

# **Measuring Childhood Obesity**

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## ***Guidance to Primary Care Trusts***

## Measuring Childhood Obesity Guidance to PCTs

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## **Summary**

1. Obesity is one of the biggest public health issues facing England.
2. The Government has responded to this issue by developing a PSA target to “halt the year on year rise in obesity among children aged under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole”.
3. Local data on childhood obesity are needed for the following purposes:
  - To inform local planning and targeting of local resources and interventions.
  - To enable tracking of local progress against the PSA target on obesity, and local performance management.
4. This guidance provides advice to Primary Care Trusts on how to measure the height and weight of children aged between 4 and 11 years. Further guidance on data transfer, handling and analysis and feedback to PCTs will follow.
5. PCTs should measure:
  - All primary school children in the Reception Year (ages 4-5 years).
  - All primary school children in Year 6 (ages 10-11years).
6. PCTs are free to develop models that fit their local circumstances but PCTs should ensure that the data collected is accurate, timely and contains the stipulated core elements.
7. Schools will inform parents that the PCT will be measuring their child’s height and weight in school. The parents should be informed that they are entitled to opt their child out of the measuring process.
8. Local models should recognise the needs of children, and follow the good practice suggested in this guidance. It is vital that PCTs work to minimise stigmatization and bullying and acknowledge the children’s and parents’ right to withhold consent. The Children’s Commissioner has commissioned research into children’s attitudes to being weighed and measured<sup>4:9</sup> which has been used to inform this guidance.
9. Measuring outlined in this guidance is for the purpose of population monitoring. The guidance discourages giving out BMI to children or parents. This position will remain until such time that research defines the effects (benefit vs. harm) of doing so. BMI will be calculated separately from the measuring process.
10. The local healthy schools programmes should be involved in this measurement process by encouraging schools to make use of the PCT system of weighing and measuring children.

## 1. Introduction – Why are we measuring?

### 1.1. Obesity as a public health issue

- 1.1.1. Obesity is one of the biggest public health issues facing England. Obesity increases the risk of type 2 diabetes, cardiovascular disease, joint disease and some cancers. The National Audit Office<sup>1</sup> clearly highlighted the damaging impact obesity has on health: both the impact on the individual – for example, on health and life expectancy – and the huge financial costs for the NHS and the community as a whole. Obesity is responsible for more than 9,000 premature deaths per year in England (6% of all deaths compared to 10% for smoking). 36 % of cases of hypertension, 47% of cases of type 2 diabetes and 15% of cases of angina are attributable to obesity. For obese individuals, even a modest weight loss can have substantial benefits.
- 1.1.2. The prevalence of obesity in England has continued to rise among adults, in both sexes. In 1994 14% of men and 17% of women were obese. By 2003 this had risen to 23% in both sexes, almost 1 in 4.
- 1.1.3. The prevalence of obesity among children, aged 2 to 10, rose, between 1995 and 2003, from 10% to 14%. The increase in obesity was most marked among older children aged 8-10, rising from 11% in 1995 to 17% in 2003<sup>2</sup>.

### 1.2. The Government's Strategy on Obesity

- 1.2.1. The Public Service Agreement (PSA) target on obesity is the Government's first, high level response to the major public health problem posed by the continuing rise in obesity. The target is challenging – **“halting the year on year rise in obesity among children aged under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole.”** Halting the rise in obesity goes against recent trends - no other country has managed to achieve this and it will require a step change.
- 1.2.2. The target is jointly owned by the Department of Health (DH), the Department for Education and Skills (DfES) and the Department for Culture, Media and Sport (DCMS), recognising that delivery will depend upon a concerted, joined-up effort across government and at local level. The target focuses upon preventing and managing obesity in children, but also recognises that wider action to tackle obesity at a population level will be critical to achieving this.

### 1.3. Why do we need to collect local data on obesity?

- 1.3.1. Direct measurement of delivery of the PSA target at national level will rely on the Health Survey for England (HSE). Data for children aged 2 to 10 are available at regional level, which Strategic Health Authorities (SHAs) may

find helpful. However, data are not available for detailed monitoring at SHA level or below, and a new local data collection mechanism is needed.

- 1.3.2. Local data on childhood obesity are needed for the following purposes:
  - To inform local planning and targeting of local resources and interventions
  - To enable tracking of local progress against the PSA target on obesity, and local performance management
- 1.3.3. In November 2004 *Choosing Health*<sup>3</sup> charged the Department of Health and the Department for Education and Skills with developing appropriate systems for recording lifestyle measures, for example obesity through weight and height measure requirements, among school age children. At the same time the Department of Health outlined a Local Delivery Plan line based on obesity data for children aged 4-11 years. The Department of Health envisaged a data source be developed on children's height and weight based on Strategic Health Authorities /Primary Care Trust areas. The Department of Health and Department for Education and Skills agreed that height and weight data should be collected in all maintained primary schools in England.

#### **1.4. Background to this guidance**

- 1.4.1. This document is the first part of guidance on this issue. It provides advice to Primary Care Trusts on how to measure the height and weight of children aged between 4 and 11 years. It will be followed by guidance covering issues of data transfer, handling, analysis and feedback to PCTs.
- 1.4.2. The guidance has been prepared with the help of the Expert Advisory Group on Measuring Childhood Obesity. Membership of the group is included in APPENDIX 1.
- 1.4.3. The Department of Health will be reviewing PCTs' experiences with the measurement process outlined in the guidance, in order to learn lessons and help to improve practice. If appropriate, further guidance on good practice will be issued to PCTs.

#### **1.5. Resources**

- 1.5.1. PCTs will be expected to resource and commission the data collection and record and deliver the measurement process from within their existing resource allocations.

## **2. Core data set**

### **2.1. Which children are to be measured?**

- 2.1.1. PCTs should measure:
  - All school children in the Reception Year (ages 4-5 years)
  - All school children in Year 6 (ages 10-11years)

2.1.2. PCTs should measure children in Reception year and Year 6 annually. Children's height and weight varies with age, as the year progresses. The time of year that measurement takes place has not been stipulated. However, for the sake of consistency it is recommended that measurement in individual schools takes place at a similar time each year. Comparability between PCTs would be improved if all data collection happened in the same term of the academic year, across the country. For this reason collection would be preferred in the summer term, but local circumstances may dictate that this is not possible.

2.1.3. A sampling approach was considered by the Expert Advisory Group. However, the large sample sizes needed to accurately monitor obesity at a PCT and sub-PCT level, and the potential for introducing systematic errors through non-random sampling mean that sampling is not considered to be a valid approach.

## **2.2. What core data elements are to be collected?**

2.2.1. PCTs should collect the following data on each child:

- Full Name
- Date of Birth
- Gender
- School name
- School address
- School year
- Date of measurement
- Height (in centimetres)
- Weight (in kilograms)

2.2.2. PCTs are asked NOT to calculate Body Mass Index (BMI) at the point of measurement.

2.2.3. PCTs are invited to approach schools to provide them with pupil year-lists containing names and dates of birth. Data needs to be identifiable to individual children at the time of collection to ensure that every child is measured and no-one is measured twice.

2.2.4. If possible the data should be held electronically, so that it can easily be shared, manipulated and analysed.

## **2.3. In which schools should measurement take place?**

2.3.1. Measurement should take place in every maintained primary school within the PCT boundary. It is expected that PCTs will have established working relationships with these schools.

2.3.2. It is expected that as many children as possible who attend primary schools within the PCT boundary will be measured. This will include the measurement of children who live, or are registered with GPs in, neighbouring PCTs. PCTs should collect data on all children who attend

primary schools within the PCT's boundary, not just children who belong to that particular PCT. This is necessary because evidence supports tackling obesity at community and school level and interventions will be reliant on PCTs engaging with whole school populations, not differentiating between individual children according to which PCT they belong.

- 2.3.3. Independent schools educate 5-6% of the primary school population. It is recognized that PCTs may not have developed relationships with these schools. As the population attending independent schools is relatively small and because links may not be developed, PCTs may choose not to concentrate on measuring these children initially. As PCTs develop relationships over time, it will be increasingly possible for measurement of children in independent schools to happen at a later date.
- 2.3.4. Some PCTs will have maintained schools and independent schools within their boundaries that cater for children with special needs. Some children with special needs will attend mainstream schools. Measuring children with special needs may be more likely to cause physical or psychological distress<sup>4</sup> and PCTs may want to discuss with the schools whether measurement is appropriate for these children.
- 2.3.5. While measurement may not occur in special or independent schools these children are still at risk of being overweight and obese. PCTs should be working with these schools and interventions should be offered in all schools according to need and priority, regardless of whether measurement has taken place.

## **2.4. How is obesity being defined?**

- 2.4.1. Body Mass Index (BMI) is a well-recognised measure for assessing obesity and overweight. BMI is calculated by dividing weight, in kilograms, by the square of the height, in metres. BMI is easy to measure and is not invasive.
- 2.4.2. In adult practice BMI is widely accepted as a measure of obesity. Cut-off points of BMI scores of 25 and 30 are accepted as definitions of overweight and obesity respectively as they can be clearly related to increased risks in morbidity and mortality.
- 2.4.3. There is still discussion as to the appropriateness of BMI as a measure of overweight and obesity, especially in children. At the level of an individual child a single BMI measure is difficult to interpret and needs to be used in conjunction with other findings, if it is to assist with the management of overweight and obesity.
- 2.4.4. BMI has been accepted as a tool to monitor change at a population level. The 2005 HSE report on obesity in children under 11<sup>2</sup> and the Scottish Intercollegiate Guidelines Network (SIGN) on the management of obesity in children and young people<sup>5</sup>. Both use BMI in their reports on childhood obesity.

2.4.5. The link between morbidity and mortality and BMI is not as clearly demonstrated in children as in adults. Despite the known link between childhood obesity and early onset of diabetes, stroke and cardio-vascular disease<sup>6</sup> there are no obvious cut-off points at which there is a clear link between BMI and a change in risks of morbidity and mortality. Opinions differ as to which definition of obesity and overweight should be used and which baseline population should be used. The 2005 Obesity among children under 11 report<sup>2</sup>, the SIGN report<sup>5</sup> and the obesity PSA target define children as overweight and obese if their BMI falls above the 85<sup>th</sup> and 95<sup>th</sup> centile, respectively, of the reference curve for their age and gender. This cut-off is derived from the UK National BMI classification which uses 1990 reference population from TJ Cole et al<sup>8</sup>. The International Obesity Task Force (IOTF) developed a classification of BMI, based on an international population, with BMI cut-offs extrapolated back from the adult cut-offs of 30kg/m<sup>2</sup> and 25kg/m<sup>2</sup><sup>7</sup>. This is suggested as the best definition to use when making international comparisons. Clinicians tend to use the 91<sup>st</sup> and 98<sup>th</sup> centile when dealing with individual children.

2.4.6. PCTs need to be aware of the variety of methods of presenting BMI when using and presenting childhood obesity data.

### **3. The role of the PCT**

#### **3.1. Models that work locally**

3.1.1. PCTs are free to develop a measuring model that fits their local circumstances, reflecting available resources and relationships. A variety of models of measurement have already been developed around the country. Some of these models are described in APPENDIX 2, along with the contact details of those involved. The examples are presented in order to share ideas, approaches and information about lessons learnt. The models pre-date the guidance and do not necessarily present examples that mirror the guidance.

3.1.2. Within the variation of these local solutions PCTs should ensure that the data collected is accurate, timely and contains the stipulated core elements.

3.1.3. Local solutions must recognise the needs of children, and follow the good practice suggested in this guidance. It is vital that PCTs work to minimise stigmatization and bullying and acknowledge the children's and parents' right to withhold consent. The Children's Commissioner has commissioned research into children's attitudes to being weighed and measured<sup>4;9</sup> which has been used to inform this guidance.

#### **3.2. The role of school nurses**

3.2.1. PCTs may want to use the expertise of the school nurse workforce to facilitate partnership working with schools and other aspects of this measuring programme.



3.2.2. Where they are available, school nurses have an essential role to play in helping tackle the childhood obesity epidemic by engaging in activities to monitor the obesity target in their schools and developing and supporting whole school interventions according to need.

### **3.3. What will happen to the data once it is collected?**

3.3.1. This guidance covers the collection of the data. Further guidance will be published to cover the movement, storage, collation, analysis and feedback of the data. This will include guidance on how height and weight data collected from individual schools can be translated into obesity prevalence rates, which form the indicators for monitoring the obesity PSA at a local level.

3.3.2. Child Health Information Systems are not, at present, sufficiently developed or consistent, at a national level, to hold this data.

### **3.4. What will happen to current measuring systems?**

3.4.1. Around the country there are PCTs that already have local systems for measuring height and weight, especially at school entry. This data is often held in Child Health Information Systems. In some cases these systems provide valuable longitudinal data on childhood height and weight in their locality.

3.4.2. It is hoped that these databases will continue. One of the reasons for deciding to measure children in Reception Year is that this coincides with activity already ongoing in many places, thus reducing the demand for new resources.

## **4. Population monitoring, not screening**

### **4.1. A population monitoring process**

4.1.1. The measuring outlined in this guidance is for the purpose of population monitoring. The guidance discourages PCTs from telling children and their parents their BMI as this would then, in effect, become a screening programme.

4.1.2. An explanation of the difference between population monitoring and screening is outlined in APPENDIX 3.

### **4.2. What does this mean in practice?**

4.2.1. This programme measures the BMI of groups of children, without those results being made known to the individual children, their parents, school staff or healthcare personnel.

4.2.2. This issue was discussed at length between DH, the National Screening Committee (NSC), the Children's Commissioner and other members of the Expert Advisory Group on Measuring Childhood Obesity. It was agreed that height and weight should be recorded for each child but BMI should not be

calculated at the point of measurement. BMI should not be used in relation to individual children, only in relation to populations as a whole.

- 4.2.3. Parents have a right to know their child's height and weight measurements. Although these should not be given routinely they should be given if requested. PCTs should develop a system for responding to parental requests for height and weight values.

## **5. Good practice when measuring**

### **5.1. The potential for harm**

- 5.1.1. Children can be very sensitive about their own size and those of children around them. Measuring height and weight could accentuate these sensitivities and increase the risk of stigmatisation and bullying. It is important that the process of measuring is handled in such a way as to minimise any potential for harm.

- 5.1.2. In the autumn of 2005 the Children's Commissioner undertook research into the attitudes of primary school children towards being weighed and measured<sup>9</sup>. The report findings are outlined in APPENDIX 4. The report findings are consistent with the thinking of the Expert Advisory Group and this guidance. A major anxiety raised by the research was the removal of clothes, but this is not asked for in the guidance.

### **5.2. The process of measuring**

- 5.2.1. Children's height should be measured in centimetres, to the nearest half centimetre. Shoes should be removed.
- 5.2.2. Children's weight should be measured in kilograms, to the nearest 100 gram unit (0.1kg). They should wear normal, light, indoor clothing without shoes.
- 5.2.3. Children's gender should be recorded with a (M) or (F).
- 5.2.4. Children should not be routinely told their height and weight measurements.
- 5.2.5. BMI should not be calculated at the point of measurement so should not be available to the children, schools or parents.

### **5.3. Improving accuracy and minimising harm**

- 5.3.1. PCTs should ensure that trained individuals are responsible for the process of measuring the children. All staff engaged in weighing and measuring children should have a completed CRB check in keeping with current employment arrangements. Guidance issued by DfES on working with children is available at:  
<http://www.teachernet.gov.uk/docbank/index.cfm?id=2172>. Thought should also be given to ensuring the quality of the measuring, including the training and number of individuals carrying out the measurement.

- 5.3.2. Training is important to ensure that staff understand why they are undertaking the measuring, the importance of accuracy and consistency in measuring and how to support children with any anxieties they may have.
- 5.3.3. Training for staff should include:
- How to weigh and measure children accurately. Quality needs to be assured for the height and weight measures by auditing the performance of measuring staff. This may be done prior to deployment, and then annually, by taking replicate measures on a sub-sample of children.
  - How to complete the data collection forms accurately and submit them centrally to the PCT.
  - Issues relating to confidentiality and how to prevent stigmatisation or bullying of vulnerable children.
  - How to address children's, staff or parents' questions.
- 5.3.4. PCTs may wish to use the Department of Health's directory "Obesity Training Courses for Primary Care"<sup>10</sup>, which can be found on [www.domuk.org](http://www.domuk.org).
- 5.3.5. Schools should be given advance warning of data collection. Parents should receive a letter explaining that the PCT will be measuring their child's height and weight in school. The parents should be informed that they are entitled to opt their child out of the process. Standard letters to head teachers, Chairs of the School Governors, and parents, approved by DfES and DH, are contained in APPENDIX 5. The draft letter to parents includes a tear-off and return opt-out form.
- 5.3.6. Measurements should take place in such a way that the privacy of each individual child is ensured, in order to reduce the risk of bullying and stigmatisation. Children should never be told the measurements of other children.

#### **5.4. Quality and calibration of measuring equipment**

- 5.4.1. Accuracy of measurement will be increased if good quality equipment is used and regularly calibrated.
- 5.4.2. Weighing scales must comply with EU Directive 90/384/EEC. These cost approximately £200 to £250 and should be calibrated in line with the EU recommendations. This EU directive is applicable whether the measurement is for individual clinical use or population monitoring.
- 5.4.3. Accurate height measurement is dependant on careful and accurate use of equipment.

## **6. The link with the National Healthy Schools Programme**

### **6.1. What is the National Healthy Schools Programme<sup>11;12</sup>?**

6.1.1. The strategic aims of the programme are:

- Encouraging a healthy lifestyle.
- Reducing health inequalities.
- Helping to raise pupil achievement.
- Promoting social inclusion.

6.1.2. Achieving national healthy school status enables schools to show how they are contributing to the national outcomes for children and provides evidence to include in their Self Evaluation Form.

### **6.2. How does monitoring obesity link with this programme?**

6.2.1. A healthy school, as part of the process of achieving healthy school status, should ensure that it is addressing the health needs of all its pupils. This should include action to prevent or address actual overweight or obesity among pupils. Using the monitoring system organised by the local PCT, schools will be able to ascertain from the PCT the degree and patterns of obesity in the school and respond with appropriate action, while NOT using the process to focus on or screen individual pupils (guidance on effective preventative practice will be available later in 2006).

6.2.2. Local healthy schools programmes should:

- Encourage schools to work with the PCT in the weighing and measuring of children.
- Work with the PCT to ensure that its practice in weighing and measuring adheres to this Department of Health guidance.
- Work with schools, teachers, parents and pupils to ensure that no stigma, bullying or harassment occurs as a result of weighing and measuring.
- Encourage schools to record its work in weighing and measuring in its Self Evaluation Form (section 4 may be most appropriate).

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## APPENDIX 1

### Membership of the Expert Advisory Group on Measuring Childhood Obesity

| <b>Name</b>                  | <b>Title</b>  | <b>Organisation</b>   |
|------------------------------|---|---|
| Walters, Dr Helen<br>(Chair) | SpR Public Health   | Department of Health<br>and<br>Portsmouth City PCT                                |
| Booth, Dr Lorna              | Assistant Statistician  | Standards and Quality<br>Analytical Team,<br>Department of Health                 |
| Buchan, Dr Iain              | Senior Lecturer in Public Health<br>Informatics and Director of<br>the Northwest Institute for Bio-<br>Health Informatics | University of Manchester<br>and Northwest Institute<br>for Bio-Health Informatics |
| Carpenter, Dr Jennie         | Head of Screening and<br>Specialised Services   | Standards and Quality,<br>Department of Health                                    |
| Chadwick, Dr Ruth            | Programme Manager, Research<br>and Evaluations  | Department of Health  |
| Dr Tim Crayford              | Director of Public Health   | Croydon PCT   |
| Crowther, Dr Rachel          | Locum Consultant in Public<br>Health  | Association of Public<br>Health Observatories                                     |
| Edmondson-Jones, Dr Paul     | Director of Improving Health and<br>Quality   | Portsmouth City PCT   |
| Elliman, Dr David            | Consultant in Community Child<br>Health   | Islington PCT and Great<br>Ormond Street Hospital<br>for Children                 |
| Fahey, Dr Daragh             | Information and Intelligence<br>Workstream Lead   | Obesity, National<br>Programme Delivery,<br>Department of Health                  |
| Gibson, Dr Penny             | Consultant Community<br>Paediatrician, RCPCH Advisor on<br>Childhood Obesity  | Child Health Department,<br>Blackwater Valley & Hart<br>PCT                       |
| Hall, Professor Sir David    | Professor of Community<br>Paediatrics   | University of Sheffield   |
| Hubbard, Mr John             | Health Strategy Team, Children,<br>Young People and Families<br>Directorate   | Department for Education<br>and Skills  |
| Jay, Ms Tabitha              | Obesity Programme Manager   | National Programme<br>Delivery, Department of<br>Health                           |
| Jewell, Dr Tony              | Director of Clinical Services<br>and Public Health, Norfolk,<br>Suffolk and Cambridgeshire<br>Strategic Health Authority  | Norfolk, Suffolk and<br>Cambridgeshire Strategic<br>Health Authority              |
| Jones, Dr Judy               | Regional Consultant in Public<br>Health Medicine  | East Midlands Public<br>Health Group,<br>Department of health                     |
| Koudra, Mr Mike              | Obesity Delivery Manager  | National Programme  |

|                          |  |   |
|--------------------------|--|---|
|                          |  | Delivery, Department of Health                              |
| Levine, Dr Ronnie OBE    | Hon. Senior Research Fellow, Academic Unit of Paediatrics  | University of Leeds   |
| McIntosh, Professor Neil | Vice-President for Science and Research  | Royal College of Paediatricians                             |
| Momin, Ms Nazeema        | Statistician   | Standards and Quality Analytical Team, Department of Health |
| Newland, Mr Toby         | Project Team Member, Recovery and Support  | Department of Health  |
| Noble, Mr Colin          | National Coordinator, National Healthy Schools Programme   | Department of Health/Department for Education and Skills    |
| Phillips, Mrs Claire     | Head of Policy   | Office of the Children's Commissioner                       |
| Powell, Dr Catherine     | Nurse Advisor for Children and Young People  | Department for Education and Skills / Department of Health  |
| Reddy, Dr Sheela         | Principal Nutritionist   | National Programme Delivery, Department of Health           |
| Rudolf, Professor Mary   | Consultant Paediatrician in Community Child Health   | University of Leeds   |
| Rutter, Dr Harry         | Head of Health Impact Assessment, South East Public Health Group and Deputy Director, South East Public Health Observatory | South East Public Health Observatory                        |
| Snider, Dr Ken           | Director, Co Durham & Tees Valley Public Health Network  | Co Durham & Tees Valley Public Health Network               |
| Tanner, Professor M. S.  | Academic Unit of Child Health  | Children's Hospital, Sheffield                              |
| Turner, Ms Karen         | Programme Manager - Healthy Schools  | Department of Health  |
| <b>Invited Attendee</b>  |  |   |
| Tam Fry                  | Honorary Chairman  | Child Growth Foundation                                     |

## APPENDIX 2

### Examples of existing schemes to measure BMI in children

These examples of existing schemes, surveys and innovative practice provide a range of approaches to BMI surveillance. They pre-date the guidance and do not necessarily present a model that will fulfil the guidance. They are presented in order to share ideas, approaches and information about lessons learnt.

Information on these schemes was sought by email and telephone interview and was subsequently verified.

#### 1. Birmingham

|   |   |
|---|---|
| <b>Reason for the scheme</b>                          | To develop a sustainable way of gaining BMI data from schoolchildren in Birmingham.<br>This follows a successful pilot scheme in 2004 involving 252 Year 5 children in North Birmingham PCT. The scheme is now being rolled out across Birmingham, beginning with schools that are already involved in the National Healthy Schools programme.  |
| <b>School year &amp; approximate numbers annually</b> | All Year 5 pupils in participating volunteer schools will be measured (~6000 children in this year's roll out).   |
| <b>Details</b>  | <b>Resources:</b> For the pilot scheme health staff took measurements. For wider roll-out Learning Support Assistants will take measurements. The roll out will occur 2005-6 with the first data available by Christmas 2005. Coordinator (Senior teacher) seconded to take the procedures from the pilot and roll out across the city.<br><b>Measurement setting:</b> Pupils measured in the classroom, in the context of numeracy work. Devised lesson plan fits in with National Numeracy Strategy. Children measure and record shoe size, hand span, eye colour, foot length while height and weight measured.<br><b>Data:</b> Collected by coordinator and then transferred to PCT PH analyst.<br><b>Consent:</b> Parents get an explanatory letter with chance to opt out (three children withdrawn in pilot).<br><b>Equipment:</b> Standardised equipment used.<br><b>Other issues:</b> Avoiding stigmatisation - the scales have a remote display so that only the recorder sees it. Also the class is provided with dummy data to work with rather than data recorded about the group. |
| <b>Innovation</b>                                     | Taking measurements as part of a numeracy lesson in the classroom. Partnership between Health and Education.  |
| <b>Issues &amp; Challenges</b>                        | The problem of low school nurse capacity has been addressed by training LSAs to take on the measurement role.<br>Being withdrawn from a lesson is potentially stigmatizing for a child.<br>Special schools need appropriate individualised protocols.<br>Data will be biased by using volunteer schools in the roll out.<br>Networking across sectors (Health and Education) can be challenging.  |
| <b>Cost/resources</b>                                 | Main costs are in start up (e.g., co-coordinator salary and equipment). School nurse time in local management of the process. In order to sustain the project ongoing co-ordination will be essential (~ 0.5 WTE).  |
| <b>Other comments</b>                                 | Lesson currently designed for Year 5, but could be adapted for other primary year groups.   |



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|------------------------|--|
|                        | Schools will value this work as evidence of their commitment to reducing childhood obesity, providing much needed baseline and follow up data to evaluate the effectiveness of their interventions.              |
| <b>Contact details</b> | <a href="mailto:Deirdre.Bryant@northbirminghampct.nhs.uk">Deirdre.Bryant@northbirminghampct.nhs.uk</a><br><a href="mailto:Kristina.Routh@northbirminghampct.nhs.uk">Kristina.Routh@northbirminghampct.nhs.uk</a> |
| <b>References</b>      | Routh K, Rao J, Denley J, (in press) <i>A low cost method for measuring the prevalence of childhood obesity</i> . Child: Care, Health and Development.   |

## 2. Derwentside

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|---|---|
| <b>Original reason for the scheme</b>                 | Existing school entry (Year R) surveillance of height and weight. Scheme has been in place for three years.   |
| <b>School year &amp; approximate numbers annually</b> | Year R – all children (1050).   |
| <b>Details</b>  | <b>Resources:</b> Measuring done by HCA 'school screener', who is NNEB. Works alone.<br><b>Measurement setting:</b> Few schools have a health room so they use whatever space is available e.g., school hall.<br><b>Data:</b> CHS provide a list of children and measurements are recorded onto this sheet. CHS calculate BMI and provide feedback to the schools.<br><b>Consent:</b> Letter & leaflet informs parents about school health and nursing service, including entry surveillance, with opt out consent available. |
| <b>Issues &amp; Challenges</b>                        | Screen vision and hearing measurements are also taken at school entry but usually in a separate session (this is done to avoid confusion between screening and surveillance).   |
| <b>Cost/resources</b>                                 | Existing HCA staff used but additional HCA recruited (0.5) as well as specialist health advisor (0.5) addressing the obesity strategy.  |
| <b>Contact details</b>                                | <a href="mailto:Kathleen.campsell@cddah.nhs.uk">Kathleen.campsell@cddah.nhs.uk</a>  |
| <b>Other comments</b>                                 | There is a lot of work to do with children deemed to be obese and a need to think about the psychological aspects of recall in surveillance.  |

## 3. Durham & Chester-le-Street

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| <b>Original reason for the scheme</b>                 | Started this academic year in response to obesity strategy.   |
| <b>School year &amp; approximate numbers annually</b> | All Year 7 (~ 1400 pupils) linked to existing intervention (vision screening).  |
| <b>Details</b>  | <b>Resources:</b> Two health care assistants carry out height and weight measurement at the same time as vision screening. Schools are informed of all changes planned for the year via a letter. There have been no reactions or concerns reported.<br><b>Measurement setting:</b> Usually done in school hall because space is needed for vision screening. Measuring area is screened.<br><b>Data:</b> CHS provides names of pupils to be included in the programme. HCAs record on this and return to CHS for data input and reporting.<br><b>Consent:</b> Letter to parents clear about height/weight surveillance and that no intervention would follow. Opt out consent. |

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| <b>Innovation</b>              | 'Family Initiative Supporting Children's Health' (FISCH): A health advisor and physical activity officer is working with Years 4 & 5 in mainstream and 1 special school to address obesity. Wheelchair scale purchased via capital bid for special school measurements. Pilot project is using a collaborative approach to tackle obesity i.e., working with health and leisure services to promote physical activity and healthy eating. A Health Advisor works with individual families as identified in Care Pathway. |
| <b>Issues &amp; Challenges</b> | Consent: 10 refusals to date, two for clinical reasons, others no reason given. Noted a cluster of three in one school.<br>It was considered linking scheme to immunisation but felt that was a sensitive issue and schools do not always have enough staff available to support and deal with any anxieties and to add a further activity would be counter-productive.  |
| <b>Cost/resources</b>          | 10 mainstream state schools (no SLAs with private schools)<br>One of the HCAs is additional (20 hrs term time only).<br>CHS have said it will increase their workload and estimate an additional 10hrs at grade 2 needed to input data and prepare reports.  |
| <b>Other comments</b>          | Also measure Year Reception – but data not currently used/analysed as BMI. Plan to do so for this academic year.<br>Existing scales are calibrated annually so need to address a process to monitor the new scales based in the schools.   |
| <b>Contact details</b>         | <a href="mailto:tricia.cresswell@durhamclspct.nhs.uk">tricia.cresswell@durhamclspct.nhs.uk</a><br><a href="mailto:rhonda.earl@cddah.nhs.uk">rhonda.earl@cddah.nhs.uk</a>   |

#### 4. Langbaourgh PCT

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| <b>Initial reason for the scheme</b>                  | A two-stage randomised sample survey of Year 6 pupils (aged 10 & 11) in summer 2005 using Regional Dental Survey methodology.  |
| <b>School year &amp; approximate numbers annually</b> | Year 6 (488 pupils from 1300 total).<br>All Year R children are also routinely measured.   |
| <b>Details</b>  | <b>Resources:</b> Measuring by school nurses. If repeated, it is envisaged that lower grades will do this rather than Sisters. It is viewed as a task that could be carried out by Nursing Assistants (none in this area at present).<br>Letters are sent to LEA Director of Education and School Head Teachers to inform and to ask for their support.<br>Survey carried out in summer term, after SATs.<br><b>Measurement setting:</b> In school, some as part of PE.<br><b>Consent:</b> Opt out consent. A letter to parents made it clear that the data was for surveillance not screening and offered routes to help/services if required.<br><b>Data:</b> Data collation and analysis by a PCT based PH analyst. |
| <b>Innovation</b>                                     | Child Health System allows population queries. They are currently implementing a new system that will allow analysis of routinely collected data by population groups.   |
| <b>Issues &amp; Challenges</b>                        | There is general consensus that a whole Year 6 survey is the preferred scenario - the randomisation made it complicated logistically. Some schools were not included in the survey, and as only every other pupil on the class register was measured, those who weren't felt left out.   |

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|                        | No clear route for analysis. Currently being undertaken by a PH analyst.  |
| <b>Cost/resources</b>  | Difficult to estimate and in future would depend on grade of staff.<br>Need to ensure that decent equipment is available (scales have to be to a certain standard now and are very expensive).<br>Cost of analysis of data.                           |
| <b>Contact details</b> | <a href="mailto:julie.hatfield@langbaorghpct.nhs.uk">julie.hatfield@langbaorghpct.nhs.uk</a>  |
| <b>Other comments</b>  | Schools keen to take part and to receive feedback. Currently the sample size from each school is too small to give reliable results at school level. Very few parents opted out. Future plans depend on guidance and new configuration of local PCTs. |

## 5. Leeds

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| <b>Original reason for the scheme</b>                 | Initially a pilot research scheme (2004) to develop a simple and reproducible methodology to monitor trends in childhood obesity. 10 primary schools took part. A specific aim was to calculate the number of schools needed to accurately identify a halt in year on year growth in obesity.<br>This was repeated in 2005 with 25 schools (10% of Leeds schools). It is now being implemented by CHS to monitor the obesity epidemic within Leeds.   |
| <b>School year &amp; approximate numbers annually</b> | Year Reception – 740, Year 4 – 830, Year 8 - 679  |
| <b>Details</b>  | <b>Resources:</b> In pilot scheme, all measurements were undertaken by one trained school nurse. Now HCAs are employed in teams of two for each PCT (one trained to measure and the other as scribe).<br><b>Measurement setting:</b> Measurement done in classroom behind a screen.<br><b>Data:</b> Measure height, weight, body fat and waist measurement. A class list, including postcode, is available to ensure ascertainment is known and facilitate follow up of any missing on the day.<br><b>Consent:</b> Opt out consent (initial pilot research project had ethics approval, but is now moving to routine practice). |
| <b>Innovation</b>                                     | Development of an efficient, low cost methodology to accurately monitor the obesity epidemic and setting up of a PCT database so that data entry is local. Currently training a PCT employee to analyse the data and present summaries and feedback.  |
| <b>Issues &amp; Challenges</b>                        | Unable to use the CHS because it is geared to the individual and is impossible to query at a population level.<br>Specifically sought feedback from HCAs – no issues of confidentiality were reported. Plan to extend feedback request to teachers next time.   |
| <b>Cost/resources</b>                                 | HCAs are all in existing posts or working on another university project.<br>HCAs - £2310<br>Admin - £3,400 (but nature of it being a research project increased this).<br>Other specifically research costs included statistical consultancy fees, data entry etc.<br>Set up costs – charging the PCT £1000 to train HCAs, set up database and train analyst  |
| <b>Other comments</b>                                 | The reason behind this scheme is to obtain accurate data – at present PCTs can't use existing data as routine school nurse entry measures   |

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|                        | are missing data and have huge inaccuracies. This way is efficient and if it included all schools at Year R and 6 it would only need one team of measurer and scribe.<br>Feedback is to the school rather than to the parent. This avoids the concerns regarding introduction of screening for obesity. |
| <b>Contact details</b> | Mary.rudolf@leedsth.nhs.uk  |
| <b>References</b>      | Rudolf MCJ, Feltbower RG, Levine R, Connor A, Robinson M. (in press). <i>The trends project: development of a methodology to reliably monitor the obesity epidemic in childhood</i> . Archives of Disease in Childhood.   |

## 6. Middlesborough

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| <b>Original reason for the scheme</b>                 | BMI survey of Year 7 and Year 10.   |
| <b>School year &amp; approximate numbers annually</b> | Two whole-year surveys of children in Years 7 (ages 11 & 12) and 10 (ages 15 & 16). There were approximately 2500 children in each year group.  |
| <b>Details</b>  | <p><b>Resources:</b> 15 school nurse assistants conducted the survey and were trained in the measurement of height and weight prior to beginning the pilot survey.</p> <p><b>Measurement setting:</b> All the measurements took place in the school hall. Children in Year 7 were measured separately and not in connection with any other screening or vaccination programme. Screens were used to ensure privacy. Year 10 children measured at the same time as attending their school leaving vaccination booster. Height and weight measured followed the vaccination.</p> <p><b>Consent:</b> Only the children whose parents had returned a consent form for vaccination attended for vaccination and height/weight measurement. Opt in consent.</p>   |
| <b>Innovation</b>                                     | <p>School nurse assistants were very enthusiastic and positive about their role and conducting the survey.</p> <p>Despite curriculum pressures, schools were very receptive to cooperating with the BMI surveillance programme.</p> <p>Quality of data collected was of a high standard.</p> <p>Conducting the survey in 10 secondary schools took 10 mornings.</p> <p>Conducting the survey in all primary schools would have resulted in significantly more work, although less staff would be needed for each session. For example, a school nurse and two school nursing assistants could conduct the survey in each primary school.</p> <p>Home address postcode data was collected and was 96% complete for all those who participated. PCTs were therefore able to analyse the data by area-based deprivation measures (IMD 2004).</p> |
| <b>Issues &amp; Challenges</b>                        | <p>Two schools did not participate. Although no explicit reason was given, it was felt that pressure on the curriculum was an important factor.</p> <p>Running the BMI surveillance alongside a vaccination programme resulted in low participation rates (48%) and would not be recommended. The participation rate for the concurrent vaccination programme was only 65%</p> <p>The participation rate for the Year 7 survey was 71%.</p> <p>Whilst anecdotal, it appears that overweight children were more likely to</p>  |

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|                        | <p>opt out of having their height and weight measured. Furthermore, some children seemed to refuse due to peer pressure from other children.</p> <p>A number of practical issues were highlighted (such as consent forms not being sent out and classes out on school trips). This could easily be rectified in future programmes.</p> <p>Only a handful of parents contacted the PCT with specific questions or concerns about the BMI surveillance programme. Of those who did contact the PCT, most were concerned about what the PCT was doing to address the problem of underweight/anorexic young girls.</p> <p>Screens were not used in the first instance. After some children expressed concerns about privacy, screens were introduced and were welcomed by children and staff.</p> |
| <b>Cost/resources</b>  | <p>The BMI surveillance programme was built into the day-to-day work of the school nursing assistants. A whole year group survey was conducted in less than 4 hours during a morning session. A school nurse had overall responsibility for each session whilst five school nursing assistants conducted the measurements (2 responsible for administration duties and checking consent and 3 responsible for completing paper-based records and conducting the measurements).</p> <p>As a rough estimate, the survey was conducted across 10 schools within 40 hours with approximately 5 staff at any one time. Data entry time took approximately 40 hours and staff training time 3 hours.</p>  |
| <b>Contact details</b> | <a href="mailto:peter.heywood@middlesbroughpct.nhs.uk">peter.heywood@middlesbroughpct.nhs.uk</a>  |

#### 7. Newcastle-under-Lyme

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| <b>Initial reason for the scheme</b>                  | Routine school entry and Year 7 health interview. Have routinely calculated BMI but were able to draw off existing data to do a pilot assessment of calculating BMI.  |
| <b>School year &amp; approximate numbers annually</b> | Year R and Year 7.  |
| <b>Details</b>  | <p><b>Data:</b> Health interview in Year Reception and Year 7.</p> <p>Year Reception - Height and weight plotted on centile chart in Red book and advice/follow up given as appropriate.</p> <p>Year 7 - First year at high school for individual health assessment (without parents). Height and weight is part of this and is plotted on the child's centile chart. Individual support and follow up is offered if the young person wishes it.</p> <p><b>Consent:</b> Opt in consent.</p> |
| <b>Innovation</b>                                     | Data is computerised. Surveillance data available from 2000 for Year Reception and 2003 for Year 7.   |
| <b>Issues &amp; Challenges</b>                        | Potential problem if national guidance is different, thereby disrupting existing systems.   |
| <b>Cost/resources</b>                                 | Within existing resources   |
| <b>Contact details</b>                                | <a href="mailto:AmandaC.Cooke@northstaffs.nhs.uk">AmandaC.Cooke@northstaffs.nhs.uk</a><br><a href="mailto:Stephen.Bridgman@northstaffs.nhs.uk">Stephen.Bridgman@northstaffs.nhs.uk</a>  |

#### 8. Middlesborough (Special Schools)

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| <b>Original reason for the scheme</b> | A pilot study involving children from 5 Middlesborough schools were measured (a mix of entirely special needs and mainstream schools with |
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|   | large special needs intakes)  |
| <b>School year &amp; approximate numbers annually</b> | All children (mainstream and special needs) from Years 1, 7 and 10 were invited to take part subject to receipt of parental consent. 124 children (37 had a statement of special educational needs and only a few of these had profound disabilities).  |
| <b>Details</b>  | <b>Resources:</b> Undertaken by special needs school nurses– the nurses knew each child and allowed the necessary time required for the children with more complex needs. Estimate 4x the time required that for child in mainstream for child with severe disabilities, but many less.<br><b>Equipment:</b> Height measured using 3 different techniques – standing, lying down and a proxy measure of ulna length (gained by placing the forearm on a sheet of paper and marking the start and finish of the ulna on the paper). All 3 height measures were gained from most of the mainstream children in order to gain validated measurements in the special needs children. Used chair and sling scales to weigh those children who were unable to stand on the traditional electronic platform scales (all scales were calibrated before use). Waist circumference was also measured in all children. |
| <b>Innovation</b>                                     | Although uptake was low, the project was well received by the children, staff and nursing teams involved.   |
| <b>Issues &amp; Challenges</b>                        | The opt-in consent resulted in quite poor uptake – (~ 35%, although uptake was better for the younger year groups). It is possible that many of the parents did not opt-in as they thought it would be too much of a burden on their child. This is a difficult issue as it is very important to gain measurements from all children and low uptake will place significant bias on the findings. Research is being carried out with Dr Julian Shield (a consultant paediatrician from Bristol) with the aim of is securing additional funding for a much larger multi-centred study to explore the issues mentioned above.  |
| <b>Cost/resources</b>                                 | Equipment.  |
| <b>Contact details</b>                                | Louisa Ells <a href="mailto:L.Ells@tees.ac.uk">L.Ells@tees.ac.uk</a>  |

### Abbreviations

|     |   |
|-----|---|
| HCA | Health Care Assistant (or school nursing assistant) |
| LSA | Learning Support Assistant                          |
| SN  | School Nurse  |
| CHS | Child Health System                                 |
| PH  | Public Health                                       |
| PCT | Primary Care Trust                                  |
| BMI | Body Mass Index                                     |

## APPENDIX 3

### Population monitoring, not screening

#### 1. Background

- 1.1. The recommendation from the Health Select Committee on Obesity was that “children should have their Body Mass Index measured annually at school...the results should be sent home in confidence to their parents, together with, where appropriate, referral to more specialised services”<sup>9</sup>. The Expert Advisory Group and the National Screening Committee expressed concern that this equates to a screening programme. The original purpose of the PSA target was to monitor the population as a whole, not individuals, and how the work of the Cross-Government Obesity Programme was affecting national levels of obesity in children.
- 1.2. In this guidance we have discouraged that children, and their parents, are told their BMI as this monitoring exercise would then, in effect, become a screening programme.

#### 2. Why screening for childhood obesity is not good practice.

- 2.1. The National Electronic Library for Health (NeLH) defines screening as “a public health service in which members of a defined population, who do not necessarily perceive they are at risk ... are asked a question or offered a test, to identify those individuals who are more likely to be helped than harmed by further tests or treatments to reduce the risk of a disease or its complications.”<sup>10</sup> The NeLH screening library web page is headed by the title “Screening: doing more good than harm”.
- 2.2. The National Screening Committee set criteria for appraising the validity, effectiveness and appropriateness of a screening programme<sup>11</sup>.
- 2.3. There is insufficient current evidence to support the effectiveness of any interventions for obesity in individuals identified through screening and who are not otherwise concerned. The evidence does support tackling obesity through whole family therapy for highly motivated families, and at an environmental and community level, influencing the way whole populations eat and exercise<sup>12;13</sup>. The National Screening Committee criteria for any proposed screening programme<sup>11</sup> include that “there should be an effective treatment or intervention for patients identified.”
- 2.4. There is no agreed BMI cut-off point that can be consistently linked to increased morbidity or mortality in children. BMI is recognised as a valid measure for population obesity. However, at the level of an individual child, it is difficult to interpret. An individual child’s BMI can be affected by their ethnicity and the amount of muscle they have. The National Screening Committee criteria stipulate that the screening test is validated with a suitable cut-off point defined. The criteria also ask for evidence from high level randomized controlled trials demonstrating effectiveness of detection. These are not available for measuring childhood obesity.

- 2.5. Measurement of height and weight is unlikely to cause physical harm but the psychological effects of drawing attention to height and weight are not fully known. The Expert Advisory Group has voiced concerns regarding the risks of feeding back BMI, or any measure of obesity, as this could lead to stigmatization and bullying. These issues should be investigated further once the programme is in place. The National Screening Committee criteria stipulate “the benefit from the screening programme should outweigh the physical and psychological harm”.
- 2.6. The Expert Advisory Group acknowledged that National Screening Committee criteria are difficult to apply to obesity because interventions to encourage physical activity and healthy eating have benefits wider than those which might be measured by BMI. Furthermore many of the interventions apply to families and communities rather than individuals
- 2.7. Screening for childhood obesity could not guarantee to do more good than harm. For these reasons the Expert Advisory Group advised that a screening programme was not appropriate.

### **3. What is meant by population monitoring**

- 3.1. In order to tackle the obesity epidemic it is vital to know how obesity is developing in the population as a whole. Population monitoring takes measurements of the population in question, and uses these measurements, in an anonymised fashion, to describe populations as a whole.



## APPENDIX 4

### **A summary of the report for the Children's Commissioner on primary school children's attitudes to being measured in school**

1. In the autumn of 2005 the Children's Commissioner undertook research into the attitudes of primary school children towards being weighed and measured<sup>9</sup>.
2. The report suggests that primary school children will respond *pragmatically and positively* to a national programme for regularly weighing and measuring if their concerns and wishes with regard to the planning and delivery of the intervention are addressed.
3. Based on feedback from the 250 children involved in this research, the recommendations focus on:
  - The child being aware of the situation, knowing and understanding why they are being measured and having time to ask questions about the process, in order to reduce anxiety and confusion.
  - The children understanding what would happen to the results, who would see them and how they would be used.
  - Children, especially those in Year Reception, being allowed to choose someone to accompany them during the process if they wish.
  - Consideration given as to how schools engage with parents and carers.
  - The practitioner being skilled in talking to and working with children and being able to adapt an informal, friendly and light-hearted approach without being patronising. A good knowledge of health and healthy lifestyle issues and the ability to promote a holistic approach to health is important.
  - Measuring taking place in private space.
  - Weighing and measuring should be done within the context of a whole school approach to health and well-being and within the context of wider activities for promoting health as part of Healthy Schools and Extended schools. This will ensure it is not received as a one-off, isolated and intrusive event but be experienced by the children as supporting their health.
  - The child's anxieties or issues about size and weight are addressed sensitively and appropriately. Particular attention should be paid to issues relating to body image as children are aware of how their own and other people's bodies look and how society, including the media respond to 'fat' and 'thin' people.

## APPENDIX 5

### Suggested wording for information for schools and parents

#### 1. Suggested wording for a letter from a PCT to the Chairman of Governors.

##### **Measuring height and weight of children in Reception and Year 6**

As part of our ongoing effort to improve children's health and well-being, a shared programme between the Department for Education and Skills and the Department of Health, we are planning to weigh and measure the height of children across two year groups – Reception and Year 6, in all primary schools in our area. Simple height and weight measurements, which are easy to collect through non-intrusive means, will be extremely helpful in enabling us to gain a greater understanding of the needs of the children in this area as they are indicative of a range of issues. Every Primary Care Trust (PCT) will be writing to all primary schools in their area along similar lines.

The information we collect will give an overview showing which neighbourhoods need the most support. In some cases, we may later approach schools to discuss how the PCT and schools can best work together to improve outcomes for children: as you will be aware, poor health is a barrier to learning. Our resources could be used to support the school in promoting healthy lifestyle choices in eating, exercise and emotional well-being and removing health barriers to learning.

I have written to your Head Teacher outlining the help we will need from the school, and to reassure him/her that all weighing and measuring will be carried out by staff from the Primary Care Trust.

We are keen to ensure that the weighing and measuring process will involve the minimum disruption, and should involve very little extra work for school staff. We are hoping to work closely with schools, involving them as much, or as little, as they wish. PCT staff will bring all equipment necessary for weighing and measuring. It will be a simple process which should take no more than 4 to 5 minutes for each child. We would expect to collect measurements at some point between April and July, on days which best suit the business of the school.

The help we will need is as below.

For school staff:

- to inform parents about what is happening; a letter is enclosed which can be sent to parents and clearly explains the process, including a tear-off declaration to complete and return if they do not wish their child to take part
- to provide the PCT measuring staff with a list of the children in Reception and Year 6 with the pupils' name and date of birth (excluding those whose parents have asked that their child should not be included).
- to identify a room in which measurements can be collected
- to facilitate the bringing of children to and from the measurement room

We would expect that all children, excepting those covered by a parental opt-out, or who are absent on the day(s) of weighing and measuring, should be weighed and measured. We recognise the importance of handling this process with sensitivity to avoid the potential for stigmatisation or bullying. All information gathered will be treated with confidentiality.

Individual children's height and weight will not be routinely fed back to parents, children or staff, and schools will not hold the collected data.

### **Communications to parents**

I have asked the school to gain parental consent to the weighing and measuring process, and parents who do not wish their child to be weighed and measured will be able to opt-out. This consent forms part of the attached letter which I have asked your Head teacher to send to parents, and which also covers issues of confidentiality and stigmatisation.

Where parents ask for information about their child's measurements:

- if a parent asks on the day of measurement for their child's height and weight, the PCT staff will tell them there and then.
- for queries after the day of measurement, the school should refer parents to the PCT as schools will not hold data.

I have asked your Head teacher to contact me to let me know which dates are convenient. If you wish to discuss this issue with me, I would be very happy to do so.

## **2. Suggested wording for a letter from a PCT to the Headteacher**

### **Measuring height and weight of children in Reception and Year 6**

As part of our ongoing effort to improve children's health and well-being, a shared programme between the Department for Education and Skills and the Department of Health, we are planning to weigh and measure the height of children across two year groups – Reception and Year 6. Simple height and weight measurements which are easy to collect, through non-intrusive means, will be extremely helpful in enabling us to gain a greater understanding of the needs of the children in this area as they are indicative of a range of issues. Every Primary Care Trust (PCT) will be writing to all primary schools in their area along similar lines.

The information we collect will give an overview showing which neighbourhoods need the most support. In some cases, we may later approach schools to discuss how the PCT and schools can best work together to improve outcomes for children. As you will be aware, poor health is a barrier to learning. Our resources could be used to support the school in promoting healthy lifestyle choices in eating, exercise and emotional well-being and removing health barriers to learning.

I want to reassure you that all weighing and measuring will be carried out by staff from the Primary Care Trust. It will also build on the work already being carried out as part of school entry health checks.

We are keen to ensure that this will involve the minimum disruption for your school, and should involve very little extra work for your staff. PCT staff will bring all equipment necessary for weighing and measuring. It will be a simple process which should take no more than 4 to 5 minutes for each child. We would expect to collect measurements at some point between April and July, on days which best suit the business of the school.

We are hoping to work closely with schools, involving them as much, or as little, as they wish. However we shall need some help from you on:

- informing parents about what is happening; a letter is enclosed which can be sent to parents and which clearly explains the process, including a tear-off declaration to complete and return if they don't wish their child to take part
- providing the PCT measuring staff with a list of the children in Reception and year 6, excluding those whose parents have asked that their child should not be included, showing the pupils' names and dates of birth.
- identifying a room in which measurements can be collected
- facilitating the bringing of children to and from the measurement room

We would expect that all children, excepting those covered by a parental opt-out, or who are absent on the day(s) of weighing and measuring, should be weighed and measured. We recognise the importance of handling this process with sensitivity to avoid the potential for stigmatisation or bullying. All information gathered will be treated with confidentiality.

Individual children's height and weight will not be routinely fed back to parents, children or staff, and schools will not hold the collected data.

### **Communications to parents**

We will need to gain parental consent to the weighing and measuring process and parents who do not wish their child to be weighed and measured can opt-out. This forms part of the explanatory letter attached. The letter also covers issues of confidentiality, stigmatisation and bullying.

Where parents ask for information about their child's measurements:

- if a parent asks on the day of measurement for their child's height and weight, the PCT staff will tell them there and then.
- for queries after the day of measurement, the school should refer parents to the PCT as schools will not hold data.

I will follow this letter with a phone call, and I will be very happy to discuss my request with you. I have written a similar letter to the Chair of Governors of your school so that they are in the picture.

### **3. Suggested wording for a letter from Headteacher to Parents**

#### **Measuring height and weight of children in Reception and Year 6**

Children are weighed and measured by health professionals when they are born and in the early years of their lives. Many children also have a school entry health check which includes height and weight measurement.

The NHS Primary Care Trust (PCT) for this area has approached me to ask that children in Reception year and year 6 have their height and weight measured. All the weighing and measuring will be carried out by trained staff from the PCT, and the information will be used by the PCT to help it decide what kind of services should be offered to children and families in this area. This could include supporting our work in helping our pupils follow a healthy lifestyle, including healthy eating, exercise and their emotional well-being.

The PCT would like to weigh and measure all children in Reception and Year 6. The Governors and I have agreed that this will happen on the following day(s):

We would hope that all children should be weighed and measured. The PCT will be extremely careful to handle this process with sensitivity: for example, it will not be necessary for children to undress and they will not be weighed and measured in front of their class mates. All information will be treated with confidentiality.

However, if a child is absent from school on the appointed day, or if you return the slip at the end of this letter to the school to say that you do not wish your child to be weighed and measured, the PCT will not measure your child.

Yours sincerely

Head teacher

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**Child's name**

**Year**

**Class**

**I do not wish my child to be weighed and measured by the PCT.**

----- **parent/carer's signature**