

Taking Stock: a rapid review of the National Child Measurement Programme

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Executive summary

Purpose of the review

This independent review of the National Child Measurement Programme was undertaken for the Department of Health in March 2011 by the Thomas Coram Research Unit, Institute of Education. It aimed to take stock of progress and challenges faced by the programme since its launch in England in 2005, drawing together new and existing information and reflecting on how the NCMP could be improved. Specific objectives were:

- to identify the common issues in the current delivery model that affect the impact and effectiveness of NCMP, from a national to a local level, and
- to suggest what is needed to help the NCMP make an effective transition into the proposed new public health system.

Methodology

A multi-method approach was used. This included:

- **Document analysis** (of studies commissioned by DH between 2006 and 2010, notes from regional workshops held in autumn 2010, and a small number of additional published studies identified through a rapid literature review);
- **Interviews with 17 key stakeholders** at national, regional and local levels; and an
- **Online survey** which was completed by over 200 local NCMP leads and other relevant professionals from all regions of England.

The timeframe for the review was very short (six weeks) and so the different strands of work were undertaken in parallel rather than sequentially.

Main findings

The focus of the review was on the *delivery* of the NCMP rather than on assessing its impact on children and families. Findings are summarised under the following headings: overall achievements and benefits of the NCMP; local delivery arrangements; routine feedback letters; proactive follow-up, IT issues; data analysis and data sharing; and issues for the NCMP in the future as public health responsibility moves to local authorities.

Achievements and benefits

Stakeholders emphasised the important role the NCMP had played in raising the profile of childhood obesity, by providing much needed evidence of the scale of the problem and allowing targets to be set to address this. Benefits of the programme included helping to prioritise spending in areas where it was most needed, competing more effectively for funds because need could be demonstrated, and facilitating discussions with local partners.

Although media attention has focused on negative reactions from parents to being told their child's weight category, the literature suggests that the great majority of parents are supportive of the NCMP and most welcome receiving routine feedback. Parents of children outside the normal weight range were also generally positive about the programme and about receiving feedback, although some objected to the way in which the information was given.

Local delivery arrangements

More than half of the survey respondents judged delivery of the NCMP to be 'somewhat successful, with minor challenges', and very few reported major unresolved challenges. Concerns focused on the feedback letter; resource and capacity issues, data sharing problems and the programme's remit. Issues likely to have created most difficulty for delivery were lack of weight management services to refer on to and insufficient staffing. Areas generally judged less problematic were lack of guidance from the DH, lack of support locally, and lack of support from schools. In fact, the DH guidance, DH systems to support data upload and generate result letters, and regional workshops and training had been helpful in delivering the programme and were generally valued. Locally, factors most helpful in delivering the NCMP were engagement from schools, local processes for data entry and producing letters, commitment and support from key local agencies, and in particular the NCMP data itself as evidence of the need to act on child obesity.

Overall, the large majority of eligible schools allow children to be measured though difficulties with a small number of schools are experienced in some local areas. Factors helping areas to engage their local schools in the NCMP were the involvement of the Healthy Schools coordinator, sharing the NCMP results with them, engaging Directors of Children's Services, and visiting schools to explain the NCMP to head teachers and other staff. Concerns were raised about sustaining good school coverage due to schools becoming academies and choosing not to participate or because of less encouragement from central government, the changing status of the healthy schools programme and loss of support from Healthy School coordinators. Much will depend upon how the NCMP is positioned within the school's priorities and whether schools see the programme as useful in meeting their priorities or targets.

Weighing and measuring was predominately carried out by school nurses, but healthcare assistants, nursery nurses and dedicated NCMP teams were also mentioned. A common theme was that school nurses were frustrated by the amount of their time taken up by the weighing and measuring exercise, and that it would be preferable to have this done by less specialist staff with appropriate training and supervision. Weighing and measuring was usually commissioned as part of an existing service level agreement, most commonly with no extra funding. Around a quarter of survey respondents reported additional payments, for example to cover the administrative and recording work involved, or for the production of feedback letters. Regional and PCT leads generally thought that a commissioning template for the NCMP would be helpful, particularly if it took an integrated approach and clarified how NCMP commissioning relates and fits into Healthy Child commissioning.

Among regional leads and PCT representatives, there was some support for a national service specification though one that allowed scope for local flexibility. The need for standards and consistency, a core set of expectations and 'must do's, providing information to help local authorities to understand what is involved, and helping to secure funding were all mentioned as reasons for a service specification.

Routine feedback

Studies of the NCMP have generally found that the majority of parents welcome their child being weighed and measured at school and appreciate receiving feedback. However, the research has also consistently found that a small minority of parents report a negative impact from receiving the results letter, in that it makes them angry, worried or upset; or they are concerned that feedback could increase the risk of eating disorders by making children and parents over-focused on weight issues.

Almost three quarters of survey respondents said that feedback was provided to all parents of children taking part in the NCMP in their area. Where reasons were provided for not sending results letters to all parents, these included a decision to send them only to parents of children who were not a healthy weight and lack of resources to offer follow-up weight management interventions.

Based on research commissioned by the DH several changes have been made to the template feedback letter since the programme started. However, concern was expressed by a small number of interviewees about the removal of the weight continuum from the letter, and about the appropriateness of using BMI based weight categories mentioned by both interviewees and survey respondents. The great majority of survey respondents said that the template letter was used in their area although almost all had made some changes to it, often relatively minor. Feedback letters with a wide range of additional information added, most commonly the DH Change4Life leaflet, was most often posted to parents; very few areas used pupil post. Although there was some evidence of local areas wanting to be able to develop their own letter, the prevailing view among regional leads was that the templates were important for consistency.

There was variation across areas as to who took calls from parents following routine feedback. Although school nurses were most likely to take the calls, other professional health staff, nursery nurses, administrative staff, Family Change4Life advisors, Healthy Weight team leaders, public health consultant lead or commissioning manager, PCT Patient Advisory Liaison Service, nurse assistants and support workers were also mentioned. Whilst just over a third of survey respondents rated the experiences of those handling the calls as 'working well', the majority reported 'some difficulty'. Reasons given for experiencing problems included the angry response from some parents to the letter; lack of training or skills to handle such calls; insufficient weight management programmes to refer families on to; and lack of capacity to take the calls. Where training or resources had been provided for those taking the calls the most common was the DH script/conversation guide, but the motivational interview training that the DH had organised was very well received according to regional leads.

Two thirds of survey respondents thought that the benefits of providing routine feedback outweighed the negative impacts. Benefits of providing routine feedback were said to be raising parents' awareness, providing an opportunity for professionals to engage with parents in relation to their child's weight and increased uptake of weight management programmes, although others commented that take up was generally low. However, a fifth of survey respondents did not think there had been any benefits from sharing results with parents, and queried the value of doing so. When asked about any negative impacts of routine feedback, by far the most common was the angry phone calls that were received after the letters had been sent out, followed by the unwillingness of parents to accept advice, adverse media coverage and an increase in complaints about the NCMP.

Some survey respondents supported the idea of providing routine feedback, but were not convinced that the current system of feedback letters was the best way to do this. Other reservations about routine feedback held by both interviewees and survey respondents were due to: lack of evidence of the effectiveness of routine feedback together with some fears that it could do more harm than good;

lack of additional funding for routine feedback and the resulting impact on capacity and resources; a lack of weight management services or insufficient capacity within the service to help those who needed it; and current feedback practice not meeting the accepted medical criteria for a screening programme.

A recurring theme in this review was the need for clear direction on whether the NCMP is intended to function as a surveillance exercise or as a screening programme with referral on to weight management services. The introduction of routine feedback has seen a move away from the surveillance programme that the NCMP initially set out to be to one of screening. Many of the challenges that areas faced were thought to stem from this change, particularly the lack of resources. Mixed views were expressed by both interviewees and survey respondents about whether the NCMP should be a weighing and measuring exercise for population surveillance and planning purposes, or whether it should also function as a screening exercise identifying children and providing feedback to parents on their child's results.

Proactive follow-up

Studies have consistently indicated that simply asking parents to get in touch with a named professional if their child is outside the healthy weight range rarely results in them making such contact and shows that although parents generally welcome receiving feedback about their child's weight, there is little hard evidence that this leads to changes in behaviour without further encouragement and support. The literature thus suggests that a more proactive approach is needed especially for those who are outside the healthy weight range. Nearly two thirds of survey respondents thought that proactive follow up in the form of a phone call or visit was essential for very overweight children, although this dropped to below half for overweight and underweight children.

Over half of survey respondents said that they were able to offer proactive feedback in their area, defined as any follow-up contact with the family over and above providing the result letter and leaflets. This is higher than anticipated, but does include small scale pilots and follow up only in specific cases or at school nurses' discretion, as well as more established schemes. Where proactive follow up was not provided, by far the most common reason was lack of capacity or resources.

Among those providing proactive follow-up a third thought that there had not been any negative impact, and just over a quarter thought that there had (the rest did not know). Negative impacts were similar to those cited for routine feedback, namely parents being angry and unwilling to engage, although several survey respondents noted that parents of unhealthy weight children responded better to being provided with their child's results in a phone call than in a letter, as regional leads had suggested. Views were mixed on whether proactive follow-up increased engagement in weight management services, with some noting that parents did allow their child to be referred following a phone call or visit, whilst others believed there was little evidence to show increased take-up of such provision. Almost all of those providing proactive feedback said that the benefits outweighed the negative aspects although sometimes adding that it was too soon to judge.

IT issues

There was strong support for the continuation of the national IT tools and advice that have supported delivery of the programme in local areas. However, concerns were also expressed about the incompatibility of the upload tool with local IT systems, resulting in data having to be entered twice; and about the reliability of the national system. These problems have largely been caused by the

development of the NCMP from a population surveillance exercise to a screening and feedback programme. This has placed new demands on the IT system which it was not designed to meet.

Now would seem a key time to redevelop the system to support the local delivery of the NCMP and the transition to local authorities, providing a reliable IT infrastructure which meets current requirements of the programme. Given the amount of time that is currently spent by NHS Information centre staff in dealing with problems and maintaining the current system, investing in a new system could be cost effective if the NCMP is to continue for a number of years.

Data analysis and sharing

Survey, interview and regional workshop data all highlighted the importance and value of local and regional analyses of NCMP data. A wide range of local organisations are provided with aggregated NCMP data, both within health services and within the council. The data is an important source of information for multiagency planning groups, and is often used in Joint Strategic Needs Assessments. Survey respondents indicated that local data analyses were most commonly shared with schools and health professionals, followed by planning services and leisure services. Less than a quarter shared aggregated information with GPs, although many more would have liked to do so.

Compared with aggregated data, information to enable follow-up of individual children was shared far less frequently. There was a lack of clarity over what level of sharing was allowed, with or without a formal data sharing protocol in place, and different practices were evident in relation to feeding back results to individual schools. There was no clear consensus about the desirability of providing school level data, with those who supported this claiming it was necessary to keep schools engaged with the programme and to facilitate the provision of support, whilst others pointed out difficulties such as the data being misinterpreted or misunderstood, the risk of identifying individual children in small schools, and the danger of creating yet more 'league tables' of schools.

Half of the survey respondents reported some difficulties with data sharing, mostly due to governance and data protection issues. There was a strong call for more detailed guidance about information sharing and how best to do it, including clarity on the level at which NCMP data could be disaggregated, and a template for producing summaries for different stakeholder groups. Other suggestions for what would help to address data sharing challenges were changing the wording of the opt-out letter to obtain parental consent for sharing results, setting up local multiagency data sharing groups, and quicker availability from the NHS Information Centre of the 'cleaned' local data.

NCMP in the future

The two main areas of concern for the future of the NCMP are lack of staff capacity and lack of funding. These were cited as 'major concerns' by around half of all survey respondents and as 'little or no concern' by only nine percent. In at least one area, the programme was being suspended in 2011/12 because of lack of funding. In contrast, the transfer of public health to local authorities was a major concern for just over a third of respondents.

Various actions were mentioned that could facilitate a smooth transition and help to ensure continuation of the NCMP. Government support for the programme was thought unlikely to be sufficient to ensure its survival as a national programme, despite the perceived value of the data collected, unless there were some mechanism such as ring-fenced funding or other drivers to encourage local areas to continue. Possible drivers that were suggested by interviewees included:

- Ring-fenced money for the programme or a strong directive to continue.
- Retaining the NCMP data collection requirement for local authorities.
- Inclusion of childhood obesity in the Public Health Outcomes Framework.
- Requirements of the Joint Strategic Needs Assessment (JSNA).
- Providing evidence of the data's value and of the programme's impact.
- Having a champion for the NCMP within each local authority.

A particular concern in relation to the future of the NCMP was the risk that key expertise and business continuity would be lost if the programme lost momentum, and the need to raise the profile of NCMP and obtain buy-in from local authority chief executives. Where the NCMP had already moved to being managed within the local authority, as has happened in a small number of local areas, interviewees emphasised the importance of establishing strong partnerships between agencies, particularly health and local authority children's services. Also important were joint posts and/or joint commissioning, clear aims and delivery plans, and good leadership. Even with these in place, there were challenges to resolve especially in relation to data sharing.

Conclusions

There is generally strong support for the programme's principal aim of monitoring childhood obesity levels. Local areas have worked hard to overcome initial problems with measuring and to achieve good coverage, which often reflects the goodwill and commitment of the staff involved. However, funding and capacity have in many areas been a challenge and continue to be so. As a result, local areas differ in terms of whether they are providing routine feedback to parents of their child's results and providing proactive follow-up.

With the introduction of routine feedback, the NCMP has evolved to take on some characteristics of a screening programme, although the Department of Health does not present it as such. The evidence from this review reveals divided views about this change to the programme. On the one hand, routine feedback and follow-up are seen by some as key parts of the programme, whilst on the other the NCMP is acknowledged as working well as a surveillance tool, but less well for screening purposes.

Central guidance and support for the programme were generally valued and seen as critical in maintaining standards and consistency. Although there is a need for flexibility to accommodate local conditions, a national programme needs national guidance and standards and continuing support for local areas.

It is difficult to know how the transition of public health to local authorities will affect the NCMP, but in the current financial climate with many areas struggling to resource the NCMP, it is likely that the future will be challenging. The review highlights a number of areas that the DH could begin to address to improve delivery of the NCMP and to facilitate a smooth transition of the programme to local authorities.

- Further explanation and debate about the programme's purpose. Although the DH is clear that the NCMP is not a screening programme, the requirement to provide routine feedback to parents of all participating children has created a lack of clarity about whether the emphasis is on surveillance or screening.
- Raising the profile of the NCMP within local authorities and the public more widely, aiming to explain its purpose and benefits.
- Entering into a dialogue with local authorities and encouraging collaboration between PCTs and local authorities in preparation for the transition to local authorities.

- With the move away from centralised direction and performance management, incentives to ensure NCMP continues as a national programme may be necessary.
- Continuing support from the centre in the form of workshops, advice and national guidance. Templates on commissioning and on delivery models would also be helpful.
- Guidance on governance and data protection to clarify what data can be shared and with whom. Examples of how the data can be presented to different organisations and professional groups would be helpful too.
- Review IT requirements and consider commissioning a new IT system for the NCMP.

At a local level, the review also indicates what might help the NCMP to be delivered effectively in the new public health system.

- Multiagency working group or specific post to oversee delivery of the NCMP, reporting to the Health and Wellbeing Board .
- Discussion of governance issues and agreement about accountability for different aspects of the NCMP. Data sharing groups with involvement or backing of senior managers have been found useful.
- Clarity in service specifications/contracts about what is required of providers.
- Commissioning an appropriate skill mix for delivery of the programme, including consideration of whether school nurses need to be involved in weighing and measuring or whether this could be carried out by less qualified staff with appropriate training and supervision.

1. Introduction

1.1 Background

The National Child Measurement Programme (NCMP) is a monitoring programme which collects annual data on the height and weight of all children in English state primary and middle schools in two age groups: Reception (age 4-5) and Year 6 (age 10-11). Primary Care Trusts (PCTs) are responsible for collecting the data and providing anonymised information for the National Child Measurement Database, which allows the Government to track trends in childhood obesity.

A national and regional support structure for the NCMP has consisted of a central team at the Department of Health (DH) who has produced national guidance and tools to support each stage of the delivery process, and a network of regional Obesity Leads who have facilitated collaborative learning and supported local leads in their implementation of the programme. Analysis and presentation of the NCMP data has been supported by the National Obesity Observatory (NOO) and Public Health Observatories in each region. Central collation, analysis and publication of data has been undertaken by the NHS Information Centre in Leeds, which also offers assistance to local areas with technical queries.

Since its launch in 2005 the programme has developed and changed in a number of ways. Participation rates have increased substantially, so that in 2009/10 over 90 percent of eligible pupils took part, and less than one percent of eligible schools had no children measured for the NCMP. Data quality has improved, with the proportion of incorrectly recorded or rounded measurements reducing and the proportion with required fields such as the child's home postcode and ethnicity increasing, to 99 percent and 83 percent respectively in 2009/10¹.

There have also been changes to the delivery and functions of the NCMP over time, with screening and monitoring functions added to the original remit of population level surveillance. From 2008/09, PCTs have been encouraged to provide feedback to all parents of their child's results, and in 2009/10 approximately 80 percent of PCTs were planning to do so². Proactive follow-up by PCTs of parents where children have been identified as being overweight or very overweight was recommended in the 2009/10 guidance, and some PCTs have started to do this.

The Public Health White Paper '*Healthy Lives, Healthy People*'³, published in November 2010, confirms the Government's commitment to continuing the NCMP in order to provide local areas with information about levels of overweight and obesity in children, to inform planning and commissioning of local services. The White Paper sets out a new approach for improving public health services in England, which has implications for how the NCMP will be commissioned and delivered in the future. It is proposed that public health funding will be administered by a new body, Public Health England, through one of three routes: allocating funding to local authorities; commissioning services via the NHS Commissioning Board; or commissioning or providing services itself. It is proposed that local authorities should be the lead commissioner for local programmes to prevent and address obesity, which would include delivering the National Child Measurement Programme and commissioning of

¹ NHS Information Centre for Health and Social Care (2010) <http://www.ic.nhs.uk/>

² Cross Government Obesity Unit (2010) *Healthy Weight, Healthy Lives: Two Years On* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113486

³ Department of Health (2010) *Healthy Lives, Healthy People: Consultation on the funding and commissioning routes for public health* <http://www.dh.gov.uk/publications>

weight management services. There will be a new health premium whereby local authorities will receive an incentive payment, or premium, that will depend on the progress made in improving the health of the local population and reducing health inequalities.

In light of these changes, both to public health structures and to the national and regional system for supporting the NCMP, the Department of Health commissioned the Thomas Coram Research Unit at the Institute of Education, University of London, to undertake this rapid review.

1.2 Aims and objectives

The review aims to take stock of progress and challenges faced by the NCMP across England, drawing together existing information and reflecting on how the programme can be improved to enable it to work effectively within the proposed new public health system. It has three specific objectives:

- To identify the common issues in the current delivery model that affect the impact and effectiveness of NCMP, from a national to a local level;
- To suggest how these common issues and other elements of the delivery model might be improved;
- To suggest actions that will help to ensure NCMP effectively transitions into the new public health system.

The focus of the review is on the *delivery* of the NCMP, rather than on assessing its impact on children and families (which is the subject of another ongoing evaluation). The review addresses the following key aspects of the programme:

- Local delivery arrangements (including transition issues)
- Routine feedback letters
- Proactive follow-up
- Data analysis and information sharing
- IT upload tool and support

1.3 Methods

A multi-method approach was used. This included document analysis; interviews with key national, regional and local stakeholders; and an online survey of local NCMP leads across England. The timeframe for the review was very short (six weeks) and so these different strands of work were mostly undertaken in parallel rather than sequentially. However, early analysis of notes from regional workshops (see below for details) and consultation with DH was used to inform design of the online survey, and emerging survey findings helped to identify a small number of local areas for more detailed exploration.

a) Document analysis

Eight studies evaluating or testing out different aspects of the NCMP were carried out for DH by external organisations between 2006 and 2010. This included market research, insight work, case studies and qualitative research. The review team was supplied by DH with reports from these studies

and with notes from regional workshops held in late 2010, where local NCMP leads shared their experiences and views (these documents are listed in Appendix 2). This material formed the core of the documentary analysis. It was supplemented by a rapid literature review which identified ten additional published studies containing information on the NCMP, including journal articles, research reports and a Masters dissertation. Several interviewees also provided unpublished local evidence about the operation of the NCMP in their area. The documentary analysis extracted key information from the material relevant to the five key aspects of the programme listed above. Particular attention was paid to when the study was undertaken, since as described earlier aspects of the programme have often been adapted in response to feedback from earlier studies.

b) Interviews with key stakeholders

A combination of telephone and face-to face interviews (both individual and group) was undertaken with 17 key stakeholders, who were identified in consultation with the Department of Health. Interviewees were sent a topic guide in advance. The individual interviews lasted from 30 minutes to an hour, and the group interview for two hours. Most were recorded (with interviewees' permission) and in all cases detailed notes were written up afterwards.

In order to capture experiences and perspectives at all levels, interviewees included:

At national level: the NHS Information Centre (group interview including managers, analysts and IT specialists), National Obesity Observatory, National Childhood Obesity Support Team, Department for Education.

At regional level: Obesity leads based in five of the Government Regional Offices.

At local level: An interview in each of four areas where there has been some integration between PCT and LA. Three interviews were with commissioners and the fourth was with the Head of Information and Performance in Children's Services.

In addition, written responses were received from a number of key stakeholders whom it was not possible to interview within the timeframe, including the School and Public Health Nurses Association (SAPHNA) and another regional obesity lead. The review team was also provided with feedback from a meeting of the Obesity Expert Group in July 2010 where progress and future directions for the NCMP were discussed.

c) Electronic survey of NCMP leads

An online survey containing both open and closed questions was designed (Appendix 1), covering the key areas of NCMP delivery arrangements, feedback to parents, proactive follow up, data analysis and information sharing, IT issues, views on the challenges and successes of the programme so far and what would help it to continue effectively in the future. Regional obesity leads circulated an email to all NCMP leads in their region with a message prepared by the research team, explaining the purpose of the review and providing a link to the survey. The NHS Information Centre also circulated the message and link to their list of people involved in the programme, which included the local coordinators but also a wide range of other practitioners including data analysts and information managers.

The survey received 215 responses during the one week period that it was open, with many respondents including additional comments and explanations. This high response reflects the commitment of those involved in the programme and their belief in its importance and value.

Respondents were not required to indicate which PCT or local authority they worked for, to preserve confidentiality, and this combined with the way in which the survey was distributed means that it is not possible to calculate an overall response rate to the survey. However, the total of completed questionnaires (215) exceeds the number of local PCTs (150). Where respondents chose to provide an email address to allow further contact (in approximately half of cases), these indicated a wide coverage of local areas across England.

Responses were received from all nine regions of England, ranging from 10 in the North East to 50 in the North West (this does not reflect response rates since regions vary in the number of PCTs they cover). Almost three quarters of those responding worked for a Primary Care Trust (73%), with a further 20 percent working for an NHS provider, three percent working for the local authority and the remaining four percent mostly having joint appointments (PCT and LA).

The job titles of those completing the survey showed that it was completed by a wide range of personnel involved with the NCMP, including both commissioners and providers. Respondents included senior managers with strategic responsibilities (e.g. Assistant Directors and Consultants in Public Health, Head of Children and Family Services, Head of Health Promotion); specialists (e.g. Public Health Nutritionists, Community Dieticians, Public Health Improvement Specialists); school nursing staff (including team leaders and managers, school nurses and school health assistants); and clerical and administrative staff involved with the NCMP. One large group of respondents (44 of the 215 responses) consisted of analysts and information managers. The range of issues covered by the survey meant that not all respondents were in a position to answer all the questions, but survey findings are almost always based on at least 150 responses.

1.4 Structure of the report

In the rest of this report, the findings from each of the main sources of information – research literature, key stakeholder interviews and survey of local areas – are presented together under the main headings that the review was asked to address: local delivery arrangements, routine feedback, proactive follow-up, data analysis/information sharing and IT issues. These sections are preceded by an overview of the successes and benefits of the programme to date (drawing on the same sources of data), and the review concludes with an analysis of the challenges that the NCMP faces and suggestions for action that might be taken (at both national and local level) to help the programme make an effective transition into the new public health system.

2. Achievements and benefits of the NCMP

2.1 Raising the profile of childhood obesity

Stakeholders interviewed for this review emphasised the important role the NCMP had played in raising the profile of childhood obesity, by providing much needed evidence of the scale of the problem and allowing targets to be set to address this. Childhood obesity could now be found in most Local Area Agreements and Children and Young People's Plans – an acknowledgement that it is now seen as a significant issue.

For some stakeholders the key value of the programme lay in the comprehensive overview of obesity levels among children. The Obesity Expert Group highlighted the importance of the national dataset, describing it as 'internationally recognised as a flagship surveillance programme' and noting that the value of the dataset increases as the programme continues and more uses are found for the information it provides. At local level, a qualitative study of data sharing and analysis in five PCTs (Ipsos Mori Social Research Institute, 2010c) reported that the NCMP was considered a very worthwhile exercise, despite the significant financial outlay and pressure it placed on the school nursing service, because of the value of the data it produced. Benefits cited by interviewees in this study included helping to prioritise their spending into areas where it was most needed, and to compete more effectively for funds because need could be demonstrated. Some survey respondents also highlighted 'the benefits of the NCMP in [name of PCT] are far reaching and we use our data in many different ways with different partners'.

2.2 Supporting partnership working

The ability of the NCMP to open up discussions and dialogue with local partners was seen as another strength by those interviewed in the Ipsos Mori data sharing study (Ipsos Mori Social Research Institute, 2010c). This was reiterated in feedback from regional workshops held in late 2010 which brought together local NCMP coordinators to share experiences and discuss key issues. Other consistent messages about the benefits of the NCMP which emerged from these regional workshops were the programme's role in flagging up the importance of healthy eating and exercise for children among a wide range of partners; encouraging joint action based on analysis of the local data; smarter commissioning of services and targeting of resources; identifying obesity trends and helping to secure funding for healthy weight initiatives.

2.3 Informing parents

Although media attention has focused on negative reactions from parents to being told their child's weight category, the literature suggests that the great majority of parents are supportive of the NCMP and most welcome receiving routine feedback (e.g. Grimmett et al., 2008; Shucksmith et al., 2008; Mooney et al., 2009). In the TCRU study (Mooney et al., 2009) parents of healthy weight children reported that the benefits of receiving information from the NCMP were that it confirmed they were 'doing the right thing', and most found the advice enclosed with the letter useful (although some reported that they 'knew all this already'). Parents of children outside the normal weight range were also generally positive about the programme and about receiving feedback, although some objected to the way in which the information was given.

3. Local delivery arrangements

This section of the review reports findings from the survey, interviews, workshops and published literature on different aspects of delivery of the NCMP, including who carries out the weighing and measuring, how it is commissioned, views on which year groups should be measured and overall views on the successes and difficulties with the current delivery model. Providing feedback to parents and proactive follow up are covered in more detail in later sections.

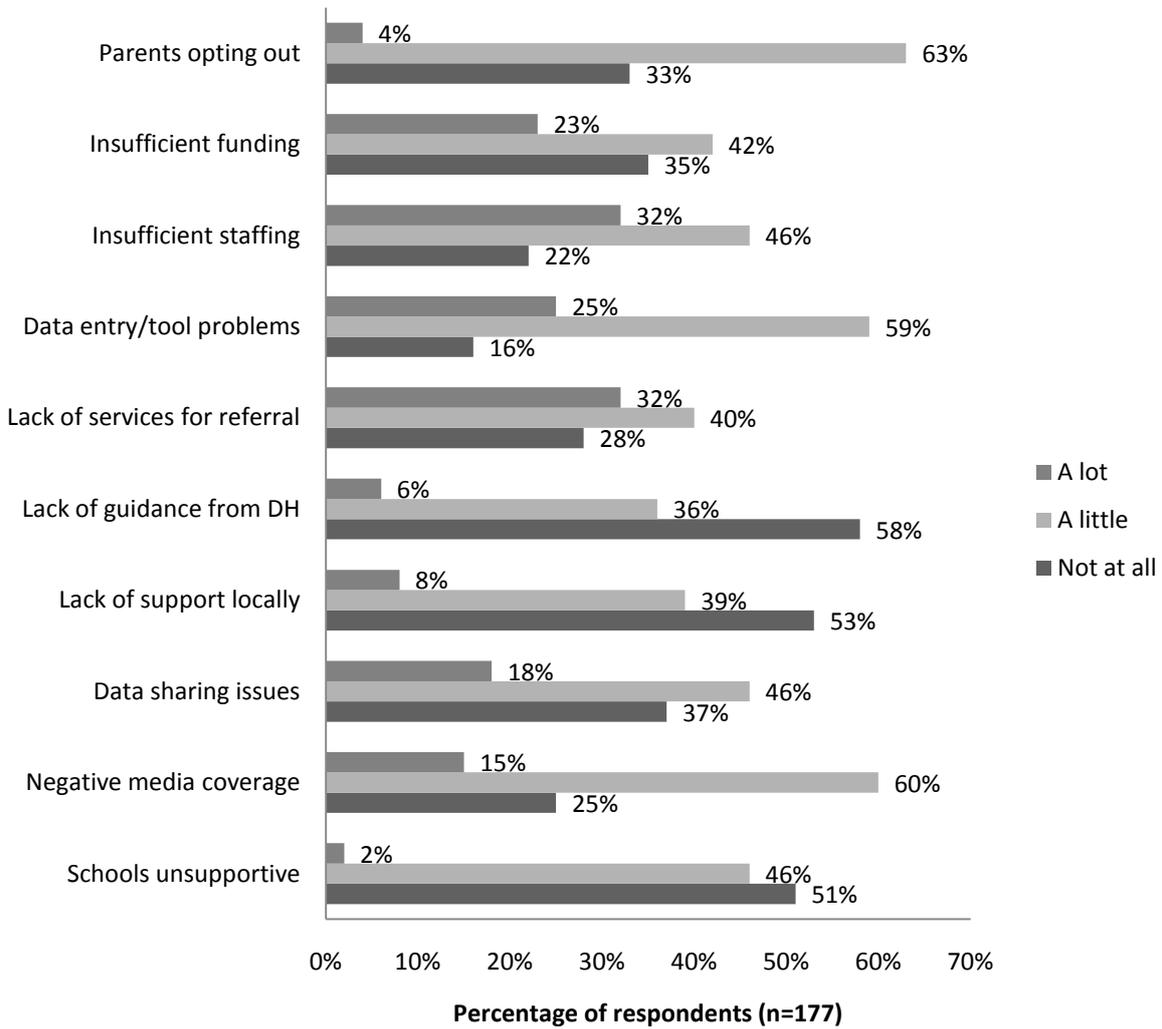
3.1 Successes and difficulties

Overall, forty percent of respondents to the survey thought that the NCMP was being delivered very successfully in their area with few or no challenges. A larger proportion (56%) judged its delivery to be 'somewhat successful, with minor challenges', and just four percent reported major unresolved challenges.

Where comments were added, these focused particularly on concerns about the feedback letter; resource and capacity issues, data sharing problems and also the remit of the programme – for example, 'it works as data collection, but not as follow up'; 'as a data collection programme it is successful, but families are unwilling to engage in follow up services'. Many noted that early difficulties had been overcome and delivery of the NCMP programme was now well established: 'it has taken a significant amount of time and effort but now works very well'; 'it has become more efficient over the years'; 'we did have a few problems in the early collections but these have been addressed'. Comments also stressed the time and effort needed to ensure the programme did work well: 'It takes a lot of work to make it run successfully'.

When survey respondents were presented with a list of potential difficulties that had been identified from the literature and feedback from regional workshops, the issues most likely to have created 'a lot' of difficulty for delivery of the NCMP in their area were lack of weight management services to refer on to (32%) and insufficient staffing (32%) (see Fig 3.1). Most of the potential challenges were judged to have created 'a little' difficulty. However, three areas of potential difficulty were judged *not* to have been a problem at all by over half of respondents: lack of guidance from the DH (58%), lack of support locally (53%) and lack of support from schools (51%).

Figure 3.1 To what extent have the following created difficulties for delivery of the NCMP in your area?



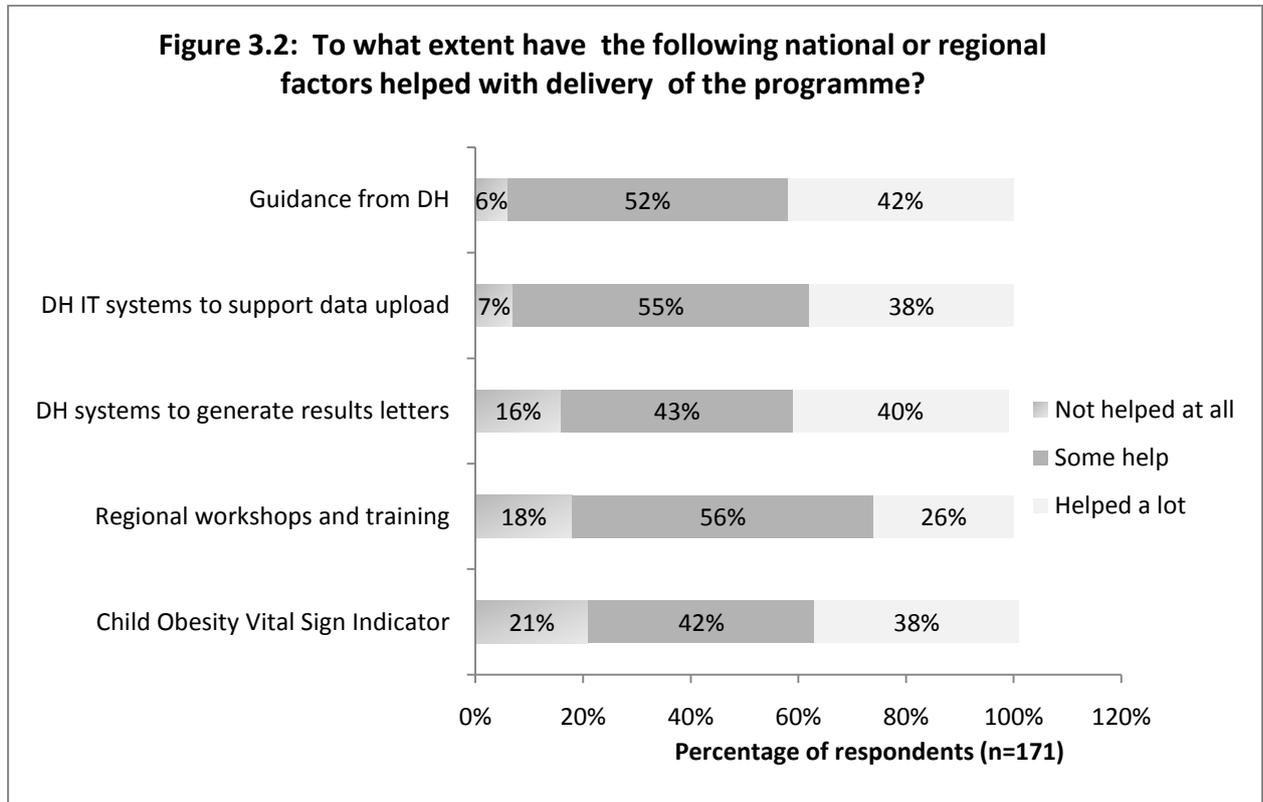
3.2 What has supported local delivery?

Survey respondents were also asked about the extent to which various national and local factors had helped with delivery of the NCMP.

At national and regional level, the provision of DH guidance, DH systems to support data upload and generate result letters, and regional workshops and training were all judged to have been some or a lot of help by over 80 percent of survey respondents (Fig 3.2). Not all respondents had heard of the Child Obesity Vital Sign indicator, but where they had 42 percent judged that it had provided some help in the delivery of the NCMP. Other national or regional factors that were mentioned as useful to aid NCMP delivery were incentives and schemes to support school involvement in the programme, such as Healthy Schools Plus.

The local factors that had been the most helpful in delivering the NCMP were schools that were engaged and supportive, local processes for data entry and producing letters, commitment and support from key local agencies, and in particular the NCMP data itself as evidence of the need to act on child

obesity. Half of survey respondents judged that having a child obesity indicator in the Local Area Agreement or NHS Operating Framework helped a lot. Comments indicated the importance of a holistic approach and joint working between health and children’s services, described by one as ‘a partnership approach to the NCMP as part of an overall solution’. The significant role played by highly committed staff was also highlighted: ‘people going above and beyond to get it done’.



Interviews at regional and local level confirmed the extent to which the support and guidance that the DH provided was valued by local areas, and helped to ensure consistency:

The templates, structures and expectations around the NCMP are important for providing a standard and quality assurance, so long as there is local flexibility built into the system’ (regional lead).

The danger is that if national and regional support for the programme goes, it will become very piecemeal with different areas collecting data in different ways and the quality of the data will go down (joint PCT/LA lead).

Speaking from a local perspective, a public health programme manager explained how in her area the DH guidance had been reproduced in simple flow charts and diagrams to help providers better understand the process and not feel daunted by a large document.

Interviewees said that encouraging participation and engagement through for example regional workshops where the national team have met people directly and answered their questions has been very positive and helped to build a strong foundation for the programme. As a result there was a huge commitment to the NCMP locally and a belief that it can make a difference. One regional lead commented: 'As a model and way of working, whether there is a regional tier or not, for local areas to have someone that they can raise queries with has really helped in sustaining motivation, fostering relationships and building commitment to the programme'.

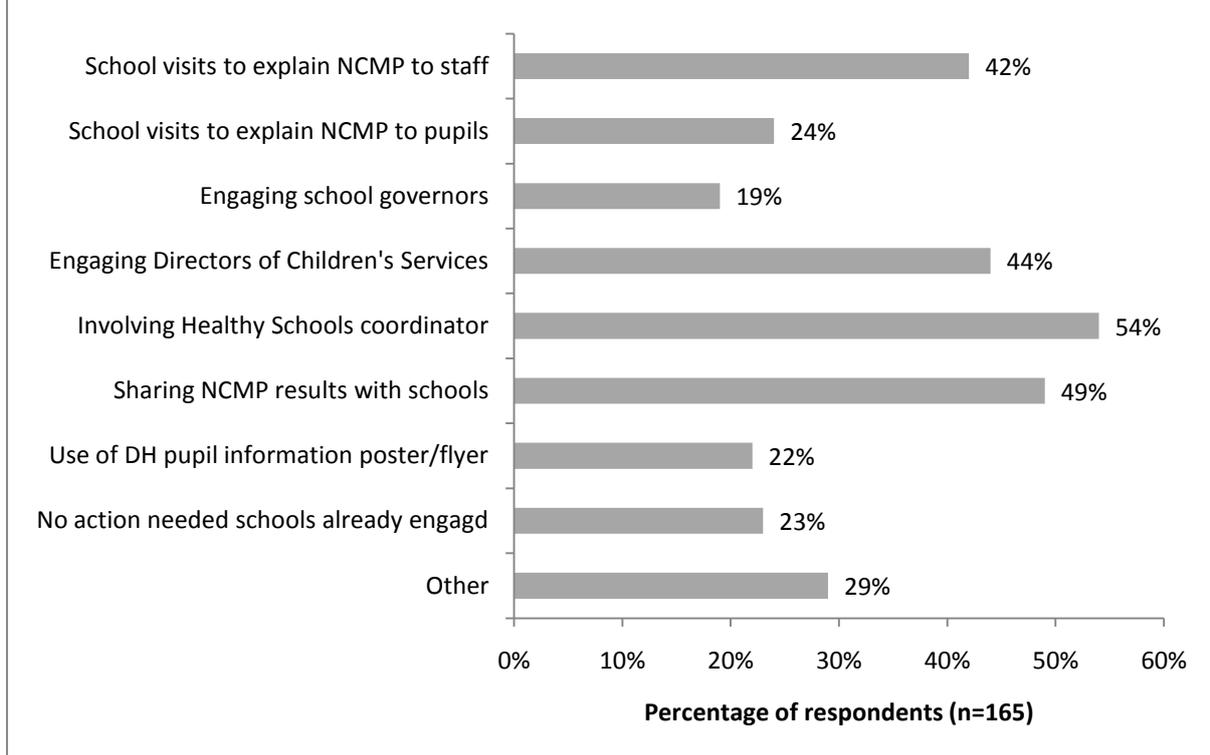
3.3 Involving schools

An early study of PCTs' experiences of delivering the NCMP (Opinion Leader Research, 2006) found that although most PCTs were able to obtain lists of eligible children directly from schools, some experienced difficulties in getting schools to participate, mostly because of the perceived time commitment and concerns about confidentiality. Stakeholders interviewed in early 2008 (Shucksmith et al., 2008) also reported that some schools were difficult to engage, and that the NCMP tended to be viewed as a PCT exercise rather than a partnership project. However by 2010 the great majority of eligible schools allowed children to be measured, and an education stakeholder interviewed for this review thought that once a 'critical mass' of schools was reached, involvement in the NCMP became accepted as part of normal practice. Were numbers to fall again, for example through schools that become academies choosing not to participate or because of less encouragement from central government or loss of support from Healthy School coordinators, this interviewee and a number of survey respondents were concerned that this 'critical mass' factor would be lost.

Survey respondents were asked what had helped to engage their local schools in the NCMP. A key factor was the involvement of a Healthy Schools coordinator, cited by over half of those responding to this question (Fig 3.3). Other important factors helping to engage schools were sharing the NCMP results with them, engaging Directors of Children's Services, and visiting schools to explain the NCMP to head teachers and other staff. However, there was some concern that the inability to share individual schools' results with them was a barrier to engagement (see later), and that the involvement of Healthy Schools coordinators was being threatened by changes to that programme. Other survey respondents noted that although visiting schools would help, they did not have the capacity or resources to do this.

Additional factors mentioned as supporting the engagement of local schools in the NCMP included gaining positive local press coverage before the measurement exercise; a joint letter to schools from the Assistant Director of Children's Services, the Assistant Director of Education and the Director of Public Health; close working relationships with the school nursing service and school secretaries; and integrating the measuring exercise into school lessons and healthy schools activities – including in one case providing pedometers and frisbees for children to use.

Figure 3.3: What has helped engage schools in the programme?



It was pointed out by interviewees that the NCMP has been developed as part of a holistic cross-departmental approach to obesity in which schools have played a significant role, including for example healthy eating initiatives and breakfast clubs, school food targets, sports and physical activity, healthy schools and extended services. This wide range of activities were described as 'fitting together as a coherent package' which was promoted and facilitated centrally. With the loss of the cross-government obesity team and the ending of some central programmes, such as the School Sports Strategy, and a move towards deregulation and devolution, fears were expressed about how the NCMP would develop, particularly sustaining schools' engagement with the programme.

The impact of changes to the Healthy Schools Programme appeared of greatest concern. Healthy Schools coordinators have championed the NCMP and helped win schools engagement, but with an emphasis on the Healthy Schools Programme being voluntary and withdrawal of the programme's support systems, there was a significant risk that the Healthy Schools Programme would disappear and as a result it would become more difficult to promote health in schools. This, together with greater autonomy within schools and a changed DfE agenda wherein promotion and support of the NCMP was no longer seen as part of their core remit, could mean delivery of the NCMP becomes more challenging. The general view was that much will depend upon how the NCMP is positioned within the school's priorities and whether schools see the programme as useful in meeting their priorities or targets. It was feared that a focus in the 2010 Schools White Paper *The Importance of Teaching* on educational attainment might be at the expense of promoting children's health and wellbeing.

3.4 Weighing and measuring

The survey indicated that the weighing and measuring exercise was predominantly carried out by school nurses, but healthcare assistants were mentioned by 42 percent of respondents and nursery

nurses by 19 percent (see fig 3.4). Responses add to more than 100 percent because more than one category could be involved, for example healthcare or school nurse assistants supervised by a school nurse. Several respondents noted that they had a dedicated NCMP team, comprising for example a school nurse and a dietician or an NCMP coordinator and an administrator. Arrangements sometimes depended on who was available at the time:

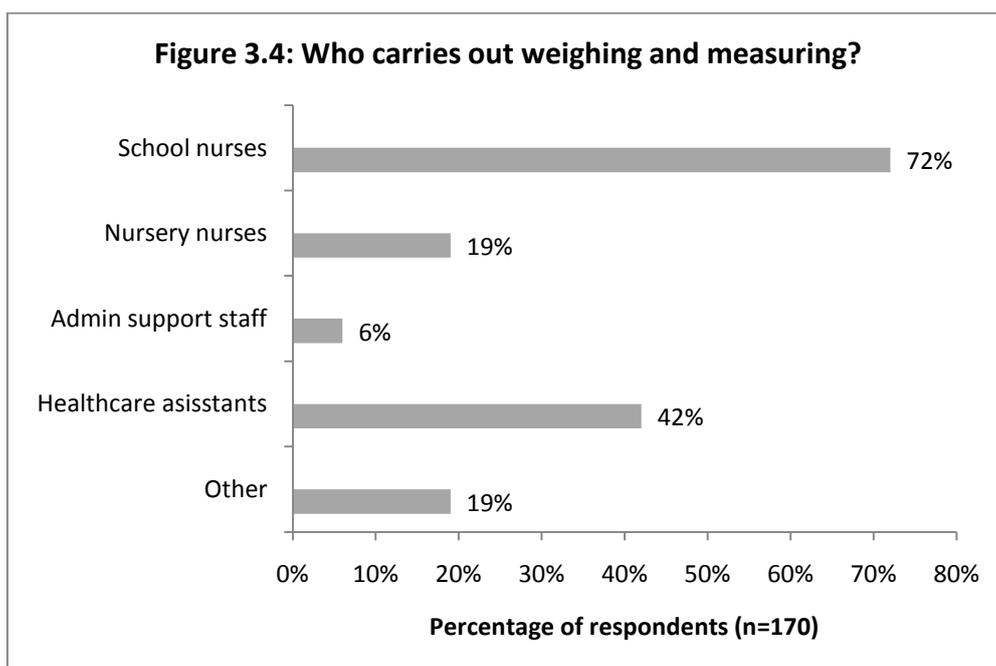
We try to use lower grade staff working under supervision, but staffing availability does not always permit this.

We also have a Children’s Healthy Weight Team who assist in the weighing and measuring where there is a lack of capacity with the school nurses.

One respondent noted that measurement had previously been done by school nurses ‘under duress’, but for the coming year was likely to be done by bank nurses.

A common theme in comments made elsewhere in the survey was that school nurses were frustrated by the amount of their time taken up by the weighing and measuring exercise, and that it would be preferable to have this done by less specialist staff with appropriate training and supervision. ‘You do not need a Band 5/6 nurse to measure and data input’. However, this could be difficult to arrange within existing resources, as one commissioning manager explained:

[We need] additional, ring-fenced, resources to enable us to use more junior grade staff to deliver the programme, freeing up school nurses to deliver interventions and follow up with families. For school nurses, weighing and measuring the children is time consuming and expensive, but with a shortage of school nurses already it's difficult to reallocate any funding away from the nursing budget to bring in more junior staff to free up school nurse time. A very small additional resource for staff to weigh, measure and administer the programme under the supervision of school nurses would actually reduce costs in the longer term by enabling nurses to make better use of their skills set and actually tackle obesity proactively.



Impact on school nurses

There are a number of published reports of the impact that involvement in the NCMP has had on the role of school nurses, most of them questioning whether undertaking routine weighing and measuring is the best use of their time. In 2007, the Community Practitioners and Health Visitors Association consulted with its school nurse members to find out how the NCMP guidance was working in practice (Unite/CPHVA, 2007). There was wide variation in how the measuring was undertaken, with some areas employing health care assistants solely to do this work, but most expecting school nurses to do it alongside their other tasks. At this early stage, the nurses had concerns about whether the data collected was an accurate reflection of the population, since they reported that in most classes two or more children opted out and these were nearly always the overweight children. They also had ethical concerns about the fact that there was no opportunity to follow up overweight children and that parents were not told their child's results (this was before routine feedback was introduced).

Gleeson (2009) argued that the targets for weighing and measuring set for PCTs had an 'overriding influence on school nurses' ability to deliver other parts of the government's obesity strategy', and should be scrapped. School nurse members of the Royal College of Nurses, surveyed in 2009, wanted to spend more time on activities such as health promotion and addressing obesity and less on screening and monitoring, and two thirds of nurses working in state schools reported feeling over-stretched in their roles (although this had not changed significantly since an earlier survey in 2005) (RCN, 2009). A study commissioned by the DH on the role of nurses in schools (Chase et al., 2010) likewise concluded that the NCMP took up a substantial amount of the time of school nurses working in primary schools and detracted from the proactive health promotion and prevention work which they could otherwise be doing. Some areas however had managed to secure an 'appropriate skill mix', with Band 3 or 4 nursery nurses or nursing assistants doing the weighing and measuring under the supervision of more senior nursing staff. Levine et al. (2008, 2009) reported on routine measurement carried out by dedicated teams of two healthcare assistants prior to the introduction of the NCMP, and found that the dedicated teams made more accurate measurements and were more cost effective than school nurses undertaking routine surveillance of children at school entry.

A detailed study of the involvement of fifteen school nurses in the NCMP in one PCT (Bunker, 2009) found more mixed opinions as to whether weighing and measuring was a good use of school nurses' time. Most saw it as a data gathering exercise that would be more appropriately done by other suitably trained staff such as health support workers or a small dedicated team, leaving nurses more time to advise and support children with unhealthy weights. But others thought it provided a useful opportunity to engage with children. The number of schools visited by each nurse in this study to conduct the measurements varied from less than five to 18. More organisation, time and effort was needed to carry out the exercise in small rural schools compared to big urban ones where there might be several reception and Year 6 classes. Most nurses were able to do the measuring in pairs, as recommended in the DH guidance, and reported that this worked much better than doing it single-handed.

3.5 Which year groups should be measured?

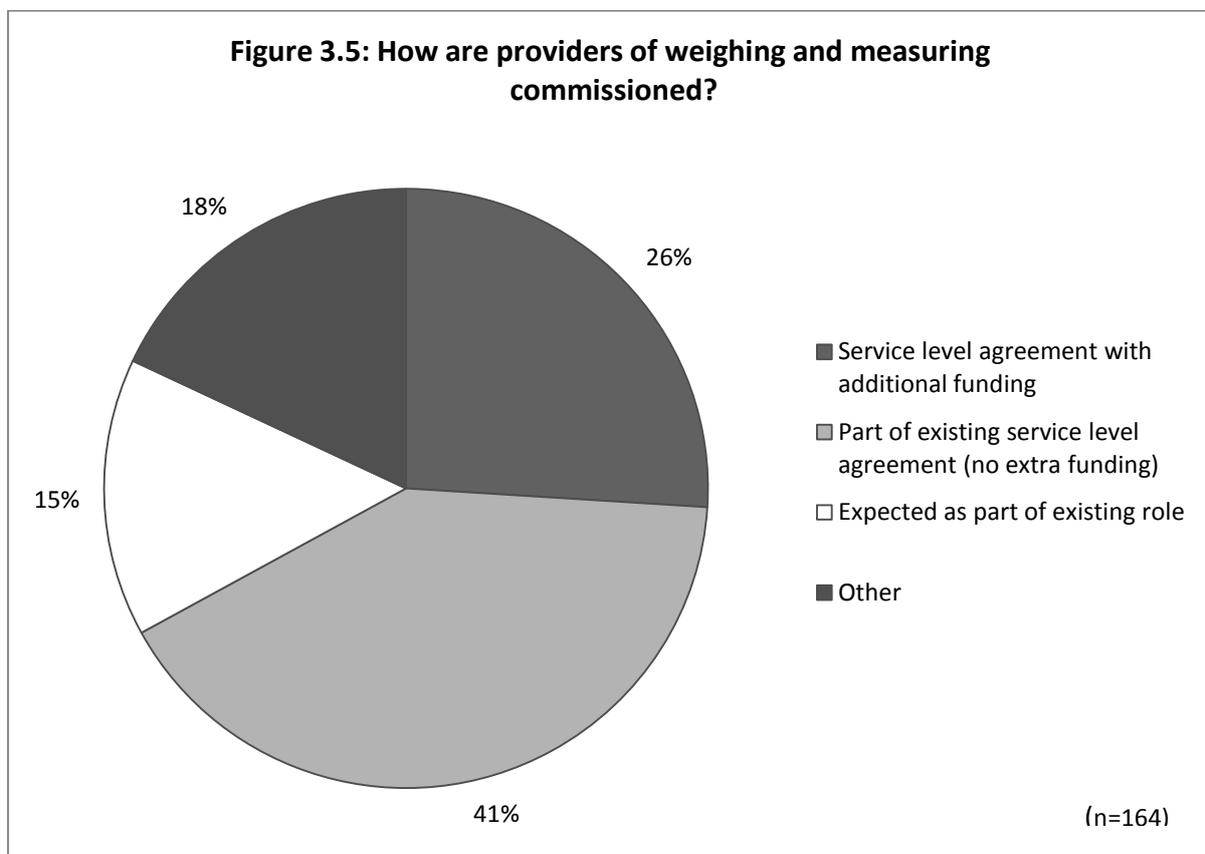
Some concerns were expressed by both interviewees and survey respondents (the latter by adding comments, rather than responding to a survey question) that Year 6 may not be the most appropriate year group to be measuring. It was said that children, particularly girls, can be very sensitive about body image at this age, and that timing was also an issue since unless Year 6 children were measured early in the school year, it was often too late for any follow-up work to be undertaken before their move into high school. Year 5 was suggested as an alternative, and there were also a few suggestions that the NCMP could be extended to measure children in secondary school (Years 7 or 10) or preschool –

but this was a minority view, since it was recognised that this would create significant capacity issues and that the measurement of children across two year groups in every primary school was already demanding enough for many areas.

3.6 Commissioning

Weighing and measuring was usually commissioned as part of an existing service level agreement, most commonly with no extra funding (Fig 3.5). Around a quarter of survey respondents reported additional payments, for example to cover the administrative and recording work involved, or for the production of feedback letters (in other cases provision of feedback was done by the PCT rather than being part of the provider's contract). When commissioners expected that the weighing and measuring would be done as part of the school nursing service's existing contract, this could create difficulties for both sides. One public health dietician reported a 'continued feeling that they [school health team] are 'doing us a favour' by taking the measurements - some staff really support it and see it as valuable; others less so'. Another noted that because there was no identified budget for the programme and school nurse capacity was limited, 'NCMP work is threatened in current negotiations about the School Nursing contract'.

In a number of cases comments indicated that commissioning arrangements were in a state of flux, either because additional elements were being added to the programme for the first time (such as proactive follow up), or because of structural changes: 'This year has been particularly problematic agreeing responsibilities as the PCT is no longer the provider'.



Regional and PCT leads generally thought that a commissioning template for the NCMP would be helpful, particularly if it took an integrated approach and clarified how NCMP commissioning relates and fits into Healthy Child commissioning. This guidance should also clarify who the commissioner should be and who should be commissioned since there seemed to be some confusion in this respect. A regional lead commented on the variation across areas and that although there was a move to more formal commissioning some aspects of the programme have been commissioned on an informal basis or not at all (i.e. it was done 'in house').

3.7 A service specification?

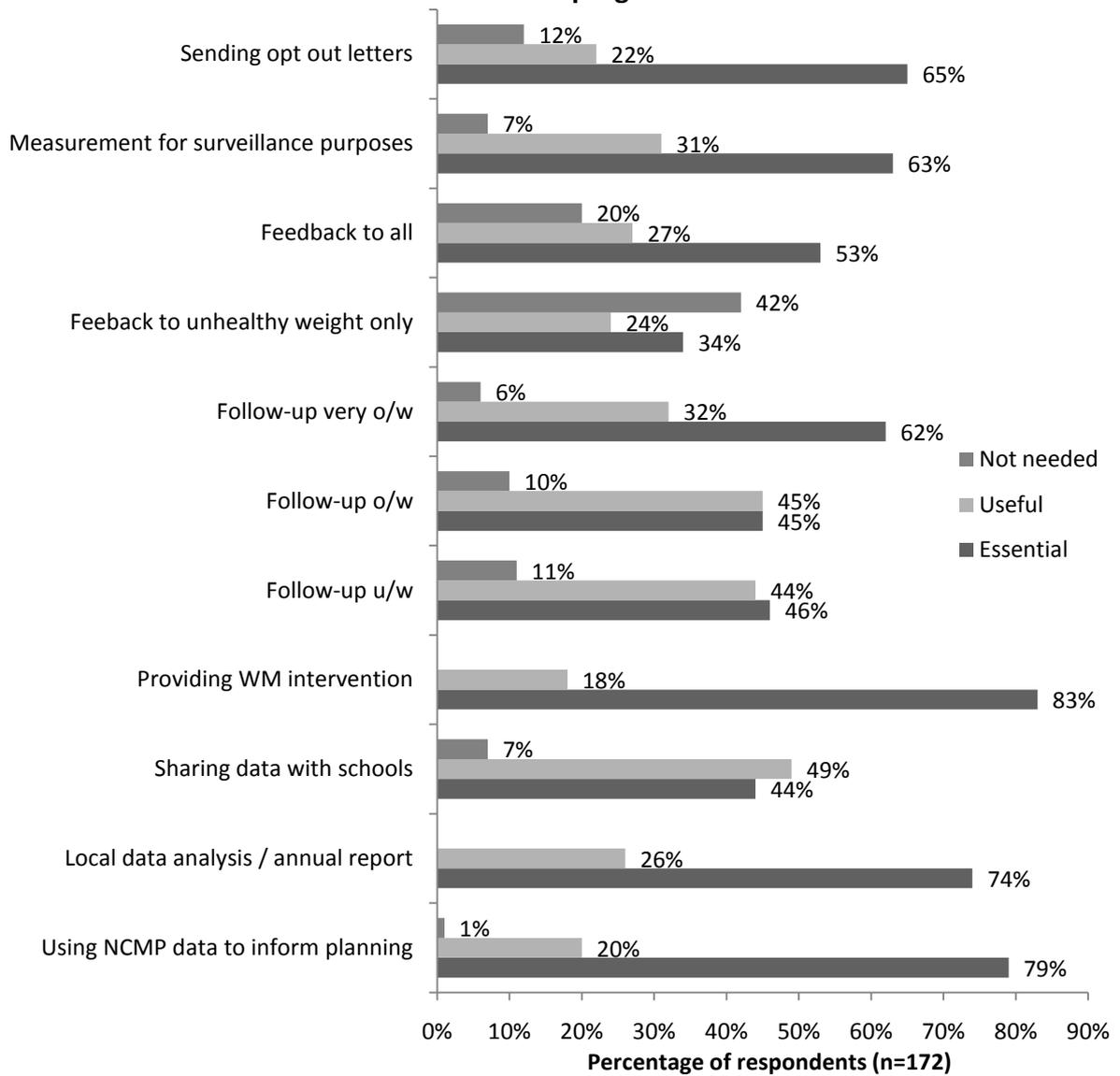
Some regional leads and PCT representatives were supportive of the development of a national service specification or minimum delivery model. Others thought that this would not be helpful, either because local areas had already developed their own or because a national specification would be difficult to implement given so much variability in local structures. Those who supported the idea of a national specification gave the following reasons:

- The NCMP is a national programme and therefore needs some standards and consistency, though with scope for local flexibility.
- There is a need for a core set of expectations and 'must do's'.
- It will help local authorities to understand what is involved and what they are taking on. The NCMP is often labelled as a simple programme, yet it straddles several different areas with many co-dependencies which makes it complex.
- A national service specification could be useful in helping to secure funding.

Supporters of a national service specification suggested that it should include data sharing as well as specifying what should be expected of providers at each point in the process. Measurement was seen as an essential requirement of any specification, including provision of training both for measurement and for any follow-up that local areas decided to undertake. However, it was recognised that such a specification would take time to develop, and that data sharing difficulties which may prevent providers adhering to a national service specification would need to be resolved first.

Survey respondents were not asked directly if they favoured a national service specification or minimum delivery model for the NCMP, but they were provided with a list of elements of the programme and asked which they thought were essential, which were useful and which were not needed. The results are presented in Figure 3.6. Responses to the option 'feedback of results only if not a healthy weight' need to be treated with caution as this wording is open to misinterpretation. The findings for this question are discussed in the relevant sections of this report.

Figure 3.6: Which of the following should be essential elements of the programme



4. Routine feedback

One aim of the NCMP is to raise awareness among parents of the importance of healthy weight in children. Although the NCMP began in 2005 as a population surveillance tool, from 2008 PCTs were encouraged by the national guidance to provide feedback as a matter of routine to all parents or carers on their child's height and weight. Before this, only a handful of PCTs did so, with most offering feedback only on request or not at all (Shucksmith et al., 2008). The need to raise awareness of what is and is not a healthy weight for a child was illustrated by a recent survey where parents were shown pictures of children in different weight categories (Ipsos Mori Social Research Institute, 2010a). The majority found it difficult to judge when a child was overweight.

Studies of the NCMP have generally found that the majority of parents welcome their child being weighed and measured at school and appreciate receiving feedback, whether they are asked about this as a hypothetical possibility (BMRB Social Research, 2007; Shucksmith et al., 2008) or as parents who have actually received a feedback letter giving them their child's results (Grimmett et al., 2008; Mooney et al., 2009). However, the research has also consistently found that a small minority of parents report a negative impact from receiving the results letter, in that it makes them angry, worried or upset; or they are concerned that feedback could increase the risk of eating disorders by making children and parents over-focused on weight issues. Parents of overweight or very overweight children, particularly those whose weight only just falls into these categories, are the most likely to disagree with the results and the least likely to find the feedback letter helpful. It was this that had led one regional lead we interviewed to suggest that more work was needed either locally or nationally in preparing parents for the letter, particularly those parents whose child is on the cusp of overweight and who are often taken by surprise by the results.

4.1 The extent of routine feedback

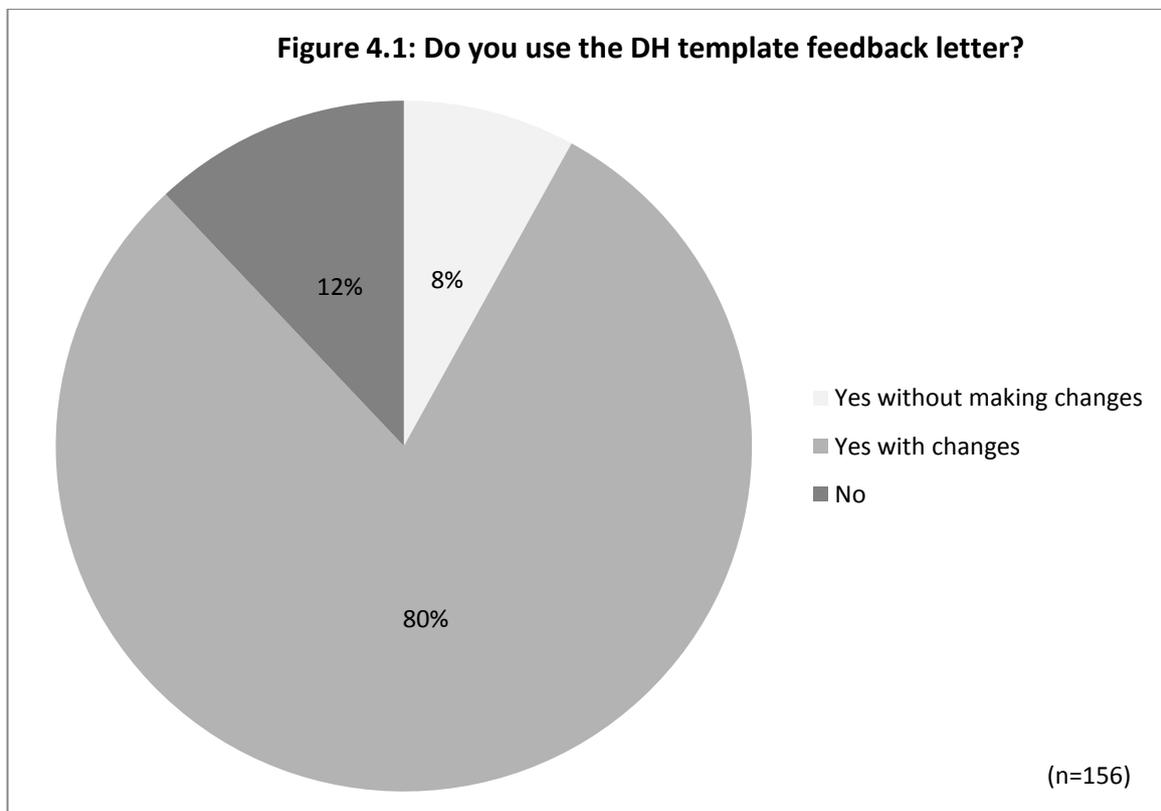
Almost three quarters (74%) of survey respondents said that feedback was provided to all parents of children taking part in the NCMP in their area. Some added that they planned to provide feedback for the first time in the coming year, but one respondent noted that although feedback letters had previously been sent to all parents this was now ending due to lack of capacity. Where reasons were provided for not sending results letters to all parents, these included a decision to send them only to parents of children who were not a healthy weight, lack of resources to offer follow-up weight management interventions, and (in one Borough with a very high ethnic minority population) a concern that the feedback would be misleading because the weight categories did not take account of a child's ethnic background.

4.2 The feedback letters

Studies commissioned by DH have tested out responses to different forms of the results letter, and changes have been made to the recommended template in subsequent years in response to feedback (e.g. Shucksmith et al., 2008; Counterpoint Research, 2009; Mooney et al., 2009). For example, the tone was 'softened' in the 2009/10 letter template compared to the previous year, removing references to overweight children being at increased risk of specific diseases like cancer and diabetes. A scale illustrating the range of weights and the average proportion of children in each weight category was also dropped, although focus groups by Counterpoint Research (2009) suggested that parents generally appreciated the visual information and thought it important to be able to see where their child's result fell along a continuum.

Concerns were also expressed by a small number of those interviewed for this review about the removal of the weight continuum from the letter, and about the appropriateness of allocating children to specific weight categories in the feedback letter based on their BMI. It was argued that whilst BMI based weight categories might be appropriate for surveillance purposes, they worked less well in a screening context to feed back individual children's results since there was no clinical engagement to take account of medical or other issues. The weight categories constituted a 'blunt tool' where a difference of a tenth of a kilogram could move a child from 'healthy' to 'overweight'.

The great majority of survey respondents used the DH template feedback letter: 88 percent of those providing routine feedback used the DH template to do this. Almost all had made at least some changes to the letter, although comments suggested that these were often relatively minor (Figure 4.1). Examples included adding Change4Life or local branding; removing the imperial conversion; including details of relevant local services and highlighting referral processes; using simpler language; 'softening' the tone of the letter for example by removing the term 'obese' and references to diseases like cancer or diabetes; and adding back in the healthy weight range which was removed in the latest DH version of the letter. One respondent noted that 'the ability to change the letter is essential'.



Several survey respondents expressed an interest in developing their own letter, rather than just adapting the DH template, but appeared unclear if this was allowed. One noted that 'however much we adapt the letter, people see it as a formal letter telling them that "their child is fat" - it does not sit with a supportive model to motivate people'. A regional lead also commented that PCTs in her region would welcome a directive that they could do their own letters: 'I don't know what they think they are going to write but they all think they could do it better'. However, the prevailing view among the regional leads

who were interviewed was that the templates were important for consistency: 'they provide a standard and it is important to have a consistent means of relaying the information'.

How the letters are sent out

Letters were most commonly sent out by the PCT (61%), or by the service commissioned to undertake the weighing and measuring (this was the most common response linked to the 'other' category). In line with DH guidance, very few gave pupils the letters to take home, either on the day of measurement (3%) or afterwards (7%). Where this was done it tended to be for Reception class children rather than Year 6, who were thought more likely to open the letters. In some cases, letters were not sent to parents of unhealthy weight children until after they had been spoken to directly (see proactive follow up).

Information enclosed with the result letters

A wide range of additional information was enclosed with the result letters, most commonly the DH Change4Life leaflet (this was sent with almost all letters to parents of overweight and very overweight children, and with around seven in ten letters to parents of underweight and healthy weight children). Information about local weight management services was included with around six in ten letters to parents of overweight and very overweight children, and also in letters to around a quarter of parents of underweight and healthy weight children. The dietics department in one PCT had devised an underweight advice leaflet specifically to be enclosed with letters to parents of underweight children, although specific attention to this group appeared unusual. Just under a third of respondents said their PCT had designed its own leaflet with lifestyle tips which was enclosed in at least some of the letters.

Whilst the Change4Life leaflet was by far the most common enclosure, some PCTs used the feedback letter to convey a wide range of information to parents, promoting local resources and events. One public health programme manager described a particularly extensive amount of additional information:

Information on local healthy cookery classes on a budget, allotments, parks and open spaces, cycle training, walking (self-help info. including pedometers and where to go), local sports clubs, provision for disabled children, free school meals, plus links to national websites - 5ADAY, Change4Life, Food Standards agency (who do lunch box ideas).

4.3 Handling calls from parents following routine feedback

Who takes the calls from parents in response to the feedback letter?

Regional leads indicated that different levels of staff took the calls in different local areas, ranging from administrative personnel to public health consultants. However the survey showed that it was usually school nurses who dealt with calls from parents after the latter had received the feedback letter. Three quarters of survey respondents said that school nurses took the calls, although just over a third (35%) also mentioned professional staff such as a nutritionist or the NCMP coordinator, 13 percent indicated that administrative staff took at least some calls and 8 percent that nursery nurses did so. 'Other' staff taking calls (18%) included Family Change4Life advisors, Healthy Weight team leaders, public health consultant lead or commissioning manager, PCT Patient Advisory Liaison Service, nurse assistants and support workers. Percentages add to more than a hundred because different groups of staff could be involved in the same local area, for example with calls initially coming to a school nurse or administrator but then being passed on to more senior or specialist staff as needed. A number of respondents noted that calls initially went to a designated answering machine, and that this had created problems when

messages were not picked up and responded to quickly, or where parents did not leave a number to ring back.

The experiences of staff handling the calls

Whilst just over a third of survey respondents rated the experiences of those handling the calls as 'working well', the majority (58%) reported 'some difficulty' and six percent had experienced major difficulties. Reasons given for experiencing problems included the angry response from some parents to the letter (particularly those whose child was just within the overweight or very overweight category); lack of training or skills to handle such calls; insufficient weight management programmes to refer families on to; and lack of capacity to take the calls. Because parents were often upset and/or angry the calls could take considerable time (one respondent estimated 20 minutes on average), and it was generally felt that staff taking the calls needed to be well prepared and supported. Literature on the role that school nurses play in the NCMP has also noted their concerns about responding to complaints from parents who have received their child's NCMP results (e.g. Chase et al., 2010).

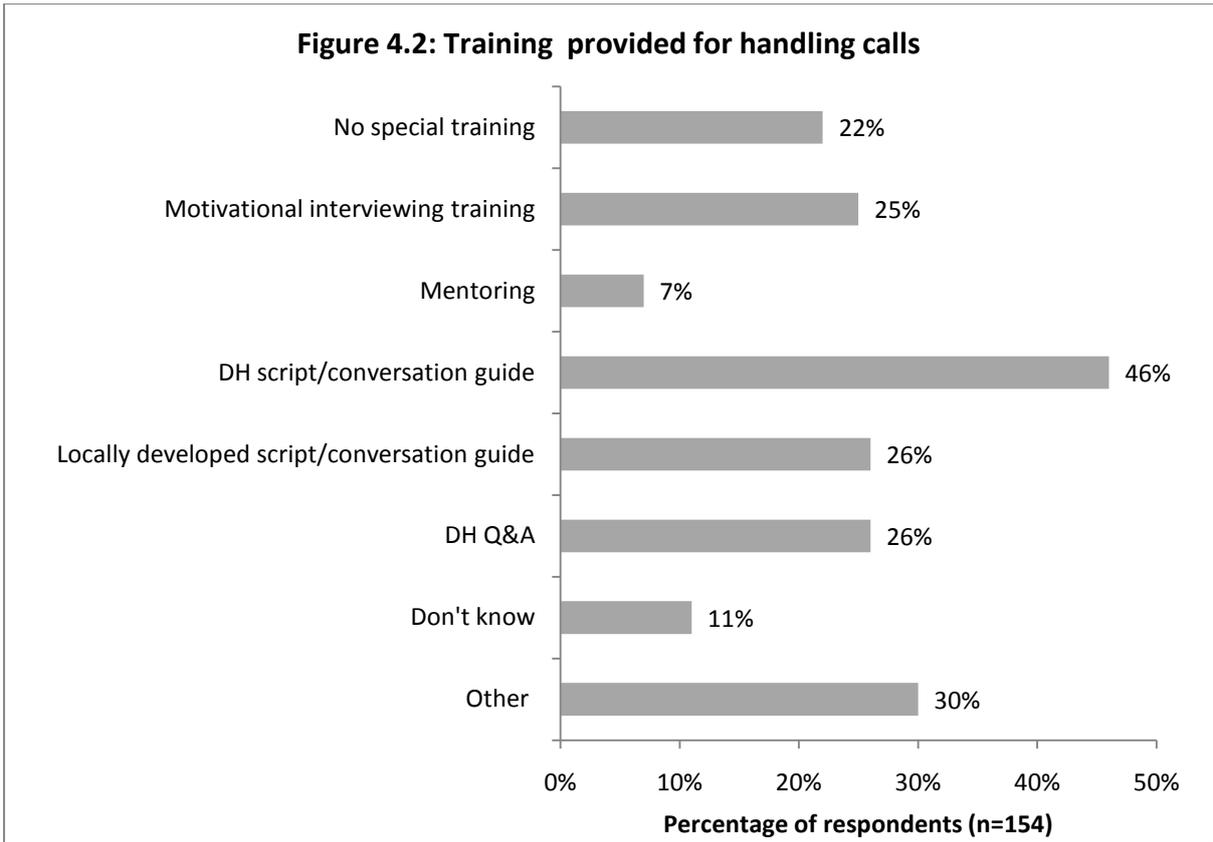
Among the survey respondents who judged that the experience of handling calls from parents was working well, some said that this was because parents of overweight or very overweight children were proactively contacted before the results letter was sent out. Other reasons included the staff receiving calls being experienced or well trained, and having motivational interviewing skills and up-to-date information about services available to families in their local area. One area believed that adopting an opt-in rather than opt-out system for the measurement process had helped to avoid negative parental reactions to the feedback letter. Another commented that the skills and local knowledge of the school nurses had been crucial to handling calls well:

They know the families and local area. They are also skilled communicators and handle calls from parents who are distressed or angry well with most resulting in positive outcomes.

Training for staff taking the calls

Nearly a quarter of respondents reported that those taking the calls from parents had no special training, sometimes commenting that this was not needed because they were already professionals skilled in this kind of work. Where training or resources had been provided, the most common was the DH script/conversation guide (Fig 4.2).

Regional leads reported that the motivational interview training that the DH had organised was very well received, although staff still sometimes struggled with the calls. As the NCMP is a national programme the regional leads thought that training should be consistent across areas, but with some scope to address local contexts.



4.4 Practitioner views about routine feedback and its impact

Two thirds of survey respondents thought that the benefits of providing routine feedback outweighed the negative impacts, fifteen percent thought that the benefits did not outweigh the negative impacts, and twenty percent did not know. Some commented that it was difficult to assess impact, since the vast majority of families did not get in touch, and it was clear from additional comments that many were 'hoping' that routine feedback was worthwhile rather than being able to base this on any evidence.

Among the benefits of sharing information with parents, over half (59%) of those responding to this question thought that the feedback had raised parents' awareness, and the same proportion that it provided an opportunity for professionals to engage with parents in relation to their child's weight. Around a quarter of survey respondents thought that feedback had increased uptake of weight management programmes, although others commented that take up was generally low. However, a fifth of survey respondents did not think there had been any benefits from sharing results with parents, and queried the value of doing so.

When asked about any negative impacts of routine feedback, by far the most common was the angry phone calls that were received after the letters had been sent out. Comments suggested that these were very few in number compared to the amount of letters sent, but they could be difficult to deal with. Other negative impacts were the unwillingness of parents to accept advice, adverse media coverage and an increase in complaints about the NCMP. One respondent noted that they had seen more of a negative impact since changing to the national letter template from their previous local letter. Some survey respondents supported the idea of providing routine feedback, but were not convinced that the current system of feedback letters was the best way to do this. 'I think we have to have feedback results but I am not sure the best way for this to occur – it does not feel right in the current system'. The same

respondent pointed out that 'there is no point in feedback without the interventions afterwards', and this was a common theme. In fact, the element of the NCMP which was most commonly ticked as 'essential' (by 83% of survey respondents) was providing weight management interventions (Fig 3.6). Other survey comments referred to a lack of evidence that providing feedback and follow up through the NCMP was an effective way of getting families to make lifestyle changes.

Interviewees expressed similar reservations about routine feedback, which can be summarised as:

- Lack of an evidence base for the effectiveness of routine feedback together with some fears that it could do more harm than good.
- No additional funding provided to PCTs, and the resulting impact on capacity and resource.
- A lack of weight management services or insufficient capacity within the service to help those who needed it.
- Current feedback practice not meeting the accepted medical criteria for a screening programme.

Several regional leads were of the opinion that it was not ethical to provide routine feedback if there were no services in place to refer parents to for help. A joint PCT/LA commissioner explained that parents were not sent letters in their area because 'we do not see it as appropriate to be highlighting a problem that we can offer no help for'. Another NCMP lead questioned the ethics of continuing routine feedback if weight management services were cut, which was her fear in the current efficiency drive. Some described PCTs choosing not to routinely feedback to all parents, but to target only those in the unhealthy weight category to better enable pro-active feedback and a better use of limited resources.

However, the alternative view among interviewees was that it was not acceptable or ethical to provide routine feedback only to the parents of children of unhealthy weight, and that telling all parents their child's results helped to 'normalise' this. Routine feedback was also seen as providing a good opportunity for school nurses to engage with parents, which they would not otherwise have had.

Discussions at regional workshops similarly highlighted both positive and negative aspects of routine feedback. Common challenges were resource and capacity issues (including the cost of translating the feedback letters), the difficulty of individualising the letters, problems with engaging parents (especially those needing it most) and dealing with parents who did not accept that their child was overweight. One area was trying out a separate results letter for Year 6 children whose weight just fell into the 'overweight' category (up to three pounds over) in an attempt to forestall negative responses.

4.5 A surveillance or screening programme?

Most interviewees drew attention to how the NCMP's purpose had changed since it was launched, with some arguing that the introduction of routine feedback had moved the purpose of the programme from surveillance to screening. Indeed, many of the challenges that areas faced were thought to stem from this change, particularly the lack of resources. One regional lead explained that PCTs were struggling to respond to the increased demands that routine feedback and follow up had placed on them and varied as to how far they have been able to adjust their resourcing to meet these additional expectations, and whether there was a pathway in place for services for children identified as an unhealthy weight. Another interviewee felt that although the move to providing feedback might be a good one, it would be wrong for the programme to be judged on the impact it had made on individuals when this had not been its intended purpose.

On the other hand, In the view of one PCT/LA lead, primary care were not very successful in identifying children who are overweight and therefore the NCMP was the main screening programme to identify childhood obesity even if it was not labelled as such. In fact, she believed it would help if the programme was publicised as a screening programme since it was more likely to get schools engaging with it in areas where they were having problems, and would also promote discussions about information sharing and might in fact facilitate access.

The survey indicated mixed views about whether the NCMP should be a weighing and measuring exercise for population surveillance and planning purposes, or whether it should also function as a screening exercise identifying children and providing feedback to parents on their child's results. Just over half of respondents (53%) thought that feedback of results to all parents was an essential element of the programme. Nearly one in five (22%) thought this was useful but not essential, and 12 percent thought that feedback of results to all parents was not needed. Just over a third (34%) thought it essential to provide feedback on a child's results only if they were outside the healthy weight range (Fig 3.6)

Comments added to the survey indicated strong views both for and against what one respondent described as the 'morphing' of the NCMP from a surveillance to a screening programme. Some queried whether the cost and effort of providing results letters for all parents would be better spent on interventions for those most needing support:

Feedback does not have the desired result, doesn't engage those parents who would benefit from support, [has a] negative impact on school nursing service and PCT. Should have stuck to this being a population measure and using this [resources spent on routine feedback] for targeted work with schools, children's centres and nurseries (Head of Health Improvement).

The alternative view was that 'if the results are being taken, they should be shared with parents', and that routine feedback made the measuring exercise more worthwhile:

Overall the fact that parents of 4,000 children are contacted and written advice sent, and further telephone and face to face advice is offered means that the benefits will outweigh the negatives. It also makes it more meaningful for school nurses etc doing the measurements as it is an intervention not just a monitoring exercise (Consultant in Public Health).

A recurring theme in this review was the need for clear direction on whether the NCMP is intended to function as a surveillance exercise or as a screening programme with referral on to weight management services.

5. Proactive follow up

Studies have consistently indicated that simply asking parents to get in touch with a named professional if their child is outside the healthy weight range rarely results in them making such contact. The low uptake of support and advice was a source of concern to PCT staff interviewed by Mooney et al. (2009), and some parents in that study indicated that they would expect professionals to contact them if further action was necessary. Research with focus groups to test out routine feedback letters (Counterpoint Research, 2009) also found that parents viewed their child's participation in the programme as a kind of contract: they allowed their child to be weighed and measured, and in return, expected that they would be alerted, contacted and supported to make changes if there was a problem.

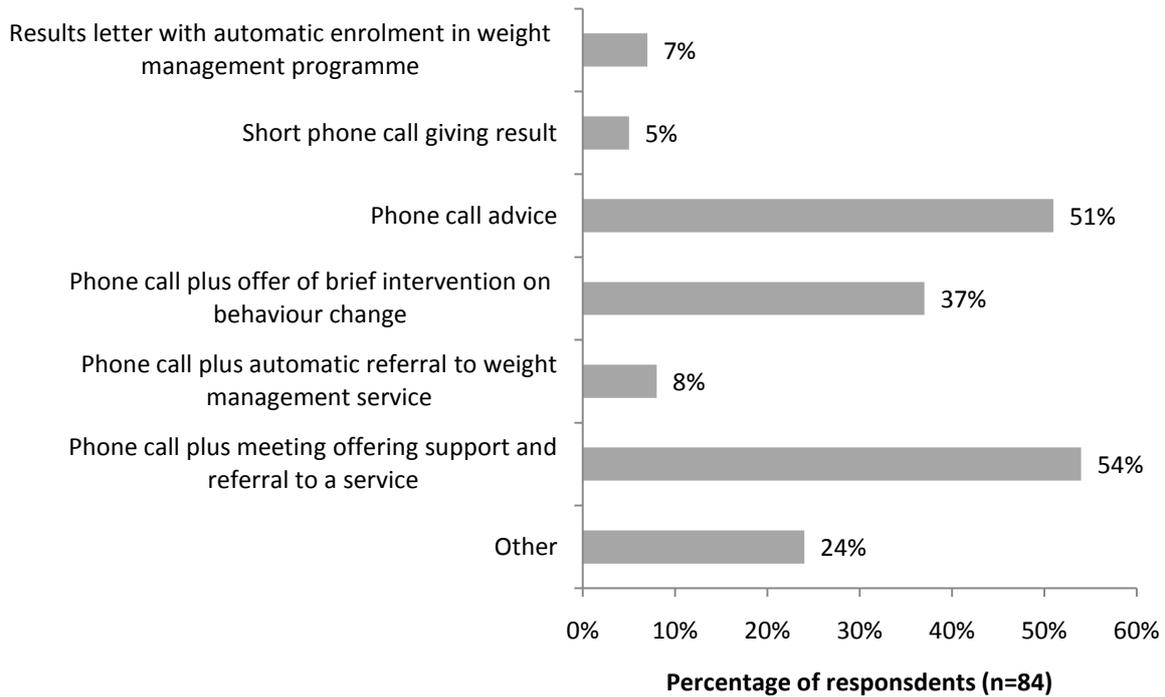
Although the research shows that parents generally welcome receiving feedback about their child's weight, there is little hard evidence that this leads to changes in behaviour without further encouragement and support. Whilst a third of parents surveyed by Mooney et al. (2009) said that they planned to make some changes as a result of the feedback letter, particularly parents of overweight and very overweight children, there was little evidence of changes having been made when a sub sample of parents were interviewed some months later. Very few parents contact weight management services themselves as a result of the feedback letter, even when this includes contact details. An evaluation of weight management programmes in the West Midlands region (Upton et al., undated) reported that the NCMP letters had not been successful for recruitment purposes, as 'parents either did not understand the implications of the letters or did not believe that their child had a weight problem' (Upton et al., p3).

The literature thus suggests that a more proactive approach is needed especially for those who are outside the healthy weight range. Nearly two thirds (62%) of survey respondents thought that proactive follow up in the form of a phone call or visit was essential for very overweight children, although this dropped to below half for overweight and underweight children (45% and 46% respectively). Comments indicated that many thought follow up was desirable, but not possible because of the resources it would require.

5.1 The extent of proactive follow-up

Over half (56%) of survey respondents said that they were able to offer proactive feedback in their area, defined as any follow-up contact with the family over and above providing the result letter and leaflets. This is higher than anticipated, but does include small scale pilots and follow up only in specific cases or at school nurses' discretion, as well as more established schemes. Proactive follow up most commonly took the form of a phone call with or without a meeting, to provide advice and support and to offer referral to a weight management service (Fig 5.1). Some PCTs were piloting proactive follow up for the first time and just offering it in a few schools or in one geographical area, or to parents of Year 6 but not Reception class children. Whilst almost all those providing follow up did so for very overweight children, just under half followed up underweight or overweight children. Other target groups included children weighing over 60 kilos, or children already linked to health services to warn them that the letter was on its way.

Figure 5.1: What does your offer of pro-active follow -up involve?



School nurses were the ones most likely to undertake proactive follow up (85%), although 15 percent of respondents said that nursery nurses did this, 25 percent other professional staff such as nutritionists or NCMP coordinators, 3 percent administrative staff, and 16 percent 'other' staff which included family support workers, school health assistants and public health consultants. Some respondents noted that different categories of staff followed up with different groups, for example 'school nurses for underweight and healthy weight, Family Change4Life Adviser for overweight and very overweight'.

Where proactive follow up was not provided, by far the most common reason was lack of capacity or resources.

We did proactive feedback last year but it is too labour intensive and there is not enough capacity in the team to repeat it. You have to phone up several times to get to speak to someone and most people are not in when the calls are made but are at work. When the calls need to be made in the evening there are not staff to do this.

We offered it [proactive follow up] in the first phase, the impact on the team was huge and no extra funding was available so we rewrote the pathway for parents to contact the Healthy Weight team directly.

Other respondents referred to the large number of families that might need to be contacted ('we are identifying around 1,500 obese children per year in our area'), or to a lack of services to offer families if they were contacted. A few thought that proactive follow up was not possible since they were not allowed to share details of very overweight children with weight management services, only with parents themselves and with Public Health:

We have discussed this locally and the view of the Caldicott Guardian was that parents/carers would need to consent to have their details passed to the appropriate service...we considered this [asking for parental consent to automatic referral to a weight management service] may have an impact on increasing the potential to opt out.

5.2 The impact of proactive follow-up

The overall perception of regional leads commenting on proactive follow-up was that it resulted in fewer complaints and less angry parents. However, there appeared to be little data on impact of proactive follow-up on take-up of weight management services or on behaviour change, though there were individual examples of awareness raising and of parents taking up the offer of services.

Some interviewees stressed the need for evidence regarding the effectiveness of proactive follow-up and which was the most effective and cost effective approach, since this would assist with commissioning. One regional lead thought that in areas that had invested in weight management services and undertook proactive follow-up, the prevalence of obesity might drop by Year 6, but this did not seem to be reflected in their data and she suggested the need for further work in this area.

Turning to the survey data, among those providing proactive follow up a third thought that there had not been any negative impact, and just over a quarter thought that there had (the rest did not know). Negative impacts were similar to those cited for routine feedback, namely parents being angry and unwilling to engage, although several survey respondents noted that parents of unhealthy weight children responded better to being provided with their child's results in a phone call than in a letter, as regional leads had suggested. Views in the survey were mixed on whether proactive follow up increased engagement in weight management services, with some noting that parents did allow their child to be referred following a phone call or visit, whilst others believed there was little evidence to show increased take-up of such provision.

When asked if the benefits of providing proactive follow up outweighed the negative aspects, almost all (96%) of those replying to this survey question said that they did, although often adding comments that it was really too early to say. Some PCTs that were not currently offering proactive follow up indicated they hoped to do so in the future, resources permitting. However, the time consuming nature of the task and the need for it to properly resourced were frequently mentioned.

It's not a commissioned service, and staff feel pressured, although recognise the value of being able to do something if they are identifying children through NCMP.

We are only piloting proactive follow up in a limited number of schools. The feedback from those doing the proactive feedback is good in terms of engaging with parents – however, it does take an awful lot of time.

Hull PCT has offered proactive follow up since the NCMP was first launched. This involves the school nursing team (sometimes assisted by other members of the community nursing team) telephoning the parents of all overweight and very overweight children *before* routine feedback letters are sent. An external evaluation by Ipsos Mori Social Research Institute (2010b) highlighted the value of developing a flexible approach, allowing nurses to discuss with the family the most appropriate course of action for them rather than having a prescribed care pathway. Another helpful factor was the Eat Well Do Well team which acted as a single referral point to locally designed weight management programmes. Having follow-up services to offer, and good training and support for those contacting families, were

also crucial. The costs of proactive follow up in Hull varied considerably between families, depending on the level of input required from healthcare professionals.

Nottingham city has also evaluated a pilot of proactive follow up offered in two schools (Braisby and Waddall, 2009). This 'enhanced delivery of routine feedback' involved school nurses contacting parents of overweight and very overweight children within a week of their child's measurement, to explain the results and offer a 30 minute appointment. Although the pilot was judged a success, in that approximately one in five of the families contacted attended an appointment and most reported finding this useful, the evaluation also highlighted some of the difficulties and challenges that would need to be overcome if the proactive follow up were undertaken more widely. For example, although 37 children were identified as overweight or very overweight in the two schools, it only proved possible to contact the parents of 27 of these, and of the 15 offered an appointment, five declined and three did not turn up. The nurses offering the follow up also felt they needed more training in behaviour change techniques and motivational interviewing.

5.3 Partnership working and proactive follow-up

According to one regional lead, those areas that have been most successful in proactive follow-up and working with parents have thought more holistically about how they work with partner organisations. Evidence of this way of working was provided by one of the PCT/LA interviewees who described how they had involved the weight management service in proactive follow-up. Such a move had been advantageous in a number of ways including removing the onus on the school health team to do follow-ups and placing the responsibility on the weight management programme team, who may be better placed to explain the programme to parents and to start building relationships which would encourage them to join the programme. Additionally, it was seen to be to the advantage of the weight management service to undertake the follow-up work since it would provide them with potential service users and therefore help them to meet their own targets.

Transition of the NCMP to local authorities was thought to have the potential to improve proactive follow-up, if more services are made available through pooled budgets.

6. IT issues

6.1 National tools and need for robust IT system

Support for the continuation of the national IT tools and advice that has supported delivery of the programme in local areas was strong among survey respondents. All the response categories for this question were judged 'very important' by at least half of respondents with most of the rest saying that they were 'quite important'. They are listed in descending order of importance in Figure 6.1.

Figure 6.1: Percentage of respondents judging aspects of IT support as 'very important' (n=156)

	%
A national upload tool	83
Compatibility with other local systems	75
National written guidance on software use	75
User support for feedback/upload tools	72
Local resources for IT support	66
A national tool for producing results letters	65
Software for entering data at time of measurement	64
National training workshops on use of the tools	51

Although these items were judged as very important, that did not necessarily mean that respondents were satisfied with the current situation as reflected in their additional comments. These centred on incompatibility of the upload tool with local IT systems creating the need for duplication in data entry; and difficulties and 'glitches' in using the DH tools. Regional leads also reported frustration with the IT systems in some local areas and that confidence in the system's accuracy was undermined due to issues and problems with the upload tool. There was they said an urgent need for a robust IT system that was reliable and efficient.

The NHS Information Centre (IC) was very aware of the problems with the system, which was initially designed as a population monitoring surveillance tool and had, over a short period of time, changed considerably to include routine feedback to parents. Because the system was not initially designed for this purpose it has struggled to accommodate the changes, and to adapt to new requirements each year such as different versions of the feedback letter for different weight categories or adding the child's NHS number. A particular concern was the potential for user error, for example the wrong letter being sent out. The NHS IC advocated a redesign of the system as a solution to the problems, which in their view would provide:

- Improved data and more opportunities for data sharing.
- Less risk than the current system carries, which is 'hanging by a thread'.
- Annual maintenance reduced.
- Fewer resources to keep the system running and therefore greater efficiency.

Investing in a new system was viewed by the group at NHS IC to be highly desirable, and likely to be cost effective if a commitment were made to continue the programme for say at least another four years. Now would seem a key time to review the system, with the move of the NCMP to local authorities and the need for new systems providing a 'window of opportunity' to ensure that the IT underpinnings of the NCMP are fit for purpose.

6.2 Extracting data from Child Health Systems

From the interviews it was clear that there was much variation in how the measurement data was administered. Whilst some areas entered data on encrypted laptops at the point of measurement, others brought it back to base to enter. Some areas entered it once only into the upload tool whereas others entered it into their Child Health System, and because of software incompatibility (highlighted by survey respondents too) also into the upload tool, resulting in duplication of effort and the potential for increasing the number of errors. Allowing the NCMP system to import an extract from the Child Health System would, interviewees said, be very welcome since it would save on data inputting and potentially reduce the number of errors. Survey respondents in their comments also wanted to see compatibility between the upload tool and their own systems: 'It must have an interface with RiO as electronic records are the future and staff will not want to waste time entering the data into NCMP and then RiO.

However, issues were raised by regional and PCT leads about using the Child Health System. Firstly, the Child Health System software is not standard, but varies across areas and even within areas: systems mentioned by interviewees and survey respondents included RiO, PARIS and System One. Some PCTs are still using a paper-based system though moves to an electronic system were sometimes in process. Secondly, for feedback letters to be produced using the Child Health System would it would seem require the involvement of the software developers in order for the systems to have this functionality.

7. Data analysis and data sharing

7.1 Importance and benefits of data analysis

Survey, interview and regional workshop data all support the importance and value of data analysis. All survey respondents thought that local data analysis and/or producing an annual local report was a useful element of the NCMP, and almost three quarters (74%) thought this was an essential component of the programme. Regional leads cited a number of benefits provided by regional and local level analysis:

- Being able to make comparisons in prevalence of obesity between regions and local areas.
- Having a local robust dataset helping to increase credibility of obesity issues.
- Helps to facilitate and influence negotiations with relevant partners.
- Informs service planning (79 percent of survey respondents also thought that using NCMP data to inform priorities and service delivery was an essential element of the programme).
- Enables local area mapping to target services.
- Provides figures to support the business case for providing services.

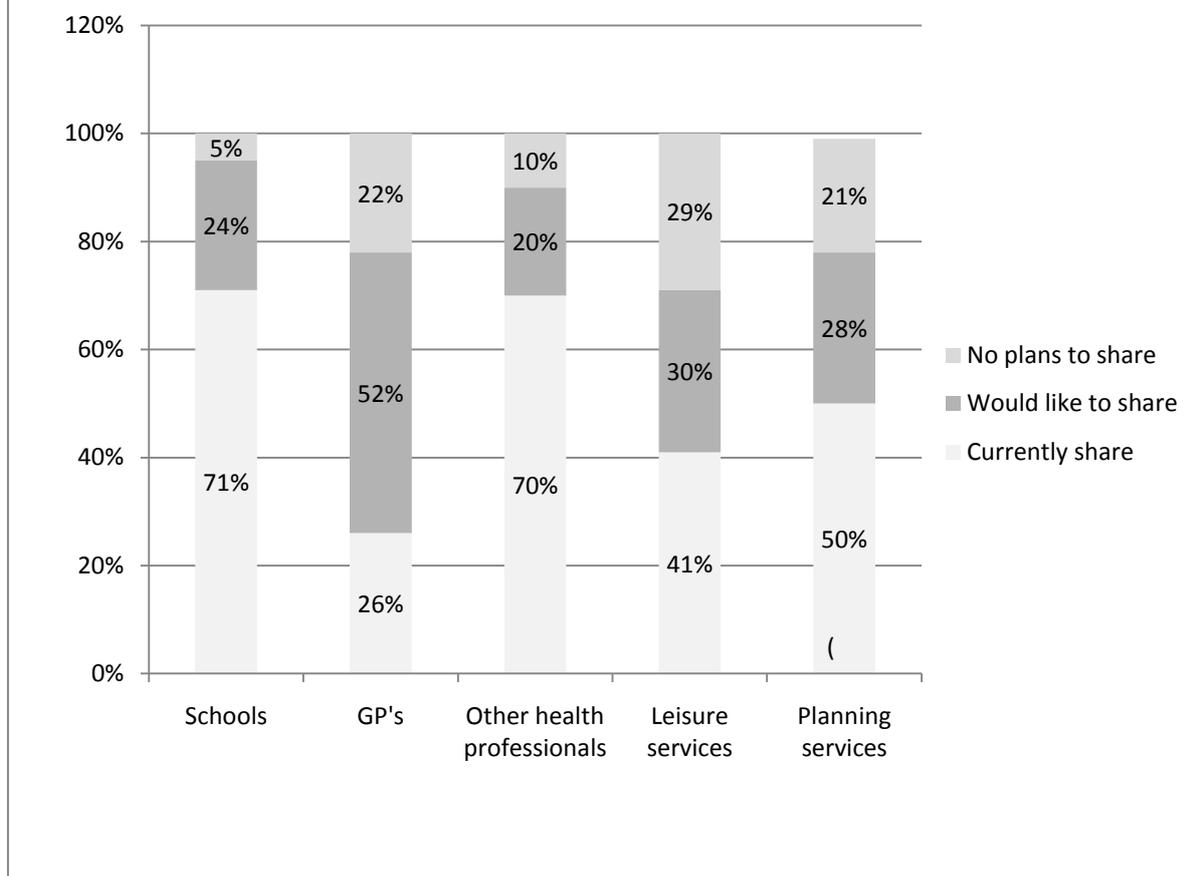
Concern was raised by some interviewees over what would happen to the role Public Health Observatories have played in terms of data analysis in the event of them being discontinued. One regional lead was of the view that there should be a national lead that took over this responsibility.

7.2 Sharing the NCMP data

The survey asked how and with whom NCMP data was shared. Aggregated information (a collated summary, rather than individual information) from local data analysis was most commonly shared with schools and health professionals, followed by planning services and leisure services. Less than a quarter shared aggregated information with GPs, although many would have liked to do so (Figure 7.1). A wide range of other recipients of such summary information were mentioned by survey respondents, both within health services (e.g. dieticians, healthy weight teams) and within the council, including multiagency groups (Children's Trusts, Health and Wellbeing Boards, Community Area Boards); Children and Young People's Services, Children's Centres and Schools Sports Partnerships. Analysis of NCMP data was frequently used in Joint Strategic Needs Assessments.

A qualitative study of how the NCMP data was being shared and used (Ipsos Mori Social Research Institute, 2010c) focused on five PCTs that were proactive in sharing the information with local partners such as the Children's Trust Partnership. A wide range of local organisations were provided with aggregated NCMP data, including school catering teams, weight management service providers, GP consortia, health visitors, children's centres, regeneration partnerships, the local police authority and school nursing cluster leads.

Figure 7.1: Who do you share aggregated data with to inform service planning?



Compared with aggregated data, information to enable follow up of individual children was shared far less frequently (Figure 7.2). Whilst around a quarter of survey respondents said that such information was shared with other health professionals, very few currently shared individual level data with other services such as schools, GPs or leisure services, and comments indicated a belief that this was not allowed.

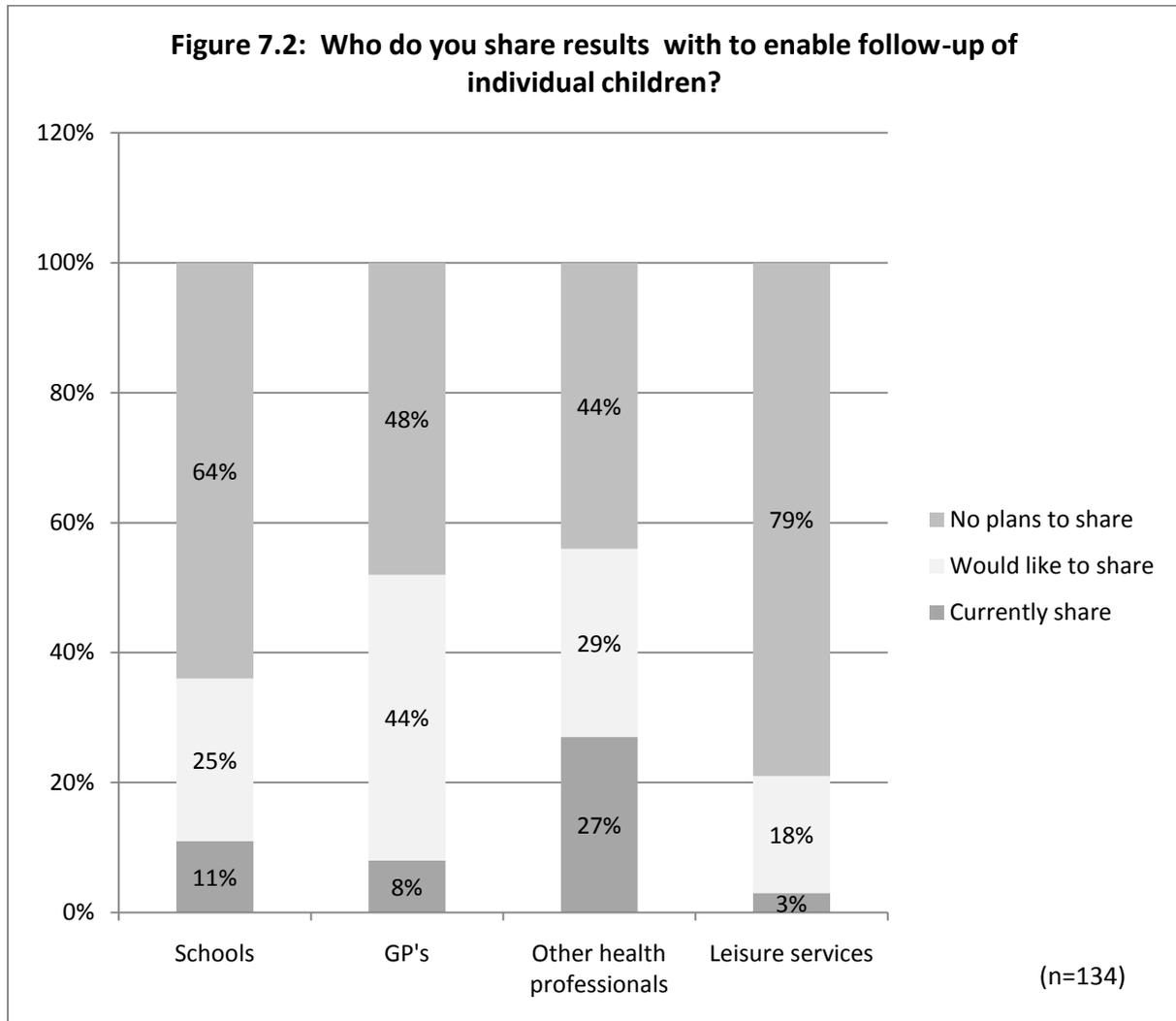
We have taken the perspective that sharing details of individual pupils outside the project team contravenes the confidential nature of the NCMP. If this is incorrect and greater sharing is encouraged, the national team need to issue clear guidance.

Others thought that such sharing would be possible if the correct protocols were in place:

[We] want to share with leisure services, schools and other professionals but don't have the data sharing protocols in place to enable this at the moment

One respondent noted that individual information was shared with the consultant paediatrician and GPs 'in extreme cases'; another that GPs were told they could contact the School Nursing Service to obtain a particular child's results if necessary. There was some support for being able to share data about individual children with GPs (only 8% of those responding to this question did so, but 44% would like to)

and to a lesser extent with schools (11% currently sharing, 25% would like to). However, concerns were also expressed about the impact that sharing at this level might have on the NCMP: 'it could jeopardise the programme if used insensitively'.



7.3 Sharing school level data with schools

The Ipsos Mori research in five PCTs reported that individual school level data were shared with a small number of partners who had data sharing and confidentiality agreements in place, predominantly within the PCT (Ipsos Mori Social Research Institute, 2010c). Providing feedback to schools was an area where the five PCTs differed: some provided no feedback at all while others provided data at PCT level or school cluster level. All reported some frustration at not being able to provide individual school-level feedback within the current guidelines, and would welcome help from the DH on how best to explain this to schools.

Issues about sharing school-level data with individual schools were also raised by survey respondents, with some commenting that schools often requested figures rather than just being told their school's position in relation to the local or England average, but that these requests had to be turned down. There was no clear consensus about the desirability of providing school level data, with those who

supported this claiming it was necessary to keep schools engaged with the programme and to facilitate the provision of support, whilst others pointed out difficulties such as the data being misinterpreted or misunderstood, the risk of identifying individual children in small schools, and the danger of creating yet more 'league tables' of schools.

According to regional leads confidentiality issues appear to prevent the majority of PCTs sharing the results with schools at the school level, unless the size of the school roll precluded the identification of individual children. In some PCTs, results at ward or area level are shared with schools. For example, in one PCT the results were presented to schools at a locality level which was based on the authority's Sure Start catchment areas. However, there seems to be a lack of clarity on what the DH expects in this area and guidance would be welcome. If the expectation is that data should be shared at school level then it was said to be important to address the fear that some schools have around the identification of individual children.

7.4 Accessing pupil data

Getting pupil data could also be difficult, though in many areas there were agreements between Health and the LA that information from the education service who maintain the pupil database could be shared with Health. Several survey respondents commented that schools were not always cooperative in providing pupil information: 'Most schools helpful, some refuse to share info re child's address, ethnicity, etc.' One PCT/LA lead recounted the difficulties they had in getting pupil data from schools since schools varied as to how, what and where they will share such data. In this area the MS Excel form for the NCMP is sent to each school to populate with each pupil's name, address and postcode, and because the form comes from the Department of Health it is seen as legitimate to provide the information requested, and schools agree to do it. However, telephone numbers, which are needed for proactive follow-up are not a data sharing requirement currently on the system and schools refuse to share this information, which means that in trying to find the family's telephone number additional and unnecessary resources are needed. Adding another column to the MS Excel form for schools to add telephone numbers would appear to be a simple resolution to this problem. However, it is a small change such as this that according to the NHS IC can cause problems in the system, because different fields are linked together and 'if you change one thing it knocks out the rest'. The example given was adding a column for the NHS number, which then 'threw out all the other columns' (NHS IC focus group). Collecting the telephone numbers in the PCT concerned has also required a new information governance process.

7.5 Challenges in sharing NCMP data

Survey respondents were divided in their views on the challenges of data sharing, with half of the survey respondents reporting that they had experienced difficulties but half that they had not. The most common reason given for difficulties both in the survey and in the local area interviews were governance and data protection issues:

Providers do not want to share data with postcodes as they see it as a potential breach of confidentiality. How can public health map areas of concern or links with deprivation such as poor housing, transport or cultural communities without this?

Data sharing has become more difficult since our PCT provider side became a separate body

One area, which had gone some way to integrating children's health and wellbeing across the PCT and LA, with jointly funded senior management posts based within the LA and some pooled or aligned budgets, found that data sharing difficulties were primarily due to the governance across different organisations. The commissioner of health improvement services in this area was endeavouring to develop a governance agreement across all the organisations to resolve the difficulties. She felt that the NCMP guidance made the assumption that everyone was within the PCT which was not the case. For example, this area wanted to implement proactive follow-up with children who were obese, but the school nursing team who collect the data are an NHS provider and are prevented from passing on contact details to the healthy weight service that had the capacity to engage in the follow-up, but were within the local authority.

Some survey respondents had concerns about insufficient resources to support local data analysis and interpretation for partners. The interviewees in the Ipsos Mori study also highlighted the time and effort involved in sharing data, and the need for resources to be allocated both to analysing the data and to acting on it (Ipsos Mori Social Research Institute, 2010c). Concerns about accuracy and quality of the data due to schools opting out for example were also mentioned by a small number of survey respondents.

The issue of data sharing was also raised by the focus group at the NHS IC, particularly the governance for the programme that restricts data sharing and how the data can be used for wider analysis. It was thought that clauses in the NCMP regulations that specify data can only be shared in a format that does not allow a child to be identified were unintentionally restrictive, and had to be interpreted strictly even when there was little likelihood of such identification happening. As a consequence people wanting to use the NCMP data could usually only have access to the archived dataset, which excludes information such as the school identifier. This meant that the DfE for example were unable to use the data to assess the impact of free school meals.

7.6 What would help?

Clarity and guidance

There was a strong call from most interviewees – national, regional and local – for guidance about information sharing and how best to do it. Issues that needed resolving included ownership of the data and governance, and a regional lead suggested the need for guidance on how NCMP data can be interpreted to facilitate the commissioning of services. There was strong support for guidance among survey respondents too. When asked what could be done nationally to improve data sharing locally, guidance on data protection and data sharing (78%) and a template for producing summaries for different stakeholder groups (74%) were thought to be useful. Survey respondents wanted clarity on the level at which data could be disaggregated, for example to school cluster or GP cluster level. Overall, the main plea was for clarity: 'It is possible to share anything with permission, so it is a matter of clarifying what and how that is achieved and where it is appropriate to share without it.'

Changes to the opt out letter

A few survey respondents suggested that the wording on the opt-out letter could be changed to obtain parental consent for sharing the results. This was also suggested by the NHS Information Centre. One PCT/LA had made changes to their letters in the process of getting a data sharing agreement to enable the school health team, who undertook the weighing and measuring, to make a direct referral to the childhood obesity team who were running the weight management programmes and undertaking proactive follow-up. The commissioner took it up with clinical governance and data intelligence and was able to resolve the situation within a week 'because I knew what to do, knew the language to use

and what clinical governance would be asking or looking for, but I could also stress that by not sharing the information we were putting children at a disadvantage. ...It hasn't been an easy process to make sure all the paperwork is there' (Public Health Manager). The opt-out letter in this area now includes information about details being passed on, if relevant, to an appropriate provider so that parents are aware that this is part of the process and the feedback letter explains that their details have been passed on to the weight management programme and that someone from the team will be in touch.

Data sharing groups

The success of data sharing groups or steering groups, which included representatives from both the PCT and local authority, was mentioned by a number of PCTs participating in the Ipsos Mori study (Ipsos Mori Social Research Institute, 2010c). Some suggested that it would speed up the often lengthy process of getting data sharing agreements in place if the DH and other bodies promoting joint working on issues such as obesity, recommended or required that these be developed.

Quicker availability of cleaned data

The need for the 'cleaned' uploaded data to be made available more quickly by the NHS Information Centre, so that it could be shared with local partners in a more timely way was made by regional leads and survey respondents: Comments by survey respondents when asked what could be done at national level to improve data sharing locally included the following:

Prompt analysis and release of previous years weighing and measuring results, currently far too long – results lose impact and momentum, by the time results released no time to plan activities and services before children finish school year.

Delay in ratification of data and our ability to feed back to schools, PCT and local authorities in a timely manner for planning is a problem. For example, information on children measured in October 2010 will not be available until December 2011.

8. NCMP: the future

In the survey, respondents were asked about the impact of a number of factors on the delivery of the NCMP over the coming twelve months. The two main areas of concern for the future of the NCMP were lack of staff capacity and lack of funding, cited as 'major concerns' by around half of all survey respondents and as 'little or no concern' by only nine percent. That lack of funding in some areas could risk the future of the NCMP as illustrated by the following comment:

We will be suspending the programme in 2011/12 because of lack of funding. This will result in key staff moving on to other employment and loss of momentum and experience for whenever the programme is reinstated locally.

Factors more likely to cause 'some' rather than 'major' concern included local efficiency savings, a perceived lower priority of the NCMP both nationally and locally, and the ending of Local Area Agreements. However, over a third of respondents had few or no concerns about lower priority being given to the NCMP in their area in future.

The transfer of public health to local authorities was a major concern for over just over a third of respondents (36%) and of some concern to just over two in five (45%).

Public Health (PH) are essential to the leadership and interpretation of the data - our present strong links with providers mean they are well placed to undertake the measurements but PH is essential to ensuring appropriate interpretation. Much of the screening will sit with the NHS Commissioning Board - NCMP is best placed in the new PH teams in local authorities only if the appropriately qualified staff exist there.

The perceived impact of the new transition arrangements and what could be done to facilitate a smoother transition were explored in greater depth in the interviews. This data together with the views of survey respondents responding to the open-ended question about what might be needed to support delivery of the NCMP in the future are reported in the following sections.

8.1 Embedding and promoting the NCMP within a wider framework

The negative media coverage that the NCMP on occasion has received and the public's lack of awareness of the programme's purpose led some regional leads to call for more national publicity about the NCMP and a better integration of the NCMP with other programmes, such as the Change4Life Programme, the Healthy Child Programme and the programme of developmental checks in the early years. Such moves it was said would help parents to see that NCMP was not a stand-alone programme, but part of a bigger agenda around health and well-being: 'NCMP needs to become as routine as immunisation' (regional lead).

Within this context, it was said to be important for the NCMP to be part of an obesity pathway that included referral on to services. A pathway was seen as essential not only in terms of commissioning, delivery and services, but to enable evaluation of intervention services. Asked if guidance in this area would be useful, the general view was that there was guidance already on developing pathways (e.g. NICE, DH) and what was required was to ensure that the NCMP was aligned with this guidance. The public health manager in one area where the local authority and NHS were to some extent integrated, explained how their childhood obesity pathway had been developed with all interested parties through their Children and Young People Healthy Weight Group which included school health, healthy schools,

extended schools and the obesity programme. Thus, the NCMP was no longer seen as a stand-alone identification programme, but one part of a pathway - different professional groups and services could see where they fit into the pathway and how the NCMP was relevant to them.

8.2 Ensuring continuation of the programme

The achievements and benefits of the NCMP (see section 2) including the value of the data and the investment made to date in the NCMP, were given by interviewees as strong reasons why the programme should continue. However, it was thought that government support for the programme may not be sufficient to guarantee the NCMP survives as a national programme without ring-fenced funding or mechanisms to ensure continuation. They pointed out that the NCMP is time-consuming and expensive to deliver, and even though local authorities may want to continue with the programme they may struggle to do so given the pressure on resources.

Funding was a recurring theme in survey respondents' comments. More funding and/or ring-fenced budgets to support the programme and its different elements were frequently mentioned:

Additional funding would ensure already stretched resources are able to effectively implement the programme

Adequate resources to deliver the height and weight measurement

Sufficient funding to provide weight management programmes for families informed that children are at risk of obesity following identification by NCMP

Drivers suggested by interviewees that might ensure continuation of the programme were:

- Retaining the NCMP data collection requirement for local authorities.
- Inclusion of childhood obesity in the Public Health Outcomes Framework.
- The Joint Strategic Needs Assessment (JSNA).
- Ring-fenced money for the programme or a strong directive to continue.
- Providing evidence of the data's value and of the programme's impact.
- Having a champion for the NCMP within each local authority.

Keeping childhood obesity in the Public Health Outcomes Framework would it was thought be a useful lever and more likely to lead to programme delivery: 'It will be much easier to secure support for the programme if they are there and there will less risk of it becoming fragmented' (Joint PCT/LA commissioner). However, dropping childhood obesity or the measurement of one year group from the framework would it was said risk losing the intelligence that had already been gained. Measuring two year groups provided both trend data and a longitudinal component, which would be available in year 2011/12 when comparisons can be made between YR and Y6. It was said by some that such comparisons may provide evidence of the longer term impact of the programme, although other interviewees pointed out that drawing such conclusions would be difficult since it is not possible to determine which children received earlier weight management interventions.

Survey respondents rarely mentioned the Public Health Outcomes Framework, but did highlight national targets and indicators which had helped with delivery of the programme to date (see 3.2) and were seen as important incentives: 'Continued vital signs/national indicators to support childhood obesity as a local priority' and 'Vital signs have made collecting this data a priority for the organisation'.

On the other hand some survey respondents thought such targets were unhelpful. One interviewee considered they were unnecessary since the need for NCMP data to inform Joint Strategic Needs Assessments (JSNAs), which the new Health and Wellbeing Boards will take responsibility for, was an incentive that would ensure the continuation of the programme. It was therefore important that the NCMP was viewed as a joint intelligence endeavour and an integral component of the JSNA rather than a stand-alone exercise.

Some survey respondents and the NHS IC focus group were of the view that participation rates may not be the most appropriate performance management indicator. A survey respondent for example thought it would be helpful to have 'relaxation of high level local coverage targets applied to what is a voluntary activity on the part of parents / children'. Another respondent explained how the participation rate performance indicators were unhelpful in their area because of their approach to consent which involved opting in rather than opting out, which in their view was engaging parents in the healthy weight programme. The NHS IC focus group thought that drivers to increase participation may be better focused on improvements to the consent forms and the feedback letter rather than on setting high participation rate targets, which could risk compromising the data if local areas felt the need to manipulate the figures in order to meet them.

Some interviewees thought that without a ring-fenced budget for the NCMP it was difficult to be certain if local authorities would prioritise continuation of the programme unless directed that they must do so. They spoke of the risk that the programme will become destabilised if some local authorities discontinue the programme and the data of those who continue becoming less relevant if it is no longer a national dataset. It will be important therefore to convince local authorities of the value of the data in reviewing and planning service provision and the investment that has been made in the programme. It will also be important to gather evidence that the NCMP is having an impact.

8.3 Maintaining business continuity

Survey respondents' comments highlighted how staffing changes created a challenge for the NCMP: 'change in lead individuals [results in] less continuity of programme year on year'. By the same token, staffing consistency had contributed to successful delivery of the programme: 'consistency of local staff involvement over the whole period, which has enabled the development of a well-established process'. Although there was uncertainty about how the programme would develop when it moved into local authorities, interviewees talked of the major programme of change that had started in the NHS and Public Health. Business continuity for data collection and data flows at local level along with loss of staff with experience and expertise in the NCMP were cited as major challenges. The fear that those delivering and supporting the NCMP, who have become a critical mass over the years, might be lost led one interviewee to suggest that a commitment should be made to protecting jobs in the interim: 'even if replacements are appointed there will be a loss of continuity and learning'.

8.4 Raising the NCMP profile in LAs

Several interviewees said there was an urgent need to raise the profile of the NCMP within local authorities. Local Authority Chief Executives needed help to gain a good understanding of the NCMP and where it fitted into the bigger picture as had been done with PCT Chief Executives in the past: '*it needs to be given a high profile*' (regional lead). Suggestions were made as to how the DH could help with this:

- Communicating with local authorities to address the perception that the NCMP is just an NHS function – ‘the programme is much broader than this and the links to other related work and programmes such as Healthy Start need to be made’.
- Establish what local authorities are doing to maintain, sustain and develop the programme in the future. Authorities need to start taking leadership of the programme early in the transition process such as moving staff over and setting up systems, which some authorities have already done with jointly funded posts based within the local authority, and which will assist with a smoother transition.
- The DH regional workshops should include the local authority – ‘each PCT lead could be asked to bring along a local authority ‘friend’ (regional lead).
- Future guidance for the programme should be aimed at local authorities too and a dialogue between the DH and local authorities will be needed to establish what will be required.

8.5 Information sharing and IT

It was thought that one of the biggest challenges to overcome will be resolving governance issues with respect to data sharing, and as discussed above (see 7.4) there is an urgent need for guidance on governance particularly in relation to transition. It was by no means certain that moving into the local authority would facilitate data sharing as some would hope. A PCT/LA lead in an area where there were already good links between the PCT and LA, was of the view that transition was unlikely to improve data sharing: ‘commissioning will be within the local authority, but service delivery will be an NHS service provider and their governance procedures will be different’. Some survey respondents made similar points: ‘Separation of providers from PCT to other trusts who may be even worse at sharing data or have differing priorities’.

A local authority lead for information and performance with responsibility for all data systems, including data protection and information sharing in children’s services, explained the difficulties that had arisen when it was brought to her attention that children’s addresses taken from the multi-agency database integrating social care and education data (but not health) were being used for the routine feedback letters. This created the potential for letters about a child’s measurements to go to an address where the child may no longer be living, for example to an estranged father. A complex piece of work had to take place to ensure that address management in this multi-agency context could be dealt with securely. This included informing the police not to change the child’s address if there was a notification of domestic violence, and a pre-mail merge report to check if there had been any social care involvement. Not only had this resulted in an operational review to ascertain the merits of routine feedback -‘the screening is seen as being of value’ – but also uncertainty about who is accountable for health data:

I know I am [accountable] for social care and education data but in health, [there is] still someone else in post. Other authorities must have this too. Health data has more stringent governance than education – we don’t have that. I am nervous if something goes wrong, who is accountable.

The NHS IC group had raised the need for a review of IT systems with the transition of public health to local authorities (see 6.1) and other interviewees also raised the need for decisions to be made locally as to which system data will be held on - whether the Child Health System or a Local Authority system. As one regional lead pointed out: ‘transition should see public health and the local authority as ‘one family’, but IT systems as they currently stand are unable to understand that’. Data sharing issues are also raised if transferring data from an NHS system to a non NHS system.

8.6 What has helped where Health and LA are to some extent integrated

Leads in four local areas where some transition of public health into the local authority had occurred were asked specifically about what had helped in the process. The following factors were mentioned:

- Establishing partnerships and recognising skills of partner agencies.
- Being clear about aims, delivery and operating plan.
- Joint posts able to authorise expenditure across PCT and LA budgets.
- Joint posts based in local authorities have encouraged greater ownership of the programme across all stakeholder groups.
- Commissioning undertaken jointly by LA and PCT.
- Good leadership.

It was also clear from comments made by survey respondents about delivery of the NCMP that good partnerships between health and education and/or between provider and commissioner could encourage or hamper successful delivery of the programme:

As the commissioner we have a very good relationship with our provider, regular meetings and clear understanding of who has what role which certainly helps with the delivery'

'Still lack of 'shared responsibility' between health and education. Education perceives the NCMP as a health/external initiative being 'done to' the school.'

The importance of developing partnerships across the local authority and PCT was emphasised in three of the four local area interviews. In one, the Healthy Weight Board and CYP healthy weight group had brought together councillors and other council services such as family learning, park rangers, extended school team, school representatives as well as health professionals to encourage ownership and engagement with the programme. Now was thought to be a good time to start building such relationships, but in doing so it was important to consider the ways in which the programme can benefit these different groups.

Some thought that the shift of public health responsibilities to local authorities could facilitate delivery of the NCMP. It could be said that the school-based model for weighing and measuring means that the programme is already part of the local authority system, and the transition could make it easier to obtain the contact information on children which most local authorities currently supply to PCTs, and improve the engagement of schools. One joint PCT/LA lead based within a local authority said it was easier to get cooperation from groups such as the head teachers' forum in her area because 'you can say to them your director supports this so can we come along and talk to your group'. However, the key factor of success according to one regional lead was thought to be who had lead responsibility for the NCMP: 'if they are a PCT person, how well they are integrated within the LA, or if an LA person how well they understand the NCMP'. Success was also thought to depend on the relationships the authority has with professional groups such as GPs, school nurses and health visitors who played a role in the success of the NCMP.

9. Conclusions

This review has drawn on different data sources to consider how well the NCMP is working, the challenges it faces and how it can be improved, particularly in light of the new public health arrangements within which the programme will in the future be operating. This section provides an overview of the findings and discusses what might be done to facilitate programme delivery in the new arrangements.

The NCMP, which was launched in 2005, is viewed overall as having played an important role in raising the profile of childhood obesity locally and providing a robust and valued dataset, which has informed the planning of services in many areas and supported partnership working. There is generally strong support for the programme's principle aim of monitoring childhood obesity levels. Local areas have worked hard to overcome initial problems with measuring and to achieve good coverage, which often reflects the goodwill and commitment of the staff involved. However, funding and capacity have in many areas been a challenge and continue to be so. As a result, local areas differ in terms of whether they are providing routine feedback to parents of their child's results (recommended in the NCMP 2008/9 guidance) and to provide proactive follow-up (recommended in the 2009/10 guidance). Whereas some areas have been providing routine feedback and proactive feedback since it was recommended, sometimes even earlier, other areas are only just beginning to adopt these elements of the programme and some are unable to see any prospect of doing so due to the pressure on resources. Indeed there is evidence in some cases that what had previously been offered is being withdrawn: in one area the programme was being suspended for the coming year due to resourcing difficulties.

With the introduction of routine feedback, the NCMP adopted some elements of a screening programme. The evidence from this review reveal divided views about this change to the programme. On the one hand, routine feedback and follow-up are seen as key parts of the programme, whilst on the other the NCMP is acknowledged as working well as a surveillance tool, but not for screening. For many the 'jury was still out', and with limited resources they remained to be convinced that routine feedback in this way was appropriate and cost effective. Others were of the opinion that it was unethical not to tell parents of their child's measurements, though they sometimes questioned whether the feedback letter was the best way to do it, and thought that routine feedback provided the opportunity to engage with parents about healthy lifestyles. In areas that had put a lot of thought and resources into follow-up work, the programme offered a very useful framework within which to develop interventions to address childhood obesity.

Central guidance and support for the programme were generally valued and seen as critical in maintaining standards and consistency. Although there is a need for flexibility to accommodate local conditions, a national programme needs national guidance and standards and continuing support for local areas. There is already local diversity in terms of what is offered to families following measurement, but if it is left for local areas to decide without any guidance or standards, the value of the programme particularly as a surveillance tool comes into question. The robustness of the NCMP dataset rests on accurate measurements and good coverage.

It is difficult to know how the transition of public health to local authorities will affect the NCMP, but in the current financial climate with many areas struggling to resource the NCMP, it is likely that the future will be challenging. Many who participated in the review raised concerns about the future development of the programme. Now is an opportune time for the DH to address a number of issues that this review has identified.

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Appendix 1 NCMP Rapid Review: online survey

The White Paper 'Healthy Lives, Healthy People' (Nov 2010) states that the National Child Measurement Programme will continue to provide local areas with information about levels of overweight and obesity in children in order to inform planning and commissioning of local services. The government is exploring how the programme can run effectively in the new public health system.

This survey is part of a rapid review being carried out by the Thomas Coram Research Unit for the Department of Health, to inform the next steps for NCMP.

We want to hear your views on different aspects of the programme: local delivery arrangements, feedback to parents, proactive follow up, data analysis and sharing, IT and the upload tool, and what would help support delivery of NCMP in the future.

The survey should take around 15 minutes to complete and does not require any special preparation. It can be completed anonymously and only the research team will see your responses.

PLEASE COMPLETE THE SURVEY BY MARCH 9th 2011

1. Your job title?

2. The organisation you work for? (tick only one)

- PCT
- Local authority
- NHS provider
- Non-NHS provider
- Other (please specify)

3. Please indicate the region in which you are based. (This allows us to gauge the range of survey responses collected across the country and will not be used to identify survey respondents).

- East of England
- East Midlands
- London
- North East
- North West
- South East
- South West
- West Midlands
- Yorkshire and Humberside

4. If you are willing to be contacted for further information, please give your email address. (We will only be able to follow up a very small number of those who agree to be approached, because of time constraints for the rapid review.)

5. Overall, how successful is NCMP delivery in your area? (tick only one)

- Very successful – few difficulties
- Somewhat successful - minor challenges

Less successful – major challenges

Any comment? (optional)

6. To what extent have the following created difficulties for delivery of NCMP in your area? (tick one for each category)

	Not at all	A little	A lot
Opt-out from parents			
Insufficient funding			
Insufficient staffing			
Problems with data entry/upload tool			
Lack of weight management services for referral			
Lack of guidance from the DH			
Lack of support locally			
Data sharing issues			
Negative media coverage			
Lack of support from schools			
Other (please specify)			

7. To what extent have the following national or regional factors helped with delivery of the programme in your area? (tick one response for each category)

	Not helped at all (1)	Some help (2)	Helped a lot (3)
Guidance from DH			
DH IT systems to support data upload			
DH systems to generate result letters			
Regional workshops and training			
Child obesity Vital Sign indicator			
Other (please specify)			

8. To what extent have the following local factors helped with delivery of the programme in your area? (tick one for each category)

	Not helped at all (1)	Some help (2)	Helped a lot (3)
Well resourced / good staffing levels			
Schools engaged/supportive			
Local processes for data entry/producing letters			
Availability of child weight management services			

Commitment/support from key local agencies

Formal agreements for sharing data

Child obesity indicator in the Local Area Agreement or
NHS Operating Framework

NCMP data itself as evidence of need to act on child
obesity

Other (please specify)

9. Have any factors helped to engage your local schools in the programme? (tick all that apply)

School visits to explain NCMP to head teachers or other staff

School visits to explain NCMP to pupils

Engaging school governors

Engaging Directors of Children's Services

Involving Healthy Schools coordinators

Sharing NCMP results with schools

Use of the DH pupil information poster/flyer

No particular action needed – schools already interested

Other (please specify)

10. In your view, which of the following should be essential elements of the programme, which are useful, and which are not needed? (tick one response for each category)

	Essential	Useful	Not needed
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Sending an opt out letter to parents

Weighing and measuring for surveillance purposes

Feedback of results to all parents

Feedback of results only if not a healthy weight

Follow up (phone call/visit) of very overweight children

Phone call/visit - overweight children

Phone call/visit - underweight children

Providing weight management interventions

Sharing data with schools

Local data analysis / annual report

Using NCMP data to inform priorities and service delivery

Other (please specify)

11. Who carries out the weighing and measuring in your area? (tick all that apply)

School nurses

Nursery nurses

Admin support staff

Healthcare assistants

Other (please specify)

12. Is an opt-out letter sent to parents in your area?

Yes
No

13. How are the providers of the weighing and measuring commissioned? (tick only one)

Service level agreement with additional funding
Part of existing service level agreement (no extra funding)
Expected as part of existing role
Other (please specify)

14. Do you evaluate programme delivery in your area?

Yes
No

15. Do you provide feedback to all parents?

Yes
No

16. Do you use the DH template feedback letter?

Yes, without making changes
Yes, with changes
No

Any comment? (optional)

17. How do you send out the routine feedback? (tick only one)

Pupil post on the day of measurement
Pupil post after measurement
PCT mailing
Other (please specify)

18. What information do you enclose with each feedback letter? (tick all that apply)

	Underweight	Healthy weight	Overweight	Very overweight
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None

DH Change4Life leaflet

PCT designed leaflet with lifestyle tips

Information about local weight management services

Information about leisure facilities

Other (please specify)

19. Who takes the calls from parents in response to the feedback letter? (tick all that apply)

	Underweight	Healthy weight	Overweight	Very overweight
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School nurses

Nursery nurses

Other professional staff (e.g. nutritionist, NCMP coordinator)

Administrative staff

Other

If other, please specify:

20. Overall, how would you rate the experiences of staff handling the calls? (Tick only one)

Working well

Some difficulty

Major difficulties

Why do you think that is?

21. What training / resources have staff taking the calls been provided with? (tick all that apply)

No special training

Motivational interviewing training

Mentoring

Department of Health script/conversation guide

Locally developed script/conversation guide

Department of Health Q&A

Don't know

Other (please specify)

22. Have you seen any benefits arising from sharing results with parents? (tick all that apply)

None or few

Raises parents' awareness

Opportunity to engage with parents in relation to child's weight

Increased uptake of weight management programmes

Other (please specify)

23. Has there been any negative impact of sharing results with parents? (tick all that apply)

Angry calls from parents

Unwillingness of parents to take advice

Decrease in uptake of weight management programmes

Adverse media coverage

Increase in complaints about the NCMP

Negative impact on staff involved

Other (please specify)

24. Thinking overall about the experience of routine feedback in your area, do the benefits outweigh the negative impacts?

Yes
No
Don't know
Any comment? (optional)

25. Are you able to offer proactive feedback in your area (e.g. a phonecall or visit to the family)?

Yes
No [if no skip to Q31]

26. Which weight categories do you proactively follow-up? (tick all that apply)

Underweight
Overweight
Very overweight (obese)
Any comment? (optional)

27. What does your offer of proactive follow-up involve? (tick all that apply)

Results letter with automatic enrolment in a weight management service
Short phone call giving the result
Phone call plus advice
Phone call plus offer of brief intervention on behaviour change
Phone call plus automatic referral into a weight management service
Phone call plus meeting to provide advice/support and offer of referral to a service
Other (please specify)

28. Which staff group undertakes pro-active follow up in your area? (tick all that apply)

School nurses
Nursery nurses
Other professional staff (e.g. nutritionist, NCMP coordinator)
Administrative staff
Other (please specify)

29. Have there been any negative impacts from pro-active follow up in your area?

No
Don't know
Yes (please give details)

30. Thinking about the experience in your area, do the benefits outweigh the negative impacts of proactive follow-up?

No- negative impacts are greater than benefits
Yes – benefits are greater than negative impacts
Any comment? (optional)

31. If your area has not offered pro-active follow-up, why do you think that is? What has prevented pro-active follow-up in your area?

32. Do you share aggregated information from your local data analysis (a collated summary, not individual level data) with any of the following groups to inform service planning? (tick one response for each category)

	Currently share	Would like to share	No plans to share
Schools			
GPs			
Other health professionals			
Leisure services			
Planning services			
Other			

If other, please specify:

33. Do you share information from your local data analysis with any of the following groups to enable follow-up of individual children? (tick one response for each category)

	Currently share	Would like to share	No plans to share
Schools			
GPs			
Other health professionals			
Leisure services			
Other			

If other, please specify:

34. Do you have any difficulties with sharing data?

No
Yes

35. Are difficulties with data sharing due to any of the following? (tick all that apply)

Data governance/data protection issues with stakeholder agencies
 Incomplete data (e.g. because of school level opt-out)
 Lack of resources to support data sharing/interpretation for other partners
 Other (please specify)

36. What could be done at national level to improve data sharing locally? (tick all that apply)

Templates for producing summaries to different stakeholder groups
 Guidance on data protection and data sharing
 Other (please specify)

37. How important is each of the following aspects of IT support for delivery in your area? (tick one response for each category)

	Not important	Quite important	Very important
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	(1)	(2)	(3)
A national tool for producing results letters			
A national tool for uploading data to the central NCMP database			
User support for feedback/upload tools			
National written guidance on use of tools			
National training workshops on use of tools			
Local resources for IT support			
Software for entering data at time of measurement			
Compatibility with other local systems			
Other			

If other, please specify:

38. To what extent are you concerned about the impact of the following factors on the delivery of NCMP over the next 12 months? (tick all that apply)

	Little or no concern (1)	Some concern (2)	Major concerns (3)
Local efficiency savings			
Perceived lower priority of NCMP centrally			
Lower priority of NCMP locally			
Transfer of public health functions to the LA			
Conclusion of Local Area Agreements			
Lack of funding			
Lack of staff capacity			
Other (please specify)			

39. Finally, what is needed to support delivery of NCMP in the future?

40. Any other comments on the programme? (optional)

Appendix 2: NCMP research considered in the NCMP Rapid Review (list prepared by DH Obesity Team)

Title	Researchers	Date	Objectives	How the study was done
<p>What has been the impact of NCMP in your area? An informal process evaluation*</p> <p>*Analysed alongside stakeholder interviews and survey</p>	DH Obesity Team	December 2010	<ul style="list-style-type: none"> To gain feedback from staff involved in delivery of the NCMP at local level on the impact NCMP has had in their area since the programme began in 2005. 	<ul style="list-style-type: none"> Regional workshops were held in November and December 2010 with PCTs staff who deliver the NCMP. During one session of the workshop, staff were asked to respond to the following questions: <ul style="list-style-type: none"> What have been the benefits of the NCMP? What have been the challenges? What one thing do you think Government could do differently to improve the programme? Respondents wrote their feedback onto sheets of flip chart paper, which were then handed to and typed up by DH staff.
National Child Measurement Programme: proactive follow-up, Hull PCT	Ipsos MORI Social Research Institute London	November 2010	<ul style="list-style-type: none"> To better understand how PCTs are implementing proactive follow-up and to provide a best practice example and lessons learned to other PCTs planning to implement proactive follow-up. 	<ul style="list-style-type: none"> A discussion group was held with key individuals involved in commissioning and delivering NCMP proactive follow-up and associated weight management programmes in Hull.
National Child Measurement Programme: Assessing parents' ability to identify child obesity	Ipsos MORI Social Research Institute London	October 2010	<ul style="list-style-type: none"> To assess parents ability to identify child obesity through a national Omnibus survey 	<ul style="list-style-type: none"> Face-to-face survey conducted in-home among a nationally representative sample of 1186 parents who have children aged 15 or under. Parents shown images of children (with known BMI centiles) and asked whether they thought the child was underweight, of normal weight, overweight or very overweight.
<p>NCMP : its achievements and challenges*</p> <p>*Analysed alongside stakeholder interviews and survey</p>	Discussion with the DH Obesity Expert Advisory Group	July 2010	<ul style="list-style-type: none"> To seek views of the DH Obesity Expert group on the achievements and challenges of NCMP to date and its future direction 	<ul style="list-style-type: none"> A session tabled at DH Obesity Expert Advisory Group meeting. The following questions discussed: <ul style="list-style-type: none"> Do you feel that the current delivery model for NCMP is the most appropriate model? Do you feel that the current delivery model is Value for Money? If no then what do you think would be better? What do you feel have been the positive outcomes of NCMP? What do you feel have been the negative outcomes of NCMP?
A qualitative assessment of data sharing and usage in the National Child Measurement Programme	Ipsos MORI Social Research Institute London	May 2010	<ul style="list-style-type: none"> How data are shared with partners (eg, local authority and weight management service providers), what format the data are being shared in, and how data are being used to inform service delivery; barriers and enablers to data-sharing. Specifically, where data are not being shared – and where this is creating barriers to partnership working; and areas for improvement – what guidance and support PCTs 	<ul style="list-style-type: none"> Case studies of five PCTs, involving interviews with key staff delivering the NCMP to assess how NCMP data are used and shared in these PCTs. one-day action-planning workshop with NCMP delivery staff from a range of PCTs and local authorities.

			require from the DH Obesity Team.	
National Child Measurement Programme: Early experiences of routine feedback to parents of children's height and weight	Thomas Coram Research Unit Institute of Education University of London	January 2010	<ul style="list-style-type: none"> • explore impact on parents of receiving routine feedback about their child's height/weight, and their views on how information was presented to them; • learn from experiences of PCTs who had chosen to implement routine feedback procedures in 2008/09. 	<ul style="list-style-type: none"> • Postal survey of parents of children in Reception and Year 6 receiving feedback letter in four PCTs; • sample of surveyed parents followed-up with a telephone interview; • telephone interviews with 11 key staff involved in the NCMP across the four participating PCTs and with a key staff member in each of 11 schools selected from the four PCTs.
National Child Measurement Programme Qualitative Research Report of Findings Phase 1 & 2	Research Works Ltd, St Albans	October 2008	<ul style="list-style-type: none"> • The work was done in two phases to test two different iterations of the template results letter and find out parents' views in terms of: <ul style="list-style-type: none"> ○ understand how parents want information about their child's weight status presented ○ identify parents' concerns about information within the letters and leaflets ○ gauge understanding of content and meaning of information, where to go for further information and healthy living tips ○ determine if amount of information provided to parents is appropriate ○ discover what action parents would take from reading information ○ understand what expectations parents have after receiving the letters. • Phase 2 had the same objectives as above as well as to test preferences for describing weight: 'very overweight' or 'obese', exploring which term is most likely to trigger action 	<ul style="list-style-type: none"> • Four focus group discussions with parents of children in Reception or Year 6 from a range of socioeconomic groups and ethnic backgrounds were conducted for phase 1 and 2 of the research
National Child Measurement Programme: routine feedback research	Centre for Health and Social Evaluation (CHASE) University of Teesside School of Health and Social Care	May 200	<ul style="list-style-type: none"> • examine preferred content of feedback for parents and children • explore parent (and child) preferences for detail and style of information provided • assess what follow on information parents (and children) would like to assist them in interpreting result and/or finding information or resources that would support any resolution on their part to change things • find out if parents would like to monitor their child's weight and height in a more continuous way over time, and if so, how they would like to be able to do this • examine views of professionals working on obesity on most appropriate form of feedback of measurements. 	<p>Six phases:</p> <ul style="list-style-type: none"> • scoping and preparation (which involved email audit of current feedback practices in PCTs in England); • short literature review; three short case studies reviewing work in several PCTs that had already decided to implement feedback of results to all parents; • consultation with parents and children in four areas of England; • consultation with representatives of various professional organisations and stakeholder groups.

Research into parental attitudes towards the routine measurement of children's height and weight	British Market Research Bureau Social Research	March 2007	<ul style="list-style-type: none"> • Explore the perspectives of parents and children towards weighing and measuring in relation to the 2005/06 programme; and • consider impact of providing feedback to parents on height and weight data regarding their children, as well as considering Body Mass Index (BMI) and other generic information. 	<ul style="list-style-type: none"> • A qualitative approach was used to allow individual experiences and views to be explored in detail. • The research consisted of three stages: <ul style="list-style-type: none"> ○ an overview of published literature on the subject of child height/weight measurement; ○ in-depth family interviews ○ mini-group discussions with parents.
Measuring childhood obesity: Understanding PCTs' experiences of implementing the DH guidance	Opinion Leader Research	December 2006	<ul style="list-style-type: none"> • To better understand PCTs' experiences of implementing the 2005/06 NCMP, including: • Views on the guidance issued by DH; • roles of key groups in the NCMP; • problems arising from the measurement exercise; • communications to parents and schools and feedback from these audiences that PCTs have received. 	<ul style="list-style-type: none"> • 74 telephone interviews, using a questionnaire, with staff from PCTs that had submitted height and weight data to DH during the 2005/06 school year.