



Tackling Child Obesity – First Steps

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EXECUTIVE SUMMARY



1 Child obesity is a complex public health issue that is a growing threat to children's health, as well as a current and future drain on National Health Service (NHS) resources. The United Kingdom has seen an unprecedented rise in obesity, but this is not a problem unique to Britain. A comparable rise has also been seen in the European Union. No country has yet achieved a reduction in the prevalence of obesity. It is estimated that obesity already costs the NHS directly around £1 billion a year³ and the UK economy a further £2.3 to £2.6 billion in indirect costs.⁴ It has been estimated that, if the present trend continues, by 2010 the annual cost to the economy would be £3.6 billion a year.⁵

2 In response to this growing concern, reducing child obesity was made a Public Service Agreement (PSA) target in the 2004 Treasury Spending Review:

*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.*⁶

3 The target is owned jointly by three Government Departments with direct impact on children's lives – the Department of Health (DH), the Department for Education and Skills (DfES) and the Department for Culture, Media and Sport (DCMS). The three Departments are coordinating their action at a national level. A draft delivery plan has been developed and a jointly-funded cross-departmental Obesity PSA Programme Manager has been appointed to support a Programme Board, which has been set up to give strategic direction and to oversee

the various initiatives. Progress towards the target is being monitored at Cabinet level by the Public Health Sub-Committee chaired by the Deputy Prime Minister.

4 The Departments plan to tackle child obesity through a range of approaches aimed at both prevention and treatment: for example, encouraging and supporting healthy eating and physical activity, particularly in schools; targeting antenatal nutrition; media campaigns; and treating those children who have become overweight or obese.

5 Tackling child obesity requires changes in the behaviour of individual children and their parents and of society in general, which reflects recent trends across most developing countries to greater fat and sugar consumption and reduced physical activity. Although existing cross-government programmes aim to deliver wider benefits, many also have the potential to contribute to achieving the obesity target. For example, some behavioural programmes covering education, physical exercise and diet are already in place including, for example, the School Sport Strategy (formerly Physical Education, School Sport and Club Links strategy – PESSCL) led jointly by the DfES and DCMS, the DfES programme for improving school meals, the combined DH and DfES Healthy Schools Programme, and DCMS' programme for children's play (**Figure 1 overleaf**). There are key opportunities for aligning these programmes with their own and other Departments' PSA targets; such as that of the Office of the Deputy Prime Minister (ODPM), which is represented on the Obesity Programme Board, to achieve cleaner, safer and greener public spaces, which increase children's opportunities to be active.

³ House of Commons Health Committee, *Third Report of 2003-04*, HC 23-1, <http://www.parliament.the-stationery-office.co.uk/pa/cm200304/cmselect/cmhealth/23/2309.htm>.

⁴ *Ibid.*

⁵ D. Wanless (2004) *Securing Good Health for the Whole Population, Final Report*, p95.

⁶ Department of Health, *National Standards, Local Action. Health and Social Care Standards and Planning Framework*, 2005-06 – 2007-08.

1 Key programmes contributing to the delivery of the child obesity PSA target

School Meals

DfES is revising the nutritional standards applied to school meals in order to reduce the fat, salt and sugar content and to increase consumption of fruit and vegetables. Subject to legislation these standards will be introduced from September 2006 and will be extended to other food in schools, including vending machines and tuck shops. DH supports the work in schools by leading on the School Fruit and Vegetable Scheme, which offers a free piece of fruit or vegetable on every school day to all children aged between four and six. DfES is the sponsor department for the School Food Trust, which will promote the education and health of children and young people by increasing the quality of food supplied and consumed in schools.

School Sport Strategy

The School Sport Strategy aims primarily to achieve the PSA target 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 school sport within and beyond the curriculum from 25 per cent in 2002 to 75 per cent by 2006 and 85 per cent by 2008”. The Departments consider that this will have a significant and supportive impact on meeting the child obesity PSA. For example, starting in April 2003 and running until at least March 2008, the strategy includes the creation of School Sport Partnerships, which typically bring together a specialist sports college, eight secondary schools and around 45 primary schools, in order to enhance sports opportunities for all. Each partnership receives an annual grant averaging £270,000. Club Links focuses on strengthening the links between schools and local sports clubs to increase the number of children participating in accredited clubs. Playgrounds in more than 600 primary schools are being improved to increase physical activity and to enhance the delivery of the PE curriculum.

Healthy Schools Programme

The Healthy Schools Programme aims to encourage schools to promote good health across its activities and across the whole school community. Up until now, schools have been accredited in up to eight key areas of the National Healthy Schools Standard. From September 2005, schools have to meet four core standards including healthy eating and physical activity. Schools are accredited against criteria in all four themes before being awarded Healthy School Status. There are targets for half of all schools to be healthy schools by 2006, with the rest working towards healthy school status by 2009. There is a drive for the Healthy Schools Programme to target work in schools in more deprived areas.

Play

Play has a significant role in helping to increase levels of physical activity amongst children, and on 31 March 2005 the Big Lottery Fund announced that one of its new funding programmes would include £155 million to create, improve and develop children’s play provision (in England) and develop innovative practice. Eighty per cent of the money will be used to develop free, open access play provision in all local authority areas, with the remaining 20 per cent divided between an innovation fund and a regional support and development infrastructure fund. Each local authority has been provisionally allocated a certain amount, based on the number of children in the area and weighted according to the child poverty level. As well as the play programme, £324 million in England will be dedicated to helping communities improve their local environment including £90 million for parks which will be run in partnership with the Heritage Lottery Fund.

Obesity Campaign

A campaign is under development to encourage people to lose weight or maintain a healthy weight through improved diet and increased physical exercise. DH is working with other Government Departments and a wide range of stakeholders to develop and implement the campaign. Early focus will be on children aged 0 to 11 and their influencers, especially parents.

6 These approaches require the Departments to build on their experience of joint working on the Every Child Matters: Change for Children programme to work across a complex delivery chain involving over 20 programmes and initiatives delivered through a wide range of organisations and partnerships across four tiers – national, regional, local and frontline. Organisations include Government Departments, Government Offices for the Regions, local authorities, Strategic Health Authorities (SHAs), Primary Care Trusts (PCTs), and schools. The requirement for a large number of organisations to work together inevitably has risks as well as benefits. Ongoing coordination and alignment are needed so that

they are mutually supportive, focusing effort to meet the PSA target so that progress is not delayed. The proposed Commissioning a Patient-Led NHS reforms, which will bring much greater coterminosity of local authorities and PCTs, should help reduce these risks.

Every Child Matters: Change for Children

A new 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.

7 Over the next three years, more than £1 billion has been allocated to nutrition and physical activity programmes for children, and approximately £3.6 billion will be spent on wider programmes such as Extended Schools and, although not part of the scope of this report which focuses on 5-10 year olds, Sure Start for younger children that have the potential to influence children's and family behaviour and include contributing to reducing obesity among their wider aims. Although evidence to date suggests that an approach combining actions to improve diet and increase physical activity is the most appropriate way to address obesity, the effectiveness of these particular programmes in addressing childhood obesity in these specific settings needs to be tested; hence good evaluation will be critical.

Extended Schools

Extended Schools provide a range of services and activities, often beyond the school day, to help meet the needs of their pupils, their families and the local community. These can include childcare, healthcare and social services, and cultural, sporting and play activities.

Sure Start

Sure Start is a programme that aims to achieve better outcomes for children, parents and communities by increasing the availability of childcare, improving health and emotional development for young children, and supporting parents as parents and in their aspirations towards employment.

8 As a complex problem, child obesity draws together a wide range of programmes and interventions that do not fit any one Department's remit and each of which has its own funding and delivery arrangements. This in itself creates a complex coordination challenge.

The purpose of this report

9 The Audit Commission, the Healthcare Commission and the National Audit Office, through their different national and local responsibilities, are uniquely placed to examine this delivery chain. This joint report is intended to assist all those within the chain, from the three target-holding Departments to those on the frontline. It assesses the risks, opportunities and barriers to achieving the target, and makes recommendations about how the delivery chain might be strengthened or made more efficient.

10 Our report focuses on children aged five to ten to highlight specific issues that can readily be addressed through existing structures, but it also recognises the importance of other elements – for example what children do outside school, their parents' access to buying healthy and affordable food, and food promotion to children in improving diet and promoting healthier lifestyles.

Findings

While the evidence is that a multifaceted approach to child obesity is the most effective, there is little evidence as yet to determine whether the Departments' range of programmes and initiatives to improve children's health and nutrition generally is sufficient to achieve the target.

11 The target-holding Departments are tackling child obesity in 5-10 year olds through a range of programmes and initiatives established to increase children's physical activity levels in schools and to improve the quality of the food they eat while at school. These programmes are targeted at children in general. They need tight policy guidance, coordination and assessment systems if they are to work together to achieve change. There is at this stage, however, no evidence whether this range of programmes and initiatives to improve children's health and nutrition generally will encourage obese children or children at risk of obesity to eat more healthily or to exercise more. Evaluation of these programmes will need to focus on how they impact on different children, especially those who are overweight or obese. Children most at risk, for example, may be reluctant to participate in such programmes without individual support and encouragement to do so. In September 2005, DH appointed an economist to carry out assessments of evaluations of individual interventions in the draft delivery plan for how well they focus on obesity relevant outcomes. Strong evaluation is particularly important, given that evidence on what works to tackle this new problem is in short supply.

12 In common with other complex health promotion programmes, the cost-effectiveness of the various programmes is difficult to gauge. The health benefits of physical activity and dietary interventions are particularly difficult to quantify because they deliver a wide range of health benefits, beyond obesity, over long time scales. The School Sport Strategy (formerly known as PESSCL) (Figure 2) has an established system of performance management that operates through a private contractor responsible for distributing funds to local bodies and for collecting performance data as agreed in the delivery plan for School Sport. For some other programmes and initiatives associated with child obesity, however, PCTs, sports organisations, schools and local authorities will have the discretion to spend grants to meet local needs. While this has the potential to better target local interventions, it may make it harder to assess cost-effectiveness at the national level.

13 In the case of school meals, for example, the DfES is investing £220 million (2005-08) in transitional grants to support schools and local authorities with the aim of improving the quality of school meals so that, as a minimum, they meet the nutritional standards that become mandatory from September 2006. Local authorities and schools have discretion within the context of an agreed strategy to spend the grants to meet local needs; for example on planning, training or ingredients. While DfES' transitional money can be spent on ingredients, the Department has attempted to steer local authorities and schools towards spending the money in areas that might yield longer term benefits, for example training. The Department has, however, indicated that standards are unlikely to be met unless expenditure on ingredients rises to 50p per meal in primary schools and 60p per meal in secondary schools.⁷ This extra funding, accompanied by new minimum standards announced by the Department, will have some effect on the overall nutritional quality of school meals.

14 At this stage, with the programme not yet rolled out, there are few data on how efficiently the extra money will be used by different local authorities and schools, including to what extent the money will be spent to buy produce and how efficiently a school runs its kitchen. There is also little evidence how the availability of school meals with better nutritional quality will influence the eating habits of children who are obese or at risk of obesity. Ofsted intends to address issues of food and health in three ways:

considering school food as part of its regular inspections; piloting, in collaboration with nutritionists, a thematic study with a sample of schools; and considering, as part of joint area reviews, what local authorities are doing to achieve the Every Child Matters outcomes of "be healthy" and "stay safe". In addition, the Departments intend to commission evaluation of the new School Meals standards and the Healthy Schools Programme to identify the health interventions that are most effective.

The Office for Standards in Education (Ofsted) is the inspectorate for children and learners in England. Its job is to contribute to the provision of better education and care through effective inspection and regulation. To achieve this, Ofsted undertakes a comprehensive system of inspection and regulation covering childcare, schools, colleges, children's services, teacher training and youth work.

Joint area review (JAR)

Over the three years from September 2005, all local authority services for children and young people, and the wide range of services from other agencies and organisations, will be subject to a joint area review. The review aims to provide a comprehensive report on the outcomes for children and young people in the local area. It will incorporate the inspection of youth services and replace the separate inspections of local education authorities, local authorities' social services, Connexions services, and the area-wide provision for students aged 14-19.

The three Departments are starting to coordinate their action at a national level, but levers to prevent and tackle childhood obesity are not yet sufficiently developed

15 With delivery planning underway, a cross-departmental Obesity PSA Programme Manager appointed and a Programme Board established, the Departments have begun to put in place key elements to direct or manage delivery of the PSA target. In addition, the draft delivery plan contains indicators by which the success of the programme will be measured. These include increasing by one per cent each year to 2010 the percentage of children meeting Chief Medical Officer recommendations on physical activity, which include children achieving a total of at least 60 minutes moderately intense physical activity a day.

⁷ Source: Department for Education and Skills.

2 Major initiatives for primary school years supported in the delivery chain, allocation of funding and responsibility for performance

Initiative	Funding £ million	Department(s)	Allocated	How performance is assessed
School Meals	£220m (2005-08) £15m (DfES) and potential Lottery Funding subject to bidding (Big Lottery Fund) (2005-08)	DfES Big Lottery Fund/DfES	Schools and local authorities School Food Trust to give independent advice to local authorities, schools and parents	Subject to legislation, schools and local authorities will, from September 2006, be required to meet a revised set of nutritional standards for food and drink provided in schools. Schools are expected to evaluate their performance as part of their self evaluation. Schools record the main outcomes of their self evaluation in a Self Evaluation Form, which is updated annually and submitted to Ofsted. When completing their self evaluation, schools are asked to reflect on how well their provision enables children to meet the Every Child Matters outcomes, including "being healthy". The Self Evaluation Form is used by inspectors when inspecting schools. Alongside routine inspections, Ofsted also carries out a rolling programme of surveys, covering a range of topics. In Autumn 2005, a pilot survey on school meals was carried out. On this survey, nutritionists accompanied inspectors. From 2006, support for healthy eating will be one aspect of children's services joint area reviews at area level.
School Sport Strategy	£459m (2003-06), [of which £200.85m in year 2005-06]; £519m (2006-08)	Funding shared between DCMS and DfES	Through a private contractor to schools	The majority of the funding monitored through the collection of performance data by a private contractor Momenta against targets in the PSA, for example hours of sport provided each week.
Children's Play	Big Lottery Fund (£155m) for play facilities in England	Big Lottery Fund	To local authorities in consultation with local stakeholders including play partnerships and the community and voluntary sector	Eighty per cent of the £155 million available under the Big Lottery Fund's Children's Play programme will be used to develop free, open-access play provision in all local authority areas. To draw down funding, each local authority is required to develop and agree a robust local strategy for children's play in consultation with local stakeholders including play partnerships and the community and voluntary sector. The Big Lottery Fund is determining how to monitor and evaluate the programme, to ensure that this lottery funding provides value for money.
Healthy Schools Programme	£5.7m annually (2002-05) £9.3m (2005-06)	DH and DfES	To local healthy schools partnerships (LEAs and PCTs)	Local Healthy Schools Programmes devise arrangements for assessing evidence of national criteria having been met. National team and Regional Coordinators provide guidance on assessment good practice.

Source: National Audit Office, Audit Commission, Healthcare Commission analysis

Children’s trusts

Underpinned by the Children Act 2004 “duty to cooperate”, children’s trusts bring together all services for children and young people in an area (including local authority services, a range of community and acute health services as well as Sure Start partnerships and others) to focus on improving outcomes. The five outcomes (be healthy, stay safe, enjoy and achieve, make a positive contribution, achieve economic well-being) are ambitions for every child and young person, whatever their background or circumstances.

16 The natural lead for this public health issue rests with the DH. Many of the programmes supporting the PSA target are led, however, by the DfES, the DCMS, local authorities, schools and sports bodies, over which the DH has no direct control. The Obesity Programme Board will therefore need to ensure the coordination of the delivery chain. Traditionally, coordination has been made more difficult because the various organisational tiers of health, education and sport have not been aligned. This has compounded the difficulty of coordinating activities and of assessing the performance of different bodies in tackling a range of issues, including childhood obesity. For example, PCTs are not always coterminous (sharing geographical boundaries) with local authorities. The education and sport sectors have no direct equivalent to the 28 SHAs that share responsibility for raising the profile of public health issues such as child obesity.

Without reliable baseline data, there is a risk that resources will be wasted in unproductive activity

17 The PSA defines childhood obesity using a version of the Body Mass Index (BMI) (calculated by dividing an individual’s weight in kilogrammes by the square of his or her height in metres) adjusted for children. The use of BMI is the best available measure for determining trends in whole populations, but is less useful for measuring individuals, particularly children. The reason for gathering BMI is to gain a population-wide view for better understanding of the issue, planning where to put resources and monitoring effectiveness of interventions, rather than to treat individuals.

18 At the time of our fieldwork, there was lack of clarity at the local level of the delivery chain about the purpose of measuring children. This has now been clarified at Departmental level, in that PCTs will be responsible for executing delivery of weighing and measuring of pupils, with the intention that the data collected can be mapped against schools as the basis for school-level data interventions and performance management.

19 The pressure to tackle child obesity presents a risk that organisations within the delivery chain will start to collect measurements based on their own judgement of what is required. Inevitably, this would produce inconsistency, resulting in potentially wasteful activity. DH and DfES are pursuing the optimum method of collecting data on the height and weight of each pupil in two school years (Reception and Year 6) for all maintained primary schools in England. At local level, the guidance issued in January 2006 to PCTs sets out to explain the purpose of this measurement, the methodology to be used, the involvement of schools, and the need to obtain parental consent. This provides the basis for a consistent approach; although ongoing PCT restructuring in 2006-07 could lead to a temporary delay in PCTs’ ability to respond.

Regional roles are not clear

20 Roles and responsibilities are particularly unclear at regional level, and performance management arrangements differ markedly between the three Departments. For every one regional Government Office, for example, there may be three SHAs, six to ten PCTs, four county councils, 25 district councils, and four County Sports Partnerships, all of which have different responsibilities, organisational arrangements and lines of accountability. Without clear leadership and sponsorship of the target by those representing the target-holding Departments (**Figure 3**) local delivery agents may fail to devote sufficient resources to deliver the target.

3 Regional responsibilities	
DH	Regional Directors of Public Health (championship and coordination role) based in each Government Office.
DfES	Directors of Children and Learners based in each Government Office.
DCMS	Regional Directors of Sport England (although not having a specific role in obesity, contribute to the targets through driving up participation in sport).
NHS	SHAs responsible for performance management of PCTs.

21 There is clear support in the field, in particular, for an enhanced role for Regional Directors of Public Health who sit within the Government Offices to increase coordination between regional and local tiers of government. This would involve linking with the new DfES appointed Directors of Children and Learners who will look across the full range of issues for children and young people. DH is considering the role of Government Offices and Regional Public Health Groups and relationships with SHAs, which performance manage PCTs, and how best they should be developed in the light of SHA/PCT restructuring and DH efforts, which are subject to consultation, to align boundaries between Government Offices and SHAs and between PCTs and local authorities.

Local structures and mechanisms exist to promote joint working, if used effectively

22 Tackling child obesity requires the cooperation at local level of the health and education sectors. As part of the Every Child Matters: Change for Children programme, supported by the Children Act 2004, children's trusts are currently being established with an important role in coordinating local programmes to tackle child obesity. They encompass the relevant local authority services, a range of health services, and others, and are charged with bringing together all services for children and young people in an area. As they become established, the Departments consider that children's trusts and their local public health and PCT partners will be well placed to develop local strategies to tackle childhood obesity. PCTs have local delivery plans against which they are performance assessed by SHAs. The plans for 2005-08 include agreement to measure the prevalence of childhood obesity from 2006-07.

Local Strategic Partnerships (LSPs) bring together representatives from health, local government, education, other public sector agencies, the private sector and the voluntary and community sector to agree local priorities and coordinate activities.

Local Area Agreements (LAAs), currently in the process of being rolled out, set out the priorities for a local area agreed between central government, represented by Government Offices for the Regions, and the local area, represented by the local authority and key local partners including children's trusts and the LSP. The aim is to enable local partners to provide a holistic and integrated approach to policy-making and delivery, reduce bureaucracy and set out how achievement in agreed areas will be rewarded.

23 Children's trust arrangements are being developed across the country. All local authorities in consultation with PCTs and other partners are required to have a statutory Children and Young People's Plan in place by April 2006 that identifies local priorities to support the five Every Child Matters outcomes through their individual constituents and as a collective partnership. Local Strategic Partnerships (LSPs) do not receive mainstream funding for childhood obesity, although they are well placed to coordinate funding of local programmes, avoiding duplication of effort. At present, for example, PCTs, schools and local authorities can all bid for funding through programmes and local authorities receive allocations to fund School Travel Advisers as part of the Travelling to School initiative to bring about a change to home to school travel patterns, allowing more pupils to take regular exercise. Local Area Agreements (LAAs) offer the potential to pool funding at local level for programmes that can best address local needs, including addressing health inequalities through specific interventions to meet the needs of communities most at risk. The Children's and Young People's Plan and outcomes framework will serve as the children's section of LAAs.

24 The importance of child obesity will vary between localities. Children's trusts and LSPs and their various constituents will decide its relative priority depending on local circumstances, thereby determining whether they agree with their regional Government Office to set a specific local target or another indicator, such as level of participation in the 5 A Day initiative. Much depends, therefore, on data being available locally to determine whether child obesity is a pressing public health issue, but as yet information is scarce. PCTs are required by their local delivery plan lines to collect data from 2006-07 on childhood obesity to fill this gap. PCTs, working through children's trust arrangements (where established) will have a role in collating needs assessment information from across all partners and using this to inform commissioning plans around local priorities. PCTs will have a central role in partnership activities to tackle obesity at a local level.

25 Where local leadership sits will depend on local structures and individual strengths, but clear identification of who is leading within local partnerships is critical. The Departments expect that in future the key leadership figures for child obesity issues will be the PCT Chief Executive, the Director of Children's Services, and the elected Lead Member for children and young people for the local authority.

Schools are a key setting for the delivery of effective coordinated interventions and have an important role to play but need support and clear guidance

26 The teachers we consulted during this study considered that, to do justice to their responsibilities as part of these programmes, they needed clearer guidance and support. This included better information and advice to help children who were obese or at risk of becoming obese and, crucially, guidance on the advice they should give to parents. However, it is important to note that although teachers viewed obesity as an important health and lifestyle issue, there was also concern about under-nourishment.

27 As part of their work to improve children's nutrition, DH and DfES have produced the Food in Schools Toolkit and in July 2005 published guidance for schools setting out clearer criteria for the Healthy Schools Standard (two of the four strands of which are nutrition and physical activity). The Departments accept that further advice and guidance specifically on obesity will be helpful to teachers and parents.

28 Many teachers we consulted cited the lack of a health professional in schools as a barrier to effective monitoring and early intervention in child health issues. Healthy Schools Coordinators, funded through the Healthy Schools Programme, were considered by teachers to play a valuable role in encouraging the development of health-related activities in schools. PCTs did not consider that they had sufficient staff with a health education remit, such as school nurses, dieticians or nutritionists, to provide obesity-specific advice comprehensively across their areas. For PCTs in Spearhead areas, health trainers (who provide advice to people on healthier lifestyles)⁸ were also seen as playing a potentially important role.

Care pathway

An approach to managing a specific disease or clinical condition that identifies at the outset what interventions are required and predicts the chronology of care, including treatment options, referral to appropriate services and follow-up. The approach is designed to provide comprehensive quality of care for patients and to give patients a clear view of their treatment and care plan.

29 To support health professionals, DH plans to provide an interim care pathway before the National Institute for Health and Clinical Excellence (NICE) guidance on child and adult obesity which will be put to consultation in March 2006 and published in 2007⁹ (see blue text below). The DH has consulted with NICE on its care pathway to ensure consistency and has supported the joint Faculty of Public Health and National Heart Forum Obesity Toolkit. Both the pathway and the toolkit will be published by March 2006. Once published, the NICE guidance should become the primary source of information and guidance on preventing and treating child obesity.

8 The Spearhead Group is made up of 70 local authorities and 88 Primary Care Trusts based on the local authority areas that are in the bottom fifth nationally for three or more key indicators of deprivation (such as male / female life expectancy at birth, cancer / cardiovascular disease mortality in under 75 year olds). These will be the first to get funding for health trainers, improved smoking cessation services and school nurses, from January 2005. Health trainers will be NHS accredited and will assist people to make healthy lifestyle choices.

9 Details of the NICE guidance can be viewed at: www.nice.org.uk/page.aspx?o=63364.

National Institute for Health and Clinical Excellence

The National Institute for Health and Clinical Excellence ('NICE') and the National Collaborating Centre for Primary Care are developing guidance on the prevention, identification, assessment, treatment and weight management for adults and children who are either overweight or obese.

The guidance is intended to provide recommendations on the clinical management of overweight and obesity in the NHS. It will also provide guidance on primary prevention approaches aimed at supporting adults and children to maintain a healthy weight. The latter will include advice as to what can be done in schools, in the workplace and in the wider community. This is the first time that NICE has aimed to develop guidance on both the prevention and management of a condition and the first time that existing NICE methodology has been applied to public health evidence.

The final Scope for the guideline (which sets out precisely what the guideline will and will not cover) has been published on the Institute's website, www.nice.org.uk.

30 Outside the delivery chain, wider initiatives to influence the behaviour of food manufacturers and retailers regarding food promotion to children were considered by the bodies in our fieldwork to be an important element of any overall strategy to address poor diet and the rise in obesity in children. DH, DCMS and the Food Standards Agency are taking action to restrict further the advertising and food promotion to children of foods high in fat, salt and sugar, working with the food and advertising industries, Ofcom and the Advertising Standards Authority.

There is potential to increase efficiency in the delivery chain associated with the child obesity target

31 Following publication of the Gershon Review in June 2004, all Government Departments have been assigned a target for annual efficiency gains. Given the high level of expenditure on programmes for children's nutrition, activity levels and related health issues associated with childhood obesity, relatively small savings could have high impact on efficiency. There are examples of schools and local education authorities, for example, achieving savings in school food provision by forming or participating in procurement consortia and improving nutritional quality and sustainability through increasing the proportion of food sourced from local producers.¹⁰

32 The complexity of child obesity and the programme of interventions needed to address it creates administration and coordination costs and care must be taken to avoid leakage of monies through unnecessarily complex tiers of administration or poor coordination of activities. Each additional organisation or tier of bureaucracy has the potential, if not controlled tightly, to consume resources without making a proportionate contribution to frontline services. Building on existing and developing mechanisms, such as LSPs and children's trust arrangements, rather than establishing new arrangements to deliver the target will help reduce administrative costs. LAAs will enable organisations and services to link up and work strategically to coordinate and pool funding streams.

33 In **Figure 4 overleaf**, we set out five key areas where there is potential to realise efficiencies in the delivery chain associated with the child obesity target.

¹⁰ National Audit Office report *Food Procurement*, (in preparation).

4 Potential efficiencies in the delivery chain

Key areas for efficiency

Potential sources of efficiency

1 Better designed funding arrangements

- Pooling of funding at local level through new initiatives such as Local Area Agreements offers the potential to target resources at programmes that can best address local needs, including health inequalities, through specific interventions for communities most at risk.
- Local Strategic Partnerships and children's trust arrangements, have the potential to bring together bids for funding and to pool budgets, reducing the risk that frontline and local delivery agencies each have to work with multiple funding streams, particularly when the amounts involved are small.

2 Controlling administration costs

- To help control administration costs, it is important to ensure that new local initiatives make best use of existing resources and consolidate existing administrative arrangements as much as possible, particularly those of Local Strategic Partnerships and children's trusts arrangements.
- Better long-term planning and capacity building through the development of the Children and Young People's Plan¹ and the joint commissioning cycle for services can help to secure greater efficiency.
- Within each of the three Departments' delivery chains, there may be scope for the joining up of administrative activities such as human resources, finance or procurement. Recent research by A.T. Kearney² indicates that savings of 14 per cent are achievable where support services are successfully shared³. Current DH proposals to restructure PCTs offer the potential to reduce back office costs.

3 Effective collaborative working

- Government Offices could play a key role in bringing together the various elements of the delivery chain at a regional level, but at present their role – and that of Regional Directors of Public Health, based in the Government Office – is unclear, particularly in respect of their relationship with Strategic Health Authorities.
- Improved means of sharing good practice, such as that arising from the target to reduce teenage pregnancy, would also help to spread more efficient and effective ways of working.

4 Clear measures of progress

- Developing measures to assess the cost-effectiveness for achieving obesity outcomes of target-related nutrition and activity programmes will be important for improving the efficiency of the delivery chain.
- Guidance to PCTs on measuring children was published on 11 January 2006 including, amongst other things, that arrangements for collecting data on child obesity can fit local circumstances, provided core data are collected as stipulated. This means that PCTs can make use of existing health data collection methods and staffing to avoid the risk of setting up new and expensive stand-alone systems. Clear guidelines and standardised arrangements for measuring child obesity are necessary to help ensure nationwide consistency. Before January 2006 in the absence of such direction there have been instances where local delivery bodies have devised or continued collecting their own sets of potentially incompatible measures.
- Beyond measurement itself, arrangements for the national collation of local data and for giving feedback to PCTs on those data need to be implemented quickly to enable better informed local planning, to target local resources and interventions where need is most apparent, and to provide a base line against which to performance manage PCTs' contribution to the target.

5 Making better use of assets

- Where services are well designed around the needs and lifestyles of children, better use will be made of them. For example, Extended Schools in themselves create increased use of public assets and in addition can allow swimming pools and sporting facilities to be used by children in their leisure hours to encourage greater use.

NOTES

1 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 will produce 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.

2 A.T. Kearney (2005) *Success Through Shared Services: From Back-Office Functions to Strategic Drivers*. A.T. Kearney Marketing and Communications, Inc., Chicago, Ill.

3 Examples of such efficiency savings include the United States Postal Services' saving of US\$71.4 million (16-18 per cent of costs) through sharing services in its finance function; and in Ireland, the Eastern Health Shared Services' savings of 15 per cent of operating costs between 2002 and 2004. [Accenture (2005) *Driving High Performance in Government: Maximizing the value of public-sector shared services.*]





RECOMMENDATIONS

34 Following the establishment of the PSA target in July 2004, a number of important initial steps have been taken to tackle the issue of child obesity, including the development of a draft delivery plan and the establishment of the joint Programme Board. Addressing this important public health issue is, however, very complex.

35 Our fieldwork indicates that there are five key ways in which the delivery chain needs to be strengthened.

- a** **Greater clarity and direction from target-holding Departments.** Evidence about the particular programmes and initiatives that have most impact upon child obesity is needed to allow Departments to issue guidance and assess the cost-effectiveness of activities, but there is currently limited evidence about what works. This will be addressed progressively over time; by Departments testing and evaluating new procedures, together with other measures being tried locally, international evidence and academic research. Of particular importance, NICE is due to issue guidance, based on all the available evidence of the effectiveness of different interventions on the prevention and management of child and adult obesity (to be put to consultation in March 2006 and published in 2007).

With so many organisations delivering such a wide variety of programmes bearing on child obesity, the three Departments need to work closely together to provide joint leadership to others in the delivery chain. The target has been in existence since July 2004 and at the time of our fieldwork, in the summer of 2005, organisations were still seeking guidance about their roles.

The Departments acknowledge the need to publish such guidance, including the key contents of their delivery plan (planned for May 2006). This will build upon the proposals set out in the *Choosing Health* delivery plan (2005) to inform all those in the delivery chain about what is being done nationally, what toolkits will be provided in support of local efforts and how respective roles and responsibilities fit together.

The activities of local partners will be a critical element for successful delivery of the PSA target. If they are to plan resources effectively and for there to be effective performance management throughout the delivery chain, then good local data is required. Similarly, local partners need clear advice and guidance on which local interventions are most effective.

Local data on child obesity prevalence will not become available until 2006 and NICE's guidance on which interventions are proving most effective is not due out until early 2007. These will be key ingredients for effective local plans. The fact that they will not be available until relatively late in the PSA period, means that the last three years of the PSA period will be particularly critical for the target holding departments.



- b Regional roles and responsibilities should be better defined.** Government Offices could play a greater role in delivering the target, acting as a point of coordination for the various administrative and delivery partners within a region, and bringing clarity to relationships between SHAs, Regional Directors of Public Health, the new DfES appointed Directors of Children and Learning and representatives of sport, as well as Public Health Observatories, which have a significant role to play in collating measurement of obesity across local areas and modelling of obesity trends. In the meantime, Government Offices, SHAs and others must work more effectively together to provide leadership to local partnerships.
- c Local partnerships need to be strengthened.** Guidance on the strategic, overarching Children and Young People's Plan for all services for children and young people, and on the duty to cooperate under the Children Act 2004, envisages the local authority, PCT and partners working through the children's trust mechanisms to develop the Children and Young People's Plan and to commission services for children and young people. To avoid the risk of duplication of activities or wasteful and unnecessary interventions, local partners need to:
- Determine the priority that should be attached to child obesity in their area and decide on the best means to bring together the relevant agencies and a process for establishing a lead;
 - Ensure data are available at local level to support appropriate targeting of resources;
 - Ensure appropriate linkages and communication between children's trusts and LSPs and their constituent members, using Local Area Agreements as appropriate;
 - Identify available resources and mechanisms (such as Local Area Agreements) to bring together funding so that resources can be more sharply focused around agreed priorities; and,
 - Establish local indicators to measure progress against priorities.
- Inspection and assessment bodies – such as the Healthcare Commission – should ensure that their systems include an assessment of the effectiveness of partnership working at regional and local level for the achievement of the obesity target.



RECOMMENDATIONS CONTINUED

- d Frontline staff require more support.** Frontline staff in a range of settings need to be given training and information based on local need to raise awareness of what they can do to support the obesity target, to enable them to deliver clear and consistent messages to parents and children and to identify and offer appropriate interventions or referrals for those most at risk. Schools, in particular, where staff have many competing demands upon their time, have a key role to play, and need clear guidance and support from the three Departments on what to do to support children who are overweight and at risk of being overweight and their parents. For school staff, this can build on support, advice and information provided by DfES jointly with DH on how to support children to exercise and eat healthily through the Healthy Schools Programme. Similarly, other professionals, such as school nurses, will need guidance on what they can do to support interventions in individual cases. As part of *Choosing Health Commitments*, DH completed, in January 2006, consultation on the obesity care pathway and weight loss guide which it aims to disseminate as a package to PCTs in March 2006.
- e Involving and influencing parents and children.** The impact of any programmes and initiatives will be limited if children and their families are not engaged and the wider realms of advertising, health education and social issues, such as increased opportunities for active travel and the opportunities parents have to buy affordable healthy foods, are not addressed. *Choosing Health* recommendations include proposals to address a number of these wider issues, including work on food promotion to children (being undertaken by Ofcom on the broadcasting side) and industry (such as the Advertising Standards Agency [ASA] – through the new food and drink promotion forum on the non broadcast side). The three Departments will need to build on engagement with other organisations, such as the Food Standards Agency, which in recent years has commissioned research on how advertising influences children's eating preferences and patterns, to establish the most effective means to engage children and families and to determine how best to tailor programmes, advice and support.