ANNUAL BMI CHECKS IN SCHOOLS WORKSHOP

[convened by the Child Growth Foundation]

Leolin Price Theatre
Institute of Child Health
30 Guilford St London WC1N 1EH
Friday June 17th 2005-07-28

REPORT

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HEADLINE VOTES

[Questions 1-3 were recorded by the ICH voting system: Questions 4-7 were approximated following a show of hands]

1] Should BMI checks in school be taken universally?
YES 70%
NOT 30%

2] Should every child be monitored every year in primary school?
YES 17%
NO 83%

3] Should the first check be taken at school entry [4-5 yrs]?
YES 95%
NO 5%

4] How many further checks should be taken in primary school [6-11yrs]?
ONE 64%
MORE 24%
NONE 12%

5] How many checks should be taken in secondary school [11-16yrs]?
ONE 12%
MORE THAN ONE 24%
NONE 64%

6] How should the data be collected?
COMPLETELY ANONYMOUSLY 6%
PSUEDO-ANONYMOUSLY 94%

7] Which definition should be used for overweight/obesity?
85th - 95th CENTILE 10%
91st - 98th CENTILE 80%
IOTF 10%

EXECUTIVE SUMMARY

the workshop's background

The workshop was the third in a series facilitated by the Child Growth Foundation to inform policy makers on various aspects of childhood obesity [1]. It was called to discuss a recommendation by the House of Commons Health Committee that the BMI of every UK child be assessed annually and the Government's acceptance of that recommendation. In the context of an alleged increase in the numbers of overweight and obese British children, and the need to tackle the epidemic, was such a frequency feasible and desirable as a public health, clinical and/or educational measure.

In the Report of its Inquiry into Obesity the Committee stated " We recommend that throughout their time in school, children should have their BMI measured annually at school, perhaps by a school nurse, a health visitor or other appropriate health professional. The results should be sent home in confidence to parents, together with, where appropriate, advice on lifestyle, follow up and referral to more specialist services. Where appropriate, BMI measurement could be carried out alongside other health care interventions which are delivered at school, for example inoculation programmes. Care will need to be taken to avoid stigmatising children who are overweight or obese, but given that research indicates that parents are no longer even able to identify whether their children are overweight or not, this seems to us a vital step in tackling obesity. " [2]

The Department of Health's acceptance of the recommendation was first announced at a Foundation workshop on December 17th 2004 discussing BMI as a tool to identify and audit childhood obesity. The meeting was informed that the DH and Department of Education & Skills [DfES] were jointly looking to measure height and weight in schools universally and annually - at least initially [3]. The DH/DfES had already been given the job of " halting of the year-on-year rise of obesity in children under-11 " and a PSA target to achieve this was confirmed in the public health White Paper, CHOOSING HEALTH; MAKING HEALTHIER CHOICES EASIER [3]. It was possible that annual BMI checks could be seen as helping achieve this target and a logical way of knowing if, and when, it had been achieved. Further confirmation that they were being considered was then given by the former Minister for Public Health, Melanie Johnson, during the Parliamentary debate on the White Paper [4]. She stated that both the DH/DfES were working closely on appropriate systems for recording weight and height measurements among schoolchildren and addressing the " vexed " question of BMI – although she neither expanded on, nor was questioned, why she thought that BMI was vexed. [5].

the workshop's participants

The workshop's participants [see page 4] received personal invitations to attend in order to ensure a fair representation of DH and DFES civil servants, public and clinical health professionals and practitioners in education. The Foundation regrets that only one teaching union was represented and that a second declined to come having already decided that teaching staff would not be involved with the checks [6]. Unfortunately, the Royal College of Nursing, although it did send representatives, warned the Foundation beforehand that it had also already decided that school nurses shouldn't be involved [7]. Hey ho!

At each seat electronic voting equipment was provided with the aim of recording participants' views on specific questions that might be posed during the day and you may have already scanned the responses on the cover page. The same system had been installed at both the previous workshops and, in the December 2004 workshop [see above], had been very effective in its task. Unfortunately in June it broke down mid-way through the day but nevertheless issues were voted on, and openly agreed, by a show of hands. Interestingly, by the end of the day they were largely superseded and also contradicted the responses to similar questions posed in December [see overleaf].

the workshop's conclusions

The workshop began with a consensus that action to halt childhood obesity was urgently needed and the audience was dismayed to be told that any PCT performance management may be deferred for as much as 2 years. By the end of the day however Professor Sir David Hall had voiced a proposal that, coupled with other suggestions garnered from the debate, seemed both to answer the aim of the day and present a course of action that both the DH/DfES might take up without too much delay. The 4 hrs of discussion that it took to get to this point are summarised in the bulk of this report.

The proposition was that, if a school had implemented its Healthy School policy or was working towards its implementation, the school could take a complete snapshot of all children's BMIs at the end of every year using some kind of nationally agreed minimum dataset. Whether the data was taken anonymously or could be linked to an individual child might still be open for discussion but it would allow the school to report back to the parents year-by-year how the school was doing. In this way Ministers could fulfil their declared commitment that every child would be measured annually and the results sent home without having to feed back data on individual children. The report could say what the school was doing and the progress it was making towards halting the year-on-year rise of obesity in its children under-11yrs and, in this way, providing a good handle on local public health. There was an incentive for the school to do well.

The measurements could be taken in PE class or maths lessons or wherever and whenever convenient by trained classroom assistants/support staff and, advantageously, " demedicalise " weighing and measuring by making it an educational exercise. School nurses should not be expected to take the measurements – there are not enough them to complete the job anyway.

The schools' reports could be filed with the LEA and/or Director of Public Health much like GP practices file their 'flu uptakes with their PCTs. The reports could also be published at local and national level. The former would allow local councillors, politicians, parents and children to see what was being done by their local school in the improvement of meals and vending machines merchandise etc - and searching questions could be asked if they weren't. When collected at a national level, the statistics would allow Public Health Observatories to provide national analyses and inform Ministers/CMO when making statements about achievement. Most importantly they should choose a single definition of overweight/obesity from the three currently available and stick to it.

The proposal in some respects had already been successfully tested in a pilot project in North Birmingham and was to be rolled out across the city. Yr 9 children had been measured as part of a lesson plan by both school nurses and school staff, had got fun out of the experience, had shown little inclination to stigmatise or bully fellow pupils who appeared overweight and the teacher adviser believed there to be no obstacle to repeating the exercise at any school years. The Birmingham experience was being replicated in Blackburn and Middlesborough and Hull had also decided to trial universal measurement.

As indicated in the Introduction the votes taken during the day were largely superseded by Professor Hall's proposal and did not always complement the votes recorded on similar issues six months earlier. In December, 48% of the audience thought that BMI should be assessed annually in primary school whereas, by June, only 24% wanted more than one assessment following school entry. With regard to secondary school, December's 38% who wanted annual checks were upended by 64% of the June audience who wanted no annual checks at all!

The DH/DfES representatives, to whom the day was directed, professed that they had learnt from the day despite – and may be because of - the confusion that they had sometimes witnessed. If they accept Professor Hall's proposal it will have been a hot June day worth going through.

GUEST LIST				
B	Baker	Pat	Researcher	Manchester University PHI
	Blair	Mitch	Consultant Paediatrician	British Association for Community Child Health
	Boltong	Anna	Lead, Diet & Nutrition	London Public H
	Bryant	Deidre	Teacher Adviser	North Birmingham PCT
	Butt	Yinglen	Nurse Adviser, PH	Department of Health [DH]
C	Cameron	Lizbeth	PH Nurse for Schools	Chiltern & South Bucks PCT
	Carnell	Susan	Dietician	Weight Concern, University College of London
	Cresswell	Tricia	DPH	Durham & Chester-le-Street PCT
	Croker	Helen	Dietician	Weight Concern, University College of London
	Crowther	Rachel	Locum PH Consultants	SE Public Health Observatory
D	Dawson	Eileen	Interim Assistant Director of Family Services	Barking & Dagenham PCT
	Dawodu	Jummy	Head, School Nursing	Southwark PCT
	Doyle	Toni	Head, School Nursing	Salford PCT
	Dumble	Pauline	Act Director of Modernisation	Eastern Hull PCT
E	Edmunds	Laurel	Research	Oxford
	Elliott	David	Project Manager	West Midlands Obesity Task Group
	Emmerson	Pauline	Clinical Lead, School Nursing	Southwark PCT
	Evans	Sian	Assoc PH Specialist	PH Research Unit, Cambridge
F	Feltbower	Richard	Statistician	Centre for Epidemiology & Biostatistics, Leeds University
G	Gillie	Oliver		London School of Hygiene & Tropical Medicine
	Gibson	Penny	Obesity Adviser	Royal College of Paediatrics & Child Health [RCPCH]
H	Hall	David	Professor of Community Paediatrics	Sheffield
	Hourihan	Ann	School Nurse	Harrow PCT
	Hough	Heather	Head, School Nursing	Brighton PCT
	Hubbard	John	Obesity Lead	Department of Education & Skills
J	Jackson	Pat	School Nursing Adviser	Community Practitioners and Health Visitors Association [CPHVA]
J	James	Janet	Specialist Diabetes Nurse	Bournemouth Hospital
	Jerram	Patrick	Director of Sport	Bedford Modern School
	Jones	Mary	Consultant Paediatrician	British Association for Community Child Health
L	Leigh	Richard	Project Mgr	Cumbria & Lancashire HA
	Leonard	Moira	School Nurse	Brighton PCT
	Levine	Ronnie	Director	TRENDS, Project Leeds
M	Maidment	Lisa	Head, School Nursing	Ashford & Shepway PCT
	Mindlin	Miranda	SpR, PH	Richmond & Twickenham PCT
N	Nolan	Christine	Health Promotion Specialist	“ Health First “ Lewisham PCT
P	Pheasant	Hannah	Public Health Research Obesity & Diabetes	North Central London HA
	Powell	Catherine	Nurse Adv: Children & YP	Department for Education & Skills [DfES]
	Peto	Julian	Chair, Epidemiology	Cancer Research UK London School of Hygiene & Tropical Medicine
	Planck	Jock	Sales Director	seca ltd
	Pritchard	Tricia	Professional Officer	Professional Association of Teachers
R	Rao	Jammi	DPH	North Birmingham PCT
	Rodriguez	John	DPH	Ashford & Shepway PCT
	Richardson-Todd	Barbara	School Nurse	Royal College of Nursing [RCN]
	Routh	Kristina	PH Specialist Registrar	North Birmingham PCT
	Ross	Helen	School Nurse	Uttlesford PCT
S	Sadler	Catherine		*Nursing Standard*
	Saunders	Karen	Business Manager	West Midlands Obesity Task Group
	dos Santos Silva	Isabel		London School of Hygiene & Tropical Medicine
	Short	John	Marketing Director	Harlow Printing
	Shukla	Heema	Assoc DPH	Hillingdon PCT
	Smith	Stephen	Headmaster	Bedford Modern School [Headmaster’s Conference]
	Snider	Ken	Director	Co Durham & Tees Valley Public Health Network
	Soljak	Michael		NW London HA
T	Thain	John	Nurse Adv: Children &YP	Royal College of Nursing [RCN]
W	Warbey	Jeannie	Classroom Assistant	Saffron Walden
	Walters	Helen	PD Doctor	Department of Health [DH]

	Williams	Katie	Public Health Lead for Healthy Eating & Obesity	Camden PCT
Y	Yule	Christine	Designer	Harlow Printing

THE WORKSHOP

Professor Julian Peto was invited give the first of the workshop's four opening presentations because it was his testimony that was credited to have most influence on the Health Committee's " annual BMI " recommendation. At the committee hearing he had spelt out the need for the measurements faced with the appalling obesity epidemic and felt that they would be enormously useful for many reasons. Not only would it have considerable publicity value that the problem existed, allow parents to know where their children were on the BMI scale and which way they were moving over years but also it would be a huge help to research. To have data at a national level as a basic framework was vital. It should be a framework within which one could do more detailed studies and would be a huge contribution which would cost virtually nothing at all. It didn't need a school nurse to do the measurements because teachers could do them. In this way they wouldn't all have to be done on one day but could be taken over time.

Pauline Dumble summarised the initiative in Hull. It was to prevent, identify and manage overweight/obesity in a city dubbed the " fat capital of the UK ". They had already scheduled the training of the staff who were going to measure all school entrant and Yr 6 children [age 10-11yrs] as of September 2005. The objective was to acquire baseline data about the baseline data about local prevalence or trend in school obesity. Hull would promote monitoring BMI in primary care for " at risk " children [i.e. those children with large parents]. Hull had only limited resources and there was a need for cost-effectiveness. Parents and parental consent was integral to the initiative and would be involved in the development of multi-faceted family based behaviour modification programmes. There were many things still to be put in place but they had already started to improve school meals. For a whole year Hull schoolchildren had already received a healthy school meal free of charge [8],

Kristina Routh then presented her work with Jammi Rao in North Birmingham PCT the full account of which had been circulated to all the workshop's participants for background reading [2]. The North Birmingham objective was to trial a low cost method for measuring the prevalence of childhood obesity and was based on the observation that numeracy and data handling skills were often taught in schools by getting children to measure their height and weight. A numeracy " lesson plan " suitable for Yr 5 [age 9-10yrs] children was devised in which each child's height and weight was recorded anonymously by school nurses and school health link workers. In addition shoe size, eye colour, foot length and hand span were recorded. All the data was logged against the date of birth, gender and home postcode of each child.. The trial's objective, to get a snapshot of the level of overweight/obesity in Birmingham children before they entered puberty, was achieved and the evaluation of the trial was equally positive. It showed that both teachers and school nurses were happy with the method and would repeat it. There were no problems with the process of weighing children: indeed, the lessons were " enjoyed " by the children. The trial was so successful that it was to be rolled out across Birmingham and the attendant cost would be relatively small [9].

Professor Sir David Hall, whilst agreeing that a BMI taken at Yr 1, Yr 3 and Yr 5 was an attractive idea as a public health tool, was distinctly concerned about its use for clinical use and had written a Memorandum to amplify his concerns [3]. His main concern was because of measurement errors which could be substantive and compounded if one wished to compare successive measurements over time. A degree of imprecision is acceptable, provided it is random, if one is measuring huge numbers of children for public health purposes but if this information is to be used at the level of the individual its quality must be assured and the way the information is used must be carefully considered. He went through a number of steps which would need to be taken before he could accept any individualised use of BMI and he outlined the work that had to be done before that stage was reached. He was particularly alive to the child who might be further stigmatised and bullied as a result of yearly BMIs being taken [10].

Helen Walters completed the short presentations by introducing herself as the public health specialist whose sole task, on a 2 day week secondment to the DH was to " sort out " the school BMI issue. Her problem was that to every question she asked she got no answer but 4-5 more questions. In her home PCT of Portsmouth she had been wanting to know how to evaluate the local healthy eating policy and she hoped that her secondment would help find the answer. She talked of political drivers – politicians that had already announced intentions to measure every child, send information back to parents etc. She amazed some of the audience by confirming that the performance management of PCTs re the PSA target [see p..] had been deferred –for maybe as long as 2 years until some guidance and models could be produced. An expert advisory group was going to help in the work. It may take a year to complete: " it certainty won't happen to-morrow ". It wouldn't even be done and dusted by September which was her boss' deadline. The target remains but no action is demanded [*hollow laughter from audience*]!

With the workshop proceedings thrown open to the floor **Pauline Dumble** was first to comment. Somewhat to Helen Walters' surprise she stated that Eastern Hull had not been told that it was not yet being monitored. **Jammi Rao** was then on his feet to accuse the DH of " cold feet ". He and Birmingham City Council wanted action now to see if things were getting better or worse. He wanted a result by Spring 2006. **John Rodriguez** also wanted to see action and stated that target were extremely important because they helped prioritise PC work. **Penny Gibson** declared that, in a PCT that is already in the red, no money would be forthcoming to combat obesity unless there was a target and pointed to the difficulty of keeping obesity high on the agenda in the interim. **Mary Jones** was concerned that without leadership from DH scores of PCTs around the country would go off to do their own thing without any cohesion. Their work will be dribbled out and needs to be pulled together.

[*The debate then started – and leapt from issue to issue. In order to make for better reading the following pages will report the discussion surrounding each of the questions posed. The Chairman is indebted to **Tricia Cresswell** for having formulated the questions [often with many interruptions and some difficulty!] and regrets that the voting system in the Institute of Child Health packed up after she has posed the day's third question. The approximate percentages thereafter were agreed by the workshop audience immediately after a show of hands]*.

Jammi Rao began by stating that he was very clear that he wanted a reasonable estimate of the prevalence of obesity in children under-11, had gone for measurement of children between 9-10yrs of age in his own PCT and wanted to see results not in 2 years time but by Spring 2006. He stated that for practical purposes measurements must be taken in school and taken universally in order not to stigmatise children. Universality was easier because setting up random samples is, paradoxically, more difficult. **Tricia Cresswell** wondered if that was soon enough. She believed that the DH should immediately pull out all the existing school entry data from the child health information consortia [CHIC] systems to obtain a national BMI sample. It was, she thought, " daft " that it hadn't yet been done and the DH should get all the CHIC providers to pull it. It might cover only half the country [Mitch Blair's estimate was 53%] but it would be better than nothing which is what we presently had. **Heema Skula** regretted that the other half couldn't get their data online. It was not possible to export her CHIC system data on to any database since it produced only paper. She also stated that PCTs with diverse ethnic populations needed to remember that the definitions of overweight/obesity varied by ethnic background. **Penny Gibson** feared that though obtaining her CHIC data was possible it was very dirty. Several participants in the workshop recognised that problem.

To **Deidre Bryant's** inquiry as to what was done with the data that was taken at school entry [*embarrassed laughter*] **Barbara Richardson-Todd** had the answer. " We do measure all children and input it into computer ", she said, " but then it gets lost! ". She had tried to get data from whole of Suffolk but got only three pages which she couldn't make head or tail of. it. **The Chairman** then made the point that for sometime the CHIC system had been a graveyard of data, nothing meaningful could be extracted from it and that the process was tremendously demoralising to the people taking the measurements. One of the reasons

why we have bad measurements in the country is because the workforce being asked to take the measurements see absolutely no point because it is not being manipulated. All over the country there are little pockets of information locked away which could have been used very beneficially on behalf of children for the last twenty years. If it had better used then maybe we wouldn't have been in the mess that we are in now because people would have been able to observe the insidious increment of weight over that period of time. There was no dissent from the audience.

In fact **Richard Leigh** positively supported the observation. He was project managing a school health workforce and confirmed that many health professionals were so demoralised that nothing has been done with the measurements that one of his teams has stopped measuring altogether. So to ask teams to resume would have a massive effect on capacity. He challenged the view that it needed an overworked school nurse to measure: it could be done with a suitably trained support worker. **Zoe McDowell** saw the measurements as a public health matter and that, if done by health visitors and school nurses, it would further " medicalise " the problem and parents would get suspicious about why they were being taken.

Tricia Pritchard confirmed that her job was to protect her school workforce and asked Helen Walters how closely the DH was working with the DFES and whether they intended to consult unions. Getting the unions on side would be crucial. **Helen Walters** confirmed that the unions were being consulted and stated that the DH was negotiating with the DfES to link height and weight into the annual pupil census carried out in primary schools which could be cross referenced to post codes and ethnicity. The DfES was doing a very good job at defending the schools from having to do a lot of extra work. It was being quite obstinate and had obviously done focus group with teachers and unions about the issue. **Pat Jackson** certainly thought that the school nurses shouldn't be doing the measurements and would be cautious about any idea that school nurses might remove clothing or " strip " children. She also pointed out that parents of overweight children might not consent to have their BMI's recorded and this would distort the figures. **John Thain** supported her on the school nurse and consent issues. There was a lot of resentment that BMIs should be taken by school nurses. He raised the issue of children's rights, particularly as they get older, against what they perceive to be unnecessary interventions and cautioned against stigmatisation and stereotyping. **Patricia Dumble** stated that in Hull they hadn't finally decided who would take the measurements but they were getting on with what they currently had. " The school nurses are very happy at the moment that they have extra resources to do the job and because they know it's a benchmarking process " she said. They may be the facilitators rather than the actual people doing the job. The issue needs to be a local solution rather than one size fits all and in Hull SNs follow the wider public health model and would link measuring into a holistic health/education model ".

Julian Peto still believed that measurement should be done by GPs but **Tricia Cresswell** immediately summarised the collective public health outrage at the suggestion. She would not want GPs anywhere near the issue. She said that if children were going to be dealt with in a non-stigmatising way we could not medicalise the problem [*see Zoe McDowell above*]. They need a different approach than adults.

It struck **Stephen Smith** that somewhere along the line baseline statistics were needed and this was the problem. He told the workshop, "you can argue till the cows come home but you have to start somewhere. From my view you need to start now with a baseline so that the discussion ought to be what is the basis of that baseline. It ought to be as universal as possible. because the more data you have the more likely that baseline is to be accurate. You then go with that. Then over the years with the things that you put in place those statistics will become more and more accurate. If you don't watch out you won't start because you're arguing what the baseline is going to be ". **John Rodriguez** had a slightly different twist and asked whether BMI was even the right thing to measure. With adult obesity waist circumference was being used as a predictor for the metabolic syndrome etc and asked whether this was appropriate for children? He was also concerned about the local democratisation of data. Getting data in a super computer would be nice for epidemiologists but there was also local data that needed to be considered. If data is published and available

locally we should be looking at many other indicators surrounding BMI [breastfeeding rates per HV for example]. **Penny Gibson,** in responding to his question about waist circumferences stated that currently no one knew what to do with it but it could be useful in the future. " It's also quite hard to measure the waist of an obese child " she said and **David Hall** agreed. He reported that Professor Mary Rudolf had described how unreliable it was for a single observer [herself] to measure waist in her Leeds' studies and Hall suspected that it would be worse with a fleet of people. Waist had to be a low priority at the moment. **Ronnie Levine**, who worked with Mary Rudolf, confirmed how difficult it was. It was easy with primary school children but older children don't like removing clothing and so on. There is also a problem with the definition of where the waist actually was!

Mary Jones, an immunisation and vaccination co-ordinator in her area, suggested that the model used for getting PCT vaccination statistics nationally could be also be used for collecting BMI data. but **Penny Gibson** doubted that it could work as vaccinations were related to targets and were "categorical " - you either had them or you didn't and were easier to record.

Tricia Cresswell wanted to put the first question of the day. She affirmed that it was not the measuring but what was done with the measurements that was all important. The evidence was fairly robust about some of the prevention possibilities but pretty poor about interventions with people who are already obese. We knew that prevention needs to be life course and the things that we need to measure [breastfeeding rates, deferred weaning, promotion of healthy eating, physically activity etc]. We should all be doing that now and we should have to have a PSA target to do the right thing wherever the evidence base. We have NICE guidance coming out which may help us with the relatively difficult issue of children who are already obese because the evidence is weaker. It might be useful to focus now on some really clear questions. For instance, she asked, does everyone here think that we need to do a universal measurement?

Almost before she could complete her sentence **Jammi Rao** intervened by saying no question could be that simple [*sympathetic laughter]*. Every word in every question needed to be carefully worded so that everybody was answering the same question. **Heema Shukla** agreed and wanted to know the objective before she could answer it. " Are we measuring just population or what? " she said. **David Hall** thought " universality " important because one could make a case for measuring thoroughly in towns and cities and funding it properly or make the case of sampling in one in five schools across a conurbation. " I don't think that it's a question of measuring all the children in any one school ", he said, " I would take it for granted that in every school you would measure every child but I think there is a legitimate question about whether you need to do it in every school. The question about universality is to some extent a resources and statistical one because you have to consider the benefits ". On Mary Rudolf's analysis some 400-500 children's BMI were needed in order to pick up any useful trends. At least a cluster of schools would be involved before getting anything useful. "By the time I had looked at her data I came to the conclusion that it would probably be more logical and useful to go for a universal target of measuring in all schools. I'm not sure that that's very sound but that is the conclusion I came to ". **Richard Feltblower** confirmed David Hall's analysis. He stated that samples should be taken wherever they can as long as they are in the right numbers and other facts are known - ethnicity and social status/class etc. Postcoding was key. This prompted **David Hall** to continue by saying that " it would be better to do this with all children across the country and if you have it all postcoded you can do a huge amount with that information and coupled with the 5yr old data that even better because you can them look at trends over time. But the resources required must be considerable ". **Ronnie Levine** revealed that a power calculation indicated that 25 primary schools were needed to detect a standard deviation [SD] of 1% and, using data from all over Leeds, 2,700 children would be sufficient to detect a relatively small SD change. As far as cost was concerned, 5 teams were doing the Leeds' studies on a shoestring. He wanted to make two further points. Trends in childhood obesity must be recorded from cross sectional rather than longitudinal data and it must be centrally coordinated. It could be by the DH, a Royal College, the Child Growth Foundation [??] or even a PHO. **Sian Evans** agreed that PHOs had a role in making data accessible and agreed absolutely that there must be national coordination. All the good work

that was going on individually needed to be consistent for epidemiological purposes and there needed to be some central guidance. With everyone doing the same things at the same time PHOs did have an important role to play. **Helen Walters** confirmed that she had met with Catherine Powell and the DfES childhood obesity group and had talked about what PHOs could add in this respect. They had been very helpful.

Miranda Mindlin thought that if the project was going to be costly it would be a complete scandal not to come out with nationally comparable data. She thought that a national minimum data set was needed which had to be specified, collected and analysed at national level. The question was whether that could be integrated with data from local projects in some way and interpreted locally. This was John Rodriguez' point. She agreed that one had to be a little cautious at BMI outcome measures for small areas like schools. **Sian Evans** agreed with that, too. She thought that it was " heartbreaking " that data could be collected routinely, put into child health information systems and couldn't be accessed. There was also NPfIT that could be explored in the long-term to try to address the issue. **David Hall** however was wary. He said that the question of a national dataset was at least as long running as his career in paediatrics – 30 years – and a CHIC group had been discussing one over and over again. He advised against waiting for NPfIT: doomsday might come sooner. " We just need age, gender, BMI and postcode " he concluded.

Kristina Routh was concerned about putting a lot of resource into information collecting as opposed to doing something about the childhood obesity problem. It would be lovely to have the data but she wanted some resource to go into some action. She also wondered if the Health Survey for England [HSE] didn't already have the answer. It was supposed to be nationally representative, albeit small sample size, but people did seem to use the data and they do appear to show trends quite effectively. **Jammi Rao** put the cost of getting a local PCT " boost " in every UK PCT at £40m which would be horrendously expensive. **Helen Walters** confirmed that HSE was sufficient to show national trends but there was talk and negotiation around getting an enhancement to its work. As a public health doctor she wanted PCT – or even sub-PCT - data however and she thought that in the long term data collected at a local level would be more valuable at monitoring trends. Harking back to Richard Feltblower's intervention **Miranda Mindlin** couldn't see how ethnicity could be gathered: she couldn't even get a simple " yes/no " answer from children about whether or not they had walked to school or not!

Barbara Richardson-Todd wanted to know what information schools were already getting data at their 4yr-old Foundation Assessment. **Deidre Bryant** couldn't answer that specific question but questioned the assumption that measuring BMI would be an impossible workload for school teachers. Children already had to learn about numeracy and she saw no reason why staff, properly trained over a half-day, couldn't measure in any year group. There was no reason why they couldn't be trained by the school nurse who could also pass the data back to the PCT. That would give a clear pathway. And if the teachers measured as part of a lesson plan they could replicate it year on year. She questioned whether it was necessary to do it every year – maybe once at every key stage was enough - – but as children get older they were going to need to access information as part of their entitlement to good health. **The Chairman** reminded the audience that Scotland already had a policy of measuring BMI every three years. **Jeannie Warbery** was also quite happy about the measuring required and couldn't see any reason why classroom assistants couldn't be trained to do it. She worked with some 500 children all year round and the children themselves could input their own measurements into XL spreadsheets. She couldn't see what the problem was. **Kristina Routh,** though initially having been concerned about having to take weights, found that the children appeared to be quite comfortable with it. There was the odd [overweight] child who might have a bit of worry but after a few moments of reassurance that worry tended to go away. Above all, the children needed to know that you were in control and would protect them from other children wanting to pry and see the weights on the scale. The majority of children also had no problem in removing their clothes. The worst thing to do would be to make a big issue of it and take weight in a separate room. It should be just part of life. She would be happy to repeat the exercise and reassure parents about its objective. **Catherine Powell** was herself fairly reassured by this but would want to question why in North Birmingham the full evaluation was sent to everyone but the

children themselves. **Laurel Edmunds**, speaking as both a teacher and researcher, confirmed that she had measured 500 children out of the classroom but only because this was written into her study protocol. Her biggest problem, she said, was not with the children but with the schools themselves. Head Teachers were fearful of parent aggression. She added that she had had 40 children opted-out of measuring by their parents and 30 of them were the biggest in their classes. You would automatically stigmatise them if you did it on a class basis.

When **Julian Peto** again asked again why GP surgery practice nurses couldn't be required to weigh and measure every year [*laughter again*] it was the turn of **Helen Walters** to put him right. Taking BMIs would not happen in general practice, she said. Period. Though it was assumed that GP computer systems had fields for BMI, it was not currently so for adults and might not be even after the nGMS contract QOF negotiation. Children didn't go to GPs very frequently and, anyway, GPs were a more expensive resource than school nurses. **Laurel Edmunds**, also reminded the workshop that GPs were not particularly interested in helping families with fat kids. They saw childhood obesity as the parents' fault and that they should go away and do something about it. She thought the chances of GPs measuring children sympathetically were pretty slim.

Stephen Smith wanted to remind the workshop that if school is to be the place where the measurement is done it had to look at a whole school ethos from the head teacher down. It had to look at all school policies, life style issues, healthy eating issues. His independent, non-residential school had taken BMI at Yr 7 – his school's entry year – but linked it to the whole school approach and it had gone remarkably well. The sports staff took the BMI and relayed the information to parents with an explanation of the meaning of whatever the BMI figure was and if the parents wanted to talk about it they could ask to meet. The discussion point centred around what the respective roles of parent and school should be in improving the lifestyle of the child. He told the workshop that he was quite emphatic that he/the school was not prepared to take over the parents' role and they were still in the process of discussing the exact relationship. What was muddying the water was that most teachers cared passionately about the lifestyles of their children and naturally wanted to be involved. They could be too conscientious. He had to underline where their and the parents' responsibilities lay.

This may have partially satisfied **Zoe McDowell** who wanted to know whether parents had been consulted in the various screening projects the workshop had heard about. If parents were not part of them and not aware of their responsibilities regarding intervention, she predicted that even more children would finish up in secondary care and the NHS couldn't deal with it. She may have been further reassured when **Lizbet Cameron** summarised her pilot in Amersham where all school entry children were measured with full parental consent. If they reached an " overweight " level [17.5 BMI for boys and 17.00 BMI for girls] the parents were called in to be given simple advice re lifestyle. No parent had refused and they were going to be contacted over a 2yr period to see if the advice had changed lifestyle.

Talk of screening was too much for **David Hall.** He stated that whilst he was happy to talk about monitoring, he had an allergic response to the word " screening". Screening, and the possibility of individual clinical intervention, opened up a can of worms for him. He feared that the workshop's rational debate had been pre-empted by the political commitments that Ministers had made " without thinking " - a circumstance not unknown in politics. He was thoroughly opposed to the commitment to feed back individual BMIs to parents unless there was evidence that it might be useful. That was what the workshop had to struggle with. **Helen Crocker** also wanted to highlight the difference between screening and monitoring. She said that there was no good evidence about what health professonals could do for individual children. She would be interested to know what success the low level intervention in Amersham and Bedford had had because even high level intense interventions at Gt Ormond Street Hospital were not very effective. She also supported Laurel Edmunds' observations about GPs. " When you talk to parents and children about weight you have to be very careful in how you do it and health professionals in general do not deal with it sensitively however

hard they might try ", she said, " Screening is a long way off because we don't have the evidence for intervention at the moment ". **Laurel Edmunds**, in turn, referred back to the Bedford PE sessions and shuddered at the thought. In her experience children reacted against changing for PE, wearing the same clothes and doing the same tasks identifies them very strongly as having an unacceptable body. PE was a nightmare in the state school system through lack of resources, though she conceded it might be easier in the independent sector.

The first question of the day was still on " hold " when **Pauline Emmerson** admitted that she was feeling a bit heretical about the whole issue of taking BMI's universally. Since everyone already knew the nature of the problem and what had to be done about it, she asked what was the point of the screening? We were operating in an environment which was not conducive to healthy living and we needed a more integrated approach to it than just measuring. She liked Pauline Dumble's approach in Hull. Though the public health bit of her knew the value of painting a picture of the problem, she thought the path being trod was going to be costly. That was why she was feeling heretical.

It was not heresy but a bee in his bonnet that led **David Hall** to hark back to the proposition of using data for an individual child. There was a lot of support for the overall concept of wanting to know what was happening to the epidemic but he reminded the workshop that even that the figures could be debatable. Several people had identified that overweight children who avoided being measured would distort the overall figures. As soon as the conversation turned to using the child's individual data he got very worried.

He conceded, however, that there could be a graded response to the problem. Obesity was a dynamic problem, not something that you got or didn't get overnight. It was a lifestyle issue and could change over the whole of childhood. It would make much more sense to say to someone " although your child's BMI is not actually in the overweight category its creeping up, it's gone up since last year and the year before that and you're heading down the wrong path. " That was not actually screening or not screening, he continued, screening is one end of a clinical feedback process. There was another way of going about it which is what Stephen Smith was talking about and give parents the results with, hopefully, graded information. The problem that he had with that, of course, was that the information was highly sophisticated you needed highly sophisticated parents to use it.

Tricia Cresswell was to get her chance finally to pose not only her first question but a number of supplementaries. In putting them she insisted that two overriding assumptions needed to be made. The first was that it was population monitoring and not individual screening that was to be voted on. The second was that she assumed that the wider, whole school, young child population interventions [promotion of breastfeeding, deferred weaning, health eating, lots of exercise etc] were being pursued. This having been accepted, and despite the technical problems referred to above, the workshop began voting as follows:-

Q1

Should BMI checks in school be taken universally?
Q YES 70%
A NO 30%

Q2

Q Should every child be monitored every year in primary school?
A YES 17%
NO 83%

December workshop voted	ANNUALLY 48%

Q3

Q Should the first check be taken at school entry [4-5 yrs]?
A YES 95%
NO 5%

Q4

Q How many further checks should be taken in primary school [6-11yrs]
A ONE 64%
MORE THAN ONE 24%
NONE 12%

December workshop voted	ANNUAL EPISODE 48% BIANNUAL EPISODE 4% ONLY AT YR 6 OR NOT AT ALL 48%

Q5

Q How many checks should be taken in secondary school [11-16yrs]?
A ONE 12%
MORE THAN ONE 24%
NONE 64%

December workshop voted	ANNUALLY 38% ONCE WITH PLANNED INTERVIEW 46% ONLY AT YR 10 [SCHOOL EXIT] 16%

[lunch break]

At the start of the afternoon session, and just before a vote to decide if data should be collected anonymously or not, **Deidre Bryant** asked why couldn't they couldn't be recorded both ways and plundered again and again? For the purpose of a trend they could be used anonymously but if resources later on allowed them to be used as part of screening, you would know who you had measured and you wouldn't have to measure them all over again. **Zoe McDowell** still thought that the questions were being asked without any decision about what to do with the data. "We're putting the cart before the horse" she said. **Tricia Cresswell** understood her viewpoint but stated that it was important to start with the " how " otherwise the workshop would continue to loop around the issues as it had before lunch.

Jammi Rao stated that no data was truly anonymous. At the point of collection they were identifiable: they became anonymous only at the time that they were transmitted. If they were made identifiable one would be extending the minimum data set and its complexity. When voting, the workshop should think of the consequences. Non-anonymous was identifiable and the BMI remained known a] to the child and the parents and b] to the person who recorded it **John Rodriguez** still was not happy. He understood that it had been decided that we were monitoring and not screening and treating individuals - but what were we monitoring? If it was the whole population we needed only the national survey data and there was no point in paying for

anything more. If we were monitoring a local programme of some description, we need to have local data. At the moment he wasn't clear what was being monitored. **Tricia Cresswell** wanted to help by saying that if we were truly monitoring populations and not screening we needed to answer the simple question " anonymised or not? " At this point **David Hall** also felt he had to recap on the morning by stating why a national set of data was not as good as a local one. The benefit of measuring all children was that each district or PCT could have an idea as to whether or not it was making an impact. If it was just a generalised national dataset it removed all responsibility from local PCTs or LEAs to do anything. He did not think that there was a purpose of having data anonymised but it should nevertheless identifiable to particular parts of the country. Furthermore, re anonymisation, if you entered height/weight into a laptop you didn't have to work out the BMI. That could be done on some central processor. The data could then be anonymous in the sense that neither the child nor the professional need ever know the BMI.

Michael Soljak, - who was absent for the morning session - then informed the workshop that data could be " pseudo-anonymised " by attaching an NHS/DfES number to them. The advantage was that although the child is anonymous you can track individuals or whole cohorts and add information and interrogate by social class, post code, deprivation scores etc. Very useful information could be obtained by using pseudo-anonymity.

This intervention then sparked off more discussion about whether the data should be linked or not, what was happening currently to data and whether the data would be locally owned by PCTs or not. **David Hall** queried why a vote had to be taken at all because, thinking of policy, all the Government needed to do was to require PCTs or local authorities to produce a dataset of what was happening to children's BMIs at age 11 with a postcode, a gender and the age. Whether the PCT or local authorities then chose locally to link the data to their child health system or not would depend on what facilities they had locally. From a professional point of view, he couldn't see that this decision mattered very much one way or the other.

Tricia Cresswell assumed that the data would be collected locally because that is where the children were and then fed back into some dreadful national system. If it was local data, the crucial question was whether it could be linked or whether it was completely anonymised and never intended to be linked. She thought that the workshop would be split 50/50 split on this question but she could be wrong. **The Chairman** asked her how much money she would put on it. 50p was all she was prepared to stump up. As you will read below, she lost the bet.

Q6

Q How should the data be collected?
A COMPLETELY ANONYMOUSLY 6%
PSUEDO ANONYMOUSLY 94%

Even after the vote had been recorded some of the 6% still wanted to be heard again! **Jammi Rao** reminded the workshop how much more expensive linked data could be notwithstanding all the technical difficulties that would accompany it. In Birmingham they knew they couldn't link data because they had a child health system that was falling into disuse with inadequate data etc so they went for a very basic, anonymous population measure in different parts of the city. That is what they now had - at a modicum of the cost. **David Hall** agreed with him and felt that most PCTs would make the same decision. **Kristina Routh** reminded everyone that Birmingham felt that they could go get away with parental " opt-out " consent precisely because their data was going to be collected anonymously. Anyone going for linked data might find they had to get parents to " opt-in " to the measurements and that might be much more difficult to obtain. As with immunisation, much will be lost if "opting -in " was required.

Helen Walters was worried about the ethical issues of having a measurement that can be traced back to an individual when there was no evidence-based intervention to offer that individual. In her head there was still a " screening v monitoring " conflict - but maybe she was missing the subtleties. **Penny Gibson** believed that she was even changing camps. As a clinician, if someone was being measured as part of a population measure she might do nothing with it at the time but it would be very nice three years later to have the data. That might be a luxury we couldn't afford but it might nonetheless be useful for that individual. She thought one question was whether you did anything with the data at the time and a second question was whether you need it at all. **The Chairman** reminded the workshop that no-one could know when taking a measurement how valuable it might be later on and no-one had touched on this issue except a word or two earlier about prevention from David Hall. The workshop had talked all the morning about *de facto* overweight and obesity and what could be done about it but it really needed to address prevention - and you needed serial measurements. **Jammi Rao** disagreed. He could not imagine any instance – except for height - -when he would want to know what the child's BMI was three years before. If the child was fat now he probably was then. He couldn't see the worth in seeing them shifting across centile lines. It would divert resources and staff time and management time from doing the things that we know we can do to prevent the obesity epidemic. **The Chairman** was not to be cowed and asked him to explain why the House of Commons Health Committee had recommended yearly measurements and why the DH and DfES had accepted their advice? Without giving Rao the opportunity to respond, he presumed that the Committee had made its recommendations for the annual check because it had travelled widely to find out what was being done in other countries. That was always the first question: what was happening in America? In America they found the self-same advice being given and thought it would be quite appropriate for the UK, too.

John Rodriguez, still unhappy at the way the workshop was progressing, felt that a lot of the discussion was being based on the premise that nothing could be done about obesity. But was that really the case? Was there evidence that really nothing positive could be done, that parents couldn't do things for their children? If this really was so and we believed that, what was everyone doing there? He felt that he might as well go home. **Laurel Edmunds** couldn't hold out much hope for him either. She stated that the lastest update of Cochrane literature confirmed that there is still very little robust evidence to show how changes in children's BMI could be impacted - but there were hopeful signs that things might improve in the future. There were changing attitudes around weight gain, particularly with girls. The evidence base was still weak because of the difficulties of getting research funding worldwide. Treatment was still family-based but the innovation was that that kids were being asked what they wanted so treatment was focussed towards their needs. Hopefully this will be effective in the near future but it was still difficult to say " yes, we know what we are doing.".

definitions of overweight/obesity

Tricia Cresswell then suggested a vote on which definitions should be used and listed the options – the UK 91st/98th centiles for overweight and obesity respectively, the 85th/95% centiles, the IOTF lines or any combination. **David Hall** again questioned why the workshop had to make a decision and **Tricia Cresswell** told him. She thought that there was a powerful reason why. If the DH didn't ultimately make the decision, what we would have is things being published which people didn't understand and wrong comparisons would be made. This was already happening. Academics clearly stated what they were using but journalists didn't. We had bizarre coverage such as " just how big is our epidemic? " and this allowed the forces of darkness, the food industry, to rubbish what was being said because they knew that we were using confused figures. She emphasised her point by saying " Believe you me, the forces of darkness are amassing their armies of demons as we speak. We have to be sure about what we are measuring, and in the publication of figures both nationally and locally we need to be explicit about what we're publishing and it would be easier if we were publishing only one set all the time ". **The Chairman** reminded the workshop that in December the same issue had surfaced for discussion and the GP who headed the National Obesity Forum, Dr David Haslam, had

thrown up his hands in exasperation. He had pleaded for just one set of definitions to be chosen so that everyone could abide by that decision.

Helen Walters thought that the forces of darkness had perhaps been trained by the tobacco industry *[laughter*] and wanted to know if one set was better for clinical use and one for monitoring populations. Since she was probably the person to facilitate a DH decision she would be happy to be swayed either way. **Jammi Rao** reminded everyone that the Office of National Statistics [ONS] used the $85^{th}/95^{th}$. He was an agnostic but he too asked that one set was chosen and used regularly year-in-year-out. When **Helen Walters** corrected him by saying that ONS used both $85^{th}/95^{th}$ and $91^{st}/98^{th}$, **Jammi Rao** concluded that the ONS ought to be brought into line.

Penny Gibson shared David Hall's view that it was a slightly sour argument. She thought that the workshop should decide whether it was trying to get a definition useful for clinical and epidemiological use or not. If it divorced the two it could decide what it liked: if it married the two up it became much more difficult. There were many people not comfortable using the IOTF for clinical purposes and they were not a smooth match with the UK charts. They were fairly close to $91^{st}/98^{th}$ in some places but not in others. **Laurel Edmunds** stated, however, that more and more papers were coming out supporting the IOTF cut off. JJ Reilly had written a paper plumping for the 98th centile as being best for defining obesity . That was so close to the IOTF that the UK should go with the rest of the world**. Ken Snider** chipped in to say that the DH, in its PSA ruling, had opted for the 95th for obesity and that was the definition to be used to monitor progress towards the PSA target. He was at the December 17th BMI workshop and understood Dr Sheela Reddy to have said that, for monitoring trends, the DH used the UK $85^{th}/95^{th}$ but for international comparisons it was going to use the IOTF. .Snider had some sympathy with the view that, for international comparisons, the IOTF definitions had sense but, for UK trends, it seemed more sensible to use the $85^{th}/95^{th}$. **Jammi Rao** asked why the IOTF couldn't be used for clinical purposes as well. At a recent workshop in Birmingham local paediatric endocrinologists stated that they were seeing more and more obese children who had been easily picked up by IOTF definitions. Rao wanted to know why they couldn't be used.

David Hall was concerned about an absolute figure of BMI as a determinant of clinical referral. Any protocol which just specified a cut-off – whichever one you happened to choose – as an indicator for action seemed flawed from the very beginning. He thought that the point that the workshop might agree on was that the DH must establish as policy for what data it is going to present year-on-year. The ease at which data can be rubbished was clearly a problem but the data do need to be analysed not only in the number of children who had reached certain levels [IOTF or anything else] but also what was happening in the shift of the distribution curve. Several studies had shown that more and more children are shifting up even if they haven't got over the line. When the CMO is holding his press conference he will need to give a clear message that when the DH says that it has or hasn't achieved its objective of halting the rise everyone knows what definitions they are using. He was still not convinced that the workshop need choose which they should be or that there was any academic argument as to which set should be chosen. But it should be one of them.

Tricia Cresswell agreed absolutely. She recounted the joy of trying to explain the various definitions to a group of local councillors and it would have been easier to have had only one measure. We had to have clarity and it didn't matter which set we used as long as there was a rational argument for using it and people felt comfortable with it and it was fixed. **Zoe McDowell** stated that the Scottish SIGN [Scottish Intercollegiate Guidelines Network], on which she sat, had decided to use the $91^{st}/98^{th}$ for clinical use and $85^{th}/95^{th}$ for research. SIGN was a bit dubious about the IOTF cut-offs because they had low sensitivity and therefore didn't necessarily didn't pick up the fattest children. Research might now have changed things but that was SIGN'S evidence-based Guideline in April, 2003.

The Chairman asked if the workshop would like to see the $85^{th}/95^{th}$ centiles printed on the UK charts? **Tricia Cresswell**, thinking of how much easier this might make the explanations to her local councillors,

pleaded that whatever the workshop agreed should be printed on the charts. **David Hall** thought that, if he were the CMO explaining data an his annual press conference, he would find it easier to explain the 91st/98th centiles because they are based on UK data, because they are fixed points that everyone has agreed to and he would find it easier to explain to the media what the figures meant. The IOTF definitions were quite a complicated concept and the 85th/95th hadn't got any particular justification. His decision wasn't academic – just political.

Q7

Q Which definition should be used for overweight/obesity?
A 85th/95th CENTILE 10%
91st/98th CENTILE 80%
IOTF 10%

secondary school

David Hall wanted the workshop to discuss the teenage years because Russell Viner who runs the Middlesex Hospital's Adolescent Unit had argued that teenage obesity was every bit as important – and maybe more so – than early obesity. A lot of obesity continued to get worse in the teens and epidemiological logic would argue that we should have at least one more measurement at 14 - 16yrs. Against that there was the problem of getting a meaningful sample of children because by that age they were clear about their human rights and voted with their feet. He suspected that such an enormous number would refuse to be weighed and measured and you would get useless data. The GPs could do it but it would cost a lot and he suspected that the value of the data would not justify the cost. Epidemiologically he would argue strongly for a measurement in the teens but it might be a nightmare to get anything meaningful. We might have to be content with some fully-focussed ad-hoc studies in which people would have to invest a lot of time and effort.

The Chairman wished to remind David Hall that he was speaking in a 2005 context. He agreed that measuring in secondary school to-day might be difficult and the kids would tell you to stuff it. However, in the future, if children had been accustomed to being measured in primary school, this would not be such a culture shock and they might take to it more readily. Perhaps the workshop should think about the future a bit more. [*He was then rebuked a school nurse who had been in post since 1988. She said that even though children had been measured in Reception, Yr3 and Yr 6 they still didn't want to get on the scales in Yr 7 and Yr 9!*].

Jammi Rao reported the current practice at a surgery in Birmingham of taking a BMI at the time of the school leaving booster [14-15yrs old]. It was doing this because of the QOF target of getting BMI coded in 15-75 yrs adults and the GPs thought they would take the opportunity of getting a BMI when the kids came in for a vaccination and health check. Several people in the workshop reminded him that though that would work if the vaccination was done in surgery, it wouldn't work if it was done in school.

Michael Soljak stated that only 20% of the UK population had a BMI calculated in 2004. He stated that the DH was pushing very hard to get a target of 70% in place by 2008 but that would depend on how the nGMS negotiations went. The DH had made a submission to have BMI recorded. If it succeeded it would help a lot in reaching that target.

This set off **Stephen Smith.** He said that there were so many defeatists in the workshop that it was beginning to annoy him. He recalled that in the 1950s children were checked and "autocratised ", [told what to do] and somewhere along the line we had got fouled up by this issue of " rights ". He said he was getting increasingly pessimistic about this. " If we are going to use this information, if we're going to monitor we

have got to monitor teenagers otherwise what are we wretched monitoring for? " The more he listened to the debate the more he thought " forget it! ". Forget the monitoring and just let's get on with the health initiatives and do something about it. He was increasingly appalled by targets and the workshop going round a cycle of despair about all the monitoring issues. " Let's just get on with it, " he said, " and I'm telling you that the schools are. I do not think that the national data we are talking about will help us in the slightest and, as an educationalist; I've heard nothing here that will encourage me to think that I'm going to get anything out of it. I got a lot from the presenters this morning and have some tremendous messages from them and was quite enthusiastic this morning but I've completely lost my enthusiasm! ".

Lynn Owen-Jones appeared equally frustrated by the debate. She stated that once it had been decided what should be done, when it should be done and why the information was needed, school health and education should get together and do it. " We always do and we always will! ". This was an intervention was shared by others. **Helen Walters,** wearing her Portsmouth PCT, said that this information was required to evaluate what they had been doing in schools and have been doing over a number of years. Until it can be evaluated, Portsmouth couldn't build up the evidence base to then go on and do it.

Laurel Edmunds stated as a point of information that the 7,000 children still registered with the ALSPAC study [Avon Longitudinal Study of Parents and Children] had reached the age of 13. She thought that they were due to be measured now, and again at age 16, so that there will be data available from that study.

Ronnie Levine stated that it was difficult to measure teenagers and he had been struck by the difference in the two Leeds school obesity projects he was involved with [APPLES in primary and TRENDS in secondary school]. There was declining co-operation in the latter and the chances of getting anything useful at ages 13-14 was very low. We had to accept this however desirable monitoring might be. But **Pauline Dumble** wanted at least to try it. Hull couldn't be that different from Leeds and she was willing to give it a go with the help of the schools/children. " We must get away from making it just a weighing and measuring exercise and turn it into a lifestyle measure " she said.

The Chairman now got cross with the defeatism and reminded the audience that they should be discussing what they needed to do rather than arguing about the difficulties of doing anything. He understood Stephen Smith's disillusionment and **David Hall** agreed, too. What he worried about most however was that Ministers would see this giant measuring exercise as a proxy for doing the things that really matter.

Jammi Rao questioned one of the stated aims of teenage measurement being to prevent the future explosion of adult obesity. The evidence for that was lacking in a big way . For example, although it is said that half of the children who are obese go on to be obese adults, the majority of obese adults were not obese as children. So in terms of educating children about future lifestyle we must target a far wider range of children than those who are overweight. The population approach is the only approach and therefore we don't need a measurement of who is or isn't obese because the intervention applies to everyone.

Tricia Cresswell warmed to the Hull approach of doing the measuring within the context of a beneficient intervention around healthy lifestyles and so on because that was more " ethical " for want of a better word. That seemed to her very important for a number of reasons.

prevention

In the final session of the day **Jeannie Warbery**, speaking as a mum, wondered when society was going to begin to stop children becoming obese in the first place. Why are we not teaching our mothers to feed their children properly? **David Hall** thought she was right. His fear was that measuring looked like being an easy thing to do and that the important things – teaching parenthood, properly funding breakfast clubs, school meals, getting rid of vending machines etc – would be put to one side. Measuring was an easy cover and that

was his real worry. The only point of measuring in his view was as a public health measure to see if things were getting worse or better. No other point at all. Real danger is that politicians are basically scared – scared of the food industry, scared of the nanny state, they are scared of this, that and the other. They've got to be seen to do something. They don't think like us.

Pat Jackson confessed to becoming panicky. The panic was setting in because she remembered the days of successive school interviews which had little to do with the needs of school children. She feared that the measurement issue would go the same way, that it would fall on the doorstep of the school nurse and they would be spending so much time measuring that they would have no time to do the things they should such as supporting classroom lessons in healthy eating etc and how to cook. To a stunned audience she recounted that, for some 16yr olds, a potato was something that came out of a freezer in chip form and went into the microwave. **Michael Leigh** wanted to emphasise however that there was more to the school health workforce than school nurses. Support workers could be found and trained. BMI does not have to be done by school nurses. And, talking as a parent, he confirmed that he and his family did was just what the head teacher dictated in relation to healthy snacks and fizzy drinks. He didn't regard it as health fascism. He just did it..

Deirdre Bryant took up this point and wanted to reassure the workshop that there was a great deal happening in schools about health eating. If primary schools set the rules, parents took note. Schools were already working hard on the Healthy Schools Standard to improve diet and physical activity. They needed the measuring to tell where they were, how they were doing as the years went by and see if they were having an impact. It doesn't need to be anything brilliant or brilliantly accurate but we need to have something so that we can measure what we're doing now and how we are doing in the future. **The Chairman** emphasised the audit aspect of the measurement and **Yinglin Butt** agreed with Deirdre Bryant's holistic approach. It can't be " can we reduce obesity? ": it has to seen in the context of a healthy lifestyle.

David Hall thought the comments helpful. Helen Walker's job was doubly difficult given than the Ministers had made a commitment. It occurred to him that if a school had implemented its Healthy School policy or was working towards it could take a complete snapshot of all children's BMIs at the end of every year and report back to the parents year-on-year about how the school is doing as a whole. The Minister could fulfil his commitment without having to feed back data on individual children. The report could say what the school was doing and the progress which was making. Everyone would be seen to playing their part is playing their part and getting a good public health handle on what was happening. The attention is focussed on the school and though there were a lot of caveats about difficulties of small changes in data it could be finessed. In this way we might be able to emphasise the importance of what we were all trying to do, we would have measurements and the Minister's commitment could be fulfilled. The data could be collected centrally to get a national picture. That sounded to him a sensible sort of solution to the problem that the workshop was working on. **Helen Walters** agreed.

Ronnie Levine was still concerned about pulling the days debate together and there didn't seem to be any framework for doing that. It would be nice if the workshop could arrive at some sort of decision. He presumed that it might be Helen Walters' remit to do that. It's no good having fragmented data at a local school or PCT level. It's got to be brought together in a coherent form that can be accessed. If we didn't do that, we would be missing so much.

Jammi Roa thought David Hall's suggestion was very good to get every school to report much like a GP practice with it's 'flu uptake rates and the schools could the measurements in PE class or maths lessons. This data could then be available at local, regional and national level. That would solve everything. It would also focus the minds of councillors, politicians and the media on what was being done or not done to improve meals, get rid of vending machines and bring parent and pupil power to bear on it. **Anna Boltong** said that the London Health Observatory had tried to set up a pan-London boost to the HSE and had been talking with

PCTs about this. This would produce data at a regional level. **Kristina Routh** underlined the point that when the data left the school it would have to be anonymised.. Earlier the workshop had voted 94% for linked data but she thought that would be impractical because consent would not be obtained.

Heema Shukla said that it has to be made clear that it couldn't be an NHS target but a local strategic policy target. Then it would work. Hillingdon didn't like the London Health Observatory plan because it was too expensive. It also didn't include children and it would be even more costly if it did. It was getting its children's information via GP reporting systems.

Barbara Richard-Todd still thought that society was still shutting the door after the horse has bolted. It was still talking " school " but it should get right back to pre-parenting with the midwives, pregnant mothers getting involved with mothers paying down the foundation of healthy eating.

wrap up

The Chairman began to upsum the day by thanking David Hall for, maybe, paving the way to a successful outcome to the day. He then asked those in the audience with the responsibility of taking the decisions if they had anything further to say and **Helen Walters** immediately thank everyone for sharing their views so openly. She said that it was a small crumb of comfort to her that all the issues discussed had previously crossed her radar and that there were no horrible questions that she had not picked up on. She didn't have any answers at the moment but was very willing to have people contact her at any time [email address below] with anything else that she needs to consider and she will definitely listen. **Yinglen Butt** was delighted to see the different approaches being made re this issue. The Department did not want to be prescriptive about what should or shouldn't happen. Based on local need people would be taking different approaches which fitted their needs and go with them. **Catherine Powell** said that she had found the day fascinating and thoroughly enjoyed all the arguments. Her key reason for being at the workshop was regarding workforce issues in relation to school nursing and what was particularly good was to hear people acknowledge some of the important strategies for tacking the issue.

David Hall thought that there many ways of skinning a cat and believed the discussion had showed that there were lots of good ideas around. Over the last few years the Government had had an enormously difficult balancing act between actual prescription and local freedom but on this issue there has to be some fair, firm leadership if things were actually going to happen. He thought it was reasonable to require that people demonstrate how they are working towards the PSA target but unless there was some degree of prescription it would never get top of a list of things to do. How to reach the target might be questionable but the fact that it had to be reached somehow had got to be stressed. One of the models of approach that he had come across in his dealings with the Department of Health was that it set out specific things that had got be achieved and problems that have got to be solved and then offered a number of models of good practice as a way of getting there. If things are left too wishy-washy we knew what would happen – nothing!

In responding to an intervention by the Chairman about the relatively low cost of properly equipping and training schools to do their measuring [some £300 per school], **David Hall** also warned against being too bland about cost. A very good argument had been made to have school staff to do the BMIs but there were other costs too – coordination costs etc. Things didn't get done as if by magic. It might be vastly cheaper than £40m country-wide but he couldn't see anything happening without a team-leader type of person. **The Chairman** wanted to remind the workshop that the loss to the Exchequer as a result of obesity was calculated by the Health Committee being £6.8 – 7.2bn per annum and that could not be sustainable. The yearly " spend " needed to avoid a catastrophe like that had been estimated at approximate £½bn per annum and the cost of team leaders and equipment would be peanuts compared to that. **David Hall** agreed but emphasised that the cost should not be underestimated if it were going to have any chance of happening. It probably wouldn't cost even £40m but you had to pay people to coordinate it all.

Ronnie Levine gave the workshop a final homily. Do not ever take money for research or anything else from the food industry. Government must pay for everything done in this respect.

[1] Child Growth Foundation " Obesity " Workshops

December 17th 2004	" The use of BMI in the identification/audit of childhood obesity "
May 9th 2005	" Breastfeeding and Obesity
June 17th 2005	"Annual BMI checks in primary school "
Spring 2006 [tbc]	" Weaning and First Foods "

references

[2] " Obesity " House of Commons Health Committee: 3rd Report of Session 2003-4: Vol 1 para 369
[3] Report of December 17th 2004 Workshop [see {1} above], Child Growth Foundation
[4] " Choosing Health, Making Healthier Choice Easier ", DH, November 2004
[5] Westminster Hall Debate on the above, Hansard, 10 Feb 05 Col 524WH
[6] National Primary Heads Association reply 01 Apr 05
[7] RCN email [16 Jun 05]

[8] " A low cost method for measuring the prevalence of childhood obesity " Routh K, Denley J, Rao JN North Birmingham School Project
[9] " Preventing, identifying and managing overweight and obesity in Children and Young People in Hull and the East Riding " Dumble P
[10] " Measuring BMI in schools – issues to be considered " Hall DMB