new tastes. This does require an entrepreneurial and marketing mindset. On the positive side, the campaign by Jamie Oliver is providing a wider context whereby parents are more able to see the issues, and appreciate the value of good food for their children.

Whether and when schools take this route depends on the benefits and challenges they see, and the timing of the contracts they have. Schools need to be given useful advice for overcoming the barriers, controlling costs and increasing the uptake of school meals.

The experience of the North Essex schools consortium shows what can be done in putting in-house provision on a positive footing. (Described on page 22). More recently the Chelmsford Schools Consortium has ended its contract with a major supplier[65], over which it had little control, and was getting a poor service. It is now providing food in-house and faces the challenge to win children and parents over, in order to increase turnover. In this case the consortium is using the services of the private company, Ashlyn's Organic Farm[66], to look at the issues in running a kitchen, and organise the supply routes, some of which is from organic sources.

[65] From discussion with Mark Cresswell, Business Manager, Chelmsford Schools Consortium. This is a consortium of 16 primary schools.
[66] Ashlyn's Organic Farm is based in the Epping Forest area. As well as managing a farm and having local and national food suppliers, it also has a training kitchen for catering staff.

Appendix 6: Measuring Childhood Obesity

There have been concerns about the measurement of height and weight in children to calculate the prevalence of obesity, both nationally and in Essex.

These concerns include:

- The impact on the child in measuring height and weight. Although the reason for measuring children is simply to ascertain population trends, it is inevitable that the act of measuring has some impact, perhaps negative, on the child being measured. Those measuring, often school nurses, feel a duty of care to the child, and a sensitive and professional approach is always required whoever actually does the measurement. Some PCTs have used the measurement as an opportunity to provide further helpful information for the child and family. (See Harlow good practice example on page 29)[67]

- There appear to be different practices determining whether a child is measured. For instance, in many areas children and parents can decide to opt out of measurement, with different rules as to how this is applied. In some areas parents and children had to opt in to be measured.

We have just had the first round of measurement, which is providing useful results. However, there are still concerns about different interpretations of the guidelines that may limit the comparability of the data. The practice of measurement is likely to vary in each school, and is important that flexibility of approach does not result in data that cannot be compared with other areas.

[67] An interesting debate about measurement and the role of School Nurses is given in the journal School Health, Spring 2006, and is available at: http://www.childgrowthfoundation.org/Pdf%20Files/SCHOOLHEALTH-May06.pdf

Glossary

BMI Body Mass Index.

Care Pathway A Care Pathway covers the stages of care that a patient group requires for the achievement of best outcomes. It is often represented by a flow chart. These stages are based on agreements between professionals and should be based on evidence of what works.

Children and Young Peoples Strategic Plan The Children and Young People's Plan is an important element of the reforms underpinned by the Children Act 2004. Implementing a new statutory duty and following best local planning practice, local areas have produced a single, strategic, overarching plan for all services affecting children and young people. It should support more integrated and effective services to secure the outcomes for children, as set out in the Ten Year Childcare strategy, the National Service Framework for Children, Young People and Maternity Services and the Children Act 2004. It is a key part of the children's services improvement cycle, set out in Every Child Matters: Change for Children. The Children and Young People's Plan brings together 17 previously separate plans. In Essex, there is a Children's Plan at the County level with local priorities determined at local Children and Young People's Strategic Partnership level.

Children's Centre/Sure Start Children's Centres provide good quality integrated services (education, care, family support and health) to children, their parents and the wider community. In Essex, the introduction of Children's Centres is being rolled out in 3 phases. Their development is closely related to the earlier development of Sure Start. Sure Start is a government programme designed 'to deliver the best start in life for every child by bringing together early education, childcare, health and family support'. Sure Start Centres engage closely with parents.

Children's Fund

The Children's Fund is a central part of the government's strategy to tackle the disadvantages and inequalities that derive from child poverty and social exclusion. The Fund focuses on developing services that support multi-agency working, including services that identify children showing early signs of difficulty. The aim is to prevent children falling into drug abuse, truancy, exclusion, unemployment and crime, and to raise aspirations and prevent underachievement. The Children's Fund is managed by local partnerships who make decisions about which projects to fund in their area.

Children's Trust/Children and Young People's Strategic Partnerships (CYPSP)

The CYPSP brings together agencies working at the local level including: the Health Service, the Police, the District Council, Schools and Local Delivery Groups, Voluntary and Community Organisations and services provided by Essex County Council. The CYPSP is responsible for:

a) Ensuring there is good communication between the partners;
b) Undertaking a local needs and gap analysis and identifying priorities in the context of the outcomes of the Children and Young People's Plan;
c) Co-ordinating and brokering provision at local level to ensure that it is joined up and avoids duplication;
d) Disseminating good practice;
e) Encouraging services to respond to the needs of children and young people and their families; and
f) Challenging under-performance.

Common Assessment Framework

A Common Assessment Framework enables different professionals, including Social Workers, School Nurses and Connexions Advisors etc, to assess children using the same criteria. It helps to identify vulnerable children and assign them to the professional best placed to help the child. The increasing use of a Common Assessment Framework is part of the broad policy to develop a common language to recognise and respond to the needs of children and young people.

County Sports Partnership

A partnership that creates strategic leads for sport within a County, to help more people get actively involved in sport. In Essex, this is Sport Essex.

DCMS

Department for Culture Media and Sport. This department is responsible for Central Government

	policy on the arts, sport, and the tourism, creative and leisure industries.
DfES	Department for Education and Skills. This is a Central Government Department, responsible for education and life-long learning in England, with wider responsibilities for a range of policies to ensure children are safe, well and ready to learn.
DH	Department of Health.
Essex Obesity Alliance	A greater Essex partnership established in 2006. It is developing action plans for delivering the Essex Local Area Agreement obesity targets and will support relevant targets in Southend and Thurrock.
Every Child Matters	Every Child Matters is an approach to the well-being of children and young people from birth to age 19. The Government's aim is for every child, whatever their background or their circumstances, to have the support they need to; be healthy; stay safe; enjoy and achieve; make a positive contribution; and achieve economic well-being.
Extended Schools	A school or group of schools that provide a range of services and activities, often beyond the school day, to help meet the needs of pupils, their families and the wider community. In Essex, these, with Children's Centres, are becoming part of Local Delivery Groups
Local Area Agreement	Local Area Agreements (LAAs) set out the priorities for a local area agreed between Central Government and the local area, represented by the Local Authority and key local partners including Children and Young People's Strategic Partnerships and Local Strategic Partnerships. The aim is to enable local partners to come together to provide a holistic and integrated approach to policy-making and delivery, and reduce bureaucracy.
Local Delivery Group	In Essex, Local Delivery Groups comprise Children's Centres and Extended Schools in a given area. There are 25 of them in Essex.
Local Development Frameworks and Local Development Plans	The Local Development Framework including Local Development Plans is produced by Local Authorities and informs day to day decisions as to whether or not planning permission should be granted. Local Planning Authorities are required to produce a statement of community involvement setting out how

	and when they propose to involve local communities and stake holders in the planning process.
Local Strategic Partnership	These are single, multi agency bodies that match Local Authority boundaries, which bring together parts of the public sector (such as Local Authorities and PCTs), Private, Community and Voluntary sectors. Through contracts and agreements (such as the Local Delivery Plan and Local Area Agreements), LSPs are expected to take a coordinated approach to making major decisions about priorities and funding for their local area.
MEND	Mind Exercise Nutrition – Do It! programme. The MEND programme is a nationally developed and evaluated programme and is one of few, family based and evaluated interventions. It is run specifically for obese children and their families. It uses cognitive behaviour therapies 'to reveal practical ways to remove unhealthy food triggers'.
National Healthy School Status	This is part of the Government's drive to improve standards of health and education and reduce health inequalities through the National Healthy Schools Standards. It focuses on improvement in areas such as healthy food and drink in schools, high quality physical education and school sport. Activity is co-ordinated by a Healthy Schools Partnership. For the Essex County Council area this partnership is the Essex and Southend Healthy Schools Partnership
NCC	National Consumer Council.
NICE	The National Institute for Health and Clinical Excellence (NICE) is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health. NICE produces guidance in three areas of health: • public health - guidance on the promotion of good health and the prevention of ill health for those working in the NHS, Local Authorities and the wider Public and Voluntary Sectors • health technologies - guidance on the use of new and existing medicines, treatments and procedures within the NHS • clinical practice - guidance on the appropriate treatment and care of people with specific

diseases and conditions within the NHS.

PCT

Primary Care Trust. In Essex, since October 1st 2006 there are 5 PCTs. Previous to this there were 11 PCTs in the Essex County Council area.

PE School Sport and Club Links Strategy

An initiative to implement a national strategy for Physical Education and School Sport, to enhance the take-up of sporting opportunities by 5 to 16 year olds. The overall objective is to increase the percentage of 5-16 years old who spend a minimum of 2 hours each week on high quality PE and school sport, within and beyond the curriculum, to 75% by 2006. By 2008 the aim is to raise this to 85% with all schools being offered this entitlement. Also, by 2008, all school partnerships, (families of schools working together to enhance school sport), should be enabling at least 75% of their pupils to take up this entitlement. The key staff who deliver are: Partnership Development Managers and School Sports Co-ordinators. A main strand is the development of club links: By 2006 - 20% of young people aged 5-16 to be taking part in high quality club sports on a regular basis.

PSHE (Personal, Social and Health Education)

PSHE includes everything schools do to promote pupils' good health and well-being. It is backed by the National Healthy Schools Programme. The subjects covered are:

- Citizenship at Key Stages 1 and 2;
- Drugs, Alcohol and Tobacco;
- Emotional Health and Wellbeing;
- Nutrition and Physical Activity;
- Personal Finance;
- Safety;
- Sex and Relationship Education.

School Food Trust

The School Food Trust is funded by the Department for Education and Skills (DfES), to promote the education and health of children and young people by increasing the quality of food supplied and consumed in schools.

School Travel Plan

A plan to bring about a change in home to school travel patterns, also allowing more pupils to take regular exercise. The Traveling to School initiative provides grants to schools with approved School Travel Plans and supporting School Travel Advisers.

SHA (Strategic Health Authority)	The East of England Strategic Health Authority, which came into being on 1st July 2006, has 3 key roles in relation to the local NHS. • Strategic leadership • Developing organisations and the workforce • Ensuring local health systems operate effectively and deliver improved performance
Social Marketing	Social Marketing seeks to employ best marketing methods for influencing the behaviour of individuals and groups. In this case these will be those who are obese or are at risk of obesity. It has been defined as: 'the systematic application of marketing concepts and techniques to achieve specific behavioural goals, for a social or public good'. (French, Blair Steven's 2006).
Sport England	Provides services and funding to sport in England, and responsible for delivering the Government's sporting objectives.
TOAST	The Obesity Awareness Solutions Trust.
WHO	World Health Organisation.
Youth Sport Trust	This is a registered charity with a mission to support the education and development of all young people through physical education and sport. It aims to create opportunities for more young people to participate in high quality PE and school sport. It is funded by the DfES and provides the funds for Schools Partnership Development Managers and Partnership Development Managers.

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