Walsall Metropolitan Borough Council

Health Scrutiny Panel

Children and Lifelong Learning Scrutiny and Performance Panel

Childhood Overweight and Obesity

Scoping the Problem And Moving Forward

October 2005

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1. Purpose of this Report

- This report sets out the size and scale of the issues facing Walsall in tackling the 'time bomb' of childhood overweight and obesity.
- It examines the best evidence available for interventions to prevent and treat childhood overweight and obesity, what is currently being done by Government and locally in Walsall to address these issues, and what more needs to be done.
- Finally, the report makes recommendations about the next steps.

2. Background

- In November 2004, the Government's White Paper 'Choosing Health' put overweight and obesity second only to smoking as the focus for increasing life expectancy, reducing inequalities and improving health

- Earlier this year, Walsall Metropolitan Borough Council's Scrutiny and Performance Panels for Health and Children and Lifelong Learning established a Joint Working Group to consider how to tackle the problem of overweight and obesity in Walsall in the light of significant increases in the proportion of people in these categories. Walsall's Director of Public Health Dr Sam Ramaiah was invited to advise the Joint Working Group on finding the best way forward.

- The Walsall Teaching PCT had already published in 2004 a draft strategy for tackling obesity in adults. It was therefore agreed that the Joint Working Group would initially focus on considering how to tackle overweight and obesity in children.

    - This report is the product of a very considerable amount of work undertaken over the last few months, including:

        - The development of a Walsall protocol for a pilot project to collect data on overweight and obesity amongst children in Walsall. The pilot project will shortly be launched with funding provided by the Walsall tPCT
        - Research into all the local, national and international evidence available for effective interventions to prevent and treat childhood overweight and obesity
        - Collection of information on the actions already being taken in Walsall to deal with the issues
    - A particular objective has been to ensure that the outcomes of this work are developed and owned by Walsall people.
    - As an important step in this process, a half-day workshop was held on Wednesday 15th June 2005 at Bescot Stadium to provide a multi-agency focus for this work and to create a momentum for taking this work forward. The workshop succeeded in attracting people from all the agencies and groups, including parents of overweight and obese children,

who will be central to delivering the strategy which emerges from this work. The informal feedback from those who attended was that the workshop had been extremely useful in raising awareness of the issues and in enabling those present to better understand what they, their organisations and their partner agencies need to do to tackle childhood overweight and obesity. The report on the workshop is attached at Appendix 1.

3. What Causes Overweight and Obesity in Children?

- As with adult-onset obesity, childhood obesity has multiple causes centering around an imbalance between energy in (calories obtained from food) and energy out (calories expended in the basal metabolic rate and physical activity). Childhood obesity most likely results from an interaction of nutritional, psychological, familial, and physiological factors.

- The risk of becoming obese is greatest among children who have two obese parents. This may be due to powerful genetic factors or to parental modelling of both eating and exercise behaviours, indirectly affecting the child's energy balance.

- Poor diet is a significant cause of childhood obesity. Snacking has increased with over reliance on fast food and processed foods which are high in salt, sugar and fat. School vending machines often only provide energy-dense foods and snacks. The intake of fruit and vegetables is low in many children, often due to poor access to healthy food and retail outlets selling fresh fruit and vegetables.

- Levels of physical activity have fallen dramatically over the last two decades. The average child spends several hours each day watching television; time which in previous years might have been devoted to physical pursuits. American research suggests that obesity is greater among children and adolescents who frequently watch television not only because little energy is expended while viewing but also because of concurrent consumption of high-calorie snacks.
- Since not all children who eat non-nutritious foods, watch several hours of television daily, and are relatively inactive develop obesity, the search continues for alternative causes. Heredity has recently been shown to influence fatness, regional fat distribution, and response to overfeeding.

4. How is Overweight and Obesity Defined?

- A detailed definition is included in Appendix 2. The main measure used is Body Mass Index (BMI) which is calculated by diving the weight (in kilograms) by the square of the height (in metres).

- In summary, for adults
    - A BMI of **under 20** is considered **underweight**
    - A BMI of **between 20-25** is considered **healthy**
    - A BMI of **between 25-30** is considered **overweight**
    - A BMI of **between 30-35** is considered **obese**
- However, for children body ‘fatness’ depends on age and sex. For this reason, the charts in Appendix xx have been developed to help identify those children who are within or outside the ‘normal’ range.
- An important point to note is that height and weight measurements require

5. Why is Overweight and Obesity a Concern?

- In his 2002 Report on the State of Public Health, the Chief Medical Officer for England described the epidemic of obesity as a ‘time bomb’ for the future health of our country. This warning followed data showing significant increases in overweight and obesity over the last twenty years across the whole age range.
- It is well documented that obesity is associated with many of the leading killers in England, such as Coronary Heart Disease (CHD), Stroke, and some kinds of cancer. Other serious health problems can be attributed to obesity, including hypertension, hypocholesteralaemia, type 2 diabetes mellitus, diseases of the gall bladder, respiratory disorders, and osteoarthritis.
- The strongest correlation between overweight and disease is that between increasing weight and the development of type 2 diabetes. The risk of type 2 diabetes developing increases exponentially with increasing BMI, with the risk at BMI 35 being 90 times higher than BMI 22. The Diabetes National Service Framework highlights this relationship, and sets out standards aiming to halt, and ultimately reverse, the current trend.
- In addition to the physical risks, obesity can also have considerable negative psychological and social effects, such as low self-esteem and poor relationships with peers. Some authorities feel that social and psychological problems are the most significant consequences of obesity in children.
- These factors taken together could have a devastating effect on the health and life expectancy of the population. It is estimated that, if this epidemic is not tackled, the life expectancy of future generations could actually be lower than that of the current generation, reversing an increasing trend over two centuries.

6. So, What do the figures tell us about Obesity ?

- Taking the UK population as a whole, since 1980 the prevalence of obesity has nearly trebled and is continuing to increase. In 2001, nearly two thirds of men and over half of women were either overweight or obese.

- Among English school children, the International Obesity Task Force (IOTF) estimates that obesity and overweight rates have risen dramatically in the past five years and are four times higher than 30 years ago. The report shows that more than one in four children are overweight and 6-7% are classified as obese.

- A report published in April 2005 by the National Centre for Social Research examined obesity among children under 11 in more detail. Some of the key conclusions are as follows:
  - Between 1995and 2003 the prevalence of obesity among children aged 2-12 rose from 9.9% to 13.7%
  - The percentage of children who were overweight (including those who were obese) rose from 22.7% to 27.7% in 2003
  - Overall, levels of obesity were similar for both boys and girls aged 2 to 10. For boys, obesity rose from 9.6% in 1995 to 14.9% in 2003, for girls obesity rose from 10.3% in 1995 to 12.5% in 2003
  - The steepest increases in obesity occurred in the 8-10 year olds, rising from 11.2% in 1995 to 16.5% in 2003

- Overall, therefore, the situation is getting worse and, if not addressed, at least one third of adults, one fifth of boys and one of girls will be obese by 2020.

- Added to this, there is clear evidence of growing inequalities. Obesity is more common among lower social groups, with 16% of males and females obese in the 'professional group' as against 23% males and 29% of females in the 'unskilled manual' group. Obesity in parents is a strong predictor for obesity in children.

- Also, in 1999 obesity in Asian children was four times more common than in white children.

- Not all obese infants become obese children, and not all obese children become obese adults. However, the prevalence of obesity increases with age among both males and females), and there is a greater likelihood that obesity beginning even in early childhood will persist through the life span.

- Unfortunately, the quality and quantity of information available for Walsall is so sparse that no accurate estimates of overweight and obesity are available for Walsall children. In line with national practice, the only time weight and height are measured routinely is at the point of entry to primary school.

- Given that Walsall has higher levels of deprivation and a higher proportion of minority communities than the national average, it is relatively safe to assume that

the levels of overweight and obesity in Walsall children is likely to be higher than the averages quoted above.

7. What Should We Aim For?

- The National Institute of Clinical Excellence (NICE) has been tasked with preparing by 2007 definitive guidance on prevention, identification and management of obesity.

- For now, the Government's strategy for improving the health of the population 'Choosing Health' published in 2004, contains the national target 'to halt the year-on-year rise in obesity among children under 11 by 2010, in the context of a broader strategy to tackle obesity in the population as a whole'. (2004 Government PSA Target)

- This is a challenging target to achieve in less than 5 years, not least because we do not yet know the true position in Walsall and also because the evidence shows that the forces driving up overweight and obesity have gathered further momentum in the last few years.

- Therefore, tackling overweight and obesity will require unprecedented levels of partnership working between central government and local agencies, between local statutory agencies and the communities most at risk, and between the public, private and voluntary not-for-profit sectors.

8. Evidence of What Works, What We're Already Doing and What More We Need to Do in Walsall

- It is important to ensure that Walsall's resources are focused on those actions which will have the greatest impact on the issues. To achieve this, an extensive examination has been undertaken of the local, national and international evidence for effective interventions to prevent and treat childhood overweight and obesity.
- It is clear that there can be no success without effective partnership working between central government, local agencies, local communities and individual children and families.
- The key issues are set out below under a number of themes, with each theme covered under the following headings:

    - What Works?, which captures the best evidence available for interventions
    - What has the Government done, or is planning to do about this?
    - What is currently happening in Walsall?
    - What more should we do in Walsall
- Although agencies and individuals were invited to contribute information about what is already happening in Walsall to address these issues, it is possible that the list of initiatives is not comprehensive since not everyone responded.

- Many of the ideas under the last heading have emerged from the workshop held in June 2005, others arise from experience elsewhere. A detailed examination of each suggestion will be a key part of the next stage of this work.

Theme 1: Obtaining High Quality Information about the Prevalence of Overweight and Obesity Amongst Walsall Children

- **What Works?**

  - Dealing with the epidemic of childhood overweight and obesity requires high quality information about prevalence by age, sex, ethnic group, locality etc.
  - The data needs to be collected on a continuing basis so that trends can be determined and allow judgements to be made about whether the actions being taken to address the issues is having the desired effect or not.
  - At the present time, all we collect routinely in Walsall (and across the country) is height and weight measurements taken at the time of entry to primary school.
  - It is possible to extrapolate the Walsall figures from the national studies of prevalence, such as the National Centre for Social Research Report published earlier this year. However, such figures can be no more than crude estimates, given that Walsall is one of the more deprived areas of the country and also has a higher than average minority ethnic population

- **What has the Government done, or is planning to do about this?**

  - The Department of Health is considering how to establish a new national data collection system but nothing has yet been agreed.
  - It is not known when a national data collection system will be introduced.

- **What is currently happening in Walsall?**

  - A data collection working group has been meeting since March this year to examine how best to collect appropriate data.
  - The group has examined a number of different approaches and received presentations and reports about data collection initiatives in other parts of country.

- On the basis of this thorough review, a robust protocol for a pilot data collection exercise has been developed and the tPCT has found funds for this.
- The Department of Health has been consulted and the staff to run the pilot is currently being recruited.

- **<u>What more should we do in Walsall?</u>**

  - The protocol for this pilot data collection exercise is at Appendix 1.
  - The Scrutiny Panel is recommended to support the pilot and ask for a progress report to be presented six months after the commencement of the project

THEME 2: ROLE OF THE MEDIA IN RAISING PUBLIC AWARENESS; COMMUNICATIONS; BRANDING

- **What Works?**

    - There is good evidence that the public's imagination has to be captured if changes in the behaviour of significant sections of the community is to be achieved.

- **What has the Government done, or is planning to do about this?**

    - In Choosing Health, the Government has set a national target 'to halt the year-on-year rise in obesity among children under 11 by 2010, in the context of a broader strategy to tackle obesity in the population as a whole'. (2004 Government PSA Target)
    - By doing this, the Government has put all the local statutory agencies on notice that it expects theses issues to be tackled vigorously by each organisation as well through effective partnership working
    - The Government is considering how best to counter the media advertising/selling poor habits to young people, perhaps through passing new legislation
    - A new cross-government campaign is planned to raise awareness of the health risks of obesity, and the steps people can take through diet and exercise to prevent obesity, although the timing of this is not clear.

- **What is currently happening in Walsall?**

    - Specific pieces of work are being undertaken by the agencies (referred to under the various themes below) but there is currently no coordinated campaign to raise public awareness of the issues in Walsall.

- **What more should we do in Walsall?**

    - A key task is to raise the awareness of the issues amongst the general population, perhaps using high profile campaigns. Examples of national campaigns which had a powerful impact include the 'Back to Sleep' initiative

which had led to significant reductions in infant cot deaths. The ‘shock tactic’ advertisements for seat belts and drink driving are other examples of possible approaches.

- In the business world there is a recognition of the power of ‘branding’ and perhaps the use of a catchy slogan or strap line could help to connect the public to the issues of overweight and obesity and how to prevent them.
- Locally, thought should be given to working more closely with all the media to ensure better and more informed coverage of the issues.
- Perhaps a high profile local individual, such as a sports or TV personality, could be invited to lead a profile-raising initiative and establish the ‘brand’ in the public consciousness. Recently, Jamie Oliver’s TV initiative on school meals has carried the message to more people than any other media coverage.
- It is vital that local opinion-formers e.g. Head Teachers, business and community leaders, heads of faith groups, GPs etc. are incentivised to champion the issues in Walsall
- There is a role for the media and for local agencies in promoting the message that ‘breast-feeding is normal’.
- There should be a statutory requirement for local authorities and planners to create a healthy environment by carrying out health impact assessments of planning proposals. The environment will promote activity, provide access to healthy food choices and limit availability to less healthy choices/outlets for all people - particularly disadvantaged and vulnerable groups. Walsall could lobby for this.

THEME 3: WORK WITHIN SCHOOLS AND WITH YOUNG PEOPLE

- **What Works?**
  - Multi-faceted, school-based interventions can reduce obesity and overweight in schoolchildren, particularly girls.
  - Effective interventions include nutrition education, promotion of physical activity, reduction of sedentary behaviour, behavioural therapy, teacher training, curriculum materials, and modification of school meals and tuck shop stock.

- **What has the Government done, or is planning to do about this?**
  - The Government has a vision that half of all schools will be healthy schools by 2006, with the rest working towards healthy school status by 2009.
  - Nutrition and diet as well as physical exercise standards are to be fully integrated within this programme.

- **What is currently happening in Walsall?**
  - Walsall is fortunate in have school catering and Leisure services managed together. There is a genuine interest in addressing issues of nutrition and diet in schools as well as opportunities for increasing physical activities in schools and within the community.
  -

- **What more should we do in Walsall?**
  - Engaging Head Teachers and school governors is key if schools are to play their full part in addressing these issues
  - A ‘holistic’ approach is needed in schools and teachers involved in determining how best schools can be helped to deliver the objectives
  - The School Health Service needs to be considerably strengthened if it is to take on the additional tasks concerned with dealing with overweight and obesity
  - There is a need for more and better health promotion materials to be available to schools

- There should be rewards and incentives for young people to adopt healthy lifestyles
- It is important to make healthy lifestyle messages ‘cool’ for young people
- PE lessons should perhaps be graded for ability and there could be a role for more active playground management
- The interventions and approach should not disempower families. Children should themselves be consulted and invited to create the services which they will value most

THEME 4: NUTRITION AND DIET

- **What Works?**

  - Infants who are breast-fed are five times less likely to be admitted to hospital in the first year of life with infections and are less likely to become obese in later childhood.
  - Multifaceted school-based interventions which are integrated within a curriculum involving nutrition, activity, cooking, modification of school meals and tuck shops, teacher training, reduction in sedentary behaviour, behaviour therapy and the extension of the National Healthy Schools Standard to all schools in the country should be introduced. This could include the prohibition of all snack products except water, fruit, milk and juice in school premises.
  - A whole-school approach to promoting healthy eating and consumption of more fruit and vegetables is more effective than using individual interventions in isolation, eg setting up a fruit tuck shop without the support of a wider approach.
  - A whole-school approach can:
    - Improve knowledge and attitudes towards healthy eating
    - Show small but valuable changes in consumption of fruit and vegetables
    - Participatory approaches are important – involving pupils, teachers, catering staff, parents, governors and the community.
  - The National Healthy Schools Standard (NHSS) provides a good framework for a whole-school approach to promoting healthy eating: an audit of activities linked to the NHSS found that 59% of schools reported 'uptake of healthy food' as a measure for monitoring impact.
  - Nutritional standards for school lunches were introduced in 2001 and have not yet been evaluated. However, adaptation of the school menu and promotion of lower-fat choices have been shown to:
    - Reduce fat intake and increase intake of polyunsaturated fat
    - Increase the choice of low-fat options.
  - The outcomes of breakfast and after-school clubs tend to be broad – they may increase punctuality and attentiveness and provide pre- and after-school childcare. They provide an opportunity to encourage the consumption of fruit or cereal, and may help address low intakes of iron and other micronutrients.
  - Clubs offering play activities as well as breakfast may be more successful than those offering breakfast alone.

- School-based cooking skills clubs can stimulate interest and confidence in developing cooking skills outside the school setting and may produce social and educational benefits.
- Pre-school and daycare settings are likely to be appropriate settings for interventions and parental involvement may enhance the effectiveness of interventions and should be encouraged.

- **<u>What has the Government done, or is planning to do about this?</u>**

  - A system is being introduced to standardize the signposting of food building on the nutrient criteria for the 5 A DAY logo
  - Work with retailers, caterers and manufacturers to promote the 5 A DAY message.
  - New Government action is planned on food labeling by 2006
  - A Food and Health Action Plan was to to be disseminated in 2005
  - As part of the School Fruit and Vegetable scheme, all four to six year old children in Local Authority maintained infant, primary and secondary schools are eligible for a free piece of fruit or vegetable every school day.
  - A Strategy for Food promotion to children is planned to be published by 2007
  - Work with industry to develop voluntary action on targets for sugar and fat in food, as well as portion sizes
  - Working with key organisations to strengthen voluntary codes on food and drink promotion to children
  - Revision of primary and secondary school meals standards to reduce the consumption of fat, salt and sugar and increase the consumption of other essential ingredients
  - Subject to legislation, extending the new school standards to cover food across the school day, including vending machines and tuck shops
  - It is planned to put in place a comprehensive package to assist schools in implementing the whole school approach to healthy eating and drinking, including the above. This approach is to be integrated into the Healthy Schools Programme and will support the Healthy Living Blueprint

- **<u>What is currently happening in Walsall?</u>**

  - Walsall has appointed a Breastfeeding coordinator and rates of breast feeding have improved, although still below target levels.

- In terms of specific dieticians, the Acute Trust has a specialist Paediatric Dietician but no one specifically for obese children.
- Aaina Asian Women's Group runs an after school club five days a week. Children are provided with refreshments including a drink and a snack, and this time is used to educate children about healthy eating.
- A number of other community organisations in Walsall run healthy eating/obesity clubs for parents and other adults and this has the potential to encourage healthy eating in families with young children.
- The 'Groundmiles' project in the New Deal area, funded by Health Action Zone monies, rewards individuals who take part in a range of activities that benefit their health, including healthy eating sessions. Although a number of children participate, they have not so far been the main target group and the project would like to extend its work to focus on children if additional resources could be made available.
- Walsall has a 5 A DAY initiative coordinator and in its first two years the project has supported sow-and-grow schemes in primary schools; training Health Visitors, practice nurses, school health advisors, District Nurses and GP practice staff in the 5 A DAY message.

- **What more should we do in Walsall?**

  - All the effective breastfeeding interventions should be introduced.
  - Consideration should be given to providing free, high quality school meals for all
  - Cooking lessons could be introduced as education sessions
  - Children could be involved in school breakfast clubs and also after school clubs which kids attend for fun but could help to raise awareness of healthy lifestyles
  - Family mealtimes are now less common with consequent effects on childrens' eating habits. For example, the lack of breakfast is often made up with 'tuck' which fills the gap.
  - Consideration should be given to agreeing cheap deals with supermarkets and retailers for healthy foods
  - There has been an erosion of cooking skills and healthy cooking lessons using normal ingredients have a part to play
  - There could be early advice e.g. from midwives, about healthy feeding of children.
  - There could be 'weening parties' where parents and children could try different foods

- The possibility of strict regulation or a total ban on the advertising and promotion of foods directly to children (including school manufacturer link-ups for the purchase of school equipment and learning resources) should be urgently reconsidered. This should include taking forward the findings of the FSA-commissioned research on the effects of food advertising to children. Walsall could lobby for this.
- Vat could be reduced to 0% for healthy products and increased from the current rate for unhealthy products and Walsall could lobby for this.
- The use of brief interventions in primary care for obesity management and healthy nutrition should be a routine part of all medical consultations.
- Within the current Food and Health Action Plan, a comprehensive and long-term nutrition strategy for England should be developed. This would require, short, medium and long-term goals; supported by sufficient resources to deliver at local level and to provide the necessary research. This would include a national strategy on obesity. Walsall could lobby for this.

THEME 5: PHYSICAL ACTIVITY

- **What Works?**

    - Targeting parents and children together (family-based interventions involving at least one parent with physical activity and health promotion) is effective in treating obesity and overweight in children.
    - Children and young people should achieve a total of at least 60 minutes of at least moderate-intensity physical activity each day.
    - Research into 5–15 year olds' beliefs, concerns and attitudes to physical activity suggest that –
    - **For children aged 5–11:**
        - Physical activity is regarded as important, 'good for the body', pleasurable, and prevents people from becoming lazy and idle
        - PE is viewed positively
        - Social aspects of physical activity, such as walking to school, are regarded as important
        - Few factors are seen to inhibit physical activity, apart from a lack of their own and their parents' time.
    - **For children aged 11–15**:
        - Physical activity is viewed as important and beneficial for health and weight control
        - Girls report reduced physical activity in and out of school after the transition to secondary school
        - Girls at secondary school are more negative than boys about PE
        - There is a growing divide between girls and boys in the favoured activities
        - Barriers to participation include a general feeling of inertia, especially among girls; a preference for other activities; self-consciousness, especially among girls; and lack of time, owing mainly to homework
        - Motivators include feelings of wellbeing and enjoyment; avoiding boredom; and, especially among girls, helping to control weight.
    - Interventions – schools
        - Physical activity programmes in schools have produced good outcomes.
        - They may encourage lifelong physical activity and enhance academic activity.
        - School travel plans (including Safer Routes to Schools) can increase cycling, walking and bus use (including 'walking buses').

- **What has the Government done, or is planning to do about this?**

    - The Government has published a Physical Activity Action Plan with the goals of encouraging activity in early years, in schools, in further and higher education. It also proposes extending further the use of education facilities as a community resource for sport and physical activity, including out-of-hours use.
    - Physical activity is to be fully included within the Healthy Schools Programme, the targets for which are set out elsewhere.
    - The Government has set a target (2004 PSA Target) to' enhance the take-up of sporting opportunities by 5 to 16 year olds so that the percentage of school children in England who spend a minimum of two hours each week on high quality PE and school sport within and beyond the curriculum increases from 25% in 2002 to 75% by 2006 and to 85% by 2008'

- **What is currently happening in Walsall?**

    - The tPCT with Walsall MBC is currently holding a special weight management clinic for young people. The fun-4-life programme, which is delivered by Carnegie Weight Management Team who are part of Leeds Metropolitan University, is currently held once a month with an activity session between each clinic. The clinic promotes successful weight loss and lifelong weight management to help children who are overweight to lead healthier lifestyles.
    - The tPCT in conjunction with Walsall MBC has secured funding from Sport England to develop a project titled - 'Preventing Obesity through Activity.' It targets children and young people and is for three years to 2008.
    - There are three distinct elements within the project:
        - Appointment of an Obesity Outreach Team to develop prevention and awareness raising programmes within the local community- principally through Sure Starts / Children's Centres - promoting a family centred approach, and Schools Sport Partnership Networks. Aims to reach under-represented groups, those 'at risk'.
        - Establishment of three young people's gyms within the borough.
        - Role out of specialist weight management programmes/clinics.

- The overarching objectives are to:
  - promote the benefits of physical activity and healthy lifestyles to key stakeholders including schools, children's centres, leisure centres, Walsall MBC, Walsall tPCT, community/voluntary sector, parents and young people as a community prevention project and to increase the number of services and opportunities for those people at risk through obesity
  - pilot and deliver community multi-sport/activity opportunities to prevent weight gain in young people at risk of obesity and encourage weight gain in overweight young people
  - develop Walsall's activity infrastructure in order to facilitate access to a range of physical exercise opportunities which meets the needs of young people, including multi-sports outreach provision within community venues and statutory multi-sport facilities.
- This is a joint venture between the tPCT and WMBC Sport and Leisure services, with WMBC the Lead/Accountable body. The outreach element will include appointment of an Outreach Obesity Strategy Co-ordinator (OSC) and 2 Obesity Outreach team workers who will work through a joint management steering group which will set their objectives and priorities.
- Total funding for the project is 644k, Sport England contribution = £334k, balance picked up through WMBC, PCT and Sure Start.

- **<u>What more should we do in Walsall?</u>**

  - A much more sedentary population needs to be encouraged to undertake more physical activity, not least walking more and cycling. This may require improving people’s perception of safety before they can be persuaded to change their behaviour
  - The creation of safer neighbourhoods can help young people to undertake more physical activity in the neighbourhood, including in designated play areas.
  - Tax incentives to employers to encourage exercise and physical activity at and while getting to the workplace should be introduced. Walsall could lobby for this.

THEME 6: SPECIALIST SERVICE PROVISION AND ORGANISATION

- **What Works?**
  - Obesity treatment programs for children and adolescents rarely have weight loss as a goal. Rather, the aim is to slow or halt weight gain so the child will grow into his or her body weight over a period of months to years. American researchers estimate that for every 20 percent excess of ideal body weight, the child will need one and one-half years of weight maintenance to attain ideal body weight.

- **What has the Government done, or is planning to do about this?**
  - Although no specific organizational arrangements are being proposed by the Government, many national groups are engaged in formulating legislation, in research and in developing guidelines for dealing with overweight and obesity.
  - The definitive Government guidance will not be available until 2007.

- **What is currently happening in Walsall?**
  - Reference has already been made to a number of the specialist services aimed at improving access to physical exercise and improving diet for young people.
  - In terms of specific dieticians the Acute Trust has a specialist Paediatric Dietician but no one specifically for obese children.

- **<u>What more should we do in Walsall?</u>**

    - There is an urgent need for a clear organizational focus on overweight and obesity if the considerable task ahead is to be managed.
    - A clear set of strategies need to be developed which spell out the responsibilities of each of the agencies in Walsall.
    - Now that separate reports reports have been completed on children and adults, it is appropriate to establish a coherent Walsall-wide approach to addressing overweight and obesity in the whole population.
    - Specialist obesity treatment services for children and/or adults to which GPs can direct patients should be universally available. These services must provide services that deliver to disadvantaged and vulnerable groups in the population.
    - Family-based behaviour modification programmes, where the whole family is involved where appropriate, incorporating diet, physical activity and behaviour modification should be made widely available.
    - All the relevant services should be organised 'under one roof' or a single 'umbrella
    - Consideration should be given to appointing an 'Obesity Coordinator' who would work with a high profile influential 'team of champions', including people like the editor of the Express and Star
    - Targeted community approaches can be effective, with the role of the GP being particularly important
    - A directory of services should be prepared and be readily accessible to all. This would help the coordination of services and help to create referral pathways across services
    - The importance of agencies working in partnership, together with individuals, parents, families and the community cannot be overemphasised.
    - There should be more systematic evaluation of services and interventions to identify what really works and best practice e.g. Hull School

9. Conclusions and Recommendations

- Dealing with childhood overweight and obesity is one of the most important public health challenges facing Walsall. This challenge cannot be met without unprecedented levels of partnership working between all the agencies in Walsall. Some excellent joint work is already taking place but a step-change is required to engage other key players, such as the schools, in moving forward
- Prevention is much more effective than treatment and this relies on individuals and their families making different lifestyle choices about diet and exercise. Helping and supporting them to make these healthy choices requires the active engagement of Walsall's population. New strategies are required to engage communities so that an unstoppable momentum for change is created.
- Walsall MBC and Walsall tPCT will be held jointly accountable for meeting this challenge. It is vital that clear leadership is established for this work and that there is a clear line of accountability for delivery into the new LSP/LAA arrangements which are being established.
- The scale of the task will undoubtedly require additional resourcing. Some of these may come from reallocation of existing resources and review of current priorities within the Walsall MBC and the tPCT. However it is likely that additional new resources will be required and consideration should be given to this urgently, given that the Government's deadline for achieving the PSA target is just over 4 years away.
- As Members will know, a draft strategy for Adults has already been developed and this report provides the basis for a clear strategy and action plan for children. There remains the need to develop a strategy focused on the working population.

- **It is therefore recommended that**:
  - The Joint Working Group consider this report, suggest any amendments and commend it to the Scrutiny Panels
  - A strategy for addressing overweight and obesity in children should encompass all the 6 key themes identified above
  - The Scrutiny Panels agree to the establishment of an Obesity Steering Group which would cover children, adults and the working population and has responsibility for determining the overall strategies and priorities for action across Walsall to address overweight and obesity.
  - The Steering Group should be provided with sufficient resources to develop a prioritized action plan which spells out the responsibility of each agency in implementing the overall action plan.
  - This action plan should be completed by the end of January 2006 at the latest.
  - An 'Obesity Coordinator' be appointed to support the work of the Steering Group and with managerial responsibility for ensuring that the agreed actions are being implemented across all the agencies.
  - Progress on implementation should be underpinned by an explicit performance management process.

APPENDIX 1: SOURCES

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APPENDIX 2

Walsall Metropolitan Borough Council
Walsall Teaching Primary Care Trust

Notes of a Half-Day Workshop on

Tackling Overweight and Obesity in Children

Held on Wednesday 15th June 2005

At Bescot Stadium

Prepared By: Jeff Chandra, Josam Associates

1. Background

- In November 2004, the Government's White Paper 'Choosing Health' put overweight and obesity second only to smoking as the focus for increasing life expectancy, reducing inequalities and improving health

- Earlier this year the Borough Council's Scrutiny and Performance Panels established a Joint Working Group to consider how to tackle the problem of overweight and obesity in Walsall in the light of significant increases in the proportion of people in these categories. Walsall's Director of Public Health Dr Sam Ramaiah was invited to advise the Joint Working Group on finding the best way forward.

- The Walsall Teaching PCT had already published in 2004 a draft strategy for tackling obesity in adults. It was therefore agreed that the Joint Working Group would initially focus on considering how to tackle overweight and obesity in children.

- The Joint Working Group commissioned Jeff Chandra of Josam Associates, who have extensive experience of health and local government services, to support the work of the Joint Working Group. As a crucial part of this work, it was important to identify best practice nationally, to determine what was already being done in Walsall to tackle this issue and to engage the key agencies and local people in generating the most creative approaches to tackling these difficult issues.

- As an important step in this process a half-day workshop was held on Wednesday 15th June 2005 at Bescot Stadium to provide a multi-agency focus for this work and to create a momentum for taking this work forward. The attendance list at Appendix 1 demonstrates that the workshop succeeded in attracting people from all the agencies and groups, including parents of overweight and obese children, who will be central to delivering the strategy which emerges from this work. The informal feedback from those who attended was that the workshop had been extremely useful in raising awareness of the issues and in enabling those present to better understand what they, their organisations and their partner agencies need to do to tackle childhood overweight and obesity.

- This document is a brief record of the outcomes of that workshop. It will be disseminated to all interested parties as well as those who attended the workshop, who are an ideal 'reference group' for testing the quality of the strategies and action plans which emerge from this work.

2. Setting the Scene

- The workshop was opened by David McNulty, Director of Education for Walsall MBC. Following his welcome to delegates he made a number of important observations about the way forward:
    i. He emphasised the importance of partnerships between organisations in tackling the issues, and particularly the partnership between the Borough Council and the tPCT.
    ii. He pointed out the powerful evidence which connects education and health to life chances of individuals. Overweight and obesity if not addressed vigorously could become significant barriers to an increasing number of individuals in reaching their full potential, not least in terms of life expectancy.
    iii. It was important to engage with children themselves in finding ways forward
    iv. Whatever action is agreed must be based on sound evidence of effectiveness.

- Dr Ramaiah, Walsall's Director of Public Health set out the main health priorities in 'Choosing Health' and how Walsall compared on a number of the key indicators of health. He referred to the national picture on overweight and obesity which had led the Government to give this issue such a high priority. If not tackled there was a danger that the life expectancy of future generations could actually be less than that of this generation.

- Dr Ramaiah strongly supported David McNulty's comments about the importance of partnership working to deliver the changes necessary to turn around the obesity 'epidemic'.

3. The scale of the problem: What the figures tell us

- Rachel Neal, epidemiologist at Walsall tPCT, spoke about the national and local information about overweight and obesity. Her full presentation is at Appendix 2.
- A key issue being tackled as part of this project was the lack of local information about overweight and obese children. Routine data collection currently ceases at the point of school entry at age 5. There is no reason to suppose that Walsall had any less of a problem than suggested by the national figures. In fact, the real situation could be worse given that rates of overweight and obesity are higher in poorer, deprived populations and Walsall is certainly high on the deprivation indices.

4. How are we doing so far in Walsall? What really works?

- Rachel Humphreys, recently appointed as Head of Health Promotion for Walsall tPCT, set out a range of issues around tackling overweight and obesity. Her full presentation is at Appendix 3.
- She also briefly reviewed the national evidence for effective interventions in the prevention and treatment of overweight and obesity.
- A key message was that although there are a number of initiatives currently taking place in Walsall, there is a need for better coordination and partnership working to ensure that these projects can have the maximum impact possible.

5. Outcomes of Facilitated Group Work and Plenary Discussions

- A key objective of this workshop was to engage individuals with an interest as well as the staff of local agencies in developing ways forward. Each delegate was allocated to one of 4 groups and asked to address a number of questions about the issues raised (Appendix 4). They were then asked to propose 5 actions which would have the greatest impact on preventing or tackling childhood obesity in Walsall. Each group presented their conclusions and this was followed by an open discussion where any delegate was free to raise any issues which they wished to highlight..

- The feedback from this process was rich in ideas and demonstrated a high degree of commitment in Walsall to tackling the issues. It was not a purpose of the workshop to finalise a strategy or action plans but the ideas which emerged will be carefully evaluated in preparing the report for the Joint Working Group which has commissioned this work.

- For the purposes of this document the ideas which emerged are recorded below for reference, grouped under a number of themes.

- **Role of the Media, Communications and Branding**

  i. A key task is to raise the awareness of the issues amongst the general population, perhaps using high profile campaigns. Reference was made to the powerful impact of national campaigns such as ‘Back to Sleep’ initiative which had led to significant reductions in infant cot deaths. The ‘shock tactic’ advertisements for seat belts and drink driving were also highlighted as possible approaches.
  ii. In the business world there is a recognition of the power of ‘branding’ and perhaps the use of a catchy slogan or strap line could help to connect the public to the issues of overweight and obesity and how to prevent them.
  iii. Locally, thought should be given to working more closely with all the media to ensure better and more informed coverage of the issues. Perhaps a high profile individual such as a sports personality could be

invited to lead such a profile-raising initiative and establish the 'brand' in the public consciousness.

iv. It is vital that local opinion formers are incentivised to champion the issues in Walsall
v. There is a need to counter the media advertising/selling poor habits to young people, perhaps through legislation
vi. There is a role for the media and for local agencies in promoting the message that 'breast-feeding is normal'

- **Work within Schools and with Young People**
  - Engaging Head Teachers and school governors is key if schools are to play their full part in addressing these issues
  - A 'holistic' approach is needed in schools and teachers involved in determining how best schools can be helped to deliver the objectives
  - The School Health Service needs to be considerably strengthened if it is to take on the additional tasks concerned with dealing with overweight and obesity
  - There is a need for more and better health promotion materials to be available to schools
  - There should be rewards and incentives for young people to adopt healthy lifestyles
  - It is important to make healthy lifestyle messages 'cool' for young people
  - Consideration should be given to providing free, high quality school meals for all
  - Cooking lessons could be introduced as education sessions
  - PE lessons should perhaps be graded for ability and there could be a role for more active playground management
  - Children could be involved in school breakfast clubs and also after school clubs which kids attend for fun but could help to raise awareness of healthy lifestyles
  - The interventions and approach should not disempower families. Children should themselves be consulted and invited to create the services which they will value most

- **Information and Education**
  - There should be a central department for preparing and disseminating health leaflets into the whole range of outlets where the public could access them
  - Relevant information should be made available on a website for use in IT classes in school
  - There is a need to establish data collection systems which provide an accurate picture of the changes in overweight and obesity locally on a continuing basis
  - Educating through awareness has already been highlighted earlier under the 'media and communications' heading

- Education for all is a matter of priority, including health professionals, community groups, parents and families
- In fact education about promoting good health, and importance of diet and exercise should start before age 5 for children and their parents. There is a role here for Children's Centres and Sure Start
- There should be better coordination of information in schools and the community, with attractive display boards etc

- **Service Provision**
  - All the relevant services should be organised 'under one roof' or a single 'umbrella
  - Consideration should be given to appointing an 'Obesity Coordinator' who would work with a high profile influential 'team of champions', including people like the editor of the Express and Star
  - Targeted community approaches can be effective, with the role of the GP being particularly important
  - A directory of services should be prepared and be readily accessible to all. This would help the coordination of services and help to create referral pathways across services
  - The importance of agencies working in partnership, together with individuals, parents, families and the community cannot be overemphasised.
  - There should be more systematic evaluation of services and interventions to identify what really works and best practice e.g. Hull School

- **Food access and Awareness, Diet and Exercise**
  - Family mealtimes are now less common with consequent effects on childrens' eating habits. For example, the lack of breakfast is often made up with 'tuck' which fills the gap.
  - Consideration should be given to agreeing cheap deals for healthy foods
  - There has been an erosion of cooking skills and healthy cooking lessons using normal ingredients have a part to play
  - There could be early advice e.g. from midwives, about healthy feeding of children.
  - There could be 'weening parties' where parents and children could try different foods
  - Government could legislate a ban on the advertising of unhealthy foods for children
  - Vat could be reduced to 0% for healthy products and increased from the current rate for unhealthy products.
  - Current treatment programmes such as fun4life should be continued with family involvement
  - A much more sedentary population needs to be encouraged to undertake more physical activity, not least walking more and cycling.

This may require improving people's perception of safety before they can be persuaded to change their behaviour

- o The creation of safer neighbourhoods can help young people to undertake more physical activity in the neighbourhood, including in designated play areas

6. Concluding Comments

- The workshop was enjoyable and, as set out above, provided a wealth of ideas for taking forward Walsall's work on childhood overweight and obesity
- What is more, the workshop demonstrated a genuine commitment to partnership working between the agencies and this will be a solid foundation on which to develop the strategies and action plans which emerge later this year.
- Nevertheless, the workshop made explicit that the task of turning round a rising trend is considerable and will require sustained effort over a long period if success is to be achieved. In this, there is much that Government and other agencies will need to provide but the burden of achieving the goal resye squarely with Walsall.

Appendix 1

ATTENDANCE LIST FOR
WORKSHOP - CHILD OBESITY
15th JUNE, 2005 AT BESCOT STADIUM
12.30pm - 5.00pm

Name	Where based
Carol Lakin	Walsall tPCT Employ Retention Proj
Michelle de Garis	Walsall tPCT 5 A Day Co-ordinator
Graham Fee	Walsall tPCT Public Health Dept
Dr Paul Carter	Walsall tPCT Sycamore House
Shirley Archibald	Walsall tPCT Sycamore House
Sue Clark	Walsall tPCT Inform Dept, Jub House
Karen Smith	Walsall tPCT Inform Dept, Jub House
Mary Griffiths	Walsall tPCT Child Health
Dr James Chipwete	Walsall tPCT PH Dept, Lich House
Bal Kaur	Walsall tPCT PH Dev Manager
Dr D.C. Johnson	Walsall tPCT Bloxwich Medical Centre
Dr Narinder Sahota	Walsall tPCT Kingfisher Med Centre
Dr Z. W. Neeves	Walsall tPCT St Peter's Surgery
Ann Smith	Walsall tPCT Nurse, Coalpool Surgery
Jill Day	Walsall tPCT Willenhall HC
Patrica Rushton	Walsall tPCT HV, Pinfold HC
Rosie Bamford	Walsall tPCT Community Dietitian
Suni Desai	Walsall tPCT Primary Prev Facilitator Comm PH Team

Julie Tibbetts	Walsall tPCT School Health Adviser Harden Health Centre
Diane Wright	Walsall tPCT Short Heath Clinic School Health Advisors Assistant
Fiona Beckwith	Manor Hospital
Hilary Hastings	Sure Start Birchills/North Walsall
Cllr Eileen Pitt	Walsall MBC
Ishbel Murray	Walsall MBC Lifelong Learning & Community
Max Bailey	Walsall MBC Community Arts Team
Kate Halsey	Walsall MBC Sport&Leisure Dev Serv
Rachel Parker	Walsall MBC Community Arts Team
Jeff McBride	Walsall MBC Countryside Services
Diana West	Walsall MBC Countryside Services
Jane Bonner	Education Walsall
Fran Oaker	Healthy Schools Co-ord Education Walsall
Anthony Derrer	Willenhall School Leisure & Community
Kathryn Waite	Walsall Catering Service
Jackie Groves	Walsall Catering Service
Cath Whitehouse	Asda Stores, Darlaston
Chris Kinsey	Asda Stores, Bloxwich
To be notified	Asda Stores, Bloxwich
Harjinder Singh	Health Theme Leader Walsall New Deal
William Gwilt	Bloxwich Leisure Centre
Frank Foster	Chair: East HAZ Steering Group
A'isha Khan	Aaina Women's Centre
Saima Irfan	Aaina Women's Centre

Plus facilitators/ Speakers	
Jeff Chandra	Josam Associates, Workshop Facilitator
David McNulty	Walsall MBC
Rachel Neal	Public Health Dept
Dr Ramaiah	Public Health Dept
Rachael Humphreys	Health Promotion
Caroline Southern	Walsall tPCT, HAZ Team
Paul Wicker	Walsall MBC Sport & Leisure Dev Serv
Pat Warner	Scrutiny Team, Walsall MBC
Stuart Bentley	Scrutiny Team, Walsall MBC

Slide 1

Obesity in Children

The Scale of the Problem: What the figures tell us

Rachel Neal
Epidemiologist – Walsall tPCT

Walsall NHS Teaching Primary Care Trust

APPENDIX 2

Slide 2

Why is it important?

- "Epidemic"
- "Tidal wave"
- "Time Bomb"

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Slide 3

Why is it important?

- Problems caused:
  - asthma
  - diabetes
  - high blood pressure
  - bones & joints
  - hormonal
  - skin
  - sleep
  - self esteem
  - body image
  - bullying
  - isolation
  - depression
  - anxiety

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Slide 4

Why is it important?

- National target to halt by 2010 the year on year increase in obesity in children under 11 – Joint target DoH, DfES and DCMS
- Obesity is a Spearhead target and a Strategic Health Authority Target
- Inequalities, Deprivation and ethnicity

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Slide 5

How big is the problem: Nationally?

- Increased prevalence
- In 1995 9.6% 2-10yr olds obese
- In 2002 15.5% 2-10yr olds obese
- This could be 50% by 2010

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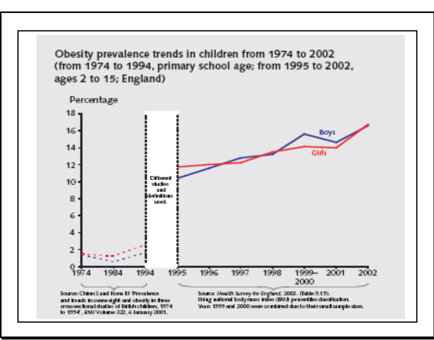
Slide 6



Slide 7

How big is the problem: Locally?

- Historical Walsall data shows that:
  - 5 year olds
  - 7 year olds…..

To add some data

- 2002 estimates for Walsall suggest:
  - 4,800 obese 2-10 year olds in Walsall but in reality likely to be underestimates
- However, we do not have any current data in Children over the age of 5.

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Slide 8

Collecting Data

- This is not just an issue in Walsall
- Nationally plans to return childhood obesity data have been deferred as local data sources are being explored
- A workshop is being held in London on the 17th June to explore some options for a national data collection programme
- North Birmingham have piloted a system of data collection as part of an educational classroom activity

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Slide 9

Collecting local data

- In Walsall a group has been established and plans are in progress to establish a system to collect childhood obesity data locally.
- Various options have been considered
- Currently data is only available up to school entry.
- Ideally we need to collect height and weight data in:
  - Birth to 4 years ✓
  - School entry ✓
  - Year 5 (9-10 year olds)
  - Year 7 (11-12 year olds)
  - Year 10 (14-15 year olds)

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Slide 10

Collecting local data

It is proposed to run a pilot which will:

- Employ a support worker to take and input, height and weight data from children in:
  - Year 5, Year 7 and Year 10
- The data would be input onto the child health system, school nurses would be able to see the records and the public health department would analyse the data at a population level.

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Slide 11

Collecting local data

- The support worker would send a letter to parents containing their child's height and weight measurements and a growth chart for the parents to plot the child's growth.
- A leaflet would be enclosed with information and contact details for concerned parents.
- This work would be audited

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Slide 12

Collecting local data

Timescales:

- The proposal has been accepted
- Funding has been secured
- The recruitment progress is underway
- The programme will be piloted from September/October in 6 schools
- The intention is to roll out the programme following the completion and feedback on the pilot

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Slide 13

Summary

- Childhood obesity is a major public health issue
- It is estimated that 16% of 2-10 year olds are obese
- Very little data is available locally around childhood obesity
- We are currently looking at setting up a system to collect local data

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Slide 14

Any Questions?

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APPENDIX 3

Slide 1

Tackling Childhood Obesity

Prevention & Treatment: The Evidence

Rachael Humphreys
Head of Health Promotion
Walsall Teaching PCT

Walsall NHS
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Slide 2

INTRODUCTION

- The Big 'O'
- Obesity: The Risk Factors
- The Complexity of Obesity
- Prevention
- Treatment
- Environmental Change
- National Policy
- Local Action
- Summary

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Slide 3

The Big 'O'

- Obesity is associated with health & social consequences
- Precursor to adult obesity
- No marked gender difference in prevalence
- More prevalent with increasing age
- Of lifestyle origin with genetic causes of obesity extremely rare
- Prevention is the best long term approach

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Slide 4

Obesity: The Risk Factors

- Obesity in childhood is strongly linked to social class
  - -Risk approx doubles from families social class V to social class 1
- Parental obesity
  - -2 obese parents increases risk by a factor of 12 for boys & 10 for girls
- Sedentary inactivity
  - -particularly TV viewing
- Dietary composition
  - -Low fruit & veg intake V high intake of savoury snacks, confectionery & soft drinks
- Not breast fed
  - -May protect against later risk of obesity

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Slide 5

The Complexity of Obesity

- No weight gain as height increases or weight gain slower than height gain
- Rapid weight loss and strict dieting are not appropriate unless under specialist care
- Treatment (e.g. service provision, training, resources) is very different to Prevention (e.g. Policies & interventions to encourage environmental change)

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Slide 6

Prevention: The Evidence

- School-based health promotion programme
- School-based physical activity programmes
- School-based multi faceted interventions
- Family-bases health promotion interventions
- Family-based behaviour modification programmes

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Slide 7

Treatment: The Evidence

- Targeting parents & children together (family-based physical activity & health promotion interventions)
- Family-based programmes with parents as agents of change
- Family-based behaviour modification programmes
- Behaviour modification programmes with no parental involvement
- Exercise treatment programmes (within a laboratory setting)

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Slide 8

	Evidence of effectiveness	Current limited evidence of effectiveness	Current lack of evidence of effectiveness
Prevention	•School-based multi faceted interventions (particularly for girls)(nutrition education, physical activity promotion, reduction in sedentary behaviour, behavioural therapy, teacher training, curricular material, modification of school meals & tuck shops)	•School-based health promotion (classroom curriculum to reduce TV, video & video game use) •Family –based behaviour modification programmes to impede weight gain(family therapy in addition to diet education, regular visits to a paediatrician & encourage exercise)	•School-based physical activity programme(led by specialist staff or classroom teachers) •Family-based health promotion(strong focus on dietary & general health education & increased activity, involving sustained contact with children & parents
Treatment	•Targeting parents & children together(family-based interventions involving at least one parent, with physical activity & health promotion) •Multi faceted family-based behaviour modification programmes, where parents take primary responsibility for behaviour change in primary schoolchildren •Lab-based exercise programmes	•Behaviour modification programmes with no parental involvement(reduced calorie diet & an exercise programme, combined with cognitive-behavioural 'obesity-training', or muscle relaxation training)	•Family-based behaviour modification programmes(behaviour modification, dietary & exercise education with a mix of sessions involving the child. Parent(s) or in some cases the entire family

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Slide 9

Prevention: Environmental Change

- SCHOOLS
  - Healthy school meals
  - Free school meals to all
  - Healthy vending machines
  - Cooking for boys & girls
  - Water
  - Play/activity
  - Travel plans
- LEISURE
  - Safe,accessible play areas
  - Low cost facilities
  - Accessible
  - Scheduling

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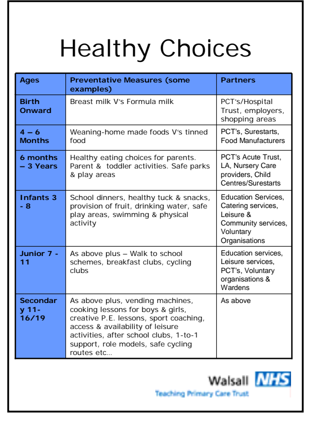
Slide 10

Slide 11



Healthy Choices

Ages	Preventative Measures (some examples)	Partners
Birth Onward	Breast milk V's Formula milk	PCT's/Hospital Trust, employers, shopping areas
4 – 6 Months	Weaning-home made foods V's tinned food	PCT's, Surestarts, Food Manufacturers
6 months – 3 Years	Healthy eating choices for parents. Parent & toddler activities. Safe parks & play areas	PCT's Acute Trust, LA, Nursery Care providers, Child Centres/Surestarts
Infants 3 - 8	School dinners, healthy tuck & snacks, provision of fruit, drinking water, safe play areas, swimming & physical activity	Education Services, Catering services, Leisure & Community services, Voluntary Organisations
Junior 7 - 11	As above plus – Walk to school schemes, breakfast clubs, cycling clubs	Education services, Leisure services, PCT's, Voluntary organisations & Wardens
Secondary 11-16/19	As above plus, vending machines, cooking lessons for boys & girls, creative P.E. lessons, sport coaching, access & availability of leisure activities, after school clubs, 1-to-1 support, role models, safe cycling routes etc...	As above

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Slide 12

National Policy

- White Paper 'Choosing Health'
- Food & Health Action Plan
- Activity Co-ordination Team
- Welfare Food Scheme
- Healthy Start
- National Schools Fruit
- Food in Schools Programme
- National Healthy Schools
- School Sport & Club Links Programme
- Local Exercise Action Pilots
- NICE (Health Development Agency)

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Slide 13

Local Action: Tackling Obesity the Walsall Way

Slide 14

SUMMARY

APPENDIX 4

Childhood Obesity Workshop -15th June 2005 at Bescot Stadium

Group Task

For this discussion please do not limit yourself to thinking within the existing policy or budgetary framework. Imagine that that your most effective ideas could be fully implemented!

Each Group is asked to **come back with a list of 5 things** we can do in Walsall which would have the largest impact on preventing or tackling childhood overweight and obesity.

You might want to use some of the following questions to get the discussion going:

1. Do we fully understand **why** childhood overweight and obesity is increasing so rapidly?
    - If not, who should be doing what to get a better understanding?

2. Is the population of Walsall **sufficiently aware** of the scale of the potential problems?
    - If not, who should be doing what to raise awareness?

3. **Who should be doing what in Walsall** to prevent childhood overweight and obesity? Consider the role of parents, schools, Borough Council, NHS, supermarkets and other food retailers

4. How should the agencies **work better together**, as well as with the community at large, to tackle this problem?

APPENDIX 3

DEFINITION OF OVERWEIGHT & OBESITY

Many people get confused about what the terms “overweight” and “obese” actually mean. In its most simple form, the commonest measure used is the **Body Mass Index or BMI.** This is a formula which works out the relationship between the height and weight of a person as a ratio[1].

- A BMI of **under 20** is considered **underweight**
- A BMI of **between 20-25** is considered **healthy**
- A BMI of **over 25** is considered **overweight**

[1] The formula for working out the BMI is:-

$$\frac{\text{Person's bodyweight in Kilograms}}{(\text{Person's height in metres})^2}$$

ie a person who weighs 90 kilograms and is 1.73 metres tall

$$= \frac{90}{(1.73)^2} = \frac{90}{3} = \text{BMI of } 30$$

The calculation for children is more complex, with healthy BMI’s varying with the sex of the child, and age. Example charts from the U.S. Centre for Chronic Disease Control (CDC) “**BMI-for-age**” are included below.

In children and teens body mass index is used to assess underweight, overweight, and risk for overweight. Children’s body “fatness” changes over the years as they grow. Also, girls and boys differ in their body fatness as they mature. This is why BMI for children, also referred to as BMI-for-age, is gender and age specific. The charts below are used for children and teens 2-20 years of age. Each chart details a series of lines indicating specific percentiles. These are used as cut-off points to identify underweight and overweight in children.

Underweight	$\leq 5^{th}$ Percentile
At Risk of Overweight	85th to $<95^{th}$ Percentile
Overweight	$\geq 95^{th}$ Percentile

In general terms these classifications can be matched to adult BMI terminology as follows:-

BMI	CLASSIFICATION
<20	Underweight
20-25	Ideal Weight
25-30	Overweight
30-35	Obese
>40	Morbidly Obese

(or >35 with associated co-morbidites)

NAME ______________________

Weight-for-stature percentiles: Boys

RECORD # ____________

Date	Age	Weight	Stature	Comments

Published May 30, 2000 (modified 10/16/00).
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

NAME ______________________

Weight-for-stature percentiles: Girls

RECORD # ______________

Date	Age	Weight	Stature	Comments

Published May 30, 2000 (modified 10/16/00).
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

APPENDIX 4

OBESITY IN CHILDREN: DATA COLLECTION

Proposed options and methodology to facilitate the collection of obesity data in children

1 INTRODUCTION

This document outlines the need to collect baseline information and monitoring data around childhood obesity locally. It discusses what data is already available, what is needed and the gaps in the information provision. Finally this paper considers the various options/methods for collecting this information and the financial implications of these options.

2 BACKGROUND

2.1 Childhood Obesity, the National Picture

The prevalence of obesity in children aged 2 to 10 years has increased from 9.6% in 1995 to 15.5% in 2002. Obese children, especially girls, are more likely to come from lower social groups. Children who are obese are more likely to become obese adults, this likelihood increases if the child's parents are obese.[i] Obesity in adults and children is a major Public Health issue.

2.2 National Targets for Childhood Obesity

The White Paper, *Choosing Health: Making Healthy Choices Easier* highlighted the national 2004 Public Service Agreement inequalities target to halt, by 2010, the year-on-year increase in obesity among children under 11 in the context of a broader strategy to tackle obesity in the population as a whole. This objective will be shared jointly by the government departments with responsibility for health, education and sport. Baselines and progress towards this target need to be monitored locally.

Spearhead Funding

2.3 70 Local Authorities and 88 Primary Care Trusts are in the Spearhead Group. These are areas that are in the bottom fifth nationally for at least 3 of the indicators relating to; life expectancy, cancer, circulatory disease and deprivation. Walsall is one of these areas and as a result will receive extra funding. The funding is linked to *Choosing Health* and will require Spearheads to focus on specific issues. One of these is obesity. Locally this means that £800,000 has been specifically allocated to the Obesity Programme in Walsall between 2006/07 to 2007/08.

Strategic Health Authority

2.4 The Strategic Health Authority and DoH has delayed setting local obesity targets in this LDP due in part to data issues. The PCTs have been tasked with improving data collection during this interim period.

2.5

Local Direction

The Local Authority Health Scrutiny & Performance Panel and Children's Services & Lifelong Learning Panel have established a joint Working Group to focus on obesity in Walsall. A report is being produced for the group. One of the key requirements is to look at, and begin to establish, data collection processes.

3 OVERVIEW OF THE CURRENT POSITION IN WALSALL

3.1 **Working Group**

A working group was established in February to look at the issues around data collection and obesity in children. The group is made up of key professionals involved in children's services, health promotion, education and information. The remit of the group was to look at what data is currently available, what we need, the gaps and to propose a way forward. The group will manage and monitor the system for data collection as members of the broader Obesity Group who will responsible for overseeing the work to tackle obesity in Walsall.

3.2

What data is available?

Data is currently available around:

- Birth weight
- Health visitors had collected weight and height data at several different ages until a child reached 5, however this programme is being reduced
- Children aged 5 have a school entry assessment where height and weight is recorded. Assessments are no longer routinely carried out in older children
- Lifestyle surveys have been carried out in local schools in 2000 and 2003. This includes information on diet and exercise. However, there are currently no plans to repeat the survey due to shortages of funds.

3.3

What data is required?

The following information is required to establish a baseline around local levels of obesity in children, it would allow monitoring of time trends and among cohort groups and provide information to help evaluate interventions.

- Weight and height data by various **age groups**, corresponding to school systems and Government targets.
  - At birth
  - Year 1 = 5 year olds,
  - Year 5 = 9 and 10 year olds,
  - Year 7 = 11 and 12 year olds, and
  - Year 11 = 15 and 16 years old.
- Data around **lifestyle**, looking at children's physical activity levels, diet etc.
- Socio-economic, deprivation, cultural and ethnicity data
- **Individual data** to enable children to be followed up and interventions put in place where appropriate.

What are the Gaps and Issues?

3.4

- Information is not routinely collected in children older than 5. Capacity in terms of school nurses, link workers, admin or analysts is not available to repeat the assessment in older

age groups.

- Lifestyle data is obtained from ad-hoc surveys, this data is not routinely collected and there are no plans to repeat the local survey.
- Information is put on the system by admin support. However, other information such as immunisation data, may be more of a priority.
- Once the information is on the system, it can be accessed, but if more data is collected, more support may be needed to download and analyse it.
- There needs to be one system for interpreting the data e.g. BMI charts
- Should programmes of data collection be linked to interventions and healthy schools?
- The Government is looking at introducing annual health checks in the autumn of 2006 to all schools, this would include height and weight data. It is unclear who will carry out these checks.

4 OPTIONS

4.1 Option 1: The North Birmingham Model

This model developed in North Birmingham PCT to collect BMI data in school children involved working with a sample of children in year 5 as part of a numeracy lesson. The data was collected anonymously and then cross-referenced to demographic details at a later date for analysis. The work could be adapted to other key stages. The costs were minimal and could be carried out by a link worker or trained parent.

1. **The group discussed the project and while it found it was a stimulating way of engaging children, it expressed concerns. While the work collected the BMI data it did not link to any interventions and as a result was a "missed opportunity". The group felt this work needed to be linked to children so that it could lead to an intervention where appropriate.**

4.2 Option 2: Universal linked data collection

The favoured option is option 2 which would involve approaching all children in all schools in particular year groups using a link worker to collect and input the data. The data would be linked to child health records and therefore children could be followed up as necessary and the aggregate data could be pulled off for monitoring purposes. From this data a case and control could potentially be identified of those children who have had prevention and treatment interventions, and those who have not. This data would also allow analysis to be carried out around some of the factors causing obesity in children.

4.3 Option 3: Sample of schools via rotation

Should option 2 prove too costly and impractical, a scaled down version would be an alternative, where a link worker could collect data on a rotating basis from a sample of around 20% of schools. However, at this stage a universal approach was favoured.

5 PROPOSED OPTION: OPTION 2 METHODOLOGY

- Data collection would be targeted universally to all schools, to all children in a specified year group. Birth data and data at age 5 are already collected. This project would aim to collect additional data in each year, if money becomes available a cohort of children may also be able measured throughout :
  - Year 5 = 9 and 10 year olds,
  - Year 7 = 11 and 12 year olds, and
  - Year 10 = 14 and 15 years old.

- A link worker would be employed to visit children in these years in all Walsall schools. The link worker would be responsible for recording the child's height and weight. Initially this would be input on a paper class list, in the same way school nurses currently do. The link worker would also be required to input the data onto the computer, linked to the child health records. The worker would be responsible for sending mail merged letters out to parents with the measurements and an information leaflet. The letter would state that their child's height and weight have been taken, it would provide the measurement and an information leaflet, which will include a simple growth chart for the parents to plot their child's BMI. The leaflet would contain health promotion material and contact numbers for parents if they were concerned about their child's weight and growth. This work would be audited in the pilot stage.

- Data analysis at a population level will be carried out by informatics and public health. Data will be downloaded in a flat file from the child health systems by Informatics, on a routine basis (annually). Public Health will have responsibility for analysing and interpreting the aggregated data which will be anonymised.

- The work will be piloted initially in 4 primary schools and 4 secondary schools. This will include 4 schools that are already doing a lot of work in this area and where there is good practice, but also schools which have been historically less active. Any issues could then be resolved before the universal introduction of this scheme.

- At the pilot stage an audit will be carried out looking at those children whose measurements suggest they are obese and the children/parents who have contacted local services for more information and support.

- Timescales. The aim is to pilot this in September 2005 and run it universally later that year after the half term in November.

6 COST IMPLICATIONS

- £10,000 has been allocated to the project from HAZ. Additional obesity funding is available from April 2006. Annual checks may be introduced in 2006, therefore this scheme may only need to run to that date, however it is not clear yet what the annual checks will involve.

Staff

Community Link Worker

- One full term time, community link worker is required to carry out the work in schools (195 days).
    - It is estimated that 1 class of 30 children could be measured in an hour, approximately 4 classes in a day. Although in many primary schools there would only be 1 class in a year group. There are currently 93 primary schools in Walsall with an average of 36 pupils in a year group. There are 20 secondary schools in Walsall with around 190 pupils in a year group, with an average of 6 classes per year group. A total of 11,000 children per year. Therefore an estimated 2 primary schools could be visited in a day and 1 secondary school every 2 days. This would therefore take an estimated 90 full days to carry out the measurements. Time also needs to be allocated for travel, inputting and sending out letters to parents.
- Currently community link workers are banded at an A&C grade 3 subject to agenda for change. One full time link worker on an A&C grade 3 will cost approximately £20,000 including on costs. A term time equivalent would cost 14,050 (salary 11,750).
- Travel Expenses

Data Analysts

- Informatics have the capacity to download the files routinely. Some training will need to be given to the link worker to allow them to input the child's measurements onto the child health system for informatics to download.
- An Information Officer will be recruited in Public Health. Analysis, interpretation and report writing of this obesity work will be part of the postholder's remit. Funding for 2005/06 year has been approved.

Equipment

- A computer will be needed, with software to enable to computer to be linked to the child health system.
- Measuring Equipment for the link worker to ensure consistency of data measures, suggested: Haldane type stadiometer
- Stationary and Postage to send out letters

Other

- Production of Information Leaflets
- Purchase of growth charts to send to parents

Costing Summary for first year:

Salaries + on-costs =	£14,050
Postage and stationary =	£ 4,000
Computer maintenance, telephone and incidentals =	£ 2,000
Travel =	£ 1,000
Production of Information Leaflets =	£ 1,000
Growth Charts =	£ 2,500
Equipment =	£ 500
TOTAL =	£25,050

7 KEY MESSAGES

- Obesity in Children is a major national issue.
- Key to the work around obesity is collecting and monitoring BMI data for children.
- Currently data is only available in children aged 5 and under.
- A system for data collection needs to be in place as by the end of 2005.
- The group favours Option 2, a universal data collection system, in all schools collecting additional data from 3 year groups.
- This programme would involve a link worker rotating round schools to take measurements, input data and send out letters to parents offering them access to interventions.
- The programme would be piloted in September 2005 and rolled out later that year.
- The costs of this programme would be an estimated £25,050
- £10,000 has already been allocated to the project, but this would leave a short fall of £15,050

[1] Department of Health, *Choosing Health: Making Healthy Choices Easier,* 2004, HMO.