

Supporting Healthy Lifestyles

Northumberland Care Trust's Childhood Obesity Strategy

(Working with our statutory and non statutory partners)

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Contents	Page No
1. Executive Summary	5
2. Key Facts	6
3. Introduction	7
4. What is Obesity?	9
5. The Case for Action – Profile of Childhood Obesity in Northumberland	10
5.1 Childhood Obesity Population Monitoring	10
5.2 Northumberland Data 2002	10
5.3 Breakdown of year groups and gender	11
6. Aims of Strategy & Vision	14
7. Proposed Actions	16
7.1 Universal Provision – Physical Activity	16
7.2 Universal Provision – Healthy Eating	21
7.3 Targeted Provision	23
7.4 Secondary Prevention & Obesity Management	26
Appendix 1: List of Partners	27
Appendix 2: Proposed Action (Logical Framework)	28

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- The Childhood Obesity Strategic Planning Group
- The Physical Activity Sub Group
- The Food and Nutrition Sub Group
- The Care Pathway Sub Group

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A big thank you to Councillor Lawrence Thompson for chairing the initial Overview and Scrutiny Committee Working group, and to all the councillors and support staff who helped make addressing Childhood Obesity a priority

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1. Executive Summary

To halt the year-on-year rise in obesity among children under 11 by 2010, a strategy spanning prevention to obesity management will need to be in place. Focusing only on those who are already very overweight or obese will not prevent the steady rise in obesity that we have seen over the past decade.

The childhood obesity strategy will therefore primarily focus on preventing the increase in obesity, and will place a greater emphasis on working with children in Northumberland under the age of 11 and their families.

The vision is based on the notion that the early provision of information, advice, guidance and where necessary specific support to children and their families will lead to an increase in knowledge. This will help children and their families make informed choices and decisions about their chosen lifestyle.

We will increase our universal provision to children and their families in and around schools, by helping to provide additional opportunities to increase physical activity and adopt healthy eating and healthy lifestyles.

Structures and systems will be developed, piloted and evaluated to manage children and young people who are already overweight and pose some cause for concern. Clear assessment and referral criteria will be developed to ensure that where a child or young person is experiencing difficulties because of their weight and other factors, or where a family member or professional is concerned a robust system is in place.

New interventions to support families and children experiencing problems will initially be piloted to ensure that we develop a locally acceptable and suitable programme. The initial intervention or multi-component programme will be aimed at children aged 8 - 11 years old who will be accompanied by a family member. The first pilot programme will be in the South East of the county thus targeting the area of highest need. A second programme will be developed within a rural community. Aims are towards the roll out of any successful programme to other areas. However, many additional opportunities will be on offer throughout the county

Discussions via the strategy group will need to take place to consider the appropriate interventions for 12 – 18 year olds. They will be supported by the assessment and referral system under development.

The Care Trust will support our staff and partners in providing some additional training to ensure that professionals are providing consistent messages in relation to increasing physical activity and healthy eating. School nurses and health visitors will receive additional training to support the assessment and referral of children of concern.

Finally, this strategy relies on the active involvement of our partners in the planning and delivery of information, advice and guidance and service provision. We already have a robust, active and positive strategy group, which demonstrates the sign up, from our partners. Continued support is essential if we are to meet our jointly owned public service agreement between the Department of Health, the Department for Education and Skills and the Department for Culture, Media and Sport.

Dawn Scott, Nurse Consultant in Public Health

2. KEY FACTS¹

Overweight and obesity in England

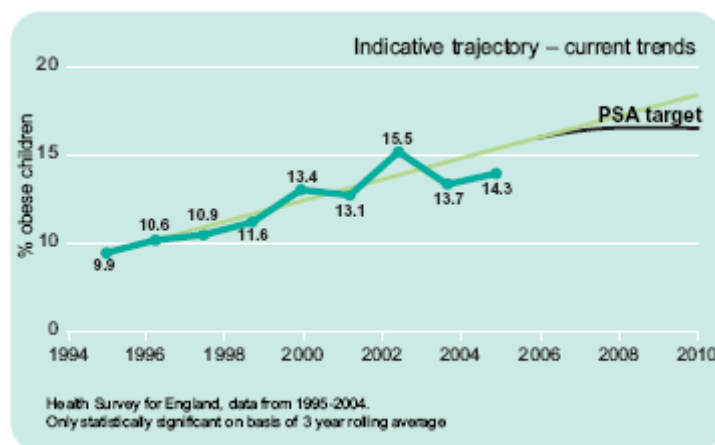
- Overweight and obesity increase the risk of a wide range of diseases and illnesses, including coronary heart disease, type 2 diabetes, high blood pressure and some cancers.
- Obesity reduces life expectancy on average by nine years and is responsible for 9,000 premature deaths a year.
- The prevalence of obesity has trebled since the 1980s. In 2005, 22.1% of men and 24.3% of women were obese and almost two-thirds of all adults – approximately 31 million adults – were either overweight or obese.
- Overweight and obesity are also increasing in children. In 2005, 31% of children aged 2-10 years were overweight (including obese), and 16.8% were obese. Among 11-15 year olds, 35.1% were overweight (including obese) and 20.6% were obese. This represents a 33% increase in overweight (including obese) and a 59% increase in obesity since 1995 for 2-15 year old children. If the proportion of obese children continues to rise, a whole generation may have a shorter average life expectancy than their parents.
- It has been estimated that, if current trends continue, about one-third of adults and one-fifth of children aged 2-10 years will be obese by 2010.
- There are social group differences in obesity, particularly for women and children – 18.7% of women in professional households are obese compared with 29.1% in routine and semi-routine households. A similar pattern is seen among children, with 12.4% in professional households classified as obese compared with 17.1% in semi-routine households.
- Most evidence suggests that the main reason for the rising prevalence of overweight and obesity is a combination of less active lifestyles and changes in eating patterns.
- Obesity has a substantial human cost by contributing to the onset of disease and premature death. It also has serious financial consequences for the NHS and for the economy. The economic costs of obesity are estimated at between £3.3 billion and £3.7 billion per year and the costs of obesity plus overweight at between £6.6 billion and £7.4 billion per year.

¹ http://www.fph.org.uk/policy_communication/publications/toolkits/obesity/obesity.asp

Lightening the Load: Tackling Overweight and Obesity. Produced by the National Heart Forum in association with the Faculty of Public Health, 2007.

3. Childhood Obesity in Northumberland - Introduction

Addressing Childhood Obesity is a public health priority. The prevalence of obesity in children aged under 11 increased from 9.9% in 1995 to 13.7% in 2003 (Health Survey for England²). Prevalence has trebled since the 1980s, and well over half of all adults are either overweight or obese - almost 24 million adults. Obesity in both adults and children is more common among lower social groups.



In March 2004 the Government set the Obesity Public Service Agreement (PSA) – ‘Halting the year on year rise in obesity among children aged under 11 by 2010 in the context of a broader strategy to tackle obesity in the whole population’.

This PSA target is a jointly owned target between the Department of Health, the Department for Education and Skills, and the Department for Culture, Media and Sport. Therefore to avoid duplication, to ensure cost effectiveness and to share skills and knowledge a strong multi agency and multi disciplinary partnership approach has been adopted and continues to flourish. The Northumberland Care Trust Childhood Obesity Strategy has been developed and is reliant on commitment from key partners (Appendix 1: List of Partners).

The Care Trust will work together with County Council and the District Councils to tackle obesity through the Trusts Local Delivery Plans, the Local Area Agreements and the Local Authorities Children and Young People’s Plans.

- District Councils have already developed or are involved in developing Play Strategies aimed at developing and improving play opportunities for children of all ages to include increasing free and supervised play
- Childhood obesity is a priority area for action in the Children and Young People’s Plan

² Health Survey for England, 2005. National Centre for Social Research. Note: The Health Survey for England (HSE) figures are weighted to compensate for non-response.

Achieving the target to halt the year on year rise in childhood obesity requires a coordinated multi-agency approach. There are numerous targets already set by the Government at a National level which will if achieved contribute to this broader Public Service Agreement target. Examples include;

- 5% increase in breast feeding leading to 60% initiation rate by 2009 (Local Area Agreement Stretched Target)
- All schools to be Healthy Schools by 2009 (Local Area Agreement Stretched Target)
- School based Food Standards implemented by September 06 and Nutritional standards by 09
- Enhance the uptake of sporting opportunities by 5 - 16 year olds – minimum of 2 hours each week high quality PE & school sport within & beyond the curriculum increases by 75% by 2006 and 85% by 2008
- Increase participation in sport for over 16's by 1% per annum

The prevention and management of obesity should be a priority for all, because of the considerable health benefits of maintaining a healthy weight and the health risks associated with overweight and obesity. The strategy and the work of key partners help us meet a variety of the outcomes across the five Every Child Matters areas³. To include:

- Children and young people live healthy lifestyles
- Children and young people are safe from bullying and discrimination
- Children and young people achieve personal and social development and enjoy recreation
- Children and young people develop positive relationships and choose not to bully or discriminate
- Children and young people are ready for employment

The primary focus of this strategy is on prevention and early intervention; however it will also cover the development of systems to manage overweight and obesity in children.

³ Every Child Matters - www.everychildmatters.gov.uk/aims/outcomes/

4. What is Obesity?

“Overweight and obesity are terms used to describe increasing degrees of excess body fatness which can lead to increasingly adverse effects on health and well being”.

Lightening the Load: Tackling Overweight and Obesity⁴

Engaging in regular physical activity and eating a healthy diet are extremely important in helping maintain a healthy body weight. If the food eaten provides more energy (calories) than are used in being active, the extra energy is stored as fat, which could lead to overweight and obesity.

For a few people obesity is associated with more complex clinical problems. It is therefore essential that we offer a robust assessment to children and young people to ensure that genetic and endocrine problems for example are discovered and appropriate support and treatment offered.

Overweight and obesity are commonly assessed in adults by calculating the Body Mass Index (BMI). BMI is defined by a person’s weight in Kilograms divided by the square of their height in metres (kg/m^2). BMI can be clearly related to risks in morbidity (illness) and mortality (death).

‘Overweight’ is classified as a BMI of 25 to 29.9 kg/m^2

‘Obesity’ is classified as a BMI of > 30 kg/m^2

Measurements should be interpreted with caution because it is not a direct measure of adiposity (body fatness). NICE recommends that BMI (adjusted for age and gender) should only be used as a practical estimate for overweight in children and young people. BMI in children should be related to the UK 1990 BMI Growth Reference Charts to give age and gender specific information.

Pragmatic indicators for action have been recommended at the 91st centile for overweight and the 98th centile for obesity. For details of the proposed action anticipated for children of concern refer to page

⁴ Lightening the Load: Tackling Overweight and Obesity. Produced by the National Heart Forum in association with the Faculty of Public Health, 2007.

5. The Case for Action - Profile of Childhood Obesity in Northumberland

5.1 Childhood Obesity Population Monitoring

In 2005 / 06 the Care Trust undertook a survey of childhood obesity within Northumberland in line with Department of Health guidance⁵. This is at present an annual requirement. The purpose of the survey is to monitor Childhood Obesity in our population to:

1. Estimate levels of overweight and obesity
2. To provide a baseline of data from which we can monitor our effectiveness in tackling it

All of our Reception (4-5 year olds) and Year 6 (10-11 year olds) children were invited through a letter home to parents to be height and weight measured in school.

Some families and children did opt out, choosing not to be measured. Some children were not in school due to sickness or holidays.

The following is an analysis of the data of those children who were measured during the summer term of 2006.

5.2 Northumberland Data 2006

5655 children were height / weight measured in 2006 out of a possible 6740 children in the year groups, resulting in **84%** of the potential sample being measured. Improving the uptake of measurement will be an underlying target in the summer of 2007 as part of a Local Area Agreement, and in line with Government recommendations. Nationally only 48% of children in the stated year groups were measured.

In Northumberland, of those children measured **13%** (n=736) were classed as obese using Body Mass Index Calculations for children (BMI).

- Of the 2807 children measured in Reception a total of 262 children (**9%**) were classified as obese.
- Of the 2848 children measured in Year 6 a total 474 children (**16%**) were classified as obese

This reflects the national picture of childhood obesity rising with age, and the concerns specified in the Health Survey for England 2005 report, which demonstrates a sharp rise in obesity in 8-10 year olds. Obesity in 2-10 year

⁵ Department of Health (2006). Measuring Childhood Obesity: Guidance to Primary Care Trusts

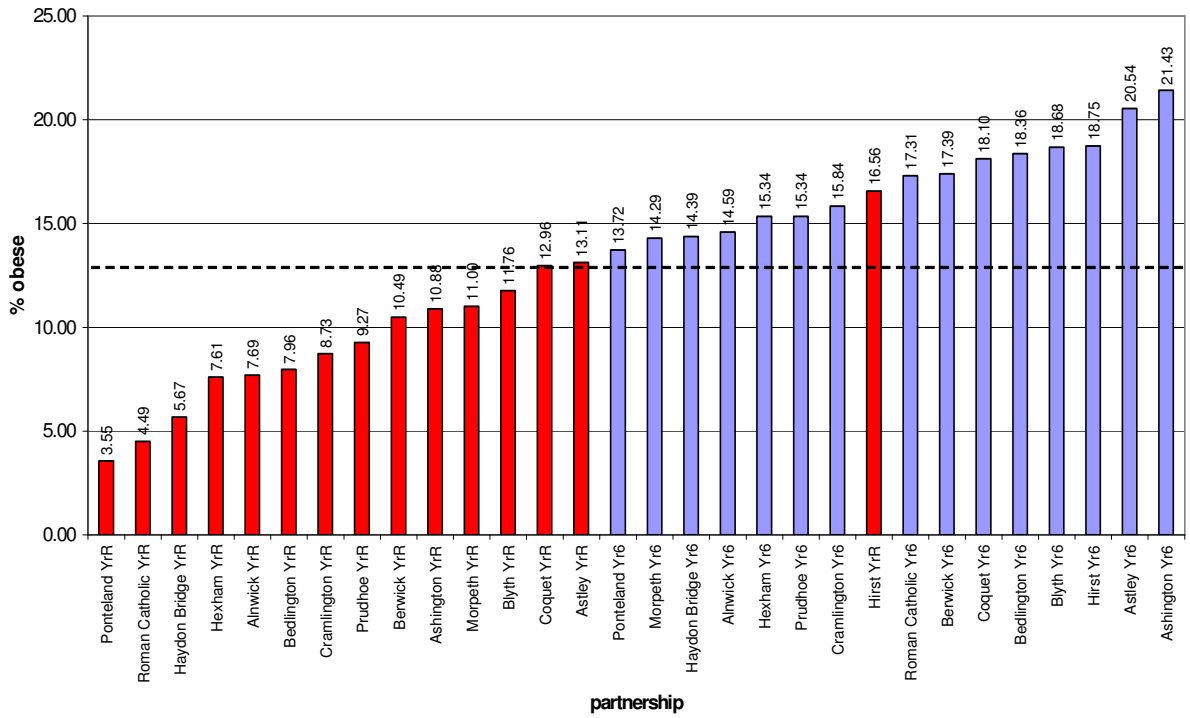
olds measured rose markedly from 1995 - 2003 from 10 -14%, but most marked were the measures for 8-10 year olds from 11 – 17%.

5.3 Breakdown of year groups and gender

- Of the 5655 of the children measured **2938** were **boys**
- **14.8%** of the boys measured (n=436) were classified as Obese
- Of the 436 identified - **9.6%** (n=136) were in Reception and **19.8%** (n=300) were in Year 6
- Of the 5655 of the children measured **2717** were **girls**
- **11%** of the girls measured (n=300) were classified as Obese
- Of the 300 identified - **9.1%** (n=126) were in Reception and **13.1%** (n=174) were in Year 6

In order to target those populations most in need the data has been analysed by School Partnerships. This data can then be used to highlight activities and interventions required as part of the Extended Services Plans. The data in Figures 1 & 2 highlight in red the % of reception children measured as obese / overweight, and in blue the % of Year 6 children measured as obese / overweight (School Year 2005 / 6). Figure 1 clearly demonstrates the rapid rise in obesity seen between the ages of 4-5 year olds and 10-11 year olds. This trend demonstrates and reflects the data shared in the Health Survey for England.

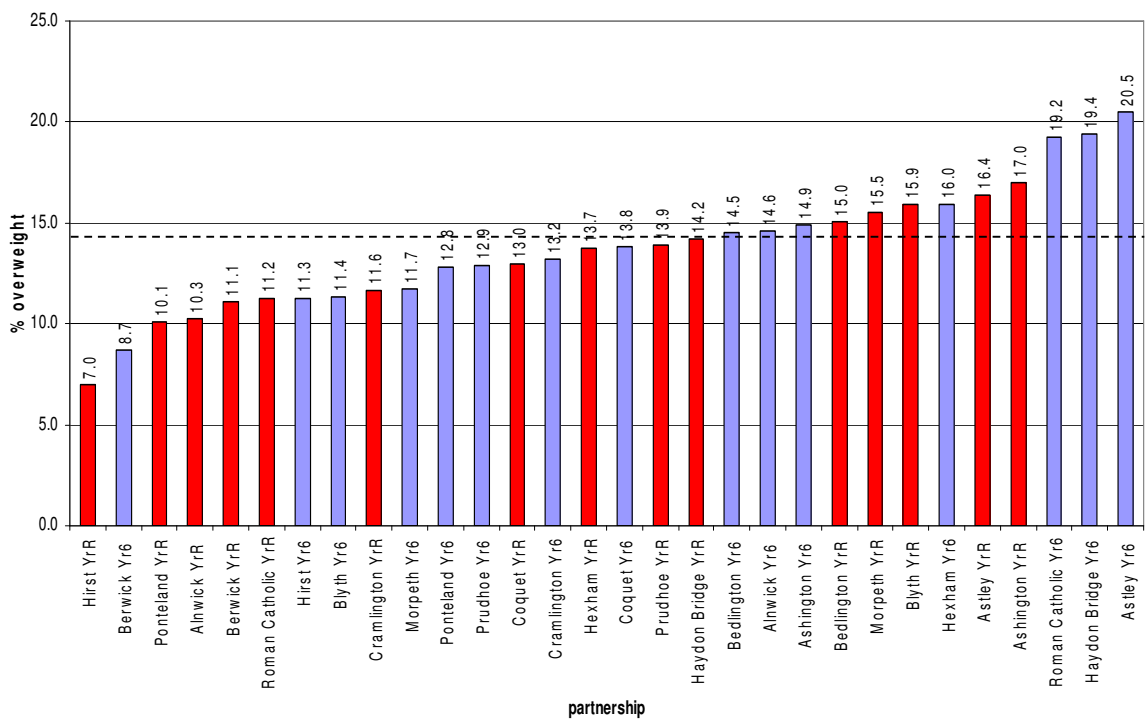
**NORTHUMBERLAND CARE TRUST
% OBESE CHILDREN BY PARTNERSHIP**



■ Reception ■ Year 6

Figure 1

**NORTHUMBERLAND CARE TRUST
% OVERWEIGHT CHILDREN BY PARTNERSHIP**



■ Reception ■ Year 6

Figure 2

Figure 3 depicts a combination of the overweight and obesity results by partnership of schools (first and middle).

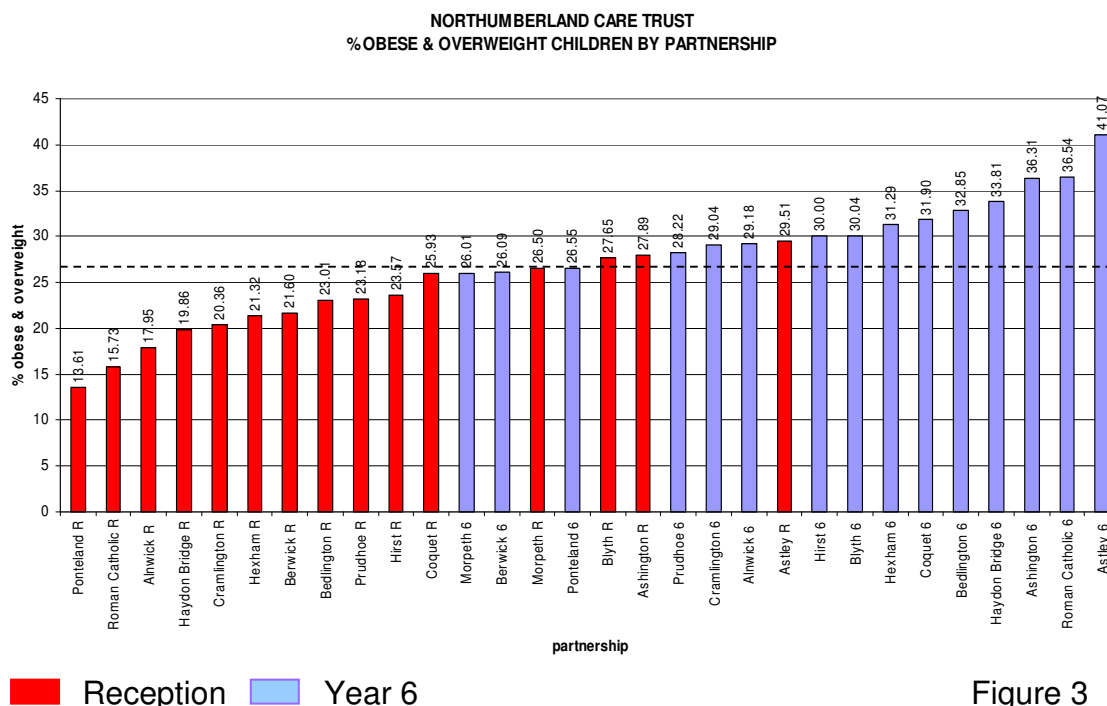


Figure 3

Using this data it will be possible to target our interventions to partnerships with the biggest overweight / obesity problem. The Department of Health does not support the sharing of individual school-based data. The number of children weighed in some schools is extremely small and therefore sharing such data would compromise the anonymity of the data, making some pupils identifiable.

New Department of Health guidance⁶ this year recommends the additional data collection of ethnicity and the child's postcode data. This will help us analysis the data by super output area in autumn 2007, and thus will assist us in placing community based interventions in areas of highest need.

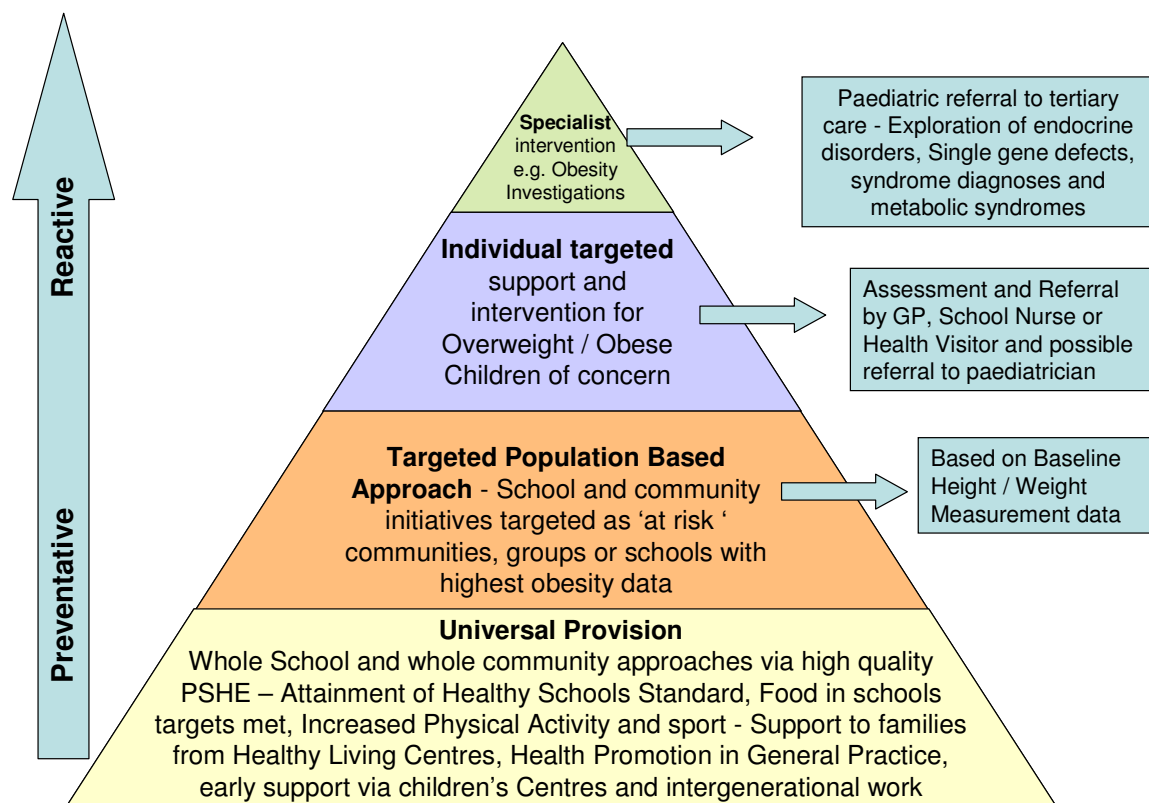
⁶ Department of Health (2007), Supporting Healthy Lifestyles: The National Child Measurement Programme (2nd Edition)

6. Aims of Strategy and Vision

The baseline data gives us at best a guide to the obesity problem in Northumberland. However with 736 children already measured as obese in reception and year 6 only, a strategic and targeted approach is essential.

The National Institute for Health and Clinical Excellence (NICE) advocate sustained interventions that address diet, physical activity and support for behaviour change.

The obesity problem needs to be addressed via the availability of whole community population based approaches, both at a universal and targeted level. Prevention of this problem is paramount if we are to halt the year on year rise in obesity. However, any strategy must also take into account the needs of children with an existing overweight problem. The pyramid below pictorially reflects the proposed care pathway from universal provision (population based) through to provision to meet the individual care needs of the child and family.



Northumberland Childhood Obesity Pathway to intervention and care

Examples of whole community population approaches are seen on the bottom sections of the pyramid. Schools, Healthy Living Centres, and General Practice surgery staff have a significant role to play. Each needs to be aware of the data supporting the need for these **Universal** services and equally

should play their part in signposting and referring families and individual children to support services. The baseline height / weight data will help us **target** our population focused interventions to areas of highest need. It is possible that a package of interventions could be offered to partnerships of schools where obesity levels are high.

Our strategy also needs to cater for children identified to be at increased risk due to overweight or obesity. At present we have no coordinated systems of referral, information or support for children who fall into this category. Some children are presently referred for support via GPs, Paediatricians, School Nurses, Dieticians and Health Visitors, but there is no clear care pathway in place and 'Referral Criteria' do not exist. At present we are considering different intervention packages for this smaller group of children (and their families), and will establish a referral pathway with our local health partners for children who are 'Overweight' or 'Obese' and who are experiencing problems.

For a very small percentage of children obesity may be associated with a clinical problem. Exploration of endocrine disorders, single gene defects and syndromes requires **Specialist** interventions and investigations. Obesity or increasing weight may be one of the presenting symptoms. Referral routes via Paediatricians and General Practitioners need to be clearly established, and an appropriate commissioning framework agreed.

A coordinated and clear approach at all levels of the pyramid needs to be established. For the present rise in obesity to be halted a partnership approach and commitment to the PSA Target is essential.

7. Proposed Actions

There is a huge amount of work already going on to increase physical activity and improve diet across the county. We need to build on this work and ensure that we target our limited resources wisely to ensure that healthy living becomes the norm.

Engaging in regular physical activity and eating a healthy diet are extremely important in helping maintain a healthy body weight. If the food eaten provides more energy (calories) than are used in being active, the extra energy is stored as fat, which could lead to overweight and obesity.

Where possible our community interventions will involve children, young people and their families. Behaviour change and action cannot be focused on the child in isolation. Many children adopt their lifestyle behaviours at home. Helping “whole family” change is important particularly as we know most obese children live with an obese parent.

7.1 Universal Provision - Physical Activity

What do we mean by Physical Activity?

Not all children, young people and adults enjoy sporting activity. Any type of activity is beneficial if it gets children moving and less likely to be sitting or doing sedentary tasks. There is no robust evidence to suggest that the increase in inactivity due to TV watching and computer games is a sole reason for increases in obesity. Obesity is usually associated with a combination of inactivity and unhealthy eating habits. However, children and young people should be encouraged to get more active in a way that they are comfortable with. Physical activity within this strategy relates to a range of activities that involve exercise and movement such as planned activities e.g. walking, running, basketball and other sports. Physical activity might also include daily activities such as household chores, gardening, walking the dog and playing out.

Physical activity is any bodily movement that results in energy expenditure above a baseline level (beyond daily functioning). The greatest benefits come from engaging in a broad range of physical activities including:

PE Lessons	Outdoor Activities	Walking to playgroup / school / park
Sports	Active Play / street games	Playing football in the park
Dance	Cycling	Climbing the stairs
Gardening	Exercise and training sessions	Running, jumping, skipping

Why Physical Activity is Important?

Physical Activity can contribute to the physical, social and emotional well being of all children and young people and their families.

Potential benefits of regular participation in physical activity of moderate intensity include:

<ul style="list-style-type: none">➤ Improve overall health➤ Healthy growth and development➤ Improved muscular strength, endurance and flexibility➤ Maintenance of energy balance➤ Reduced risk of developing adult diseases and conditions such as diabetes, heart disease, and high blood pressure	<ul style="list-style-type: none">➤ A sense of well being➤ Enhance self esteem➤ Reduction in anxiety and stress➤ Improved social and moral development➤ Improved cognitive functioning and academic achievement at school
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Levels of Physical Activity – Recommendations

To improve health, it is recommended that children and young people should participate in a minimum of one hour of at least moderate physical activity everyday. In addition twice a week all children and young people should take part in activities that help to develop muscular strength, flexibility and bone health.

Presently **inactive children** should aim to take part in **half an hour of moderate activity per day** and gradually work towards reaching the one-hour target.

Moderate intensity activities include those activities, which make participants feel warm and slightly out of breathe (e.g. brisk walking)⁷

Early Years settings:

Those working in early year's settings and with younger children and their families such as Children Centre staff, childcare providers, health visitors and

⁷ www.healthyschools.gov.uk/Theme-Physical-Activity.aspx

nursery nurses are in a good position through their relationships and contacts with families to positively promote physical activity and unstructured play.

Children's Centres must provide information to parents on a number of specified areas including; ante natal and post natal health; Children's emotional and Physical Health; Children's Play and learning; How to access services for children and families and Child and Family Nutrition.

The Sure Start Children's Centres Practice Guidance⁸ provides new recommendations relating to childhood obesity. Children's centres should promote a whole family approach to eating well and keeping active. They can

- Organise and promote physical activities through for example baby massage, play and tumble tots
- Promote parental fitness, e.g. adult exercise classes
- Encourage family increases in physical activity aiding interaction between parents and their children, e.g. cycling and walking, nature trips
- Parents should be encouraged to lead by example – opt for active play over sedentary entertainment, reduce car journeys and walk more.

Health Visitors, Childcare providers and staff working to Children's centres are in a good position to support families who are already overweight.

We support the promotion of positive structured and unstructured play as part of the child's physical and emotional development. Play in early years also contributes to increasing Physical Activity opportunities for children and families. District councils across the county have or are presently developing Play Strategies.

Where physical Activity programmes are developed in and around schools across the county the Childhood Obesity PA Sub group will consider with early years leads the suitability of roll out to early years e.g. Skipping Workshops are being offered in early years and childcare settings.

Health Visitors will be offered additional training on Assessment and Referral to help support children who are overweight.

School Settings:

The Care Trust will help support the county wide roll out of programmes that increase physical activity in schools in addition to those already expected as part of the school curriculum. For example we would like to see all First

⁸ Department for Education and Skills. Sure Start Children's Centres Practice Guidance, revised 2007 or www.surestart.gov.uk

Schools across the county trained in and delivering the ACTIVATE and the Wake and Shake programmes in school time.

ACTIVATE programmes increase physical activity of moderate intensity by 15 minutes per day and help children's concentration.

In addition, skipping and other activities will be introduced into schools ready to take the challenge with supported training. Some schools have already implemented programmes, but we would like to ensure a coordinated consistent approach across all of our First schools. A Young Sports Leaders programme has been developed in ten middle schools in Northumberland resulting in 100 Young leaders (KS 3 pupils) being trained. The Young Leader Award is a programme of leadership training for young people between the ages of 9 and 13 that promotes them working with younger children, teaching leadership skills through a range of games and activities. It is these types of initiatives we wish to promote. We will therefore be

- Increasing physical activity opportunities in schools with our partners, and
- The childhood obesity strategy group will work with partners to support an increase in access to schools sports facilities / playing fields
- Offering support to coordinate and project manage this approach via choosing health funds and partnership work with children's services

We hope this will help strengthen the work our School Sports Partners are already undertaking and assist the teams to meet local needs, and where cost effective share training opportunities.

Increasing physical activity through play

free2play

There is growing evidence to suggest that limiting children's outdoor play experiences is likely to damage physical, social, mental and emotional development. Free2play is a partnership project between Extended Service's, Children Centre's and Northumberland Early Years and Childcare Service. It aims to provide a Free2play pod on a first school site in Hexham, which will be used as a base from which skilled, qualified play workers can facilitate out of school, community based, free, open access, play opportunities. It will create opportunities for adventurous, inclusive and accessible activities for all children. The project will also provide an outreach service around rural Tynedale. The play workers will take resources to school grounds, parks and open spaces using the proposed Free2play bus, where they will facilitate outdoor play.

This project will ensure that children and young people will have better access to supervised outdoor play facilities and opportunities which reflect the Every Child Matters agenda. This type of supervised play provision has been identified as missing in Tynedale through Tynedale's Play Strategy. Funding for a play worker has been secured from the Big Lottery, Children's Play

Initiative, together with funding from Extended Services and Milecastle Housing for the purchasing, siting and equipping of the Play Pod.

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.

Community Settings:

Northumberland Care Trust public health/health improvement staff are forging stronger links with our sporting partners through Leisure Services, School Sport Partnerships, Northumberland Sport and voluntary sports groups. All partners have been actively working together to identify need, and find joint solutions to increase physical activity through a number of steering groups, by offering a variety of sporting and physical activity opportunities.

Sport England as the strategic lead for sport in England is committed to supporting the development of a single system for community sport and physical activity that is simple, systematic and joined up. At a community level Community Sports Networks (CSNs), or Sport and Physical Activity Alliances (SPAAs) are being developed in each of the six districts, bringing together people who have a desire to develop and promote sport and physical activity in their locality. CSNs / SPAAs will develop action plans that will influence delivery to increase local participation in sport and physical activity based upon needs analysis and wider strategic priorities. Health Improvement will have representation on all local CSNs / SPAAs, and will ensure that childhood obesity data is available in order to influence shared action plan priorities.

Northumberland Care Trust have provided a £50,000 fund, managed under a partnership arrangement with Northumberland Sport, to start addressing the childhood obesity issue and make a difference to the health of children and their families across the county.

Northumberland Care Trust and our partners recognise the important role that many voluntary and community sector groups have in promoting physical activities opportunities to children and young people via for example youth groups, girl guiding and scouting activities; and the important social skills element to such groups. Where possible we will link our developing work to local programmes and projects and offer access to training.

Increasing Intergenerational Physical Activity

Community Development Workers employed through the FISHNETS (Fitness, Involved, Safety and Health Networks) programme are helping to develop intergenerational walking groups through a Walk Leader in Alnwick by

encouraging and training local older people to volunteer as walk leaders and open up their access to children and families

7.2 Universal Provision – Healthy Eating

Why is Healthy Eating Important?

Good nutrition is vital for good health. Improving people's health through improved diet and nutrition will help reduce cardio vascular disease, cancers and in particular obesity, which is a major risk factor for diabetes, heart disease and some cancers.

Whilst there is awareness of healthy eating many of us still eat less than the recommended amounts of fruit and vegetables and more than the recommended amounts of fat, sugars and salt. Over consumption of energy relative to our needs is a major factor in increasing levels of obesity.

Healthy Eating – Recommendations

The recommendations for promoting a healthy balanced diet are presented in '*Choosing a better diet: A Food and Health Action Plan*⁹

The overall aim is to improve the nutritional balance of the average diet, with an emphasis on lower calorific alternatives.

The Government recommends that individuals over 5 years of age eat a healthy balanced diet that is rich in fruit and vegetables and starchy foods. The 'Balance of Good Health' produced by the Food Standards Agency, recommends a balance of different food groups within the diet. A healthy balanced diet should include:

- **5-A-Day** – A minimum of at least 5 portions of fruit and vegetables per day which could lead to a reduction in premature deaths from chronic diseases
- Includes meals based on starchy foods such as pasta, rice, bread and potatoes and where possible these should be high fibre varieties
- Includes moderate amounts of milk and dairy products – choose low fat options where possible
- Includes moderate amounts of protein rich foods such as meat, fish, eggs, beans and lentils, and
- The diet should be low in foods high in fat, especially saturated fats, sugar and salt.

⁹ Department of Health 2005, *Choosing a better diet: A Food and Health Action Plan*

Early Years

Good nutrition is essential for both mother and the unborn child. We will continue to encourage breast feeding as breast fed babies benefit from less hospital admissions for infections, and are less likely to become obese in later childhood. Mothers who breast feed are more likely to regain their pre pregnancy weight. The Care Trust presently has a Local Area Agreement stretched target to increase breast feeding across the county.

The new Healthy Start Scheme¹⁰ will help improve diets in pregnancy and early years, particularly by encouraging fruit and vegetable consumption. The scheme also encourages earlier and closer contact with health professionals who can give advice on pregnancy, breastfeeding and healthy eating.

All General Practice Surgeries and Care Trust premises are working towards the achievement of the UNICEF Baby Friendly Initiative.¹¹ The Baby Friendly Initiative works with organisations to ensure a high standard of care for pregnant women and breastfeeding mothers and babies. We will provide support for organisations seeking to implement best practice including Children's Centres and District Councils. The certificate of commitment has already been awarded to the Care Trust by UNICEF.

Mothers are encouraged to breastfeed exclusively for the first 6 months of their infant's life. Health Visiting teams and Children's Centres provide information and advice (through groups and 1:1's) at the weaning stage to promote good nutrition.

The Nursery Nurse in Amble visits every family when their child is 3 months old to provide information on weaning. Advice is provided about weaning using family foods, rather than packets/jars, and a pack containing an ice cube tray and £1 worth of fruit and vegetables is given to the family. There is anecdotal evidence that these babies continue to consume 'real' food, and the Health Visiting team are in the process of auditing this.

- Food and Nutrition training will be offered to staff working in and around Children Centres to build capacity, ensure consistent and clear messages can be relayed to the public, and to encourage staff to set up healthy eating initiatives in their areas. Some staff have already attended the training on offer this will be extended over the next few years.
- We will review the present level of cooking skills sessions on offer with and via Children's Centres. Some additional support will be available to provide Cooking Skills sessions in Children's Centres via Choosing

¹⁰ Healthy Start Scheme

¹¹ <http://www.babyfriendly.org.uk/>

Health funds and professional support. The aim is to skill up local staff from a variety of early years settings (including some parents willing to offer cooking skills sessions) so they can cascade consistent food and nutrition messages and offer cooking skills and advice to local communities.

Children's Centres should review their whole centre policies on healthy eating, and should role model good practice. The care trust staff will support them to review their policies and approaches to healthy eating.

School Settings

Schools offer a place where the Government and others can support most children and young people in making informed choices about their diets and can provide access to healthier foods. Healthy eating is one of the four themes of the National Healthy Schools Programme. The main aim of this theme is for pupils to *'have the confidence, skills and understanding to make healthier food choices'*, and for *'Healthy and nutritious food and drink' to be 'available across the school day'*. This means that schools provide a good arena where, health promotion messages can be presented and debated within the curriculum, and where schools can provide healthy food options. The Healthy Schools team are presently explaining the schools legal responsibilities in line with the food in schools legislation via Governor training and information sessions; and additionally support schools with teacher training in this area.

- Opportunities for cooking skills sessions via extended services partnerships will be developed in areas of high need where appropriate venues can be provided, and will be supported by choosing health funds. Priority areas will be established through the Food and Nutrition childhood obesity sub group
- Appropriately trained food workers will support dieticians to deliver cooking skills sessions in children's centres, schools and community buildings. As previously stated the training will be available to wide variety of individuals willing to cascade their learning with community groups.

Alnwick South First School runs a cooking club for their pupils with the aim of developing basic skills and enthusiasm for food. This is being developed to include work around an allotment – for which the school have been awarded some set up funding. They are also hoping to produce a recipe book which could contain advice for other schools in running a cooking club, and how to manage with limited facilities.

7.3 Targeted Provision

Northumberland is a diverse county and this is reflected in the obesity figures with our lowest levels of obesity in reception at 3.5% (Ponteland Partnership) and our highest at 16.5% of those measured (Hirst partnership). The range of obesity in year 6 children was from 13% – to almost 22% in one partnership. These massive variations in obesity across our county highlight why we must target some of work to areas of high need.

Targeted Response at a population level

Using the survey information recently collected from the under 11's Height / Weight measures (NCT), from Northumberland Sport's Time out Survey and from the Schools Physical Activity data, targeted provision is possible. Some of our provision will be targeted to areas of highest need, as follows:

- Food and Nutrition training from 'awareness raising' to accredited programmes will be prioritised to professionals in areas of highest need. Once prioritised training has taken place staff working with children and young people across the county will be offered food and nutrition training if it is relevant to their work. The level of training on offer will be dependent on local and professional need and a willingness to cascade their learning
- Cooking Skills sessions will be prioritised to areas of highest need
- Physical Activity training for school based staff (such as ACTIVATE training) will be prioritised to areas of highest need first and will ultimately be on offer countywide within two years
- Public Health and Health Improvement staff are presently working with our leisure services partners, Psychology Services and dietetics to develop a Family Intervention Programme (Get Active Northumberland) to support children who are already overweight (and their families). By autumn 2007 we will deliver our first pilot programmes (one urban, one rural), the second phase of this programme delivery begins in February 2008. The first programme will be in Wansbeck, the area where obesity levels were highest in the 2006 survey

Nutrition Skills training has already been offered to health professionals and workers who can disseminate nutrition messages to the groups or individuals they work with. The courses are accredited with the North East Open College Network. The level 1 course covers the basics of nutrition from pre-conception to older people, while the level 2 course guides participants to be able to run a cooking session. A total of 57 people have completed Level 1 and 10 people have completed Level 2 including Health Trainers, Youth and Community Workers, Children's Centre Staff and Physical Activity staff.

Targeted Support at an individual child and family level.

Clear assessment, referral and outcome options need to be established for children who are of concern to parents, health professionals and education staff. A child, parent or health professional will be able to self refer or refer a child or young person for assessment.

- Standard primary assessment criteria, systems and guidance are presently being developed, for use by healthcare professionals
- This new criteria is supported by training and resources and is primarily aimed at Health Visitors, School Health Advisers and GPs
- School Health Teams have been given priority to access this training, with school aged children most likely to need support

Concerns about obesity or increasing weight will be one of the referral criteria. However, referral will normally be associated with other factors such as a child who is experiencing concentration and self esteem problems, bullying due to weight / physical appearance, or is recognised to be inactive.

School Nurses and Health Visitors are in a prime position to undertake such assessments because of their close link with the child, family, children's Centres and education provision.

Continued long term family support by the school nurse will be difficult given staffing levels and other responsibilities. We therefore need a variety of other support mechanisms to ensure the family are suitably supported over time.

- Choosing health funds will help support an increase in staff and skills development
- By autumn 2007 we will pilot our first Get Active Northumberland (GAN) Family Intervention programme for children and a family partner within the South East corner of the county and one rural setting. It is anticipated with appropriate financial support and if positively evaluated this programme could then be rolled out to localities in early 2008. Health professionals who have assessed children will be able to refer those requiring lifestyle changes into the programme for targeted support. In line with NICE guidance the Intervention programme will be a multi component programme addressing readiness for change, healthy eating and physical activity. The programme will be available for children assessed as in need of support aged between 7-11 years old
- Multi agency staff delivering the GAN Programme will receive motivational and behaviour change training from a clinical psychologist in September 2007, funded via the Choosing Health, Childhood Obesity budget

- The Physical Activity sub group will determine sustainability of the programme and integration into leisure services, and will work with partners to secure external funding to help support this programme

Families will be signposted to community activities to increase the whole family's physical activity and these will range from walking clubs to access to dancing, swimming and gym work out.

A family pack of information will be provided and additional parent's sessions could compliment the children's sessions (partnership work with Healthy Living Centres and community groups).

To ensure that attendees continue to maintain their new levels of physical activity after the intervention programme, some leisure service providers will provide taster sessions, reduced cost or free access to leisure facilities for a specified time.

7.4 Secondary prevention and obesity management

Assessment and referral

School Health Advisers, General practitioners and Health Visitors will have the opportunity to refer children of concern to the community paediatricians in Northumberland after primary assessment. Criteria for referral are being established and form part of the Obesity Training that will be on offer to the above stated health professionals over the next year.

Paediatricians in Northumberland are working with their colleagues to establish clear referral criteria in to tertiary care.

Appendix 1

List of Partners

Representatives from the following organisations and departments are active members of the **Childhood Obesity Strategy Group**

Care Trust Members

Public Health Nurse Consultant (Chair)
 Director of Public Health
 Public Health Consultant
 Public Health Lead Nurse
 Health Improvement Practitioner / Specialist (Chairs of sub groups)

Local Authority Members

School Improvement Adviser (Health & Well being)
 School Sports Partnership Manager (Rep)
 Facilities / School Meals

Northumberland Sport

Chief Executive or Representative

Northumbria Health Care Trust

Dietetics
 Oral Health

Mental Health Trust

Psychology

Representatives from the following organisations and departments are active members of the Childhood Obesity Strategy Sub Groups

Food and Nutrition sub group	Physical Activity sub group
Healthy Schools / Care Trust	Care Trust Members
Health Improvement Practitioner / Specialist (Chair)	Health Improvement Practitioner / Specialist (Chair) Public Health Nurse Consultant
Care Trust Members	Healthy Schools / Local Authority
Public Health Nurse Consultant	PE Schools Adviser Early Years Representative
Northumbria Health Care Trust	
Dietetics	Leisure Services
Oral Health	Locality Representatives
Local Authority	Northumberland Sport
School Representatives	Representative
Sure Start / Early Years	School Sport Partnerships
Facilities / school meals	Representative

Care pathway sub group

Public Health Nurse Consultant
 Community Paediatrician
 Community Dietician
 School Health Lead
 Health Visitor Lead

Appendix 2

Logical Framework-Childhood Obesity

Lead: Dawn Scott, Nurse Consultant Public Health

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**Goal: Halt the year on year rise in obesity among children under 11 by 2010
(Part of PSA to address obesity within the broader population)**

Purpose:

- 1. Population Monitoring**
- 2. To provide whole community and school primary prevention approaches through Healthy and Extended schools agenda, Nutrition and Physical Activity Strategies**
- 3. To establish a childhood obesity care pathway**

National Drivers:

- Choosing Health – Making Healthy Choices – November 2004
- Every Child Matters
- The National Healthy Schools Standard. Department of Education and Skills / Department of Health
- Public Service Agreements DfES Objectives 4& 9, DH Objective 3, DCSM objectives 1, 2, 3.
- Food in Schools Standards, Schools Food Trust
- Physical Activity Targets - Department for Culture, Media and Sport's (DCSM) Public Service Agreements 2003-06

Local Drivers:

- Children's Plan
- Local Delivery Plan
- Healthy Schools Standards in Northumberland
- Northumberland Sport Targets
- Local Area Agreement
- Health Strategy

Addresses inequalities by:

- Targeting those children most in need at an individual, group, school and school partnership level

Contributes to chronic disease prevention by:

- Via PHSE lifestyle activities
- Increasing awareness and ownership of health promoting activities in schools
- Increase public health knowledge and capacity of school nurses and teachers
- Targeting interventions according to identified need (Health related behaviour survey and baseline data)

Contributes to chronic disease management:

- Increases in Physical Activity and improved nutrition will lead to a long term reduction in CHD and Type 2 Diabetes

	Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions and risks	Progress
Goal	Halt the year on year rise in obesity among children under 11 by 2010	SHA Trajectory - No more than an 0.4 and 0.3 increase in Childhood obesity over the next 2 years	Data Analysis and 2010 report	Success reliant on cross partnership commitment to reach their own set and related targets	Committed multi agency partners are on board and regularly attending strategic and operational planning groups
Purpose	1. Population Monitoring	1. Database and collection mechanisms in place September 2006	Northumberland Childhood Obesity Database feeding in to NCOD	Some problems in 2006 with NCOD creating some reporting delays	Data input and shared on time
Outputs	1. An effective data collection system established	1. Process evaluated and amended in line with DH Guidance and audit prior to next data collection	Copy of National Audit Strategy Minutes Dawn Scott – Public Health	Choosing Health Resources need to be secured	Strategic and operational groups established and well attended.
Activity	<p>1.1. Establish a systematic approach to HT/WT measurements in line with DOH guidelines (with Children's Services)</p> <p>1.2.Undertake baseline and annual measurement of heights and weights of all Reception and Year 6 children in Northumberland.</p> <p>1.3 Undertake data analysis of progress in halting year on year rise in obesity</p> <p>1.4 Provide obesity guidance update for those undertaking: Ht / Wt measures</p>	<p>1.1. By end of April 06 (and amend annually)</p> <p>1.2. By end of July annually 1.2.1. Increase coverage rate to 87% - 07/08, 90% - 08/09</p> <p>1.3. Annual analysis – October/November each year 1.3.1. Full Report 2008 and 2010 (from baseline)</p> <p>1.4. Annually</p>	<p>Sandra Thompson / Dawn Scott – for NCOD (restricted access)</p> <p>School Health Lead (Linda Parmley) and PH Nurse Consultant (Dawn Scott) to keep paper copies Dawn Scott Public Health with support from Sandra Thompson</p> <p>Dawn Scott to inform and update Linda Parmley for dissemination to School Health Team</p>	<p>Reliant on DH changes to process and audience in good time to plan effectively</p> <p>In Choosing Health SLA for school nurses</p> <p>Data available in time – input undertaken by trainee IT staff 2006 – added to departments workload</p> <p>Reliant on DH changes to process and audience in good time to plan effectively</p>	<p>System established and strong partnership approach between Informatics and PH established SLA now agreed – good first year coverage (84%) achieved 2006</p> <p>Analysis shared across partnerships (Sports Partnerships, Healthy Schools) and with OSC, heads of NCC, and some district councils</p> <p>Took part in National Audit of process.</p>

	Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions and risks	Progress
Goal	Halt the year on year rise in obesity among children under 11 by 2010	SHA Trajectory - No more than an 0.4 and 0.3 increase in Childhood obesity over the next 2 years	Data Analysis and 2010 report	Success reliant on cross partnership commitment to reach their own set and related targets	Committed multi agency partners are on board and regularly attending strategic and operational planning groups
Purpose	2. To provide whole community / School primary prevention approaches through the Healthy and Extended schools agenda, Nutrition and Physical Activity Strategies	5% increase in breast feeding leading to 60% initiation rate by 2009 (Stretched Target) All schools to be Healthy Schools by 2009 (Stretched Target) School based Food Standards implemented by September 06 Nutritional standards by 09 Increase physical Activity in school from 25% 2002 to 75% in 2006, 85% in 2008	Link to Breast Feeding Log Frame Link to School Health Log Frame Link to School Health Log Frame and Food and Nutrition childhood obesity sub log frame PESCL data Alan Wallis NCC		Breast Feeding Rates improving. Pump Priming money secured to assist Healthy Schools Team in supporting schools towards Healthy Schools Standards. Schools already increases level of PA
Outputs	2.1. A variety of primary prevention interventions in place 2.2. Schools consider childhood obesity in their healthy schools plans	Details of proposed interventions on Sub Group Log Frames and via school action plans towards healthy schools	Childhood obesity Sub log frames and minutes to meetings Helen Tomlinson – Physical Activity Julie Fletcher – Food and Nutrition	Choosing Health Resources need to be secured Reliant on Schools commitment	
Activity	2.1 Deliver a variety of levels of Food and Nutrition training to ensure frontline workers can support children and families 2.2 Map out the present health improvement interventions delivered in and around schools (Food in schools and PA initiatives) for children 2.3 Identify gaps and new initiatives required to help us increase PA and improve nutrition in schools, and families	2.1. From April 07 – March 09 prioritise training for school health and sports partnership staff, health visitors, and Children Centres staff 2.2. First Draft by end of March 08 (Sub Group work) 2.3. First Draft by end of March 08 (Sub Group work) 2.4 All schools to be Healthy Schools by 2009 (Stretched	2.1. Training records AND Food and Health Work plan – Linda Henderson 2.2. Minutes of Childhood Obesity Sub Groups in Pubic Health 2.3 Audit of food activity – Linda Henderson Audit of PA – Andy Brown 2.4 Katherine Vero Northumberland	Need to secure food and nutrition / dietetic resources Food and Health Workers in Post	Some Schools have already met the new standards

	<p>2.4 Healthy Schools team to support schools in achieving NHSS</p> <p>2.5 Increase cooking skills training / sessions</p>	<p>Target)</p> <p>2.5 X 1 children's centre staff train the trainers per locality by march 08</p>	<p>Healthy Schools Database</p>		
	Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions and risks	Progress
Goal	Halt the year on year rise in obesity among children under 11 by 2010	SHA Trajectory - No more than an 0.4 and 0.3 increase in Childhood obesity over the next 2 years	Data Analysis and 2010 report	Success reliant on cross partnership commitment to reach their own set and related targets	Committed multi agency partners are on board and regularly attending strategic and operational planning groups
Purpose	3. To establish a childhood obesity care pathway	3. Care Pathway in place by June 2007	Care pathway	Reliant on school health, early years and paediatric input and delivery	
Outputs	3. Clear referral options in place	3. Care Pathway in place by June 07	Care Pathway	Time to bring all practitioners together to agree pathway	SLA with School Health Agreed using School Health's allocated choosing health budget 05/06
Activity	<p>3.1 Write Childhood Obesity strategy and Care pathway and establish robust systems to ensure a staged approach to referral via schools and school health, children's centres and early years staff</p> <p>3.2 Work with secondary and tertiary care to agree and develop assessment and referral systems which are locally acceptable across PCO's North of Tyne</p> <p>3.3 Develop and deliver care pathway training specifically around assessment and referral</p> <p>3.4 Inform local planning and provide secondary targeted interventions</p>	<p>3.1 Care pathway to be written with protocol for referral and guidance by June 07</p> <p>3.2 Attendance to meetings with PCO and RVI colleagues to agree assessment and referral criteria</p> <p>3.3 To all School Nurses by Summer 2007 50% of Health visitors trained by end of 2007</p> <p>3.4 Interventions targeted using baseline data and local intelligence –</p>	<p>3.1 Copy of Pathway (Dawn Scott)</p> <p>3.2 Copy of Assessment and referral criteria Dawn Scott (Nurse Consultant) and Jonny Cardwell (Paediatrician)</p> <p>3.3 Training records – Dawn Scott / Linda Parmley / Janet Leigh</p> <p>3.4 Sub Group minutes – Helen Tomlinson and Julie Fletcher Public Health</p>	<p>Promotion via schools could result in high pressure on service with no additional resources secured</p> <p>Availability of staff to attend</p> <p>Financial support required</p>	<p>Beginnings of strategy written and agreed – draft strategy available in June 07</p> <p>Working group across primary, secondary and tertiary care established and SHA engaged</p> <p>Commitment from PH and Paediatrics to develop and</p>

	<p>3.5 Work with the Overview and Scrutiny Committee (NCC) to instigate action at a countywide level</p>	<p>agreement by June 2007 First two locality Family interventions to be piloted in autumn 07, second two locality based interventions by February 08</p> <p>3.5 Revisit working group by end of 2007 to report progress</p>	<p>3.5 OSC Report – Jackie Roll NCC</p>	<p>Difficulty in working with 6 district councils to implement action</p>	<p>deliver training</p> <p>Massive support from OSC to help instigate change</p>
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