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# Tackling Child Obesity – First Steps

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

PREPARED JOINTLY BY THE AUDIT COMMISSION, THE HEALTHCARE COMMISSION AND THE NATIONAL AUDIT OFFICE

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# Tackling Child Obesity – First Steps

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This report is based on a joint study conducted by the Audit Commission, the Healthcare Commission and the National Audit Office, one of a series that looks at the “delivery chains” between important national policy intentions (set out in government departments’ Public Service Agreement targets agreed with HM Treasury) and local delivery.

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## CONTENTS

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ANALYSING DELIVERY CHAINS	4
ABSTRACT	6
EXECUTIVE SUMMARY	8
<b>PART 1</b>	
Why child obesity is a Public Service Agreement target	24
What works when tackling childhood obesity?	27
Aligning partnerships and programmes presents inherent risk for joint delivery of the PSA target	28
Resourcing the programme	29
Achieving an efficient delivery chain	29
What our analysis set out to achieve	33



## **PART 2**

Achieving a cost-effective delivery chain – fieldwork findings 34

Resources 35

Partnership and multi-agency working 37

Performance management 41

## **PART 3**

What the delivery partners can do to strengthen the delivery chain 44

a) Clarity and direction from target-holding Departments 45

b) Clear regional roles and responsibilities 46

c) Strong effective local partnerships 47

d) Support and capacity building of frontline staff 47

e) Involving and influencing parents and children 47

Detailed recommendations 48

Conclusion 48

## **GLOSSARY AND ABBREVIATIONS**

53

## **APPENDIX**

1 Our methodology

58

## ANALYSING DELIVERY CHAINS

**1** Improving the quality and provision of public services has been a key governmental priority for many years. As more money has been provided, the public has expected to be able to choose from a wider range of better, locally-delivered services. At the same time, there has been the need to manage the delivery of those services more efficiently. As part of the 2004 Spending Review, Sir Peter Gershon identified scope to achieve efficiency savings across public expenditure of at least £20 billion by 2007-08. This has caused Departments to look closely at how they operate and provide services, with each having to specify how they will secure the savings for which they will be accountable.

**2** This focus on efficiency has complemented the range of performance management tools introduced across central government and the wider public sector in recent years to improve the effectiveness of local public services. In particular, in 1998, the Government introduced Public Service Agreement (PSA) targets, linking funding, for the first time, with the performance expected from Departments and their partners at national, regional and local level.

**3** The Spending Reviews in 2000, 2002 and 2004 have gradually refined the target-setting process. The number of PSA targets has reduced from 600 in 1998 to 110 in 2004. And targets have increasingly focused on outcomes – for example *reducing crime* – instead of on inputs, processes or outputs such as *more police on the street* or *better utilisation of court time*.

**4** These developments to improve the efficiency and effectiveness of local public services are welcome. There is consensus in government and more widely that fewer, more outcome-focused targets reduces the risk of the unintended consequences which come from measuring inputs or processes. This understanding, combined with a sustained drive for improved efficiency, provides a fresh opportunity for Departments to review their PSA targets and the means by which they can best be delivered.

**5** More sophisticated outcome-focused services, better tailored to the diverse and local needs of the public, can rarely be achieved by one organisation alone; instead they require close partnership working between different organisations at national, regional and local levels. These relationships, ultimately linking the responsible ministers to the frontline health worker, school teacher or police officer, have become known as the *delivery chain*, echoing the business concept which refers to the network of systems, processes and organisations through which strategic objectives are achieved.

**6** Such complex delivery arrangements, if not well managed, create significant risk that resources, far from being more effectively targeted at citizens' needs are lost in confusing and wasteful administrative activities. Thus, as delivery chains have become more sophisticated, involving a wider range of organisations of different kinds, the need to understand them better, and to make them more efficient and effective, has become increasingly evident. Some long-standing delivery chains are strong and clear and more likely to succeed. Others, less developed, have struggled to meet the requirements asked of them.

**7** This then forms the backdrop to three joint studies examining the delivery chains associated with particular PSA targets. Here the Audit Commission, the Healthcare Commission and the National Audit Office, through their different perspectives at national and local level, and by combining their knowledge and expertise, have examined the delivery chain associated with the delivery of the child obesity PSA target<sup>1</sup>; from the challenges faced by the joint owners of the target – the Departments of Health, Education and Skills and Culture, Media and Sport – through to the actions being taken by or now required at regional and local level by those organisations that have to deliver the target.

**8** The Audit Commission and National Audit Office have prepared two separate similar reports on increasing the use of buses and on affordable housing.

**9** Our aim in producing the three reports is to examine the characteristics of the specific delivery chains, and their capacity to deliver the PSA target for which they were designed. In so doing we identify ways in which the various parties involved in the chains might work more closely together, as well as suggesting some ways in which the target might be achieved both efficiently and effectively. An analysis of the delivery chain as a whole facilitates this by recognising that, whilst individual links in the chain may be effective, efficiency across the longer chain can still be improved. We intend these lessons to play a role in assisting those designing and implementing PSA targets in future.

**10** We have also produced a fourth report to be published in early 2006 in which we bring out issues of more general relevance to the ways that public sector delivery chains are constructed and how they can best operate.

<sup>1</sup> To halt, by 2010, the year-on-year increase in obesity among children under 11 in the context of a broader strategy to tackle obesity in the population as a whole.

## ABSTRACT

### Introduction

**1** Obesity is a complex public health issue that is a growing threat to children's health, as well as a current and future drain on National Health Service (NHS) resources. The Wanless Report stated that public health – the promotion of good health and the prevention of disease – should be central to the work of the NHS.<sup>2</sup> Obesity already costs the NHS directly around £1 billion a year and the UK economy a further £2.3 to £2.6 billion in indirect costs. If this present trend continues, by 2010 the annual cost to the economy could be £3.6 billion a year.

**2** In response, in 2004, reducing child obesity became a PSA target – *to halt, by 2010, the year-on-year increase in obesity among children under 11 in the context of a broader strategy to tackle obesity in the population as a whole* – with the target jointly owned by three Government Departments; the Department of Health (DH), the Department for Education and Skills (DfES) and the Department for Culture, Media and Sport (DCMS).

**3** An overarching difficulty with reducing child obesity is the inherent complexity of the issue, including changing the behaviour of children and their parents, and attitudes in society generally. The Departments plan to tackle the issue through some 20 interventions aimed at both prevention and treatment, many of which are already in place. These are delivered through a range of organisations and partnerships at national, regional, local and frontline level.

**4** This joint report from the Audit Commission, Healthcare Commission and the National Audit Office aims to identify how the barriers to creating a successful delivery chain can be addressed and makes recommendations about how the delivery chain might be strengthened and made more efficient as part of the need for the Departments to contribute to the Government's wider efficiency programme.

### Findings

**5** The report's key findings are as follows:

- a** **While the evidence is that a multifaceted approach to child obesity is the most effective, there is little evidence as yet to determine whether the Departments' range of programmes and initiatives to improve children's health and nutrition generally is sufficient to achieve the target.** Given the shortage of evidence on what works for obesity, it will be of critical importance to ensure that high quality evaluations are put in place as programmes and initiatives are rolled out.

<sup>2</sup> D. Wanless (2002) *Securing Our Future Health: Taking a Long-Term View – Final Report*. London, HM Treasury.

- b** **The three Departments are starting to coordinate their action at a national level, but levers to prevent and tackle childhood obesity are not yet sufficiently developed.** At a regional and local level, clear leadership is required, as poor coordination and inefficient use of resources present a risk to delivery of the target. The various organisations need to align their activities so that they are mutually supportive to ensure that progress towards the PSA target is both effective and efficient.
- c** **Without reliable baseline data, there is a risk that resources will be wasted in unproductive activity.** With pressure to tackle child obesity, there have been instances where local delivery bodies have devised or continued collecting their own sets of potentially incompatible measurements of child obesity, with the risk of producing inconsistency in activity and data. To address this, DfES and DH have issued guidance in January 2006 on weighing and measuring, with weighing beginning later in the year. Further guidance is planned for April 2006 on collation of that data. The requirement for PCTs to oversee local weighing and measuring should help to ensure a consistent approach nationally.
- d** **Regional roles are not clear.** Without clear leadership and sponsorship from those representing the target-holding Departments and their representatives at regional/Strategic Health Authority (SHA) level, local delivery agents may fail to devote sufficient resources to deliver the target.
- e** **Local structures and mechanisms exist to promote joint working, if used effectively.** Local Strategic Partnerships and children's trusts are well placed to exert influence over how the range of local programmes can be best coordinated and can use new mechanisms such as Local Area Agreements to deliver this.
- f** **Schools are a key setting for the delivery of effective coordinated interventions and have an important role to play, but need support and clear guidance** to help address child obesity.
- g** **There is potential to realise efficiencies in the delivery chain associated with the child obesity target.** Given the high level of expenditure on programmes for children's nutrition, activity levels and related health issues, relatively small administrative savings could have a high impact on efficiency.

## EXECUTIVE SUMMARY



**1** Child obesity is a complex public health issue that is a growing threat to children's health, as well as a current and future drain on National Health Service (NHS) resources. The United Kingdom has seen an unprecedented rise in obesity, but this is not a problem unique to Britain. A comparable rise has also been seen in the European Union. No country has yet achieved a reduction in the prevalence of obesity. It is estimated that obesity already costs the NHS directly around £1 billion a year<sup>3</sup> and the UK economy a further £2.3 to £2.6 billion in indirect costs.<sup>4</sup> It has been estimated that, if the present trend continues, by 2010 the annual cost to the economy would be £3.6 billion a year.<sup>5</sup>

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

*To halt, by 2010, the year-on-year increase in obesity among children under 11 in the context of a broader strategy to tackle obesity in the population as a whole.*<sup>6</sup>

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

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

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

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

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

<sup>4</sup> *Ibid.*

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

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

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

**School Meals**

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

**School Sport Strategy**

The School Sport Strategy aims primarily to achieve the PSA target to “enhance the take-up of sporting opportunities by 5-16 year olds by increasing the percentage of school children who spend a minimum of 2 hours each week on high quality PE and school sport within and beyond the curriculum from 25 per cent in 2002 to 75 per cent by 2006 and 85 per cent by 2008”. The Departments consider that this will have a significant and supportive impact on meeting the child obesity PSA. For example, starting in April 2003 and running until at least March 2008, the strategy includes the creation of School Sport Partnerships, which typically bring together a specialist sports college, eight secondary schools and around 45 primary schools, in order to enhance sports opportunities for all. Each partnership receives an annual grant averaging £270,000. Club Links focuses on strengthening the links between schools and local sports clubs to increase the number of children participating in accredited clubs. Playgrounds in more than 600 primary schools are being improved to increase physical activity and to enhance the delivery of the PE curriculum.

**Healthy Schools Programme**

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

**Play**

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

**Obesity Campaign**

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

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

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

**Every Child Matters: Change for Children**

A new approach to the well-being of children and young people from birth to age 19. The Government’s aim is for every child, whatever their background or their circumstances, to have the support they need to: Be healthy; Stay safe; Enjoy and achieve; Make a positive contribution; and Achieve economic well-being.

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

#### Extended Schools

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

#### Sure Start

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

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

## The purpose of this report

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

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

## Findings

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

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

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

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

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

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

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

**Joint area review (JAR)**

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

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

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

7 Source: Department for Education and Skills.

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

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

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

### Children’s trusts

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

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

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

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

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

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

### Regional roles are not clear

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

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

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

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

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

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

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

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

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

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

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

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

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

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

#### Care pathway

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

**29** To support health professionals, DH plans to provide an interim care pathway before the National Institute for Health and Clinical Excellence (NICE) guidance on child and adult obesity which will be put to consultation in March 2006 and published in 2007<sup>9</sup> (see blue text below). The DH has consulted with NICE on its care pathway to ensure consistency and has supported the joint Faculty of Public Health and National Heart Forum Obesity Toolkit. Both the pathway and the toolkit will be published by March 2006. Once published, the NICE guidance should become the primary source of information and guidance on preventing and treating child obesity.

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

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

### National Institute for Health and Clinical Excellence

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

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

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

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

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

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

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

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

<sup>10</sup> National Audit Office report *Food Procurement*, (in preparation).

## 4 Potential efficiencies in the delivery chain

### Key areas for efficiency

### Potential sources of efficiency

#### 1 Better designed funding arrangements

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

#### 2 Controlling administration costs

- To help control administration costs, it is important to ensure that new local initiatives make best use of existing resources and consolidate existing administrative arrangements as much as possible, particularly those of Local Strategic Partnerships and children's trusts arrangements.
- Better long-term planning and capacity building through the development of the Children and Young People's Plan<sup>1</sup> and the joint commissioning cycle for services can help to secure greater efficiency.
- Within each of the three Departments' delivery chains, there may be scope for the joining up of administrative activities such as human resources, finance or procurement. Recent research by A.T. Kearney<sup>2</sup> indicates that savings of 14 per cent are achievable where support services are successfully shared<sup>3</sup>. Current DH proposals to restructure PCTs offer the potential to reduce back office costs.

#### 3 Effective collaborative working

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

#### 4 Clear measures of progress

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

#### 5 Making better use of assets

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

### NOTES

1 The Children and Young People's Plan is an important element of the reforms underpinned by the Children Act 2004. Implementing a new statutory duty and following best local planning practice, local areas will produce a single, strategic, overarching plan for all services affecting children and young people. It should support more integrated and effective services to secure the outcomes for children, as set out in the Ten Year Childcare strategy, the National Service Framework for Children, Young People and Maternity Services and the Children Act 2004. It is a key part of the children's services improvement cycle, set out in Every Child Matters: Change for Children. The Children and Young People's Plan brings together 17 previously separate plans.

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

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





## RECOMMENDATIONS

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

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

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

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

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

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

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



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



## RECOMMENDATIONS CONTINUED

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



## Our report

This report considers the efficiency and effectiveness of the delivery chain to reduce child obesity in relation to the Departments' draft delivery plan. **Part 1** of our report describes how the Department of Health, Department for Education and Skills and the Department for Culture, Media and Sport are addressing the issue of child obesity. In **Part 2**, we describe the findings of our fieldwork, carried out at regional and local level, and the capacity of the delivery chain to deliver the PSA target under three broad themes – resources, partnership and multi-agency working and performance management. In **Part 3**, we discuss what delivery partners can do to strengthen the delivery chain. At the end of Part 3, Figure 11 outlines specific recommendations for national, regional and local bodies, addressing the risk areas identified in our fieldwork.

## PART ONE

# Why child obesity is a Public Service Agreement target

*In Part 1, we outline a definition of obesity and why it is a public health concern. Part 1 also looks at evidence of what works when tackling obesity and how the Department of Health, Department for Education and Skills and the Department for Culture, Media and Sport are tackling child obesity.*



**1.1** The increase in childhood obesity has become an increasingly important issue on the public health agenda, with concerns being raised not only about the risks to children's health but also the current and future drain on National Health Service (NHS) resources. Obesity is a causal factor in a number of chronic diseases and conditions including hypertension (high blood pressure), heart disease and type 2 diabetes. In 1998, the cost of treating diseases attributable to obesity was £470 million. This sum does not include the impact of being overweight (but not technically obese), which can also be a significant risk factor for these diseases and conditions. By 2002, this cost was estimated to be approximately £1.075 billion.<sup>11</sup> By 2010, if the current trend continues, the annual cost to the economy has been estimated to be £3.6 billion a year.<sup>12</sup>

**1.2** In response to the growing problem of overweight and obese children, a Public Service Agreement (PSA) target was agreed during the 2004 Spending Review to tackle the underlying determinants of ill health and health inequalities, and in particular:

*To halt, by 2010, the year-on-year increase in obesity among children under 11 in the context of a broader strategy to tackle obesity in the population as a whole.*<sup>13</sup>

**1.3** This PSA target is shared by the Department of Health (DH), the Department for Education and Skills (DfES) and the Department for Culture, Media and Sport (DCMS), reflecting the complexity of tackling childhood obesity.

**1.4** Obesity in adults is relatively easy to define and is considered to be a body mass index (BMI) of greater than 30kg/m<sup>2</sup>.<sup>14</sup> This simple definition cannot, however, be applied to children, as the ratio of weight gain to height gain changes during children's normal growth, so the figure must be adjusted for age and sex when using BMI for children. *The Public Service Agreement 2005–2008: Technical Note*<sup>15</sup> sets out the exact method by which achievement of the target is to be measured. The method adopted uses the prevalence of obesity as defined by the National BMI classification and measured through the Health Survey for England. Children above the 95th percentile of the 1990 reference curve are defined as obese and above the 85th percentile as overweight.<sup>16</sup> This definition has caused debate, because it has been based on the growth charts currently in use and an arbitrary date (1990) and the cut-off points (85th and 95th percentiles) do not relate to health or disease risks. The more recent international growth charts do relate to health risks but these are yet to be evaluated for UK use. One important consideration for the Departments for using the national BMI classification is the need for consistency of approach over time.

11 House of Commons Health Committee, *Third Report of 2003-04*.

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

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

14 Department of Health, Specialised Services National Definition Set: 35 Specialised morbid obesity services (all ages) [www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SpecialisedServicesDefinition/SpecialisedServicesDefinitionArticle/fs/en?CONTENT\\_ID=4001826&chk=a017Ao](http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SpecialisedServicesDefinition/SpecialisedServicesDefinitionArticle/fs/en?CONTENT_ID=4001826&chk=a017Ao).

15 Part of the Public Service Agreement delivery plan.

16 Department of Health Technical note for the Spending Review 2004. Public Service Agreement 2005-2008. Reference to T.J. Cole, J.V. Freeman, M.A. Preece (1995) Body mass index reference curves for the UK, 1990. *Archives of Disease in Childhood*, July: 73(1):25-9.

### Body mass index

Body mass index (BMI) is a widely accepted measure of adult obesity. It compares an individual's weight with their height. It is calculated by dividing the individual's weight in kilogrammes divided by their height in metres<sup>2</sup>. If the result of this calculation exceeds certain thresholds, the individual is categorised as obese. Height and weight data used to calculate BMI are collected in the Health Survey of England, commissioned by DH. However, BMI does not distinguish between mass due to body fat and mass due to muscular physique. It also does not take account of the distribution of fat.

**1.5** The 2005 DH White Paper, *Choosing Health: making healthier choices easier*, and its implementation guide, *Delivering Choosing Health* (2005), identify obesity as one of six key national priorities. There are two supporting action plans, *Choosing a Better Diet: a food and health action plan* and *Choosing Activity: a physical activity action plan*, which focus further on the activities to be undertaken to reduce obesity. *Delivering Choosing Health*<sup>17</sup> identifies "big wins" for tackling obesity, which include:

- national obesity awareness campaign
- simple labelling of packaged food
- helping people who want to lose weight
- food promotion to children
- *Healthy Schools* – implementing the new Healthy School Standard<sup>18</sup>
- encouraging physical activity
- high-quality family and early years support.

**1.6** Clearly, a number of factors, from conception to age 11, need to be taken into account to address obesity in children under 11 effectively. There are consequently a range of initiatives – including advice on healthy lifestyles during pregnancy, Sure Start children's centres, early years provision and work with school age children – that help address obesity within the target age range. This report focuses on the five to ten age group of the target, with a particular focus on schools, due to the numerous initiatives being delivered and directed at children of primary school age.

**1.7** The data in **Figure 5** highlight the rapid rise in obesity rates in children and young people, as well as the potential impact on levels of health and on the finances and resources of the NHS. It has been predicted that, if the current upward trend in childhood obesity continues, children will have a shorter life expectancy than their parents, potentially reversing the longevity gains of the last century.<sup>19</sup>

## 5 Key facts about child obesity

- The prevalence of obesity in children aged two to 10 years has increased from 9.6 per cent in 1995 to 13.7 per cent in 2003.<sup>1</sup> The combined percentage of children aged two to 10 who were overweight or obese rose from 22.7 per cent to 27.7 per cent in the same period.
- Obese children, especially girls, are more likely to come from semi-routine and routine households<sup>2</sup>: 17.1 per cent of children from households where the chief wage earner has a job classified as semi-routine or routine were obese compared with 12.4 per cent of those from managerial and professional households.<sup>3</sup> Between 1995 and 2003, levels of obesity increased 11.2 per cent for those in the least deprived fifth of the population and 16.4 per cent for the most deprived fifth.<sup>4</sup>
- Children who are obese are more likely to become obese adults, and this likelihood increases the more obese a child is, as well as increasing if the child's parents are obese.<sup>5</sup> Asian children are four times more likely to be obese than those who are white. The first cases of type 2 diabetes are being seen in obese children.<sup>6</sup>
- Obesity reduces life expectancy by an average of nine years – and by much more in smokers – and greatly increases the risk of heart disease, cancer, type 2 diabetes and high blood pressure.<sup>7</sup>

### NOTES

- 1 Jotangia et al (2005) *Obesity among Children under 11*. Joint Health Surveys Unit, p7.
- 2 Analysed using the National Statistics Social-Economic Classification, a classification similar to social class.
- 3 Jotangia et al (2005) *Obesity among Children under 11*. Joint Health Surveys Unit, p14.
- 4 Jotangia et al (2005) *Obesity among Children under 11*. Joint Health Surveys Unit, p12.
- 5 Department of Health (2004) *Choosing Health*, p43.
- 6 Association of Public Health Observatories (2005) *Indications of Public Health in the English Regions 3: Lifestyle and its impact on health*, p11.
- 7 APHO (2005) *Indications of Public Health in the English Regions 3: Lifestyle and its impact on health*, p10.

17 Department of Health (2005) *Delivering Choosing Health: making healthier choices easier*, p26.

18 From 1 April 2005, a Healthy School will provide a supportive environment including policies on smoking, and healthy and nutritious food, with time and facilities for physical activity and sport both within and beyond the curriculum; and comprehensive Personal, Social and Health Education (PSHE). DH (2005) *Delivering Choosing Health: making healthier choices easier*, p66.

19 Association of Public Health Observatories (2005) *Indications of Public Health in the English Regions 3: Lifestyle and its impact on health*, (2005) p11.

**1.8** As noted in Wanless' Treasury Report *Securing Good Health for the Whole Population* (2002), there has been an increase in the numbers of overweight and obese people over the past 30 years in the majority of developing countries.<sup>20</sup> The scale of the problem is unprecedented – over half the population in England is currently overweight or obese.<sup>21</sup>

## What works when tackling childhood obesity?

**1.9** There has been little comprehensive research on the effectiveness of prevention strategies in this area. The Health Development Agency<sup>22</sup> (2003) previously reviewed the evidence surrounding effective interventions in the prevention and management of obesity. A lack of strong evidence, however, does not necessarily mean evidence of ineffectiveness – only that more research is needed and better methods for evaluation should be developed (**Figure 6**).

**1.10** Further research is in progress. Of particular importance, NICE is considering the effectiveness (including cost-effectiveness) of interventions on the prevention and management of child and adult obesity. The guidance (including evidence reviews) is available for consultation from March 2006 and the final guidance will be published in February 2007. The Faculty of Public Health, together with the National Heart Forum, are producing a primary care toolkit to tackle overweight and obese adults (for publication in 2006). This resource should provide practical support for primary care teams and signposts evidence of effectiveness of interventions until the NICE guidance is published.

### 6 Effectiveness of obesity and overweight prevention interventions for children and adolescents<sup>1</sup>

#### Evidence of effectiveness<sup>2</sup>

- to support the use of multi-faceted school-based interventions to reduce obesity and overweight in schoolchildren, particularly girls. These interventions included: nutrition education, physical activity promotion, reduction in sedentary behaviour, behavioural therapy, teacher training, curricular material, and modification of school meals and tuck shops.

#### Limited evidence of effectiveness<sup>3</sup>

- to support school-based health promotion (classroom curriculum to reduce television, videotape and video game use) for the prevention of obesity and overweight in children.
- that family-based behaviour modification programmes (family therapy in addition to diet education, regular visits to a paediatrician and encouragement to exercise) impede weight gain in obese children.

#### Lack of evidence of effectiveness<sup>4</sup>

- for school-based physical activity programmes led by specialist staff or classroom teachers for the prevention of obesity and overweight in children.
- that family-based health promotion interventions impact on obesity and overweight. These interventions focused on dietary and general health education and increased activity, and involved sustained contact with children and parents.

#### NOTES

1 Faculty of Public Health/National Heart Forum summary of HDA evidence review.

Each summary statement sets out the evidence regarding effectiveness based on the following factors:

2 Evidence of effectiveness: derived from systematic reviews and meta-analyses that included four studies or more, where the results were all in agreement.

3 Limited evidence of effectiveness: derived from systematic reviews and meta-analyses that included three studies or less.

4 Current lack of evidence of effectiveness: applied to interventions in systematic reviews and meta-analyses that showed no current impact on obesity and overweight outcomes.

20 D. Wanless (2004) *Securing Health for the Whole Population*. Final Report, p93.

21 *Health Survey for England* (2002).

22 Now part of the National Institute for Health and Clinical Excellence (NICE).

## Aligning partnerships and programmes presents inherent risk for joint delivery of the PSA target

**1.11** Tackling childhood obesity is made more difficult by requiring, in addition to the delivery of services and programmes, a change in the behaviour of individual children and their parents and carers to counteract wider social trends towards greater fat and sugar intake, snacking and reduced physical activity throughout much of the developed world.

**1.12** Given the wide range of programmes and initiatives in education, physical exercise and healthy eating needed to tackle childhood obesity, responsibility is shared by numerous organisations at national, regional and local levels. This increases the complexity of delivering the programme effectively and efficiently. There is therefore a high degree of challenge in providing a complex suite of programmes through a delivery chain that encompasses four tiers and multiple partners.

**1.13** The fact that this target is jointly owned by three Departments is a positive development, but one that brings considerable challenge. At a national level, the three Departments have to align priorities for child obesity with their other PSA targets, and at least two further Departments – the Office of the Deputy Prime Minister (ODPM) and the Department for Transport – have significant contributions to make to the delivery of the target.

**1.14** This challenge is further compounded by the wide range of existing local partnerships that already coordinate programmes and activities and are required to deliver against the child obesity target. In a typical shire county area, tackling child obesity requires the active engagement of the relevant Government Office (GO), the County Council, district councils, the Strategic Health Authority (SHA), several Primary Care Trusts (PCTs), primary schools, a range of leisure facilities and many other organisations (**Figure 7 overleaf**). Local Strategic Partnerships (LSPs) are the existing vehicle for bringing these local bodies together for delivery. In future, children's trusts will aim to pull together planning, commissioning and delivery of services.

**1.15** Added to this administrative complexity, there is a range of programmes and initiatives of widely varying scale that contribute to the target, ranging from the School Fruit and Vegetable scheme to the School Sport Strategy. Some 20 interventions are identified in the Departments' draft plan for child obesity delivery.

**1.16** Each Government Department is responsible for programmes that will have an impact on the target. For example, the DH will lead cross-government action to promote healthier lifestyles through programmes such as Healthy Start, which provides families with vouchers that can be exchanged for fruit, vegetables and milk. NICE is currently developing guidance for the prevention and treatment of obesity that will be published in 2007. Meanwhile, DH is developing a comprehensive care pathway for the treatment of obesity in children. This aims to inform frontline health professionals as to when and how to refer children who are overweight or obese for specialist services. However, it should be noted that NICE is currently developing guidance on the prevention and treatment of obesity and the guidance will include clinical care pathways. When published, this work will be the primary source of advice and guidance on preventing and treating obesity. The NICE guidance will be available for consultation in March 2006. DH and the Food Standards Agency are also working with the food industry to address the promotion of food and drink that is high in fat, salt and sugar, including reducing portion sizes and the salt, fat and sugar content in foods, as well as developing a common system of signposting of food which will aim to help consumers to identify and choose healthier foods.

**1.17** The contribution of the range of programmes is reflected in the draft delivery plan, which sets out indicators in addition to the headline measure, by which the success of the programme will be measured:

- increasing the average consumption of fruit and vegetables to at least 5 portions a day (current mean intakes range from 2.4-2.5 portions in children aged 5-11)
- reducing the average intake of saturated fat to 11 per cent of food energy (currently 14.3 per cent)
- maintaining the current declining trend in the average intake of total fat at 35 per cent of food energy (currently 35.3 per cent)
- reducing the average intake of added sugar to 11 per cent of food energy (currently ranging from 16-17.5 per cent)
- increasing the percentage of children meeting Chief Medical Officer (CMO) recommendations on physical activity by 1 per cent each year to 2010
- increasing the initiation and duration of breastfeeding.

**1.18** At the time of our fieldwork, the three Departments were determining how best to coordinate their activities, as well as those of the many delivery partners at regional and local level. To do this, a draft delivery plan had been developed and a joint Programme Board established. Prime responsibility for developing the delivery plan had fallen to the DH, the natural lead for this public health issue. However, many of the programmes that are planned to deliver the target are led by the DfES and the DCMS, over whose delivery agents the DH has no direct control. This presents considerable risks to delivery and places a great deal of reliance on the effectiveness of the joint Programme Board's ability to assemble and manoeuvre resources effectively, to monitor ongoing performance and to identify appropriate courses of remedial action where this becomes necessary. Other joint working arrangements will however provide a basis for cross-departmental working. Children's trust arrangements are being developed through the cross-Government Every Child Matters: Change for Children programme, with the active involvement of DH on the children's trust-PCT partnerships. Similarly, the expansion of school sport is led by DCMS and DfES.

**1.19** The structure of the Programme Board and its position within the overall governance arrangements for the PSA target are set out in **Figure 8 on page 32**.

**1.20** The complexity of these arrangements is reflected in the delay in finalising the delivery plan and in determining the composition of the Programme Board which was to be in place by early 2005, but key post-holder changes, restructuring and other priorities have delayed progress. In June 2005, a jointly-funded cross-departmental Obesity PSA Programme Manager was appointed whose responsibilities include aligning the initiatives between the three organisations. Senior Responsible Owners (SROs) for the target were appointed by DH, DfES and DCMS respectively in April, June and August (2004). Membership and Terms of Reference were agreed by the Permanent Secretaries of DH, DfES and DCMS at a trilateral meeting on 13 July 2005. Progress towards the target is being monitored at Cabinet level – the Public Health Committee chaired by the Deputy PM.

## Resourcing the programme

**1.21** The funding for nutrition and physical activity programmes for children with the potential to impact positively on child obesity amounts to more than £1 billion over the three-year period from April 2005 to March 2008. Several component projects predate the obesity PSA target and the largest – Physical Education in schools – is in itself a PSA target. Major programmes and their funding are summarised in Figure 2 (Executive Summary). The DH also intends to allocate funding for an Obesity Social Marketing Campaign to influence public attitudes. In addition, approximately £3.6 billion will be spent over the same period on wider programmes such as Extended Schools and, although not part of the scope of this report, Sure Start for younger children, which, through their wider focus on the whole child obesity target age range, will also contribute towards the childhood obesity target.

**1.22** Beyond this, but difficult to quantify, is the proportion of mainstream funding to PCTs, local authorities and the significant contribution from the work of frontline professionals, such as GPs and teachers, and from activities aimed at a wider audience, such as the provision of leisure facilities.

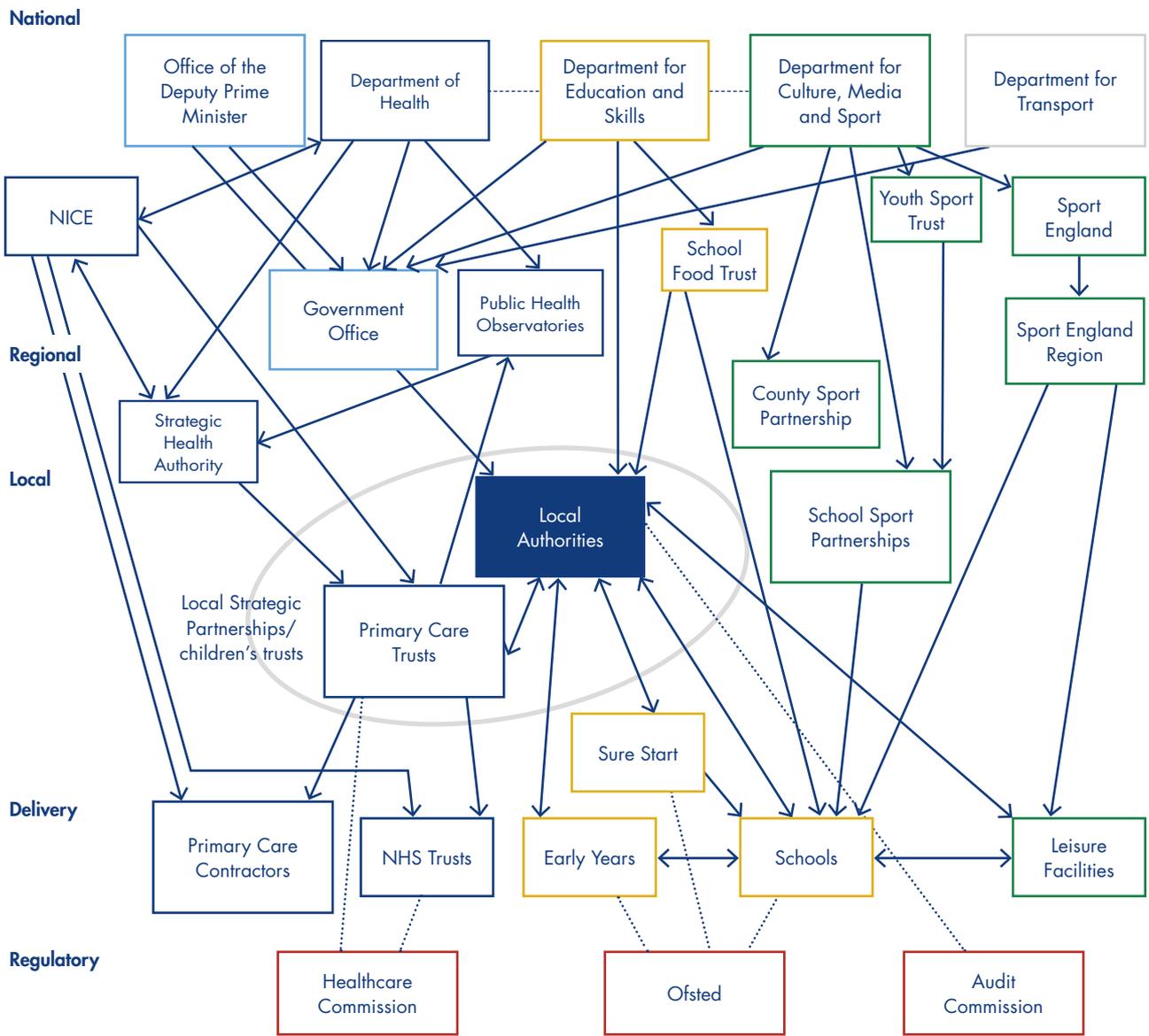
## Achieving an efficient delivery chain

**1.23** The child obesity PSA target is being delivered against a background where Departments are under strong pressure to be more efficient in their delivery of services. Following the publication of the Gershon Review in June 2004, the Government launched its Efficiency Programme to secure £21.5 billion of annual efficiency gains in the three years 2005-06 to 2007-08 across all public expenditure.<sup>23</sup>

**1.24** At a programme level, by Departments working together, there is the potential for significantly improved integration of services and efficiency gains. This will require an effective and well-managed delivery chain. Each of the target-holding Departments has a target for annual efficiency gains. Since overall expenditure on programmes to influence children's nutrition and physical activity is large, even small efficiencies in their delivery could have a considerable financial impact.

23 The Gershon Review (the Independent Review of Public Sector Efficiency: releasing resources to the front-line) can be downloaded from [http://www.hm-treasury.gov.uk/spending\\_review/spend\\_sr04/associated\\_documents/spending\\_sr04\\_efficiency.cfm](http://www.hm-treasury.gov.uk/spending_review/spend_sr04/associated_documents/spending_sr04_efficiency.cfm).

**7** The current delivery chain for child obesity



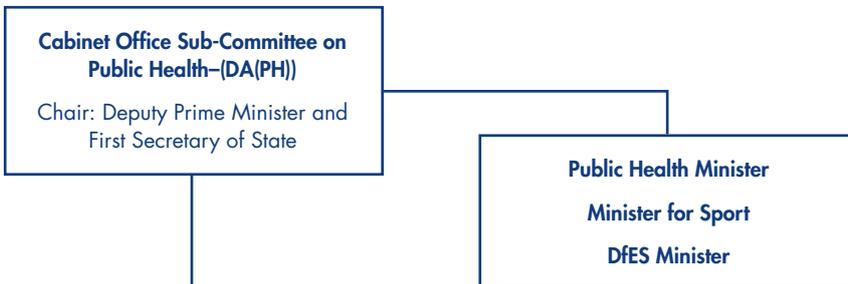
Source: National Audit Office, Audit Commission and Healthcare Commission analysis.

**Key**

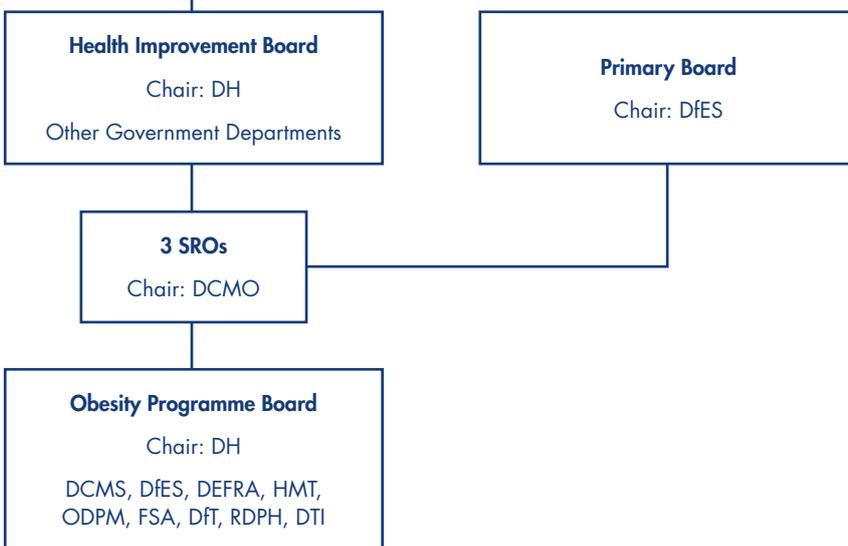
<b>Children's trusts</b>	Partnership arrangements generally within a Local Strategic Partnership, that bring together all services for children and young people in an area for integrated frontline delivery, processes and strategy as well as inter-agency governance.
<b>County Sports Partnership</b>	Partnership which creates strategic leads for sport within a county to help more people get actively involved in sport.
<b>Early Years</b>	The Government's Ten Year Strategy for early years and childcare.
<b>Government Office (GO)</b>	Nine Government Offices for the Regions bring together the interests of ten different Government Departments within a single organisation.
<b>Local Strategic Partnerships</b>	Local Strategic Partnerships (LSPs) bring together representatives from health, local government, education, other public sector agencies, the private sector and the voluntary and community sector to agree local priorities and coordinate activities.
<b>National Institute for Health and Clinical Excellence (NICE)</b>	Provides national guidance on the promotion of good health and the prevention and treatment of ill-health.
<b>Public Health Observatory</b>	Supports local bodies in an NHS region by monitoring health and disease trends, evaluating progress by local agencies and providing advice.
<b>School Sport Partnerships</b>	School Sport Partnerships are families of schools that come together to enhance sports opportunities for all. This pays for a full-time Partnership Development Manager, the release of one teacher from each secondary school two days a week to allow them to take on the role of School Sport Coordinator. The grant also pays for release of a primary school teacher for up to 12 days per year to develop and enhance school sport in their school.
<b>Strategic Health Authority (SHA)</b>	Manages the local NHS on behalf of the Secretary of State.
<b>Sure Start</b>	Government programme to deliver the best start in life for every child by bringing together early education, childcare, health and family support.
<b>Youth Sports Trust</b>	Registered charity with a mission to support the education and development of all young people through physical education and sport. It aims to create opportunities for more young people to participate in high quality PE and school sport.

**8** Governance arrangements for the child obesity programme

**Ministers**



**Officials**



**Stakeholders**



Source: Department of Health

## What our analysis set out to achieve

**1.25** The aim of this report is to assist the three target-holding Departments and others in the delivery chain at regional and local level and at the frontline. The report examines the delivery arrangements for the child obesity PSA target, with a focus on children aged between five and ten, and a specific focus on schools. This joint approach enables the National Audit Office, Healthcare Commission and Audit Commission, through their different perspectives and by combining their knowledge and expertise, to take a unique look across the delivery chain, from the challenges faced by the three Departments through to those faced by frontline deliverers who have to make achieving this target a reality.

**1.26** The study examined four levels of the delivery chain – national, regional, local and frontline delivery – to identify examples of good practice and recommendations for improvement (**Figure 9**).

**1.27** This review was undertaken early in the PSA's implementation period. Fieldwork was carried out 5-11 months after the target was agreed. The report analyses the efficiency and effectiveness of the target's delivery arrangements at that time. It has not attempted to identify the best mix of interventions to deliver the target, but rather to understand the opportunities and barriers that exist across the different tiers and geographical spread of the chain. We have examined the delivery chain against key criteria for efficient and effective delivery, including the clarity of arrangements for monitoring performance towards the target, the capability and capacity of frontline organisations to deliver, the clarity of roles and responsibilities, and whether the target has been clearly communicated to frontline service providers. Recommendations are made for national, regional and local levels that will support both those agencies and organisations and the frontline in its delivery of the target.

### 9 How we approached the work

Our report draws on evidence from different levels of the delivery chain:

- **National:** meetings and interviews with managers in the three target-holding Departments; discussions with other national bodies; participant-observation of two DH *Choosing Health* Delivery Planning Task Group Workshops of obesity, physical activity and healthy eating experts
- **Regional:** 27 interviews in three regions – the North West, West Midlands and South West – with directors and senior managers of regional bodies with responsibility for the target (Government Offices, Strategic Health Authorities), and regional directors of Sport England and the Health Development Agency
- **Local:** four workshops of sub-regional authorities and stakeholders in the three regions, including PCTs, local authorities, local education authorities, schools and Local Strategic Partnerships (LSPs); interviews with local authority directors and managers
- **Frontline delivery:** 12 focus groups of head teachers or their nominated representatives from 57 primary schools drawn from two local authority areas in each of the three regions
- **Whole delivery chain:** two workshops of national, regional and local representatives of the delivery chain from within and outside the fieldwork regions, to critique emerging findings
- **Documentation:** examination of relevant reports and documents

Fieldwork was carried out between November 2004 and May 2005 and involved over 150 representatives of the delivery chain. Interviews at national level were carried out by the members of the National Audit Office, Audit Commission and Healthcare Commission project team. Interviews at regional level were carried out by PricewaterhouseCoopers (PwC) who also organised the sub-regional and whole delivery chain workshops. School focus groups were conducted by MORI. Further details on the fieldwork are in Appendix 1.

## PART TWO

### Achieving a cost-effective delivery chain – fieldwork findings

*In Part 2, we assess our fieldwork findings and analyse the key risks to efficiency and effectiveness that the target-holding Departments face in implementing current and future initiatives to meet the PSA target, as well as the preparedness of relevant local bodies for delivering the target and their perceptions of barriers and risks. Findings are discussed under three headings:*

- *Resources*
- *Partnership and multi-agency working*
- *Performance management.*



## Resources

**2.1** With multiple partners, programmes and initiatives coming together for the first time, and over £1 billion available for 2005-08 for nutrition and physical activity programmes for the wellbeing of children (including child obesity), it is important that Departments invest time and effort to ensure that money is not absorbed in successive levels of administration or allocated to ineffectual programmes.

**2.2** At the time of our fieldwork, awareness of the existence of the target at regional and local levels, and the role that these levels of the delivery chain would need to play in achieving it, was very variable. The Departments have a joint draft delivery plan to achieve greater coherence of the different programmes and associated funding streams. In parallel, they have set up a Programme Board to oversee delivery. The Programme Board had its first meeting on 27 September 2005. The Board is assisted by an Obesity PSA Programme Manager, and involves, in addition to the target holders, other Departments with a role to play in delivering the target; in particular the ODPM through its neighbourhood renewal programmes and the Department for Transport in respect of its joint school travel plan initiative with DfES.

**2.3** Our fieldwork evidence has revealed three key issues that need careful management if resources within the delivery chain are to be used cost-effectively.

a) There is limited evidence about what works

**2.4** As discussed in Part 1, because obesity is a relatively new problem, there is limited evidence about which activities are most effective in reducing child obesity, and limited evidence of the long-term health costs of obesity to the economy and society more generally. Guidance, academic research and evaluation evidence on obesity interventions are needed, but time will be needed to build up the evidence base.

### Implications for achievement of the target

**2.5** It is essential that strong evaluation is built into new programmes as they are rolled out. If there are delays in determining the effectiveness of programmes, and in particular their ability to engage children who have become obese or who are at risk of obesity, there will be knock on delays for the delivery of the target.

### Implications for efficiency – key cost drivers

**2.6** By understanding which programmes contribute most to the reduction in child obesity, target-holding Departments can focus their efforts to halt the rise in obesity on the most successful programmes.

b) There is no ring-fenced money for the child obesity target and there are numerous funding streams, often involving small amounts of short-term money

**2.7** Funding available to PCTs through the *Choosing Health* White Paper will not be ring-fenced for public health purposes. While this may have advantages in giving PCTs flexibility to address local priorities and avoiding additional narrow funding streams, the 33 PCTs who participated in this study expressed concern about their ability to fund public health measures given other pressures on their budgets from acute services. This presents a risk that funding may be used to address other priority targets or financial deficits. Directors of Public Health in PCTs were seen as having an important role in championing child obesity to counter this risk. Effective performance management is therefore critical to ensure that public health targets are appropriately resourced at local level.

**2.8** As a complex problem, child obesity draws together a wide range of programme of interventions that do not fit any one Department's remit and each of which has its own funding and delivery arrangements. In addition to mainstream funding, in putting together their programmes to address obesity, healthy eating and physical activity, local level staff in PCTs and local authorities apply to a range of existing national and local sources for funding, such as Neighbourhood Renewal Funding (NRF), local Sure Start grants and resources for 5 A Day from the New Opportunities Fund (NOF). There was a widely held view among workshop and focus group participants that the multiplicity of funding sources creates confusion as to what is available.

**2.9** Head teachers and PCT representatives were also concerned about the amount of information and paperwork they are required to produce when bidding for funds, particularly in respect of small schemes. Often this required them repeatedly to submit the same or similar information. They were therefore wary that new priorities, such as the child obesity PSA, could burden them with further administration and excessive paperwork for, at best, limited returns.

**2.10** Feedback from workshops and MORI focus groups highlighted concerns about the sustainability of funding, and related uncertainties arising from annual funding cycles. An example was given of an individual, funded by lottery money, who was coordinating work to tackle obesity in a region and who had made a substantial contribution to running the School Fruit and Vegetable and 5 A Day programmes. But funding was shortly to run out and there was uncertainty about the future of the position, with the loss of valuable knowledge and key contacts and implications for the continued success of the programmes.

#### Teachers were concerned about the costs of bidding for funding

*Paperwork – excess paperwork – is definitely a disincentive to us.*

School focus group participant, Rugby

*The frustration is the initiative overload... another initiative with no money to do it, which I find insulting and it makes me angry, because obviously – good ideas, but no money to back it up.*

School focus group participant, Rugby

Source: MORI

**2.11** Faced with limited mainstream resources, many local partners sought access to other funding that would help them to develop local initiatives to tackle obesity, with the risk that localised pilot programmes may waste money and lead to a confusion of initiatives.

#### Implications for achievement of the target

**2.12** Uncertainty about continuation of funding in one sector may cause important decisions to be postponed elsewhere. For service deliverers, having to manage this uncertainty means there is reduced incentive to plan for the longer term or to invest in the capacity to deliver services efficiently. This risk was clearly set out in a recent recommendation in the NAO report *Managing Resources to Deliver Better Public Services*.

**Greater alignment of the targets and resource allocations of key organisations involved in delivering specific services is needed to ensure that they are mutually supportive in working to a common good.**

Most Departments depend on a number of organisations in a delivery chain to provide public services. Delivery is put at risk however if the targets and underlying resource allocations of organisations providing complementary or supporting elements of a public service are not comparable or consistent.<sup>24</sup>

**Implications for efficiency – key cost drivers**

**2.13** Where any discretionary funding is available for programmes that may contribute to the child obesity target, overly bureaucratic bidding processes for small amounts of finite funding across the wide range of funding streams can lead to inefficient use of resources by reducing the productive time of frontline staff. The Departments should design into any central funds that require bidding, from the outset simple standard application forms and processes and avoiding the repeated resubmission of core information, possibly through a single access website or other system.

**c) There are insufficient staff with the right skills**

**2.14** PCTs, in particular, said they lacked funding to recruit staff to ensure they have the capacity to address the target (for example, the salaries of administrative staff required to coordinate and run some of the programmes set out in the draft delivery plan). There was also a danger of false economies in that a succession of temporary staff were taken on to coordinate particular initiatives, building up knowledge and contacts, who would then be lost to the organisation.

**2.15** Workshop and focus group participants indicated that more needs assessment is required to identify and plan for skill shortages at regional and local level. At present, for example, there is a general shortage of dietitians and nutritionists.

**2.16** While committed to prevention as a more effective approach than treatment, some concerns were expressed by PCTs that raising the profile of child obesity could result in increased referral to medical services which might not have the capacity to deal with them. This highlighted the importance of liaising effectively with education partners to focus delivery on prevention rather than treatment.

**Implications for achievement of the target**

**2.17** As well as the need to fill particular skills gaps, suggestions were also made at workshops that delivery capacity could be enhanced through innovative use of existing networks. As child obesity is in part a lifestyle issue impacting on and impacted upon by multiple sectors and stakeholders, it could be addressed by broadly increasing capacity and skills in a range of fields, including teachers, Sure Start staff, and others working with local communities.

**2.18** In the longer term, effective capacity planning should better equip the delivery chain with the right skills, avoiding over-burdening staff who might properly be doing other duties, such as relieving medical and health professionals of the need to deliver training and guidance on children's healthy living issues.

**Implications for efficiency – key cost drivers**

**2.19** Investing for the long term could be money well spent. Where local delivery agents come together around a sound business case for coordinated action on child obesity, with clear review points and performance targets, funding bodies should aim not just to coordinate funding streams, but also be prepared to enter into commitments to provide funding for the lifetime of the intervention, avoiding unnecessary and excessive staff turnover with the associated loss of knowledge and expertise and the incurred costs.

**Partnership and multi-agency working**

**2.20** A major challenge for target-holding Departments is that there is no direct alignment between the various administrative tiers of health, education and sport, and that geographical boundaries vary. Planned reorganisation of the NHS and new planning arrangements such as children's trusts aim to work towards addressing these challenges, particularly at a local level. As the main commissioning agent, PCTs will continue to have a key role.

**2.21** With no direct funding and with delivery relying on a range of programmes led by a variety of different bodies, leadership is crucial to ensuring effective collaboration across the child obesity delivery chain. Our fieldwork found four key issues that need to be addressed if partnerships are to work effectively and efficiently.

24 *Managing Resources to Deliver Better Public Services: Report by the Comptroller and Auditor General, HC 61-1, Session 2003-04: 12 December 2003.*

## a) Regional roles and responsibilities are unclear

**2.22** Given the number of programmes and bodies involved in reducing child obesity, it was clear that individuals could not entirely understand the purpose and functions of those from other agencies. This was most clearly expressed about the role of the Government Office.

**2.23** This lack of clarity stems in part from the different ways in which the various bodies are organised. For example, the Department for Education and Skills and Department for Transport deliver their Travelling to School Initiative through part-time regional coordinators based in their home local authorities rather than in Government Offices.

**2.24** There are also widely differing lines of management and accountability. While SHAs have a clear role to monitor the performance of PCTs, there is no equivalent in education; the traditional model of a county-based Local Education Authority has changed in recent years, with a stronger emphasis on commissioning and quality assurance as schools have become more autonomous. However, as part of the Future Role of Government Offices (FROGO) programme, Directors of Children and Learners will be responsible for managing the performance of local authorities across the range of children's services.

**2.25** Against this backdrop, there was clear support from interviews and workshops for an enhanced role for the Government Offices for the Regions. This, however, was expressed alongside concern about the extent to which Government Offices would be able to influence organisations in the delivery chain for which they have no statutory responsibility.

**2.26** There was also clear support in the field, in particular, for an enhanced role for Regional Directors of Public Health who sit within the Government Offices. In addition to promoting public health within SHAs and PCTs, Regional Directors were seen as a pivotal force in bringing about better coordination between the various regional and sub-regional tiers of administration.

### Implications for achievement of the target

**2.27** Without clear leadership and sponsorship of the target by regional directors representing the target-holding Departments and SHAs, local delivery agents may fail to devote sufficient resources to deliver the target.

## Implications for efficiency – key cost drivers

**2.28** Failure to engage with other Departments at regional and local levels will weaken effectiveness and risk duplication of effort.

## b) Other Departments need to be engaged

**2.29** Other Government Departments, including ODPM and the Department for Transport, are represented on the Obesity Programme Board. Beyond its responsibilities for Government Offices, the ODPM has a central role in the child obesity target through its neighbourhood renewal programmes, which address issues of healthy eating (such as access to fresh food and the 'Growing for schools' type programme in which children are encouraged to grow their own food) and physical activity, and its 'liveability' PSA target, with its focus on parks and play areas.

### Office of the Deputy Prime Minister's 'Liveability' Public Service Agreement target

Lead the delivery of cleaner, safer, greener public spaces and improvement of the quality of the built environment in deprived areas and across the country, with measurable improvement by 2008.

**2.30** By 2010, all schools will be required to have School Travel Plans that encourage walking or cycling to school, or travel by bus, rather than door-to-door car transport. The Department for Transport is keen to work with the target-holding Departments to share information about children's health and the impact of walking and cycling initiatives; recognising that, without this close linkage, the requirement on School Travel Plans could be achieved in a way that made little contribution to the child obesity target.

### Implications for achievement of the target

**2.31** Close coordination with other Departments allows opportunities to be identified for making use of other delivery chains to help achieve the child obesity target, such as through the Office of the Deputy Prime Minister's neighbourhood renewal initiatives mentioned in 2.29 above.

## Implications for efficiency – key cost drivers

**2.32** Coordinated activity between Departments, such as DCMS' promotion of children's play and ODPM's development of cleaner, safer, greener open space, and use of their associated delivery chains may prevent costly duplication of activities.

### c) Local partnerships need to be strengthened

**2.33** A number of the new partnership arrangements, including LSPs and the emerging LAAs and children's trusts have a role to play in bringing together planning and commissioning arrangements. PCTs play a key role in these partnerships. Our fieldwork identified good examples of multi-agency working at local level. In Birmingham, for example, the four PCTs had formed a city-wide obesity strategy group and were developing obesity care pathways for children and adults. Elsewhere, there were examples of partnerships established to deliver other programmes being used for child obesity. Lancashire County Council's Healthy Schools Forum, for example, draws together the health and education sectors, including PCTs, representatives of the different local authority directorates and schools to encourage healthier lifestyles for children. In Suffolk a county-wide 'Fit for the Future' group has recently been created, including representation from seven LSPs and other relevant parties from health and education, the voluntary and private sectors, around a Local PSA specifically targeted at child obesity. In addition, as one of 21 pilot LAA areas, Suffolk is able to bring together funding around local priorities including child obesity.

**2.34** Workshop participants identified the combination of LSPs and LAAs as providing a promising basis for effective collaborative working and the means by which delivery bodies could pool mainstream funding around agreed priorities. At this early stage for LAAs, there was however little evidence to date of this happening.

**2.35** Children's trusts were also viewed as a vehicle for tackling child obesity, particularly between PCTs and local authorities. Departments also see these new trusts as a key means to bring about better multi-agency working and currently have in place a national evaluation. Children's trusts are, however, at an early stage and it will be important to make sure that the emerging findings from the evaluation inform their continuing development.

**2.36** In terms of multi-agency working, community and neighbourhood support mechanisms were seen as crucial, with the potential to enhance capacity by involving families and children in healthy living. Community representatives were seen by workshops as particularly important for reaching Black and ethnic communities and other minority groups.

### Implications for achievement of the target

**2.37** Effective local delivery requires coordination and leadership at a local level. Initiatives such as LAAs and children's trusts offer considerable potential to bring about effective partnership working but will need close management if they are to deliver their objectives and avoid duplication of activity and effort.

**2.38** Failure to engage with community representatives of diverse communities could result in programmes that fail to meet the needs of people with different eating and physical activity patterns as well as a failure to address health inequalities.

### Implications for efficiency – key cost drivers

**2.39** A joined-up approach to local service provision would extend to ensuring that services are integrated around the needs of children. Extended Schools, for example, can allow swimming pools and sporting facilities to be used by children in their leisure hours to encourage greater use, while improving efficiency through the increased use of a public asset.

### d) Frontline staff require more support

**2.40** Child obesity was viewed by teachers in our focus groups as only one among many health and lifestyle issues, and not necessarily the most pressing. Other issues of concern included under-nourishment.

#### Teachers do not see obesity as the only or most important health problem for primary school pupils

*I think the problem for our school is not so much that children are obese but that children aren't particularly fit.*

School focus group participant, Gloucester, affluent area

*I've been looking particularly, and you can certainly count on your two hands the number of children out of 250-odd who, I would say, are obese.*

School focus group participant, Rugby, affluent area

*If you're looking at numbers, I've got far more children that look as if nutrition is an issue and they're too thin and pale rather than children that are fat.*

School focus group participant, Rugby, less affluent area

Source: MORI

**2.41** Teachers were concerned about the information available about child obesity and saw their schools often acting in isolation when delivering programmes designed to improve children's health. Teachers commented on the lack of formal structures for sharing or learning from best practice, a lack of channels of communication with other agencies, and lack of coordination between agencies. Teachers also cited the lack of a health professional within their schools as a barrier to effective monitoring and early intervention in child health issues.

**2.42** The Healthy Schools Programme was widely cited by teachers and PCTs as a means to bring together health and education partners. Healthy Schools Coordinators were valued by teachers as sources of advice and in some areas helped schools bid for funding from, for example, the pilot phase of the School Fruit and Vegetable schemes before they were made universal. The strength of the role was seen as their ability to build up health and education networks and to develop strong links with schools.

**2.43** Changes in eating patterns were being encouraged by schools through initiatives such as breakfast clubs, which teachers saw as making a positive contribution both to children's nutrition and to their social skills. Teachers emphasised the importance of reaching parents and getting them on board as essential partners on obesity and health issues. They were keen to have clear information, such as leaflets from the local authority, to give to all parents about how they can help their children live a healthier lifestyle. Information that signposted parents to obesity services was seen as being particularly helpful. PCTs likewise identified the need for clear information that primary care practitioners could use to guide parents about diet and exercise.

#### **Liaison between health and education could be unclear**

*If PCTs don't talk regularly to individual head teachers (where the average PCT covers 60 local primary schools), how quickly can we expect good lines of communication to develop?*

*Who should be liaising with the 28 SHAs, when there are no equivalent bodies on the education side?*

*Source: PricewaterhouseCoopers interviews and workshops*

**2.44** Good information for GPs and other primary care practitioners about care pathways was also considered by PCTs to be an important part of ensuring a good local infrastructure for medical or other interventions to help children who were obese or at risk of becoming obese.

**2.45** As part of *Choosing Health* commitments, DH completed in January 2006, consultation on the obesity care pathway and weight loss guide, which it intends to disseminate, as a package, to PCTs in March 2006.

**2.46** Other healthcare programmes, such as for teenage pregnancy, were cited by PCTs and healthcare professionals as models for sharing good practice around standards of data, clear guidance and effective partnership working (**Figure 10**).

#### **Implications for achievement of the target**

**2.47** The child obesity target can be delivered effectively only if parents and children want to address overweight and obesity problems. School staff, other non-health professionals and primary care practitioners who have contact with children and parents are in a good position to encourage behavioural change but need information and guidance to assist them. The Departments recognise that they have not yet been given the information they need to be fully effective in this role. The Departments accept the need to provide increased guidance and information about tackling obesity and the obesity PSA programme.

**2.48** For care pathways to work successfully, the agencies that have face-to-face contact with children – schools, primary care centres, school nurses and other health workers – need to have clear signposting to appropriate services and the capacity and skills to make referrals.

#### **Implications for efficiency – key cost drivers**

**2.49** Giving schools clear guidance and direction about health and lifestyle education will assist in delivering the child obesity target, and will have particular impact if it reduces referrals to health services for treatment.

**2.50** The present limited ability to share good practice inhibits better ways of working. There is also a risk that, without clear guidance, interventions will be delayed or the wrong interventions applied.

## 10 Teenage Pregnancy: potential lessons for obesity programmes

**Context:** The UK has the highest teenage birth rates in Western Europe, with around 41,000 conceptions to under-18s in England, resulting in 23,600 births (1998). Infant mortality for babies of teenage mothers is 60 per cent higher than for babies of older mothers; teenage mothers are three times more likely to suffer post-natal depression than older mothers.

**Government response:** The Prime Minister published the Social Exclusion Unit report on teenage pregnancy in 1998, with two targets, jointly held by DH and DfES:

- to halve the rate of conceptions among under-18s by 2010
- to increase to 60 per cent the participation of teenage mothers in education, training or employment by 2010.

The Teenage Pregnancy Unit (TPU) is located in DfES, with a national network of regional and local Teenage Pregnancy Coordinators (TPCs) to drive forward the programme.

Since the start of the strategy, there has been a 9.8 per cent reduction in under-18 conceptions (1998 – 2003); previously the rate had been rising. Around four in five local authorities have seen an overall reduction, but there remains considerable variation across the country, with 50 per cent of under-18 conceptions occurring in the 20 per cent of wards with the highest rates; virtually all local authorities have at least one of these wards.

**Lessons for obesity:** Like obesity, teenage pregnancy is a complex issue. To be effective, programmes require accurate data, joined-up partnership working, evidence of effectiveness and strong performance management. Some lessons drawn from discussions with the TPU that may be useful for the obesity programme include:

- **Data:** Getting baseline information right at the beginning – and clarity about what is being measured and by whom – are crucial to being able to determine the programme's impact. Local data (e.g. ethnic monitoring and deprivation data) are important to ensure targeted programmes and effective monitoring.

- **National guidance and performance management:** Clear national guidelines to support implementation of the strategy, and a tight performance management framework with high-level accountability and standardised reporting provide direction to the work. It is important to be clear and specific about what works.
- **Good infrastructure:** Every local authority area has a Teenage Pregnancy Coordinator. Good working relations and effective communication networks with Local Strategic Partnerships and their partners are essential for programmes to work. The seniority and clout of the Teenage Pregnancy Coordinators are important issues.
- **Funding related to targets:** Ring-fenced 'pump priming' resources were allocated according to the degree of local challenge and linked to targets; this has resulted in a range of successful local initiatives, as well as ensuring the availability of staff to carry out programmes. Challenges associated with ring-fenced funding include difficulties mainstreaming initiatives, and the risk of developing isolated programmes in 'silos'. Programmes can miss out on mainstream resources as they can be perceived as fully funded. It was seen as important to be specific about the type of services that could be funded.
- **Partnership:** Working in partnership at all levels, with clarity about roles and responsibility, is crucial. Delivery plans can play a critical role. Senior sponsorship is important to ensure the issue is championed locally.
- **Generic vs. Targeted programmes:** Clarity about what works and knowledge of where problems are most acute have been essential to facilitating the approach taken by the TPU:
  - Universal services and programmes for all
  - Targeted programmes for populations at higher risk
  - Intensive programmes for individuals with greatest need.

## Performance management

**2.51** Effective partnership working requires a clear overarching strategy, common performance measurement systems, robust risk analysis and senior management support across all organisations. At this stage of establishing the obesity programme, there is limited alignment between the different reporting and performance regimes across the delivery chain, and an absence of baseline data against which to track performance.

**2.52** There are two key issues that need to be addressed to ensure effective performance management of the target.

a) National and local data are needed to monitor progress

**2.53** Across the delivery chain, there was concern at the absence of an agreed, commonly understood definition of child obesity, together with a lack of baseline data against which to measure progress. PCTs had received little guidance on baseline data or on setting local targets. Body mass index – adjusted for children – was considered the best measure for monitoring the target at a population level (both in terms of children who are obese and those who are overweight), but there are concerns about the uncertainty about the measurement process. Regional and local levels of the delivery chain were unclear about how, when, where and by whom children were to be measured.

There were also questions about who would be responsible for managing, analysing and reporting the data and whether there is an appropriate IT infrastructure in place to support these activities. The Departments acknowledge this risk and have issued guidance in January 2006 on measurement which also includes a recognition that further guidance is necessary on the management of this data which is due for publication in April 2006.

**2.54** Among workshop participants, confusion was apparent at a local level about the purpose of measuring children, particularly whether this would be for establishing trends or to identify children in need of help – or both. To address this, the Departments' guidance on measurement states that the purpose is to establish trends and to enable the problem to be managed at PCT, school or community level, rather than screening for individual overweight children. Participants suggested that a focus on the prevalence of obesity as measured by body mass index could lead to an emphasis on tackling the problem once it exists, rather than on preventative action identified through an assessment of risk (although the measurement would actually identify those who are overweight as well as those who are obese).

**2.55** Concern was expressed at workshops that, in the absence of national measures, there was a danger that alternatives might be developed at a local level that are not useful or valid. Some PCTs were already setting up their own pilot programmes for measuring children, risking local activity running ahead – possibly in an inconsistent direction – of any national and regional data collection processes. The Departments acknowledge this risk and inform us that it will be addressed in the best practice guidance planned for early 2006.

### Implications for achievement of the target

**2.56** A lack of definition and measurement of child obesity creates potential difficulties in establishing baselines, setting trajectories and monitoring progress towards the PSA target, increasing the risk that individual programmes within the child obesity delivery plan are not monitored robustly and may therefore fail to achieve their objectives.

### Implications for efficiency – key cost drivers

**2.57** The lack of definition and common measurement also risks the inefficient use of resources, with a range of organisations gathering inconsistent data. There is a need for standardised arrangements across regions. As noted above, the best practice guidance planned for 2006 would help address these issues.

### b) The child obesity target is to be achieved through physical activity and nutrition programmes not directed specifically at child obesity

**2.58** Those responsible for the child obesity target are aiming to achieve it through the delivery of other programmes. DCMS views its contribution to the target in terms of delivering with DfES their joint PSA target on school sport, and in terms of food promotion and broadcasting, dance and play, for which DCMS has lead policy responsibility. In addition, under present performance management arrangements, schools could not be responsible for delivery of the child obesity target, despite their being one of the main delivery vehicles for the target. Schools will assess themselves when they evaluate their work for their contribution to the “be healthy” part of the children’s agenda. Ofsted will take account of this when inspecting how well the school meets the outcomes for Every Child Matters. The Healthy Schools Programme also serves as a mechanism for encouraging schools to deliver improved physical activity and nutrition.

### Implications for achievement of the target

**2.59** Some parts of the delivery chain see reducing child obesity not as their target, but just as a worthwhile but coincidental benefit. As it is not a prime performance driver, there is therefore a risk that other priorities may divert resources away from the child obesity target.

### Implications for efficiency – key cost drivers

**2.60** If local performance targets for child obesity are not carefully aligned with other targets, there is a risk of confusion and contradiction, taking up excessive time of both frontline and administrative staff.



## PART THREE

### What the delivery partners can do to strengthen the delivery chain

*In Part 3, we consider the issues identified in our study that should be addressed in order to build on progress and overcome barriers to achieving the target.*



**3.1** The PSA target, backed up by commitments in *Choosing Health*, provides an opportunity for all those involved in the existing delivery chain to look hard at priorities and to consider how effectively and efficiently they currently work with partners to coordinate programmes and services. The child obesity target should be the means not to further expand or duplicate delivery mechanisms, but to rationalise and reform existing arrangements.

**3.2** With limited funding directly targeted at child obesity and complex delivery arrangements, involving year-on-year budget changes and reprioritisations, there is a risk of unbalanced and unfocused interventions. It is crucial that the Departments communicate clear messages to those in the delivery chain about the need to prioritise and coordinate activities, to enable best use to be made of disparate funding streams contributing to the achievement of the target.

**3.3** We discuss below the implications of our key findings for each level of the delivery chain and issues that need to be addressed if the target is to be achieved. These are discussed under the following headings:

- a) **Clarity and direction from the target-holding Departments**
- b) **Clear regional roles and responsibilities**
- c) **Strong effective local partnerships**
- d) **Support and capacity building for frontline staff**
- e) **Involving and influencing parents and children**

## a) Clarity and direction from target-holding Departments

**There is a need for the three target-holding Departments to be clear about how they will work together effectively and how they will establish the means by which different programmes can be assessed to determine their contribution to meeting the target.**

**3.4** Each Department has separate delivery plans for those programmes and initiatives that it sees as its main delivery vehicles for the child obesity target. Many of these were in place before the obesity target and have, to a greater or lesser extent, different aims, providers and reporting structures. The draft delivery plan and Programme Board need to bring together these different strategic approaches as soon as possible, with responsibilities, definitions and procedures communicated quickly throughout the delivery chain.

**3.5** Those further down the delivery chain are asking for guidance about what they should be doing to address child obesity. At present, they may be wasting resources on ineffective and confused interventions, or interventions that fail to target those children most at risk. At present DH is developing a care pathway for the treatment of obesity in children and a weight loss guide (which will be published as a package in March 2006). These and the forthcoming NICE guidance on the prevention and management of obesity, which considers the effectiveness (including cost-effectiveness) of interventions should provide clarity. This guidance will be available for consultation in March 2006 and will be published in February 2007. The primary care toolkit produced by the Faculty of Public Health and the National Heart Forum that has been supported by DH should also contribute to clarity.

**3.6** The fieldwork demonstrated that many local organisations were not clear about the definition of child obesity, the nature and existence of baseline data, and guidance on measures to be used to manage performance against the target. This resulted in instances where local delivery bodies were devising and collecting their own sets of potentially incompatible measures. The guidance issued in January 2006 on measuring children in schools aims to address these issues and the DH plan to follow this with further guidance (due for publication in April 2006) on how data should be managed.

**3.7** Other Departments, such as the ODPM and the Department for Transport, which are represented on the Obesity Programme Board, will be important partners in achieving the target and should be involved through formal collaboration and coordination of approaches. They can also contribute by carrying out health impact assessments (used to consider the potential impact of policies on health and health inequalities) on existing and new Government policies for children to ensure that they contribute to the child obesity target – or do not work against it. The DH notes as an example of collaboration that it is funding the Health Impact Assessment of the Department for Transport's Local Exercise Action (LEAP) pilots.

## b) Clear regional roles and responsibilities

**Roles and responsibilities are least clear at a regional level and performance management arrangements differ markedly between the Departments. This creates a significant risk of uncoordinated approaches, inefficient use of funding and an inability to performance manage local delivery agencies. One possible mechanism for addressing this risk would be an enhanced role for Government Offices – the DfES is strengthening its presence there. It will be important for regional and sub-regional bodies (such as Government Offices and SHAs) to collaborate effectively and to provide leadership for local bodies, making best use of current and developing performance management responsibilities.**

**3.8** There is considerable potential for the target-holding Departments' programmes to be coordinated at regional level through Government Offices, with Regional Directors of Public Health playing a key role promoting public health improvement and, for the DfES, new lead Directors of Children and Learners within Government Offices, and for sport/physical activity, DCMS Government Office representatives and Regional Directors of Sport England. The proposed new SHAs will lead for NHS performance management. The new arrangements create opportunities for the target-holding Departments to form effective working relationships at regional level to performance manage public health and lifestyle issues such as child obesity. However, any new system also creates risks.

**3.9** Until there is further clarity from Departments about the relative roles and responsibilities within Government Offices and between Government Offices and SHAs, both of which have a responsibility in relation to public health, it will be important for these bodies to work collaboratively to support achievement of the obesity target. Regional bodies, and sub-regional bodies such as SHAs, are well placed to provide leadership on addressing obesity and should take advantage of their accountability relationship with local organisations and build on this role throughout their activities. Local authorities, in particular, already look to Government Offices to provide leadership on the implementation of PSA targets through support for agreement on Local PSA targets and other mechanisms. Government Offices also have the potential to ensure resources are more efficiently targeted to achieve Government priorities.

### c) Strong effective local partnerships

**There is risk that new structures or mechanisms for coordination will be set up unnecessarily, or existing but ineffectual ones preserved. To avoid duplicating existing arrangements and adding additional bureaucracy and costs, it is important to identify existing, efficient vehicles with the potential to coordinate local activity.**

**3.10** Local partners will need to reach decisions on the priority to attach to tackling obesity and how this should be best coordinated. The effectiveness of these arrangements will rely on making use of emerging evidence and ensuring local funding mechanisms are mainstreamed, coordinated and efficient. Local indicators for national targets will help to ensure obesity is prioritised locally.

**3.11** LSPs, and children's trust arrangements as they emerge, through the means of Local PSAs and LAAs (currently in pilot stage), bring together key local agencies for funding and commissioning, including initiatives that target those most at risk. Currently, LAAs do not directly manage mainstream funding. As evidence about the effectiveness of interventions emerges, LSPs, through such means, should aim to reduce administrative costs by pooling significant amounts of mainstream funding around agreed local priorities, joining up funding for other health and lifestyle initiatives to provide a single, integrated approach. This coordinated approach could also minimise bureaucracy and reduce resources spent by frontline delivery agencies chasing multiple funding streams, particularly where the amounts involved are small.

**3.12** Local partnerships should ensure they monitor the effectiveness of their joint working arrangements in line with guidance on good practice from Departments; for example the Every Child Matters website provides detailed guidance for managers and practitioners about to embark on multi-agency working. Effectiveness of partnerships will also be monitored by review bodies and national inspectorates, which have a role to play in ensuring that review frameworks include measures to determine whether delivery chain partners are working together effectively to address the target.

### d) Support and capacity building of frontline staff

**Frontline staff need a framework of information and training to enable them to deliver clear, consistent messages to parents and children and to identify and offer appropriate interventions or referrals for those children most at risk.**

**3.13** In the light of a clear need by PCTs, the DH should provide guidance to ensure that obesity is addressed within the context of reducing health inequalities, integrated wherever possible with current programmes addressing health and wider inequalities. In addition to communicating the principal elements of the delivery plan and publishing guidance on the care pathway, to address the risk of confusion the DH should clarify the status of all existing and forthcoming guidance.

**3.14** Local public health networks, which link those involved in public health, health promotion and health improvement to share information and encourage learning and development, should take a lead in developing effective training and information to support local frontline staff. Local employers should ensure that staff are encouraged and supported to attend development programmes to increase their capability to address the obesity target within their work.

### e) Involving and influencing parents and children

**This study focused on the part of the PSA programme that targets primary school children. But it is clear that the impact of any programme will be limited if children and their families are not engaged and if wider issues of health education to prevent chronic diseases and of food advertising targeted at children are not addressed. All levels of the delivery chain need to address how to engage parents and children effectively and to influence their behaviour.**

**3.15** The draft delivery plan includes specific activities to influence the behaviour of food manufacturers and retailers to stimulate demand for healthier nutrition. The target-holding Departments will need to build on existing campaigns by the Food Standards Agency (FSA) and DH such as 5 A Day and evidence of effective efforts internationally to develop public awareness of healthy

food choices and to monitor progress in influencing children's and parents' behaviour. *Choosing Health* commits the Departments to developing an obesity education campaign by 2007, which is currently in development. It will be essential to determine by 2007-08, mid-way through the child obesity target period, whether campaigns are achieving their objectives and where more focused awareness raising may be needed. The Departments and the Food Standards Agency are also campaigning to stimulate demand for healthier foods and are working with Ofcom and the Advertising Standards Authority on food promotion and advertising.

**3.16** Additionally, at the other local end of the delivery chain, there is a need to find effective ways to encourage parents and children to adopt healthier and more active lifestyles. There are already examples of activity in schools, such as the Healthy Schools Programme to educate children about healthy eating, the Water in Schools Programme to encourage children to drink water rather than fizzy drinks, breakfast clubs that bring parents and children together to introduce regular meal times, and programmes to encourage family physical activity, but these are not universal. It is important that those higher up the delivery chain with the ability to garner and disseminate good practice, such as Government Offices, put in place the means to do so.

**3.17** Accurate data on communities most at risk will be needed to ensure health inequalities are effectively addressed. It will also be important to ensure that local programmes are effectively addressing local need by involving representatives of local communities and young people's groups in developing approaches.

**3.18** Raising awareness of obesity may have the potential to stigmatise obese and overweight children. It is important therefore that actions to achieve the target, either through media campaigns or weighing of children, are monitored to ensure they do not have a negative impact on children's self esteem, or contribute to bullying.

## Detailed recommendations

**3.19** **Figure 11 on page 49** outlines specific recommendations for national, regional and local level to address the key risks identified in this report.

## Conclusion

**Achieving the obesity PSA target in England will involve major social change, sophisticated approaches to raising awareness and to changing behaviour, and a comprehensive range of policy measures and interventions. This report identifies the critical factors that can be addressed by key players in the delivery chain, notably resources, partnership working and performance management. Beyond the delivery chain, the role of parents and children as well as that of the food and advertising industries will be pivotal. Ensuring all approaches are driven by principles of efficiency and effectiveness will be essential if the target is to be achieved.**

## 11 Detailed recommendations

### Risks

#### Funding

Lack of coordination and complexity of the range of funding sources may mean that resources are not focused efficiently and effectively.

Lack of ring-fenced funding may result in public health resources being reallocated for other priorities and *Choosing Health* resources not having an impact on the obesity target.

#### Evidence of effectiveness

Resources are spent inappropriately due to lack of information on relative effectiveness of programmes. This is particularly significant since achievement of the PSA is dependent on multiple programmes, some of which are new.

Planned programmes may not achieve the necessary change in parents' and children's behaviour and the opportunities they have to eat or exercise differently.

### National recommendations

The PSA Programme Board should consider whether there is scope for any of the national funding processes to be streamlined and how other services can contribute to achieving the target.

Coordination of evidence is a central function. In parallel with work to develop NICE guidance, target-holding Departments should issue interim guidance based on current knowledge of what is known to work and lessons learned from other health campaigns. Departments should evaluate effectiveness of interventions, including exit, modification and rollout strategies, and update and publicise findings throughout the delivery chain promptly so they are acted upon within the life of the PSA programme and as part of the planning and commissioning cycle.

Departments should invest in interventions shown to be most cost-effective and efficient in reducing overweight and obesity (including education and information to change attitudes and behaviour), with a focus on integrated programmes and narrowing health inequalities.

DH should publicise the primary care toolkit produced by the Faculty of Public Health and National Heart Forum and ensure that there is no slippage in development of the care pathway.

### Regional recommendations

Government Offices should assess existing funding streams that impact on obesity and maximise their impact.

DfES, Government Offices and SHAs should create coordinated, formal structures for learning from promising practice as well as a supportive framework of training and information for schools and other local agencies.

### Local recommendations

LSPs should use their contracts and agreements (such as the Local Area Agreements and authority given by the Children Act 2004) to coordinate and simplify funding procedures to increase the efficiency of processes and effectiveness of programme targeting, and provide sustainability through integration into mainstream services wherever possible.

Local commissioning of services (coordinated through children's trusts or, where these are not in place, LSPs) should integrate monitoring and evaluation into delivery of programmes. Frontline professionals should be encouraged to contribute to the emerging knowledge base. Local commissioners of services should use evidence of effectiveness in planning and commissioning services.

Local partners should investigate how existing successful community-based health improvement initiatives could be used to deliver evidence-based messages about child obesity.

**11** Detailed recommendations *continued*

Risks	National recommendations	Regional recommendations	Local recommendations
<p>Health inequalities</p> <p>Without clear data and information about those most at risk of obesity and evidence of effectiveness of programmes, funding and programmes will not be efficient or effective at reducing overweight and obesity.</p>	<p>Departments should coordinate and disseminate data about risk of overweight and obesity as well as evidence about effective targeting of programmes.</p>	<p>Narrowing health inequalities in relation to obesity should be a key element of the performance management framework for regional bodies.</p>	<p>Local delivery agents need to target programmes at those most at risk of overweight and obesity and to support people who are obese to participate.</p> <p>All programmes should be adapted to ensure that health inequalities in relation to obesity are taken into account.</p>
<p>Coordination</p> <p>The complexity of a target owned by three Departments may result in an uncoordinated approach at all levels.</p> <p>Other Departments' programmes do not contribute to achievement of the obesity target.</p>	<p>Target-holding Departments should further refine their accountability, planning, communication and performance management systems so that they are effectively linked with other key Departments, including ODPM.</p> <p>A strong, integrated strategic approach is needed to ensure the obesity target is effectively and efficiently addressed throughout Government programmes.</p> <p>Target-holding Departments should promote key aspects of effective partnership working throughout the delivery chain, drawing on existing guidance or developing new guidance if necessary.</p>	<p>Government Offices, with Regional Directors of Public Health taking a key role, should coordinate actions of relevant regionally-based government officers from all Departments.</p> <p>Regional bodies, including Strategic Health Authorities, should take child obesity into account in local planning processes, including within Local Area Agreements.</p> <p>Key Government Office leads, including Regional Public Health Directors, should coordinate work at a regional level to maximise the potential of economic, educational and workforce development systems.</p>	<p>Local partners should use current planning structures (where effective) rather than establish new ones. Local Strategic Partnerships (LSPs) and children's trusts are key bodies and should take child obesity into account in local strategies (such as the Children and Young People's Plan and Local Area Agreements).</p> <p>Local indicators for national targets will ensure obesity is prioritised locally.</p> <p>Local planning bodies should involve a range of local partners in the planning and coordination of programmes, including:</p> <ul style="list-style-type: none"> <li>■ Local authority directorates, such as planning and regeneration, to maximise access to fresh food and green spaces</li> <li>■ Umbrella-type programmes, such as Healthy Schools</li> <li>■ School sport and school dinner provision</li> <li>■ Partnerships currently addressing obesity issues (such as Coronary Heart Disease partnerships)</li> <li>■ Voluntary sector and community representatives, including Black and minority ethnic groups.</li> </ul>

## 11 Detailed recommendations *continued*

### Risks

#### Accountability

Greater devolution of decision-making to a local level may weaken the accountability of frontline delivery agencies, producing a fragmented delivery network and making it difficult to deliver national policies at a local level.

#### Data and monitoring

The lack of baseline data or clarity about how the PSA is to be monitored may lead to lack of uniformity of approach and difficulties in obtaining robust performance data.

Data collection is not linked to mechanisms that identify and refer obese or overweight children.

Frontline staff may not identify obesity as a particular problem locally (e.g. in schools), and may not prioritise this issue.

#### Capacity and capability

There may be insufficient staff numbers to carry out the necessary programmes.

There may be gaps in skills and knowledge particularly since many frontline professionals are relatively inexperienced in issues concerned with child obesity.

### National recommendations

The Departments should set out clear accountability from the frontline to the national level, putting robust governance arrangements in place so that progress towards the target can be accurately monitored.

Data requirements should be set centrally. Target-holding Departments should promptly communicate the relevant content of the delivery plan, with particular focus on standardised definitions, baseline data and methods of data collection to appropriate organisations throughout the delivery chain.

Target-holding Departments should make certain that initiatives on child obesity are set in the context of wider concerns about children's health in order to maximise buy-in.

DH should produce information for frontline professionals (including teachers, school nurses, health advisors) on what constitutes child obesity and how best to tackle it, as well as resources for the public.

Target-holding Departments should produce guidance for all sectors on how to incorporate knowledge and skills development on obesity into training and development programmes.

Target-holding Departments should ensure that the needs of the workforce are given appropriate attention by initiatives such as the Children's Workforce Strategy.

### Regional recommendations

Strategic Health Authorities should performance manage obesity work in healthcare organisations regularly and in a standardised way. SHAs should coordinate their work with Regional Directors of Public Health in Government Offices.

Government Offices should take a more active performance management role in relation to schools and related obesity programmes, such as the Healthy Schools Programme.

Government Offices and Strategic Health Authorities (SHAs) should help local service providers to develop relevant proxy or indicative measures and milestones for achieving the target.

Directors of Children and Learners, Regional Directors of Public Health and SHAs and other key regional post-holders should disseminate definitions of obesity and details of the data to be collected to local delivery agencies.

Key regional post-holders should reduce the administrative burden on frontline professionals by aligning and streamlining funding processes.

Regional bodies should lead negotiations with local training establishments or universities to develop and provide relevant accredited training.

### Local recommendations

Local partners should clearly agree their respective roles and responsibilities.

Champions: There should be PCT board level or local authority champion for addressing obesity.

Local agencies should collect robust information about the extent of child obesity and should encourage Local Strategic Partnerships (and Local Area Agreements where they exist) to use this information to assess whether to make child obesity a priority issue.

Information should be made available in accessible formats to frontline staff to support effective obesity work.

Public health networks should develop effective internal training and information.

Local delivery agents should jointly develop local staff for a coordinated approach to addressing obesity.

Local delivery agents should develop, implement and review accessible mechanisms for information dissemination.

PCTs should map current services against the needs of their population and against the DH care pathway, and develop plans with local partners to resource any gaps in local service provision.

**11** Detailed recommendations *continued*

Risks	National recommendations	Regional recommendations	Local recommendations
<p>Inspection and review</p> <p>Obesity-related indicators might not be taken into account by relevant audit and inspection bodies which could result in obesity not being taken seriously by key agencies.</p>	<p>The DH should further reinforce the Healthcare Commission’s role in assessing public health and health inequalities, including the specific issue of obesity and inclusion of measures to assess effectiveness of partnership working to address obesity.</p> <p>The Department of Health should consider jointly with ODPM whether child obesity should form part of local authority inspection regimes in order that it has an appropriate profile at a local level.</p>	<p>Strategic Health Authorities and Government Offices should ensure obesity-related indicators are integrated into their assessment frameworks.</p>	<p>Health and Social Care Overview and Scrutiny Committees (and other relevant groups, such as Children’s Services groups) should take obesity-related issues into account on a regular basis.</p>

## GLOSSARY AND ABBREVIATIONS

Capacity building	Shorthand for a wide range of support, techniques and initiatives that aim to build the skills and abilities of individuals or organisations.
Care pathway	A care pathway is an approach to managing a specific disease or clinical condition that identifies at the outset what interventions are required and predicts the chronology of care, including treatment options, referral to appropriate services and follow-up. The approach is designed to provide comprehensive quality of care for patients and to give patients a clear view of their treatment and care plan.
Children and Young People's Plan	The Children and Young People's Plan is an important element of the reforms underpinned by the Children Act 2004. Implementing a new statutory duty and following best local planning practice, local areas will produce a single, strategic, overarching plan for all services affecting children and young people. It should support more integrated and effective services to secure the outcomes for children, as set out in the Ten Year Childcare strategy, the National Service Framework for Children, Young People and Maternity Services and the Children Act 2004. It is a key part of the children's services improvement cycle, set out in Every Child Matters: Change for Children. The Children and Young People's Plan brings together 17 previously separate plans.
Children's Centre	Provides good quality integrated services (education, care, family support and health) to children, their parents and the wider community. Based in the most disadvantaged wards in England.
Children's Commissioner	Acts as an independent voice for children and young people, to champion their interests and bring their concerns and views to the national arena.
Children's Director	Responsible for bringing together education and children's social services at local authority level, reporting to local councils.
Children's trust	Underpinned by the Children Act 2004 "duty to cooperate", children's trusts bring together all services for children and young people in an area (including local authority services, a range of community and acute health services as well as Sure Start partnerships and others) to focus on improving outcomes for children and young people.
Community Sports Network	Pilot networks established to coordinate and develop community sport across regions.
Comprehensive Performance Assessment (CPA)	A measurement of how well councils are delivering services to local people and communities, and how well they are run. Reviews are carried out by the Audit Commission.

County Sports Partnership	A partnership that creates strategic leads for sport within a county, to help more people get actively involved in sport.
Delivery chain	Business concept, used increasingly in the public sector, which refers to the systems, processes and organisations through which government seeks to achieve its strategic and policy objectives.
Delivery plan	Internal management document setting out what a project or programme intends to achieve, when, where and at what cost.
Department for Culture, Media and Sport (DCMS)	Responsible for central Government policy on the arts, sport, and the tourism, creative and leisure industries.
Department for Education and Skills (DfES)	Central Government Department, responsible for education and life-long learning in England, with wider responsibilities for a range of policies to ensure children are safe, well and ready to learn.
Department of Health (DH)	Central Government Department, responsible for setting health and social care policy in England, and for providing guidance and publications.
DCMS	<i>See Department for Culture, Media and Sport</i>
DfES	<i>See Department for Education and Skills</i>
DH	<i>See Department of Health</i>
Every Child Matters	Every Child Matters: Change for Children is a new approach to the well-being of children and young people from birth to age 19. The Government's aim is for every child, whatever their background or their circumstances, to have the support they need to: Be healthy; Stay safe; Enjoy and achieve; Make a positive contribution; and Achieve economic well-being.
Extended Schools	A school that provides a range of services and activities, often beyond the school day, to help meet the needs of pupils, their families and the wider community.
Five A Day	Programme to increase fruit and vegetable consumption by raising awareness of the health benefits and improving access to fruit and vegetables.
Government Office (GO)	Nine Government Offices for the Regions bring together the interests of ten different Government Departments within a single organisation.
Healthcare Commission	Promotes improvement in the quality of the NHS and independent healthcare, through inspection and regulation.

Health Impact Assessment	An approach to ensure that decision making at all levels considers the potential impacts of decisions on health and health inequalities, and identifies actions that can enhance positive effects and reduce or eliminate negative effects.
Healthy Living Blueprint	Helps schools take a “whole school” approach to health and nutrition, by looking at the environment and organisation of the school as well as the curriculum to promote healthy living among pupils.
Healthy School	A Healthy School is one that promotes the health of children, staff, parents and the surrounding community in line with nationally agreed standards.
Healthy Schools Programme	Part of the Government’s drive to improve standards of health and education and reduce health inequalities through the National Healthy Schools Standards. Focuses on improvement in areas such as healthy food and drink in schools, high quality physical education and school sport. Coordinated by a Healthy Schools Partnership.
LEAP	See <i>Local Exercise Action pilot</i>
Local Area Agreement (LAA)	Local Area Agreements (LAAs), currently in the process of being rolled out, set out the priorities for a local area agreed between central government, represented by Government Offices for the Regions, and the local area, represented by the local authority and key local partners including children’s trusts and the Local Strategic Partnership. The aim is to enable local partners to come together to provide a holistic and integrated approach to policy-making and delivery, reduce bureaucracy and set out how achievement in agreed areas will be rewarded.
Local authority	Local government bodies that delivers local services to the community through democratically accountable leadership to local communities.
Local Exercise Action pilot (LEAP)	Locally run pilot programme to test and evaluate new ways of encouraging people to take up physical activity.
Local Public Service Agreement (LPSA)	Agreements between individual local authorities and the Government setting out the authority’s commitment to deliver specific improvements in performance, and the Government’s commitment to reward these improvements. The agreement also records what the Government will do to help the authority achieve the improved performance.

Local Strategic Partnership (LSP)	Single, multi agency bodies that match local authority boundaries, which bring together parts of the public (such as local authorities, PCTs, private, community and voluntary sectors). Through contracts and agreements (such as the local delivery plan, Local Area Agreements), LSPs are expected to take a coordinated approach to making major decisions about priorities and funding for their local area.
Mainstreaming	Integrating programmes and initiatives (particularly those aimed at reducing inequalities) into general service provision. Involves realigning the allocation of mainstream resources – such as local authority and health services – to better target the most deprived areas.
National Cycle Network	A national network of cycle routes on quiet country lanes and traffic-free paths.
NHS	National Health Service.
National Institute for Health and Clinical Excellence (NICE)	Provides national guidance on the promotion of good health and the prevention and treatment of ill health.
Ofsted	Office for Standards in Education. The inspectorate for children and learners in England. Its job is to contribute to the provision of better education and care through effective inspection and regulation. To achieve this, Ofsted undertakes a comprehensive system of inspection and regulation covering childcare, schools, colleges, children's services, teacher training and youth work.
PCT	See <i>Primary Care Trust</i>
Primary Care Trust (PCT)	Responsible for securing and delivering health and social care and tackling health inequalities locally.
PSA	See <i>Public Service Agreement</i>
Public Health Network	Local networks linking those involved in public health, health promotion and health improvement to share information and encourage learning and development.
Public Health Observatory	Supports local bodies in an NHS region by monitoring health and disease trends, evaluating progress by local agencies and providing advice.
Public Service Agreement (PSA)	PSAs set out Departments' aims, objectives and key outcome-based targets to provide a clear statement of priorities and direction. They include value for money targets and a statement of who is responsible for the delivery of the targets. PSAs help Departments to focus on delivery and work effectively with the bodies they need to get things done. PSAs form an integral part of the spending plans set out in Spending Reviews.

Ring-fenced funding	Money that is allocated to a programme, which must be spent on that specific programme.
School Food Trust	£15 million has been provided by the Department for Education and Skills to enable a new School Food Trust to promote the education and health of children and young people by increasing the quality of food supplied and consumed in schools.
School Fruit and Vegetable Scheme (SFVS)	A scheme under which all 4-6 year olds in LEA-maintained infant, primary and special schools, are entitled to a free piece of fruit or vegetable each school day.
SHA	See <i>Strategic Health Authority</i>
School Sport Strategy	An initiative to implement a national strategy for Physical Education and School Sport, to enhance the take-up of sporting opportunities by 5 to 16 year olds.
Spearhead Group	Seventy local authorities and 88 Primary Care Trusts based on the local authority areas that are in the bottom fifth nationally for three or more key indicators of deprivation (such as male/female life expectancy at birth, cancer/ cardiovascular disease mortality in under 75 year olds).
Sport England	Provides services and funding to sport in England, and responsible for delivering the Government's sporting objectives.
Strategic Health Authority (SHA)	Manages the local NHS on behalf of the Secretary of State.
Sure Start	Government programme to deliver the best start in life for every child by bringing together early education, childcare, health and family support.
Travelling to School Action Plan 2003	A plan to bring about a change in home to school travel patterns, also allowing more pupils to take regular exercise.
Travelling to School initiative	Provides grants to schools with approved School Travel Plans and supporting school travel advisers.
Youth Sport Trust	Registered charity with a mission to support the education and development of all young people through physical education and sport. It aims to create opportunities for more young people to participate in high quality PE and school sport.

# APPENDIX 1

## Our methodology

**1** Fieldwork took place between November 2004 and May 2005 and involved interviews, meetings and workshops with over 150 representatives of the delivery chain. To ensure a geographical spread across the country, regional and local fieldwork took place in three regions – the North-West, West Midlands and South West. The fieldwork included “Spearhead” sites for health inequalities work, which have among the highest rates of obesity in England, and areas with high proportions of children in whose demographic profile there are higher rates of obesity, for example Asian and black Caribbean girls.

**2** Fieldwork took place at four levels of the delivery chain:

### National

**a** Desk research: mapping of the whole delivery chain, identifying key government initiatives, funding, and responsible managers. Analysis of *Choosing Health* Public Health White Paper – mapping key initiatives relevant to child obesity PSA.

**b** Meetings and interviews with managers in the three target-holding Departments, discussions with other national bodies.

**c** Participant-observation of two Department of Health *Choosing Health* Delivery Planning Task Group Workshops of obesity, physical activity and healthy eating experts – practitioners, policy-makers and academics.

### Regional

**d** Twenty-seven semi-structured interviews with the Director of Public Health (or nominee) of the Government Offices in the three regions, plus up to four directors/senior managers with responsibilities relevant to the target, the Regional Associate Director of the Health Development Agency, and a director or senior manager of Strategic Health Authorities (SHAs) in the region.

The purpose of the regional interviews was to give key stakeholders the opportunity to provide information on how the delivery chain for the target currently operated in their area of responsibility, and their perceptions of the barriers to, and opportunities for, delivery.

### Local

**e** Four workshops of invited staff from PCTs, local authorities and other relevant stakeholders in the North West, West Midlands and South West. The workshops focused on examining existing delivery chains and how these might be developed to meet the target; and resourcing, partnership working and performance management issues.

**f** Interviews with local authority directors and managers to explore resourcing, partnership working and performance management issues and to critique emerging findings.

### Frontline delivery

**g** Twelve focus groups of primary school head teachers or their nominated representatives with responsibility for sport or nutrition, in six local authority areas within the three regions. Focus groups examined teachers’ awareness of child obesity as an issue, how schools were addressing the issue, and the role schools could play in delivering the target.

### Whole delivery chain

**h** Two workshops of all levels of delivery chain, including the target-holding Departments, other government Departments, Government Offices, Strategic Health Authorities, Primary Care Trusts and schools, primarily from regions and areas outside the fieldwork areas, plus some representatives from fieldwork regions to critique and build on emerging findings.