Tackling Obesity in Children and Young People in County Durham and Darlington: A Strategy for Prevention and Treatment 2004

A Consultation Document for Local Strategic Partnerships

Purpose of this document

Obesity is frequently described as a global epidemic. This strategy highlights the problem of obesity in children and young people and what needs to be done locally to prevent obesity and to develop services to treat obesity. It has been produced by a small multiagency task group (page 4) and is based on the best available current evidence.

Obesity in children depends on the interaction of many factors including parental behaviour; access to healthy food and opportunities to be physically active. In older children and young people additional external factors become increasingly important such as peer pressure and the media. Tackling obesity in children and young people therefore requires action both at government level and across agencies locally.

Local Strategic Partnerships (LSPs) are asked to:

- Endorse this strategy.
- Identify a named group and individual lead to take the strategy forward.
- Develop and agree detailed local action plans for implementation in 2005/06 onwards.

In addition LSPs may wish to advocate for national legislation such as the restriction of television food advertising directed at children and the reduction of fat and sugar content in processed foods.

Members of the task group

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1. Why tackling obesity in children and young people is a priority

- **Over half the UK population is overweight or obese.**
- **The proportion of overweight pre school children rose from 14.7% to 23.6% between 1989 and 1998**
- **Obesity in pre school children almost doubled (from 5.4% to 9.2%) between 1989 and 1998.**
- **Obesity in six to 15 year olds tripled (5% to 16%) between 1990 and 2001.**

Obesity has been highlighted as a major national problem in a series of recent reports:

- The *Report on Obesity* from the House of Commons Health Committee in May 2004 highlighted the need for joined up solutions requiring cultural and societal changes.[1]
- In *Storing up problems; the medical case for a slimmer nation*, the medical Royal Colleges summarised the extent of the problem and the evidence for prevention.[2]
- In his 2002 report, the Chief Medical Officer described obesity as "the health time bomb".[3]
- In 2001 the National Audit Office in *Tackling Obesity in England*, highlighted the cost to individuals, the economy and the NHS of the rapid increase in levels of obesity and its complications.[4]
- Evidence for prevention and treatment has been summarised by the NHS Centre for Reviews and Dissemination,[5] the Health Development Agency[6] and the Scottish Intercollegiate Guidelines Network.[7]

A joint review undertaken by the County Durham and Tees Valley Public Health Network and the Health Development Agency (HDA) in 2004, *Preventing, Identifying and Managing Childhood Obesity in County Durham and the Tees Valley: Examining the Gap Between the Evidence Base and Current Practice,* highlighted a number of gaps in practice.[8] This strategy builds on the review.

Obesity in children and young people impacts on their current health and on their future health as adults. Obesity also causes emotional distress and is linked with low self esteem and being bullied.

Tackling obesity in children is now a Public Service Agreement (PSA) target incorporated in the *National Standards, Local Action: Health and Social Care Standards 2005/06 – 2007/08* as one of the targets to tackle the underlying determinants of ill health and health inequalities by:
Halting the year on year rise in obesity among children under 11 by 2010 (from the 2002-04 baseline) in the context of a broader strategy to tackle obesity in the population as a whole.

This target is a joint PSA target with the Department for Education and Skills and the Department of Culture, Media and Sport.

1.1 Measuring obesity

The simple Body Mass Index (BMI) classification is used for obesity in adults; BMI>25 is overweight; BMI>30 is obese. This classification is not applicable to children, since the ratio of weight gain to height gain changes during normal growth, especially around puberty. Many different methods are currently in use to estimate body fatness or relative weight, and for each method, various cut-off levels are used to describe overweight or obesity.

The method recommended is to plot BMI on agreed age and sex reference charts. Those currently in use are the UK 1990 reference charts for BMI centiles for children. For epidemiological and international comparison purposes the following definitions are used:

- Obesity is defined as BMI greater than or equal to 95th centile of the 1990 reference chart;
- Overweight is defined as BMI greater than or equal to 85th centile of the 1990 reference chart.

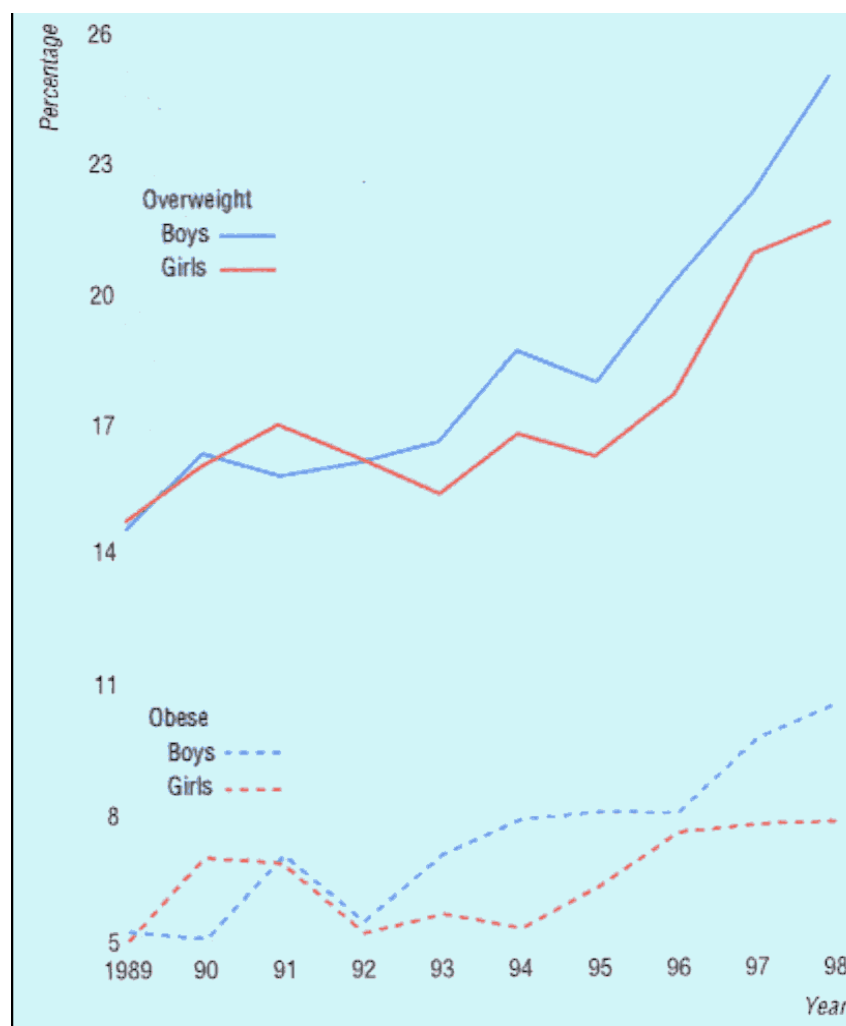
For routine clinical use (for intervention or referral for treatment) however, the following definitions are currently used in the UK:

- Obesity is defined as BMI greater than or equal to 98th centile of the 1990 reference chart;
- Overweight is defined as BMI greater than or equal to 91st centile of the 1990 reference chart.

This latter clinical definition will be used in this strategy as defining thresholds for intervention. The National Institute for Clinical Excellence (NICE) is currently developing obesity guidelines and this may result in a change in these definitions.

1.2 Prevalence of Obesity

Figure 1: Annual increase in proportion of overweight and obese three to four year old children (n=28,786) in UK.



Source: Bundred et al *BMJ* 2001; 322: 1-3 with permission of Prof Summerbell

Regardless of the method of assessment used, prevalence of overweight and obesity is rising (see figure 1):

- The Health Survey for England reported that in 2001 8.5% of 6 year olds and 15% of 15 year olds were obese and the Health Survey for England 2002 reported that 16% (one sixth) of all children aged 2-15years were obese.
- The proportion of overweight pre school children rose from 14.7% to 23.6% between 1989 and 1998.
- Obesity in pre school children almost doubled (from 5.4% to 9.2%) between 1989 and 1998.
- Obesity in 6 to 15 year olds tripled (5% to 16%) between 1990 and 2001.
- Inequalities in the prevalence of overweight and obesity exist in children, with higher rates in lower social classes and Asian groups.

1.2 Impact of obesity

In childhood, excess weight can directly cause mobility problems, hypertension and abnormalities in glucose metabolism. Obesity-related cases of type 2 diabetes in white adolescents are now being reported in the UK. In addition there may be emotional issues related to low self-esteem and the stigmatisation of obesity that is heightened in adolescence and may lead to bullying or exclusion from the peer group. Obesity in adolescence is linked to poor social relations and educational disadvantage.

In the long term the most significant consequences are the persistence into adulthood. Overweight young people have a 50% chance of becoming overweight adults. Obesity in adults is a serious health problem, increasing the risk of hypertension, heart disease, osteoarthritis, gout, reproductive problems, lower back pain and linked to certain cancers. The most important direct causal link is with type 2 diabetes.

1.3 Cause of obesity

The cause of childhood obesity (as with adults) is multi-factorial having behavioural, genetic and environmental components. Specific to children are complex family behavioural factors that include early overfeeding, poor dietary habits developing early in childhood and food being used as an emotional tool. However, reduced physical activity rather than an increase in energy intake may be key to the increasing trend in childhood obesity. In particular this inactivity may be related to changes in lifestyle, such as the increased use of the car, television and computer. Children are now sedentary rather than active.

Poverty is the key determinant of what families eat. Lower income families spend a much higher proportion of income on food than higher income families. In addition, fresh food is increasingly only available in supermarkets with local “corner shops” stocking long shelf life, processed foods with high fat, sugar and salt content. Price is the most important factor leading to purchase of cheaper calorie dense foods. Families are often aware of what the “healthy choice” would be but cannot afford it and may have difficulties with access to it. Initiatives to reduce child poverty are therefore essential in preventing obesity.

The National Diet and Nutrition Survey reported in 2000 that 40% of boys and 60% of girls were not participating in physical activity of moderate intensity for at least one hour per day. The same survey reported that half of those surveyed had eaten **no** fruit or vegetables in a given week. There is a decline in physical activity in children as they get older which is much more marked in girls than boys; by age 15 only 36% of girls undertake 30 minutes of physical activity on most days compared with 71% of boys.

The term "obesogenic" has been used to describe modern environments which encourage and promote high energy (food) intake and inactivity. The WHO recently reported that the obesogenic market appears to be directed at adolescents, making healthy choices more difficult.
There is a socio economic gradient in eating habits of children up to age 15 but not in young adults. There is a decrease in fruit and vegetable consumption and an increase in consumption of sweet foods and crisps from affluent to poorer households. Participation in sport is greater in children from more affluent households, the difference being most marked in girls.

There is important emerging evidence that low birth weight followed by excess weight gain linked to overfeeding in early childhood is strongly associated with childhood and adult obesity. Very rapid weight gain in early childhood is also associated with later obesity independent of birth weight.

2. Prevention

- **Prevention of obesity in children requires both promotion of healthy food and promotion of increased physical activity.**
- **Tackling the obesogenic environment requires action at government and agency level.**
- **Promotion of good nutrition and not smoking during pregnancy must be part of the prevention strategy.**

Prevention of obesity needs to target children from a young age (and their families) to promote healthy foods and lifestyle. In particular, there needs to be a real emphasis on increasing physical activity levels in children.

The evidence on effective prevention programmes is still emerging:
- School based multi faceted programmes appear most effective, particularly for girls.
- There is limited evidence of effectiveness for school programmes focussed on specifics such as reduction in TV watching or computer games.
- There have been no evaluations (or evaluations have shown little effect) for school based physical activity programmes and family based health promotion.

Increasingly, evidence suggests that interventions to prevent low birth weight (tackling smoking in pregnancy, promoting good nutrition) and interventions to promote breastfeeding should reduce later obesity.

3. Treatment

Treatment should only be considered where:
- **A child is obese (BMI at 98th centile or greater)**
- **The child and family are ready to change behaviours**

Overweight children and young people (BMI at 91st centile or greater) may need annual (or more frequent) monitoring to reinforce weight maintenance (and resulting reduction in BMI).

The aim of treatment in children and young people who are actively growing is usually weight maintenance while growth in height continues. Only in severely obese children or

those with medical complications or underlying conditions should weight loss be the goal. This requires supervision by a specialist unit/team.

Emphasis on management should be on changing behaviour patterns and not just looking at weight. There is short term benefit to children returning to normal weight for their height in terms of health, but strategies need to ensure weight is controlled into adulthood to improve adult health.

There needs to be great sensitivity in dealing with children and young people. An obese child may have issues regarding low self-esteem and stigmatism. The structure and set up in an out patient clinic is far removed from surroundings to which children can relate. This may exacerbate the issues rather than help the child manage his/her weight more appropriately. These issues become increasingly important in adolescence.

Most research comes from the United States of America and Canada. There is evidence for the effectiveness of:

- Multi-faceted family based behaviour modification programmes covering diet, exercise and lifestyle change.;
- Slightly less intensive family based interventions around physical activity and health promotion;
- “Laboratory” based exercise programmes.

Lifestyle and behaviour modification programmes with no parental involvement are less effective.

4. What does this mean for County Durham and Darlington

A crude estimate of need based on national prevalence figures applied to our population suggests that in County Durham and Darlington there are around:

- **3100 obese children aged 0-4 years**
- **12 300 obese children and young people aged 5-14**

In addition there are around 5000 children aged 0-4 who are overweight but not obese.

5. What is already being done in County Durham and Darlington: prevention

5.1 Tackling smoking in pregnancy

Great steps have been taken to tackle smoking in pregnancy during the last year. There have been dedicated staff appointed to help mothers, their partners and families who want support in stopping. There has been training of Obstetricians, Midwifery staff, Sure Start staff and Health Visitors in smoking cessation and tobacco control issues, and emphasis has been placed on increasing the level of appropriate brief interventions to raise awareness of the services for pregnant women in County Durham and Darlington.

There is now a fully endorsed policy for the prescribing of Nicotine Replacement Therapy (NRT) for pregnant women who attend the hospitals and GP Practices in County Durham and Darlington and surrounding areas such as Sunderland.

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5.2 Breastfeeding promotion and support

Breast feeding is supported across the PCTs by midwives and health visitors.

The SureStart programmes within County Durham and Darlington are all actively promoting and supporting breastfeeding. Sure Start Peterlee is the first Sure Start Programme nationally to receive the UNICEF Baby Friendly Award.

In Darlington the Health and Social Care Overview and Scrutiny Group has been awarded funding to review the barriers to breastfeeding across public and private sector organisations.

5.3 North Durham Healthy Eating Policy 0-5 years

Derwentside and Durham and Chester-le-Street PCTs have a *Healthy Eating Policy 0-5 years* which provides consistent advice for all professionals on:

- Breast feeding
- Bottlefeeding where this is indicated
- Weaning and infant feeding to 12 months
- Healthy eating for 1 to 5 year olds.

5.4 The Healthy School Standard

County Durham & Darlington Healthy School Standard (CDDHSS) seeks to help the whole school community create a productive learning environment where staff and pupils are healthy, happy and knowledgeable about health. The local programme is inclusive and encourages all schools to meet minimum criteria in a number of themes, including diet and health, physical activity, and emotional health and wellbeing. By March 2004, 117 schools across County Durham and Darlington had achieved the Standard. The national target is that all schools with 20% or more free school meal eligibility (FSME) will be action planning and target setting to meet the Level 3 criteria of the National Healthy School Standard by March 2006.

The CDDHSS requires a whole school approach ensuring that practice matches what is taught in the curriculum and reflects school policy. The standard supports a culture of nutrition and health by:

- Helping schools audit their practice re provision and curriculum
- Supporting schools in the development and adoption of a School Food Policy
- Fostering partnership working (including school meal providers and young people)
- Increasing awareness of the issue of free school meal uptake
- Developing Breakfast clubs, fruit bars and School Nutrition Action Groups "SNAGS"
- Improving access to drinking water
- Encouraging schools to offer adequate opportunities for physical activity
- Encouraging schools to consider the role of emotional health in tackling issues impacting on levels of obesity
- Promoting the use of the resource pack 'Food for Thought'.

5.5 National School Fruit Scheme

The Government campaign to improve the diet of children has resulted in the roll out in March 2004 of the National School Fruit Scheme. Under this scheme every child aged 4 to 6 years in a maintained primary school is entitled to a free piece of fruit each school day.

This initiative has been given high importance across County Durham and Darlington as it is regarded as being an effective intervention in educating for healthier choices in children. To

date 249 schools out of eligible 254 (98%) have signed up across County Durham and Darlington. Is hoped that the remaining five schools may engage later in the year or in 2005.

5.6 “5 A DAY”

5 A DAY Local Community Projects aim to increase public awareness of the health benefits of eating more fruit and vegetables within their target populations. There are two New Opportunities Fund initiatives in the County, one covering Derwentside and Durham and Chester-le-Street PCTs and the other covering Easington PCT and both include projects directed at young people. These projects are funded until 2005

Why 5? – Derwentside and Durham and Chester-le-Street – work with children includes pump prime funding for setting up breakfast clubs and fruit tuck shops; input into various areas of the school curriculum eg. Food Technology, PHSCE; joint working with leisure services on out-of-school holiday club activities; training for professionals.

Strive for 5 – Easington – works primarily with children 0 – 11yrs through a variety of activities which include training for professionals; setting up breakfast clubs and healthy tuck shops; improving school lunches; and producing promotional literature and recipe cards.

Durham Dales are working with schools to set up a Drop-In Breakfast Club Scheme. It aims to improve morning eating habits by providing a basic healthy breakfast at an affordable cost in a safe, welcoming and inclusive environment. The scheme will see clubs opening from Sept 2004.

In Sedgefield Borough in 2003, 17 community food, or 5 A DAY, projects were supported including school breakfast clubs and community cafes, involving a range of education and health practitioners. Some projects were more successful than others with regards levels of participation, mainstreaming and longevity. An evaluation report of the above projects has been produced with recommendations on developing more sustainable healthy eating practices in the Borough.

Darlington Borough was one of the original pilot areas for 5 A DAY and is currently working towards mainstreaming the initiative across the Borough. The Sure Start Local Partnerships promote 5 A DAY and offer only water, milk and fruit at all activities. Darlington PCT has delivered the “Hands on Health” initiative to nine of the eleven community partnership areas.

5.7 Physical Activity

It is recommended that growing children and young people should have at least one hour of physical activity every day. A County Durham physical activity strategy has just been finalised. This includes actions which relate to children and young people, particularly:

- Increasing the use of abandoned or low grade green spaces;
- Promoting use of school based facilities by communities;
- Improving access to leisure services for families by pricing policies and support to families on low incomes;
- Promoting cycling and walking.

Each district is developing a local physical activity plan based on the strategy.

A Tees Valley physical activity strategy is also being developed.

There are a number of physical activity projects across County Durham and Darlington including:

- LEAP (local exercise and activity pilot) project, Durham Dales;

- TOPS sport award, Durham Dales;
- Active Mark Scheme, Durham and Chester-le-Street.
- Free swimming, Sedgefield;
- Health for All Get Active Programme, Easington;
- Sports Coordinator programmes, Sedgefield, Easington;
- Sports Equipment Loan Scheme Easington;
- Cycle Hire Scheme, Easington;
- SHOKK Fitness Suite, Derwentside;
- Chopwell Woods Health project, Derwentside;
- Doorstep Walks, Darlington;
- Developing sustainability of Walking to School Week, Darlington;
- Zone Active Sport England Bid, Darlington.

Physical education

Physical education is provided in schools for children aged 5-16 years. All children should receive at least two hours of PE and sport a week but many schools fall short of this standard. The national target is to increase the number of pupils accessing two hours PE and sport within and beyond the curriculum to 75% by 2006.

In County Durham there are three sports colleges and five school sport coordinator programmes. These structures encourage physical activity through curriculum development activities, after school sport and leadership opportunities for young people.

In Darlington, Leisure Services and the PCT have been working on local initiatives to deliver three hours of physical activity a week within schools (within and beyond the curriculum).

6. What is already being done in County Durham and Darlington: treatment

The results of a six-month project funded by the HDA and conducted by the County Durham and Tees Valley Public Health Network showed that referral pathways for obese children are very unclear.[8] Each PCT area appears to approach the management of obese children differently. There is currently an ad hoc system of referral which lacks consistency, with most obese children being managed in the first instance by referral to hospital dietetic services. This might not always be the most appropriate method of referral.

7. What needs to be done: prevention, a lifecourse approach

7.1 Antenatal

- Smoking cessation – continue to develop services; establish challenging targets for quit rates.
- Breast feeding promotion – provide information on prevention of childhood obesity in addition to current advice.
- Healthy eating advice for pregnancy – in particular targeted advice for overweight parents and other vulnerable groups.
- Ensure midwives, health visitors and SureStart staff have UNICEF training or equivalent.

7.2 Postnatal

- Health visitors and midwives to continue active breastfeeding support and deferred weaning

- Update *North Durham Healthy Eating Policy 0-5 Years* and ensure equivalent developed for all of County Durham and Darlington.
- Target advice and support through SureStart Children's Centres in 20% most deprived wards.
- Collect accurate data on breast feeding initiation and at six weeks.
- Collect accurate data on weight and BMI in early years.

7.3 Pre school

- Improve access to and quality of outdoor play spaces, including both formal play areas and informal green spaces.
- Consider pedestrianisation, play streets and "Home Zones"
- Continue advice on healthy eating (including restriction of sweetened drinks) through SureStart Children's Centres and routine health visitor contact.
- Add more advice on active play and limiting sedentary play (in particular TV) to routine health visitor contacts and within SureStart. Emphasise value of outdoor play.
- Ensure system in place for monitoring BMI at school entry.

7.4 Further development of the Healthy School Standard approach

Evidence supports multifaceted school based interventions which include:

- Nutrition information
- Physical activity promotion
- Reduction in sedentary behaviour
- Teacher training
- Curricular material
- Modification of school meals and tuck shops etc
- Consideration of the impact of emotional health and wellbeing

All of these areas are considered through the auditing process of the CDDHSS and support is given through action planning and targeting. However, the levels of support may not be equitable across County Durham and Darlington and this needs to be addressed.

7.5 School Food Policy

It is important that schools develop a policy about how the principles of a balanced and varied diet are supported in the school and underpin the development of a consistent approach to food and nutrition.

A Sample School Food Policy is attached to this strategy for schools to own and implement by a whole school approach.

7.6 Promoting physical activity in older children and young people

- Encourage one hour of physical activity every day for growing children.
- Develop curricular activity in relation to physical activity and develop lunch time and after school activities (linked into a multifaceted approach through Healthy School Standard).
- Promote safe walking to school.
- Promote walking and cycling.
- Build on lessons from pilots such as LEAP

7.7 National action

Preventing obesity requires commitment across disciplines and agencies. Much can be achieved by engaging Local Strategic Partnerships at district and county level in the actions above. However, tackling the obesogenic environment will also require national political action. The targeted marketing of calorie dense, nutrition poor foods and drinks at children can only be prevented by national action to restrict advertising. Tackling the insidious promotion of sedentary activity (television and computer games) is even more problematic.

8. What needs to be done: treatment

There is already work across County Durham and Darlington in relation to promotion of healthy eating and physical activity on which to build the prevention component of the this strategy. However, there is currently no community based or specialist obesity treatment service for children and young people. This is a similar situation to that across most of England and reflects the fact that obesity, as a common condition in this age group, is an emerging problem.

There are three key actions which need to be addressed:

- Identification;
- Development of criteria for referral;
- Development of appropriate pathways of care with community based services supported by a specialist service.

8.1 Identification

BMI (on centile charts) should be used to identify childhood obesity for intervention purposes:

- **Obese children have a BMI at 98th centile or greater on the UK 1990 reference charts for age and sex;**
- **Overweight children have BMI at 91st centile or greater but less than 98th centile.**

Active monitoring should be in place at (as a minimum):

- 8 months (weight), 12 months (weight)
- primary school entry (BMI)
- secondary school entry (BMI)

Additionally there is evidence for monitoring BMI at 3.5 years and BMI at school leaving.

Opportunistic identification requires height and weight checks and plotting on BMI centile charts when children and young people who appear obese come into contact with health care services.

Parents may be very sensitive to the suggestion that their child is overweight or obese. This creates particular problems for school nurses who see the child without a parent present.

8.2 Criteria for treatment or referral

Specialist service

The following should be referred to a specialist child and young person obesity service:

- children with **severe** obesity (BMI at or above 99.6th centile);
- children **under two years of age** who are obese (BMI at or greater than 98th centile)

- children who may have serious obesity-related morbidity eg sleep apnoea, orthopaedic problems, psychological distress;
- children with a suspected underlying endocrine problem, often presenting as obesity plus short stature;
- children predisposed to weight gain due to medication such as steroids.

Obese (BMI at 98th centile or greater)
Obese children and young people should be offered community based assessment. Treatment should only be offered if the child and family are prepared to change.

Overweight (91st centile or greater but less than 98th centile)
- Treatment services will not have capacity to accept referrals of overweight children.
- For children in school, effective school based programmes to prevent obesity must engage this group.
- Appropriate information materials for parents and young people are required.
- Overweight children and young people (BMI at 91st centile or greater but less than 98th centile) may need annual monitoring to reinforce weight maintenance (and therefore reduction in BMI). For pre school children monitoring should be every six months.

8.3 Development of appropriate interventions and pathways of care

There is currently no community based or specialist obesity treatment service for children and young people in the area. The following sections outline the necessary components of such a service based on current best evidence.

Specialist Service
The service will only accept children and young people meeting the referral criteria. It will deliver the following:
- Training and support to the network of practitioners delivering the community based service, including development of information materials.
- Investigation/treatment/further referral of those children and young people with severe obesity or co morbidities.
- For those with "uncomplicated" severe obesity, provision of intensive family behaviour modification incorporating physical activity, diet and lifestyle change, appropriate to the age of the child/young person.
- Assessment and referral to alternative treatment programmes in individual extreme cases such as Weight Loss Camps, drug treatment and possibly surgery.

Staffing will include sessional input from a paediatrician, a clinical psychologist and a specialist dietician. There will need to be close working links with community based services in particular physical activity coordination.

Community Service
The community based service will need to be developed in each LSP/PCT area. The evidence is strongest for family based interventions. Essential components are:
- Trained staff to undertake home visits to assess readiness for change and then engage the family in an intervention programme which includes healthy eating, increased physical activity and overall lifestyle modification.
- Availability of appropriate information materials on nutrition and activity.
- Age appropriate physical activity classes/groups/programmes for families and children together and for groups of children and young people.
- Sensitively offered school based (or out of school) programmes for obese young people as an alternative to participating in usual curricular physical education classes.
- Appropriate follow up arrangements.
- Advice and support from the specialist service.
- Referral to the specialist team following the agreed criteria.

- Engagement of children, young people and families in developing and evaluating the service.

Staffing will include:

- Dedicated physical activity coordinator time for treatment programmes and individual assessment and advice for children and young people;
- Dedicated health practitioner time to undertake assessment and initiate intervention. Joint assessment with the physical activity coordinator may be necessary.
- For pre school children the health practitioner role would be most likely to be filled by a health visitor and for older children a school nurse or health promotion specialist.

The number of staff required in any area will need to be determined. Within Sure Start/Children's Centre areas the community service for pre school children may be delivered through those programmes. For older children and young people the service could be linked to an extended school programme or young people's service. Specific physical activity coordinator time is required.

Although advice on prevention of obesity and general advice when children are overweight should be part of the generic Health Visitor and School Nurse role, practitioners delivering the community service to obese children and families require both additional training and dedicated time. Engagement of the family is essential.

Referral pathways
Children and young people and their families will be sensitive about being labelled "obese". There will be particular difficulties in weighing and measuring older children and young people, in communicating the information and in arranging initial home visits. Appropriate protocols need to be developed in relation to school based surveillance.

Referral mechanisms from General Practice to the community service will also need to be developed, including the use of BMI centile charts in by General Practitioners and Practice Nurses.

9. What needs to be done: surveillance and monitoring

Although weight is recorded for babies at a number of the routine child health surveillance checks, identification of overweight/obesity may not trigger specific action. BMI surveillance is not currently in place at initial or secondary school entry.

Height and weight is measured at initial school entry and forwarded to Child Health Information Systems but only part of County Durham and Darlington is covered by electronic Child Health Information Systems from which this data can be retrieved.

Population surveillance needs to be developed for County Durham and Darlington to enable monitoring of the national target of:
Halting the year on year rise in obesity among children under 11 by 2010 (from the 2002-04 baseline) in the context of a broader strategy to tackle obesity in the population as a whole.

More importantly, active surveillance at initial and secondary school entry will enable referral to the community service of those children and young people who are obese.

Work is being taken forward by the Public Health Network to develop surveillance through health visiting and school nursing services.

10. Action planning

The attached plan outlines the headline actions arising from this strategy.

Each LSP will need to develop more detailed action plans. Where further across organisation planning is required (for example to develop the business case for the specialist treatment service), a lead is proposed. Likewise in County Durham some actions will need to be across LSPs to match County level structures in particular the LEA.

There are cost implications for a number of agencies in developing prevention and treatment services. These costs will need to be identified to funding agencies by January 2005 to allow consideration for funding in 2005/06.

11. Key documents

1. House of Commons Health Committee. *Obesity.* Third Report of Session 2003-04. May 2004

2. Royal College of Physicians. *Storing up problems: The medical case for a slimmer nation*. London: RCP, 2004

3. Department of Health. *Annual Report of the Chief Medical Officer, 2002*. London: DH, 2003.

4. National Audit Office. *Tackling Obesity in England*. Report by the Comptoller and Auditor General. Norwich: TSO, 2001

5. NHS Centre for Reviews and Dissemination. *The prevention and treatment of childhood obesity.* Effective Healthcare Bulletins, vol 7, no 6. York: CRD, 2002.

6. Health Development Agency. The management of obesity and overweight: an analysis of reviews of diet, physical activity and behavioural approaches. London: HAD, 2003.

7. Scottish Intercollegiate Guidelines Network (SIGN). Guideline 69: Management of Obesity in Children and Young People. Edinburgh: SIGN, 2003.

8. County Durham and Tees Valley Public Health Network. *Preventing, Identifying and Managing Childhood Obesity in County Durham and the Tees Valley: Examining the Gap Between the Evidence Base and Current Practice.* County Durham and Tees Valley Public Health Network, 2004.

12. ACTION PLAN

Action	Organisation(s)	Lead(s)	Outputs	When
1. Strategy endorsement and implementation				
1.1 Endorse the stategy	LSPs	LSPChair/ DPH/LSP Support Officer		By December 2004
1.2 Identify named group and lead to take strategy forward	LSPs		• Identified lead and subgroup/task group. • May report to LSP via Children and Young Peoples Planning Group, Health Policy Group or equivalent.	By December 2004
1.3 Develop and agree local action plan based on this document	Nominated sub group/task group	Nominated lead	• Action plan to be developed for phased implementation. • Costs for 2005/06 to be identified to funding agencies as soon as possible.	By February 2005 By January 2005
2. Prevention; a lifecourse approach (local action to be confirmed through above processes)				
2.1 Antenatal services	PCTs; SureStart local programmes; County Durham and Darlington Acute Hospitals NHS Trust	PCT obesity lead	• Smoking cessation –develop services; establish challenging targets for quit rates. • Breast feeding promotion – provide information on prevention of childhood obesity in addition to current advice. • Healthy eating advice for pregnancy – in particular targeted advice for overweight parents and other vulnerable groups. • Ensure midwives, health visitors and SureStart staff have UNICEF training or equivalent.	Dates within local plans

2.2 Post natal services	PCTs; SureStart local programmes; County Durham and Darlington Acute Hospitals NHS Trust	PCT obesity leads	• Health visitors and midwives to continue active breastfeeding support and deferred weaning • Update *North Durham Healthy Eating Policy 0-5 Years* and ensure equivalent developed for all of County Durham and Darlington. • Target advice and support through SureStart Children's Centres in 20% most deprived wards.	Dates within local plans
2.3 Pre school	PCTs; SureStart local programmes; leisure services; voluntary agencies	PCT obesity lead; head of leisure services	• Improve access to and quality of outdoor play spaces, including both formal play areas and informal green spaces. • Consider pedestrianisation, play streets and "Home Zones". • Continue advice on healthy eating (including restriction of sweetened drinks) through SureStart Children's Centres and routine health visitor contact. • Add more advice on active play and limiting sedentary play (in particular TV) to routine health visitor contacts and within SureStart. Emphasise value of outdoor play.	Dates within local plans
2.4 Further developing the Healthy School Standard Approach	Schools; PCTs; LEAs	County Durham and Darlington Healthy Schools Coordinator; LEAs	• Active promotion of multifaceted school based interventions through Healthy School Standard. • Provision of sufficient local Healthy School Standard Coordinator capacity in all PCTs. • LEAs to promote curriculum based physical activity and use of school premises at lunch time and after school.	Dates within local plans
2.5 School food policy	Schools; PCTs; LEAs	Local Healthy School Standard Coordinator; LEAs	• Schools working to Healthy School Standard to adopt the agreed School Food Policy and adapt to local need. • LEAs to identify capacity to work with schools on curriculum content. • School meal contracts to be renegotiated to incorporate healthy eating.	Dates within local plans For next school year

2.6 Promoting physical activity in older children and young people	Leisure services; schools; LEAs; PCTs	Heads of leisure services; PCT obesity or physical activity leads	• Work towards target of one hour of physical activity every day for growing children. • Develop curriculum activity in relation to physical activity and develop lunch time and after school activities (linked into a multifaceted approach through Healthy School Standard). • Promote safe walking to school. • Promote walking and cycling. • Build on lessons from pilots such as LEAP.	Dates within local plans
3. Treatment services for obese children and young people (BMI at or greater than 98th centile)				
3.1 Community service	PCTs; Leisure services	PCT obesity lead; Head of leisure services	The community based service will need to be developed in each LSP/PCT area. The evidence is strongest for family based interventions. Essential components are: • Trained staff to undertake home visits to assess readiness for change and then engage the family in an intervention programme which includes healthy eating, increased physical activity and overall lifestyle modification. • Availability of appropriate information materials on nutrition and activity. • Age appropriate physical activity classes/groups/programmes for families and children together and for groups of children and young people. • Sensitively offered school based (or out of school) programmes for obese young people as an alternative to participating in usual curriculum physical education classes. • Appropriate follow up arrangements. • Advice and support from the specialist service. • Referral to the specialist team following the agreed criteria. • Engagement of children, young people and families in developing and evaluating the service.	Dates within local plans

3.2 Specialist service	PCTs; County Durham and Darlington Acute Hospitals NHS Trust	Lead DPH and specific working group	The service will only accept children and young people meeting the referral criteria (page 14). It will deliver the following: • Training and support to the network of practitioners delivering the community based service, including development of information materials. • Investigation/treatment/further referral of those children and young people with severe obesity or co morbidities. • For those with "uncomplicated" severe obesity, provision of intensive family behaviour modification incorporating physical activity, diet and lifestyle change, appropriate to the age of the child/young person. • Assessment and referral to alternative treatment programmes in individual extreme cases such as Weight Loss Camps, drug treatment and possibly surgery. Staffing will include sessional input from a paediatrician, a clinical psychologist and a specialist dietician. There will need to be close working links with community based services in particular physical activity coordination.	Outline specification to be developed by January 2005 as this will require funding by all six PCTs, if implementation for 2005/06 is agreed.
4. Surveillance and monitoring				
4.1Active surveillance	PCTs; Public Health Network	DsPH; Director, Public Health Network; School Nursing Service Managers; CHIS Managers.	Population surveillance to be developed for County Durham and Darlington to enable monitoring of the national target. Active surveillance at initial and secondary school entry will enable referral to the community service of those children and young people who are obese.	Pilot in Derwentside, Durham and Chester-le Street to commence by March 2005; County Durham and Darlington by December 2005