# NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

## Health and social care directorate

## Quality standards and indicators

## Briefing paper

**Quality standard topic:** Obesity: prevention and lifestyle weight management in children and young people

**Output:** Prioritised quality improvement areas for development.

**Date of Quality Standards Advisory Committee meeting:** 8 May 2014

## Contents

# 1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for obesity: prevention and lifestyle weight management in children and young people. It provides the Committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

## *1.1 Structure*

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the Committee in considering potential statements and measures.

## *1.2 Development source*

The key development source(s) referenced in this briefing paper is:

- Managing overweight and obesity among children and young people: lifestyle weight management services. NICE public health guidance 47 (2013).
- Obesity: guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children. NICE clinical guideline 43 (2006). (Public health recommendations only).

## *1.3 Other sources*

- Obesity: working with local communities. NICE public health guidance 42 (2012).
- Promoting physical activity, active play and sport for pre-school and school-age children and young people in family, pre-school, school and community settings. NICE public health guidance 17 (2009).
- Guidance on the promotion and creation of physical environments that support increased levels of physical activity. NICE public health guidance 8 (2008).

# 2 Overview[1]

## 2.1 Focus of quality standard

This quality standard will cover public health strategies to prevent overweight and obesity among children and young people aged under 18 years, and the delivery of lifestyle weight management interventions. It will not cover the clinical assessment and management of obesity in individual children and young people. This will be the focus of a separate healthcare quality standard.

## 2.2 Definition

Calculating body mass index is the most common method to determine if someone is overweight or obese. Assessing the body mass index (BMI) of children is more complicated than for adults because it changes as they grow and mature. In addition, growth patterns differ between boys and girls.

Thresholds that take into account a child's age and sex are used to assess whether their BMI is too high or too low. These are usually derived from a reference population, known as a child growth reference, with the data presented in a special chart called BMI centile charts. These charts compare a child's BMI against other children of the same sex and age.

**Lifestyle weight management programmes** aim to maintain the growing child's existing weight in the short term, as they grow taller. This is an appropriate short-term aim, because it will result in an improved BMI over time, and is often described as 'growing into their weight'.

Young people who are overweight or obese and are no longer growing taller will ultimately need to lose weight to improve their BMI. However, preventing further weight gain while they gain the knowledge and skills they need to make lifestyle changes, may be an appropriate short-term aim. These changes then need to become firmly established habits over the long term. Lifestyle weight management programmes focus on diet, physical activity, behaviour-change or any combination of these elements.

## 2.3 Incidence and prevalence

The National Child Measurement Programme (NCMP) measures the height and weight of around one million school children from state schools in England every year, providing a detailed picture of the prevalence of child obesity. In 2012/13 the participation rate was 93% of eligible children. 587,678 pupils were measured from

[1] Sections 2.1 to 2.2 are taken from Managing overweight and obesity among children and young people: lifestyle weight management programmes. NICE public health guideline 47 2013.

Reception (aged 4–5 years) and 489,146 were measured from Year 6 (aged 10-11 years). The NCMP data from 2012/13 showed that over a fifth (22.2%) of children measured in Reception were either overweight or obese. In Year 6 this proportion was one in three (33.3%). The percentage of obese children in Year 6 (18.9%) was over double that of Reception year children (9.3%)[2].

Obesity prevalence was significantly higher in urban areas than in rural areas for both school years, as was the case in previous years. The obesity prevalence among Reception year children living in urban areas was 9.6% compared with 8.1% and 7.5% living in town and village areas respectively. Similarly, obesity prevalence among Year 6 children living in urban areas was 19.6% compared with 16.0% and 15.4% living in town and village areas respectively[3].

Obesity prevalence varied across the country. South East Coast Strategic Health Authority (SHA), South Central SHA and East of England SHA had the lowest obesity prevalence in Reception and South East Coast SHA, South Central SHA and South West SHA had the lowest obesity prevalence in Year 6. London SHA reported the highest obesity prevalence for both years[4].

In Reception, the proportion of obese and overweight children is lower in 2012/13 than in 2006/07. In Year 6, the proportion of obese children (18.9%) was higher than in 2006/07 (17.5%) (see figure 1).

[2] Health and Social Care Information Centre (2013) National Child Measurement Programme.
[3] Health and Social Care Information Centre (2013) National Child Measurement Programme.
[4] Health and Social Care Information Centre (2013) National Child Measurement Programme.

**Figure 1: Prevalence of obesity by school year, sex, and year of measurement. National Child Measurement Programme 2006/07 to 2012/13 (Source of figure: Public Health England)[5]**

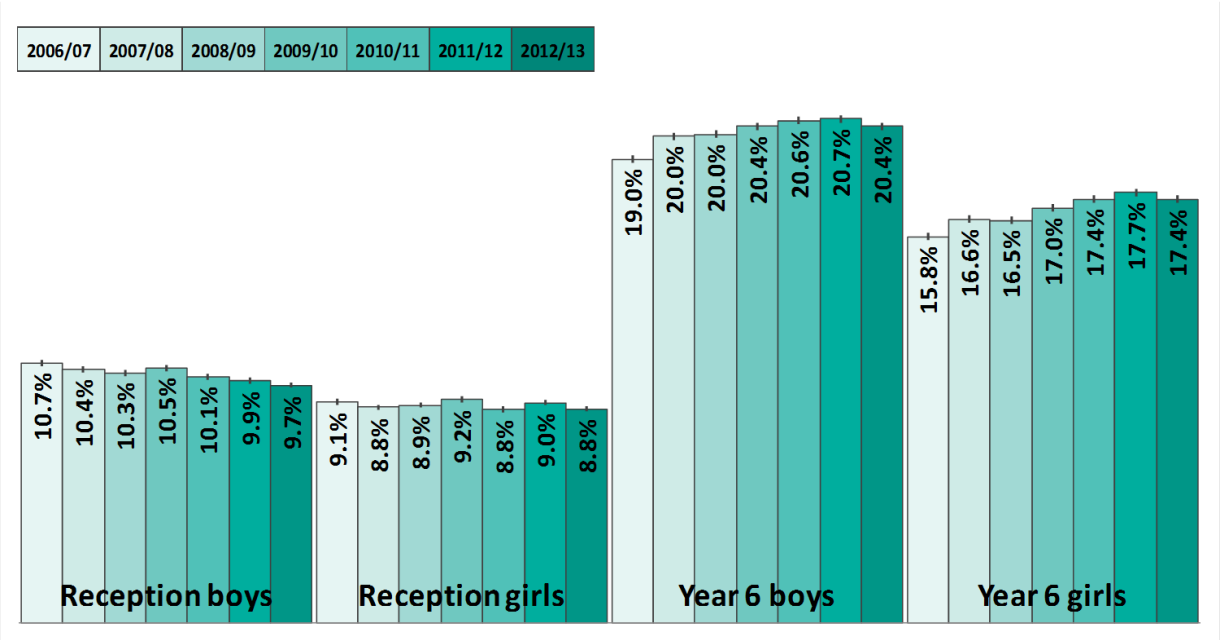
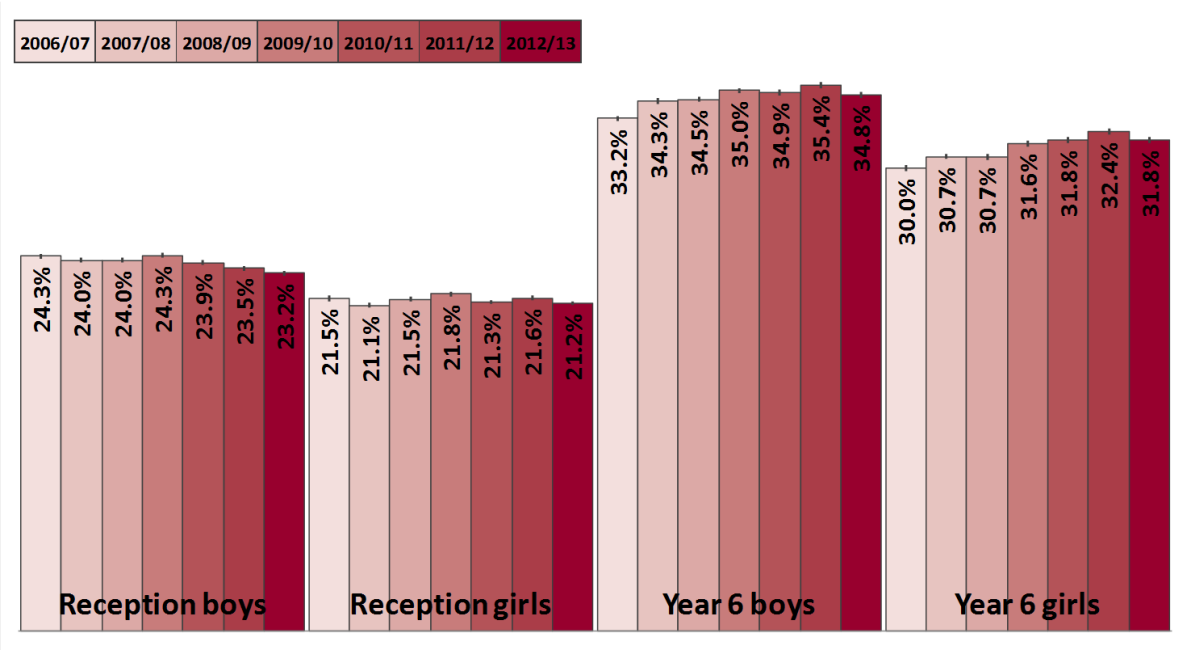



**Figure 2: Prevalence of overweight by school year, sex, and year of measurement. National Child Measurement Programme 2006/07 to 2012/13 (Source of figure: Public Health England)[6]**




The Health Survey for England (HSE) measures a smaller sample of children than the NCMP but covers a wider age range. The data from 2012 shows that among

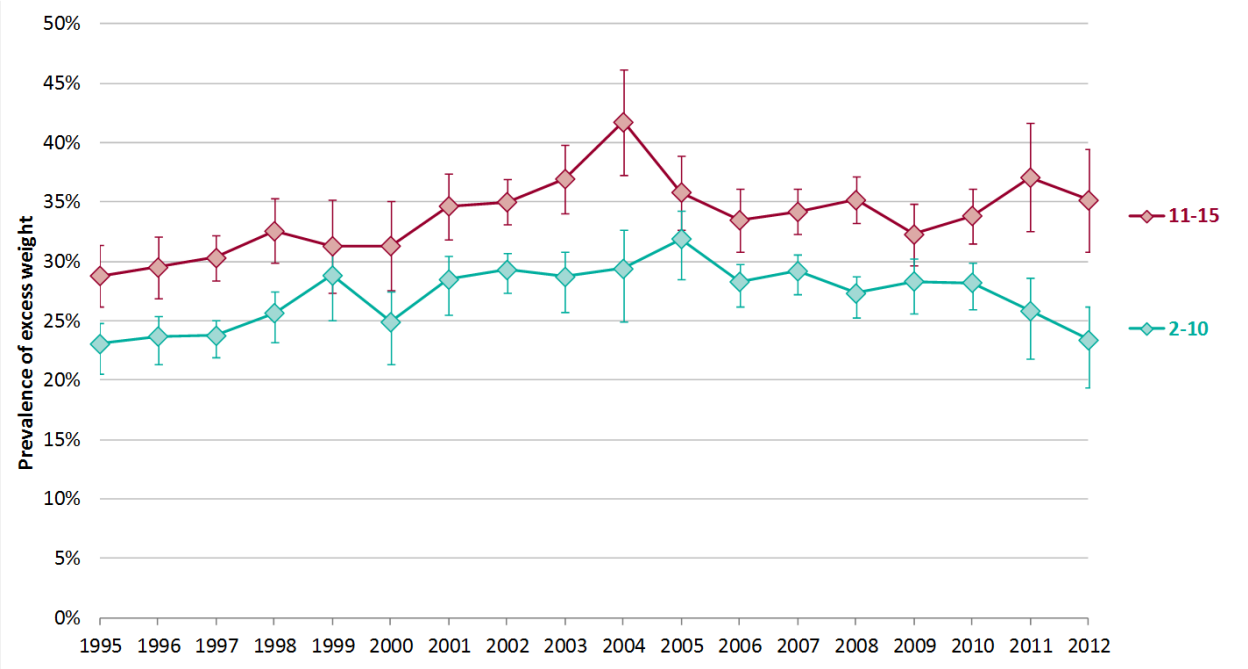
[5] Public Health England (accessed 2014) Slide sets for adult and child obesity
[6] Public Health England (accessed 2014) Slide sets for adult and child obesity

children aged 2 to 15, 14% of both boys and girls were classed as obese and 28% of both boys and girls were classed as either overweight or obese. Children aged 11-15 were more likely to be obese (19% of both boys and girls) than those aged 2-10 (11& and 10% respectively)[7]. Data from the HSE shows the prevalence of child obesity and overweight increased between 1995 and 2004, since 2004 there is evidence of a levelling off in child obesity prevalence for 2-10 and 11-15 year-olds.

**Figure 3: Trend in the prevalence of obesity. Children aged 2-10 and 11-15 years; Health Survey for England 1995-2012[8]. (Source of figure: Public Health England)**


[7] Health and Social Care Information Centre (2013) Health survey for England - 2012
[8] Public Health England (accessed 2014) Slide sets for adult and child obesity

**Figure 4: Trend in the prevalence of overweight. Children aged 2-10 and 11-15 years; Health Survey for England 1995-2012[9]. (Source of figure: Public Health England)**




If a child is overweight or obese, they tend to grow up to be very overweight adults which can lead to health problems such as type 2 diabetes, heart disease and certain cancers[10].

## *2.4 Management*

There are a variety of different management strategies for children and young people who are overweight or obese. This quality standard will only cover lifestyle weight management programmes. Clinical treatment options for example medication and surgery will be covered by a separate quality standard.

## *2.5 National Outcome Frameworks*

Table 1 show the outcomes, overarching indicators and improvement areas from the framework that the quality standard could contribute to achieving.

[9] Public Health England (accessed 2014) Slide sets for adult and child obesity
[10] NHS choices (accessed March 2014)

**Table 1 Public health outcomes framework for England, 2013–2016**

| Domain | Objectives and indicators |
|---|---|
| 1 Improving the wider determinants of health | ***Objective***<br>Improvements against wider factors that affect health and wellbeing, and health inequalities<br>***Indicators***<br>1.3 Pupil absence |
| 2 Health improvement | ***Objective***<br>People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities<br>***Indicators***<br>2.6 Excess weight in 4-5 and 10-11 year olds<br>2.11 Diet |

# 3 Summary of suggestions

## *3.1 Responses*

In total 8 stakeholders responded to the 2-week engagement exercise 10 – 24 March 2014.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 2 for further consideration by the Committee.

Full details on the suggestions provided are given in appendix 3 for information.

**Table 2 Summary of suggested quality improvement areas**

| Suggested area for improvement | Stakeholders |
|---|---|
| **Prevention**<br>• Whole system approach<br>• School curriculum<br>• Sale and marketing of unhealthy foods in local authority venues | DomUK, PHE, SCM |
| **Physical activity** | FS, SCM, SW |
| **Educating parents** | ASCL, ITF |
| **Recording and monitoring weight**<br>• General recording and monitoring of weight<br>• Use of age specific BMI charts | DomUK, SCM, SW, |
| **Lifestyle and weight management programmes – planning programmes**<br>• Equitable access<br>• Instructors<br>• Commissioning<br>• Outcome measures | DomUK, PHE, SCM, SW, |
| **Lifestyle and weight management programmes – components of programmes**<br>• Family involvement<br>• Recording and monitoring of weight for people accessing support for their weight<br>• Ongoing support<br>• Information | SCM, SW |
| **Additional areas**<br>• Advertising<br>• Labelling | ASCL, ITF, PHE, SCM, WLSI |

| | |
|---|---|
| • Advancing technology and GP practice systems to capture NCMP data<br>• Educating healthcare professionals<br>• Early weaning<br>• Appropriate referral<br>• Weight loss surgery | |
| ASCL, Association of School and College Leaders<br>DomUK, Dieticians in Obesity Management UK<br>FS, Fit for Sport<br>ITF, Infant and Toddler Forum<br>PHE, Public Health England<br>RCPCH, Royal College of Paediatrics and Child Health<br>SW, Slimming World<br>WLS, Weight Loss Surgery Info<br>SCM, Specialist Committee Member | |

# 4 Suggested improvement areas

## *4.1 Prevention*

### 4.1.1 Summary of suggestions

**Whole system approach**

Stakeholders suggested a whole system approach to tackling obesity was needed and was within the scope of the local landscape. Effective partnerships are needed between local authorities, schools, GPs and other healthcare professionals to maximise participation in interventions and ensure continued engagement. A whole system approach would also ensure a more joined up approach to the provision of care and treatment and enable clarity for commissioning responsibilities.

**School curriculum**

Stakeholders suggested the inclusion of cookery, food purchasing on a budget, food storage and weight management including issues of weight stigma, as a mandatory part of the school curriculum. Embedding these skills within the curriculum will ensure that all children have equal access throughout their school years to gain these skills.

**Sale and marketing of unhealthy foods in local authority venues**

Stakeholders highlighted the role of the environment as a potential cause of obesity and a factor in maintaining an unhealthy weight. Local authority venues including schools provide opportunities for physical activity but often also offer unhealthy food and drink. In schools there is also offsite access to unhealthy food. The move of public health to local authority provides a good opportunity to ensure healthy food is made available at these locations.

### 4.1.2 Selected recommendations from development source

Table 3 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 3 to help inform the Committee's discussion.

**Table 3 Specific areas for quality improvement**

| Suggested quality improvement area | Suggested source guidance recommendations |
|---|---|
| Whole system approach | NICE PH42 recommendation 7 |
| School curriculum | NICE CG43 public health recommendations 1.1.5.1 and 1.1.5.2 |

| | |
|---|---|
| Sale and marketing of unhealthy foods in local authority venues | NICE CG43 public health recommendations 1.1.3.2 and 1.1.5.2 |

**Whole system approach**

NICE PH42 – recommendation 7

- Commissioners and public health teams should foster an integrated approach to local commissioning that supports a long-term (beyond 5 years) system-wide health and wellbeing strategy.
- Public health teams should ensure commissioners understand the demographics of their local area, and consider local insight on the motivations and characteristics of subgroups within local communities that may impact on obesity levels.
- Commissioners and public health teams should create an environment that allows the 'local system' to take a truly community-wide approach to obesity. They should consider:
    - which 'packages' of interventions are most effective (including cost effective)
    - the 'intensity' of effective programmes (for example, the number of interventions which make up an effective programme or the percentage of the population that should be reached)
    - synergies between common actions to tackle obesity.
- Commissioners should focus on all of the following areas (focusing on just one at the expense of others may reduce effectiveness):
    - raising awareness of the health problems caused by obesity and the benefits of being a healthier weight among partners and the public
    - training to meet the needs of staff and volunteers (prioritising those who are working directly with local communities)
    - influencing the **wider determinants of health**, including, for example, ensuring access to affordable, healthier food and drinks, and green space and built environments that encourage physical activity
    - aiming activities at both adults and children in a broad range of settings
    - providing lifestyle weight management services for adults, children and families

    - providing clinical services for treating obesity.

- Commissioners should fund both targeted and universal services that can help people achieve or maintain a healthy weight. The specific package of services should be based on local needs, but should include both 'top-down' approaches such as planning cycle routes and food procurement specifications and '**bottom-up**' approaches such as running activities in local parks and breastfeeding peer support (as appropriate). They should include interventions that are known to be effective as outlined in existing NICE guidance.

**School curriculum**

NICE CG43 – public health recommendation 1.1.5.1

All schools should ensure that improving the diet and activity levels of children and young people is a priority for action to help prevent excess weight gain. A whole-school approach should be used to develop life-long healthy eating and physical activity practices.

NICE CG43 – public health recommendation 1.1.5.2

Head teachers and chairs of governors, in collaboration with parents and pupils, should assess the whole school environment and ensure that the ethos of all school policies helps children and young people to maintain a healthy weight, eat a healthy diet and be physically active, in line with existing standards and guidance. This includes policies relating to building layout and recreational spaces, catering (including vending machines) and the food and drink children bring into school, the taught curriculum (including PE), school travel plans and provision for cycling, and policies relating to the National Healthy Schools Programme and extended schools.

**Sale and marketing of unhealthy foods in local authority venues**

NICE CG43 – public health recommendation 1.1.3.2

Local authorities should set an example in developing policies to prevent obesity in their role as employers, by following existing guidance and (in England) the local obesity strategy.

- On-site catering should promote healthy food and drink choices (for example by signs, posters, pricing and positioning of products).

- Physical activity should be promoted, for example through travel plans, by providing showers and secure cycle parking and using signposting and improved décor to encourage stair use.

NICE CG43 – public health recommendation 1.1.5.2

See above.

### 4.1.3 Current UK practice

#### Whole system approach

No published studies on current practice were highlighted for this suggested area for quality improvement.

#### School curriculum

Understanding and applying the principles of nutrition and healthy eating and learning how to cook is a mandatory part of the National curriculum for key stages 1-3 (pupils aged 5-14) in England from September 2014. This curriculum will only apply to state–funded schools[11].

#### Sale and marketing of unhealthy foods in local authority venues

Local authority maintained schools and academies set up before 2010 currently have to comply with regulations setting out specific food-based and nutrient-based standards. The primary objective of the standards is to create healthy eating habits and ensure that the food service in schools provides the energy and nutrients needed by children during the school day. In March, the Department of Education consulted on new draft school food standards which will be made statutory from January 2015[12]. The food-based standards determine the types of food and drink a school must offer (and how often) and what types of food and drink are restricted or cannot be served.

In 2011-12 the take up of school lunches was 46.3% in primary schools and 39.8% in secondary schools. The rest either had a packed lunch or went off site if at secondary school[13].

In Britain, the quality of school food improved rapidly after the introduction of the current standards. For example, the number of primary school children eating the required amount of vegetables with their meals rose from 50% in 2005 to 74% in 2009. In primary schools, increases in the levels of vitamin A, folate and fibre were observed after the introduction of nutrient-based standards. The impact was more variable in secondary schools, however. Vitamin A, fibre and calcium intakes all

[11] Department for Education (2013) National curriculum in England: design and technology programmes of study
[12] Department for Education (2014) Revised standards for food in schools.
[13] Michael Nelson, Jo Nicholas, Katy Riley, Lesley Wood (2012) Seventh Annual survey of take-up and school lunches in England, School Food Trust,

rose, but folate, zinc, iron and vitamin C levels actually decreased slightly in secondary schools[14].

A survey by the School Food Trust of 80 secondary schools in England reported that 69% of pupils eating a packed lunch had 'non-permitted foods' e.g. crisps, sugary drinks, confectionary, cakes, compared with only 9% of pupils eating a school lunch[15]. The report found that compared with 2004, catering provision at lunchtime is now healthier. Fewer schools regularly offered pizza (50% vs. 66%), starchy food cooked in fat or oil (53% vs. 77%) and condiments (84% vs. 95%) in 2011 compared with 2004. In addition, in 2011, a higher percentage of schools offered starchy food *not* cooked in fat or oil (99% vs. 82%), vegetables and salad (98% vs. 60%), water (98% vs. 68%) and fruit (96% vs. 91%) on 4-5 days per week compared with 2004. Pupil meals had at least 30% less fat, saturated fat, salt and sugar than previously[16].

The seventh annual survey of take-up of schools lunches in England found 1 local authority identified the introduction of vending machines to be part of the reason for the fall in take up in secondary schools. 6 local authorities identified the removal of vending machines to be one of the contributing factors for the constant or increased demand for school meals[17].

[14] Department for Education (2014) Revised standards for food in schools.
[15] Nelson et al (2011) Secondary school food survey 2011: School lunches versus packed lunches, School Food Trust,
[16] Nelson et al (2011) Secondary school food survey 2011: School lunch: provision, selection and consumption, School Food Trust,
[17] Michael Nelson, Jo Nicholas, Katy Riley, Lesley Wood (2012) Seventh Annual survey of take-up and school lunches in England, School Food Trust,

## *4.2 Physical activity*

### 4.2.1 Summary of suggestions

Stakeholders suggested physical activity should be promoted in child-care settings and schools with it becoming part of daily life. There are well documented links between sedentary lifestyle, physical activity and childhood obesity. A large proportion of children and young people are not meeting the recommended levels for physical activity. Physical activity is important for long term health as well as obesity.

Stakeholders suggested age specific advice and targets for physical activity that is appropriate for the age of the child is important. Knowledge and understanding of the specific guidance for under 18 year olds is low across the general population and also among healthcare professionals.

### 4.2.2 Selected recommendations from development source

Table 4 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 4 to help inform the Committee's discussion.

**Table 4 Specific areas for quality improvement**

| Suggested quality improvement area | Suggested source guidance recommendations |
|---|---|
| Physical activity | NICE CG43 public health recommendations<br>Public: 1.1.1.2, 1.1.1.6<br>NHS: 1.1.2.6<br>Early years settings: 1.1.4.3<br>Schools: 1.1.5.1, 1.1.5.2, 1.1.5.6<br>NICE PH8 recommendation 7<br>NICE PH17 recommendations 1–15 |

NICE CG43 public health recommendation 1.1.1.2

People should follow the strategies listed in box 1, which may make it easier to maintain a healthy weight by balancing 'calories in' (from food and drink) and 'calories out' (from being physically active).

**Box 1 Strategies to help people achieve and maintain a healthy weight**

**Diet**

- Base meals on starchy foods such as potatoes, bread, rice and pasta, choosing wholegrain where possible.

- Eat plenty of fibre-rich foods – such as oats, beans, peas, lentils, grains, seeds, fruit and vegetables, as well as wholegrain bread, and brown rice and pasta.
- Eat at least five portions of a variety of fruit and vegetables each day, in place of foods higher in fat and calories.
- Eat a low-fat diet and avoid increasing your fat and/or calorie intake.
- Eat as little as possible of:
    - fried foods
    - drinks and confectionery high in added sugars
    - other food and drinks high in fat and sugar, such as some take-away and fast foods.
- Eat breakfast.
- Watch the portion size of meals and snacks, and how often you are eating.
- For adults, minimise the calories you take in from alcohol.

**Activity**

- Make enjoyable activities – such as walking, cycling, swimming, aerobics and gardening – part of everyday life.
- Minimise sedentary activities, such as sitting for long periods watching television, at a computer or playing video games.
- Build activity into the working day – for example, take the stairs instead of the lift, take a walk at lunchtime.

NICE CG43 public health recommendation 1.1.1.6

In addition to the recommendations in box 1, parents and carers should consider following the advice in box to help children establish healthy behaviours and maintain or work towards a healthy weight. These strategies may have other benefits – for example, monitoring the amount of time children spend watching television may help reduce their exposure to inappropriate programmes or advertisements.

**Box 2 Helping children and young people maintain or work towards a healthy weight**

**Diet**

- Children and young adults should eat regular meals, including breakfast, in a pleasant, sociable environment without distractions (such as watching television).
- Parents and carers should eat with children – with all family members eating the same foods.

**Activity**

- Encourage active play – for example, dancing and skipping.
- Try to be more active as a family – for example, walking and cycling to school and shops, going to the park or swimming.

- Gradually reduce sedentary activities – such as watching television or playing video games – and consider active alternatives such as dance, football or walking.
- Encourage children to participate in sport or other active recreation, and make the most of opportunities for exercise at school.

NICE CG43 public health recommendation 1.1.2.6

Interventions to increase physical activity should focus on activities that fit easily into people's everyday life (such as walking), should be tailored to people's individual preferences and circumstances and should aim to improve people's belief in their ability to change (for example, by verbal persuasion, modelling exercise behaviour and discussing positive effects). Ongoing support (including appropriate written materials) should be given in person or by phone, mail or internet.

NICE CG43 public health recommendation 1.1.4.3

Nurseries and other childcare facilities should:

- minimise sedentary activities during play time, and provide regular opportunities for enjoyable active play and structured physical activity sessions

- implement Department for Education and Skills, Food Standards Agency and Caroline Walker Trust guidance on food procurement and healthy catering.

NICE CG43 public health recommendation 1.1.5.1

All schools should ensure that improving the diet and activity levels of children and young people is a priority for action to help prevent excess weight gain. A whole-school approach should be used to develop life-long healthy eating and physical activity practices.

NICE CG43 public health recommendation 1.1.5.2

Head teachers and chairs of governors, in collaboration with parents and pupils, should assess the whole school environment and ensure that the ethos of all school policies helps children and young people to maintain a healthy weight, eat a healthy diet and be physically active, in line with existing standards and guidance. This includes policies relating to building layout and recreational spaces, catering (including vending machines) and the food and drink children bring into school, the taught curriculum (including PE), school travel plans and provision for cycling, and policies relating to the National Healthy Schools Programme and extended schools.

NICE CG43 public health recommendation 1.1.5.6

Staff delivering physical education, sport and physical activity should promote activities that children and young people find enjoyable and can take part in outside school, through into adulthood. Children's confidence and understanding of why they need to continue physical activity throughout life (physical literacy) should be developed as early as possible.

NICE PH8 recommendation 7

- Ensure school playgrounds are designed to encourage varied, physically active play.
- Primary schools should create areas (for instance, by using different colours) to promote individual and group physical activities such as hopscotch and other games.

NICE PH17 recommendations 2–15

Please see appendix 1.

### 4.2.3 Current UK practice

The Health Survey for England 2012[18] provides information on physical activity among children aged 2-15.

**Summary activity levels**

- 9% of boys and 10% of girls aged 2-4 were classified as meeting the current guidelines for children under 5 of at least three hours of physical activity per day.
- 21% boys and 16% of girls aged 5-15 were classified as meeting current guidelines for children and young people of at least one hour of moderately intensive physical activity per day. Among both sexes, the proportion meeting guidelines was lower in older children. The proportion of boys meeting guidelines decreased from 24% in those aged 5-7 to 14% aged 13-15. Among girls the decrease was from 23% to 8% respectively.
- Since 2008 there was a significant decrease in boys in the proportion meeting current guidelines, falling from 28% in 2008 to 21% in 2012. In girls the change was not significant, from 19% to 16%.

**Participation in walking and cycling to school**

- Two thirds of children who had attended school (includes school, playgroup or nursery) in the last week had walked to or from school on at least one occasion (64% of boys and 67% of girls). 41% of boys and 44% of girls walked to/from

[18] Health and Social Care Information Centre (2013) Health Survey for England - 2012

school every day. The proportion walking to or from school every day was higher among children aged 5-15 (45% of boys and 49%-50% of girls), while pre-school aged children (2-4) were less likely to have done so (25% of boys and 21% of girls).

- On average, children spent 1.1 hours walking to/from school in the last week.
- More boys than girls cycled to/from school on at least one occasion in the last week (6% and 1% respectively).
- The proportion of boys and girls who had walked and/or cycled to or from school on at least one occasion in the last week was similar in 2008 and 2012.

**Participation in formal and informal activities**

- 93% of boys and 92% of girls had participated in any type of physical activity in the last week. Boys were more likely than girls to have participated in formal sports (48% and 38% respectively) on at least one occasion in the last week; however, levels of walking (52% of boys and 54% of girls, excluding walking to/from school) and informal activity (85% among both sexes) were similar. Boys averaged more days of participation in informal activities and formal sports (4.0 days and 1.3 days respectively) than girls (3.8 and 0.9 respectively).
- Patterns of activity varied by age. Younger and older children (aged 2-4 and 11-15) walked on more days in the last week than those in the middle age groups. Participation in informal activities fell steadily with age, while participation in formal sports increased with age in boys up to the age of 10.
- 52% of boys and 46% of girls participated in at least seven hours of physical activity in the last week. Among boys, the proportion that participated in at least 7 hours of informal activity in the last week fell from 44% for those aged 2-4 to 27% for those aged 13-15. Among girls, this decrease with age was greater, falling from 40% to 9%.

**Sedentary activities**

- Average total sedentary time (excluding time at school) was similar for boys and girls on weekdays (3.3 hours and 3.2 hours respectively) and weekend days (4.2 hours and 4.0 hours respectively).
- The average time per day spent watching TV on weekdays increased steadily with age in boys (from 1.5 hours for those aged 2-4 to 1.8 hours for those aged 13-15); however, the increase among the same ages was steeper in girls (1.5 to 2.2 hours). Conversely, on weekend days, the increase with age in other sedentary time was steepest for boys (from 1.4 hours for those aged 2-4 to 2.9 hours for those aged 13-15, compared with 1.4 to 2.4 hours in girls).

- Among children aged 2-10, the mean number of sedentary hours on a typical weekday decreased from 3.0 hours for both sexes in 2008 to 2.9 hours for boys and 2.8 hours for girls in 2012. Among boys aged 11-15, mean sedentary time on weekend days increased from 4.8 hours in 2008 to 5.0 hours in 2012; for girls of similar age, mean sedentary time decreased from 4.8 to 4.5 hours.

## *4.3 Educating parents*

### 4.3.1 Summary of suggestions

Stakeholders suggested educating parents on the many factors that contribute to obesity including the production of quick, cheap, attractive and healthy food for their children. Many families fell that they do not have the time, money or expertise to cook food from basic ingredients and so rely on prepared food that is high in saturated fat, sugar and salt. This is particularly important during the child's first few years when parents are more receptive to advice and support.

### 4.3.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 5 to help inform the Committee's discussion.

**Table 5 Specific areas for quality improvement**

| Suggested quality improvement area | Suggested source guidance recommendations |
|---|---|
| Educating parents | NICE CG43 public health recommendation 1.1.2.17 |

NICE CG43 public health recommendation 1.1.2.17

Any programme to prevent obesity in preschool, childcare or family settings should incorporate a range of components (rather than focusing on parental education alone), such as:

- diet – interactive cookery demonstrations, videos and group discussions on practical issues such as meal planning and shopping for food and drink
- physical activity – interactive demonstrations, videos and group discussions on practical issues such as ideas for activities, opportunities for active play, safety and local facilities.

### 4.3.3 Current UK practice

No published studies on educating parents were highlighted for this suggested area for quality improvement. Data has been provided on the diet of private households in the UK as an indication of the outcome these programmes.

The National Diet and Nutrition Survey (NDNS)[19] is a continuous cross-sectional survey, designed to assess the diet, nutrient intake and nutritional status of the general population aged 18 months upwards living in private households in the UK. The NDNS collated data from interviews, four-day dietary diaries and blood and urine samples and the results were presented for 5 age groups: 1.5–3 years; 4-10 years; 11–18 years; 19–64 years and 65 years and over. The report found:

- Mean consumption of fruit and vegetables for children aged 11-18 years was 3.0 portions per day for boys and 2.8 portions per day for girls. 11% of boys and 8% of girls in this age group met the five-a-day recommendation.
- Mean consumption of oily fish was well below the recommended one portion (140g) per week in all age groups.
- In children mean energy intakes ranged from 1137 kcal/day for children aged 1.5 to 3 years, 1555 kcal/day for children aged 4 to 10 years and 1791 kcal/day for children aged 11 to 18 years.
- Mean intake of total fat met the dietary reference value (DRV) (no more than 35% food energy) in all age/sex groups.
- Mean intakes of saturated fat exceeded the DRV (no more than 11% food energy) in all age groups
- Mean intakes of *trans* fatty acids provided 0.7-0.8% of food energy for all age groups, thus meeting the DRV (no more than 2% food energy).
- Mean non-milk extrinsic sugars intakes exceeded the DRV (no more than 11% food energy) for all age groups most notably for children aged 11 to 18 years where mean intakes provided 15.3% food energy.
- Mean intakes of reported vitamins (except vitamin D) from food sources were close to or above the Reference Nutrient Intake (RNI) for all groups. For children aged 11 to 18 years, 13% had vitamin A intakes and 21% of girls had riboflavin intakes below the Lower Reference Nutrient Intake (LRNI).
- Mean intakes of reported minerals from food sources were below the RNI for some age groups, in particular children aged 11 to 18 years. In addition, a substantial proportion of this age group, particularly girls, had intakes below the LRNI. Mean intakes of iron were below the RNI for girls aged 11 to 18 years.
- Mean intakes of all minerals were above the RNIs for younger children aged under 11 years and few children in this age group had intakes below the LRNI.

[19] Department of Health (2012) National Diet and Nutrition Survey: Headline results from Years 1, 2 and 3 (combined) of the rolling programme 2008-9–2010-11

## *4.4 Recording and monitoring of weight*

### 4.4.1 Summary of suggestions

**General recording and monitoring of weight**

Stakeholders suggested children and young people should have their weight recorded and monitored at more regular intervals than just those in the National Child Measurement Programme (NCMP). The current data from NCMP is useful in helping to target weight management services for children and their families however weighing and measuring post NCMP would increase understanding of the links between childhood and adult obesity and the long-term health risks. Beyond the age of 10-11 years, when the prevalence of overweight and obesity is approximately a third there is no programme for monitoring and recording. BMI is not necessarily routinely recorded within general practice, even in adults.

**Use of age specific BMI charts**

Stakeholders suggested all healthcare professionals and weight management providers should use age specific BMI charts. These charts take into account that children are still growing. It is important these charts are used to ensure that appropriate support and advice is being given to young people with regards to suggested weight changes and targets.

### 4.4.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 6 to help inform the Committee's discussion.

**Table 6 Specific areas for quality improvement**

| Suggested quality improvement area | Suggested source guidance recommendations |
|---|---|
| General recording and monitoring of weight | Not covered in NICE guidance and no recommendations are presented |
| Use of age-specific BMI charts | NICE PH47 recommendations 2 and 13 |

**Use of age–specific BMI charts**

NICE PH47 recommendations 2 and 13

Please see appendix 2.

### 4.4.3 Current UK practice

#### General recording and monitoring of weight

No published studies on current practice were highlighted for this suggested area for quality improvement.

#### Use of age-specific BMI charts

No published studies on current practice were highlighted for this suggested area for quality improvement.

## *4.5 Lifestyle and weight management programmes – planning programmes*

### 4.5.1 Summary of suggestions

**Equitable access**

Stakeholders highlighted it was important for equitable provision of weight management programmes that were in accessible locations, familiar to the child or young person. This may increase uptake and improve consistent attendance by making them feel more comfortable. Additionally, stakeholders highlighted that if the programme can cause as little disruption as possible to the child or young person and their family then attendance could be positively impacted. A lack of services has the potential to increase health inequalities given the increased prevalence of obesity in lower socioeconomic groups.

**Instructors**

Stakeholders suggested empathetic and well-informed instructors were important to both present the programme and to act as a role model to children and young people. It was suggested that if the child/young person feels inspired and motivated by the instructor then improved attendance and adherence could be expected.

**Commissioning**

Stakeholders suggested there needed to be greater transparency and explanation for local intervention commissioning. Too many local interventions are commissioned without robust evidence of efficacy, population acceptability or good levels of retention. When services are commissioned they also need to include the views of the target groups which will increase engagement and the quality of the service.

**Evaluation of services and outcomes measures**

Stakeholders suggested there needed to be improvements in the reporting of outcomes from local interventions for example uptake of local interventions. Stakeholders also suggested additional outcome measures that should be recorded including changes in self-esteem, self-worth and general mental well-being. These outcomes will show if the intervention is having a positive impact on the young person’s life.

### 4.5.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 7 to help inform the Committee’s discussion.

**Table 7 Specific areas for quality improvement**

| Suggested quality improvement area | Selected source guidance recommendations |
|---|---|
| Equitable access | NICE PH47 recommendations 1, 2 and 5 |
| Instructors | NICE PH47 recommendations 11 and 12 |
| Commissioning | NICE PH47 recommendation 2 |
| Evaluation of services and outcome measures | NICE PH47 recommendation 15 |

Please see appendix 2 for the full recommendation wording.

### 4.5.3 Current UK practice

#### Equitable access

Stakeholders reported that the current provision of weight management programmes across the country appears to be variable for both adults and children, regardless of the prevalence of obesity. Stakeholders reported that the current spend on weight management services for children and young people reported from a survey of 109 local authorities is 0.9% of public health allocation (total spend on weight management services was 2.5% of public health allocation)[20].

#### Instructors

No published studies on current practice were highlighted for this suggested area for quality improvement.

#### Commissioning

No published studies on current practice were highlighted for this suggested area for quality improvement.

#### Evaluation of services and outcome measures

Public Health England have brought together a collection of resources on evaluation of public health interventions (CoRE)[21]. The current version of CoRE covers standard evaluation frameworks, evaluation data collection tools, a database of interventions that have been evaluated that now includes 48 case studies (children and adults) and evaluation reported from nationally- initiated schemes for example Change4Life. Two programmes cover children aged 1-4 years, 14 programmes

[20]HOOP (Helping Overcome Obesity Problems) (2014) Tackling obesity: all talk, no action
[21] Public Health England (accessed May 2014) Collection of Resources on Evaluation - CoRE

cover children aged 5-11 years and 9 programmes covered young people aged 12-17 years.

There is currently no national figure for the number of lifestyle weight management programmes that have been evaluated.

## *4.6 Lifestyle and weight management programmes – components of programmes*

### 4.6.1 Summary of suggestions

**Family involvement**

Stakeholders highlighted family involvement and commitment in the programme was important to ensure the child or young person receives positive reinforcement and support away from the programme. If the family have an increased understanding and a vested interest in the programme then the programme is likely to be more successful. A family based approach is vital due to the association between overweight and obesity in children and parental overweight and obesity.

**Recording and monitoring of weight in children and young people accessing support for their weight**

Stakeholders suggested children and young people accessing support for their weight should have their weight monitored on a 3 monthly basis. Small changes in height can impact on BMI and health status. Measuring BMI is also important to ensure that any weight management programmes undertaken by a young person does not impact on their expected growth. Regular checks are important to ensure up to date and appropriate advice is given.

**Ongoing support**

Stakeholders highlighted the importance of ongoing support and follow up. Children and young people have a wide variety and often changing set of needs. If the support is ongoing the individual will be able to access support alongside the changes in their lives. Ongoing support may reduce rates of relapse and reinforce the programmes objectives of changing the individual's behaviour towards food.

**Information**

Stakeholders suggested the availability of more literature and resources outside of the programme that is freely accessible, and could raise awareness around the subject of obesity and the availability of lifestyle and weight-management programmes. This may lead to more self-referrals into the programme.

### 4.6.2 Selected recommendations from development source

Table 8 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 8 to help inform the Committee's discussion.

**Table 8 Specific areas for quality improvement**

**Table 8 Specific areas for quality improvement**

| Suggested quality improvement area | Selected source guidance recommendations |
|---|---|
| Family involvement | NICE PH47 recommendations 3, 4 and 5 |
| Recording and monitoring of weight in children and young people accessing support for their weight | NICE PH47 recommendations 2 and 9 |
| Ongoing support | NICE PH47 recommendations 9 and 10 |
| Information | NICE PH47 recommendations 6 and 7<br>NICE CG43 healthcare recommendation 1.2.4.8 |

Please see appendix 2 for the full recommendation wording.

### 4.6.3 Current UK practice

#### Family involvement

A study[22] from Bristol performing in-depth telephone interviews with 32 parents of 6 to 8 year old children, found that improving parents knowledge of physical activity recommendations for children, and increasing their awareness of the benefits of physical activity beyond weight status may be an important first step for a parenting physical activity intervention. The study also found that 'although parents commonly perceive environmental factors as the main barriers to their child's PA, parental concern about low levels of child PA, their capacity to support behaviour change, child motivation, self-confidence and independence may be key areas to address within an intervention to increase child PA'.

#### Recording and monitoring of weight in children and young people accessing support for their weight

No published studies on current practice were highlighted for this suggested area for quality improvement.

#### Ongoing support

No published studies on current practice were highlighted for this suggested area for quality improvement.

#### Information

[22] Bentley et al (2012) Parents' views on child physical activity and their implications for physical activity parenting interventions: a qualitative study

No published studies on current practice were highlighted for this suggested area for quality improvement.

## *4.7 Additional areas*

### 4.7.1 Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise however they were felt to be outside the remit of quality standards or are addressed by other NICE quality standard topics.

This quality standard will cover public health strategies to prevent overweight and obesity among children and young people, and the delivery of lifestyle weight management interventions. It will not cover the clinical assessment and management of obesity in individual children and young people. This will be the focus of a separate healthcare quality standard.

There will be an opportunity for the QSAC to discuss these areas at the end of the session.

**Advertising**

Stakeholders suggested control of advertising of high-fat, high-sugar and high-salt food to children as it has a direct effect and also establishes habits of eating that contribute to obesity. This area of quality improvement aims to inform national policy and therefore is not within the remit of quality standards.

**Labelling**

Stakeholders highlighted that food labelling remains too complex and difficult for many. They stated prepared meals, snacks and confectionary that are high in fat, sugar and salt should be clearly marked as undesirable from a health point of view. This area of quality improvement aims to inform national policy and therefore is not within the remit of quality standards.

**Advancing technology and GP practice systems to capture NCMP data**

Stakeholders highlighted there needs to be operational and service quality improvements to enable effective collection of NCMP data. GPs can then use this data to support families. This area of quality improvement aims to data collection systems and therefore is not within the remit of quality standards.

**Educating healthcare professionals**

Stakeholders suggested healthcare professionals should be educated to consistently identify overweight and obesity in children and young people, raise the issue of weight and provide brief advice and signpost/refer to appropriate interventions. They should also be educated on the many factors that contribute to obesity. Examples of when children and young people might be identified include weighing of children

during the first year of life and at 24 months by a health visitor, recommending a healthy diet during pregnancy or encouraging healthy eating behaviours. Stakeholders report that this is not being done over fear of damaging relationships with patients however not raising the issue gives the impression that there are no concerns. This area of quality improvement would be better addressed in the healthcare quality standard on childhood obesity.

### Early weaning

Stakeholders suggested early weaning on to solid food should be avoided. High energy and protein intake from 2-12 months of age is associated with higher BMI in later childhood. It was suggested more need to be done to promote not weaning babies early by both health visitors and the children's workforce. This area of quality improvement would be better addressed in the healthcare quality standard on childhood obesity.

### Appropriate referral

Stakeholders suggested that following identification of child obesity in the national child measurement programme, appropriate referral to services from a healthcare practitioner is important. This area of quality improvement would be better addressed in the healthcare quality standard on childhood obesity.

### Weight loss surgery

Stakeholders suggested access to a multidisciplinary team in the case of extreme obesity who can offer bariatric surgery as a treatment option. There are physical improvements associated with bariatric surgery including a reduction in objective measures of identified co-morbidities. However the social and psychological benefits of intervening when a young person's illness has developed to this stage are also important. This area of quality improvement would be better addressed in the healthcare quality standard on childhood obesity.

## Appendix 1: Full wording of recommendations from NICE public health guidance 17: Promoting physical activity for children and young people

**Recommendation 1 National campaign –** the recommendation is outside the remit of quality standards and therefore has not been included.

### Recommendation 2 Raising awareness of the importance of physical activity

#### Who should take action?

- Chairs of children's trusts.
- Chairs of local strategic partnerships.
- Chief executives of primary care trusts (PCTs).
- Directors of children's services.
- Directors of public health.

#### What action should they take?

- Ensure the following explicitly address the need for children and young people to be physically active:
    - children and young people's plans
    - joint strategic needs assessments
    - local development and planning frameworks
    - sustainable community plans and strategies.
- Ensure there is a coordinated local strategy to increase physical activity among children and young people, their families and carers. The strategy should help achieve local area agreement targets.
- The strategy should ensure:
    - there are local indoor and outdoor opportunities for physical activity where children and young people feel safe
    - individuals responsible for increasing physical activity are aware of national and local government strategies as well as local plans for increasing physical activity
    - partnership working is developed and supported within local physical activity networks
    - physical activity partnerships establish and deliver multi-component interventions involving schools, families and communities. (Partners may include: schools, colleges, out-of-school[1] services, children's centres and play services, youth services, further education institutions, community clubs and groups and private sector providers)

    - local factors that help children and young people to be (or which prevent them from being) physically active are identified and acted upon
    - local transport and school travel plans are coordinated so that all local journeys can be carried out using a physically active mode of travel.
- Ensure physical activity initiatives aimed at children and young people are regularly evaluated. Evaluations should measure uptake among different groups (for example, among those with disabilities or from different ethnic backgrounds). Any changes in physical activity, physical skills and health outcomes should be recorded. In addition, progress towards local area agreement targets should be monitored.
- Identify a senior council member to be a champion for children and young people's physical activity. They should:
    - promote the importance of encouraging physical activity as part of all council portfolios
    - ensure physical activity is a key priority when developing local authority programmes and targets
    - promote partnership working with council member leads of relevant departments (for example, transport, leisure and health)
    - explain to the public the local authority's role in promoting physical activity.

### Recommendation 3 Developing physical activity plans

#### Who should take action?

- All local authority departments and other local strategic partnership agencies responsible for physical activity facilities and services for children and young people.
- Policy makers and planners working in the public, voluntary, community and private sectors.

#### What action should they take?

- Identify groups of local children and young people who are unlikely to participate in at least 1 hour of moderate to vigorous physical activity a day. Work with the public health observatory, schools and established community partnerships and voluntary organisations to achieve this.
- Involve these children and young people in the design, planning and delivery of physical activity opportunities, using the information gathered.
- Consult with different groups of children and young people and their families on a regular basis to understand the factors that help or prevent them from being physically active. Pay particular attention to those who are likely to be less physically active. Ensure

children and young people from different socioeconomic and minority ethnic groups are actively involved in the provision of activities. Also ensure those with a disability (or who are living with a family member who has a disability) are actively involved.

- Use the information gathered to increase opportunities for children and young people to be physically active and to plan dedicated programmes that tackle any inequalities in provision.

### Recommendation 4 Planning the provision of spaces and facilities

#### Who should take action?

The following should take action in partnership with, or as part of, the local strategic partnership:

- Directors of children's services.
- Directors of leisure and cultural services.
- Directors of planning and regeneration.
- Governors and heads of schools and colleges, office managers and other decision-makers involved with buildings and outdoor spaces within the public, voluntary, community and private sectors.
- Planning and regeneration service managers and project managers and those involved in developing the 'Unitary development plan' (UDP) or other strategic planning documents.
- Representatives from crime and disorder reduction partnerships.

#### What action should they take?

- Ensure physical activity facilities are suitable for children and young people with different needs and their families, particularly those from lower socioeconomic groups, those from minority ethnic groups with specific cultural requirements and those who have a disability.
- Provide children and young people with places and facilities (both indoors and outdoors) where they feel safe taking part in physical activities. These could be provided by the public, voluntary, community and private sectors (for example, in schools, youth clubs, local business premises and private leisure facilities). Local authorities should coordinate the availability of facilities, where appropriate. They should also ensure all groups have access to these facilities, including those with disabilities.
- Make school facilities available to children and young people before, during and after the school day, at weekends and during school holidays. These facilities should also be available to public, voluntary, community and private sector groups and organisations offering physical activity programmes and opportunities for physically active play.

- Actively promote public parks and facilities as well as more non-traditional spaces (for example, car parks outside working hours) as places where children and young people can be physically active.
- Town planners should make provision for children, young people and their families to be physically active in an urban setting. They should ensure open spaces and outdoor facilities encourage physical activity (including activities which are appealing to children and young people, for example, in-line skating). They should also ensure physical activity facilities are located close to walking and cycling routes.
- Ensure the spaces and facilities used for physical activity meet recommended safety standards for design, installation and maintenance. For example, outdoor play areas should have areas of shade from the sun and sheltered areas where children can play to reduce the impact of adverse weather.
- Assess all proposals for signs restricting physical activity in public spaces and facilities (such as those banning ball games) to judge the effect on physical activity levels.

### Recommendation 5 Local transport plans

#### Who should take action?

- Governors and heads of schools and colleges.
- Local transport authorities and executives.
- Police casualty reduction officers.
- Road safety officers.
- School travel advisers.
- Transport planners.

#### What action should they take?

- Ensure local transport and school travel plans continue to be fully aligned with other local authority plans which may impact on children and young people's physical activity. This includes local area agreements, local area play strategies and healthy school plans. Liaise with the local strategic partnership to achieve this.
- Ensure local transport plans continue to be developed in conjunction with local authority departments and other agencies that provide spaces and facilities for children and young people to be physically active.
- Ensure local transport plans acknowledge any potential impact on opportunities for children and young people to be physically active. Transport plans should aim to increase the number of children and young people who regularly walk, cycle and use other modes of physically active travel. They should make provision for the additional needs of, or

support required by, children, young people and their parents or carers with a disability or impaired mobility. For recommendations on local transport plans, see 'Promoting and creating built or natural environments that encourage and support physical activity' (NICE public health guidance 8).

- Continue working with schools to develop, implement and promote school travel plans (see recommendation 12). This may, for example, include: mapping safe routes to school; organising walk and bike to school days and walking buses; organising cycle and road safety training; and helping children to be 'streetwise'.
- Organise training courses for school travel plan advisers.
- Identify any aspect of transport policies which discourages children and young people from using modes of travel involving physical activity (such as walking or cycling). For example, policies that aim to keep traffic moving may make it difficult to cross the road. Consider how these policies can be improved to encourage physically active travel.

### Recommendation 6 Responding to children and young people

#### Who should take action?

- Public, voluntary, community and private sector managers and decision-makers responsible for – or able to influence – opportunities for children and young people to be physically active.
- Governors and heads of schools and colleges.

#### What action should they take?

- Identify local factors that may affect whether or not children and young people are physically active by regularly consulting with them, their parents and carers.
- Find out what type of physical activities children and young people enjoy, based on existing research or localconsultation (for example, some might prefer non-competitive or single-gender activities). Actively involve them in planning the resulting physical activities.
- Remove locally identified barriers to participation, such as lack of privacy in changing facilities, inadequate lighting, poorly maintained facilities and lack of access for children and young people with a disability. Any dress policy should be practical, affordable and acceptable to participants without compromising their safety or restricting participation.
- Provide regular local programmes and other opportunities for children and young people to be physically active in a challenging environment where they feel safe (both indoors and outdoors). Ensure these programmes and opportunities are well-publicised.
- Ensure physical activity programmes are run by people with the relevant training or experience.

## Recommendation 7 Leadership and instruction

### Who should take action?

Employers or supervisors of the above.

### What action should they take?

- Ensure informal and formal physical activity sessions for children and young people (including play) are led by staff or volunteers who have achieved the relevant sector standards or qualifications for working with children. This includes the requirements for child protection, health and safety, equality and diversity.
- Ensure staff and volunteers have the skills (including interpersonal skills) to design, plan and deliver physical activity sessions (including active play sessions) that meet children and young people's different needs and abilities. Those leading activities should make them enjoyable. The leaders should also be inspiring. They should raise children and young people's aspirations about what they can participate in – and the level of ability they can achieve. In addition, leaders should help foster children and young people's personal development.
- Use community networks and partnerships to encourage, develop and support local communities and volunteers involved in providing physical activities for children and young people.For recommendations on the principles of networking and partnership working, see 'Community engagement to improve health' (NICE public health guidance 9).
- Employers should provide regular and relevant development opportunities for employees and volunteers. The impact on practitioner performance and on children and young people's experiences should be monitored.

## Recommendation 8 Training and continuing professional development

### Who should take action?

Education and training organisations.

### What action should they take?

- Establish continuing professional development (CPD) programmes for people involved in organising and running formal and informal physical activities. The education and training should enable them to:
    - give children and young people information and advice on physical activity, taking into account their needs (for example, their developmental age, physical ability and any medical conditions they may have)

    - give children and young people confidence in their own abilities and motivate them to be physically active (this includes encouraging them to set goals, where appropriate)
    - understand the practical issues and problems that may discourage families or groups of children and young people from getting involved. (This may include, for example, time constraints, access issues – including accessibility for those with a disability – and the cultural appropriateness of activities)
    - develop and foster partnership working and get the local community involved.
- Monitor and evaluate the impact of training on practitioner performance.
- Train people to deliver physical activity CPD programmes.

## Recommendation 9 Multi-component school and community programmes

### Who should take action?

- Public, voluntary, community and private sector organisations involved in designing physical activity projects and programmes.
- Governors and heads of schools and colleges.

### What action should they take?

- Identify education institutions willing to deliver multi-component physical activity programmes involving school, family and community-based activities. Identify families, community members, groups and organisations and private sector organisations willing to contribute.
- Develop multi-component physical activity programmes. These should include:
    - education and advice to increase awareness of the benefits of physical activity and to give children and young people the confidence and motivation to get involved
    - policy and environmental changes, such as creating a more supportive school environment and new opportunities for physical activity during breaks and after school
    - the family: by providing homework activities which children and their parents or carers can do together, or advice on how to create a supportive home environment. (For example, advice on how they might help their child become involved in an activity.) It could also include school-based family activity days
    - the community: for example, by setting up family fun days and schemes such as 'Play in the park'.

## Recommendation 10 Facilities and equipment

### Who should take action?

Public, voluntary, community and private sector managers and decision-makers responsible for – or able to influence – opportunities for children to be physically active including:

- early years providers and carers of young children, including those involved with nurseries, playgroups and creches
- school governors, head teachers and teachers
- those working in children's centres.

### What action should they take?

- Ensure opportunities, facilities and equipment are available to encourage children to develop movement skills, regardless of their ability or disability (for a definition of movement skills see glossary).
- Provide children with access to environments that stimulate their need to explore and which safely challenge them. (Examples include adventure playgrounds, parks, woodland, common land or fun trails.) Also provide them with the necessary equipment. The aim is to develop their risk awareness and an understanding of their own abilities as necessary life skills.
- Ensure children have the opportunity to explore a range of physical activities to help them identify those they can enjoy by themselves and those they can do with friends and family.
- Provide daily opportunities for participation in physically active play by providing guidance and support, equipment and facilities. Keep children motivated to be physically active by updating and varying the way physical activities are delivered (including the resources and environments used).
- Ensure opportunities are available after school, at weekends, during half-term breaks and during the longer school holidays. Activities should be led by appropriately trained and qualified staff (paid or voluntary) and take place in schools and other community settings.

## Recommendation 11 Supporting girls and young women

### Who should take action?

Public, voluntary, community and private sector managers and decision-makers able to influence physical activity facilities, opportunities and programmes for girls and young women.

### What action should they take?

- Consult with girls and young women to find out what type of physical activities they prefer. Actively involve them in the provision of a range of options in response. This may include formal and informal, competitive and non-competitive activities such as football, wheelchair basketball, dance, aerobics and the gym. Activities may be delivered in single and mixed- gender groups.
- Offer school-based physical activities, including extra-curricular ones. Provide advice on self-monitoring and individually tailored feedback and advice.
- Address any psychological, social and environmental barriers to physical activity. For example, provide opportunities in easily accessible community settings with appropriate changing facilities offering privacy. Any dress policy should be practical, affordable and acceptable to participants without compromising their safety or restricting participation.

## Recommendation 12 Active and sustainable school travel plans

### Who should take action?

- Governors and heads of schools and colleges.
- Those involved in governing or leading pre-school and early years education.
- School travel advisers.

### What action should they take?

- Continue to encourage a culture of physically active travel (such as walking or cycling).
- Develop a school travel plan which has physical activity as a key aim, in line with existing guidance. Integrate it with the travel plans of other local schools and the local community (see recommendation 5). The aim is to encourage children and young people to choose physically active modes of travel throughout their school career.
- Ensure schools provide suitable cycle and road safety training for all pupils.
- Encourage children and young people, especially those who live within a 2-mile radius of their school or other community facilities, to walk, cycle or use another mode of physically active travel to get there.
- Work with local authorities to map safe routes to school and to local play and leisure facilities. Take into account the views of pupils, parents and carers and consult with the local community. Overcome any barriers that are identified (for example, a lack of secure cycle parking).
- Involve children and young people, their parents and carers, the local community and external agencies in implementing the school travel plan. Use a mix of measures to promote it (for example, walking buses, walk and bike to school days). Work with the local

authority school travel plan adviser to recruit volunteers on a long-term basis to help implement it.

- Set performance targets for school travel plans which are audited annually and which form part of delivery plans for local strategic partnerships. Remedial action should be taken when agreed targets are not reached.
- Develop parents' and carers' awareness of the wider benefits of walking and cycling and other physically active modes of travel. For example, explain how it can improve children and young people's movement skills, social wellbeing, self-confidence and independence. Also explain how it can help children to explore and become more familiar (and at ease) with their local environment while, at the same time, being physically active.

## Recommendation 13 Helping children to be active

### Who should take action?

- Children's centre staff.
- Early years providers such as playgroup (creche) leaders and child minders.
- Parents and carers.
- Teachers and school support staff.
- Those providing local opportunities for physical activity in the voluntary, community and private sectors.

### What action should they take?

- Provide a range of indoor and outdoor physical activities for children on a daily basis, including opportunities for unstructured, spontaneous play.
- Tailor activities according to the child's developmental age and physical ability. Ensure they are inclusive, progressive and enjoyable. The activities should develop the child's movement skills (such as crawling, running, hopping, skipping, climbing, throwing, catching and kicking a ball). Children should also experience more advanced activities such as swimming, cycling, playing football and dancing.
- Provide opportunities at intervals throughout the day in pre-school establishments; during playtimes and lunch breaks at school; as part of extra-curricular and extended school provision; and during leisure time (including weekends and holidays) in wider community settings and the private sector.
- Help children identify activities they can enjoy by themselves and those they can enjoy with their friends and families.

## Recommendation 14 Helping girls and young women to be active

**Who should take action?**

Practitioners who lead physical activities including youth leaders, teachers, coaches and volunteers.

**What action should they take?**

- Support participants of all abilities in a non-judgemental and inclusive way. Emphasise the opportunities for participation, enjoyment and personal development, rather than focusing on the evaluation of performance.
- Encourage those who initially choose not to participate to be involved with physical activities in other ways. Help them move gradually towards full participation.
- Encourage a dress code that minimises their concerns about body image. It should be practical, affordable and acceptable to them, without compromising their safety or restricting participation.
- Provide appropriate role models.

## Recommendation 15 Helping families to be active

**Who should take action?**

Groups and individuals who have regular contact with children, young people, their parents and carers including:

- health practitioners
- local authority personnel
- physical activity professionals in the public and private sector
- teachers and early years providers
- volunteers and staff from community organisations.

**What action should they take?**

- Ensure parents and carers are aware of government advice that children and young people should undertake a minimum of 60 minutes moderate to vigorous physical activity a day. Make them aware that, at least twice a week, this should include activities to improve bone health, muscle strength and flexibility.
- Provide information and advice on the benefits of physical activity, emphasising how enjoyable it is. Provide examples of local opportunities.
- Encourage parents and carers to get involved in physical activities with their children.
- Encourage parents and carers to complete at least some local journeys (or some part of a local journey) with young children using a physically active mode of travel. This should take place on most days of the week. The aim is to establish physically active travel (such

as walking or cycling) as a life-long habit from an early age. Parents and carers should also be encouraged to allow their children to become more independent, by gradually allowing them to walk, cycle or use another physically active mode of travel for short distances.

- Act as a role model by incorporating physical activity into daily life. For example, opt for travel involving physical activity (such as walking or cycling), use the stairs and regularly participate in recreational activities or sport.
- Promote physically active travel as an option for all the family. Raise awareness of how it can help children and young people achieve the recommended daily amount of physical activity.

## Appendix 2: Full wording of recommendations from NICE public health guidance 47: Managing overweight and obesity among children and young people: lifestyle weight management services

### Recommendation 1 Planning lifestyle weight management services for children and young people

#### Who should take action?

- Directors of public health and public health teams working on obesity and child health and wellbeing.
- Health and wellbeing boards.
- Local authority commissioners.
- Clinical commissioning groups.
- NHS England.
- Public Health England.
- Children's services.

#### What action should they take?

- Ensure family-based, multi-component lifestyle weight management services for children and young people are available as part of a community-wide, multi-agency approach to promoting a healthy weight and preventing and managing obesity. These services should contain the core elements described in recommendation 3. They should be provided as part of a locally agreed obesity care or weight management pathway.
- Dedicate long-term resources to support the development, implementation, delivery, promotion, monitoring and evaluation of these services. See recommendation 7 in Obesity: working with local communities (NICE public health guidance 42) and principle 7 in Behaviour change (NICE public health guidance 6).
- Use data from the joint strategic needs assessment and the National Child Measurement Programme to identify local need. See recommendation 1 in Obesity: working with local communities (NICE public health guidance 42).

### Recommendation 2 Commissioning lifestyle weight management programmes for children and young people

Who should take action?

- Directors of public health and public health teams working on obesity and child health and wellbeing.
- Health and wellbeing boards.

- Local authority commissioners.
- Clinical commissioning groups.
- NHS England.
- Public Health England.
- Children's services.

**What action should they take?**

- Identify needs using the joint strategic needs assessment. Use community engagement techniques with local families to identify any barriers and facilitators discouraging or encouraging the uptake and completion of programmes.
- Commission lifestyle weight management services to meet the needs of local children and young people, including those of different ages, different stages of development and from different cultural backgrounds. Services should be in line with the health and wellbeing strategy.
- Consider how best to provide services for overweight or obese children and young people with special needs or disabilities. For example, through specific programmes where these are available. Or by making reasonable adaptations to mainstream programmes (including training staff) and evaluating them. Ensure there is an appropriate interface with specialist obesity services to help those with more complex needs manage their weight.
- Ensure all lifestyle weight management programmes are designed and developed with input from a multidisciplinary team and have taken into account the views of children, young people and their families. The team should include professionals who specialise in children, young people and weight management. These include the following:
    - a state registered dietitian or registered nutritionist
    - a physical activity specialist
    - a behaviour-change expert, such as a health promotion specialist (for physical activity, a sport and exercise psychologist may be appropriate)
    - a health or clinical psychologist, or a child or adolescent psychiatrist, to provide expertise in mental wellbeing
    - a paediatrician or paediatric nurse.
- Ensure programme content is regularly reviewed and updated by the multidisciplinary team.
- Ensure providers can demonstrate that staff are trained to deliver the specific programme commissioned and are experienced in working with children, young people and their families.

- Ensure sufficient resources are dedicated to monitoring and evaluation.
- Ensure there are clearly defined programme objectives, outputs, outcomes and monitoring and evaluation requirements in programme specifications and in contracts. Contracts should also specify any at-risk groups that should be targeted, such as black and minority ethnic groups, or children and young people from low income families or neighbourhoods.
- Ensure key performance indicators are agreed with programme providers, including the proportion of sessions that must be attended to complete the programme (see recommendation 15).
- Ensure the contract or programme specification requires that height and weight are measured and that both BMI and BMI for age and gender (BMI z score) are recorded. All children and young people should be measured at the following times:
    - at recruitment to the programme
    - at completion of the programme
    - 6 months after completing the programme
    - 1 year after completing the programme.

### Recommendation 3 Lifestyle weight management programmes: core components

#### Who should take action?

- Providers of lifestyle weight management programmes.

#### What action should they take?

- Ensure all lifestyle weight management programmes for overweight and obese children and young people are multi-component. They should focus on:
    - diet and healthy eating habits
    - physical activity
    - reducing the amount of time spent being sedentary
    - strategies for changing the behaviour of the child or young person and all close family members.
- Ensure the following core components, developed with the input of a multidisciplinary team (see recommendation 2) are included:
    - Behaviour-change techniques to increase motivation and confidence in the ability to change. This includes strategies to help the family identify how changes can be implemented and sustained at home.

- Positive parenting skills training, including problem-solving skills, to support changes in behaviour.
- An emphasis on the importance of encouraging all family members to eat healthily and to be physically active, regardless of their weight.
- A tailored plan to meet individual needs, appropriate to the child or young person's age, gender, ethnicity, cultural background, economic and family circumstances, any special needs and how obese or overweight they are. This should include helping them and their family to set goals, monitor progress against them and provide feedback (see recommendation 4).
- Information and help to master skills in, for example, how to interpret nutritional labelling and how to modify culturally appropriate recipes on a budget.
- Help to identify opportunities to become less sedentary and to build physical activity into their daily life (for example, by walking to school and through active play).
- A range of physical activities (such as games, dancing and aerobics) that the children or young people enjoy and that can help them gradually become more active.
- Information for family members who may not attend the programme itself to explain the programme's aims and objectives and how they can provide support.
- Ongoing support and follow-up for participants who have completed the programme.

### Recommendation 4 Developing a tailored plan to meet individual needs

**Who should take action?**

- Providers of lifestyle weight management programmes.

**What action should they take?**

- Assess each child or young person for obesity-associated diseases or conditions (comorbidities). Use a locally approved comorbidities assessment tool, where available. Assessment is particularly important if the child or young person and their family have self-referred to the programme, or have not been assessed by a health professional. Refer them to their GP if any concerns are identified.
- Identify whether the child or young person's mental wellbeing is affected by their weight. For example, whether there are any signs of psychological distress, depression, bulimia, self-harming or other mental health problems related to their weight.

- Identify whether their weight is a consequence of circumstances that have affected their mental wellbeing. (For example, if they have experienced bereavement or have caring responsibilities.)
- If concerns about their mental wellbeing are identified refer the child or young person to their GP for assessment and treatment and, if appropriate, for onward referral to child and adolescent mental health services (CAMHS). (Note: such concerns may be identified at any stage of a weight management programme.)
- Take account of the child or young person's self-esteem, self-perception and any previous attempts to manage their weight. Provide opportunities, in either a group or one-to-one session, for them to talk about any victimisation or distress if they wish. (This includes any history of bullying or teasing.)
- Find out whether the family recognises that their child is overweight or obese and the potential benefits of managing their weight. Discuss the family's history of attempts to manage their weight, and their existing knowledge of, and attitudes towards, food, physical activity and the amount of time spent being sedentary.
- Weigh, measure, determine and record the child or young person's BMI. Offer to do the same for parents, carers and other family members. Measurements should be undertaken by staff who have been trained using standard protocols (see recommendation 11).
- They should use validated, transportable instruments that are regularly calibrated.
- Emphasise that the programme may benefit the whole family. In addition, offer information about local lifestyle weight management services to adult family members who are overweight or obese.
- Encourage children and young people from around the age of 12 (depending on their ability and stage of development) to monitor their eating, physical activity and any sedentary behaviour. For example, encourage them to keep a record of time spent watching television or playing computer games, and what they snack on and when, to identify areas that need addressing. For younger children, parents and carers should monitor these behaviours, with the involvement of the child according to their age and stage of development.
- Work with children from around the age of 12 (depending on their ability and stage of development) to identify situations in which it would be possible for them to eat more healthily or to become less sedentary and more active. For example, this might involve gradually reducing TV viewing at certain times and replacing this with more active pastimes. Work with the parents and carers of younger children to achieve the same.
- Aim to gradually increase the amount of moderate to vigorous-intensity physical activity programme participants do every day. Focus on activities they enjoy and that are easily

accessible. This includes activities that can be built into daily life, such as active play, walking or cycling. Aim to achieve the age-specific UK physical activity guidelines.

- Agree dietary changes that are age-appropriate, affordable, culturally sensitive and consistent with healthy eating advice. Ensure nutrient needs for growth and development are met by including healthier choices, in appropriate amounts, from each of the food groups (see NHS Choices Eatwell plate). Changes to diet should take into account the child or young person's likes and dislikes.
- Manage expectations of what can be realistically achieved over the duration of the programme. Small but realistic goals should be mutually agreed with the child or young person and their family. These should relate to goals that they value and that motivate them to attend.
- Work with participants and their families to regularly monitor progress against the goals and provide feedback. Praise progress and achievements and update the goals as the child or young person progresses through the programme. If they do not meet their goals, discuss the possible causes for this and modify them if necessary.
- Stress the importance of maintaining changes, no matter how small, over the longer term. Encourage participants to take up offers of ongoing support (see recommendation 10).

### Recommendation 5 Encouraging adherence to lifestyle weight management programmes

#### Who should take action?

- Providers of lifestyle weight management programmes.

#### What action should they take?

- Offer programmes to groups of children or young people and their families. Where necessary, offer programmes to individual families, if this better meets their needs and preferences. For example, some families may prefer to attend individual sessions initially and attend group sessions as their confidence and self-esteem grows.
- Offer a range of programmes for children and young people of different ages and at different stages of development. If group sessions are offered, work with groups of peers and their parents or carers. Note, some adolescents may respond better to programmes if their sessions are separate from those for their parents and carers.
- Offer programmes in venues that have the necessary facilities, are easily accessible and where the child or young person and their family feel comfortable. For example, use

local community venues that have space for physical activities or games, and that can be reached quickly and easily by walking, cycling or using public transport.

- Offer programmes at a range of times that are convenient for families with children of different ages and for working parents and carers. For example, some sessions could be offered in the evenings or at weekends.
- Adopt a flexible approach so that participants can accommodate other commitments. They may also prefer to attend programmes more frequently initially and less frequently as their skills and confidence in making changes grows. For example, use rolling programmes that allow participants to start at different points and cover the same material but not necessarily in the same order.
- Emphasise the importance of parental (or carer) support and their commitment to adhere to the programme. Stress that this support and commitment should extend beyond the duration of the programme itself and that outcomes will be reviewed for at least the first year after completion.
- Maintain regular contact with participants. Promptly follow up those who miss sessions to establish why and to restore commitment. Focus on participants from disadvantaged groups and those who miss sessions early on in the programme.
- Try to retain the same team of staff throughout each cycle of the programme.

### Recommendation 6 Raising awareness of lifestyle weight management programmes: commissioners and programme providers

#### Who should take action?

- Directors of public health and their teams.
- Local authority commissioners.
- NHS commissioners.
- NHS and local authority communications teams.
- Providers of lifestyle weight management programmes.

#### What action should they take?

- Local authorities should ensure an up-to-date list of local lifestyle weight management programmes for children and young people is maintained. This should form part of a list of services commissioned for the local obesity care or weight management pathway. It should be regularly disseminated, or accessible to organisations in the public, community and voluntary sectors.

- Use children's centres, libraries, the local media, professional and voluntary organisations working with children and young people and schools to raise awareness of lifestyle weight management programmes. Any publicity should clearly describe:
    - who the programme is for (age range, any eligibility criteria and the level of parental involvement needed)
    - how to enrol (including whether participants can self-refer or need a formal referral from a health professional)
    - programme aims
    - type of activities involved (to alleviate any anxieties about the unknown and to ensure expectations are realistic): 'healthy living' and any fun aspects should be emphasised
    - time and location, length of each session and number of sessions.
- Commissioners, public health teams and providers should raise awareness of the programmes among health professionals who may refer children and young people. This includes GPs and staff involved in the National Child Measurement Programme and the Healthy Child Programme. For example, the programme could be publicised through health professional networks and by offering training sessions on the programmes and how to make referrals.

### Recommendation 7 Raising awareness of lifestyle weight management programmes: health professionals, other professionals and voluntary organisations

#### Who should take action?

- Health professionals, in particular, GPs, dietitians, health visitors, school nurses and those involved in delivering the National Child Measurement Programme and the Healthy Child Programme.
- Schools, colleges, early years organisations, children's centres and looked-after children's teams and other professionals who work with children and young people. For example, youth workers, social workers, and pastoral care workers.

#### What action should they take?

- Health professionals should tell the parents or carers of children and young people who have been identified as being overweight or obese about local lifestyle weight management programmes. They should explain what these involve and how they can take part (including whether or not they can self-refer).

- Other professionals who work with children and young people should raise awareness of lifestyle weight management programmes for overweight and obese children and young people. They should also raise awareness of how to enrol on them.

### Recommendation 8 Formal referrals to lifestyle weight management programmes

#### Who should take action?

- Children's community nurses, dietetic teams, GPs, health visitors, primary care teams, obesity specialists, paediatricians, school nurses and school healthcare teams.

#### What action should they take?

- Where there are concerns about a child or young person's weight, weigh them in light clothing on clinically approved, regularly calibrated scales. In children older than 2 years, measure their height using a stadiometer. (See the Standard evaluation framework for weight management interventions page 32, for practical advice on weighing and measuring children).
- Use the UK growth charts for children aged 4 years and older to determine BMI centile for their age and gender. Use the UK-WHO 0–4 years growth chart to determine if children younger than 4 are a healthy weight. Record this in the child or young person's health record.
- Take account of their BMI centile, any obesity-associated diseases or conditions (comorbidities) they may have, or family medical history, and any psychosocial considerations, to determine whether referral to a lifestyle weight management programme is clinically appropriate.
- Use tact and diplomacy to find out if the family and the child or young person accepts that the child or young person is overweight or obese. If they do accept this and it is clinically appropriate to refer them to a lifestyle weight management programme, explain the potential benefits they will gain – and the risks of not addressing their child's weight. In addition:
    - identify and address any fears or concerns the child, young person or their family may have about attending (for example, fears of being the largest child on the programme, of having to do very strenuous activities, or being stigmatised for attending)
    - give the family information about the programme, or tell them where they can get this information

    - explain what can be realistically expected in terms of results over the duration of the programme itself (for example, explain that for growing children, maintaining their existing weight may be a realistic short-term aim)
    - explain that the more sessions of a programme they attend, the greater the likelihood of success.
- Assess whether the child or young person and their family are ready and willing to be referred. If they are ready, refer them to an effective lifestyle weight management programme (see recommendation 3).
- If the family is not ready to attend a programme:
    - tell them how they can enrol in the future (including the fact that they can self-refer if this is possible)
    - offer a follow-up appointment in 3 or 6 months, according to their preference
    - provide them with, or point them to, information and advice on healthy eating, physical activity and how to reduce sedentary behaviour (examples include: the NHS Choices Eatwell plate, UK physical activity guidelines and the Change4Life website).
- If children or young people need specialist support to manage their weight, refer them to specialist obesity services (if available) or to paediatric services.
- If there are concerns about the child or young person's mental wellbeing related to their weight, use the local pathway to refer them to CAMHS. Ensure their GP is informed.

### Recommendation 9 Providing ongoing support: health professionals

#### Who should take action?

- Children's community nurses, dietetic teams, GPs, health visitors, members of primary care teams, obesity specialists, paediatricians and school nurses and school healthcare teams.

#### What action should they take?

- Health professionals should use feedback from the programmes to help regularly monitor progress and provide ongoing support. They should acknowledge that:
    - for children who are growing taller, avoiding further weight gain is a realistic short-term aim that can have a positive impact in the longer term
    - for young people who are no longer growing taller, ultimately they need to lose weight to improve their BMI, and they should also aim to acquire the knowledge and skills they need to make long-term behaviour changes

    - it is important to maintain changes in behaviour once the programme is completed
    - improvements in diet and physical activity can have positive health benefits, independent of any effect on weight or BMI
    - improvements in psychosocial outcomes (such as sense of wellbeing, self-efficacy, self-esteem and self–perception) are considered important health benefits for overweight and obese children and young people.
- After the programme has been completed, health professionals should continue to monitor the child or young person's BMI centile when the opportunity arises and at 6 months and 1 year after they complete the programme.
- If the child or young person's BMI centile begins to increase, or if they or their parents or carers express concerns about their weight (or sustaining changes in their behaviour), discuss the possible causes. If necessary, consider another referral to the same or an alternative lifestyle weight management programme that may better address the needs of the family. Or consider referral to specialist obesity services (if available), or to a paediatrician.

### Recommendation 10 Providing ongoing support: lifestyle weight management programmes

#### Who should take action?

- Providers of lifestyle weight management programmes.

#### What action should they take?

- With the participants' consent, providers should send feedback to their referring GP or healthcare professional.
- Offer all participants ongoing support when they have completed the programme. This support should be offered for at least the first year and longer, if possible, depending on the family's needs. Offer a range of options including follow-up sessions at different times and in easily accessible and acceptable venues.
- Tell participants about local services and activities that may provide further support to help them manage their weight, for example, local leisure services and walking or cycling groups.

### Recommendation 11 Lifestyle weight management programme staff: training

#### Who should take action?

- Providers of lifestyle weight management programmes.

**What action should they take?**

- Ensure staff are trained to deliver the weight management programme they will be working on. Ensure the training has been developed with the input of, and is regularly reviewed by, a multi-disciplinary team of professionals (see recommendation 2). Ensure staff training needs are regularly reviewed and addressed.
- Ensure programme staff treat overweight and obese children, young people and their families with empathy, by making them aware of:
    - the reasons why some children and young people may have difficulty managing their weight
    - the experiences they may face in relation to their weight
    - the anxieties they and their families may have about attending the programme
    - the way in which obesity is perceived by different communities
    - the issues they may need to consider to ensure activities are culturally acceptable.
- Train staff:
    - to accurately measure and record height and weight and to determine BMI centile using age- and gender-specific charts
    - to help parents and carers recognise that their child is overweight or obese and the benefits of addressing their weight
    - to use a locally approved comorbidities assessment tool, where available, to determine whether lifestyle weight management programmes are appropriate, or whether they should see their GP for a referral to a specialist obesity service or other specialist services (for example, paediatric services)
    - to identify any concerns about a child or young person's mental wellbeing and how to refer them to their GP for onward referral to CAMHS
    - in how to comply with statutory requirements and local policies relating to safeguarding and information governance.

## Recommendation 12 Lifestyle weight management programme staff: knowledge and skills

**Who should take action?**

- Providers of lifestyle weight management programmes.

**What action should they take?**

- Ensure staff have the necessary knowledge and skills to deliver multi-component programmes to children, young people and their families. This includes knowledge and

skills in relation to: childhood obesity management, diet and physical activity. It may also include training in behaviour-change techniques and psychological approaches (for example, motivational interviewing).

- Ensure there are staff available who can provide parenting skills training. Also ensure there are staff trained in practical food preparation.
- Ensure staff are able to empathise and communicate effectively with the family. They should be able to work collaboratively with them and tailor interventions for individual needs. They should also be able to lead group work and set an appropriate pace when delivering the programme. In addition, they should be able to judge when changes in behaviour have become embedded, before introducing further changes.
- Ensure staff can review progress and provide constructive feedback. They should be able to help children, young people and their families to identify possible reasons for relapse and use problem-solving techniques to address these.
- Identify any gaps in staff knowledge or skills (or a lack of confidence). Address any gaps through training.

### Recommendation 13 Training in how to make referrals to a lifestyle weight management programme

#### Who should take action?

- Employers.
- Professional bodies responsible for setting competencies and designing continuous professional development programmes for health professionals.

#### What action should they take?

Ensure health professionals:

- Understand why some children and young people may have difficulty managing their weight and the experiences that they may face in relation to their weight.
- Are aware of how obesity is viewed in different cultures and the issues they may need to consider to ensure any recommended activities are culturally acceptable. See Promoting physical activity for children and young people (NICE public health guidance 17).
- Can accurately measure and record height and weight and determine BMI centile, using age- and gender-specific charts.
- Can raise the issue of weight management confidently and sensitively. They should be able to help parents and carers identify when their child is overweight or obese and understand the benefits of addressing their weight.

- Are familiar with the local obesity care or weight management pathway and any locally approved comorbidities assessment tools.
- Can assess whether referral to a lifestyle weight management service is appropriate, or whether they should be referred to specialist obesity services or other specialist services (for example, paediatric services).
- Can identify suitable lifestyle weight management programmes for children, young people and their families and can provide them with information and ongoing support (see recommendations 9 and 10).

### Recommendation 14 Supporting lifestyle weight management programme staff and those making programme referrals

#### Who should take action?

- Employers of staff working on, or referring children and young people to, lifestyle weight management programmes.
- Providers of lifestyle weight management programmes.

#### What action should they take?

- If those involved in referring to, or delivering, lifestyle weight management programmes lack the confidence and skills to discuss weight management, offer them support and training.
- If staff identify that the reason for their lack of confidence is a result of being overweight or obese themselves, offer them access to weight management programmes.

### Recommendation 15 Monitoring and evaluating programmes

#### Who should take action?

- Directors of public health and public health teams working on obesity and child health and wellbeing.
- Health and wellbeing boards.
- Local authority commissioners.
- Clinical commissioning groups.
- NHS England.
- Providers of lifestyle weight management programmes.

#### What action should they take?

- Ensure monitoring focuses on sustaining changes in the longer term. Include the following in the data reported:

    - numbers recruited, percentage completing the programme and percentage followed up at 6 months and at 1 year after completing the programme
    - for all those recruited, BMI and BMI z score a) at recruitment to the programme b) at completion of the programme c) 6 months after completing the programme and d) 1 year after completing the programme.
- Ensure other measured outcomes reflect the aim of the programme and relate to factors that can support or contribute towards a reduction in BMI. These could include: improvements in diet and physical activity, a reduction in sedentary behaviour and improvements in self-esteem. (See Standard evaluation framework for weight management interventions for examples of other possible outcome measures.)
- Ensure data collection tools are validated for the age range or population group the programme addresses and are feasible and affordable in practice settings. Do not rely on self-reported measures of height or weight, or interpretations of BMI based on them.
- Monitor any variation in the numbers recruited, numbers completing and the proportion of people retained by the programme, according to population subgroup.
- Collect data on:
    - Variations in outcomes, according to age, gender, ethnicity and socioeconomic status (for example, as indicated by the postcode of participants), so that the impact on health inequalities can be assessed.
    - The route through which participants were referred to programmes including any self-referrals. Use this information to identify areas where awareness of available programmes is low and where referral rates might be increased.
    - The views of participants: areas they found helpful and areas for improvement. Ensure the views of everyone who has participated are collected (including those who did not complete the programme).
    - The views of staff delivering the programme and of those referring participants to it. Use the information to identify any practical or process issues that may need addressing.
- Commissioners should evaluate the service using data on outcomes and the cost of promotion and delivery.
- Commissioners should regularly review monitoring and evaluation data and use it to amend and improve the service.

## Appendix 3: Suggestions from stakeholder engagement exercise

| ID | Stakeholder | Suggested key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| 1 | SCM1 | Family involvement and commitment in the individuals intervention | There will be positive reinforcement and support when the individual is away from programme support. | If the family have an invested interest in the intervention and an increased understanding of the programme, there is less chance of outside sabotage and negative intervention, Improving the programmes chance to succeed. | Please see reccomendation1 in the recent public health guidance from NICE relating to Managing overweight and obesity among children and young people: lifestyle weight management services |
| 2 | SCM1 | Providing an ongoing support | Young people and children have a wide variety and often changing set of needs, If the support is ongoing the individual will be able to access support alongside the changes in their lives. | Ongoing support is likely to reduce rates of relapse and cement the programmes objectives of changing the individuals behaviour towards food. | Please read an article Slimming world has produced explaining how the type of support they provide changes behaviour in a positive impact towards weight loss and control. |
| 3 | SCM1 | Accessible locations | Locations which the individual has a familiarity with will increase uptake and improve consistent attendance by making them feel comfortable. | If the programme can cause as little disruption to the individuals' regular life pattern as possible then attendance should be positively impacted. | |
| 5 | SCM1 | Empathetic and well informed instructors. | The instructors of the programme not only present the programme but they act as a role model to the individuals partaking in the programme. | If the individual feels inspired and motivated by the instructor attendance and adherence to the program will follow. | Niki Welds publication on "HELD" helps explain how children relate well to empathy and can improve communications towards younger people. |
| 6 | SCM1 | Information | The problem of obesity holds a lot of ignorance from where to get help to the understanding of being overweight. | If more literature and resources outside of the programme is made freely accessible, awareness around the subject will be improved. Self referrals could increase along with commitment to the programmes as they become "normalised" | |

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|---|---|---|---|---|---|
| 7 | SCM2 | 1. IDENTIFYING OVERWEGHT AND OBESITY AND RAISING THE ISSUE<br>Health professionals should consistently identify overweight/obesity and sensitively raise the issue of weight, provide brief advice and signpost / refer to appropriate interventions.<br>For example:<br>• First Year of life - Health Visitors weigh and measure children and calculate bmi centile, and raise the issue with new mums<br>• 24-month measure of children's bmi centile is done by the Health Visitor and the issue of weight (if necessary) is raised<br>• Pregnancy - it to become standard practice for midwives to recommend a healthy diet and physical activity | PH47 recommends that health professionals sensitively raise issue of weight, measure children and refer to lifestyle weight management programmes where appropriate | Evidence suggests that health professionals are not consistently identifying overweight or obesity, raising the issue with adults or children, or advising patients to lose weight. Fear of damaging relationships with patients may be a reason, but not raising the issue gives message that there is no problem, and parents expect it to be raised, and the advice may lead to a decision to take action.<br>I have pasted links to a variety of papers (NOT a systematic or exhaustive list!) illustrating the concerns highlighted above. | http://bmjopen.bmj.com/content/3/11/e003693.full<br>http://www.ncbi.nlm.nih.gov/pubmed/17263929<br>http://adc.bmj.com/content/early/2014/01/15/archdischild-2013-304090.abstract<br>http://www.biomedcentral.com/1471-2296/14/152<br>http://www.ncbi.nlm.nih.gov/pubmed/22735070<br>http://www.biomedcentral.com/1471-2296/12/54<br><br>IHV guidelines – containing evidence summaries for midwifery and HV practice regarding raising issue; monitoring etc |
| 8 | SCM2 | 2. EARLY WEANING<br><br>Early weaning on to solid food on to solid food should be avoided | High energy and protein intake from 2-12 months of age is associated with higher BMI in later childhood | More needs to be done to promote not weaning babies early by both Health Visitors and the children's workforce. | Health Visitor guidelines – containing evidence summaries for midwifery and HV practice re weaning advice etc<br>Pearce, J. and S.C. Langley-Evans, The types of food introduced during complementary feeding and risk of childhood obesity: a systematic |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | review. Int J Obes (Lond), 2013. Escribano, J., et al., Effect of protein intake and weight gain velocity on body fat mass at 6 months of age: the EU Childhood Obesity Programme. Int J Obes (Lond), 2012. **36**(4): p. 548-53. |
| 9 | SCM2 | 3. PHYSICAL ACITVITY Physical Activity should be promoted in child-care settings, it becoming a daily part of nursery / school routine | Links between sedentary lifestyle, physical activity and childhood obesity are well documented | A large proportion of children and young people are not meeting recommended levels of physical activity. This is important, not just in terms of overweight and obesity, but also for long term health. | |
| 10 | SCM3 | Recording & monitoring of weight status in children & young people. | Data from National Child Measurement Programme is useful in helping to target weight management services for children & families. Weighing and measuring post-NCMP would increase our understanding of the links between childhood and adult obesity and the long-term risks to health faced by overweight and obese children, as well as the impact of public health policies on prevalence. | Beyond the age of 10-11 years (when prevalence of overweight and obesity is already approx. a third), there is no programme for monitoring & recording. In addition BMI is not necessarily routinely recorded within general practice, even in adults. | NCMP (National Child Measurement Programme) website for annual reports on prevalence of overweight and obesity in England: http://www.hscic.gov.uk/ncmp<br><br>NOO (National Obesity Observatory) website: http://www.noo.org.uk/ |
| 11 | SCM3 | Equitable provision of effective weight management services for children & young people. | Links between obesity & ill health are demonstrable, and there is an increased risk of overweight tracking into adulthood the older the overweight child, and the more severe the obesity. There is a duty of care to manage a diagnosed clinical condition, and an ethical responsibility to provide services where needed. | Current provision across the country appears to be variable, both for adults or children, regardless of the prevalence of obesity. Current spend on weight management services for children and young people reported from 109 local authorities is 0.9% of public health allocation (total spend on weight management services 2.5% of public health | HOOP (Helping Overcome Obesity Problems) report 'Tackling obesity: all talk, no action'. Available from: http://www.hoopuk.org.uk/<br><br>NCMP (National Child Measurement Programme) website: http://www.hscic.gov.uk/ncmp |

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| | | | | allocation). Lack of services has the potential to increase health inequalities given the increased prevalence of obesity in lower socioeconomic groups.. | |
| 12 | SCM3 | Recommendation for inclusion of cookery, food purchasing on a budget, food storage and weight management as a mandatory part of the school curriculum. | 'Knowing' and 'doing' are not the same, and effective weight management requires skills. Many of the most at-risk children may have least opportunity to gain these skills at home, and embedding them within the mandatory curriculum will ensure that all children had equal access throughout their school years. | In terms of prevention of obesity, the development of skills in addition to provision of information, is crucial. Although cookery is to become mandatory in the National Curriculum for Key Stages 1-3 from 2014, this will apply only to state schools, but not to free schools, academies or the private sector. In addition, safe food storage can reduce food waste; and shopping on a budget will be particularly important for those at high risk of developing obesity (i.e. lower socioeconomic groups). An understanding of healthy weight management is vital for all. | DfES National Curriculum guidance on Design and Technology which includes cookery: https://www.gov.uk/government/publications/national-curriculum-in-england-design-and-technology-programmes-of-study/national-curriculum-in-england-design-and-technology-programmes-of-study<br><br>School Food Plan: http://www.schoolfoodplan.com/plan/ |
| 13 | SCM3 | Provision of a healthy environment, including the sale & marketing of unhealthy foods and drinks, in particular in local authority venues including state schools. | The role of the obesogenic environment is documented both as a potential cause of obesity and a factor in maintaining an unhealthy weight. | Local authority venues may provide opportunities for physical activity but often also offer unhealthy foods and drinks in canteens and vending machines. With the move of public health into the local authority this represents an important and avoidable conflict. | NOO (National Obesity Observatory) website: http://www.noo.org.uk/<br><br>Foresight report 'Tackling Obesities -Future Choices (2007): http://www.bis.gov.uk/assets/foresight/docs/obesity/17.pdf |
| 14 | SCM4 | Improved transparency and explanation for local intervention commissioning. | Too many local interventions are commissioned without robust evidence of efficacy, population acceptability or good levels of retention. Almost none has data published in peer reviewed | Effectiveness and value for money need to be demonstrated. | http://www.noo.org.uk/core/eval_collection |

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| 15 | SCM4 | Improved reporting by local interventions of take up (% of available places taken up, retention and primary outcome which should be weight related such as change in BMI) | Many commissioned services report what is in place without reporting the key outcomes. Would probably require a registry of outcomes that could be analysed on a yearly basis to identify effective and non-effective interventions. | Effectiveness and value for money need to be demonstrated. | If you look at interventions registered on NOO website there are very few and even less with published outcome data.<br><br>http://www.noo.org.uk/sefsearch.php?q307=&q276=687&q279=699&q282=&search=Search |
| 16 | SCM5 | Physical activity | Physical activity is recommended in NICE guidance (PH8, PH17). These recommendations suggest that children engage in 60 min of moderate to vigorous activity per day, engage in muscle strengthening activities 3 times per week.<br>Recent CMO guidance also recommended reducing sedentary time | A significant number of children are insufficiently active and spend large amount of time sedentary (HSE 2008). Physical activity levels are lower and sedentary time higher in children who are not a healthy weight. | CMO Report: Start Active Stay Active July 2011. |
| 17 | Association of School and College Leaders | Control of the advertising of high-fat, high-sugar, high-salt food to children. | | A huge budget is devoted to persuading children to eat such undesirable food, which has a direct effect and also establishes habits of eating that contribute to obesity. | |
| 18 | Association of School and College Leaders | Education of parents in the production of quick, cheap, attractive and healthy food for their children. | | Many families feel that they do not have the time, money or expertise to cook food from basic ingredients and so rely on prepared food that is often high in saturated fat, sugar and salt. | |
| 19 | Association of School and College Leaders | Food labelling. | | This remains too complex and difficult for many. Prepared meals, snacks and confectionary that are high in fat, sugar or salt should be clearly marked as undesirable | |

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| | | | | from a health point of view. | |
| 20 | Royal College of Paediatrics and Child Health | Children and Young People with disabilities (esp neurodisabilities), must receive special consideration. | Morbidity and mortality is higher from obesity in children and young people with disabilities who are more prone to obesity and in whom obesity may be a specific feature of the syndrome or condition (e.g. Prader Willi syndrome or comfort eating in those with significant learning difficulties or abnormal eating behaviour in autistic spectrum disorders. | Failure to consider the special circumstances of children and young people with disabilities raises equality issue concerns. These children and young people find it more difficult to access weight control programmes, so these need to be adapted to their needs (including their often limited physical activity). Special schools are excluded from the national childhood growth measurement survey and whilst it is accepted that growth parameters may be more difficult to measure readily in those with disabilities, it is important to survey this vulnerable group of the population. | Obesity and disability<br>Children and young people<br>Public Health England<br>Published March 2014 PHE publications gateway number: 2013436 |
| 21 | Fit for sport | Daily activity | Daily activity for all children is a must if we are to affect our current situation. It is not that hard but has been way over complicated! | Education on what activities, foods to try and avoid but more importantly (SAS) advice that is Simple, achievable and Sustainable need to be given. We must stop giving messages that confuse and advice we all need to go to the gym, eat fruit and vegetables for the rest of our lives.. we do not but need to show them how! | We delivered an active schools programme, please see amazing results! |
| 22 | Slimming World | All health professionals and weight management providers should use age specific BMI charts | Age specific BMI charts take into account the fact that the young person is still growing. This is vital to ensure that appropriate support and advice is being given to young people with regards to suggested weight change/targets. | The use of these charts is important to ensure that age appropriate advice is being given to young people/adolescents. In our service we use these charts routinely yet regularly come across primary health care professionals who are not familiar | The charts are available at http://www.fph.org.uk/uploads/HealthyWeight_SectE_Toolkit04.pdf |

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| | | | | with the charts and are still using adult definitions of BMI for overweight and obesity. | |
| 23 | Slimming World | All young people accessing support for their weight should have their height monitored on a 3 monthly basis. | Small changes in height can impact on a young person's BMI and health status. Also important to ensure that any weight management programme undertaken by a young person does not impact on their expected linear growth. | Regular checks in height are key to ensure that up to date and appropriate advice is given and that suitable praise is given where a young person has remained weight stable yet grown in height (thus having a positive impact on BMI status). | The charts are available at http://www.fph.org.uk/uploads/HealthyWeight_SectE_Toolkit04.pdf |
| 24 | Slimming World | Age specific advice and targets for physical activity should be used | The advice for under 18's in terms of activity is different than that for adults. | Knowledge and understanding of the specific guidance for under 18s is low across the general population and also among health professionals. This is a key public health area which should be addressed. | http://www.paha.org.uk/Resource/start-active-stay-active-a-report-on-physical-activity-from-the-four-home-countries-chief-medical-officers |
| 25 | Slimming World | Equal access to effective weight management services for children & young people should be available across the country. | Services are currently not consistent across the country meaning that some young people have access to services while others have no options. The links between overweight and poor health are well documented and there is lots of evidence which shows that being overweight as a child increases the risk of obesity in adult life. This is a key time when intervening at a young age will have positive benefits for future. | Currently there are health inequalities across the UK for both adults and children in terms of available services for weight management. | |
| 26 | Slimming World | Services should encourage a family approach in both the prevention and management of obesity. | It is vital that services who support young people encourage and adopt a family approach in terms of dietary and physical activity support. | A family based approach is vital due to the continuing evidence base of an association between overweight and obesity in children and parental overweight and | Scottish Intercollegiate Guidelines Network. (2010) Report No.115: Management of Obesity: A National Clinical Guideline. Available at: http://www.sign.ac.uk. |

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| | | | | obesity. | |
| 27 | Slimming World | Outcome measures of an intervention should include changes in self-esteem, self-worth and general mental well-being. | It is vital that any approach has a positive impact on this area in the young person's life. | It is well documented that overweight and obese children show greater signs of psychological distress than their slim counterparts and are more likely to have poor self-esteem, be depressed, have body image dissatisfaction and be perceived as unattractive, all of which may have long-term effects on the child, continuing into adulthood. | |
| 28 | Royal College of Nursing | Nurses caring for children were invited to comment on this topic engagement exercise. There are no comments to make at this stage on behalf of the Royal College of Nursing. | | | |
| 29 | Weight loss surgery info | Access to a multidisciplinary team in the case of extreme obesity which includes bariatric surgery as a treatment option. | Bariatric Surgery is associated with reduction in objective measures of identified co-morbidities and in remission (i.e. no longer on any treatment for this ) of same. This is the physical improvement, however the social and psychological benefits of intervening when a young persons illness has developed to this stage cannot be ignored | Recent analyses of routine data identified 31 bariatric surgery operations in <20 year olds in the UK in 2009 [Saxena S et al PLOS One 2013; 8: e65764] However, the prevalence of extreme obesity (BMI >99.6$^{th}$ centile of the IOTF growth reference) at a level consistent with requiring bariatric surgery in British adolescents is approximately 1% of 10-11 year olds (Ells et al 2013, submitted) and 2-3% of 14-16 year olds [Taylor SJ et al Ethn Health 2005;10:113-28.] This suggests that services have not yet matured sufficiently to offer this treatment option to those most in need. | Approximately two-thirds of extremely obese adolescents have significant elevations of cardiovascular risk [Van Emmerik NMA et al Arch Dis Childh 2012;97:818-21] |
| 30 | Infant and Toddler Forum | Education for healthcare professionals and parents on best-practice in nutrition from pregnancy through the | Evidence continues to mount supporting the need to embed the importance of early childhood nutrition in all aspects of family, | Poor child nutrition has become a major public health issue leading to poor adult health and premature death due to obesity | Please see the National Diet and Nutrition Rolling Survey 2009-2010 |

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| | | early years of life. | child and health policy. How we are fed and how we grow is likely to affect how healthy we are for the rest of our lives, and whilst the past ten years has seen a growing commitment to early years intervention, obesity is still a major public health issue that continues to threaten the health of the next generation. | and diet-related ill-health. Around half of all toddlers in the UK are overweight and a quarter of those starting school are technically obese. Child portion sizes have doubled in the past 20 years and families are confused about how much they should be eating. Education is key in reducing childhood obesity and providing practical, evidence based guidance for healthcare professionals and parents. | |
| 31 | Infant and Toddler Forum | Education for healthcare professionals and parents on the multifactorial nature of obesity. | There is no single factor which controls childhood obesity. The approach to reducing it, therefore, must be multifactorial. We must provide education for healthcare professionals to have conversations about a wide spectrum of issues on which they can engage with parents. | Encouraging healthy eating behaviours requires a sustained effort in terms of support for families from healthcare professionals. This in turn requires a sustained programme of education and resources for healthcare professionals to enable them to provide this support to parents to encourage healthy eating behaviours and reduce obesity. | HM Government – Health Lives Healthy People. |
| 32 | Infant and Toddler Forum | Effecting behavioural change to reduce a child's intake of sugar will help curb childhood obesity and reduce prevalence of conditions such as diabetes and metabolic syndrome. | Evidence shows that improving early nutrition by reducing sugar could prevent serious health problems later in life, such as obesity, cardiovascular disease, type 2 diabetes, metabolic syndrome, and some cancers. The number of children developing diabetes has increased markedly in recent years, making it the fastest growing childhood disease. The seeds of diabetes are sown very | We are facing an epidemic of ill-health - for the first time in history, today's children may not live as long as their parents. There is growing support and acknowledgment for the first 1000 critical days of life from when a baby is conceived until the age of two as a critical window of opportunity to affect change. Parents are especially receptive to advice and support during this period, and lifestyle changes may | Earlybird diabetes study. WHO draft guidance on reducing sugar intake (to be published). |

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| | | | early in life and, if left unchecked, one in five children born today will develop the disease. | be adopted more easily. Making these changes may be a challenge for many families. Unhealthy behaviours develop over the course of time, so replacing unhealthy behaviours with healthy ones requires time and the right approach. | |
| 33 | Dietitians in Obesity Management UK (domUK) | Regular recording & monitoring of weight, height & BMI status in children & young people. | Data from National Child Measurement Programme is useful in helping to target weight management services for children & families. Weighing and measuring post-NCMP would increase our understanding of the links between childhood and adult obesity and the long-term risks to health faced by overweight and obese children, as well as the impact of public health policies on prevalence. | Beyond the age of 10-11 years (when prevalence of overweight and obesity is already approx. a third), there is no programme for monitoring & recording. In addition BMI is not necessarily routinely recorded within general practice, even in adults. Children already taking part in weight management programmes will be weighed and measured as part of the programme, but those who are not may be missed, even if they would benefit from participation. | NCMP (National Child Measurement Programme) website for annual reports on prevalence of overweight and obesity in England: http://www.hscic.gov.uk/ncmp<br><br>NOO (National Obesity Observatory) website: http://www.noo.org.uk/ |
| 34 | Dietitians in Obesity Management UK (domUK) | Equitable provision of effective weight management services for children & young people, especially for the most vulnerable such as the early years, adolescents & children with disabilities. | Links between obesity & ill health are demonstrable, and there is an increased risk of overweight tracking into adulthood the older the overweight child, and the more severe the obesity. There is a duty of care to manage a diagnosed clinical condition, and an ethical responsibility to provide services where needed. | Current provision across the country appears to be variable, both for adults or children, regardless of the prevalence of obesity. Current spend on weight management services for children and young people reported from 109 local authorities is 0.9% of public health allocation (total spend on weight management services 2.5% of public health allocation). Lack of services has the potential to increase health inequalities given the increased prevalence of obesity in lower socioeconomic groups. | HOOP (Helping Overcome Obesity Problems) report 'Tackling obesity: all talk, no action'. Available from: http://www.hoopuk.org.uk/<br><br>NCMP (National Child Measurement Programme) website: http://www.hscic.gov.uk/ncmp |

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| 35 | Dietitians in Obesity Management UK (domUK) | Recommendation for inclusion of cookery, food purchasing on a budget, food storage and weight management as a mandatory part of the school curriculum. | 'Knowing' and 'doing' are not the same, and effective weight management requires skills. Many of the most at-risk children may have least opportunity to gain these skills at home, and embedding them within the mandatory curriculum will ensure that all children had equal access throughout their school years. | In terms of prevention of obesity, the development of skills in addition to provision of information, is crucial. Although cookery is to become mandatory in the National Curriculum for Key Stages 1-3 from 2014, this will apply only to state schools, but not to free schools, academies or the private sector. In addition, safe food storage can reduce food waste; and shopping on a budget will be particularly important for those at high risk of developing obesity (i.e. lower socioeconomic groups). An understanding of healthy weight management is vital for all. | DfES National Curriculum guidance on Design and Technology which includes cookery: https://www.gov.uk/government/publications/national-curriculum-in-england-design-and-technology-programmes-of-study/national-curriculum-in-england-design-and-technology-programmes-of-study<br><br>School Food Plan: http://www.schoolfoodplan.com/plan/ |
| 36 | Dietitians in Obesity Management UK (domUK) | Provision of a healthy environment, including the sale & marketing of unhealthy foods and drinks, in particular in local authority venues including state schools, NHS hospital buildings & clinics (including on site shops, canteens & vending machines). | The role of the obesogenic environment is documented both as a potential cause of obesity and a factor in maintaining an unhealthy weight. | Local authority venues may provide opportunities for physical activity but often also offer unhealthy foods and drinks in canteens and vending machines. With the move of public health into the local authority this represents an important and avoidable conflict. | NOO (National Obesity Observatory) website: http://www.noo.org.uk/<br><br>Foresight report 'Tackling Obesities -Future Choices (2007): http://www.bis.gov.uk/assets/foresight/docs/obesity/17.pdf<br>. |
| 37 | Public Health England | Improved link between identification of child obesity and appropriate referral. | Following National Child Measurement Programme (NCMP) identification of child obesity appropriate referral is key, but not necessarily actioned.<br>Importance of face to face contact with practitioners to consider appropriate referral. | In order to address child obesity appropriate referral systems and services should be in place and signposted. Practitioners need to encourage positive engagement with NCMP and be knowledgeable about local services and referral pathways. | NCMP local engagement report (attached in email)<br>More detailed analysis reports - NCMP |

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| | | | | These should be developed in consultation with children, young people and their families. | |
| 38 | Public Health England | Improved 'wrap around' care for children and young people | Effective partnerships and supportive systems between Local Authorities, school nursing, GP's and other health professionals are key to create more 'wrap-around' care and follow through for overweight and obese children and young people. | The importance of encouraging a whole systems approach to tackling obesity is well documented, and is within the scope of the local landscape.<br><br>Consistently positive support to tackle obesity is important from all professionals to ensure recognition of the problem and good take up of appropriate services. Parents/carers/CYP etc should be consulted in the design of CYP friendly services<br>Improved delivery of intervention to maximise participation and retention to the service to achieve weight loss.<br>Help to identify particular support required, ie psychological services. | NICE Guidance 47 |
| 39 | Public Health England | Advancing technology and GP practice systems to capture unique NCMP data. | Operational improvement underpins wider system and service quality improvements, enabling effective use of data and follow through across the system to support children, young people and families. | GP's need to recognise the importance of NCMP data and support action by families if necessary by inclusion in QOF.<br>Support to children, young people and families.<br>Enable GP's to access and be able to provide prompt and | |

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| | | | | effective advice to ensure continued and joined up care. | |
| 40 | Public Health England | Improvements of tier 2 service provision, within the obesity care pathway. | Improved duration of intervention and follow through. Standardisation of specifications. | Consideration of the duration of intervention with regards outcomes. Suggested extension of the duration of interventions and improved follow up to increase the quality of service provision and outcome. Evaluation of interventions important to identify 'what works' and encourage good practice | DH tier 2 guidance. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142723/Weight_Management_Service_Spec_FINAL_with_IRB.pdf<br>Standard Evaluation Frameworks – Obesity KIT http://www.noo.org.uk/core/frameworks |
| 41 | Public Health England | Support to schools for supporting children and young people with stigma issues associated with excess weight. | The stigma attached to obesity is well documented through the third sector and health professionals. Guidance on how best schools can support obese children and young people should be improved. | The quality of care provided by the school environment in supporting obese children and young people.<br><br>A whole school approach is important to ensure consistent messages and action and integration with wider Health & Wellbeing strategies.<br><br>Improvement to more innovative prevention programmes for young people avoiding stigmatisation and linked to wider wellbeing and tailored to YP's requirements (especially teenage girls) | HOOP (Helping overcome obesity problems) website for information http://www.hoopuk.org.uk/<br>Hoop report Tackling obesity: all talk no action http://www.hoopuk.org.uk/images/Board/Hoop_report.pdf<br><br>C4Life School Sports Clubs and other C4L campaign campaigns.<br><br>HWB Framework for schools and Adolescent Health Framework being developed by PHE CYPF Team |
| 42 | Public Health England | Improving Local Authority response, strategic planning and services to | Encouraging a whole systems approach at local level to ensure a more joined up | 5 pilots for child obesity peer challenge to produce learning on ' what good looks like' re LA | Learning for Outcomes for PHE child peer visits Evaluation report due May 14 |

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| | | child obesity. | approach to the provision of care and treatment. | systems approach. Using consultation and engagement with local population. | |
| 43 | Public Health England | Commissioning of obesity services | Enabling clarity at local level for the commissioning responsibilities for the obesity care pathway. | To ensure access to appropriate obesity care pathway services. | Working group report on commissioning obesity services (2014) http://www.england.nhs.uk/2014/03/14/comm-obesity-serv/ |
| 44 | Public Health England | Support for schools and families to promote healthy eating / healthy weight/ getting active messaging | | Whole School approach as above to include school meals/packed lunches, food competencies, vending and offsite access, growing initiatives and cooking clubs with parents/carers etc. | 5 year C4L social marketing report due to be published in April 2014.<br>School Food Plan implementation<br>Food competencies |
| 45 | Public Health England | Improving obesity care/prevention/services to be more user driven | Engagement with the target group on their views on types of programmes either for service type or prevention. | Increased engagement / increased service quality if more user driven.<br>Local Authorities are well placed to conduct engagement with stakeholder / patient groups, through third sector involvement.<br><br>Peer learning approaches. | Local Authority Joint Strategic Needs Assessment |