The National Child Measurement Programme: Early experiences of routine feedback to parents of children’s height and weight

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Executive summary

Introduction

Against the background of increasing prevalence of overweight and obesity among children and young people, the National Child Measurement Programme (NCMP) was established in 2005 to collect data on height and weight of all children in Reception (4-5 year-olds) and Year 6 (10-11 year-olds) in primary schools in England. The data, collected by Primary Care Trusts (PCTs), are used by government to track population trends in the prevalence of underweight, healthy weight, overweight and obesity and to inform local planning and delivery of services.

To raise awareness about the importance of healthy weight and to help parents and their families engage with issues about healthy lifestyles and weight, PCTs have been encouraged to provide routine feedback to all parents on their child’s height and weight during 2008/9. In previous years, most PCTs did not routinely provide feedback although parents could request their child’s results.

This small-scale study was commissioned by the Department of Health, to inform development of the National Child Measurement Programme, and in particular to suggest any revisions that might be necessary to the 2009/10 programme for PCTs covering the provision of routine feedback to parents on their child’s height and weight.

Study aims and methods

The study had two principal aims:

i. to explore the impact on parents of receiving routine feedback about their child’s height/weight, and their views on how this information was presented to them; and

ii. to learn from the experiences of PCTs who had chosen to implement routine feedback procedures in 2008/09.

These aims were addressed through different methods. A postal survey was undertaken of parents of children in Reception and Year 6 receiving the feedback letter in four PCTs that had met the criteria for providing routine feedback within the specified timescale, and who agreed to take part in the study. A total of 616 parents responded to the survey, a response rate of 31 percent. From the survey sample, 49 parents were followed-up with a telephone interview. The interview sample included parents of children in the four weight categories – underweight, healthy weight, overweight and very overweight. Parents of children in both overweight categories were purposely oversampled. In addition, telephone interviews were conducted 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.

Before going on to summarise the study findings, it is important to acknowledge the limitations of the research. The findings are based on a small scale study in four PCTs, and as such cannot be taken to be representative of the national picture. The selection of PCTs and the timing of follow-up interviews with parents were determined by the need to provide findings in time to inform revisions to the NCMP guidance for PCTs, in summer 2009. Sampling was thus limited to PCTs who planned to send feedback to sufficient numbers of parents to enable survey sampling within the study timescale, and who had mailing systems that allowed them to include our survey with their feedback letter. In addition, whilst the survey response rate was higher than had been anticipated, it must be acknowledged that the study may have under-represented parents with limited English literacy because those who could not understand the feedback letter are unlikely to have understood and returned the evaluation questionnaire. Whilst bearing in mind these methodological caveats, data
gathered from different sources revealed consistent messages, suggesting that the study findings offer a useful basis for the development of guidance, as well as for future research.

Parents’ perspectives on routine feedback

Response to the letter
The overwhelming majority of parents responding to the survey agreed with the results and found the letter helpful, but parents of overweight children, particularly those just over the threshold, were less satisfied – they were more likely to disagree with the results and to find the letter unhelpful. Parents in the overweight categories who were interviewed often reported being shocked or surprised by the results: very few had had concerns about their child’s weight prior to receiving the feedback.

Clarity of the letter
Only a small proportion of parents surveyed were dissatisfied with the way the information was given to them in the letter, although again, parents of children who were overweight or very overweight were more likely to be dissatisfied. The clarity of the information in the letter was explored in greater depth in the interviews, and although there were few problems in understanding the information, those not responding to the survey may well have included disproportionate numbers who did find the information hard to understand either due to poor literacy or not being fluent in English. There was criticism by some parents both in the survey and among those interviewed at the tone of the letter and the ‘harsh’ language used, though some parents appeared to have been shocked by the language into acknowledging their child’s weight status.

Health promotion material
The majority of parents in the survey thought the health promotion material enclosed with the feedback letter, usually the Change4Life leaflet Top Tips for Top Kids, was useful. Among the small number of parents who did not find the material useful or did not read it, proportionally more were in the overweight categories. Although parents, both in the survey and among those interviewed, often reported that this information was not new to them, many said it served as a reminder or as reassurance that they were doing the right things in encouraging a healthy lifestyle.

Taking action, making a difference
Almost a third of the parents surveyed reported that they planned to take action as a result of the letter, particularly parents of children in the two overweight categories and the underweight category. They usually reported plans to make changes to the child or family’s diet or activity levels, though very few said they would contact someone for advice. Among parents interviewed, however, few had actually made any changes or planned to do so, and few had sought any professional advice.

Very few parents among the interviewed sample perceived any barriers to implementing changes, but most frequently mentioned were the child’s fussiness or attitude, followed by lack of time. Again, the number of parents who commented on what would help in bringing about change was very small, but suggestions included more affordable leisure activities, action on food labelling and convenience foods, and someone making contact after sending the feedback letter.

Asked in the interview if the results had made a difference overall to either themselves, their child or their family, parents were more likely to say that the results had had a positive effect on themselves personally, while making little difference to their child or family.
Views on the NCMP
There was almost unanimous agreement among interviewed parents that children should be weighed and measured, and the majority believed that parents should be told their child’s weight category.

PCT experiences and views

Practical Issues
Although a national programme, there was clear variation in the implementation of the measurement and feedback process, and this appeared to reflect the local situation in each area – for example, in terms of resources and staffing frameworks. There were differences in who undertook the measurement (from Band 2 to Band 6 staff), how the measurements were recorded in school (electronically or on paper), and how long it took to send out the feedback letters, though most managed to meet the recommended six week deadline. Inevitably, those PCTs feeding back for the first time experienced initial difficulties to do with administration and IT, though these were thought likely to diminish as procedures become more established. Accuracy of the measurements and of the child’s details, particularly their address, was said to be critical.

Concerns were raised about the template for the feedback letter provided by DH, which PCTs had largely followed, with some minor adaptations. Concerns centred upon the acceptability of the letter to those with English as an additional language, and the tone of the letter, which was seen as somewhat insensitive, and ‘harsh’. There were mixed views about the effectiveness of using shock tactics in the letter - that is of warning parents of the long-term risks of disease that are associated with overweight and obesity.

Calls from parents
There was variation across the four PCTs in who took responsibility for handling calls from parents on receiving the letter, and in the expertise and knowledge-base in this field of those who took calls from parents. Three PCTs had retained the direct instruction asking parents of very overweight children to contact the named person given in the letter. However, in all areas, the number of calls to each of the PCTs as a proportion of all letters sent was very small and concern was expressed about the poor follow-up response.

Parents who contacted the PCT varied in their reaction to the feedback letter. Some were calling for information and advice, whereas others were angry or upset and were calling to complain. Although the number of angry parents calling to complain was small, and often comprised parents of children who were just over the ‘overweight’ threshold, these calls could have a significant impact on the call handlers. Views were mixed about the usefulness of existing DH guidance on handling calls.

Intervention and support
All PCTs had services in place to which parents who contacted the PCT for information and advice could be referred, but the uptake was low. This challenge was said to highlight the difficulty of translating the information in the letter into behaviour change. Although PCT staff wanted the feedback letter to have a greater impact with more parents seeking help, the issue of capacity to deal with a significant increase in the demand for services was also raised.

The school perspective
Administrative staff often had most to do with the measuring process within schools, reflecting the fact that schools mostly saw themselves as facilitators of the measuring process. The weighing and measuring was viewed as ‘routine’ and appeared to cause minimum disruption.
Though the number of opt-outs from the programme was very small, there were fewer opt-outs for Reception than Year 6 children, a difference which was attributed to the consent for weighing and measuring Reception children being part of the consent for the wider health development check on entry to school.

Schools were not aware of when parents had received the feedback letter, or how the letter was worded, and only four parents from across the 11 schools were reported to have contacted the school after receiving their child’s results.

School staff appeared supportive of the programme, but seemed for a number of reasons to want to maintain a distance from it. One reason was to emphasise the confidentiality of the data, but there were also indications that staff felt that to work with individual children and their parents on weight issues might jeopardise parent-teacher relationships. It was clear that schools preferred to take a whole school approach through the Healthy Schools Programme, which focuses more broadly on four health topics including healthy eating and physical activity.

Conclusions and recommendations

An overwhelming majority of parents participating in the study welcomed their children being weighed and measured in schools and thought it appropriate that parents should receive feedback on their child’s weight status. Beyond that overall finding, however, the research highlights a number of issues and recommendations for consideration for the development of the NCMP, which are discussed here.

The feedback letter

Although there was no evidence from parents responding to the survey that the feedback letter was unclear, it is not possible to conclude that the clarity of the letter is not a problem. Those who did not respond to the survey may well have included parents who did not understand the letter. Further research is therefore needed to consider the accessibility of the feedback letter to parents with limited literacy and/or limited English.

The wording of the letter, particularly the tone and the use of scare tactics, was of concern to both parents and PCT representatives. Although references to health risks may be justified on the grounds that parents may lack awareness of the health consequences of obesity and can shock people into taking action, these potential benefits must be balanced against the risk that if a ‘shock tactic’ approach is not implemented correctly it could promote denial or avoidance which may prevent parents from taking action to reduce the risk. Most parents in our small sample had not taken action as a result of receiving the letter. Scare tactics in health promotion are most effective when the target audience believes that the threat is immediate and direct, and that the recommended responses are achievable and will make a difference in averting or reducing the threat. There is also the possibility that the use of threats or scare tactics in the context of childhood overweight could be associated with unintended consequences such as parents encouraging their children to diet.

The findings from the study would suggest that the Department should reconsider the wording of the letter and review the evidence base for the effectiveness of using an approach that employs scare tactics in changing behaviour in relation to childhood overweight and obesity.

Parents’ response to the letter

Parents of overweight children, especially those who were ‘borderline’ cases, were more likely to disagree with the results. This finding is in line with a body of research showing that parents tend not to recognise when their child is overweight, though there is some evidence to suggest that routine feedback of children’s weight may increase the accuracy of parental perceptions.
The fact that so few families sought help or advice was a matter for concern for many PCT representatives. Given evidence of the complexity and challenges of successful interventions for overweight and obesity, it is unlikely that the letter and enclosures alone could produce sufficient cognitive, lifestyle and behavioural change to address established overweight or obesity in children – whatever the good intentions expressed in interviews with parents. Rather, a more targeted approach may be necessary which might involve proactively following up families whose children are overweight or obese, after they had received the results. However, such a strategy would clearly have resource implications, not least in terms of staff time, and in the availability of services to which families can be referred.

Practical suggestions
One of the four PCTs had provided routine feedback to parents for some years, but the others which had not, had all experienced some early challenges in the feedback process. Staff in these PCTs consistently highlighted the need for adequate resourcing to support the workload involved in the process. A number of practical suggestions were highlighted by the study for consideration in the revised guidance, including schools providing the contact details for children rather than relying on the Child Health Database, and PCTs providing feedback to those opting out and to absentees on the importance of weighing and measuring.
1  Introduction

1.1  The National Child Measurement Programme

Over the last ten years or more, there has been growing concern that overweight and obesity are increasing in prevalence among children and young people in the UK, alongside mounting evidence of links with future health risks including cancer, heart disease and type 2 diabetes\(^1\,\(^2\). Against this background, the government established the National Child Measurement Programme (NCMP) in 2005, to collect annual data on the height and weight of all children in English primary schools in two class groups: Reception (aged 4-5 years) and Year 6 (aged 10-11 years). Primary Care Trusts (PCTs) are responsible for collecting the data and provide anonymised information for the National Child Measurement Database. The findings allow the government to track population trends in the prevalence of underweight, healthy weight, overweight and obesity, and to analyse variation by factors including deprivation, ethnicity, age and sex. In addition to analyses of national-level data, the findings are also used to inform local planning and delivery of services for children.

One core aim of the National Child Measurement Programme is to raise awareness of the importance of healthy weight in children. To this end, the government is now encouraging PCTs to provide individual feedback to parent/carers\(^3\) on their child’s height and weight. The intent is that the information provided should help parents and families to engage with issues about healthy lifestyles and weight. The need for such awareness-raising was highlighted in the recent strategy document, Healthy Weight, Healthy Lives: One Year On\(^4\), and the associated Change4Life campaign, which is based on four key insights (Cross-Government Obesity Unit, 2009, p 11):

- although parents realise that obesity is a growing problem, they do not recognise it as their problem;
- most parents tend to underestimate how much they and their children eat and overestimate the amount of physical activity they do;
- most parents do not make the connection between unhealthy weight status in their children and long-term health problems (such as type 2 diabetes, heart disease and cancer); and
- a host of ‘unhealthy’ behaviours in children, for example sedentary behaviour, snacking levels and excessive portion size, are not seen by parents as risky.

1.2  Parental awareness of overweight in children

Healthy Weight, Healthy Lives: One Year On cited research reporting that parents often do not see obesity as their or their family’s problem, nor are they always aware of the importance of healthy weight to their child’s health. Similarly, there is evidence from studies of community samples that the majority of parents may fail to recognise or acknowledge that

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\(^3\) For simplicity, parent/carers are referred to as ‘parents’ throughout the remainder of this report.
their children are overweight. For example, Carnell and colleagues (2005) found that, in a large community sample of three- to five-year olds in the UK, only 1.9% of parents of overweight children and 17.1% of parents of obese children described their child as overweight. This evidence implies a need to raise parental awareness of children’s overweight or obesity, as a key first step in helping parents to make informed, and healthier, choices in family life.

In 2007/2008, parents whose children took part in the National Child Measurement Programme could ask to receive feedback on their child’s height and weight, but subsequently the Health and Social Care Act (which received royal assent in July 2008) has allowed PCTs to provide routine feedback to all parents. This represented a change from the previous system, whereby parents had to ‘opt in’ to feedback about their child’s measurements. PCTs have been being strongly encouraged to provide such routine feedback to all parents from the 2008/09 measurement programme onwards, although this is not currently mandatory.

Overall, then, the aim of feedback to parents from the NCMP is to raise awareness of child overweight and obesity, and of the associated health risks to children, in order to support parents and families in making healthier choices. This aim posits a link between awareness of child overweight and behaviour change, and is borne out by recent UK research, which reported that feedback was associated with dietary restriction by parents of overweight primary school-aged children. However, other evidence, from a recent five-year longitudinal study in the US, suggests that the link between awareness and behaviour change may not be straightforward. Parents of overweight teenagers (average age 14 years at time 1) who were aware of their child’s weight status did not differ from those who did not recognise their child’s overweight in any variables of potential benefit to overweight children – such as availability of fruits and vegetables at home, fewer soft drinks at home, and parental encouragement to make healthy food choices or to be physically active. The only difference between the groups was in parental encouragement to diet, which was more common among parents who accurately perceived their child to be overweight, but which actually increased the risk for overweight at the five-year follow-up.

The findings of the above study are not directly comparable to the NCMP context, because it is a US study, and is focused on older children, whose behaviour may be less readily dependent on and amenable to familial change than younger children. Nevertheless, the study is consistent with a body of literature that highlights the complex challenges involved in achieving behaviour change in the prevention and treatment of overweight and obesity, with the latter most effective when involving combined dietary, physical activity, and behavioural

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components. Moreover, ‘what works’ is likely to be context dependent. Oude Luttikhuis and colleagues’ (2009) Cochrane review concluded that:

‘the practicalities of delivering effective advice on lifestyle changes to obese children and adolescents will vary with the wide span of social, ethnic and economic circumstances, as well as with the many variations in available resources for local health service delivery’.

One strategy that has been used across a range of health campaigns is the use of fear appeals or ‘scare tactics’. Research has shown that this approach can be effective, but only when the campaign depicts a relevant and significant threat and when it is is accompanied with recommended responses that the target audience believes they are able to accomplish, and believe that this will work in averting or minimising the threat. ‘Fear appears to be a great motivator as long as individuals believe they are able to protect themselves (p607).

1.3 Parents’ views of feedback on child measurements

Arguably, another reason for feeding back weight status to parents is the ethical principle that they have a right to know their child’s results. Certainly, in Grimmett and colleagues’ (2008) study, the majority of parents in their community sample said they wanted this feedback. However, these authors also reported that a minority of participants found the feedback distressing, and they highlighted the importance of managing the process sensitively, particularly for families with overweight children. In line with that research, the Department of Health has commissioned a series of studies to inform the development of routine feedback within the National Child Measurement Programme.

The first study comprised interviews with 36 families with a child who had taken part in the 2005/06 weighing and measuring exercise, and focus groups with parents from different minority ethnic groups (BRMB, 2007). Parents were recruited from six geographical areas. The study found limited awareness of the measurement programme, but reported that parental attitudes towards the exercise and to the possibility of receiving feedback about their child’s height and weight were generally positive.

Subsequently, Shucksmith and colleagues (2008) researched views on the format and content of three different types of feedback letter to parents, using focus groups of parents identified through primary schools in four geographical areas. Interviews were also undertaken with PCT staff involved in managing and delivering the programme in three PCTs which had already provided routine feedback to parents in 2007/08. This feedback took the form of simple height and weight details, without any interpretation of the results. On the basis of this research, in August 2008, revised guidance was issued for PCTs and regional obesity leads on undertaking the NCMP in the 2008/09 school year (DH and DCSF, 2008).

The guidance included a sample results letter, telling parents both the height and weight of their child and illustrating this on a sliding scale, together with a statement about whether the figures suggested the child was underweight, a healthy weight, overweight or very overweight, and the implications of this for the child’s future health.

Most recently, at the end of 2008, the research reported here was commissioned, as a small scale evaluation of parents’ views of routine feedback, conducted in four PCTs. An interim report, submitted at the beginning of May 2009, was used to inform workshops that the Cross-Government Obesity Unit held in May with NCMP local coordinators. This final report aims to inform the development of revised guidance for PCTs for routine feedback in 2009/2010.

1.4 Structure of the report

Following this introductory overview, Chapter Two sets out the aims and methods of the study, and the characteristics of parents responding to a questionnaire survey and telephone interviews. Chapter Three provides findings on parents’ views of the feedback letter and its impact on their family, from the survey and interviews with parents. Chapter Four reports on the views of key staff involved with the NCMP in the four Trusts where the research was carried out, and Chapter Five presents the findings from interviews with a key member of staff from each of a small sample of schools that had participated in the measurement programme in those areas. Chapter Six concludes the report by summing up the research as a whole, identifying commonalities and differences in parent and professional stakeholders’ views of feedback, and highlighting recommendations for the future development of NCMP feedback, and of DH guidance to PCTs.

2 The research study

2.1 Aims

The overarching aim of this study was to inform development of the National Child Measurement Programme, in particular to suggest any revisions that might be necessary to the 2009/10 guidance for PCTs covering the provision of routine feedback to parents on their child’s height and weight. The two main aims were:

i. to explore the impact on parents of receiving routine feedback about their child’s height/weight, and their views on how this information was presented to them; and

ii. to learn from the experiences of PCTs who had chosen to implement routine feedback procedures in 2008/09.

Specific research questions fell into three broad categories:

The purpose and outcomes of feedback
- How did parents/carers respond to receiving feedback from PCTs which provided an interpretation of their child’s weight, whether or not they had requested this information?
- What benefits did they perceive of receiving this information?
- Were there any perceived negative consequences or unintended consequences?
- Did parents intend to use the results? If so, how? What did they judge to be the barriers or facilitators to acting on feedback?

The presentation of feedback
- What were parents’ views on how the information was presented in the ‘results letter’ and any accompanying leaflets?
- What information did they find useful, what was not useful, what else would they like to have seen?
- Was the feedback more helpful to some groups of parents than others?

Impact on PCTs and schools
- What level of resource was required from the PCT/partners to deliver routine feedback?
- What worked well; what was problematic?
- Did the provision of NCMP feedback result in any additional burden on schools?

2.2 Methods

Data were collected from a number of sources. The first aim was addressed through a short questionnaire survey of parents receiving the feedback letter. As PCTs could not provide the research team with parent contact details without first getting parents’ consent, PCTs were asked to distribute the survey on our behalf, and to enclose it with the feedback letter to ensure that parents received the survey at the same time that they received the results. The survey was supplemented by telephone interviews with a sub-sample of parents to obtain more detailed information on their views and experiences. The second aim was addressed by telephone interviews with key staff responsible for the weighing and measuring programme in the participating PCTs and with head teachers or healthy school

17 The study received ethics approval from an Institute of Education Faculty Research Ethics Committee.
18 DH provided a template for the feedback letter for PCTs to use. The wording of the letter varied depending on which weight category the child was in (see appendix 1).
leads in a sample of primary schools in these authorities where parents had received routine feedback.

2.2.1 Selection of PCTs

Selection of PCTs for the study was determined by the survey design and the need to provide findings in time to inform revisions to the NCMP guidance for PCTs, in summer 2009. Based on experience with similar surveys of parents, we estimated an achieved response rate of around 20 percent. Given the distribution of children between weight categories in previous national measurement programmes\(^{19}\), this would require sampling approximately 1,000 parents in each of the two year groups to ensure a reasonable number of underweight and overweight children. We therefore aimed to survey parents of 250 Reception and 250 Year 6 children in each of four PCTs (2000 in total).

Although all PCTs were encouraged by the Department of Health to provide routine feedback to parents from the 2008/09 measurement programme, not all planned to do so. Due to the short timescale for this study, the Department facilitated identification of PCTs that could help with the research by contacting NCMP coordinators and providing the research team with information (where known) about PCT’s feedback plans and willingness to participate in this research. The initial aim was to select PCTs in different parts of the country, and with higher prevalence rates for overweight children, but in practice selection was limited by the small number of PCTs who planned to send feedback to the target number of parents within the timeframe required (mid-January to mid-March 2009).

Of the 21 PCTs identified by the Department of Health Team as being possible participants, 18 were contacted to find four – referred to as PCTs 1, 2, 3 and 4 in this report to preserve confidentiality - which came closest to our selection criteria, and were willing to take part. They were the only ones proposing to provide feedback to sufficient numbers of parents by March 2009, and who had mailing systems that allowed them to include our survey with their feedback letter. The four PCTs were located in the South West of England, London and the West Midlands: all were relatively small in size, and each was coterminous with one local authority.

2.2.2 Survey of parents

Two of the four PCTs were planning to provide routine feedback to parents of Year 6 children only and one to parents of Reception children only (see 4.5). The number of questionnaires supplied for distribution across the year groups therefore varied for the four PCTs (table 2.1).

<table>
<thead>
<tr>
<th>PCT</th>
<th>Reception</th>
<th>Year 6</th>
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<tbody>
<tr>
<td></td>
<td>Target</td>
<td>Achieved</td>
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<tr>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2</td>
<td>500</td>
<td>450</td>
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<td>3</td>
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<tr>
<td>4</td>
<td>500</td>
<td>480</td>
</tr>
<tr>
<td>Total</td>
<td>1,000</td>
<td>930</td>
</tr>
</tbody>
</table>

The questionnaire, with an accompanying information sheet (see appendix 2), was designed to be as short as possible, to facilitate a good response rate and also because it was being enclosed with both the feedback letter and additional health promotion material being sent to parents by the PCT. The questionnaire covered parents’ satisfaction with the results, planned action, usefulness of the health promotion material sent with the letter and basic

\(^{19}\) NHS Information Centre for Health and Social Care (2008) National Child Measurement Programme 2007/08 School Year Headline Results. The NHS Information Centre
demographic data (see appendix 3). It was piloted with ten parents and some minor changes made as a result.

Two approaches were taken to improve the response rate: (i) in each PCT, a prize draw for a £50 voucher was offered for those who returned a completed questionnaire and who wished to be entered; and (ii) a reminder was provided to PCTs to send approximately one week after the feedback letter containing the initial survey.

A total of 616 completed survey questionnaires were returned, achieving a slightly higher than anticipated response rate of 31 percent overall. Response rates varied from 16 to 42 percent between PCT areas, with a lower rate from PCT 2, and a higher rate in PCT 1.

Survey data were entered into an SPSS data base for statistical analysis.

| Table 2.2: Response rate and distribution of survey sample across PCTs |
|-------------------------|----------|--------|--------|---------|
|                        | Number    | Number | Percent | Percent |
|                        | Distributed | returned | returned | of sample |
| 1                      | 497       | 210    | 42.2    | 34.1    |
| 2                      | 500       | 78     | 15.6    | 12.7    |
| 3                      | 256       | 93     | 36.3    | 15.1    |
| 4                      | 730       | 235    | 32.2    | 38.1    |
| Total                  | 1983      | 616    | 31.1    | 100.0   |

2.2.3 Interviews with parents

Parents responding to the survey were asked to indicate if they were willing to be contacted for further information, and 53 percent agreed. On a number of key characteristics, there were few differences between those agreeing to further contact and those who did not, although parents of very overweight children and parents with a higher educational qualification were somewhat more likely to agree. We aimed to conduct a telephone interview with up to 64 parents, spread over the four PCTs and achieving a balance of boys and girls, Reception and Year 6 children, parents’ socioeconomic status and ethnicity. Parents who had been told their child was overweight were deliberately over-sampled.

A sampling frame with target numbers for each category was constructed to guide selection, and eligible parents (those who had agreed to further contact and provided a telephone number) were entered into each cell of the framework when their survey response was received, using demographic and other information from the completed questionnaire. A total of 49 interviews were achieved, with 45 mothers and four fathers. No parent approached refused to take part, but eight proved unreachable despite multiple attempts at making contact, and a further seven parents had insufficient understanding of English for an interview to be possible. These parents were not replaced with others from the ‘pool’ of eligible survey respondents, as this would have skewed the sample towards white middle class parents of healthy weight children. Consistent themes were also emerging from the completed interviews at that stage, and it appeared unlikely that additional interviews would substantially alter this picture.

The parent interview schedule was designed, piloted and finalised before interviews with the 49 parents were conducted. It followed a semi-structured format, with open-ended questions but some pre-coding of researcher-coded response categories, as well as space for

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20 Highest educational qualification of the responding parent was used as a proxy for socioeconomic status: those with A levels or above were categorised as higher SES and those with below this level as lower SES.

21 They probably had help from a family member to complete the questionnaire.
recording parents’ comments and other information (appendix 4). Parents were interviewed over the telephone at a time of their choosing, ensuring that they were able to speak freely about potentially sensitive issues involving their children. The interviews lasted between 20 minutes to an hour, and the majority took place between four and eight weeks after parents had received the feedback on their child’s weight from the PCT. Both qualitative and quantitative data from the parent interview schedules were added to the SPSS database containing information from the parent survey, so that questionnaire and interview responses could be linked.

2.2.4 Interviews with PCT staff

Interviews with PCT staff were conducted by telephone, and were open-ended, following a topic guide (appendix 5). Detailed notes were taken during the interview, and written up in a standardised format afterwards. PCT staff selected for interview were those who were most closely involved with the NCMP, particularly the process of providing routine feedback and reaction to it and were nominated by the manager or coordinator of the Programme. In total, 11 interviews were conducted across the four PCTs, as follows. In PCT 1, interviews were carried out with a senior clinical services manager, an administrator who was responsible for dealing in the first instance with calls from parents, and the obesity lead for school nurses. In PCT 2, we spoke to a senior manager in public health, the obesity lead, and the professional lead for community public health nurses. In PCT 3, we spoke to a systems manager and public health analyst, and to the service manager responsible for nutrition and obesity. In PCT 4, we interviewed the manager responsible for commissioning of healthy weight services, and to the administrator responsible for the child measurement programme. As this range indicates, interviewees included managers, practitioners, data analysts and administrators, providing a range of professional perspectives on NCMP feedback, and including in all PCTs the workers responsible for dealing with calls from parents in response to the letter.

2.2.5 Interviews with school staff

In addition to obtaining parent and PCT perspectives, a telephone interview (see appendix 6) was conducted with a member of staff in each of 11 primary schools across the four PCTs. All of this sample were schools where children had been weighed and measured, and parents had been sent feedback about their child’s weight and height. In most cases (7/11) we were directed to speak to a member of the administrative staff, such as an administration officer, office manager or school secretary. Two interviews were carried out with the healthy school lead (this was a SENCO coordinator in one school and a Year 6 teacher in the other) and the remaining two interviews were with the head teacher, although one head had to consult with administrative staff to obtain information before the interview could be undertaken. As with the other telephone interviews, notes were taken during the interview and written up immediately afterwards.

2.2.6 Data analysis

Survey data were entered into an SPSS data base for statistical analysis. Following data cleaning (e.g., checking outliers and inconsistent or contradictory responses), data analyses were primarily descriptive. For example, frequency analyses were used to describe the range and distribution of responses in the survey sample as a whole, and for groups of interest, such as overweight and very overweight children. Statistical analysis of parent

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22 Interviews with parents of children of healthy weight tended, on average, to take less time than interviews with parents of overweight or obese children.

23 The time elapsing between survey and interview depended partly on when parents returned the completed questionnaire with their contact details. A small number of parents were interviewed more than 8 weeks after receiving the feedback letter, in order to fill particular cells in the sampling framework.
Interview data was also primarily descriptive, and given the sample size and distribution, comparative statistical analyses of interview sub-groups were not undertaken.

Written notes of PCT and school interviews were analysed thematically using the constant comparative method, with reference to the study objectives and to themes emerging from the parent interview data. Individual members of the research team led on thematic analysis of PCT interviews, school interviews and the qualitative data from parent interviews, but all analysis was carried out with input from the research team as a whole – for example, to check, challenge, discuss and agree themes emerging from the analyses.

2.3 Characteristics of the survey sample

More parents of boys than girls completed the survey, although the difference was small, but parents of Year 6 children outnumbered Reception children two to one (tables 2.3 to 2.5).

Table 2.3: Children by Year Group

<table>
<thead>
<tr>
<th>Year Group</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reception</td>
<td>215</td>
<td>34.9</td>
</tr>
<tr>
<td>Year 6</td>
<td>401</td>
<td>65.1</td>
</tr>
<tr>
<td>Total</td>
<td>616</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 2.4: Children by gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boys</td>
<td>299</td>
<td>53.2</td>
</tr>
<tr>
<td>Girls</td>
<td>263</td>
<td>46.8</td>
</tr>
<tr>
<td>Total</td>
<td>562</td>
<td>100.0</td>
</tr>
</tbody>
</table>

54 missing

Table 2.5: Year group by gender

<table>
<thead>
<tr>
<th>Year Group</th>
<th>Boys</th>
<th>Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>Reception</td>
<td>99</td>
<td>33.1</td>
</tr>
<tr>
<td>Year 6</td>
<td>200</td>
<td>66.9</td>
</tr>
<tr>
<td>Total</td>
<td>299</td>
<td>100.0</td>
</tr>
</tbody>
</table>

54 missing

Very few children in the survey sample were underweight (1.3%), however, this proportion corresponds closely to the low numbers nationally (1.3% for Reception and 1.4% for Year 6\(^2\)). Around one in five children (16%) were overweight or very overweight (table 2.6), proportions that are lower than the national figures of almost one in four for Reception and nearly one in three in Year 6. These results suggest, as might be expected, that the response rate was lower for parents whose children were overweight than for those whose child was a healthy weight.

Table 2.6: Children by weight category

<table>
<thead>
<tr>
<th>Weight Category</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>8</td>
<td>1.3</td>
</tr>
<tr>
<td>Healthy weight</td>
<td>507</td>
<td>82.3</td>
</tr>
<tr>
<td>Overweight</td>
<td>68</td>
<td>11.0</td>
</tr>
<tr>
<td>Very overweight</td>
<td>33</td>
<td>5.4</td>
</tr>
<tr>
<td>Total</td>
<td>616</td>
<td>100.0</td>
</tr>
</tbody>
</table>

\(^{24}\) NHS Information Centre for Health and Social Care (2008) ibid
Looking at weight by gender and year group, there were more overweight boys than girls in the achieved sample (table 2.7). There were more overweight and very overweight children in Year 6 than in Reception (table 2.8).

**Table 2.7: Proportion of boys and girls in each weight category**

<table>
<thead>
<tr>
<th>Weight</th>
<th>Boys</th>
<th></th>
<th>Girls</th>
<th></th>
<th>Total</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Underweight</td>
<td>4</td>
<td>1.3</td>
<td>3</td>
<td>1.1</td>
<td>7</td>
<td>1.2</td>
</tr>
<tr>
<td>Healthy weight</td>
<td>238</td>
<td>79.6</td>
<td>222</td>
<td>84.4</td>
<td>460</td>
<td>81.9</td>
</tr>
<tr>
<td>Overweight</td>
<td>39</td>
<td>13.0</td>
<td>25</td>
<td>9.5</td>
<td>64</td>
<td>11.4</td>
</tr>
<tr>
<td>Very overweight</td>
<td>18</td>
<td>6.0</td>
<td>13</td>
<td>4.9</td>
<td>31</td>
<td>5.5</td>
</tr>
<tr>
<td>Total</td>
<td>299</td>
<td>100.0</td>
<td>263</td>
<td>100.0</td>
<td>562</td>
<td>100.0</td>
</tr>
</tbody>
</table>

54 missing

**Table 2.8: Proportion of each of the year groups in each weight category**

<table>
<thead>
<tr>
<th>Weight</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Reception</td>
<td>Year Group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
<td>Total</td>
<td>% of Total</td>
</tr>
<tr>
<td>Underweight</td>
<td>3</td>
<td>1.4</td>
<td>5</td>
<td>1.2</td>
<td>8</td>
<td>1.3</td>
</tr>
<tr>
<td>Healthy weight</td>
<td>183</td>
<td>85.1</td>
<td>324</td>
<td>80.8</td>
<td>507</td>
<td>82.3</td>
</tr>
<tr>
<td>Overweight</td>
<td>18</td>
<td>8.4</td>
<td>50</td>
<td>12.5</td>
<td>68</td>
<td>11.0</td>
</tr>
<tr>
<td>Very overweight</td>
<td>11</td>
<td>5.1</td>
<td>22</td>
<td>11.0</td>
<td>33</td>
<td>5.4</td>
</tr>
<tr>
<td>Total</td>
<td>215</td>
<td>100.0</td>
<td>401</td>
<td>100.0</td>
<td>616</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 2.9 shows the distribution of weight categories across the four PCTs.

**Table 2.9: Distribution of weight categories by PCT (percent)**

<table>
<thead>
<tr>
<th>PCT</th>
<th>1 (n=210)</th>
<th>2 (n=78)</th>
<th>3 (n=93)</th>
<th>4 (n=235)</th>
<th>% of Total</th>
<th>Total n</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Underweight</td>
<td>1.0</td>
<td>1.3</td>
<td>1.1</td>
<td>1.7</td>
<td>1.3</td>
<td>8</td>
</tr>
<tr>
<td>Healthy weight</td>
<td>81.0</td>
<td>83.3</td>
<td>83.9</td>
<td>82.6</td>
<td>82.3</td>
<td>507</td>
</tr>
<tr>
<td>Overweight</td>
<td>13.3</td>
<td>9.0</td>
<td>11.8</td>
<td>9.4</td>
<td>11.0</td>
<td>68</td>
</tr>
<tr>
<td>Very overweight</td>
<td>4.8</td>
<td>6.4</td>
<td>3.2</td>
<td>6.4</td>
<td>5.4</td>
<td>33</td>
</tr>
<tr>
<td>Total percent</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>616</td>
</tr>
</tbody>
</table>

In most cases (89%) the survey respondent was the child’s mother, and it was rather more likely to be the mother if the child was overweight, though the differences were slight (tables 2.10 and 2.11). The 13 ‘other’ carers were either siblings or other family member (9) or foster carers (4).
Table 2.10: Survey respondents

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>541</td>
<td>89.1</td>
</tr>
<tr>
<td>Father</td>
<td>53</td>
<td>8.7</td>
</tr>
<tr>
<td>Other carer</td>
<td>13</td>
<td>2.1</td>
</tr>
<tr>
<td>Total</td>
<td>607</td>
<td>100.0</td>
</tr>
</tbody>
</table>

9 missing

Table 2.11: Survey respondents by weight category (percent)

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Weight Category</th>
<th>Under-weight</th>
<th>Healthy Weight</th>
<th>Over-weight</th>
<th>Very Over-weight</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
<td>80.0</td>
<td>88.3</td>
<td>93.8</td>
<td>93.9</td>
<td>541</td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td>0</td>
<td>9.3</td>
<td>6.2</td>
<td>3.8</td>
<td>53</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>20.0</td>
<td>2.4</td>
<td>0</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>Total number</td>
<td></td>
<td>5</td>
<td>504</td>
<td>65</td>
<td>33</td>
<td>607</td>
</tr>
</tbody>
</table>

9 missing

The highest qualification for more than two in five respondents was a GCSE or equivalent; though a third had an A level or higher qualification. Very few (12%) had no formal qualifications (table 2.12). Parents of children in the overweight (but not very overweight) category were more likely to have a higher qualification. Although there were only eight in the underweight category, four had no formal qualification (table 2.13).

Table 2.12: Frequencies for highest educational qualification

<table>
<thead>
<tr>
<th>Qualifications</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No formal qualifications</td>
<td>70</td>
<td>11.7</td>
</tr>
<tr>
<td>Vocational Qualification</td>
<td>52</td>
<td>8.7</td>
</tr>
<tr>
<td>GCSE or equivalent</td>
<td>269</td>
<td>45.1</td>
</tr>
<tr>
<td>A-level, degree or above</td>
<td>197</td>
<td>33.0</td>
</tr>
<tr>
<td>Other qualification</td>
<td>9</td>
<td>1.5</td>
</tr>
<tr>
<td>Total</td>
<td>597</td>
<td>100.0</td>
</tr>
</tbody>
</table>

19 missing

Table 2.13: Highest educational qualification by weight category (percent)

<table>
<thead>
<tr>
<th>Qualifications</th>
<th>Weight category</th>
<th>Under-weight</th>
<th>Healthy Weight</th>
<th>Over-weight</th>
<th>Very Over-weight</th>
<th>Total n</th>
</tr>
</thead>
<tbody>
<tr>
<td>No formal qals</td>
<td></td>
<td>50.0</td>
<td>11.4</td>
<td>9.4</td>
<td>12.1</td>
<td>70</td>
</tr>
<tr>
<td>Vocational qals</td>
<td></td>
<td>0</td>
<td>9.8</td>
<td>1.6</td>
<td>9.1</td>
<td>52</td>
</tr>
<tr>
<td>GCSE or equivalent</td>
<td></td>
<td>25.0</td>
<td>46.5</td>
<td>37.5</td>
<td>42.4</td>
<td>269</td>
</tr>
<tr>
<td>A-Level +</td>
<td></td>
<td>25.0</td>
<td>30.7</td>
<td>51.6</td>
<td>33.3</td>
<td>197</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>0</td>
<td>1.6</td>
<td>0</td>
<td>3.0</td>
<td>9</td>
</tr>
<tr>
<td>Total number</td>
<td></td>
<td>8</td>
<td>492</td>
<td>64</td>
<td>33</td>
<td>597</td>
</tr>
</tbody>
</table>

19 missing

As a rough indicator of income, we also asked about the number of wage earners in a family. Around a quarter of the families responding to the survey had either no wage earner or just one part-time wage earner, whilst 57 percent had a single wage earner and 22 percent had two (or more) wage earners (table 2.14). There was no clear association between number of wage earners in a family and children in different weight categories.
Table 2.14: Full-wage earners in the family

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two or more</td>
<td>131</td>
<td>21.7</td>
</tr>
<tr>
<td>One</td>
<td>343</td>
<td>56.7</td>
</tr>
<tr>
<td>Part-time only</td>
<td>43</td>
<td>7.1</td>
</tr>
<tr>
<td>None</td>
<td>88</td>
<td>14.5</td>
</tr>
<tr>
<td>Total</td>
<td>605</td>
<td>100.0</td>
</tr>
</tbody>
</table>

11 missing

In terms of ethnicity, three-quarters of the respondents were White British or White Other, with the largest minority ethnic group being Asian or Asian British (table 2.15). This is likely to reflect the population profile in one of the four PCTs.

Table 2.15: Survey respondents by ethnicity

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British or White Other</td>
<td>462</td>
<td>75.9</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>82</td>
<td>13.5</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>34</td>
<td>5.6</td>
</tr>
<tr>
<td>Chinese</td>
<td>3</td>
<td>.5</td>
</tr>
<tr>
<td>Mixed origin</td>
<td>5</td>
<td>.8</td>
</tr>
<tr>
<td>Other ethnicity</td>
<td>5</td>
<td>.8</td>
</tr>
<tr>
<td>Do not wish to state</td>
<td>18</td>
<td>3.0</td>
</tr>
<tr>
<td>Total</td>
<td>609</td>
<td>100.0</td>
</tr>
</tbody>
</table>

7 missing

Table 2.16 shows weight by ethnicity and indicates that, in line with the national prevalence rates for obesity, proportionally more overweight children were found with an Asian or Asian British parent or a Black or Black British parent compared with a White British parent. However, the sample size is too small to investigate this further, or to draw generalisable conclusions.

Table 2.16: Ethnicity by weight category (percent)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Weight Category</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Under-weight</td>
</tr>
<tr>
<td>White British or White other</td>
<td>0.6</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>4.9</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>0</td>
</tr>
<tr>
<td>Chinese</td>
<td>0</td>
</tr>
<tr>
<td>Mixed origin</td>
<td>0</td>
</tr>
<tr>
<td>Other ethnicity</td>
<td>0</td>
</tr>
<tr>
<td>Do not wish to state</td>
<td>5.6</td>
</tr>
<tr>
<td>Total number</td>
<td>8</td>
</tr>
</tbody>
</table>

7 missing
2.4 Characteristics of the interview sample

Among the 49 parents interviewed (45 mothers and four fathers) just under a third (15) were from PCT 4, which had surveyed a higher proportion of parents at the time the sample was selected. Fourteen were from PCT 3, 13 from PCT 1 and seven from PCT 2, which had the lowest response rate to the survey. The weight categories for their children were as follows: one underweight; 19 healthy weight; 15 overweight; and 14 very overweight. The number of underweight children was expected to be small since there were only eight in this category in the whole survey sample, and of these only two agreed to further contact, of whom one was available to be interviewed. We aimed to have roughly equal numbers of boys and girls and of Reception and Year 6 children, and to include both high and low socio-economic status families (SES) and parents from Black and Minority Ethnic (BME) groups in the interviews (table 2.17). However, we purposively set out to over sample parents with overweight children to provide more information about their views and experiences.

In practice, slightly more parents of boys than girls, and rather more Year 6 than Reception parents were interviewed, mirroring the survey sample. Just under a half of the parents were of low SES\(^25\) and around a third was from a BME group. Two-thirds of the interview sample described themselves as two-parent families and the remaining third as single parent families. Ten of the sample had just one child (the one who had been weighed and measured), while a quarter had more than two children in the family. Total household size varied from two to seven, but for over two-thirds (33) it was between two and four people (adults and children).

Table 2.17: Characteristics of interview sample

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Weight Category</th>
<th>Underweight (n=1)</th>
<th>Healthy Weight (n=19)</th>
<th>Overweight (n=15)</th>
<th>Very Overweight (n=14)</th>
<th>Total (n=49)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Girl</td>
<td>0</td>
<td>9</td>
<td>7</td>
<td>7</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>Boy</td>
<td>1</td>
<td>10</td>
<td>8</td>
<td>7</td>
<td>26</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>White</td>
<td>1</td>
<td>10</td>
<td>13</td>
<td>9</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>BME</td>
<td>0</td>
<td>9</td>
<td>2</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td>SES</td>
<td>High SES</td>
<td>1</td>
<td>9</td>
<td>10</td>
<td>8</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Low SES</td>
<td>0</td>
<td>10</td>
<td>5</td>
<td>6</td>
<td>21</td>
</tr>
<tr>
<td>Year Group</td>
<td>Reception</td>
<td>0</td>
<td>9</td>
<td>6</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Year 6</td>
<td>1</td>
<td>10</td>
<td>9</td>
<td>9</td>
<td>29</td>
</tr>
</tbody>
</table>

\(^{25}\) Educational level of the parent responding to the survey was used as a rough indicator of socio-economic status, with those holding ‘A’ levels or above categorised as high socio-economic status and qualifications below ‘A’ level as lower SES. This ensured a range of backgrounds among interviewees, but as a measure of class is too crude to permit any exploration of the relationship between SES and understandings of/ reaction to dietary and weight issues.
3 Findings: parents’ perspectives on routine feedback

This chapter brings together data from the 616 parents responding to the survey and the more detailed information from follow up interviews with 49 of these parents. The survey asked about parents’ reactions to receiving the feedback letter and health promotion materials from their local PCT, and their intentions to act on this information. The interviews explored these responses in more depth, and also asked about any concerns they might have had about their child’s weight before receiving the letter, whether they had discussed the feedback with anyone else, and what they thought would help or hinder them from making any changes to their child or family’s lifestyle that might be indicated.

3.1 Agreement with the results

Few parents disagreed with the information on the weight of their child, and those that did were generally in the overweight categories, particularly parents whose children were described as overweight (rather than very overweight) (table 3.1). From comments made in the survey by parents in the overweight group (27 of the 101 parents across all weight categories who added comments), disagreement often centred on the fact that their child was only just over the threshold and therefore the description did not fit their child, as the following comments illustrate:

My child is only 3lb overweight, he is very healthy and slim. I object to being told he is overweight. (Overweight)

You have said that he is 1lb overweight, but as long as my son is happy and healthy that is all that matters, and do you realise that with your comments you could cause people to panic and reduce their intake and cause anorexia. (Overweight)

Table 3:1 Agreement with child’s weight category by weight category (percent)

<table>
<thead>
<tr>
<th>Agreement</th>
<th>Underweight</th>
<th>Healthy Weight</th>
<th>Overweight</th>
<th>Very overweight</th>
<th>Total %</th>
<th>Total n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree</td>
<td>14.3</td>
<td>97.4</td>
<td>33.8</td>
<td>51.5</td>
<td>87.2</td>
<td>533</td>
</tr>
<tr>
<td>Disagree</td>
<td>14.3</td>
<td>.8</td>
<td>27.7</td>
<td>33.3</td>
<td>5.6</td>
<td>34</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>42.9</td>
<td>.6</td>
<td>26.2</td>
<td>6.1</td>
<td>4.1</td>
<td>25</td>
</tr>
<tr>
<td>Not sure</td>
<td>28.6</td>
<td>1.2</td>
<td>12.3</td>
<td>9.1</td>
<td>3.1</td>
<td>19</td>
</tr>
<tr>
<td>Total number</td>
<td>7</td>
<td>506</td>
<td>65</td>
<td>33</td>
<td>100.0</td>
<td>611</td>
</tr>
</tbody>
</table>

5 missing

Other reasons why some parents in the overweight categories disagreed with the results were that they had been told by other professionals that the child was not overweight, that the child’s appearance did not suggest overweight, or that other factors about the child were unknown to the PCT, who therefore had an incomplete picture of the child, resulting in an incorrect categorisation.

My child has been told by three different consultants that he is not overweight for his height. I think you need to consider the rate each child grows at! (Very Overweight)

The information portrays my daughter as a statistic in the clinically obese category! However, she is a very active girl who eats a healthy balanced diet with monitored treats therefore this information does not give a true picture (Very Overweight)

---

26 Parent(s) is used throughout to include both parents and ‘other’ carers.
Among the survey parents who were subsequently interviewed, more than half (28) said that the results were not what they had expected. Most of these had a child in the overweight categories (11 overweight and 13 very overweight), but one parent with an underweight child and three parents with healthy weight children also said they had not expected this result. In one of these cases, the child had been classed as ‘healthy weight’ on the basis of the BMI calculation, because his height and weight were in proportion, despite the fact that he was receiving specialist medical treatment for severe growth problems and was the height and weight of a child aged two. His mother was concerned and angry at this misleading feedback and the lack of communication between professionals, and had complained to the PCT.27

Some of the interviewed parents who had not expected the result they received were aware that their child was overweight, but were surprised to learn that they were very overweight; whilst some parents whose children were just over the threshold had not expected them to be classified as overweight. Parents’ reasons for their surprise often centred on the child’s appearance and the fact that they did not look overweight:

I was surprised. I knew that she was heavy, but didn’t think she was very overweight. Some children you can see they are fat, but she doesn’t look like that. (Very Overweight)

Whilst they might agree with the actual measurements, it was apparent that parents often did not see their child as overweight, describing them instead as ‘solid’, ‘big boned’ or having a ‘big frame’. One commented that her child had a lot of muscles and that ‘Jonny Wilkinson would be obese on this scale’. Some parents provided explanations, for example that the child had been a big baby or came from a large and tall family, implying that their weight was as should be expected. Others counterbalanced the feedback that their child was overweight with evidence that the child did a lot of physical exercise and was very fit.

The survey had asked parents if they agreed with the results in the letter, and in the interview some weeks later parents were asked if they still agreed or disagreed with the results. Most parents were unchanged in their view (28 agreeing and 12 disagreeing as before), but seven had changed their view, with three now agreeing (2 very overweight and 1 overweight), two who had agreed now disagreeing (one in each of the overweight categories), and one not sure (overweight). One mother who had been told her reception class son was overweight commented that she had never really thought about his weight before so had disagreed at the time the letter arrived, ‘but now, perhaps yes, we are all trying to lose some weight now’. Another, whose child was very overweight, reported being ‘cross at the time’ at the way the information was given and so had said that she disagreed with it, but now felt that her child was probably overweight - although not necessarily ‘very overweight’.

3.2 Reaction to receiving the letter

Although some parents may have disagreed with the results, the overwhelming majority of survey respondents (90%) said it was helpful or very helpful to receive them (table 3.2).

Examples of positive comments included:

I really can’t tell you how helpful it is. Well done! (Healthy Weight)

Wake up call for me personally, knowing that my son is overweight and I would have to find a solution being fully aware of the side effects. (Very Overweight)

Note: This case was also discussed in PCT interviews, and it was noted that the mother had received a formal apology.
However, there was a clear difference in the proportion of parents finding the results helpful depending on the child’s weight (table 3.2). Among those whose child was classified as very overweight, nearly one in five reported that it had been unhelpful or very unhelpful to receive this information, and this rose to just over a quarter of those with a child in the overweight category. Very few parents of healthy weight children found the results unhelpful, though one parent of a healthy weight child commented:

*I did not expect to receive this information. It is not necessary and is intrusive. I allowed my daughter to be weighed because I thought it was purely for statistics, not to be used personally.*

Table 3.2: Helpful to get results by child’s weight (percent)

<table>
<thead>
<tr>
<th>Child Weight Category</th>
<th>Under-weight</th>
<th>Healthy Weight</th>
<th>Over-weight</th>
<th>Very over-weight</th>
<th>Total %</th>
<th>Total n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very helpful</td>
<td>28.6</td>
<td>46.5</td>
<td>23.5</td>
<td>48.5</td>
<td>43.9</td>
<td>269</td>
</tr>
<tr>
<td>Helpful</td>
<td>42.9</td>
<td>47.5</td>
<td>45.6</td>
<td>33.3</td>
<td>46.5</td>
<td>285</td>
</tr>
<tr>
<td>Unhelpful</td>
<td>14.3</td>
<td>2.8</td>
<td>11.8</td>
<td>12.1</td>
<td>4.4</td>
<td>27</td>
</tr>
<tr>
<td>Very unhelpful</td>
<td>0</td>
<td>.8</td>
<td>14.7</td>
<td>6.1</td>
<td>2.6</td>
<td>16</td>
</tr>
<tr>
<td>Don’t know</td>
<td>14.3</td>
<td>2.4</td>
<td>4.4</td>
<td>0</td>
<td>2.6</td>
<td>16</td>
</tr>
<tr>
<td><strong>Total number</strong></td>
<td><strong>7</strong></td>
<td><strong>505</strong></td>
<td><strong>68</strong></td>
<td><strong>33</strong></td>
<td><strong>100.0</strong></td>
<td><strong>613</strong></td>
</tr>
</tbody>
</table>

Parents whose children were at a healthy weight said they found the feedback helpful because it provided reassurance (especially if they had thought their children might be under- or over-weight) and/or affirmed that the parents’ behaviour in terms of encouraging healthy lifestyles was appropriate:

*Receiving these results gave me and my family confidence to continue to eat and exercise as before. Knowing that we are all doing so as advised in your leaflet!* (Healthy Weight)

Very few parents whose children were in the two overweight categories and who commented (n=41) made positive comments in the survey, but those who did were pleased to be told as the following comments illustrate:

*It made me fully aware of the health hazards and I am determined to help my child* (Very Overweight)

*Was pleased to be able to share them with my son – he knows he is overweight [and this] gave us an excellent idea of how much. However, he is big boned and solid and I think this makes him appear much heavier for his height.* (Very Overweight)

In the interviews, parents’ initial feelings on receiving the feedback letter were explored in more depth. Parents sometimes expressed a mix of feelings, though the most frequent reaction was shock or surprise (mentioned by 21 of the 49 parents, the majority of whom were parents of overweight children), and feeling pleased or proud (16 parents – most of children of healthy weight). Fewer parents, almost all of them of children who were overweight or very overweight, expressed other emotions such as anger (9 parents), worry (5 parents) and/or being upset (6 parents). As had been found in the survey, parents of healthy weight children were often pleased to be told that their child was a healthy weight and parents of overweight children were generally pleased to know so that they could do something about it.
A bit of a panic, ‘cos in our family nobody is overweight. She likes chocolate too much! Her dad and I was worried, but I was happy, worried, but good to find out early so I can do something about it. (Very Overweight)

Some parents said that the letter had made them feel guilty or ashamed that their child was overweight, seeing it as their fault and bringing into question the quality of their parenting. Such comments highlight the sensitivity of the information provided, and the need to ensure that the message is clear enough to prompt action whilst not undermining or criticising parents.

Really, really bad, disappointed, shocked and not doing my job properly as a mother. (Very Overweight)

Oh my god she’s obese! I need to control her, feeling guilty it was all my fault. It was eye-opening. (Very Overweight)

A recurring theme among interviewed parents who were dissatisfied with the results was that they resented what they saw as the impersonal nature of the feedback and a failure to take account of their personal situations – for example, that the child had a medical condition which affected their weight, or that the child was already attending a weight management programme.

The letter said if you want any help, contact the Change 4 Life person. We’d already done that [last year] ... we were their star pupils, we lost more weight than anyone else on the programme. (Very Overweight)

Initially I thought it was a load of rubbish, then I was angry – it’s wrong to send this letter without knowing who it is being sent to. (Overweight)

One mother of a very overweight child described how she felt her daughter had been ‘put into a category’ in a very impersonal way, and that this felt unfair: ‘she was just considered statistically, not taking into account how fit and active she is’. Another commented that ‘I know it’s a national scheme and parents can’t have a personalised response, but the letter needs to be more appropriate’.

### 3.3 Prior concerns about child’s weight

The parents who were interviewed were asked if they had had any prior concerns about their child’s weight, and if so, whether they had done anything about this. Almost three-quarters had had no prior concern about their child’s weight (28/49) or were aware that their son or daughter was big or small for their age, but were unconcerned (9/49). Only four reported having been seriously concerned, and of these three had children who were very overweight (the other was the parent of a child categorised as healthy weight who had serious growth problems). Less than a quarter (11 parents) had concerns or had given any prior thought to their child’s diet or eating habits before receiving the letter, and among those who had, their focus was largely on eating unhealthy food and/or eating too much. Few parents (9/49) said they had prior concerns about their child’s activity level and none of these had been seriously concerned about their child’s activity level. Among the parents who did report prior concerns, most had tried to do something about it, generally by making changes to the child’s diet and/or activity levels. Only a few had sought professional advice (three from a health professional and one from their child’s school).
3.4 Views on how the information was presented in the letter

The survey asked how satisfied parents were with the way the information was given to them in the letter, and again only a small proportion (6% overall) said they were not satisfied, although this rose to nearly a third of the overweight and a quarter of the very overweight (table 3.3).

Table 3.3: Satisfaction with way information given in the letter, by child’s weight (percent)

<table>
<thead>
<tr>
<th>Child Weight Category</th>
<th>Totals</th>
<th>Underweight</th>
<th>Healthy Weight</th>
<th>Overweight</th>
<th>Very overweight</th>
<th>Total %</th>
<th>Total n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very satisfied</td>
<td>28.6</td>
<td>50.4</td>
<td>16.4</td>
<td>34.4</td>
<td>45.6</td>
<td>278</td>
<td></td>
</tr>
<tr>
<td>Satisfied</td>
<td>42.9</td>
<td>48.4</td>
<td>52.2</td>
<td>40.6</td>
<td>48.4</td>
<td>295</td>
<td></td>
</tr>
<tr>
<td>Not Satisfied</td>
<td>28.6</td>
<td>1.0</td>
<td>31.3</td>
<td>25.0</td>
<td>5.9</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>Did not understand letter</td>
<td>0</td>
<td>.2</td>
<td>0</td>
<td>0</td>
<td>.2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Total number</td>
<td>7</td>
<td>504</td>
<td>67</td>
<td>32</td>
<td>100.0</td>
<td>610</td>
<td></td>
</tr>
</tbody>
</table>

6 missing

Few parents responding to this question on the survey added comments: two found the BMI index difficult to understand, two parents would have liked to have known in what range their child’s height fell, and three found the tone of the letter harsh or patronising.

Parents’ understanding of the letter was explored in more detail in the interviews. Generally, there appeared to be few problems with the clarity of the information. Typical comments were that it was ‘very clear’, ‘I could understand it’, ‘easy to understand - you can see it in the box’, ‘straightforward’, ‘it spelled it out clearly’, ‘well set out’. In the view of one parent, the information was in fact too clear!

The visual representation of the range of children’s weights given on the reverse of the feedback letter was commented upon positively. For example, the parent of a very overweight child said that it was easy for her child to see and understand the problem because she was ‘off the scale on the chart’, while another parent liked the fact that the ‘healthy weight’ band was so wide because ‘it shows that children can be quite different and still healthy’.

One caveat to this positive message about the clarity of the feedback letter should be noted, however. Parents who did not respond to our survey may well have contained disproportionate numbers who did find the information hard to understand, either because of literacy levels or not being fluent in English. This requires further exploration, especially to establish how far the information in the feedback letter is accessible to families from minority ethnic groups where parents may speak little English. As discussed in Chapter Four, a number of PCT interviewees also raised questions about the accessibility of the letter to families who may have low literacy levels or speak little or no English.

There was one aspect of the way the information was provided in the feedback letter that did attract some criticism, and that was the tone and language used. For example, one mother objected to the phrase ‘doctors call this clinically obese’ in relation to children categorised as very overweight, others referred to the letter being ‘too blunt’ or ‘not sensitive enough’, and several would have preferred the letter to merely say their child was outside of the ‘normal’ range rather than to use terms such as overweight or very overweight. The information about health risks was felt by some to be inappropriate:

*The word cancer jumps out at you, it’s scare tactics. I think that could be put better, saying a child of five is at risk of a list of diseases! (Overweight)*
The letter is very harsh and the last sentence\textsuperscript{28} in particular was alarming. I am very aware of her weight and try very hard to keep it down ... I appreciate this campaign is to target childhood obesity but feel it does not target families who do need guidance and is at risk of alienating families who do work hard to maintain healthy ways of life. (Very Overweight)

A small number of parents in both the survey and subsequent interviews expressed concern about their child’s reaction if they were to have read the letter, and how this information could raise parents’ and children’s anxiety levels with possible negative consequences.

Because the letter was addressed to the "parents of ...", my son knew it was about him, we had to lie to him about what it said, because at his age we don't want him to have a poor body image and become anorexic at a later stage. (Overweight)

My child was very upset to read he was underweight possibly due to illness/medical condition – it is worded very insensitively for a 10 year old interested in his health to understand ...most families would have shared the info with their child so this must be considered. (Underweight)

In some cases the child had mistakenly opened the letter believing it was for them because the letter had arrived addressed to ‘the parent of’, with the child’s name in larger print. One mother described her daughter’s reaction upon opening the letter:

I heard a wail...she says ‘I could die of diabetes’. It took days to get her calmed down. (Very Overweight)

This mother thought it would help if the letter was clearly marked as ‘confidential’. Concern about children opening letters by mistake was also mentioned by some PCT interviewees (see Chapter Four).

Just under a third (14/49) of the parents who were interviewed said they had spoken to their child about the results and given them the letter to read (or the child had opened it first, as above). All but one of these were parents of Year 6 children.

In the survey, comments were occasionally made about raised anxiety levels when children were at the lower or upper end of the healthy weight range:

It is very close to the underweight category. Should we be worried about this because current diet I feel is healthy and wouldn't like to change the diet? (Healthy Weight)

Her results were 1lb below overweight which quite frankly is a load of old tosh. She is a little energetic and strongly built. For a less confident parent these results could influence them to put their child on a diet which is most definitely not required. (Healthy Weight)

In general, however, the majority of parents were satisfied with the way the information was presented in the feedback letter and found it easy to understand (with the caveat above about parents who did not respond to our survey). Whilst some found the language too blunt or ‘black and white’, others appeared to have been shocked by the language into acknowledging that there was a problem:

\textsuperscript{28} This states: ‘However, it is very important that you now contact me by telephone or email for further advice and information’.
The word ‘obese’ really worried us, we realised we needed to address this. (Very Overweight)

3.5 Usefulness of health promotion material

More than three-quarters of the survey sample thought the health promotion material enclosed with the feedback letter, usually the Change4Life leaflet ‘Top Tips for Top Kids’, was useful (table 3.4). Of the small number of parents who did not find it useful there were proportionally more in the overweight categories (table 3.4).

Table 3.4: Usefulness of health promotion material by child’s weight (percent)

<table>
<thead>
<tr>
<th>Child Weight Category</th>
<th>Under-weight</th>
<th>Healthy Weight</th>
<th>Over-weight</th>
<th>Very overweight</th>
<th>Total %</th>
<th>Total n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very useful</td>
<td>37.5</td>
<td>24.6</td>
<td>16.9</td>
<td>30.3</td>
<td>24.3</td>
<td>146</td>
</tr>
<tr>
<td>Useful</td>
<td>62.5</td>
<td>59.8</td>
<td>44.6</td>
<td>33.3</td>
<td>56.7</td>
<td>341</td>
</tr>
<tr>
<td>Not at all useful</td>
<td>0</td>
<td>2.8</td>
<td>13.8</td>
<td>15.2</td>
<td>4.7</td>
<td>28</td>
</tr>
<tr>
<td>Did not read it</td>
<td>0</td>
<td>6.3</td>
<td>15.4</td>
<td>12.1</td>
<td>7.5</td>
<td>45</td>
</tr>
<tr>
<td>Not received</td>
<td>0</td>
<td>6.5</td>
<td>9.2</td>
<td>9.1</td>
<td>6.8</td>
<td>41</td>
</tr>
<tr>
<td>Total number</td>
<td>8</td>
<td>495</td>
<td>65</td>
<td>33</td>
<td>100.0</td>
<td>601</td>
</tr>
</tbody>
</table>

15 missing

There were some mixed views expressed by the 83 parents who commented about the additional health promotion material, though in the main the comments were positive and many parents found the information useful. Although parents often said that the information was new to them, it had served as a reminder or as reassurance that they were doing the right things in encouraging a healthy lifestyle for their children, or they said that it was useful for their children to read:

I already do a lot of the things in the leaflet but I still found it interesting and for someone looking for ideas I would say it was excellent (Healthy Weight)

Its handy information and I can pick it up anytime I wish to check something out. (Very Overweight)

Useful if you are not aware of how you should eat and exercise. Not at all helpful for borderline children who do these things anyway. (Very Overweight)

Useful information and we already do around 90% of the suggestions in the leaflet and yet my child is still considered overweight. (Overweight)

It’s a very useful leaflet because if we tell them that this is good for them they never listen, but now they are at the stage where they can read and understand so it is very good for them. (Healthy Weight)

However when interviewed some weeks later, only 37 of the 49 parents could remember receiving additional health promotion material with the feedback letter. Of these, just under half (16) had read the material and found it useful, or useful in parts. The remainder had read the leaflet, but not found it useful (14) or had not read it (5) or couldn’t remember (2). Fourteen respondents said that their partner had also read the leaflet (just six reported their partner finding it useful) and eight children had read it, all but one parent saying it was useful to them. Comments about the additional health promotion material from parents who were interviewed echoed those of the survey parents: that it ‘pointed out the obvious’, contained ‘nothing new’, or was not seen as relevant because their child was not overweight. When the style of the leaflet was commented upon it was generally positive.
well-designed and in plain English; nice bright colours), and parents did not disagree with the information contained in the leaflet: it was more a case for many of reporting that this information was known already. Very few of those who planned to make changes said this was as a result of the health information sent with the results letter.

3.6 Acting on feedback

A key issue for the success of the NCMP is whether, having received feedback about their child’s weight, parents planned to take any action in response. Amongst all the survey respondents, almost a third (30%) said that they did. Considering differences between the four weight categories, 23 percent of parents in the healthy weight category were planning to make changes, whereas more than half of the parents of overweight children, nine in ten parents of very overweight children and six of the seven parents of underweight children planned to do so (table 3.5). Compared with White British or White Other, proportionally more Black and Minority Ethnic (BME) parents said they planned to make changes (table 3.6). This was not simply explained the greater proportion of overweight or very overweight children, since BME parents were more likely to report taking action whatever their child’s weight category (fig 3.1).

Table 3.5: Planning action by child’s weight (percent)

<table>
<thead>
<tr>
<th>Child Weight Category</th>
<th>Underweight</th>
<th>Healthy Weight</th>
<th>Overweight</th>
<th>Very overweight</th>
<th>Total</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>85.7</td>
<td>22.8</td>
<td>56.1</td>
<td>89.7</td>
<td>184</td>
<td>30.4</td>
</tr>
<tr>
<td>No</td>
<td>14.3</td>
<td>77.2</td>
<td>43.9</td>
<td>10.3</td>
<td>422</td>
<td>69.6</td>
</tr>
<tr>
<td>Total number</td>
<td>7</td>
<td>504</td>
<td>66</td>
<td>29</td>
<td>606</td>
<td>100.0</td>
</tr>
</tbody>
</table>

10 missing

Table 3.6: Planned changes by parents’ ethnicity (percent)

<table>
<thead>
<tr>
<th>'White'</th>
<th>BME</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>25.6</td>
<td>48.8</td>
</tr>
<tr>
<td>No</td>
<td>74.4</td>
<td>51.2</td>
</tr>
<tr>
<td>Total number</td>
<td>454</td>
<td>127</td>
</tr>
</tbody>
</table>

25 missing

Figure 3.1: Plans to act on feedback by ethnicity and weight category: survey data
The most frequently mentioned changes, among those parents planning to make changes, were changes to family eating habits and/or family activity levels, such as eating more fruit and vegetables; going swimming; cutting out crisps, fatty or greasy food and sweets (table 3.7).

Table 3.7: Frequencies for planned changes

<table>
<thead>
<tr>
<th>Change</th>
<th>Number (n=606)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes to family’s activity levels</td>
<td>121</td>
<td>65.8</td>
</tr>
<tr>
<td>Changes to family’s eating habits</td>
<td>110</td>
<td>59.8</td>
</tr>
<tr>
<td>Ask someone for advice</td>
<td>22</td>
<td>12.0</td>
</tr>
<tr>
<td>Do something else</td>
<td>15</td>
<td>9.9</td>
</tr>
</tbody>
</table>

Percentages do not total 100 as a multiple response question

Few parents said they would contact someone for advice. Of the 22 parents who did plan to do this, ten would contact their GP, six their friends and family, two the named contact in the letter and the remaining four mentioned their Health Visitor, Weight Watchers, or said they did not know who to approach.

When we interviewed parents, three of the 49 had gone on to speak to someone in the PCT, two had spoken to a school nurse and two to their child’s class teacher, whilst another parent assumed someone would get in touch with her and was waiting for this contact. There were mixed views on how helpful this further contact had been. Mostly parents had been reassured and told not to worry, especially if their child was just in the overweight category. Only one parent reported receiving concrete advice, which she said had been ‘really helpful’. This parent had rung the contact number on the letter, and reported that a school nurse came to see her, provided advice (such as keeping a diary of what her child ate and walking to and from school rather than using the bus), and had referred her child to an exercise club.

Informal discussion of the results with family and friends was much more common than discussing the letter with a professional. Only three parents (all with a healthy weight child) said they had not spoken to anyone about the letter. Almost all those with a partner had talked to them about the results (29 of 32). Other people who were consulted or informed were other relatives (20), a close friend (18) or other acquaintances - usually other mums in the school playground (13).

When asked in the interviews whether they had actually made changes after receiving the feedback letter or still planned to do so, it was clear that several of those who had intended or planned to do so at the time when they received the feedback, had not in fact made any changes, or none that lasted. This suggests that initial ‘good intentions’ often faded with time, and parents’ comments reinforced this:

*It did [make a difference] for a few days for my son, until the novelty of eating all the fruits and veg wore off.* (Healthy Weight)

*It reminds you, but nothing has changed* (Very Overweight)

*You get the letter and feel very anxious but as time passes the less urgent it seems, you just get on with your life. Making contact with the PCT is just one more thing and you can’t be bothered* (Very Overweight).

Children of the 20 parents in the interview sample who had made changes or planned to do so were distributed among three weight categories: overweight (8), very overweight (7) and

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29 Most of these responses referred to maintaining the child’s healthy diet and activity levels.
healthy weight (5). The type of changes most likely to have been implemented or planned in these families related to the child’s or family’s diet or eating habits (17) followed by changes to the child’s or family’s physical activity level (11).

*We watch what we eat more than we did, all of us* (Overweight)

### 3.7 Barriers and facilitators of change

We explored with the 20 parents who were making or planning changes what the barriers might be and what would help. Nearly half thought it was just up to them, and (although numbers were very small) this appeared to be particularly the case among the very overweight group (only one of eight mentioned any barriers). Of the 11 parents who did perceive barriers, the most frequently mentioned were their child’s fussiness or attitude (7) followed by insufficient time (5). Other factors included cost (3) lack of professional support (2), lack of information (2) lack of control over the child’s diet and lifestyle when they were looked after by someone else such as a grandparent (1) and not knowing how to change (1).

Rather more parents commented on what would help them to make the changes they wanted to introduce (15), including five of the eight parents with a child in the very overweight group. Suggestions, although each was often made by only one or two parents, included:

- free swimming, more after-school clubs, information about leisure activities;
- government action – cheaper fruit/vegetables, food labelling, less convenience foods/burger shops;
- someone to plan the child’s diet;
- the child becoming older and more independent (and so able to walk to school rather than be driven); and
- someone making contact after sending the results.

### 3.8 Have the results made a difference?

We asked the interviewed parents if they thought that, overall, getting the results had made a difference to themselves, their child and their family (Figure 3.2). Less than half said it had made any difference to their child, and this response seemed to be linked to not wanting the child to be conscious of any weight problem.

*I hope it’s not made a difference to him, if it has I have failed him* (Overweight)

*It’s put that seed of doubt into my mind – perhaps she shouldn’t be eating another cake – but my daughter is completely oblivious and I hope the rest of the family is too* (Overweight)

Where getting the results was reported to have made a difference to the child, a positive difference (14) was more likely to be described than a detrimental effect (6):

*He knows he’s not to sit down for more than two hours at a time and needs to go out on his trampoline and kicking a football* (Very Overweight)

Slightly more parents, just over half, reported that the feedback had made a positive difference to themselves, rather than their child, for example by encouraging them to eat more healthily or exercise more, or to be more conscious about ensuring a healthy diet (described by one mother of an overweight child as ‘*a little nag in my head*’). A small number
of parents (7) described a negative reaction. Few parents (11) said that getting the results had made a difference overall to their family.

*It made me realise I need to do something more quickly – I had been trying. [But] it only made a difference to [child] for one day, and no difference to the rest of the family (Very Overweight)*

![Figure 3.2 What difference has the feedback made?](image)

3.9 Views on the programme

There was almost unanimous agreement among the interviewed parents that children should be weighed and measured (only one of the 49 disagreed). The great majority (43, 88%) thought that parents should be told what weight category their child was in, with just one parent against this and five having mixed views or being unsure. Most parents (44, 90%) also said that they would consent to their child being measured again in the future, or when they reached reception if they had a younger child, with only one categorically saying ‘no’ and the remaining four undecided. Even if they disagreed with their own child’s results, or found the manner in which the feedback was provided insufficiently sensitive, almost all felt that parents needed to know if their child was underweight or overweight so that they had the opportunity to do something about it.

Several interviewees pointed out that parents often don’t recognise that their child has a weight problem, and the fact that the information was ‘official’ rather than the opinion of relatives or friends was seen as helpful. One parent of a healthy weight Year 6 child would have liked similar information to be provided to her older son, because ‘it would be easier to persuade him to take more exercise or eat less if someone outside the family said he needed to’.

However, the evidence from the interviews with parents suggested that awareness that their child was outside the healthy weight range, and good intentions to address this, were often not translated into the kind of action needed to make a difference. As the parent of one very overweight child put it, ‘sending a leaflet is not enough. You need more than that to get people eating healthily’. Although the focus of this study is on the provision of routine feedback to parents about their child’s weight, and their reaction to this information, the NCMP clearly needs to be viewed within the wider picture of the kind of support available to help parents and children deal with weight issues once they are identified.
4 Findings: PCT perspectives on routine feedback

In this chapter we describe the experience of key staff in the four PCTs in relation to providing routine feedback from the NCMP to parents in the 2008/09 year, using the materials provided by DH. Information is presented on the reasons for deciding to do this, and the practical issues encountered including the resources required; the perceived ‘reach’ of the programme; dealing with calls from parents; and the interventions and support that were available for families where a child’s weight was outside the ‘healthy’ range.

4.1 The decision to give feedback

Perhaps not surprisingly – given that the PCTs selected for the evaluation were among the few who were underway with feedback at the end of 2008 – respondents across the areas described positive reasons for choosing to send routine feedback, including wanting to be part of the early work done by the Cross-Government Obesity Unit, and wanting to treat the 2008/09 year’s feedback as a pilot. The opportunity to be part of an early evaluation of the feedback process was also seen as positive.

Several interviewees described structural and organisational factors that had facilitated or contributed to the decision to provide feedback, including clear direction from senior management, and the fact that the task seemed manageable (for example, because the PCT was relatively small, or because it had relevant existing systems in place), but one of the four PCTs had been providing routine feedback to all parents since 2005/6 when the Programme started. One interviewee described the decision to give feedback as a ‘bit of a tussle’ in her PCT’s working group, but on the whole the majority were positive about the decision. Managers in all four PCTs said they planned to continue with feedback to parents in future years, although some planned changes – for example to the feedback letter – as discussed below. In addition, several interviewees argued that there was an ethical duty to feed back to parents, as was summed up by one manager (PCT 1):

I suppose I’ve always found it difficult, the idea of not sharing information – that we were measuring obese children and not doing anything... It’s better to tell people, although utilising the information is a different thing.

4.2 Practical issues

Across the four PCTs, there were evident variations in the practicalities of the measurement and feedback process. These included differences in who carried out the measurements in schools – Band 2 health screeners in two of the four Trusts, Band 3 staff in another area, and in the fourth PCT measurement was carried out by Band 6 nurses (two, covering the whole PCT area). The PCTs also varied in how data were entered. Some used laptops to enter data concurrently with measurement, others (more commonly) recorded measurements on paper forms, and data entry was subsequently conducted by someone else.

Across areas, good relationships with schools and GP practices were seen as facilitators of the process, and it was seen as important to keep these organisations informed about what was going on.

4.2.1 Accuracy

In all four areas, workers described checks on accuracy of measurements, and this was seen as being of paramount importance given the sensitivity of the feedback letters. A range of systems were in place to ensure that incorrect measurements were not recorded. In PCT
3. a manager had personally visited a sample of schools in order to validate measurements recorded by screeners. A manager in PCT 2 said that, because their screeners did not use stationary scales, but took scales from school to school, it was necessary to calibrate the scales twice a year. It was suggested that DH guidance on calibration should distinguish between stationary scales and those that are moved.

The importance of checks built in to the DH data upload ‘tool’ was also highlighted by several respondents. For example, one observed (PCT 2):

There’s a check built in to the software when you enter measurements – “Are you sure?” You’ve got to be damn sure!

Getting the child’s home addresses right was highlighted as very important, and also necessitated checking with schools. Concern was expressed in one PCT that the Child Health Database is not up to date, and in this Trust, screeners copied and encrypted the electronic file of addresses from schools on the day of measurement. This strategy was said to ensure that addresses were up to date, and obviated the need for further checking.

4.2.2 Data processing

All but one PCT took four to six weeks to send out the feedback letters. Interviewees in PCT 4 reported that they were able to send out the letter on the same day or the following day, and said the longest delay would be a week, though this was rare. Interviewees in this Trust were very positive about their process of feeding back, but it should be remembered that this PCT had been feeding back results to all parents for three years and over this period had developed an effective system with built in checks and balances. In other PCTs, delivering routine feedback for the first time, challenges and teething problems were commonplace. Their experience suggests that such initial difficulties are to be expected as the feedback process rolls out to other areas of the country, but that they should ease as the procedure becomes more established, and PCTs learn from the early experiences of others and improved guidance from DH.

In particular, IT systems and data handling had created some challenges in generating the feedback letters which had delayed timescales such that in some cases it had been difficult to meet the six week maximum target for feeding back. There were also some technical issues, such as the data tool overwriting previous data entered when new data were added (e.g. when inserting measurements for absentees).

The account of a manager in one PCT indicates how complex the demands of data processing could be. In this PCT, screeners’ measurements were recorded on paper, and input into a data system. Data were then extracted from that system into an Excel file, and subsequently manually copied and pasted into the feedback tool so that feedback letters could be generated. The manager responsible for this element of the process commented that once she had ‘fathomed’ the necessary elements of the procedure, it was straightforward. Moreover, she commented, data handling was less time consuming than physically putting together the feedback letters. She noted that when they first started, it took three administrative staff a whole week just putting the letters together.

These remarks were echoed by interviewees in other PCTs, who commented on the time needed for envelope stuffing – folding the letters and other enclosures. In part, this reflected a concern to keep postage costs down by using smaller envelopes – a need created by the fact that the PCTs did not have any dedicated additional resources for the feedback exercise. There were also some problems reported with the letter-generating software in the three PCTs that were giving feedback for the first time. For example, one respondent observed that she had to generate letters school by school, because if she tried to do too many at once the software would crash.
4.3 The feedback letters

Several PCTs noted that it would be useful to have the national guidance available as early as possible, as this would give them more time for the measurement and feedback programme across the school year.

All the PCTs had made some minor changes to the DH template, often aiming to simplify some aspects of it such as cutting sentences from the introductory paragraph or personalising the information. This coincided with a general perception that the letter was rather wordy and the language too complicated or ‘scientific-y’ for some parents. For example, one respondent (PCT 2) said: ‘It was so damn wordy, a lot of people wouldn’t understand it.’

All the PCTs, however, included the information about the risks to children of being overweight, and the back page explaining the BMI and how it was calculated.

Concerns were also raised about the accessibility of the letter to those who speak English as an additional language. A manager in one Trust (PCT 3) observed: ‘We have a big Ghanaian population in some areas, also quite a big Polish community. I don’t get any sense of how accessible the letter is to them.’

Echoing these concerns about the complexity of the letter, a senior practitioner (PCT 1) suggested using a ‘traffic light’ system, instead of the existing categorisations, and gave the following account of her concerns:

> The letter has too much information and is too complicated – for example, the explanation of centiles, people wouldn’t understand that. And it’s long, and it’s very very busy. They need to explain why they are collecting the data, and they need to explain confidentiality, but the way of giving results at the moment is not the [right] way.

The wording of the letter was also criticised as being harsh or ‘very dramatic’ for overweight, and especially for very overweight children, and one manager (PCT 4) spoke of an ‘urgent need’ to change the letter. In another area (PCT 2), the service lead observed:

> It’s never going to be easy to tell a mother that her child is overweight, but especially when your letter talks about heart disease and cancer. ... [to say that] you’ve fed your child food that predisposes your child to cancer – my God!

There were mixed views on how effective such shock tactics were likely to be. But on the whole people had chosen to go with the letter because they were aware that a lot of work had gone into its development. That said, as discussed below in relation to calls from parents, there was a consistent view, across PCTs – and in line with feedback from parent interviews (see Chapter Three) – that the letter would be better if it were simplified and used ‘softer’ language. For example:

> I’m not sure about shock therapy

Sometimes parents know their child is overweight, but they don’t want it pushed in their face.

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30 Two examples were replacing ‘For your child at their age and height, the healthy range is...’ with ‘A healthy weight for [child’s first name] at his age and height is between...; and changing ‘It is very important that you now seek further information and advice by contacting your NHS’ to ‘It is very important that you now contact me...’
I think they are offended, and that the feeling is we’re telling them you are a bad parent.

A related issue was highlighted by a practitioner in PCT 1, who described the feedback letter as ‘one size fits all’, and argued that, as such, it did not take into account individual sources of variation – for example that a very active child might be more muscular and thus have a higher BMI. A manager in the same PCT said that they explain to those who call that it’s a screening tool and they recognise there may be other factors involved. She suggested that this kind of explanation should be incorporated into the feedback letter next year.

4.3.1 Including additional information

The PCTs varied in how much additional information was enclosed with the results letter. All but one (PCT 1) had included the Change4Life leaflet, and those who commented on the DH leaflets were positive in their feedback. The Trusts also often included local information. PCT 3 was perhaps the best developed example of this, and included, alongside Top Tips for Top Kids and Change 4 Life leaflets, vouchers for free activities at local pools and leisure centres, and other local information. This PCT had tailored the letters and supplementary information sent to different weight categories. Parents of healthy weight children were sent information including healthy tips, vouchers for services including swimming, and a timetable of leisure centre activities for children and families. Parents of overweight and very overweight children were also sent information about the PCT’s YW8 (Why Weight) programme (an alternative equivalent to MEND, see 4.1.5 below). It is not possible to say whether this approach had any impact on levels of parental calls, in comparison to the other PCTs, because this Trust only included a named contact on letters sent to parents of overweight or very overweight children.

4.3.2 Sending letters

All PCTs had posted the letters, addressed to the ‘parent or carer of’ the child. As was noted by some parent interviewees (see Chapter Three) this was said to have caused problems in a small number of cases, because the letter was identifiably concerned with the named child and could be opened by them. For example, in one area (PCT 1), the feedback mail out for some Year 6 children coincided with letters going out to notify parents of secondary school admissions, and some children had opened the feedback letter, thinking that it was their secondary school admission letter – and were said to be very upset on reading their results, causing the parents to feel both angry and guilty. Interviewees in PCT 4 stressed the importance of adding ‘In Confidence’ to the address, to reduce the likelihood of children opening the letter. However, such advice also raises an important ethical question about children’s right to know the results of their measurement. It may also be practically impossible, and ethically unjustifiable, wholly to prevent children from finding out their results or reading the letter. Rather, these comments indicate a need to anticipate that children may read the letter, and to consider how the letter may impact on children themselves, an issue not addressed in this evaluation.

4.4 The need for additional resources

You don’t realise the time commitments, especially in the first year of it
(PCT 3, Service Manager, Nutrition and Obesity)

In almost all cases, initial teething problems with the measurement and feedback process had been resolved, but this often depended on getting additional staffing input – for example to support data entry. Not surprisingly, in light of the accounts above, a clear message from PCT respondents was that the process needed to have additional resourcing to enable adequate administrative support to be provided. The resource implications in terms of
administrative time were summed up by one manager (PCT 3), in a Trust that had only provided feedback to Year 6 children:

\[
I \text{ estimated it [needed] up to two days a week of administrative time (including inputting data and generating letters, dealing with calls). As a provider unit, ultimately the cost comes to us. We’ve probably done about 1600 letters – next year with reception it will be 3000. You’ve got the printing costs, postage, and the time taken to generate the letters. If I hadn’t got someone in, we wouldn’t have managed to get the letters out in time [in the 6-8 week timeframe].}
\]

Interviewees in one PCT (4) did not raise resourcing issues, but it is worth noting, again, that this Trust had established systems for feedback over the last two to three years, and had two Band 2 administrative arrangements working full-time during term-time on the programme, including carrying out measuring in schools. This arrangement was said to have helped streamline the processes.

In the other three PCTs, interviewees identified the need for additional resources in three main areas:

- resource needs related to the IT demands of the process;
- resource needs related to the associated administrative workload – for example data entry and envelope stuffing; and
- the time required to deal with parent phonecalls. As discussed below, the number of calls received represented a very small proportion of the letters sent out, but calls were seen by some respondents as time-consuming and difficult to deal with. Several interviewees (across areas) noted that a call from a parent could last for up to an hour. Others, however, commented that they’d had fewer calls than they had hoped for.

In all three of these areas, additional resourcing had been secured, and this was seen as very helpful. As one respondent summed it up: ‘It worked well because we got someone in’. Another commented that additional support had been essential, ‘otherwise I’d be screaming by now’. However in some PCTs, pressured funding climates meant there was some concern about the need to ensure that funding is recurring, and not secured on an ad hoc basis.

### 4.5 Measurement coverage

Not all the PCTs had completed their measurement schedule at the time that managers were interviewed for this study, but all reported that they were meeting coverage targets, although it was said that these targets could prove challenging. The extent to which work had been completed depended on how early in the school year measurement had started, and many interviewees said they would hope to start the measurement process earlier next year. As noted in Chapter Two, two of the Trusts had only included Year 6 children, but they were planning to include Reception class children in the 2009/10 year. The reason for not including Reception class children in these PCTs was said to be because these children had already been measured, as part of a school entry health screen, by the time the feedback tool was ready in autumn 2008.

Some interviewees, across PCTs, raised the question of whether parents’ dissatisfaction with feedback might have an impact on coverage in future years, such that opt-out rates could increase. They advocated a need to monitor any fall in coverage that coincides with the introduction of the feedback programme. Such concerns should be considered in light of the survey findings reported in Chapter Three. Whilst most parents were happy to receive feedback, parents of overweight or very overweight children expressed more concerns with
the feedback letter, suggesting that – if there was any effect of feedback on subsequent opt-out rates – it might disproportionately affect those groups.

4.5.1 Exclusions

One issue to emerge in several PCTs related to which schools should be included in the measurement and feedback programme. As one senior manager (PCT 1) observed:

Are you aiming to cover all schools in the borough, or all children?

DH guidance states that special and independent schools are not included when calculating participation rates in the programme, as some PCTs do not have established relationships with these schools. Measurement in independent schools is nevertheless encouraged wherever possible.

It was evident that the PCTs varied in the extent to which they had included special schools or independent schools in their measurement programme, and managers in two PCTs expressed a desire for greater clarification on exclusions from measurement. One was in a Trust that had included special schools; the manager commented that a high proportion of children in an EBD school (for emotional and behavioural difficulties) took Ritalin, which could affect their weight gain. In another PCT, a manager commented that while some children in mainstream schools – such as wheelchair users – are excluded from measurement, the lack of information about children’s medical histories meant that other children, who should be excluded on medical grounds, are not. This manager’s concern may in part reflect the fact that she worked in the PCT where, as mentioned in Chapter Three, a child with severe growth faltering had been assessed as of healthy weight (because proportionately small) and the parent had made a formal complaint.

4.5.2 Opting out

None of the PCTs consistently reported problems with families choosing not to participate in the weighing and measuring programme. For example, in PCT 1 it was estimated that the opt-out rate in the current year’s programme was about 3%. Staff in PCT 4 had attended parents’ evenings in the autumn term to provide information about the measurement and feedback programme, and this was thought to have helped reduce opt-outs in that area.

A senior practitioner in PCT 1 said that she was aware that very overweight children disproportionately opted out of the NCMP, and she commented that this was an issue that central government needed to address. She observed that it might help to call the programme a health screening exercise, rather than a measurement programme, noting that – in her experience – Year 6 girls in particular (but not exclusively) could be very emotional and anxious about their weight. She reported that sometimes girls cried at the prospect of being weighed, and made comments such as ‘Am I fat, Miss?’ or ‘Please don’t tell my friends’.

In PCT 4, the consent form asks parents for reasons if a child is opted out. In line with the observations above, a worker in this Trust noted that there were more opt-outs for Year 6 than for reception, and the reason often given was that the child did not want to be measured. However, this was not seen as solely an issue for girls, and she reported that she was not aware of any gender differences in opt-outs. These comments on opt-out are borne out by NCMP data from 2006/7 and 2007/8, which show there was a significant association between opt-out rates and obesity and overweight with Year 6 pupils.


37
Another respondent (PCT 4) gave an example of a mother who had opted out because her child was very sensitive and who had commented that it would have been a good idea to have invited her to accompany the child for the measurement. The worker who described this case suggested that the idea of allowing parents to accompany their children was worth considering, although there were questions about how it could be handled – and the impact on schools – if many parents took up the invitation. Presumably, there is also a question about what would be done when parents are unable to attend, but wish to accompany their child or, and perhaps more importantly, that having parents present may increase a child’s anxiety.

4.6 Calls from parents

The member of staff allocated to respond to calls from parents varied across the four PCTs. In three areas (PCTs 1, 2 and 4) all letters included contact details for a named person – the child measurement coordinator, the school nurse lead, and in one case, a senior clinical manager, whose administrator effectively operated a filtering system, dealing with initial calls, and only referring to the school nurse lead parents who raised issues that could not be resolved in the initial call. In PCT 3, the working group for school nursing (which led on the NCMP work) had decided that parents of healthy weight children did not need a named contact on the letter. In this area, letters to parents of underweight children gave a contact number for the school nurse (and parents were advised to contact the school nurse or GP) and parents of overweight or very overweight children were given the name and contact number of the under 18s coordinator of the Trust’s obesity programme. In this area, interviewees reported that this differentiated approach worked well.

Nonetheless, variation in who handled calls raises a question about the necessary expertise and knowledge-base to deal with calls. Certainly, the call takers who were not expert in child weight or measurement suggested a need for training or guidance in dealing with queries. One commented that she made clear to parents who called that she was not medically qualified, and hence could not answer questions such as whether an existing medical condition could affect a child’s growth. In another area, the administrator who handled calls would refer any queries that she could not deal with herself to the school nursing team, and she made the following observation:

‘I’m an administrator, I’m not trained. So if they were quite irate, or if they wanted more information I would pass them on. If they were just calling to say they didn’t agree with the letter, if I could pacify them, then I dealt with it myself.

4.6.1 The volume of calls

Table 4.1 shows the volume of calls received by workers in each PCT, at the time of our evaluation interviews.

<table>
<thead>
<tr>
<th>PCT</th>
<th>Number of calls</th>
<th>Total letters sent</th>
<th>Calls as per cent of letters sent</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCT 1</td>
<td>16</td>
<td>2806</td>
<td>0.06%</td>
</tr>
<tr>
<td>PCT 2</td>
<td>27</td>
<td>1776</td>
<td>1.5%</td>
</tr>
<tr>
<td>PCT 3</td>
<td>10</td>
<td>220/1900*</td>
<td>4.5% / 0.5%</td>
</tr>
<tr>
<td>PCT 4</td>
<td>66</td>
<td>4224</td>
<td>1.6%</td>
</tr>
</tbody>
</table>

* It was reported that in total, approximately 1900 letters had been sent out at the time of interview, but only the 220 letters to parents of overweight or very overweight children had been given a named contact.

In some instances, the final number of calls may be higher, as measurement and feedback was still ongoing at the time of the evaluation.
Some interviewees, in all four PCTs, expressed concern that the number of calls was so low, relative to the number of letters sent, and that people were not responding to the letter. For example, one respondent (PCT 3) who expressed such concerns was asked if she would have liked to receive more calls. She answered:

Oh yeah. Even if they were all complaining, having a go. But no one calling me – is it a missed opportunity? I’d have much preferred to have 100 complaints – that they’d thought about it enough to do something. My fear is that they go ‘eugh’, have a moan, and then it’s forgotten, nothing changes.

Similar views were expressed by other respondents in the other PCTs. For example, another (PCT 2) said ‘I am more concerned about how to reach those that don’t call’. In another area (PCT 4), the measurement team were considering implementing follow-up phone calls to parents of overweight or very overweight children, because of the relatively poor follow-up response. However one respondent noted that the consequent increase in numbers would have an impact on their capacity to provide support to families.

4.6.2 Parents’ reactions

The reaction of parents making contact following the feedback letter varied within PCTs. Some parents called for information and advice, whereas others were angry or upset by the letter and had called to complain. For example, the worker who dealt with calls from parents of overweight and obese children in PCT 3 commented that, of the 10 calls she had received to date ‘three calls were pure complete “How dare you?”’. The other seven callers had been sent details of the Trust’s YW8 programme (equivalent to MEND), and three had since joined the programme.

Similarly, in PCT 4, it was said that a minority of callers (about one in five or six) were angry about receiving the letter, and these tended to be parents whose children just fell into the overweight category. In only one area (PCT 2) was it said that all the calls received were from parents who were complaining about the feedback letter.

Although callers who were angry or upset about receiving the letter appeared to be in the minority, several interviewees expressed concern about this group, and it was clear that these calls could have a tremendous impact on those handling the calls. For example, one participant (PCT 2) questioned the impact of feedback in terms of her professional ethics as a practitioner, saying ‘We can’t keep insulting people, that’s not what nursing’s about’. More generally, there was a perception that parental upset and anger was to be expected, given the sensitive and emotive issue of childhood obesity. For example:

There’s a feeling [among parents] of failure, of not protecting the child, not doing the right thing.

It’s very personal information, very emotional, being fed back in a very impersonal way.

Several respondents suggested that the use of categorical divisions to define overweight was a source of complaints. In all PCTs – and in line with the comments of some parents participating in this evaluation (see Chapter Three) – staff reported calls from parents who challenged the description of their child as overweight. One respondent (PCT 2) reported that most of her calls had come from parents of children who were just a pound or two overweight, and she observed that ‘if I saw them in clinic, I’d be saying, don’t worry, it’s fine’. Parents’ comments recorded by the staff taking calls included, for example:

My HV (or GP) doesn’t think he is overweight.
Children being weighed in January – it’s a ridiculous time of year. We all put weight on over Christmas.

4lbs is nothing, what’s the point of this.

In PCT 4, the parent of a Reception class child who was 5lbs overweight had sent photos of the child to the local BBC radio station, defying them to describe him as overweight. They ran the story with a reporter on the street asking passers-by if they thought the child was overweight. The story was picked up by local TV, and had resulted in the Director of Public Health making media appearances to explain the programme. Similarly, in another PCT, a parent had complained to their MP about the feedback letter. Beyond these individual examples, there was not much evidence from PCT interviews of any wider impacts, either in the media or in terms of other services such as schools or GPs. But these incidents were highlighted by a number of respondents in the PCTs concerned (and the case of press involvement in PCT 4 was mentioned by participants in other areas). Arguably, such cases provide a good example of the way in which isolated incidents may have wide impact on perceptions of parental views of the feedback, which are not representative of the views of the majority.

A related issue, highlighted by several respondents across areas, was the mismatch between the overweight and very overweight categories and public perceptions of overweight and obesity. One interviewee noted that the high prevalence of overweight and obesity means that an overweight child may not look particularly large in relation to other children in the class. Another commented that:

The general public tend to think of obese as supermorbidly obese – like on the Jerry Springer Show.

4.6.3 Dealing with calls

Views were mixed on the usefulness of the DH ‘crib sheet’ guidance on dealing with calls. One respondent said she found it helpful because it ‘keeps you on track when someone’s chewing your ear off’. Others saw it as a useful preparatory tool, but less useful in the calls themselves because it inhibited the natural flow of conversation. For example, one commented that the questions were not phrased in the way a parent would speak on the phone, and so, if following it too closely, there was a risk of not answering their questions. She commented that, ‘it’s a guide, not a script – it doesn’t lend itself to a natural flowing conversation.’ In a similar vein, another said:

it comes across as very staged and I can’t work like that, I think the parent would be able to tell.... If you come across as staged or robotic they won’t listen. You have to be ‘normal’, if you know what I mean, not a condescending health professional... The kind of script that came through is like something NHS Direct would use.

Several respondents who had dealt with calls from parents offered advice on how best to deal with calls. A clear theme to emerge was the need for parents to feel that they had been heard, to let off steam. For example:

My tactic was to let them rant, and just ‘mm’ and ‘ah’ until they run out of steam, and say ‘I’m sorry you feel this way’. When they’ve finished, I’ll clarify – that the measurement was done in this way, in private, by school nurses. That parents had the chance to opt out. I’ll explain we have to have cut off points, that we are trying to clarify. They’ve all accepted that – no one’s come back again.’
I learned to let the parent lead the conversation and work from there. I don’t go in with a set speech. Let them let off steam and then they calm down. It’s about encouraging them to talk about it, and talking to them as a person. It’s important to reassure them that it’s anonymous and that information doesn’t go back to schools. Sometimes that takes the heat out of it – they worry about their child being labelled.

4.7 Intervention and support following the feedback letter

All the PCTs had services in place to which parents who responded to the feedback letter could be referred (see table 4.2), and this was seen as critically important for several respondents. For example, the obesity lead in PCT 3 commented:

*Having a service to offer is really important. I would have been very resistant to having my name on letters if there was no service. If letters are going out and you’re telling someone their child is at risk, you’ve got to have somewhere for them to go – have a signposting mechanism at least. Parents will say ‘so what, what can you do?’ We’re offering something with no guilt attached – it’s positive, it’s about moving forward.*

Nonetheless, the uptake of these services was very low, and the difficulty of translating the information in the letter into behaviour change was highlighted by interviewees in all areas. For example, one manager (PCT 2) observed:

*Behaviour isn’t just about knowledge – if we all behaved according to our knowledge we’d be very different.*

**Table 4.2 Relevant support services, by PCT**

<table>
<thead>
<tr>
<th>PCT 1</th>
<th>There is a MEND programme in one area in the Trust, and also a pilot school-based scheme called Community Fit Club. Families take part in three consecutive 12 week courses, run by health trainers, who are trained volunteers. The respondent commented <em>‘We see that as really important – for change to happen, you need longer term input.’</em> Parents who were referred to the school nurse after calling had been given individualised advice, and follow up was planned in 3-4 months although parents could call in the interim period if need be.</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCT 2</td>
<td>The Trust offers the MEND programme but, as in other PCTs, this was said to have had very low take-up. An interviewee noted that the programme demands a big commitment from families – two nights a week for 12 weeks – and described the cost of running the programme as <em>‘phenomenal’</em>. Four of the 27 parents who called following the feedback letter were seen by the obesity lead in clinic.</td>
</tr>
<tr>
<td>PCT 3</td>
<td>This Trust runs a locally developed alternative to the MEND, YW8 (Why Weight), which has a similar programme structure and has been running for four years. They chose not to use MEND because of what was described as the prohibitive cost of the programme. YW8 provides weekly sessions over 12 weeks during the school term, and targets 8-13 year olds and their parents. As with other PCT’s experience of MEND, it was described as difficult to recruit families to YW8. The Obesity Lead offered to send a YW8 pack to all parents who called as a result of the feedback letter (all of whom were parents of overweight or obese children), and three of those families had since started the programme. The respondent said the letter <em>‘kicked them into action’</em>. In addition (as discussed above) the feedback mailout included vouchers for free leisure activities.</td>
</tr>
<tr>
<td>PCT 4</td>
<td>This Trust also offered the MEND programme, as well as a weight management programme called Way Forward, to which parents calling about overweight or obese Year 6 children were referred. Parents were also advised about free swimming lessons in the Trust area. At the time of the evaluation, referral pathways were still being developed for Reception-aged children, and so parents of these children were offered a place on a waiting list for services.</td>
</tr>
</tbody>
</table>
Participants in all areas commented on the difficulties of recruiting families to long-term intervention programmes such as MEND\textsuperscript{33} (or equivalents), because of the time commitments involved. In addition, the lack of uptake of services partly reflected the small proportion of parents who called after receiving the letter. As the manager quoted above went on to say, it had been thought that ‘people would be chomping at the bit for support, but they’re not. The change needed is massive.’ In that PCT, the obesity lead noted that they had planned to refer callers with overweight children to her clinic, but in the end, only four of her 27 callers agreed to come to clinic, and in only two cases was it decided that the family would visit the clinic again. She remarked, ‘that’s not much after 1700 letters’.

In considering these comments about the extent of impact, it is important to bear in mind a note of caution sounded by one interviewee\textsuperscript{34}. She commented that lack of capacity in her service meant that they would not have been sufficiently prepared if there had been a significant demand for advice or intervention, and in particular, capacity within the School Nursing team had precluded referrals to that team. In another area, a practitioner echoed these capacity concerns, noting that the NCMP feedback this year had been delivered alongside additional pressures on PCTs (and on school nursing teams) due to the swine flu pandemic and the HPV vaccination programme. This question of capacity was related to resourcing issues, since, in all areas, follow-up work following the feedback letters was absorbed within existing budgets. Furthermore, several interviewees noted that it would take time to determine whether the feedback programme, including the letters themselves and enclosures such as the Change4Life leaflets, had any long-term impact on the prevalence of childhood overweight and obesity.

Several respondents suggested there was a need for a more targeted approach, proactively to follow up overweight and/or very overweight children, although again, this depended on available resources. Ironically, in one Trust (PCT 1) that was not yet using the feedback tool with Reception children, very overweight children were currently followed up if identified during the School Entry Health Screening. The school nurse lead observed that they might not be able to follow up reception children in future, because, unlike consent for NCMP, parental consent for School Entry Health Screening allows for individualised follow-up of families by professionals such as the school nurse.

\textsuperscript{33} The MEND acronym stands for ‘Mind, Exercise, Nutrition…Do it!’. It is an evidence-based model of targeted intervention for families of overweight children. See http://www.mendprogramme.org/

\textsuperscript{34} Unidentified to protect confidentiality.
5 Findings: the school perspective

5.1 The school’s role in the NCMP

Administrative staff clearly had most to do with the measuring programme (making arrangements, getting parental consent, organising the actual measuring day) and so were well placed to respond to our questions. However, their involvement also reflected the fact that schools mostly saw themselves as facilitators in the measuring process, providing universal access to children and a venue for health monitoring, rather than active participants. The most common theme emerging from the school interviews was that the weighing and measuring programme was just a routine event which caused minimal disruption to school business. Comments included ‘no fuss’, ‘all very easy’, ‘not a big deal’, ‘the nurse just came in and did it’. Measurement of a whole class could be done in less than half an hour, with little call on school resources apart from the need to find a quiet room where it could be undertaken, and interviewees were not aware of any children becoming upset or being teased.

5.2 Children opted out of the programme

The arrangements used by schools to inform parents that the NCMP was due to happen and to obtain their consent differed for Reception and Year 6 children. Permission for weighing and measuring reception class children was usually obtained as part of the consent for the wider health development check undertaken when children started school, whereas parents of Year 6 children were sent a letter based on the DH template with the opportunity to ‘opt out’. This meant that there were far fewer opt-outs of reception class children – indeed several interviewees expressed surprise that parents of reception class children might be able to do this.

‘It [weighing and measuring of reception class children] is done as part of the health check – they don’t get the chance to opt out’. 

Just three schools were aware of reception class children (four in total) being withdrawn from the NCMP, with no obvious reason in three of these cases according to the interviewee (i.e. not because the child was likely to be judged overweight). Year 6 children were more likely to be withdrawn, but still only a handful of cases – between two and eight per school. Where reasons were known, it was thought to be because of fears that the children would be labelled overweight, in other words that ‘it’s the ones the programme is trying to target that opt out’ (Healthy School coordinator). However this was not a universal view, with one head teacher believing that ‘it was a group of girls who got together and decided they didn’t want to do it’, despite not having particular weight issues, and another school reporting that two Year 6 pupils who were opted out came from minority ethnic families who may not have understood what they were being asked to consent to.

No school reported sending out the consent letter in a language other than English, although one interviewee in a school with an above average proportion of pupils from minority ethnic groups said if they thought there was likely to be a language issue, they tried to ensure the child understood the letter and could explain it to their parents. Another school had picked up the fact that two families of minority ethnic children had mistakenly opted out when they had thought they were opting their children in, and had acted to correct this.

In PCT 4, where routine feedback had been provided to parents in previous years, one school said that the number of parents opting their child out of the measuring programme had reduced to zero. It was suggested that this was because parents’ fears about being ‘told off’ in the letter had been allayed, and they had realised that the information ‘wasn’t going anywhere’. This experience however related to the PCT’s previous feedback letter, which
simply gave height and weight measurements for the child, and was less explicit than the DH template about the risks to children’s health from being overweight.

Participation rates can be lowered by children being absent from school on the day of measuring, as well as by those who choose not to take part. Schools reported varying practice in relation to absences, with some saying that such children would be weighed at a later date and others not. This reflected the policy of the PCT, rather than the individual school. One PCT in our study, for example, sent information to all parents after the weighing and measuring exercise, including opt outs and absentees, which resulted in some parents of children in the latter group getting in touch and wanting their child to be measured.

5.3 Parents contacting the school after receiving feedback

Although we deliberately selected schools where we knew (from our PCT contact) that results from the measurement programme had been sent to parents, it appeared that most schools did not know when parents had received the results, nor had they seen specimen copies of the feedback letter. Where the school interviewee did know that feedback had been sent to parents, and what information the letter contained, this was usually because they or a colleague were the parents of children in Reception or Year 6 classes, and so had received feedback letters themselves. Only four parents across all 11 schools were reported to have got in touch with their child’s school after receiving the letter, although school representatives understandably did not know how many might have contacted the PCT person named in their results letter instead.

Two of these four parents who had got in touch with the school had been told their child was overweight and disagreed, but (according to the interviewee) they were more ‘bemused’ than cross, and had ‘shrugged their shoulders and said it was typical NHS’. A third parent (herself a teacher) was said to be concerned because her child had been reported as a healthy weight and she had not been contacted by the nurse after the weighing and measuring exercise even though it was apparent from the child’s extremely small size (‘like a two year old’) that he had significant growth problems. The interviewee suggested that nurses should do a visual check rather than just rely on the ratio of weight and height. The fourth parent (at a different school) had telephoned to complain because her child had been judged overweight, and was told to contact the PCT instead. The head teacher in this school explained that ‘this was a health issue being done by the PCT and this was stressed in the consent letter, so it wasn’t appropriate for us to be involved at that stage’.

5.4 Schools’ opinion of the NCMP

School staff appeared to be in favour of the programme, or at least not be against it. The over-riding impression was that it was ‘just part of the job’ for administrative staff and had little impact on the work of teachers. It was neither a particular inconvenience nor an opportunity to engage with weight issues (except in one school, where the Healthy School lead had hoped to use school-level feedback from the NCMP as the basis of a Healthy School Action Plan, but had been unable to obtain this data from the PCT). One interviewee described her colleagues as ‘all in favour of this [the NCMP] being done, because they know that something needs to be done about children who are seriously overweight – as long as they don’t have to do anything about it’.

There appeared to be a number of reasons for schools generally wishing to maintain a distance from the programme, whilst being happy that it was occurring. Partly this was to stress the confidentiality of the process, reassuring parents that information about individual children was not shared with the school by the PCT. For example, one head teacher described how although the school had invited a PCT representative to an open evening to
set up a stand and speak to parents about the weighing and measuring programme, and that this had been beneficial in encouraging a good take up of the programme, she had instructed staff to keep away from the PCT stand ‘so that parents could see it was independent and the school was not part of it’, to give them confidence that the measuring would be confidential. Maintaining a distance also meant that school staff were shielded to a large extent from angry responses, and parents were directed to contact the PCT with any concerns about the feedback. A further possible reason might be that work with individual children and their parents on weight issues could have a negative impact on parent-teacher relationships. The head of the school that had invited the PCT representative to a parents' evening had in the past spoken individually to parents whose children were obviously overweight, but this had not been successful, and the school’s work in this area was now focused on whole class or whole school activities, such as the content of school meals and packed lunches, and teaching about healthy eating.

5.5 Schools’ suggestions for improvement

Relatively few suggestions were made by interviewees in schools for how the NCMP and procedures for feeding back results could be improved. Those that were made, generally by just one interviewee, included:

- ensuring plenty of notice is given to schools about when the measurement will take place, to avoid clashes with outings and other activities;
- informing schools when results have been sent out to parents and the nature of the information they receive;
- making sure that schools receive timely feedback on their school-level results so that these can be used by the school to inform Healthy Schools activities;
- providing practical support, such as people to come into the school to give advice to parents and children to help them address the problems of being overweight, rather than just feeding back ‘figures and statistics’; and
- weighing and measuring, and sending of the results, to be done by a school nurse who knows the child and family and can follow up if necessary.
6 Conclusions and recommendations

In this final chapter we summarise the study’s main findings and discuss implications of these findings for revising the NCMP Guidance for 2009/10. This small-scale study set out to consider the impact on parents, schools and PCTs of providing routine feedback to parents on their children’s height and weight. The overall finding was of a generally positive response to the NCMP and the principle of routine feedback. We review the findings from each of the three perspectives – parents, PCTs and schools – before focusing specifically on the feedback letter, parents’ response and effecting change, and practical suggestions for PCTs.

An overwhelming majority of parents were supportive of the NCMP and most welcomed receiving routine feedback, although parents of overweight or very overweight children were more likely to disagree with the results and less likely to find the feedback letter helpful. The benefits of receiving information from the NCMP were that it confirmed for parents of healthy weight children that they were ‘doing the right thing’, and prompted parents of children outside the normal weight range to consider the need to make changes. However a small minority of parents reported a negative impact, in that the letter made them angry, worried or upset; and some concerns were expressed that feedback could increase the risk of eating disorders by making children and parents over-focused on weight issues.

A third of parents surveyed said they planned to make changes as a result of the feedback letter, and these were particularly parents of overweight and very overweight children. The parent interviews, however, suggested that this was unlikely to have happened in practice, and few parents felt the feedback letter had made any difference to their child or their family, although half of the interviewed parents believed it had made a difference to them personally. Among parents of children in the overweight categories there appeared to be a significant sub-group who believed they were already doing things to encourage a healthy weight and found it difficult to identify what more they could do.

Most PCT interviewees were relatively positive in principle about routine feedback, but had reservations about the wording of the feedback letter, as did some parents, particularly the ‘harsh’ language of the letter to parents of very overweight children, and the accessibility of the letter to parents with limited literacy in English. Concerns were raised too about the low uptake of support and advice, in that the letter did not appear to have succeeded in initiating a help-seeking response from the majority of parents of underweight, overweight or obese children. Although the number of calls to PCTs was small, they included calls from parents who were upset or angry. Although these were untypical of parents’ reactions to feedback as identified in the survey, they were a cause of considerable concern to some interviewees.

From the school perspective, NCMP appeared to cause minimum disruption; schools were often unaware of when the feedback was being sent out to parents and parents rarely contacted the school after receiving feedback. There were fewer opt-outs for Reception than for Year 6 children, attributed to the fact that consent for weighing and measuring was often obtained as part of the consent for the health development check at school entry, but overall opt-outs were perceived to be low. The school staff interviewed were generally supportive of the NCMP and routine feedback to parents.

6.1 The feedback letter

Although the majority of the parents were satisfied with the way the information was given in the letter there was a small number who commented on difficulties in understanding. We cannot conclude from this finding that clarity of the letter is not an issue. In particular, whilst the survey response rate of 31 percent is higher than many surveys of this kind, it must be acknowledged that the study may well have under-represented parents with limited English
literacy – after all, those who could not understand the feedback letter are unlikely to have understood and returned the evaluation questionnaire. In addition, limited space in the survey meant it was not possible to ask specifically about understanding of the letter, only with the parents interviewed. Even then, some parents who had completed the survey, were excluded from the follow-up interview because their English was insufficient to enable them to be interviewed (and interpreting was not feasible within the constraints of the study and the telephone interview method). Further research is needed to focus specifically on the accessibility of the feedback letter to parents where literacy may be an issue or where parents have limited English. Such focused investigation seems particularly important given that NCMP data show higher prevalence of obesity in minority ethnic groups that may speak English as an additional language, including Bangladeshi, Pakistani, and Black African families.

Both parents and PCT representatives expressed concerns about the way the letter was worded, particularly for parents whose children were in the overweight categories, although there also was a view among some that ‘hard-hitting’ language may be necessary to prompt parents into action. Not only was the wording of the letter considered somewhat insensitive, but the references to risk of disease, such as heart disease and cancer, and early death were singled out for particular criticism. The inclusion of such information may be justified with reference to evidence that parents may lack awareness of the health consequences of obesity. For example, Jones and colleagues 35 conducted focus groups with parents as part of the Gateshead Millennium Study, and reported that parental knowledge of problems associated with childhood overweight and obesity centred on social and mobility issues rather than health problems.

Nonetheless, although the use of scare tactics in health promotion can persuade people that they face a significant threat, if not implemented correctly they can also promote denial or avoidance, which prevents people from taking action to reduce the risk36. Moreover, Abraham, Norman and Conner 37 observed that threat perception in itself is not closely associated with action – particularly if the threat seems distant – and thus may be only minimally related to behaviour change. That last observation seems particularly relevant in the context of the NCMP, given that problems such as heart disease are commonly associated with later adulthood, and may not therefore be judged to be an immediate threat to a school-aged child.

As described in the introduction to this report, research suggests that ‘scare tactics’ are only effective when the threat depicted is seen as relevant and significant and when the targeted individuals believe that they can act to protect themselves (or their children). It is questionable whether the feedback letter and Change4Life pamphlet are sufficient, as an intervention, to make parents believe that they can accomplish the changes needed to make a difference to their child’s weight status. A critical related point is that some parents of overweight and very overweight children did not see how they could make such changes, because they believed that they were already doing what is recommended to maintain a child’s healthy weight, yet it had made little difference. As an additional factor, evidence suggests that parents need to have reached the appropriate stage in acknowledging or

believing that their child’s weight is a health problem, or recognise that they as parents are overweight, before they are ready to make changes.  

There is also the need to consider whether the use of threats or scare tactics in the context of childhood overweight could be associated with any unintended consequences for the child. The Change4Life material is clear that parents should not encourage children to diet, and the feedback letter for parents of overweight (but not very overweight) states that children should not aim to lose weight, but several respondents – both parents and PCT staff – expressed concerns that feedback could result in an increase in disordered eating or in parents encouraging children to diet. One parent interviewed reported weighing her child almost daily, and a senior practitioner in one PCT described the anxiety of Year 6 girls about their measurements. Such concerns are consistent with well-established evidence of body dissatisfaction and dieting behaviour in primary-school aged children, particularly girls. Neumark-Sztainer and colleagues found that parents of overweight teenagers who accurately perceived their child to be overweight were more likely than those who were unaware of their child’s weight status to encourage the young person to diet, and this behaviour actually increased the risk of the young person being overweight five years later.

The evidence from the NCMP study would suggest that the Department should reconsider the wording of the letter and review the evidence base for the effectiveness of using a scare tactic approach in changing behaviour.

6.2 Parents’ response to the letter

Parents whose children were overweight, especially those who were ‘borderline’ cases, were more likely to disagree with the results. As discussed in our introductory chapter, studies have found that mothers of overweight children tend not to recognise that their child is overweight, particularly parents of children under the age of eight and parents with a lower level of education. Providing parents with feedback on BMI percentile-for-age-and-gender, and identifying their child’s weight classification in the context of broader obesity prevention policies, appeared to increase the accuracy of parental perceptions according to recent American study evaluating a weighing and measuring programme in Arkansas. This suggests that providing routine feedback to parents whose children have been weighed and measured under the NCMP may have an impact on improving the accuracy of parents’ perceptions of their child’s weight.

6.2.1 Pro-active follow up

Given evidence of the complexity and challenges of successful interventions for overweight and obesity\(^{46}\), it is unlikely that the letter and enclosures alone could produce sufficient cognitive, lifestyle and behavioural change to address established overweight or obesity in children – whatever the good intentions expressed in interviews with parents. Rather, a more targeted approach may be necessary. The fact that so few families sought help or advice was a matter for concern for many PCT representatives, and it was suggested by several PCT interviewees that it might be better pro-actively to follow up families who are overweight or obese. The timing of the follow-up may be an important consideration since comments from some parents interviewed suggested that it took a little time for negative results to ‘sink in’. This strategy would, however, clearly have resource implications, not least in terms of staff time, and in the availability of services into which families can be referred. It may be useful to explore the potential for school nurses to have a role in such follow-up, although the capacity of the school nursing team was an issue for some of the PCTs in the study. Recent research in the US\(^{47}\) reported that parents preferred receiving information about their child’s body mass index from the school via a letter from the school nurse, and advocated a role for school nurses in supporting childhood nutrition and weight control through schools.

6.3 Practical suggestions and support for PCTs

Of the four PCTs that participated in the current study, one had been giving parents’ feedback on child measurements for several years, and reported noticeably fewer difficulties with the exercise, suggesting early problems can be overcome. The other three PCTs had all experienced some early challenges in setting up the measurement and feedback process. Interviewees in these trusts consistently highlighted the need for adequate resourcing to support the workload involved in the process, from generating letters and stuffing envelopes through to dealing with calls from parents. Such support was seen as essential, not least to meet the timescale targets for feeding back. It was noteworthy that the fourth PCT, with established and evidently effective systems, had full-time administrators managing the process. Taking capacity and resource issues into account, practical suggestions highlighted by the study for consideration in the revised Guidance include:

- using schools instead of the Child Health database for child contact details;
- putting a return address on the feedback letter envelope;
- providing feedback to ‘opt-outs’ and absentees regarding the importance of weighing and measuring and including health promotional material such as the Change4Life pamphlet;
- starting the measurement programme as early in the school year as possible;
- PCT attendance at school parents’ evenings to raise awareness of the NCMP; and
- asking parents to provide a reason for opting out on the consent form.

In addition, the study found that those taking the calls from parents would welcome further training and/or guidance in how best to handle them, particularly guidance in how the results should be interpreted. Training and support in the use of the DH tools and resulting IT issues would also be welcomed.

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Appendix 1: Template for feedback letter

Private and confidential
Parent / Carer of «Child_Firstname» «Child_Surname»
«Child_Address1»
«Child_Address2»
«Child_Address3»
«Child_Address4»
«Child_Postcode»

10 December 2008

Dear Parent/Carer,

Your opportunity to take positive action:
National Child Measurement Programme results for «Child_Firstname»
«Child_Surname»

We recently measured your child’s height and weight at school as part of the National Child Measurement Programme. A letter about this was sent to you before the measurements were done.

This national programme helps monitor children’s health and well-being and aims to make parents aware of any potential problems with their child’s weight so that they can seek help if needed. The information we collect is held by your local NHS and treated confidentially. It has not been shared with school staff or other children.

Here are the results for your child at the time of measuring:

<table>
<thead>
<tr>
<th>Date measured</th>
<th>Date of Birth</th>
<th>Height</th>
<th>Weight</th>
<th>Percentile for BMI (body mass index)</th>
</tr>
</thead>
<tbody>
<tr>
<td>«DateofMeasurement»</td>
<td>«DateofBirth»</td>
<td>«Height2»</td>
<td>«Weight2»</td>
<td>«BMI_Percentile2»</td>
</tr>
<tr>
<td>«DateofMeasurement»</td>
<td>«DateofBirth»</td>
<td>«Height3»</td>
<td>«Weight3»</td>
<td>«BMI_Percentile2»</td>
</tr>
</tbody>
</table>

These results suggest that your child is «ChildDescription» for their age and sex. For your child at their age and height, the healthy range is «M2ndkgs» - «M91stkgs» kg («M2ndvalue» «M91stvalue»)

«Childsummary1»

«Childsummary2» «PCT_Telephone» and ask to speak to «PCTLeadContact» for further advice and information.

The back of this letter shows you how we work out these results and gives you more information on what it means for children’s future health.

Thank you,
«PCTLeadContact» («PCTLeadContactTitle»)
The child summary 1 and 2 paragraphs will read as follows dependent on the result:

**These results suggest that your child is a healthy weight for their age and sex.** For your child at their age and height, the healthy range is XX–XX kg (X st X lbs – X st X lbs).

Children of a healthy weight are more likely to grow into healthy adults. To keep growing healthily into adulthood, it is very important that your child eats well and is active, so that they are healthy on the inside as well as the outside.

The back of this letter shows you how we worked out your child’s results, and the enclosed leaflet gives you tips on how to help your family eat well and be active. If you would like more advice about your child’s weight and what to do about these results, you can contact your local NHS on [PCT to add phone number] and ask to see [PCTs to add (eg, school nurse, practice nurse, or other)].

The back of this letter shows you how we work out these results and gives you more information on what it means for children’s future health.

**These results suggest that your child is underweight for their age and sex.** For your child at their age and height, the healthy range is XX–XX kg (X st X lbs – X st X lbs).

Some underweight children are perfectly healthy. But sometimes being underweight can be a sign of health problems or due to an illness.

The back of this letter shows you how we worked out your child’s results, and the enclosed leaflet gives you tips on how to help your family eat well and be active to help everyone achieve a healthy weight. If you would like more advice and information about your child’s weight and what to do about these results, you can contact your local NHS on [PCT to add phone number] and ask to see [PCTs to add (eg, school nurse, practice nurse, or other)].

The back of this letter shows you how we work out these results and gives you more information on what it means for children’s future health.

**These results suggest that your child is overweight for their age and sex.** For your child at their age and height, the healthy range is XX–XX kg (X st X lbs – X st X lbs).

Being overweight can affect your child’s health. As adults, children who are overweight are more likely to have high blood pressure, heart disease, diabetes and cancer. Most children shouldn’t aim to lose weight – but, it is important to help your child eat well and be active. Over time, this will help them reach a healthy weight for their age.

The back of this letter shows you how we worked out your child’s results, and the enclosed leaflet give you tips on how to help your family eat well and be active. If you would like more advice about your child’s weight and what to do about these results, you can contact your local NHS on [PCT to add phone number] and ask to see [PCTs to add (eg, school nurse, practice nurse, or other)].

The back of this letter shows you how we work out these results and gives you more information on what it means for children’s future health.

**These results suggest that your child is very overweight for their age and sex.** For your child at their age and height, the healthy range is XX–XX kg (X st X lbs – X st X lbs).

Being very overweight can affect your child’s health. Children who are very overweight, doctors call this clinically obese, are more likely to develop diabetes and high blood pressure. As adults, they are more likely to have high blood pressure, diabetes, heart disease and cancer. People who are very overweight are more likely to suffer poor health and die earlier than people who are a healthy weight.

You can help your child by encouraging them to eat well and be active, and the enclosed leaflet gives you some tips about this. However, it is very important that you now seek further advice and information by contacting your local NHS on [PCT to add phone number] and ask to see [PCTs to add (eg, school nurse, practice nurse, or other)].
How is your child’s result worked out?

Your child’s result (whether they are a healthy weight, overweight, very overweight or underweight) is based on a BMI percentile.

**BMI percentiles are worked out by:**

**Step 1:** Body-mass index (BMI) is calculated by dividing weight (in kilograms) by height (in metres) squared.

**Step 2:** Because children are growing, the interpretation of the BMI number depends on the age and sex of the child, so your child’s BMI is then compared with the UK 1990 growth charts. These growth charts are based on the BMI measurements of thousands of children in the UK to create charts of normal growth standards for children aged 2–20 years. These measurements are split into 100 units, to give 100 categories, or percentiles, and every child falls into one of these percentiles from 1 to 100.

![BMI Percentile Chart]

### What are the weight ranges?

The weight ranges shown below are an approximate guide for your child at their age and height.

<table>
<thead>
<tr>
<th>Underweight</th>
<th>Healthy weight</th>
<th>Overweight</th>
<th>Very overweight</th>
</tr>
</thead>
<tbody>
<tr>
<td>is the 2nd percentile or lower (&lt;M2ndkgs&gt; kg +&lt;M2ndvalue&gt; or less)</td>
<td>is from above the 2nd to the 91st percentile (&lt;M2ndkgs&gt; +&lt;M91stdkgs&gt; +&lt;M91stdvalue&gt; -&lt;M91tstdvalue&gt; -&lt;M91tvalue&gt;)</td>
<td>is from above the 91st to the 98th percentile (&lt;M91stdkgs&gt; +&lt;M98thkgs&gt; +&lt;M98thvalue&gt; -&lt;M98tvalue&gt;)</td>
<td>is above the 98th percentile (&lt;M98thkgs&gt; kg +&lt;M98thvalue&gt; or heavier)</td>
</tr>
</tbody>
</table>

Some underweight children are perfectly healthy. But sometimes being underweight can be a sign of health problems or due to an illness.

Children of a healthy weight are more likely to grow into healthy adults.

As adults, children who are overweight are more likely to have high blood pressure, heart disease, diabetes and cancer.

Children who are very overweight are more likely to develop diabetes and high blood pressure. As adults, they are more likely to have high blood pressure, diabetes, heart disease and cancer.

### Why do we use a BMI percentile measure?

BMI percentile is a measure of weight in relation to height, and gives some information about if a child is a healthy weight for their height, age and sex. It is not a perfect measure, but produces accurate results for almost all children, and is one of the best ways to tell if a child is a healthy weight.
Appendix 2: Survey Information Sheet

National Child Measurement Programme
Parents’ and carers’ views

What’s happening?

The Government’s National Child Measurement Programme measures children in Reception and in Year Six in schools in England. In a new part of this programme, some Primary Care Trusts (your local health authority) are sending information to parents and carers about their child’s measurements.

The Government has asked us to carry out independent research, to find out parents’ and carers’ views of how useful the feedback is, and how it could be improved.

What would you have to do?

We would be very grateful if you would complete the short questionnaire attached to this sheet. This asks you what you think about the results letter you have received. So we can get a picture of the range of families that send back questionnaires, there are also a few general questions about you and your family. Please send the questionnaire back to us in the FREEPOST envelope provided. You don’t need a stamp.

Send in your questionnaire straight away and you could win a £50 voucher.

To encourage a good response we are organising a prize draw. All completed forms returned within a week will be entered and four winners will each receive a £50 Love2shop voucher that can be used in a range of high street shops (e.g. Boots, Argos, Tesco)¹. You don’t have to give your name when you complete the questionnaire, but if you want to be entered in the draw, please give your contact details in the space provided.

¹No cash alternative is available. The winners will be contacted by phone to arrange posting of the voucher prize.

Anything more?

We hope you may be willing to help us again. We would like to talk to some parents to learn more about their views on receiving the results. This would involve a short telephone call to ask more about your views of the results you received. If you are willing to be called, please fill in your contact details on the questionnaire. You can change your mind about taking part, and drop out of the research, at any point.

If you are willing to be called, please fill in your contact details on the questionnaire.
You can change your mind about taking part, and drop out of the research, at any point.

Giving your contact details for the prize draw does not mean you have to agree to a follow-up phone call – you can say ‘yes’ to the prize draw, and ‘no’ to the phone call.

We can talk to everyone who agrees to be contacted, so we will select families who represent the variety of those that send back questionnaires, in four different areas of England.

What happens to the information you provide?

All the information you provide will be completely confidential and only used by our team for the purposes of the research. Information about individuals will not be shared with anyone outside the research team. All names will be removed from any information provided, so no one who takes part in the research can be identified. All information will be stored safely and securely and will be destroyed after the end of the study.

The researchers will write a report for the Government about their findings, and also provide feedback for your local health authority (Primary Care Trust).

Who is doing the research?

The research is being carried out by a team at Thomas Coram Research Unit: Janet Boddy, Ann Mooney, June Statham and Marjorie Smith. If you would like to know more, please contact Janet or Ann on 020-7612 6957 or email Janet at j.boddy@ic.ac.uk. Please contact us, not your child’s school.

You can write to the team at the Thomas Coram Research Unit, Institute of Education, University of London, 27/28 Woburn Square, London WC1H 0AA.

THANK YOU FOR READING THIS LEAFLET AND HELPING US TO LEARN FROM YOUR VIEWS.
Appendix 3: Parent Survey Questionnaire

Your views of feedback on child measurement

The National Child Measurement Programme has started to send families feedback about their child’s measurements – the letter you have just received. The Government (Department of Health) has asked us – an independent research team – to find out what parents think about getting this information, and to learn how it could be improved. We would like you to fill in this short questionnaire and return it in the FREEPOST envelope provided. All information provided will be confidential and only the research team will see your answers. To find out more, see the attached information sheet or call Ann Mooney or Janet Boddy on 020 7612 6957 or email j.boddy@ohe.ac.uk. Please contact us for more information, not your child’s school.

SEND IN YOUR QUESTIONNAIRE STRAIGHT AWAY AND YOU COULD WIN A £50 GIFT VOUCHER
All completed forms will be entered and four winners will each receive a £50 voucher to spend in a high street shop.

Your child (the child mentioned in the letter)

1. What year group is your child in?
   - Reception
   - Year 6
   (tick one box)

2. Is your child a:
   - Boy
   - Girl
   (tick one box)

Your child’s weight

3. What was your child’s weight category?
   - Underweight
   - Healthy weight
   - Overweight
   - Very overweight
   (tick one box)

4. Do you agree with that description of your child?
   - Agree
   - Disagree
   - Strongly disagree
   - Not sure
   (tick one box)

5. Do you think it was helpful to get your child’s results?
   - Very helpful
   - Helpful
   - Unhelpful
   - Very unhelpful
   - Don’t know
   (tick one box)

6. How satisfied were you with the way in which the letter gave you information about your child’s weight?
   - Very satisfied
   - Satisfied
   - Not satisfied
   - I did not understand the letter
   (tick one box)

Please add any comments about getting your child’s results, and say if there is any other information you would have found useful.

7. Now you’ve had these results, is there anything you plan to do?  
   - No
   - Yes  
   If yes, tick all that apply:

   - Make some changes to my family’s eating habits
   - Ask someone for advice (please say who)
   - Make some changes to my family’s activity levels
   - Do something else (please say what)

Any other comments:

54
8. How useful was the “Top tips for top kids” leaflet that came with the letter

- Very useful
- Useful
- Not at all useful
- Did not read it
- Did not receive it

(tick one box)

Please add any comments about the information that came with the letter:

---

So we can learn about the range of families that complete our questionnaire, please answer a few questions about yourself and your family

9. Are you the:  
- Mother of the child
- Father of the child
- Other (give details)

10. What is your highest educational qualification? (tick one box)

- No formal qualifications
- GCSE or equivalent
- A-level, degree or above

Vocational qualification (e.g. HND) Other (please say what)

11. How would you describe your ethnicity? (tick one box)

- Asian or Asian British
- Black or Black British
- White British or White other
- Chinese
- Do not wish to state
- Mixed origin (give details)
- Other (give details)

12. How many full time wage earners are there in your household? (tick one box)

- Two or more
- One
- Part-time only
- None

THANK YOU FOR YOUR HELP WITH THIS SURVEY We would like to talk to some parents to learn more about their views of the feedback. This would involve a short telephone call. If you would be willing to be called, please fill in your contact details below. We can’t talk to everyone who agrees to be contacted, but we will call a selection, chosen to represent the variety of families that send back questionnaires.

Are you willing to be contacted?  
- Yes
- No

Do you want your name to be entered into the draw?  
- Yes
- No

If yes: NAME (please print) ________________________________

TEL ________________________________ (any times we should not call)

PCT 1 2 3 4
## NCMP PARENT INTERVIEW SCHEDULE

1. **ID NUMBER**

2. **PCT**
   - 1
   - 2
   - 3
   - 4

3. **DATE OF INTERVIEW**
   - (ddmmyy)

4. **PARENT/CARER**
   - 1 Mother
   - 2 Father
   - 3 Other
   - 9 NK

5. **INTERVIEWER**
   - 1
   - 2
   - 3
   - 4
   - 5

6. **INFORMED CONSENT**
   - 0 No
   - 1 Yes
A. Demographics and family structure

We know that all families are different. So that we can get a picture of the families taking part and the parents we talk to, I’d like to ask for some basic information about you and your family.

1. HOUSEHOLD SIZE
Who is living in the household?

<table>
<thead>
<tr>
<th>NUMBER ADULTS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NUMBER CHILDREN (18 or under)</td>
<td></td>
</tr>
<tr>
<td>TOTAL HOUSEHOLD SIZE</td>
<td></td>
</tr>
</tbody>
</table>

2. NON-RESIDENT CHILDREN
Do you have any children living away from home?

| Number of non-resident children aged over 18 |        |
| Number of non-resident children 18 or under |        |

3. LONE PARENT
Would you describe your family as a two-parent or single-parent family?

1. Two-parent
2. Single parent
3. Other
9. NK

4. YEAR OF BIRTH
You answered some questions about yourself on the questionnaire you sent in (ensure we have all the information), but can I ask:

What year were you born in?

[ ] [ ] [ ]
B. Reaction to receiving results

5. FEELINGS ON GETTING LETTER

How did you feel when you got the letter? *Probe for detail, and record below.*

Can you tell me more about that? Why do you think you felt like that?

<table>
<thead>
<tr>
<th></th>
<th>Pleased/proud</th>
<th></th>
<th>Mixed feelings</th>
<th></th>
<th>NK</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Worried</td>
<td></td>
<td>What I expected (skip to q3)</td>
<td></td>
<td>10 Other</td>
</tr>
<tr>
<td>3</td>
<td>Angry</td>
<td></td>
<td>Can’t remember</td>
<td></td>
<td>11 Other</td>
</tr>
<tr>
<td>4</td>
<td>Not bothered</td>
<td></td>
<td>Shocked/surprised</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. RESULTS EXPECTED

Were the results what you expected? *Probe for reasons.*

<table>
<thead>
<tr>
<th></th>
<th>Expected</th>
<th></th>
<th>NK</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Not expected</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Had no expectations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Not sure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
7. **AGREEMENT WITH RESULTS** *(refer to q4 survey response)*

When you filled in the questionnaire, you said that you (agree/disagreed with/strongly disagreed with/weren’t sure about) what the letter said about your child’s weight category?

Do you still think that?

<table>
<thead>
<tr>
<th></th>
<th>As before – agree with results</th>
<th></th>
<th>Changed – now agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>As before – disagree</td>
<td></td>
<td>Changed – now disagree</td>
</tr>
<tr>
<td>1</td>
<td>As before – strongly disagree</td>
<td></td>
<td>Changed – now strongly disagree</td>
</tr>
<tr>
<td>2</td>
<td>As before – not sure</td>
<td></td>
<td>Changed – now not sure</td>
</tr>
</tbody>
</table>

Can you tell me more about why you felt like that at the time? About why you feel like that now? *(If changed view, probe for reasons.)*

---

**C. Before you got the letter**

8. **PRIOR CONCERN: WEIGHT**

Thinking back to before you got the letter with your child’s results, had you ever given any thought to his/her weight? Was that something you’ve been concerned about?

*Probe for detail and reasons.*

<table>
<thead>
<tr>
<th></th>
<th>No prior thought/ concern</th>
<th></th>
<th>Serious concern/worry</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Aware child is big/small for age, but not concerned</td>
<td></td>
<td>Not sure/can’t remember</td>
</tr>
<tr>
<td>1</td>
<td>Mild concern</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
9. PRIOR CONCERN: CHILD DIET / EATING HABITS
Before you got the letter, had you ever given any thought to his/her diet or eating habits? Was that something you’ve been concerned about?

Probe – not prompt - for detail and reasons, and code all mentioned

- Picky/fussy eating
- Eating unhealthy food
- Eating too much
- Eating too little

0 No prior thought/concern
1 Thought about it
2 Mild concern
3 Serious concern
4 Not sure/can’t remember

10. PRIOR CONCERN: ACTIVITY
Thinking back to before you got the letter with your child’s results, had you ever given any thought to his/her activity? Was that something you’ve been concerned about?

Probe for detail and reasons.

0 No prior thought/ concern
1 Thought about activity but not concerned remember
2 Mild concern
3 Serious concern/worry
4 Not sure/can’t remember
11. IF ANY PRIOR CONCERNS

IF NO PRIOR CONCERNS, GO TO NEXT SECTION

In the past – before you had this letter – have you done anything about those things that you were concerned about (use respondent’s description)? *Probe for detail and tick all that apply.*

0   No    Spoke to family and friends □

1   Yes   Spoke to health professional □

9   NK    Spoke to school □

                      Other professional contact □
                      Changes to child’s diet □
                      Changes to child’s activity □

Other advice (e.g. helpline/internet – specify detail including what website if relevant) □

Other □
D. After you got the letter - making changes

12. OUGHT TO CHANGE?

Thinking about after you got the letter with your child’s results, did the letter make you feel like you ought to make some changes?

0 No
1 Yes
2 Not sure
9 NK

13. PROFESSIONAL CONTACTS

Have you talked to any professionals about what the letter said – at school or through the GP or anyone else? Was that helpful? IF NOT SPOKEN TO ANYONE GO TO Q15

Probe for details of what was discussed, and tick all that apply.

0 Not spoken or planned
1 Plan to speak to, not spoken yet
2 Spoke, not helpful
3 Spoke, helpful
9 NK

GP
GP practice nurse
School nurse
Health visitor
Dietician or other PCT staff
Teacher/school staff
Other advice (e.g. helpline, internet; specify detail)
Other professional contact
14. SUGGESTED CHANGES

ASK AS NECESSARY/RELEVANT DEPENDING ON ANSWERS TO q13

Did anyone you spoke to suggest that you make any changes? What did they suggest?

Probe for detail, including who suggested change, and tick all that apply.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Eating habits – child only</th>
<th>Eating habits – whole family</th>
<th>Other dietary change</th>
<th>Physical activity – child only</th>
<th>Physical activity – whole family</th>
<th>Other activity change</th>
<th>Onwards referral (e.g. to specialist advice/support)</th>
<th>Other change</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No/NA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>NK</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
15. HAVE CHANGED?
Have you made any changes since you got the letter? Are you thinking about making any changes? What sort of things? *Probe for details including whether for family or just that child and reasons including for no plans*. **IF NO CHANGES PLANNED OR MADE GO TO Q19**

<table>
<thead>
<tr>
<th>No.</th>
<th>Option</th>
<th>Eating habits – child only</th>
<th>Eating habits – whole family</th>
<th>Other dietary change</th>
<th>Physical activity – child only</th>
<th>Physical activity – whole family</th>
<th>Other activity change</th>
<th>Seek specialist advice/support</th>
<th>Other change</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No plans</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Would like to change</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Started to make changes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>NK</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

16. CHANGE LINKED TO LEAFLETS: *ASK ONLY IF CHANGES PLANNED OR STARTED*
Are any of the changes you are trying / you have been thinking about a result of the information leaflets you got? *Probe for details*

<table>
<thead>
<tr>
<th>No.</th>
<th>Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No/NA</td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### 17. Barriers to Change: Ask Only if Changes Planned or Started

Are there any things that you think make it more difficult for you to make the changes that you want to? *Don’t prompt. Probe for details, reasons and tick all that apply.*

1. **Perceived barrier to change**
   - Lack of professional support
   - Lack of information
   - Family/friends
   - Index child (e.g. fussiness/attitude)
   - Financial resources
   - Not knowing how to change
   - Time
   - Other

2. **NA/Not mentioned**

### 18. Facilitators of Change: Ask Only if Changes Planned or Started

Are there any things that you think would help you to make the changes that you want to? *Don’t prompt. Probe for details, reasons and tick all that apply.*

1. **Perceived facilitator of change**
   - Professional support
   - Information
   - Family/friends
   - Index child (e.g. wants to change)
   - Financial resources
   - Knowing how to change
   - Other

2. **NA/Not mentioned**
E. Speaking to other people

19. SPOKE TO CHILD?
Have you talked to your child about the letter? *Probe for details (e.g. reaction) and reasons.*

- 0 Not spoken to child
- 1 Spoke to child
- 2 Spoke to child and gave them the letter to read
- 9 NK

20. SPOKE TO OTHER – FRIENDS/FAMILY
Have you talked to anyone else about what the letter said – any family or friends? Was that helpful? *Probe for details of what was discussed, and tick all that apply.*

- 0 Not spoken
- 1 Spoke, not helpful
- 2 Spoke, helpful
- 9 NK

- Partner
- Other relative
- Close friend
- Acquaintance (e.g. mums in playground)
- Other non-professional contact
- Child’s non-resident father
F. The letter itself

Now I’d like to go on and ask a bit about the actual letter about [name] height and weight – so we can learn how it might be improved in future.

21. **HOW DELIVERED**
Did the letter come in the post or did your child bring it home from school?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Post</td>
</tr>
<tr>
<td>2</td>
<td>Via school</td>
</tr>
<tr>
<td>3</td>
<td>Other (specify)</td>
</tr>
<tr>
<td>4</td>
<td>Can’t remember</td>
</tr>
</tbody>
</table>

22. **OVERALL CLARITY**
Overall, how clear was the information in the letter? How well did it explain your child’s results?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not at all clear / hard to understand</td>
</tr>
<tr>
<td>1</td>
<td>Mixed views – clear in parts</td>
</tr>
<tr>
<td>2</td>
<td>Clear /adequate</td>
</tr>
<tr>
<td>3</td>
<td>Don’t know / can’t remember</td>
</tr>
</tbody>
</table>

23. **SPECIFIC CLARITY**
Were there any bits of the letter that you think need to be clearer or better explained? *(Probe, building on answer to last question, for way weight expressed; where child placed on weight ‘bar’; information about what to do next, etc.)*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>NA/Not mentioned</td>
</tr>
<tr>
<td>1</td>
<td>Needs to be clearer</td>
</tr>
<tr>
<td></td>
<td>Height and weight info</td>
</tr>
<tr>
<td></td>
<td>Weight ‘bar’</td>
</tr>
<tr>
<td></td>
<td>Information about NCMP</td>
</tr>
<tr>
<td></td>
<td>Information about what to do next</td>
</tr>
<tr>
<td></td>
<td>Other</td>
</tr>
</tbody>
</table>
24. **LETTER IMPROVED**
Overall, how could the letter with the results have been better? How could it be improved?

25. **HOW SHOULD INFO BE GIVEN**
How should information about children’s weight and height be given to parents? Do you think a letter is the best way of doing it?

1. By letter
2. By phone – school
3. Face-to-face – school
4. By phone – health worker (e.g. GP, school nurse, GP practice nurse)
5. Face-to-face – health worker (e.g. GP, school nurse, GP practice nurse)
6. Other
7. Don’t know
G. Additional information that came with the letter

The letter should have come with some extra bits of information – leaflets and so on.

26. INFO RECEIVED

Did you get that? Did you get any extra information with the letter (e.g. Top Tips for Top Kids leaflet)?

0  No
1  Yes
2  Can’t remember/not sure

27. INFO READ or USEFUL

Did you look at the information that came with the letter? Have you had a chance to read it yet? What did you think of it? Was it useful? Why?

0  Not read
1  Read, not useful
2  Read, useful in parts/mixed views
3  Read, useful
4  Can’t remember/not sure
28. **INFO READ or USEFUL – OTHER FAMILY MEMBER**

Did anyone else in the family look at the information that came with the letter? Partner? Child?
Do you know what they thought of it? Do you think it was useful for them? *Why?*

- 0 Not read
- 1 Read, not useful
- 2 Read, useful in parts/mixed views
- 3 Read, useful
- 4 Can’t remember/not sure

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H. **Finally**

*We’re on to my last few questions now*

29. **OVERALL DIFFERENCE**

So overall, do you think that getting the letter has made a difference to you?
To your child? Family more generally? *Why do you think that?*

- 0 Negative difference
- 1 No difference / don’t know
- 2 Positive difference

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30. **VIEWS ON MEASURING**

Do you think parents should be told their child’s height and weight? Why? Why not?

- 0 No
- 1 Mixed views/not sure
- 2 Yes
31. **VIEWS OF WEIGHT**
Do you think parents should be told whether their child is underweight, overweight or average weight? Why? Why not?

0  No
1  Mixed views/not sure
2  Yes

32. **FUTURE CONSENT**
Would you let your child be weighed and measured for the Programme at school again when they were older? (Check if have younger children and whether they would let them be weighed and measured when they were in reception class). *If not, probe for reasons*

0  No
1  Maybe / not sure
2  Yes, definitely
Closure

Well, that's everything I wanted to ask you about, so thank you very much for going through all my questions. Before we finish, is there anything I have not asked you about that you would like to say? Or any other comments about the National Child Measurement Programme? Is there anything you would like to ask me?

If there is anything that you want to ask us later on, you can phone our research team on 020-7612 6957
Appendix 5: PCT interview Topic Guide

Scale, coverage and progress with routine feedback
   Number of primary schools covered by PCT
   Total number of children in Y6 and in Reception Year
   Number in each year group being measured this year and number receiving routine feedback
   Progress with routine feedback at time of interview
   How coverage and prevalence for 2007/08 compares with previous years (may not be known yet)

Process of deciding to provide routine feedback
   Previous feedback practice; who had to be involved and what helped to get everyone on board?
   Were resources allocated to support this move before the decision was made?

Resources for undertaking measurement and feedback
   Details of team; additional resources; funding issues; what has helped

When and how feedback provided
   Pupil post, mailed or other method; changes if any to feedback letter and reasons for changes
   Time between measuring and feedback; how ‘instant’ feedback is achieved or reasons for time lag between measuring and feedback
   Whether feedback can take account of poor literacy, ESL
   Any feedback to parents of children who opted out? Any follow-up by PCT after feedback letter?
   Assessment of how well method for routine feedback worked

Practical difficulties encountered in preparing for routine feedback and how resolved
   e.g. IT, admin, staffing, data issues with schools – getting correct names and addresses

Additional information provided in the letter and enclosures with letter such as leaflets
   Reasons for including or not including additional information; whether sent separately
   Who are parents told to contact if worried

Impact of routine feedback on parents, children, PCT and other health professionals, schools
   Proportion/number of parents making enquiries and how compares with last year;
   How parents responding, nature of enquiries and nature of advice; difficulties
   Process for dealing with complaints or threats to go to the media; use of the DH script
   Impact of routine feedback on schools, other health professionals, and children
Support available to parents and children
What is available for parents and/or children seeking advice and support?
What additional support was set up to address an increase in referrals?
Impact routine feedback has had on support services;

Next year’s NCMP guidance
Lessons learnt; what would do differently; what other PCTs could learn from your PCT
Recommendations for improving guidance
Appendix 6: School interview topic guide

Interviewee/school characteristics
School size and population
   No. in Reception and Y6
Interviewee role within school
Interviewee involvement in NCMP – probe for who (s)he has liaised with, etc.
Other school staff involvement in NCMP – number and role.

Securing initial permission from parents:
   How was it done? How were permission requests (a) sent out and (b) returned?
   Do you know if parents opted out? If yes:
      How many? Why? Any feedback from parents opting out? Feedback from children whose parents opted out? What do you know of opt-out characteristics?
   Resource implications for school (time or money)
   Practical issues?
   Any other issues arising?
   What response from parents?
   Differences in method or response for Reception or Y6?

Coverage in school
   Number in Y6 and in YR being measured this year
   Number in each year group receiving routine feedback (if known)
   How coverage and prevalence for 2007/08 compares with previous years (2005/06, 2006/07)

Measurement process
   How managed in school?
   Any resource implications for school (time or money)
   Barriers/Facilitators?
   Practical issues?
   Any other issues?
   Children’s reaction? Parents?
   Staff reaction?
   Differences in method or response for Reception or Y6?

Feedback to parents
   Do you know how done?
      Proportion/number of parents making enquiries after receiving feedback letter
      How parents responding, nature of enquiries to school, nature of advice and by whom
   Impact of feedback on children?
   Differences in response for Reception or Y6?
   Difficulties encountered in handling enquiries
   Overall assessment of how response to routine feedback handled by PCT.
What is available for parents and/or children seeking advice and support?

Differences in service access for Y6 and Reception. Any additional support set up in school as a result of feedback?

Impact routine feedback has had on school.

Any other issues?

### Staff/school response to measurement and routine feedback

Who had to be involved? (record number of staff and role)

Who was in favour/against. Why?

Practical or other issues?

Barriers / facilitators to school’s involvement in measurement and feedback.

Was it disruptive or helpful for school? Why? What would have made it better?

Any resource implications for school (time or money)

### Other issues / recommendations for change

Overall, how useful do you think NCMP parent feedback is? What benefits or problems?

Would you recommend any changes to measurement and feedback process? Reasons for changes.

What other PCTs who haven’t routinely feedback this year using DH template could learn from your experiences

What needs to change to assist PCTs in providing routine feedback

Recommendations for improving guidance