



House of Commons
Health Committee

Impact of physical activity and diet on health

Sixth Report of Session 2014–15

*Report, together with formal minutes relating
to the report*

*Ordered by the House of Commons
to be printed 18 March 2015*

The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

Current membership

[Dr Sarah Wollaston MP](#) (*Conservative, Totnes*) (Chair)
[Rosie Cooper MP](#) (*Labour, West Lancashire*)
[Andrew George MP](#) (*Liberal Democrat, St Ives*)
[Robert Jenrick MP](#) (*Conservative, Newark*)
[Barbara Keeley MP](#) (*Labour, Worsley and Eccles South*)
[Charlotte Leslie MP](#) (*Conservative, Bristol North West*)
[Grahame M. Morris MP](#) (*Labour, Easington*)
[Andrew Percy MP](#) (*Conservative, Brigg and Goole*)
[Mr Virendra Sharma MP](#) (*Labour, Ealing Southall*)
[David Tredinnick MP](#) (*Conservative, Bosworth*)
[Valerie Vaz MP](#) (*Labour, Walsall South*)

Powers

The committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the internet via www.parliament.uk.

Publication

Committee reports are published on the Committee's website at www.parliament.uk/healthcom and by The Stationery Office by Order of the House.

Evidence relating to this report is published on the [inquiry page](#) of the Committee's website.

Committee staff

The current staff of the Committee are David Lloyd (Clerk), Sharon Maddix (Second Clerk), Laura Daniels (Senior Committee Specialist), Stephen Aldhouse (Committee Specialist) Daniel Moeller (Senior Committee Assistant), Nathan Hug, (Committee Support Assistant) and Alex Paterson (Media Officer).

Contacts

All correspondence should be addressed to the Clerk of the Health Committee, House of Commons, 14 Tothill Street, London SW1H 9NB. The telephone number for general enquiries is 020 7219 6182; the Committee's email address is healthcom@parliament.uk

Contents

Report	<i>Page</i>
Summary	3
1 Introduction	5
The impact of physical activity on health	5
The impact of diet on health	8
Obesity and overweight	8
Other health impacts of diet	10
Physical activity—a priority in its own right	12
2 Tackling physical inactivity and diet—guiding principles and key responsibilities	16
Individual and population level interventions	16
NICE guidance on what works	18
Local authorities—key to improving public health	20
Role of the NHS	25
Workplaces	25
Cross government working	28
3 Physical activity—a key health priority in its own right	30
Promoting physical activity in clinical encounters	33
An environment that promotes physical activity	37
Engaging different groups in physical activity	38
4 Diet and obesity—reforming the food environment	42
“Normalisation” of overweight and obesity?	42
NHS prevention and treatment services	42
Reforming the food environment	44
Labelling	46
Reformulation	46
Marketing and promotion of foods to children	48
Portion size	49
Price promotions	49
Fiscal policies	51
Conclusions and recommendations	53
Formal Minutes	58
Witnesses	59
Published written evidence	60
List of Reports from the Committee during the current Parliament	63

Summary

Diet, obesity, and physical activity all have important impacts on health. For too long however, physical activity has been seen merely in the light of its benefits in tackling obesity. A core message from this inquiry is the compelling evidence that physical activity in its own right has huge health benefits totally independent of a person's weight. The importance of this—regardless of weight, age, gender or other factors—needs to be clearly communicated.

Interventions focused on encouraging individuals to change their behaviour with regard to diet and physical activity need to be underpinned by broader, population-level measures. Whilst both are important, population-level interventions have the advantage of impacting on far greater numbers than could ever benefit from individual interventions. We recommend that the next Government prioritises prevention, health promotion and early intervention to tackle the health inequalities and avoidable harm resulting from poor diet and physical inactivity. Tackling these problems will require action at all levels and must also be core business for the NHS and local authorities.

The Committee regards it as inexplicable and unacceptable that the NHS is now spending more on bariatric surgery for obesity than on a national roll-out of intensive lifestyle intervention programmes that were first shown to cut obesity and prevent diabetes over a decade ago. All tiers of weight management services should be universally available and individual clinicians should use every opportunity to help their patients to recognise and address the problems caused by obesity and poor diet, and to promote the benefits of physical activity.

1 Introduction

1. The impact of diet and physical activity on health is complex and multi-faceted. The committee reviewed recent progress in this area in order to make some recommendations for the next Government. In the time remaining in this Parliament we have tried to focus on a ‘what works’ approach based on existing evidence. We are very grateful to the many organisations and individuals who provided written and oral evidence to this inquiry. All the evidence we received is published in full on our website.¹ We would also like to thank our specialist adviser for this inquiry, Professor Mike Kelly.

2. NHS England’s *Five Year Forward View* sets out the urgent need for “a radical upgrade in prevention and public health.” It states, for example, that “it makes little sense that the NHS is now spending more on bariatric surgery for obesity than on a national roll-out of intensive lifestyle intervention programmes that were first shown to cut obesity and prevent diabetes over a decade ago.”²

3. This introductory chapter gives a brief overview of the current situation and what is known about the impact of diet and physical activity on health. The second chapter discusses general principles and key responsibilities for tackling physical activity and diet. Our report centres around two key messages:

- **Physical activity**—needs to be seen as a crucial health priority in its own right
- **Diet and obesity**—it is time for a national debate about how to make it easier for people to make healthier diet and lifestyle choices.

The impact of physical activity on health

4. Physical activity is described as body movement that expends energy and raises the heart rate. Inactivity is classed as less than 30 minutes of physical activity a week, and sedentary time means time spent in low-energy postures, e.g. sitting or lying.³ Globally, physical inactivity is the fourth leading risk factor for mortality (accounting for 6% of deaths). This follows high blood pressure (13%), tobacco use (9%) and high blood glucose (6%). Overweight and obesity are responsible for 5% of global mortality.⁴ In the UK, physical inactivity directly contributes to one in six deaths.⁵ Evidence suggests that sedentary

1 Health Select Committee, [The Impact of physical activity and diet on health](#)

2 NHS England [Five Year Forward View](#) (October 2014), p 9, p 11

3 Public Health England, [Everybody Active Every Day – an evidence based approach to physical activity](#) (October 2014), p4

4 Department of Health, [Start Active Stay Active](#) (July 2011), p10

5 Public Health England, [Everybody Active Every Day – an evidence based approach to physical activity](#) (October 2014),p6

behaviour is independently bad for health.⁶ The Chief Medical Officer has published guidelines on physical activity for different age groups and recommendations about limiting sitting time have been added to these.⁷

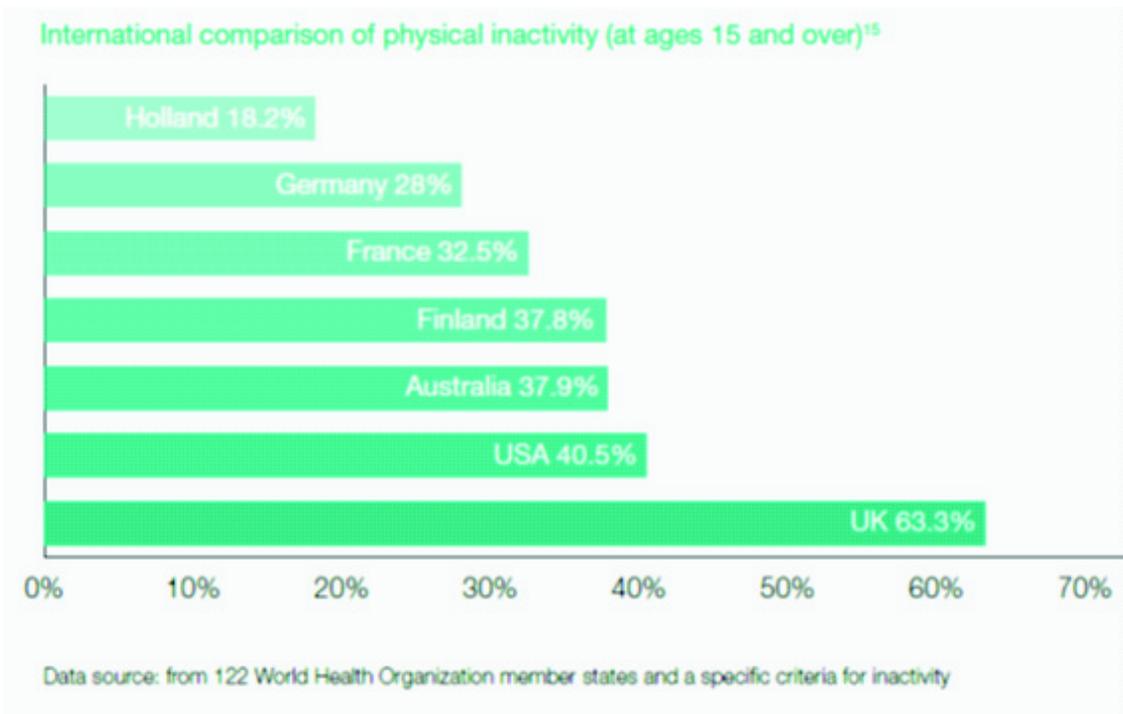
5. Public Health England state that the percentage of adults achieving recommended levels of physical activity has increased in the last fifteen years from 32% to 43% among men, and from 21% to 32% among women. In 2012, 21% of boys and 16% of girls aged 5–15 years met the national physical activity target.⁸ The Active People Survey shows that 29% of people are currently classed as “inactive”—i.e. they fail to complete 30 minutes of moderate physical activity each week.⁹

6. Professor Nick Wareham of the MRC Epidemiology Unit and the Centre for Diet and Activity Research at the University of Cambridge, echoing the report of the CMO in 2013, cautions that these self-reported statistics on physical activity may be an overestimate, noting that “adults and children tend to overestimate how physically active they are, and we lack good nationwide data about actual levels of physical activity”:

Repeated cross-sectional surveys such as the National Diet and Nutrition Survey and Health survey for England provide information about behaviours. However, because this data is self-reported, its quality and reliability can be poor...objective accelerometer data suggest that only 6% of men and 4% of women achieve recommended levels. Both adults and children overestimate how physically active they are, and parents overestimate how active their children are.¹⁰

7. While measurement differences limit direct comparisons *Everybody Active Every Day* provides data showing that the problem is worse in the UK than many other countries.¹¹

-
- 6 Biddle, S., Pearson, N., Ross, G.M. Braithwait, R. (2010) Tracking of sedentary behaviours of young people: a systematic review, *Preventive Medicine*; 51: 345-51. Rezende et al. *BMC Public Health* 2014, 14:333 Sedentary behavior and health outcomes among older adults: a systematic review; *Int.J. Behav. Med.* (2010) 17:243–245 Psychological Determinants and Outcomes of Sedentary and Physical Activity Behaviours Yvette D. Miller
- 7 Public Health England, [Everybody Active Every Day – an evidence based approach to physical activity](#) (October 2014),p22
- 8 Public Health England ([IDH0063](#)) para 23
- 9 HM Government, [Moving More, Living More](#), 2014, para 2.2
- 10 Centre for Diet and Activity Research ([IDH0069](#)) para 3.1
- 11 Public Health England, [Everybody Active Every Day – an evidence based approach to physical activity](#) (October 2014) p6



8. Public Health England provides the following statistics on physical activity:

- Walking trips decreased by 30% between 1995 and 2013
- 64% of trips are made by car, 22% are made on foot, and 2% are made by bike
- 39% of non-disabled adults regularly take part in sport, compared to 18% of disabled adults.¹²

9. As well as describing the negative effects of inactivity on health, much of the written evidence we have received details the positive impacts of physical activity in unequivocal terms:

We know that regular physical activity helps prevent and manage over 20 chronic conditions including coronary heart disease, stroke, type 2 diabetes, cancer, obesity, mental health problems and musculoskeletal conditions. In addition, evidence shows that there is a link between physical activity and good mental wellbeing. For example, exercise is moderately more effective than therapy for reducing symptoms of depression. It may also help people with generalised anxiety disorder, panic attacks and stress disorders.¹³

10. The Ramblers note that “unsurprisingly, physical activity has been described as a ‘wonder drug’”.¹⁴ The University of Bedfordshire state that “we know of no single intervention with greater promise than physical exercise to reduce the risk of virtually all

12 Public Health England, [Everybody Active Every Day – an evidence based approach to physical activity](#) (October 2014), p5

13 Department of Health ([IDH0078](#)) para 14

14 Ramblers ([IDH0014](#)) para 6

chronic diseases simultaneously”¹⁵, and the Transport and Health Study Group put the positive argument for physical activity in even stronger terms:

If physical activity were a drug then the range of its benefits on mental well being, mental illness, heart disease, obesity, diabetes and osteoporosis is such that no politician would dare withhold those benefits from the public. At a time when the NHS struggles to cope with the pressures of mental illness, obesity and diabetes, it is financially irresponsible to fail to promote physical activity.¹⁶

The impact of diet on health

Obesity and overweight

11. Overweight and obesity are commonly defined by Body Mass Index (BMI) in adults with overweight being defined as a BMI between 25 and 29.9 and obesity as a BMI of 30 or over.¹⁷ For children, these BMI standards require adjustments for age and gender. Public Health England explain the importance of diet to weight:

Excess weight gain results from an imbalance between energy consumed and energy expended and PHE recognises that eating less is crucial for weight loss. PHE estimates that the average man and woman in England consume respectively approximately 300 and 200 calories a day more than they need. Alcohol consumption is also linked to excess calorie intake and an emerging evidence base suggests that it and obesity compound problems such as fatty liver disease.¹⁸

12. Public Health England describe the negative health impacts of obesity:

Being obese can increase the risk of developing a range of serious diseases, including hypertension, type 2 diabetes, cardiovascular diseases, several cancers, asthma, obstructive sleep apnoea, and musculoskeletal problems.¹⁹

13. They also note that obese children are more likely to be ill, absent from school, and suffer psychological problems such as low self-esteem and depression than normal weight children.

14. Public Health England provide the following statistics on the prevalence of obesity:

Obesity levels remain high with two-thirds of the adult population, one in five 4–5 year olds and one in three 10–11 year olds in England [being] either overweight or obese. In the last decade, the prevalence of adult obesity has risen from 15% to 25%, whilst the prevalence of overweight has remained broadly stable (37%–39%) during this period. In the last seven years, the

15 University of Bedfordshire ([IDH0029](#)) para 4

16 Transport and Health Study Group ([IDH0048](#)) p1

17 BMI = m/h^2 , where m is mass in kilograms and h is height in metres.

18 Public Health England ([IDH0063](#)) para 21

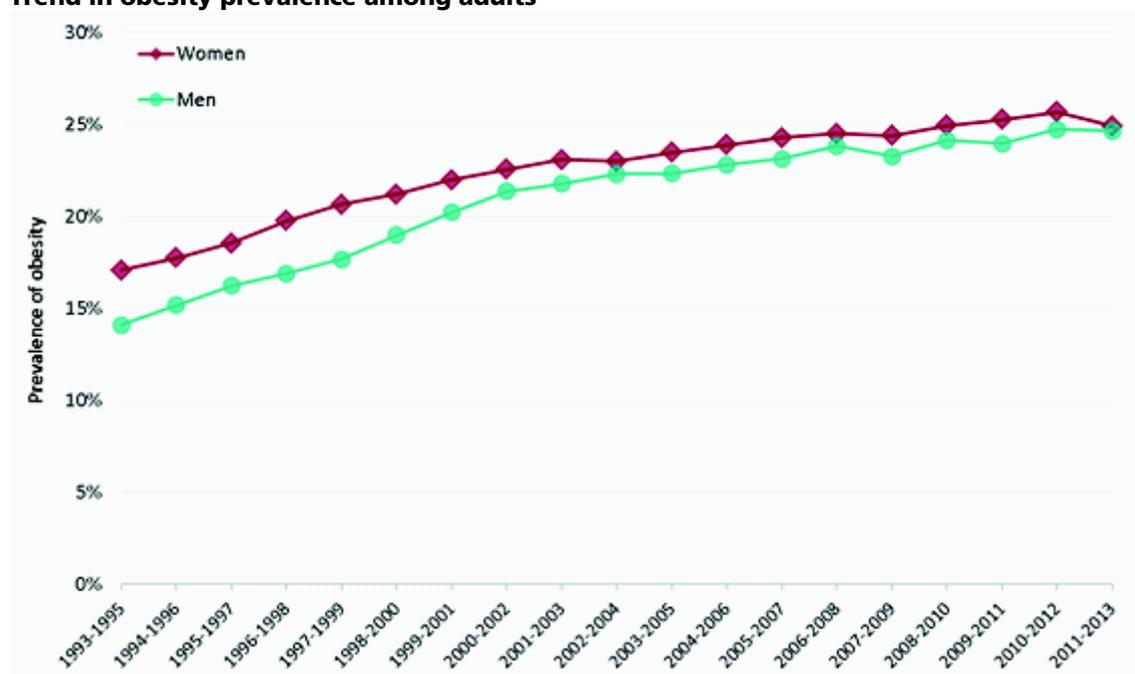
19 Public Health England ([IDH0063](#)) para 15

proportion of children aged 4–5 years who were obese has remained broadly stable (9.9%–9.5%) whilst the proportion of children aged 10–11 years who are obese has increased (17.5%–19.1%).

Obesity and related conditions vary according to ethnic group, socioeconomic status and geography. Obesity disproportionately affects those in the most deprived social groups and evidence suggests that the inequalities gap in child obesity is widening.²⁰

15. The Department of Health states that “the rising levels of overweight and obesity we have seen over the past 20 years or so appear to be stabilising, but at a very high level.”²¹ There is also recent evidence showing that the rates of morbid obesity in children are increasing.²²

Trend in obesity prevalence among adults



Adult (aged 16+) obesity: BMI \geq 30kg/m²

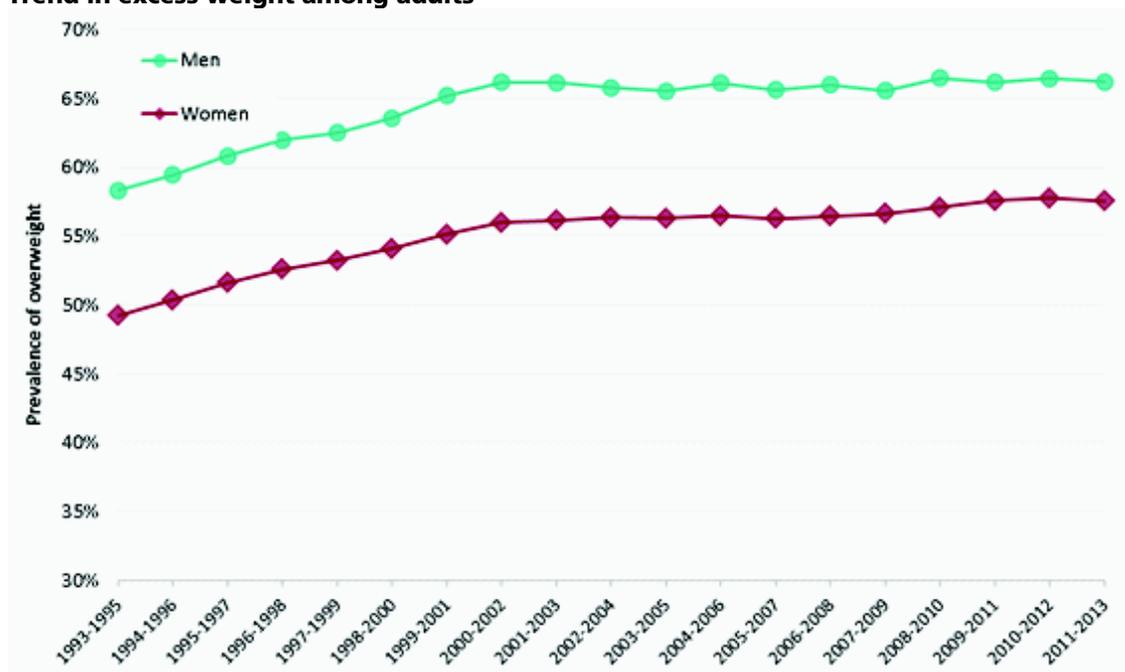
Source - Health Survey for England 1993–2013 (3-year average)–Public Health England

20 Public Health England ([IDH0063](#)) paras 12-13

21 Department of Health ([IDH0078](#)) para 16

22 Ells, L.J., Hancock, C, Copley, V.R., Mead, E., Dinsdale, H., Kinra, S., Viner, R.M., Rutter, H. (2015) Prevalence of severe childhood obesity in England: 2006–2013, Arch Dis Child doi:10.1136/archdischild-2014-307036 <http://adc.bmj.com/content/early/2015/01/27/archdischild-2014-307036.full.pdf+html>

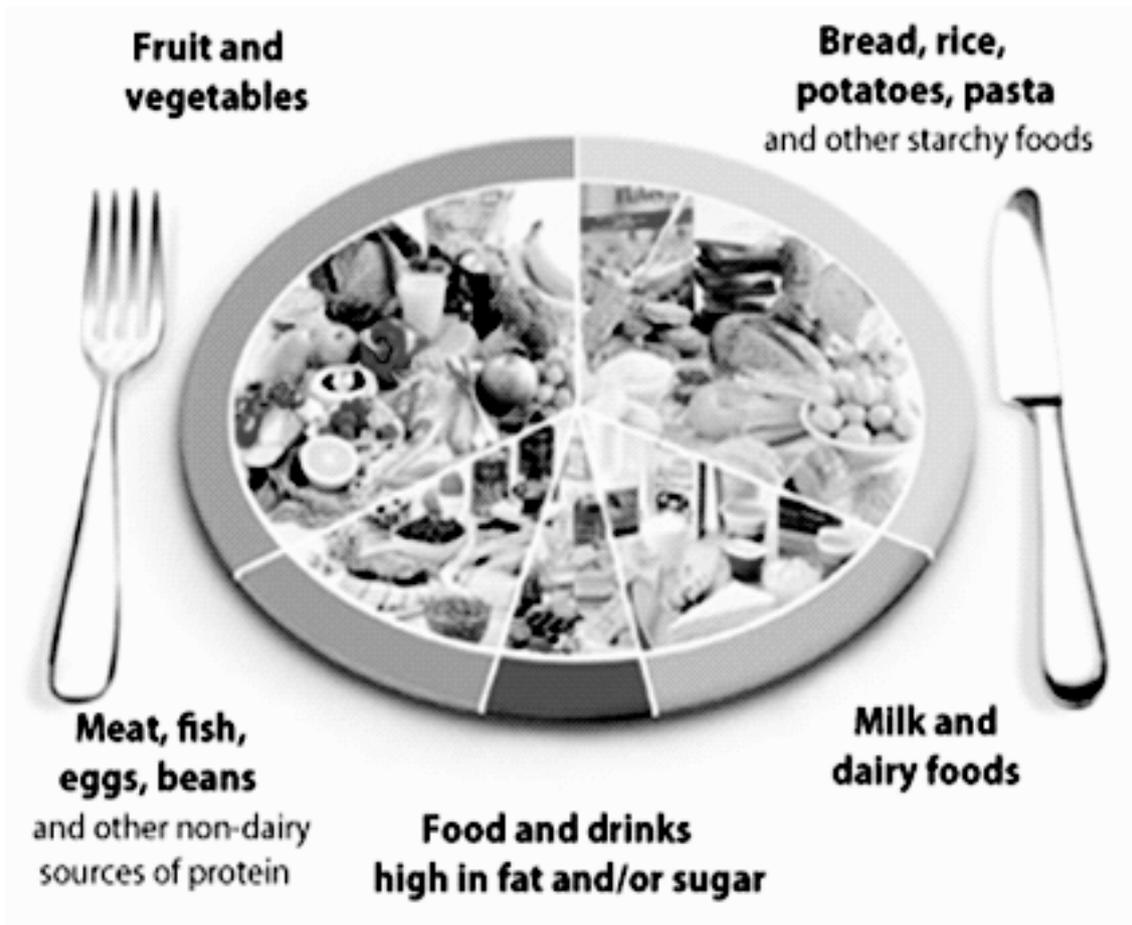
Trend in excess weight among adults



Adult (aged 16+) overweight including obese: BMI ≥ 25kg/m²
 [Source - Health Survey for England 1993–2013 (3-year average)–Public Health England]

Other health impacts of diet

16. The impact of diet on health is not limited to its impact on weight. The Scientific Advisory Committee on Nutrition (SACN) recommendations for intakes of energy, nutrients, and some food groups are translated into nutrient and food based guidance for populations. This underpins dietary advice as depicted in the national food guide ‘the eatwell plate’ and the five-a-day advice for fruit and vegetables.²³



17. Commenting on current eating habits, Public Health England state:

The population overall is consuming too much saturated fat, non-milk extrinsic sugars (which includes added sugars and free sugars in fruit juices) and salt and not enough fibre, oily fish or fruit and vegetables. On average, no population age group meets current dietary recommendations. The diets of young children under four years are close to meeting recommendations while the diets of adolescents (particularly girls) are the worst. Some aspects of diet vary with income, for example fruit and vegetables, fibre and some micronutrients show a clear pattern of lower intakes in lower income groups. Over the last 10 years salt intakes of adults have reduced by 15% but remain above the maximum recommended level.

Current intakes of sugar for all population groups exceed recommendations. Sugar increases the risk of tooth decay and of consuming too many calories, which, if sustained, causes weight gain and obesity.²⁴

18. Consumption of food and drinks high in sugar increases the risk of the development of type 2 diabetes.²⁵

24 Public Health England ([IDH0063](#)) para 18, para 20

25 Further information can be found at <http://www.nhs.uk/conditions/Diabetes-type2/Pages/Introduction.aspx> and <http://www.diabetes.org.uk/>

19. The UK Faculty of Public Health argues that “for cardiovascular disease prevention, there is clear evidence that the Mediterranean diet, even just a handful of nuts and or liberal consumption of olive oil, is effective, and could lead to a rapid 30% reduction in deaths & non-fatal events. Furthermore, this demonstrates that a healthy diet is more powerful than statins.”²⁶ In relation to children’s eating habits, the Local Government Association notes:

While the number of children eating the recommended amounts of fruit and vegetables has increased in recent years, 80 per cent of children still do not eat the recommended ‘5-a-day’. England’s young people have the highest consumption of sugary soft drinks in Europe.²⁷

Physical activity—a priority in its own right

20. One of the clearest messages the Committee has heard during the course of this inquiry is that the considerable health benefits of physical activity independent of weight must be more clearly acknowledged and communicated. The Royal College of Physicians told us:

Often the benefits of physical activity are closely linked to reductions in obesity. The RCP however, strongly recommends that wider benefits of physical activity should be recognised and promoted. Individuals who are obese but have a good level of cardiorespiratory fitness (CRF) can have better health and wellbeing than an individual with an ideal body Mass Index (BMI) but low CRF. The wider health benefits of physical fitness should be promoted to improve the health of the nation.²⁸

21. The written evidence received by the Committee also suggests that while physical activity has benefits for all people regardless of weight, and may help maintain weight loss, “increasing physical activity...is unlikely to be the best single strategy for combatting excess weight”²⁹. The Department of Health agree, stating that “although physical activity brings important health benefits...for those who are overweight and obese, eating and drinking less is key to weight loss”.³⁰

22. Research very recently published by the MRC drawing on the EPIC (European Prospective Investigation into Cancer) study reported that in terms of reducing mortality risk, for the most inactive people, walking for around 20 minutes extra per day would have a greater positive impact than not being obese,³¹ as Professor Nick Wareham explained:

26 UK Faculty of Public Health ([IDH0083](#)) p2

27 Local Government Association ([IDH0022](#)) para 25

28 Royal College of Physicians ([IDH0043](#)) para 2

29 Centre for Diet and Activity Research ([IDH0069](#)), Executive Summary

30 Department of Health ([IDH0078](#)) para 13

31 Ekelund, U et al. Physical activity and all-cause mortality across levels of overall and abdominal adiposity in European men and women: the European Prospective Investigation into Cancer and Nutrition Study (EPIC) *American Journal of Clinical Nutrition*; doi: 10.3945/ajcn.114.100065 <http://ajcn.nutrition.org/content/early/2015/01/14/ajcn.114.100065.abstract>

About 23% of people in that study—and there was a large group of people in that study from the United Kingdom—were in the category of being totally inactive; they had a sedentary job and did no recreational physical activity at all. That group had the highest mortality risk. If you look at the difference between that group and the moderately inactive, there was about a 20% reduction in mortality risk. Switching from being totally inactive to moderately inactive would require the equivalent of walking 20 minutes extra per day, which is a totally feasible public health transition. We estimated that, if everybody who was in that totally inactive category could move up to the next category, the impact on mortality would be of the order of 7%. That was greater than the impact of the avoidance of obesity. The important thing for the Committee is that that impact of physical activity was independent of obesity. So within the strata of whether someone is obese, overweight or a normal weight, the effect of physical activity was the same.³²

23. Dr William Bird, a GP with an interest in physical activity and founder of Intelligent Health, reinforced this point:

We have finally got the evidence to disentangle the connection between obesity and physical activity. I am grateful for obesity getting physical activity on the agenda because that has been the way it has managed to get up on to the podium, but we must not use weight loss as a measure of success for physical activity. Physical activity has always been the handmaiden of obesity—the way you have diet and physical activity for the objective of losing weight. That is no longer evidence based and should not be used again. Of course obesity is important, but physical activity in its own right has benefits. In fact only 10% of the benefits of physical activity for cardiovascular disease are weight-related. The other 90% are the anti-inflammatory effects—the other aspects of cellular change that take place when you are physically active.³³

32 Q6

33 Q283; for further information see Mora, S., Cook, N., Buring, J. E., Ridker, P. M., & Lee, I. M. (2007). Physical activity and reduced risk of cardiovascular events potential mediating mechanisms. *Circulation*, 116(19), 2110-2118.

He went on to give the startling example that

Giving a coronary stent to patients with stable angina or getting them to exercise for 20 minutes a day have exactly the same outcomes after one year, except that exercise is more effective.³⁴

24. Professor Dame Sue Bailey, Chair of the Academy of Medical Royal Colleges, gave two further compelling examples of the impact of exercise on health—firstly that exercise can be beneficial for treating childhood depression, and should be used tried as a first line treatment, together with psychological therapies, before using drug treatments; and secondly that exercise is effective in strengthening bone density to prevent fractures in older people. In all of these examples exercise would be a far cheaper option. Professor Dame Sue Bailey went on to say that in her view it was “regrettable” that the evidence has been there for some time and “neither the public, politicians nor practitioners have gone with this sufficiently.”³⁵ The Academy of Medical Royal Colleges has recently published a report entitled *Exercise: the miracle cure and the role of the doctor in promoting it*, aimed at publicising the “simple” message that “exercise is a miracle cure too often overlooked by doctors and the people they care for”:

The big four “proximate” causes of preventable ill-health are: smoking, poor nutrition...physical inactivity and alcohol excess. Of these, the importance of regular exercise is the least well-known. Relatively low levels of increased activity can make a huge difference. All the evidence suggests small amounts of regular exercise (five times a week for 30 minutes each time for adults) brings dramatic benefits. The exercise should be moderate—enough to get a person slightly out of breath and/or sweaty, and with an increased heart rate.

Doctors are increasingly being asked to carry out a range of interventions when they see patients, including screening and changing behaviour, with initiatives such as ‘Make Every Contact Count’. However this report calls on doctors to promote the benefits of regular physical activity to their patients and to communities in their wider roles as ‘advocates for health’. We have some tips, but the message is simple. Exercise is a miracle cure too often overlooked by doctors and the people they care for.³⁶

25. For too long, physical activity has been seen merely in the light of its benefits in tackling obesity. However, there is compelling evidence that physical activity in its own right has huge health benefits totally independent of a person’s weight—in fact research recently published suggested that increasing physical activity levels could have greater impact on reducing mortality than reducing weight. The Chief Medical Officer’s guidelines recommend levels of activity which will help people derive the greatest health benefits; but even small increases in activity levels can have a dramatic positive impact on health.

34 Q288

35 Q295

36 Academy of Medical Royal Colleges, [Exercise: the miracle cure and the role of the doctor in promoting it](#), (February 2015), p5

26. Diet, obesity, and physical activity all have important impacts on health. However, it is vital that the importance of physical activity for all the population—regardless of their weight, age, gender, health, or other factors—is clearly articulated and understood. We recommend that the Government, Public Health England and health professionals, in particular GPs, take urgent action to communicate this crucial message to the public.

2 Tackling physical inactivity and diet—guiding principles and key responsibilities

Individual and population level interventions

27. In their written evidence, the Government lists the Change4Life initiative, NHS Health Checks, and the National Childhood Measurement Programme as “key initiatives” in this area.³⁷ Change4Life is a social marketing campaign aimed at delivering health messages and getting people to change their behaviour; NHS Health Checks offer all adults aged between 40 and 75 a health check designed to assess their risk of various conditions; similarly the National Childhood Measurement Programmes provides the opportunity for babies and children to have their BMI assessed at different points in their childhood, and their families to be informed if there are concerns about their weight. However, all these interventions are focused on getting individuals to change their behaviour. While interventions at an individual level may have a role to play in improving diet and physical activity—and indeed NICE has found some interventions of this type to be cost-effective, including offering brief advice in primary care, and referral to lifestyle weight management services—which are discussed more fully in the next section—our witnesses were clear of the limitations of such individual approaches, and the need to also act to introduce population level interventions.

28. Dr Janet Atherton, President of the Association of Directors of Public Health, highlighted the “Move It” physical activity programme as an example of an intervention which can produce good outcomes, but acknowledged that this was “on a very small scale in terms of the numbers of children who are able to be supported through those routes.”³⁸ Dr Alison Tedstone of Public Health England argued that

Health campaigning can never match the industry. Change4Life spends about a tenth of what industry will spend on food advertising. We can never do that. It is important that we do it, but it must only be part of the approach.³⁹

29. Professor Nick Wareham was amongst many to explain that there are no “silver bullets” for addressing these issues, and that sustained action would be needed on many fronts:

Health behaviours are complex and there are no silver bullets for changing unhealthy patterns of behaviour to healthier ones. Physical activity is influenced by a combination of factors related to the individual, their social relationships, community, wider society and the environment (the ‘socio-ecological model’). Influences are shown to be context and behaviour

37 Department of Health ([IDH0078](#)) para 27

38 Q201

39 Q218

specific—e.g. influences on walking to work differ from those on cycling to work or walking for leisure. Therefore, strategies that target only a single aspect are unlikely to be successful: multiple barriers often need to be removed to achieve substantive change, and interventions need to be sustained rather than short term ‘projects’. Furthermore, it is increasingly recognised that much behaviour is automatic, triggered outside of conscious awareness and cued by multiple influences. This explains why, for instance, simply using information to persuade people to change their health related behaviour has had—at best—modest effects.⁴⁰

30. Dr Dagmar Zeuner, Director of Public Health at Richmond, argued that the balance between individual approaches to lifestyles and population approaches is “a little bit too tilted towards the individual, so in the end it is choice and individual responsibility”, arguing that population-based measures, such as regulatory approaches, promotion and product design are generally faster, cheaper and help to tackle inequalities because they are universal.⁴¹ Dr Janet Atherton agreed on the importance of population approaches in tackling inequalities, arguing that “often one-to-one interventions tend to be taken up by people who have more ability to take them up...sometimes that can widen inequalities, unless you are really careful about how you target those interventions”.⁴² Dr Jane Moore, Director of Public Health for Coventry, gave several examples from her local area:

In the food environment, we have food deserts in our major cities where eating healthily at a reasonable cost is really difficult because it is very difficult to access that food using public transport or whatever. There is a real issue about our more deprived communities, with less access to green space and it being more difficult to get outside the home in ways that people feel safe about, and that is at both ends of the age spectrum...We are doing work with food banks and other organisations in Coventry about how we help people in the context of what are often very difficult things. Saying to people, “Eat healthily,” when you are getting an unhealthy bag of food from a food bank is very challenging.⁴³

31. While individual approaches may focus on encouraging people to make a conscious effort to change their behaviour—for example encouraging people to purchase a low-sugar drink instead of a high-sugar drink—population-based approaches aim to make a healthy choice the default, or automatic choice—for example, by introducing fiscal policies which make the low-sugar drink cheaper than the high-sugar drink, or by reformulating the high-sugar drink to reduce its sugar content. For physical activity, a comparable population-based intervention might be encouraging people to take the stairs rather than a lift by designing buildings with the staircase in a more prominent and accessible place than the lift. Professor Theresa Marteau provides further explanation:

40 Centre for Diet and Activity Research ([IDH0069](#)), para 1.3

41 Q170

42 Q184

43 Q202

Most people value their health yet persist in behaving in ways that undermine it. This gap between values and behaviour can be understood using a dual systems model of human behaviour, a model that is well supported by recent evidence from behavioural- and neuro-sciences. This model describes behaviour as shaped by two systems. The first system, guided by conscious processes, is goal oriented and driven by our values and intentions. It requires cognitive capacity—thinking space—which is limited in all humans. Most traditional approaches to changing behaviour depend on engaging this system, for example, by providing information about the benefits of a healthy diet, not smoking, consuming less alcohol or being more physically active. At best these approaches have been modest in their effectiveness at changing behaviour. The second system, guided by non-conscious processes, is driven by immediate feelings and triggered by our environments. For example, despite intending to lose weight we still buy the chocolate bar displayed at the checkout till. Such environmental cues combine with the attraction of immediate and certain pleasure (having an extra mince pie) over larger less certain and more distant rewards (such as reduced weight and improved health) make unhealthy behaviours more likely. This second system guides the majority of human behaviour.⁴⁴

32. It is clear from the evidence we have heard that interventions focused on encouraging individuals to change their behaviour with regard to diet and physical activity need to be underpinned by broader, population-level interventions. Individual interventions include provision of information about the health benefits of exercise, workplace incentives, or referral to a lifestyle weight management scheme. Broader measures include pricing and availability of unhealthy foods, and redesigning environments to promote physical activity, which aim to make the healthy choice the default choice. Population-level interventions have the advantage of impacting on far greater numbers than could ever benefit from individual interventions, and may also be more effective at tackling health inequalities than individual interventions.

NICE guidance on what works

33. NICE has produced a wide range of evidence-based guidance on how to support people to be more physically active and eat a healthy diet. This guidance includes interventions on an individual level—including changing individual behaviour, and weight management programmes—and also more ‘upstream’ environmental interventions, such as changes to the local environment that may improve access to healthier foods or encourage active modes of transport such as walking and cycling. NICE guidance offers advice relevant to both central government, and to local government and health and social care commissioners, providers and practitioners with advice on implementing public health interventions to improve the health of their local community.⁴⁵ However, NICE state that since 2010 its work programme has focused on local interventions, and that they have not considered the cost effectiveness of national policies (such as tax or food labelling) since the

44 Professor Theresa Marteau ([IDH0073](#)) para 1

45 NICE ([IDH0098](#)) para 26

publication of guidance on the prevention of cardiovascular disease in 2010.⁴⁶ NICE supplied a summary table of their guidance and recommendations in the areas of physical activity and diet in their supplementary written evidence. Very briefly, key recommendations and publications have included:

- Brief advice given in a primary care setting to promote physical activity is cost effective
- Exercise referral schemes are not cost effective compared to brief advice in primary care, for people who are inactive or sedentary but otherwise healthy, and should only be funded for people with pre-existing health conditions
- Recommendations have also been made by NICE on local measures to promote walking and cycling, promoting physical activity for children and young people, promoting physical activity in the workplace, and physical activity and the environment.
- Good evidence exists on the effectiveness of lifestyle weight management services, although evidence is limited on the maintenance of weight loss in the long term
- Guidance on maintaining a healthy weight and preventing excess weight gain is due to be published shortly and is likely to recommend increasing walking and other incidental activities; reducing TV viewing and leisure screen time; reducing the energy density of the diet, including sugary drinks and foods eaten outside the home including takeaways. [NB this guidance has now been published]⁴⁷
- Guidance on obesity—working with local communities—makes recommendations on strategic approaches, local partnerships, commissioning, training and evaluation.
- Guidance of relevance to both diet and physical activity has included recommendations about behaviour change at an individual level; and guidance on preventing type 2 diabetes and preventing cardiovascular disease

34. NICE does not have the responsibility for evaluating the extent to which its guidance is implemented; this is done by independent researchers or may be understood through official statistics on for example prescribing patterns. Professor Gillian Leng, Deputy Chief Executive and Director of Health and Social Care at NICE, told us that compared with the other types of guidance NICE issues, very little research has been carried out into the implementation of NICE guidance on public health issues.⁴⁸ She also discussed NICE Quality Standards, which are now being developed by NICE, as potentially providing a clear way in which progress in implementing NICE's guidance could be measured.⁴⁹

35. NICE has produced a comprehensive raft of guidance on cost-effective interventions that can be introduced, either by the NHS or by local government, to improve diet and physical activity. These have included interventions on an individual level—changing individual behaviour, and weight management, and also more

46 NICE supplementary (IDH0105) p3

47 <https://www.nice.org.uk/guidance/ng7>

48 Q51

49 Q2

‘upstream’ environmental interventions, such as changes to the local environment that may improve access to healthier foods or encourage active modes of transport such as walking and cycling.

36. While we welcome NICE’s guidance, it is disappointing that there has to date been little assessment of how far these guidelines are being implemented. We have heard that NICE’s forthcoming Quality Standards will produce a clear framework against which progress towards implementing NICE guidance can be measured. We recommend that the next Government shows its commitment to improvements in this area by auditing progress against Quality Standards in the areas of diet and physical activity across the country to allow benchmarking and drive progress.

Local authorities—key to improving public health

37. Responsibility for almost all local public health commissioning and delivery has now been transferred to local authorities, although the Department of Health retains overall responsibility for public health policy, with Public Health England providing local authorities, the Department and the NHS with advice on what works best in protecting and improving public health.⁵⁰ Our witnesses largely described the transfer of public health to local authorities as a positive step that was already yielding benefits. Dr Janet Atherton reported that Directors of Public Health are “finding that being within local authorities is a much better environment from which to influence things that we need to be influencing, such as transport policies...”⁵¹ However, the limited funding available to local authorities was frequently raised. Dr Jane Moore told us that “being in the council has been incredibly valuable and it is exactly the right place ... but the timing is wrong in the face of councils having to make difficult decisions about how they protect core services.”⁵²

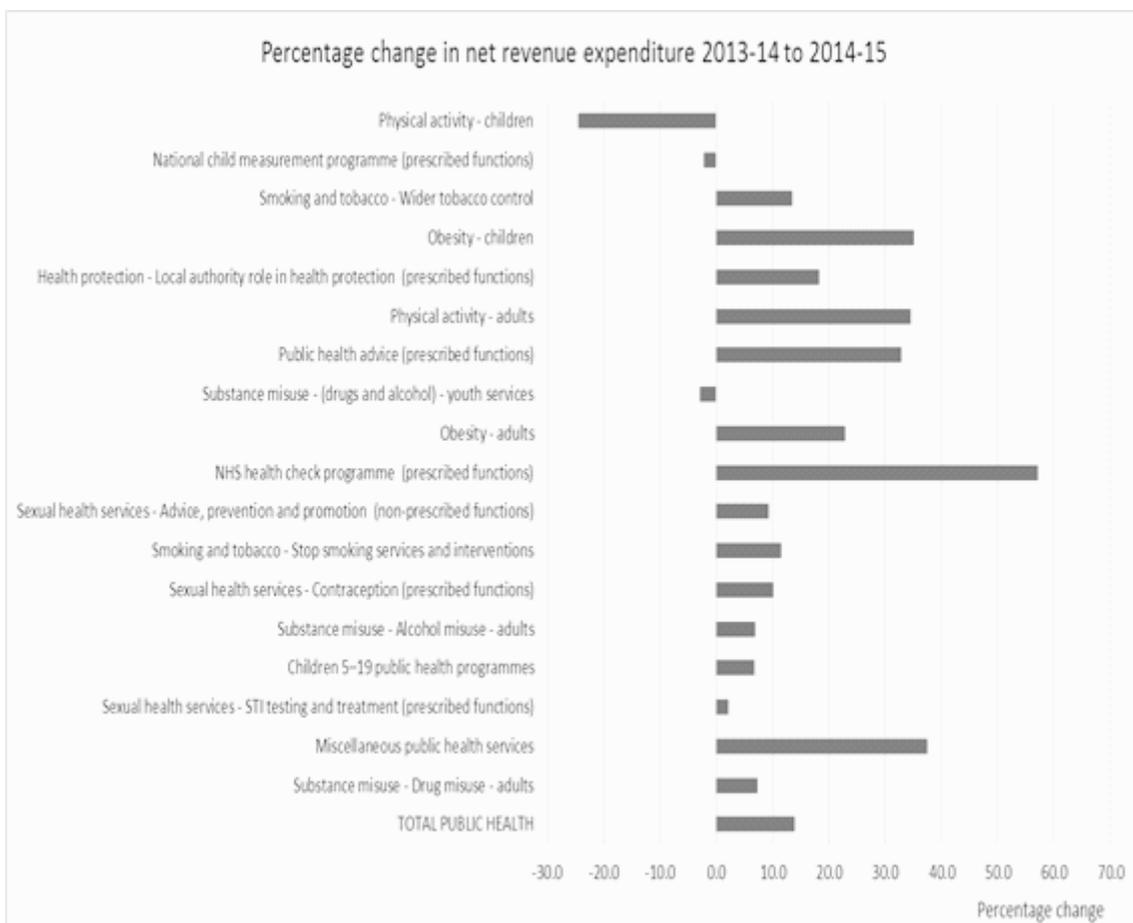
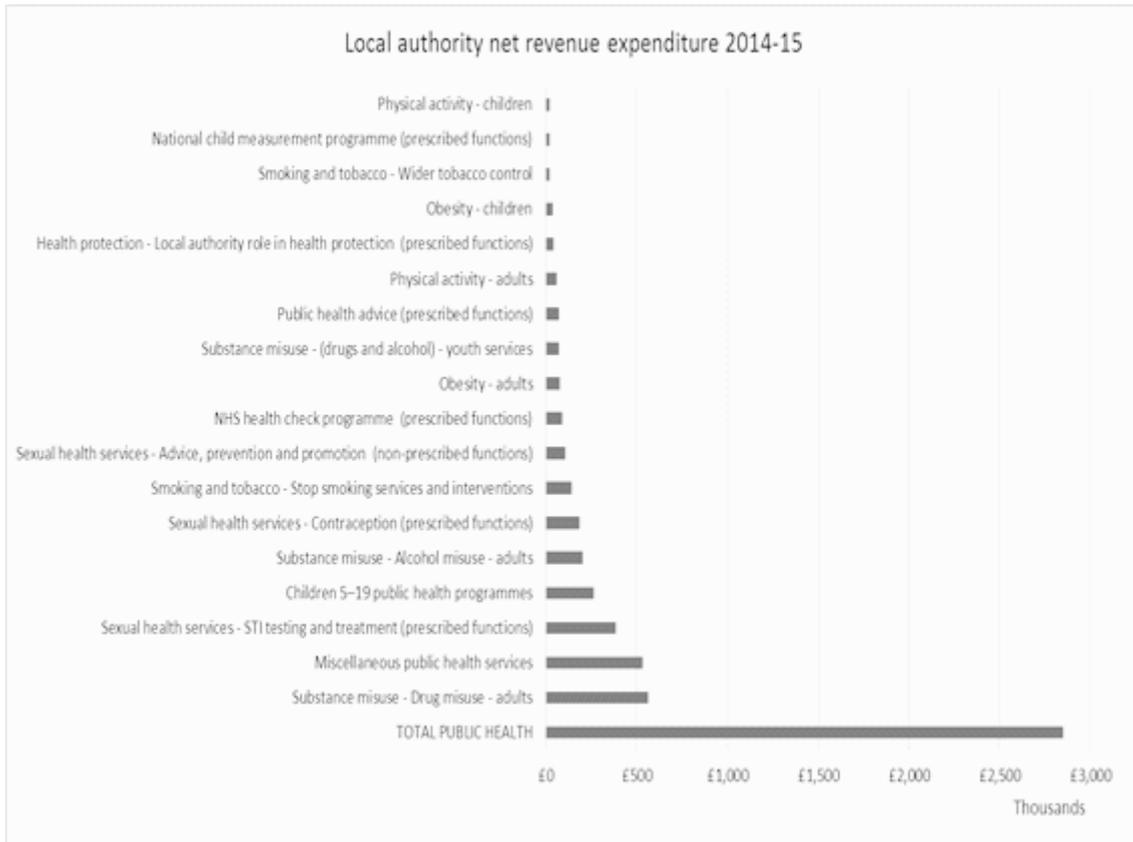
38. Local Authorities have to provide certain ‘mandated services’ from within their public health budgets. The following tables show how overall public health budgets are allocated to different priorities, and how the allocations have altered, although we heard that in fact these figures may not represent the totality of investment⁵³:

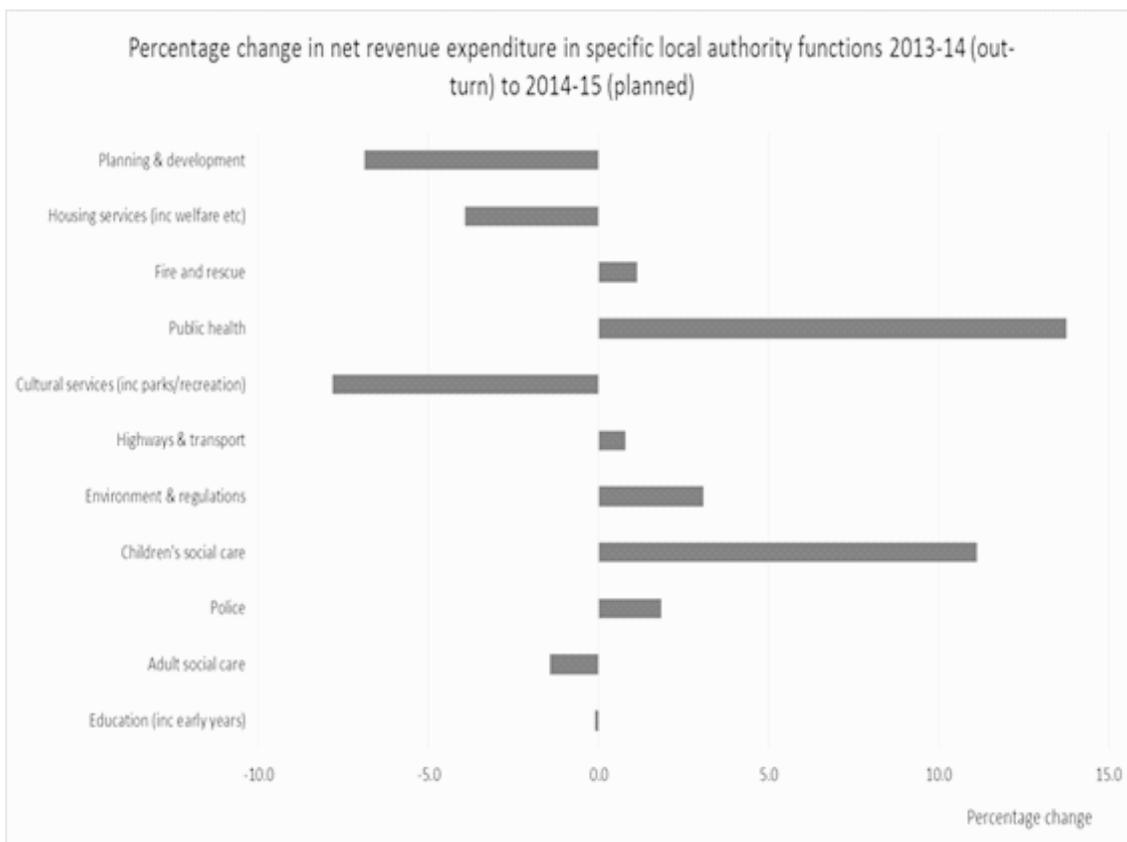
50 National Audit Office, [Public Health England’s grant to local authorities](#) (December 2014), paras 2-3

51 Q162

52 Q150

53 David Buck, [Public health gains despite slimmer budgets](#), *Public Finance*, 25 November 2014; see also Janet Atherton, Q147





39. The following table, taken from a recent NAO report, shows how spending on specific priorities, including for example obesity, varies substantially between different local authorities⁵⁴.

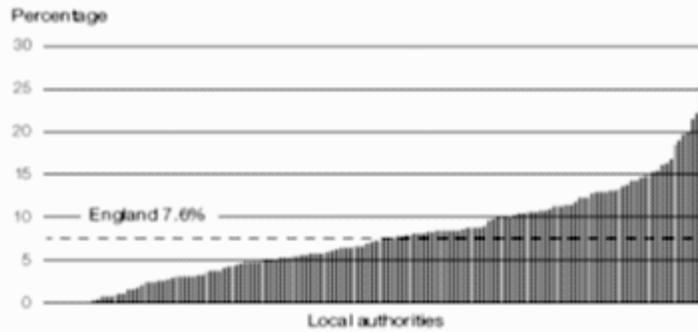
54 National Audit Office, [Public Health England's grant to local authorities](#) (December 2014), p22

Figure 6

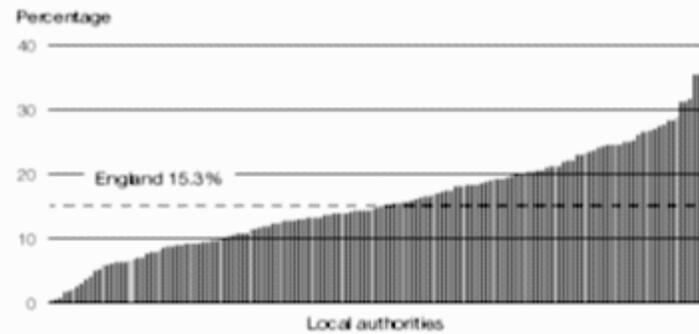
Proportion of public health spending on selected categories, by local authority 2013-14

There is considerable variation in the proportion spent by local authorities on each category

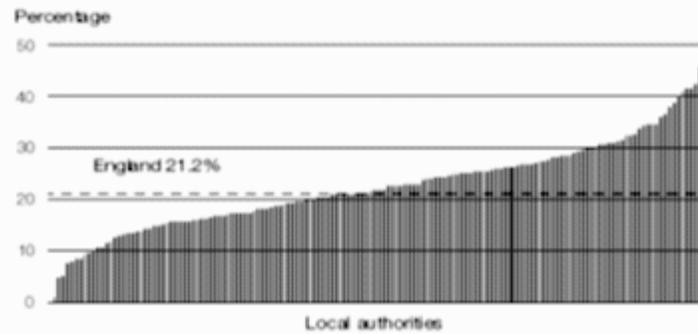
Alcohol – adults



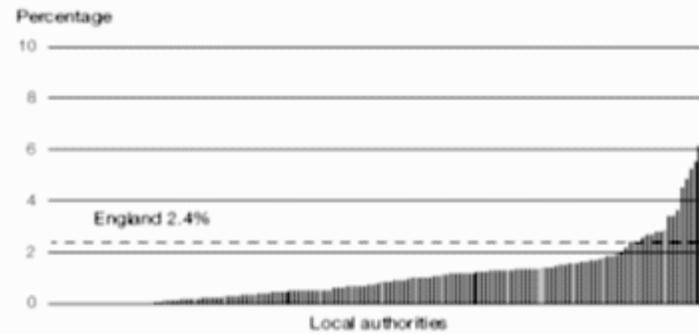
Sexually transmitted infections testing and treatment



Drug misuse – adults



Obesity – adults



Note

1 Net current expenditure, which excludes capital and non-grant income.

Source: Final outturn data 2013-14 – Department for Communities and Local Government

40. Dr Jane Moore described efforts to use their “leverage” to get other parts of the system to deliver change “on their behalf”, giving the example of work they have been doing with workplaces where they have not needed to invest any resources at all.⁵⁵ However Dr Dagmar Zeuner argued that local authorities need more resources to be able to “take prevention seriously”;

We have been very crafty with rather humble money, and our position in the local authority has certainly helped us to develop relationships and make the most out of them. But there is no doubt that austerity is a really serious enemy to any prevention and the pressure on local authority funding is no secret. If we want to take prevention seriously we do need to scale up, but the funding at the moment is humble.⁵⁶

41. Dr Zeuner went on to ask “why don’t local authorities turn around and say, ‘actually, we have tried our very best and we will continue, but we have very little. We need more.’”

42. Our witnesses also repeated the call made in the written evidence for stronger powers around planning, in order for example to limit the numbers of fast-food outlets in certain areas.⁵⁷ Dr Alison Tedstone of Public Health England agreed that there are “challenges in planning” and reported that PHE have many communities asking for help with getting fast food restaurants “under control”.⁵⁸ She went on to point out that when there is a very high density of fast-food outlets, they compete on just two things—price and portion size.⁵⁹ It is not hard to see the potential for a negative health impact, making ever larger portions of unhealthy food available at cheaper prices.

43. We welcome the transfer of public health functions to local authorities, which has the potential to enable Directors of Public Health to work creatively to get health embedded into other council functions. However, the public health funding that local authorities are able to invest in measures to tackle diet and physical activity was described by one of our witnesses as “humble”. **There is a danger that the current financial pressures on local authorities will lead them to deprioritise all but the mandated public health services to the detriment of prevention and health improvement. We recommend the next Government prioritises prevention, health promotion and early intervention and provides the resources to ensure it happens.**

44. **We also heard that local authorities need more powers to limit the proliferation of outlets serving unhealthy foods in some areas; Public Health England told us that they too had concerns about this. We recommend that the next Government works closely with the Association of Directors of Public Health and the Local Government Association to ensure local authorities have the planning powers they need for the control of food and drink outlets and for the preservation of open spaces for physical activity for public health purposes.**

55 Q147

56 Q146

57 Q107; Q207; Q154

58 Q226

59 Q227

Role of the NHS

45. The NHS also has a role to play in providing services in this area, both preventative services—for example the simple, low-tech intervention of providing brief advice about increasing physical activity in a primary care setting—and treatment services—for example referring patients to weight management programmes—two interventions which have both been identified by NICE as cost effective. Professor John Wass of the Royal College of Physicians told us that in each locality there should be a clinician with a special interest in weight and weight management, leading a team of people focused on this. However, in their recent research RCP found only four out of 32 London CCGs had this, something Professor Wass described as “a hugely missed opportunity”.⁶⁰ Professor Susan Jebb, Professor of Diet and Population Health at the University of Oxford, and Chair of the Food Network of the Government’s Responsibility Deal⁶¹, suggested that physical activity and diet interventions are lagging those focused on smoking:

We now have a situation where the GPs or practice nurses of most patients who smoke will talk about their smoking in their consultation. That is not happening in relation to people who are inactive or people who are overweight.⁶²

46. Since this inquiry concluded taking evidence, NHS England and Public Health England have announced a national diabetes prevention programme which will involve “supporting people to lose weight, exercise and eat better.” It will initially target 10,000 people at high risk of diabetes, with the initial phase of the programme beginning in seven demonstrator sites across the country.⁶³

Workplaces

47. The *NHS 5 Year Forward View* highlighted workplace-based initiatives as a promising way forward in tackling obesity and physical activity:

Workplace health. One of the advantages of a tax-funded NHS is that—unlike in a number of continental European countries—employers here do not pay directly for their employees’ health care. But British employers do pay national insurance contributions which help fund the NHS, and a healthier workforce will reduce demand and lower long term costs. The government has partially implemented the recommendations in the independent review by Dame Carol Black and David Frost, which allow employers to provide financial support for vocational rehabilitation services without employees facing a tax bill. There would be merit in extending incentives for employers in England who provide effective NICE recommended workplace health programmes for employees. We will also establish with NHS Employers new incentives to ensure the NHS as an employer sets a national example in the

60 Q210

61 Professor Jebb’s declaration of interests can be found at <http://www.nice.org.uk/guidance/ng7/chapter/10-membership-of-the-public-health-advisory-committee-and-the-nice-project-team#/declarations-of-interests>

62 Q57

63 “National diabetes initiative launched”, Department of Health [press release](#), 12 March 2015

support it offers its own 1.3 million staff to stay healthy, and serve as “health ambassadors” in their local communities.⁶⁴

48. Simon Stevens, Chief Executive of NHS England, described initiatives in the US where employees were offered incentives to lose weight, and Jane Ellison MP, Parliamentary Under-Secretary of State for Public Health, also gave examples of companies who were already offering things like subsidised gym memberships, walking groups, and programmes for minority groups within their work force.⁶⁵ Some companies in the USA provide workplace health promotion schemes as part of their package of health care insurance for their employees. To support companies in the USA, the Centers for Disease Control (CDC) provides resources.⁶⁶ In the UK there is a suite of NICE guidance on diet, physical activity, mental well being and smoking cessation in the workplace.⁶⁷

49. Public Health England flags up NHS England’s determination to set a national example in the support it offers to its own 1.3 million staff to stay healthy, including keeping a healthy weight, and serve as “health ambassadors” in their local communities. NHS England, on request from the Committee, have provided the following information about workplace incentives:

We are examining the potential to extend incentives for employers in England who provide effective NICE recommended workplace health programmes for employees.

...All NHS employers should take significant additional actions in 2015/16 to improve the physical and mental health and wellbeing of their staff, for example by providing support to help them keep to a healthy weight, active travel schemes and ensuring NICE guidance on promoting healthy workplaces is implemented. To reinforce local action, we will be launching a new broad-based task force charged with achieving a healthier NHS workforce. To support early progress, the 2015-16 NHS standard contract now requires providers to develop and maintain a food and drink strategy in accordance with the Hospital Food Standards Report.⁶⁸

50. Public Health England have recently announced a bespoke weight loss pilot scheme for NHS staff which is to be introduced to Imperial College Hospitals, which “could provide a blueprint for national roll out.”⁶⁹

51. But the Royal College of Physicians suggests that NHS Trusts themselves are falling short in this area:

64 Q282

65 Q281

66 <http://www.cdc.gov/workplacehealthpromotion/businesscase/>

67 [:http://www.nice.org.uk/guidance/ph22](http://www.nice.org.uk/guidance/ph22); <http://www.nice.org.uk/guidance/ph13>; <http://www.nice.org.uk/guidance/ph5>; <http://www.nice.org.uk/guidance/cg43>

68 NHS England ([IDH0101](#)) paras 8-9

69 “National diabetes initiative launched”, Department of Health [press release](#), 12 March 2015

The RCP recommends that all employers should have a duty to promote the health and wellbeing of their staff. NHS organisations should be supported to be exemplar employees in this respect, particularly as improved staff health and wellbeing of staff has a proven association with better patient outcomes and experience. Recent research by the RCP found that only 28% of NHS trusts in England have an obesity plan, and the many NHS staff who work unsociable hours or night shifts have poor healthy food choices. While trusts are getting better at promoting opportunities for increasing physical activity, there is little monitoring of uptake by staff. Only 44% of trusts have a physical activity plan although this has increased from 24% in the first year that the audit was conducted. The NHS must lead by example and disseminate strategies for what works, but we must see action from employers across the wider public and private sector.⁷⁰

52. Professors Susan Jebb and Theresa Marteau express the same view in even stronger terms:

Unlike smoking—where the NHS is now effectively a smoke-free environment—the NHS has done little to promote healthy diets on the NHS estate. The new requirement in the NHS Operating Contract for 2015/16 for hospitals to have a food and drink strategy provides an opportunity to address this.⁷¹

It is at best anomalous and at worst negligent that NHS properties continue to serve foods high in sugar, fat and salt (as exemplified by McDonald and Burger King outlets in some of our most prestigious hospitals, including Guy's Hospital in London and Addenbrooke's Hospital in Cambridge). Conversely, providing environments that facilitate healthier behaviours (e.g. by providing only foods compatible with healthy, sustainable diets) can signal that these are congruent with health and provide opportunities for those unused to eating healthier foods to sample such foods.⁷²

53. One commentator told us that in her view, it is "at best anomalous and at worst negligent" that that NHS properties continue to serve foods high in sugar, fat and salt, with some hospitals even having fast-food outlets on their premises. The NHS should lead by example and manage its estate in a way that stops promoting the over-consumption of energy dense nutritionally poor food.

54. Beyond the NHS, workplaces are where working age people spend the majority of their time and as such can represent a powerful resource for health promotion. We urge the next Government to work with NICE and Public Health England to find the best options for achieving this in a range of workplaces, including the use of financial and other incentives.

70 Royal College of Physicians ([IDH0043](#)) para 12

71 Professor Susan Jebb ([IDH0100](#)) p3

72 Professor Theresa Marteau ([IDH0073](#)) p5

55. While local authorities now have the lead public health role, there is an ongoing need for the NHS to provide both prevention and treatment services but greater focus needs to be given to discussing inactivity or overweight. The NHS is this country's largest employer and has a crucial role to play both in terms of promoting the health of its workforce, and in setting a wider example. More broadly, there is clearly potential for other workplaces to do more. We recommend that Primary Care takes the lead, as it has does for smoking cessation, in promoting physical activity and preventing obesity—these topics should not be off limits during consultations.

Cross government working

56. Dr Dagmar Zeuner told us that in her view “the crux of the matter is that it is neither the local authority nor the NHS; it is a whole societal issue if we want to get prevention embedded.”⁷³ Given the need for interventions at both an individual level, and at a broader, population level, it is clear that effective cross-Government working is essential, to span health, local government, education, transport, planning, food standards, industry and advertising. The Minister gave us assurances that this was already taking place.⁷⁴ However, our witnesses were not convinced and argued that better cross- Government working was needed. Professor John Wass of the Royal College of Physicians told us that in his view:

...at the moment, there is a complete lack of any co-ordination between various Government Departments in this whole issue of obesity such that we need a healthy environment in the health service; we need to educate our children; we need to grow healthy food; we need to have healthy transport with bicycles; and Work and Pensions need to take on all of this as well, just to mention a few Departments. If there was somebody—perhaps a Cross Bencher in the House of Lords who had experience of inter-governmental responsibilities and action—who could be put in charge of a co-ordinated Government programme, it seems to me that we would run the serious risk of being the first nation on the planet to solve the problem.⁷⁵

57. Similarly, Sue Davies of Which? argued that “there is no joined-up approach across Government Departments, so a longer-term issue is about making sure that there is consistency, and clear priorities that go across all Government Departments.”⁷⁶ Jane Landon of the UK Health Forum suggested health impact assessments of Government policies:

We have the tools available to us; we have dietary guidelines; we have CMO physical activity guidelines. We are only really using them when we talk to the individual, but these should be perhaps guiding decisions and policy decisions across Government Departments, whether it is transport, business and trade as well as health. We are kind of reframing some of the discussions. One of the things we are not doing is any kind of health impact assessment on Government policy; we are not looking at the impact on the food

73 Q149

74 Q220

75 Q174

76 Q141

environment or the physical environment when we make decisions across Government as routine. This could be something that could be much more effectively carried through and we would start to pick up those pressure points when things start to go wrong, which they have done over the last 30 years, and respond to those at the time that new policies are being put in place because it is very difficult to retrofit.⁷⁷

58. Finally, Dr Mike Knapp of the British Heart Foundation argued that “the scale of the prevention challenge means that all political parties should make this a priority, and we feel it should be led by the Prime Minister”.⁷⁸

59. While there now is widespread recognition of the health impacts of diet, obesity and physical activity, and the scale of the problems we now face in these areas, these problems are not "owned" by a single Department or agency. A successful strategy for tackling these problems needs to mirror the successful strategy on tobacco, and be multi-level, spanning national and local government down to every citizen. A successful strategy may need to incorporate elements as diverse as public education, regulation, fiscal measures, legislation, messaging and campaigns, evidence based behaviour change, changes to the school curriculum, and changes to planning arrangements.

60. Given the breadth of these issues, it is essential that the strategy must be cross-governmental and integrated laterally and vertically, and given the importance of these issues, led from the very top of government. We call on the next Government to introduce a co-ordinated government-wide programme to tackle poor diet and physical inactivity; this programme should be given the resources and authority necessary to secure collaboration with all relevant Departments and bodies, and should report at regular intervals on health improvements to the Prime Minister, and to Parliament.

77 Q128

78 Q143

3 Physical activity—a key health priority in its own right

61. As discussed in Chapter One, physical activity in its own right has huge health benefits totally independent of a person’s weight, and it is vital that the importance of physical activity for all the population—regardless of their weight, age, health, or other factors—is clearly articulated and understood. In its written evidence, the Department of Health states that the Government has commissioned Public Health England to develop a “5-a-day” style of message for physical activity.⁷⁹ In oral evidence to our inquiry, the Public Health Minister suggested that messages about physical activity may not currently be very well understood:

When you get off the bus a stop early, what percentage of your recommended daily activity is the distance that you walk? People do not have a sense of that”.⁸⁰

62. Dr Mike Knapton of the British Heart Foundation provided his own simple slogan to increase physical activity—“just do more”.⁸¹ Our witnesses told us that even modest increases in activity levels are beneficial to health, and for inactive people that may be a more helpful starting place than immediately trying to meet physical activity recommendations in full. CMO’s guidelines have now been updated to reflect this:

It was a subtle shift in the chief medical officer’s last guidance, which talked about achieving the guidelines that you referred to but also said, “But more is better.” So, from whatever level people are at, they should be more physically active. The public health benefits would probably be greatest if we were to focus on that group who were sedentary in work and in their recreation. Sometimes if we set a public health target that is too far away from people’s everyday reality, it can disincentivise change. Telling people “The equivalent of a 20-minute walk a day extra”—which I think most people can achieve; it is within the realms of possibility—“can have serious health benefits,” is a much more positive message.⁸²

For some people, working on spending less time watching the television may be a better place to start than thinking, “I need to go out for a run three times a week.”⁸³

63. Julie Creffield, a grassroots physical activity campaigner and blogger who supports overweight women in becoming more active through running, also recognised that it may be helpful to start slowly:

79 Department of Health ([IDH0078](#)) para 56

80 Q249

81 Q129

82 Q43

83 Q46

I have a campaign to get a million fat women running ... it is about a gradual introduction to the sport of running, not going full whack and signing up to a marathon. I have been developing a scale which could really help doctors. It is a scale that goes from non-runner to contemplator to beginner...⁸⁴

64. Professor Nick Wareham also told us that a focus on diminishing sedentary time is an important additional public health target⁸⁵, a point reinforced throughout our written evidence.

65. Our witnesses also gave us a very clear message that physical activity can and should incorporate all forms of activity, and that we should be promoting physical activity—the totality—however people choose to do it. Physical activity can include every day activities—such as walking, heavy housework, gardening, and active or manual work: active travel, including walking and cycling; sport; fitness training; and other forms of active recreation such as dance, yoga or active play. We also heard that it was important not to see active travel as an “all-or-nothing” form of activity, and that for many people mixed-modality transport—cycling to the railway station, or walking to work from an off-site car park—might be a more realistic way of engineering physical activity back into their everyday lives.⁸⁶

66. The recent report from the Academy of Medical Royal Colleges reinforces the importance of promoting a broad and inclusive range of physical activities, tailored to be appropriate for an individual’s preferences and lifestyle:

The actual activities are not important, as long as they are moderately intense, can be fitted into the person’s schedule and are regular. There is no difference between “structured exercise” and “lifestyle physical activity” in the protective effect offered for the number of minutes of activity. The choice of activity should be relevant, rational and routine. The intensity may need to build up over several sessions. For some, a sociable activity is more likely to be maintained. Young people from deprived backgrounds find group activities, sport and timetabled sessions more attractive when facilities are cheaper and they are given encouragement. Fun activities are more likely to be sustained. Many activities can be promoted; brisk walking, cycling, climbing stairs, dog-walking, using outdoor gyms and dancing—even sexual activity can bring some benefits. Basing activities in communities leads to sustained acceptance.

Doctors should promote an active lifestyle. Although the benefits of “150 minutes per week” are equivalent to “5 times a week”, there are problems with expecting a sport to fulfil the physical activity requirements; the weather, sporting injury and holidays can reduce the sustainability of sporting activity. Furthermore, there are issues around taking up sport for the first time, and maintaining sporting activity throughout the life course. The Olympic legacy may have left some with continuing sedentary

84 Q347

85 Q46

86 Q49

behaviour, if they feel that sport is for spectating and that the Olympic ideal is impossible to achieve. It may be easier and better to kick a football around for fun, than to sign up for a football team. In addition, for increasing numbers of people, signing up for a future charity challenge is an excellent way of obtaining regular training sessions in the weeks leading up to the event.⁸⁷

67. Dr William Bird gave the Committee a clear and memorable illustration of how re-building physical activity into daily life is easier if physical activity is a means to an end rather than an additional extra that needs to be fitted in on top of other pressures:

Can I use the example of Bob? Bob is a 42-year-old diabetic, depressed and living on the 14th floor of a tower block with two unruly teenage children. He is the kind of person that I will see as a doctor. To give Bob a badminton racket and tell him to go off and do some sport is not going to be the key thing. He is depressed and stressed; he has loads of problems. The kinds of ideas we have gone through before are to get off the bus a stop early and to use the stairs. These are complete anathema to Bob. He has too many problems in his life to go off on a rainy day to do that extra walk. What he does do is walk to Anfield—he is from Liverpool—two miles there and two miles back. He does not call that exercise at all. That to him is not exercise; that is going to Anfield as a supporter.

We have to find in everybody, in your constituents and my patients, the “Anfield” part, which would mean that physical activity is secondary to the end; it is a means to an end rather than the end in itself. There are those of us—and probably in this House—who are very keen on being physically active and wanting to cycle and do all those things, and we have all sorts of gadgets on us, but that is a very small proportion of the country’s population. Most people see physical activity as work and they will be prepared to do that work if there is a reward at the end. So it is a means to an end, rather than the end in itself.⁸⁸

68. Professor Dame Sue Bailey gave a further example highlighting the importance of building physical activity into daily activities:

Pragmatically, it is doing what you do but doing it slightly differently. My example would be my daughter taking children to school pushing the buggy. There will be several of them doing that and on the way back they will come back at a quicker pace; they will go more rapidly; they will meet the criteria of this. Actually, they will have the socialisation and will physically feel better for it. That is almost without cost, I would say. So it is actually looking at the routine in people’s lives and how they can alter their routine slightly each week on a regular basis. Taking children to school five days a week, here is the opportunity to do this. It is about having that conversation with people in

87 Academy of Medical Royal Colleges, [Exercise: the miracle cure and the role of the doctor in promoting it](#) ,(February 2015), p28, p34

88 Q295

the community and/or if you are the doctor in the surgery thinking of ways that it would be possible within the surgery. The practice nurses have meetings with young mothers and mothers-to-be, so there are opportunities right across the surgery to start having these conversations. The other thing is that health professionals themselves are going to have to join in and embrace this.⁸⁹

69. We have heard the hugely positive message that increasing physical activity has significant health benefits and does not necessarily mean playing organised competitive sport three times a week—it encompasses a diverse range of activities, including everyday activities such as walking. The point was made that raising heartrate was the most important thing, but any increase in activity is beneficial.

70. For some people it can be easier to fit physical activity in if it is “a means to an end” rather than an end in itself. The key message from witnesses was to “just do more”, in a way that fits with your lifestyle.

Promoting physical activity in clinical encounters

71. Despite the overwhelming evidence to support the promotion of physical activity, doctors and other clinical professionals are not yet playing an active enough role in promoting this and, in some circumstances, may be adding to the problem. Julie Creffield described at first hand the negative attitude she faced from doctors as an overweight person undertaking physical activity:

I went to my doctor in 2013 with some lower back pain which was caused by picking my daughter up. When I mentioned that I was due to run a marathon, he said I couldn't run a marathon—I was too fat. That really spurred me on to take what was a bit of a hobby—this kind of blog—to being a real campaign. I was so angry that that doctor, who wasn't my doctor but a locum, didn't want to hear that just the week before I had done 18 miles around Hyde Park and that I had been running for a long period of time; this wasn't just something I had in my head. I was determined to run in that marathon to prove him wrong but also then to use that catch phrase “Too Fat to Run?” as a way of starting these debates with parliamentarians, the people who can make changes, because, ultimately, the people who were reading my blog were the people who needed help. I have struggled over the last few years to get my voice heard and to have discussions about health and what I have learned and experienced.⁹⁰

72. She went on to describe her delight when she first heard a doctor say it was possible to be “fit and fat”:

89 Q300

90 Q344

When I heard that out of the mouth of a doctor, I almost exploded—just that phrase alone—for doctors to accept that that is a possibility—would be helpful.⁹¹

73. Professor Nick Wareham was amongst many to highlight that more needs to be done to promote physical activity within clinical encounters:

One of the areas where we can do more is in the promotion of physical activity in a clinical encounter. That sometimes gets given lesser importance than dietary change or obesity. I know from my clinical work where we are treating people with diabetes that, if we want to focus on the behaviour, even the provision of a pedometer to people in a diabetes clinic is extremely difficult, and yet we know from trials that providing a pedometer and making people aware of their own level of physical activity does promote beneficial change. There are things we can do in a clinical encounter as well as, more broadly, in a public health arena.⁹²

74. Dr William Bird agreed that:

...the GPs particularly need to have their knowledge increased. Physical activity should be part of being a good doctor. It is not quite there yet. The evidence is there but it needs to be put in the hearts and minds of doctors.⁹³

75. Professor Dame Sue Bailey agreed:

You may ask why we have not done this before—that this was something that seemed obvious—but doctors, as part of society, have forgotten what it takes to stay healthy as we are leading increasingly sedentary lives. Doctors have a unique role to play in this because we are trusted and we are in a position beyond primary care to have the critical conversation with patients about the need for physical activity and the benefits it can bring to them, particularly in primary care.⁹⁴

76. Offering brief advice promoting physical activity in a primary care setting has been found to be a cost effective intervention by NICE. The Department of Health and Public Health England raise the NHS Health Check as an intervention which offers potential to promote physical activity, but Public Health England said that they “still have work to do on maximising that opportunity”. Diabetes UK argue that in their view not enough of the target population of 40–75 year olds have had an NHS Health Check—they state that less than half of the eligible population have received an NHS Health Check and only 70 out of 152 local authorities are on course to achieve a Public Health England target of 66% uptake by March 2015.⁹⁵

91 Q350

92 Q57

93 Q284

94 Q284

95 Diabetes UK ([IDH0076](#)) p4

77. Beyond the issue of how many people are receiving a health check, many giving evidence to us also argued that even those receiving a health check may not then be being offered effective support to change their behaviour. Professor Wareham argued that whilst health checks may identify individuals at risk, there may be a “disconnect between that and clinicians then being able to help people to actually do something about increasing their activity levels.”⁹⁶ Dr William Bird also described this:

The health checks have been a way of getting people aware of what their risk factors are. In the evidence that I have seen, it has actually reduced blood pressure; it has reduced some of the areas, though not smoking so much. I have not seen any evidence that it reduces mortality from it, but, as a way of getting physical activity into a conversation for a patient, the health check is a very good way as long as the provider of that health check has a connection to understand about what they should be talking about on physical activity. Unfortunately—and I quote someone who is a very avid supporter of this—a GP went to his own health check in the practice and the nurse said, “I am meant to be talking about something to do with physical activity, but I am not quite sure what it is.” That almost summarises, in effect, that there was a tick box to talk about physical activity, but it did not mean much to that nurse because she had never been told what physical activity was about. There is a massive gap there, and the report comes through very strongly that doctors and nurses need to be upskilled in the knowledge of physical activity, which would make the health check much more effective on physical activity promotion.⁹⁷

78. Dr Bird also described the difficulties doctors face in promoting physical activity when patients may have been expecting, and attach greater value to, more high-tech interventions:

The biggest problem with the patient, going back to the example of the stent or physical activity, is that patients often were not ready to be told they had to go for a walk in the park when there was a nice shiny stent in a lovely brand new hospital down the road. They felt they were much more worthy to have that because that is where science and technology was at its ultimate and they were just being told to go for a walk. So the patients’ expectations were not met and the doctor felt uncomfortable very often in promoting that because it was not what we had been taught to do and we had not got the confidence to do it. Finally, the patients have a fear of physical activity. Most of them have never been out of breath because they have never exerted themselves to the point where they are actually going at 70% of their VO_2 max, which is a three-mile-an-hour walk. They are walking incredibly slowly, so to get to the point of being out of breath is quite scary. That is another aspect, when they come back to the doctor saying they cannot do this because it is too dangerous.⁹⁸

96 Q70

97 Q311

98 Q302

It is often more difficult to promote something simple, and walking is almost too simple. The reason I set up Intelligent Health was to add technology to walking so that everyone can do it, and then suddenly everyone finds walking is attractive and they put money into it. But when you have walking on its own it is almost too simple, and the mentality of health is that you need treatments and you need packages to help. So there is a kind of psychology of the way that we deal with health which we have to work with. As doctors, we have the responsibility to change the expectations of patients. We should not be giving antibiotics at every consultation. We have managed to win that and it is starting to take effect. We can do the same with physical activity.⁹⁹

79. Professor Dame Sue Bailey told us that improvements were required to medical education:

Maybe it needs to be recognised as an entity rather than just appearing in separate parts of different parts of medical curricula, but I can certainly come back to you on that.¹⁰⁰

Doctors will accept that physical activity is not just prevention but treatment as well, so we have to explain that almost every condition can be treated. There is a gap that we have probably not been very good at filling in getting that knowledge to GPs and all doctors, which is there, and I think they will accept it when it has been put in the right way.¹⁰¹

80. Dr Bird described his approach to engaging GPs by focusing on the medical benefits in a detailed way, rather than taking a public health approach:

...when I started teaching GPs about physical activity, I got it all wrong. I talked in a public health language—I am a GP—and it was about prevention, statistics and tables and things. It was only when I started talking about the actual physiology—when I talked about the cellular level—that it started to reconcile in their minds with a medical problem.¹⁰²

81. NICE has clearly recommended that offering brief advice in a primary care setting is a cost effective way of getting people to increase their levels of physical activity. It is clear that clinicians have a crucial role to play in promoting physical activity. Better undergraduate and postgraduate education is now required, both to ensure clinicians' understanding of the medical benefits of physical activity, and to teach them how to promote physical activity to their patients in an effective way, particularly when some patients may be sceptical of such a "low tech" approach. We recommend that the next Government works with the royal colleges and Health Education England to achieve this.

99 Q309

100 Q212

101 Q315

102 Q314

82. In relation to NHS Health Checks, we heard of a “tick box” approach to physical activity, with clinicians carrying out Health Checks lacking the skills to support people in actually changing their behaviour. We recommend that, given the considerable investment of public resources in NHS Health Checks, NICE should be tasked with assessing their clinical and cost effectiveness.

An environment that promotes physical activity

83. Dr Bird told us that “the problem is that we do not have environments at the moment that encourage people to walk.”¹⁰³ Professor Wareham also highlighted the importance of infrastructure and environmental factors in promoting physical activity, pointing to international examples:

If you want to make comparisons between cities, or between the Netherlands and Britain, it is about the infrastructure and making it conducive to physical activity. There is a major win here. If we could only get people here to be as physically active as people in Copenhagen, for example, in terms of walking and cycling, colleagues have estimated that over a 20-year horizon the benefits, in terms of health care costs averted, would be of the order of about £19 billion. So it is possible, because we are talking about near neighbours in Europe, but the solution does not lie in only encouraging people not to be lazy; we have to be more radical and think about structural changes to the wider environment.¹⁰⁴

84. Professor Susan Jebb argued that while infrastructure change may be costly, our environment is not static, and change is happening constantly, providing opportunities to redesign environments in order to promote physical activity:

People often raise the cost of making change as being a barrier when we talk about anything that involves infrastructure. Of course that is a very legitimate issue, but we need to remember that change is happening all the time; schools are being refurbished all the time and work places are being reconfigured. We are building whole new towns and we have a real opportunity to build this in from the start. It would be unrealistic to imagine that we were going to sweep across the country and retrofit some of these changes, but we can start to do things differently because we now understand that the environment—whether it is the micro-environment in your school or your home or the macro-environment in the towns and places we live—has a real impact on the way we live our lives. We need to be planning for that and planning for health as we rebuild.¹⁰⁵

85. Under the Infrastructure Act 2015, the Secretary of State for Transport will be required by law to set out a strategy for cycling and walking infrastructure and importantly the funding provided to meet it. The Infrastructure Act sets out the Government’s ambitions

103 Q291

104 Q25

105 Q48

to build a better transport system. Although initially focusing on a Roads Investment Strategy, with a number of transport groups and health organisations campaigned for a Cycling and Walking Investment Strategy to also be included in the Act to ensure that active travel is considered as a priority area for investment. This means that for the first time there is a legal obligation on the government to set targets and investment for cycling and walking.¹⁰⁶

86. We have heard that the physical environment can have a significant impact on activity. Open spaces are needed for recreation and play, and the built environment, including road infrastructure and speed limits, all impact on how easy or attractive it is to walk or cycle. We call on the next Government to make a clear commitment, together with appropriate long term funding, to significantly increase the levels of cycling and walking.

Engaging different groups in physical activity

87. We have also been struck during the course of this inquiry by the inequalities apparent in rates of physical activity. Particularly pronounced is the gender difference, with only 16% of girls aged 5–16 achieving the recommended levels of physical activity compared with 21% of boys, and 32% of women achieving the recommended levels compared with 43% of men. Looking specifically at participation in sport, 31% of females engage in sport once a week compared to 40.1% of men.¹⁰⁷ Discussing the possible reasons for this difference, Kay Thompson told us that Sport England’s work had identified “fear of judgement” as a key factor:

Three quarters of women want to become more active but something is stopping them...fear of judgement...judgement about appearance when exercising, ability to be active, confidence to turn up to a session, or feeling guilty about going to be physically active or doing something when you should have been spending more time with your family.¹⁰⁸

88. Julie Creffield described the difficulties she faced in a frank and insightful way:

When I looked online for information, there was lots about weight loss and running but nothing about running just as an overweight person, the psychological aspects of that and how tough it is when you are constantly shouted at, laughed at and clothes in fitness stores don’t fit you. It feels like the whole sport is not geared up for you.¹⁰⁹

89. Ms Creffield mentioned the fear of being ridiculed as a barrier to becoming more active, and also fear of being too slow a runner and not wanting to be the one “struggling at the back”.¹¹⁰ She stated that the virtual runs she organises are designed to ensure that

¹⁰⁶ Sustrans news release, “[Cycling and walking investment strategy now law](#)”, 13 February 2015, accessed 18 March 2015

¹⁰⁷ Sport England, [Active People Survey 8](#), 2014

¹⁰⁸ Q172

¹⁰⁹ Q344

¹¹⁰ Q355

people know they won't be comparing speeds, and that they are for all abilities. She went on to say:

You do not see a lot of overweight people exercising because they do it in secret. I have women who tell me they run on a treadmill in their shed because they just don't want to be seen in public, but that is part of the problem. Because we don't see many overweight women exercising in public, other women don't think that exercise is for them. They think it is for all the slim people that they always see out in the parks. So "Be invisible." I get a lot of feedback saying, "I bought your T-shirt because I want to support what you are doing, but I always thought I wouldn't be very confident to go out wearing a T-shirt that says 'Too Fat to Run?' But I did and I felt so empowered, and when people looked at me I didn't care because I am on my own fitness journey." So there is something about reversing that kind of psychology stuff and getting people to feel like it is their right to be in public and exercising, and they should not have to make apologies for themselves.¹¹¹

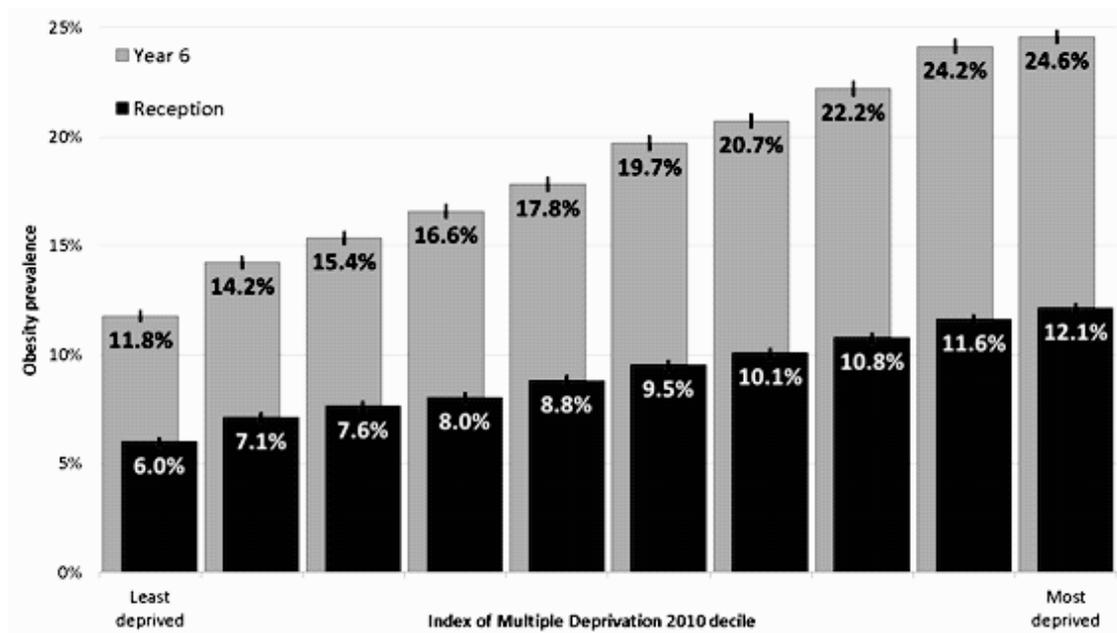
90. Ms Creffield also raised the simple but important issue of larger people not being able to find exercise kit that fits:

In the UK it is nigh-on impossible to get technical running gear in anything larger than a size 18, and even to get a size 18 in some items like a running jacket is impossible. That is a real barrier because no woman wants to dress in men's clothing to go out for a run when there is already the risk of being laughed at. That is a real problem. Initiatives like parkrun and Jantastic and all of these kinds of running things that are there to get more people active themselves don't provide T-shirts in anything larger than a size 16. So it is really hypocritical that the Government pump money into initiatives, but at the end of the line somebody goes to sign up and says, "I'm not going to sign up for that because I can't get a T-shirt in my size. So why should I?"¹¹²

91. The number of children who are obese doubles in primary school, and as the table below shows, child obesity prevalence is closely associated with socioeconomic status:

111 Q364

112 Q355



[Source - National Child Measurement Programme 2013/14–Public Health England]

92. Children fare worse than adults in meeting recommended levels of physical activity, with only 16% of girls and 21% of boys achieving the recommended levels of physical activity.¹¹³ Witnesses also gave us views on children’s and young people’s physical activity levels: while Dr Dagmar Zeuner argued that it was “quite astounding how little PE is in the curriculum”¹¹⁴, Professor Nick Wareham emphasised the need to also consider activity levels outside school:

The natural assumption is to think that it is all about what goes on in school, about PE and the school environment, but much of that decline is actually happening out of school hours and at weekends...30% of children who live within 2 km of school are driven to school.¹¹⁵

93. Physical activity must be seen in its totality, and a flexible and inclusive approach is needed to enable individuals to choose a way to increase physical activity that is right for them. Nowhere is this more important than in promoting physical activity amongst groups of people who seldom take part. The most obvious is the disparity between men and women, but inequalities in physical activity levels exist between other sectors of society too, and children fare worse than adults in terms of meeting physical activity recommendations.

94. Fear of judgement is a key barrier preventing women from being more active. Some barriers may be quite simple such as the lack of availability of sports clothes in larger sizes or mixed changing rooms. The Government-wide programme on diet and physical activity should include a specific workstream focused on identifying and

113 Public Health England ([IDH0063](#)) p23

114 Q174

115 Q20

tackling inequalities in relation to physical activity, and it should begin with work to examine how women, those with disabilities and overweight people, can be encouraged and supported to be more active.

4 Diet and obesity—reforming the food environment

“Normalisation” of overweight and obesity?

95. Some two thirds of the adult population are now overweight or obese. Public Health England argue that “excess weight is now considered a social norm in England” and that “this has potentially de-sensitised people’s judgements about their own weight, and that of their children.”¹¹⁶ However, in the view of Professor Susan Jebb, most people who are overweight would like to lose weight, and need better support to enable them to do so:

Without doubt, overweight is now the average, the typical, the normal. But I do not believe personally that that is making the problem worse. The reality is that most people who are overweight would like to lose weight. There are a few who profess to be very happy the way they are, but the vast majority of people who are overweight would like to lose weight. We need to support and enable them to do that. One thing that we do know is that people respond much better to a supportive structure than they do to criticism, discrimination and so forth¹¹⁷

96. The Committee noted the changes in dress sizing over the years which may have helped to normalise this.

NHS prevention and treatment services

97. The NHS has a role to play in both preventing and treating obesity and overweight. However, as highlighted by the NHS Forward View, “it makes little sense that the NHS is now spending more on bariatric surgery for obesity than on a national roll-out of intensive lifestyle intervention programmes that were first shown to cut obesity and prevent diabetes over a decade ago.”¹¹⁸ Professor Jebb reinforced this point in her oral evidence:

There is absolutely a place for bariatric surgery, for sure, as we have heard, and I am not going to continue that theme. I would also remind you that weight losses of maybe 20 kilos in an individual really makes you sit up and take notice, and that would be very typical after bariatric surgery. But that is one individual and we should not underestimate the benefit of having 10 people who all lose 2 kilograms because, again, at a public health level, that is going to bring similar health benefits. So we need a mixed economy and we need these tiered kinds of services where we are intervening earlier, before problems get more serious, with some of these less expensive, more behavioural interventions, which hopefully achieve some weight loss but, crucially, if they are following good practice, because they are founded on

116 Public Health England ([IDH0063](#)) para 30

117 Q31

118 NHS England [Five Year Forward View](#) (October 2014), pg 11

getting people to improve their diet and to become more physically active, will have the other independent health benefits that come from changing those fundamental behaviours. We have to see what I call behavioural weight management programmes as being that hybrid of preventing chronic disease associated with obesity but also treating the early stages of overweight and obesity. I think they are much underused...We are missing opportunities to intervene earlier with behavioural weight management programmes. Linking it into health checks is an absolutely prime opportunity to do that.¹¹⁹

98. Public Health England and the Academy of Medical Royal Colleges were amongst many to support the need for further investment in lifestyle weight management services.

Sufficient evidence on the benefits of weight loss exists to justify the continued development of and increased spend on locally commissioned lifestyle weight management services. There is, however, an unmet population need for weight loss support and sustaining a healthier weight. This places a significant pressure on local commissioning of obesity services and is a burden exacerbated by the continuing financial issues that local authorities are facing. Compounding this is evidence that access to lifestyle, complex behavioural obesity services and bariatric surgery differs across localities. The future direction of these services therefore requires prioritisation and PHE acknowledges there remains significant work to be done to ensure national strategy and investment enables local delivery.¹²⁰

The health departments in the four nations should together invest at least £100m in each of the next three financial years to extend and increase provision of weight management services across the country, to mirror the provision of smoking cessation services. This should include both early intervention programmes and, greater provision for severe and complicated obesity, including bariatric surgery. Adjustments could then be made to the Quality and Outcomes Framework, providing incentives for GPs to refer patients to such services.¹²¹

99. According to Public Health England, there is an unmet population need for support for weight loss and sustaining a healthier weight. NICE have recommended cost-effective interventions in this area and we recommend that these are funded and implemented as a matter of urgency. The Committee regards it as inexplicable and unacceptable that the NHS is now spending more on bariatric surgery for obesity than on a national roll-out of intensive lifestyle intervention programmes that were first shown to cut obesity and prevent diabetes over a decade ago. All tiers of weight management services should be universally available, and need to be well integrated.

119 Q72

120 Public Health England ([IDH0063](#)) para 41

121 Academy of Medical Royal Colleges ([IDH0038](#)) para 4.II

Reforming the food environment

100. While there is clearly a role for NHS services to prevent and treat overweight and obesity, our evidence overwhelmingly highlighted the importance of the food environment. Professor Susan Jebb told us that:

On the prevention side, there is a lot of work going on around diet in terms of information for people, but we are not changing the environment. We have absolutely got to look at some of those more fundamental structural measures, and I come back to the issues I raised at the very start about looking at the sheer availability and accessibility, and one might also add the affordability, of food. In spite of recent price rises, the reality is that food today is very cheap...The question should be: what are the policy levers which are going to make that happen? That is an incredibly important discussion to have, about how you drive change within the food industry.¹²²

101. The Public Health Minister told us that she was strongly in favour of re-setting the nation's 'default', to make healthy choices easier and more automatic:

The idea of setting the nation's default is absolutely vital. I hesitate to say this, but I think that we are at a bit of a national turning point. The publication of the Five Year Forward View for the NHS, putting public health and prevention at the heart of sustainability for our health services—right there as part of that strategy—is a really important moment. It set off a really big, grown-up national conversation about prevention and feeds into all of the work that PHE is doing.

You can see in so many other ways that it leads to other conversations. We have the £8.2 billion of ring-fenced money that local government has had around public health. Suddenly we are all beginning, essentially, to have the same conversation. That does not mean that we have not got an awfully long way to go, but it feels like the beginning of a really important national conversation, where everyone is saying, "What can we do at family level, individual level, corporate level and Government level?"¹²³

102. A key plank of the Government's action to improve the food environment has been its Public Health Responsibility Deal. The Responsibility Deal is a voluntary partnership through which the Government asks organisations to make 'pledges' of action to improve public health. Most of our witnesses expressed the view that while some progress had been made, under the Responsibility Deal, this was not enough. Dr William Bird put it bluntly:

Have they been successful? No. We still have hospitals that have certain shops at the front of the hospital. We still have the sugary drinks. We have all these things still pushing against our efforts to move things forward, so I do not think it has been successful.¹²⁴

122 Q72

123 Q253

124 Q337

103. Sue Davies of Which? argued that

There is a lot of consistent evidence showing where action is needed on things like product reformulation, access and affordability of products, looking at things like promotions and consistent labelling. That is something, through the Responsibility Deal, on which there have been some discussions, but our concern is that the pace of change and level of action across the board have been far too slow given the scale of the problem that we are facing and need to tackle.

We found it quite a frustrating process. It has achieved some things. Some of the areas where it has achieved change are things that were already in train to some extent. The salt-reduction work has been really positive and there have recently been some 2017 salt-reduction targets published. But there are still quite a few big players, particularly on the manufacturing side, that have not committed to those targets yet. There has also been some progress on things like removing trans fatty acids and out-of-home energy labelling in things like fast food restaurants, but on some of the more contentious issues the Responsibility Deal has found it hard to make progress.

There is a calorie-reduction pledge, but that is a very vague, woolly, toolkit-type approach. What we wanted to see was more specific targets around reducing sugar and saturated fat in products, recognising that that probably was not as straightforward to do as reducing salt, but making clear what were the key product categories where there needed to be more reformulation.

The really big issue still is tackling promotions, both in terms of promotions to children but also promotions within supermarkets, whether that is about product positioning or price promotions. Because that is such a contentious and difficult issue for the food industry, it is very difficult to make any progress through the Responsibility Deal-style mechanism.

The other positive thing...is the roll-out of traffic-light nutrition labelling, which, as Susan Jebb said, is a significant step forward. Hopefully, by the end of this year it will be very visible. Some of those that have committed have not actually put it on pack yet but it will be very clear with two thirds of the market providing it. That was something that was sparked by a regulatory initiative—the review of the food information regulations at EU level—rather than necessarily being through the Responsibility Deal.

Overall, we think it has achieved some things, but it is not really doing enough in enough areas. There are still some companies that do not join in and play their part. For those that do not do that there is no sanction. So, if you do not sign up to it, nothing really happens and you are just invisible.¹²⁵

104. Jane Landon of the UK Health Forum told us that:

On the overall approach of the Responsibility Deal, it has been an interesting natural experiment. It has demonstrated some of the limits of voluntarism. That is useful because we know what we can achieve under a voluntary approach and also what we cannot achieve. The risk is that we see it as a substitute for regulation rather than as a complement. It was always intended to be complementary to a whole range of other policies, and it has ended up rather isolated as being the only show in town. We cannot hang all our expectations, in terms of all the things we need to achieve on diet and physical activity, on voluntary pledges.

105. We have heard that the Government’s Responsibility Deal has achieved some successes, but should be seen as a complement to regulation rather than a substitute for it. We agree with the UK Health Forum, that we cannot hang all our expectations in terms of all the things we need to achieve in public health on voluntary pledges.

Labelling

106. Several of our witnesses discussed the adoption of a traffic light nutrition labelling system, prompted by the labelling changes required by the EU’s food information to consumers regulations, with Which? describing it as “a significant step forward”. It is estimated that two-thirds of products will carry the scheme over the next few months.¹²⁶ Jane Landon argued that a public information campaign was now needed to explain and reinforce the scheme.¹²⁷

107. Progress has been made on introducing a traffic light nutrition labelling system. We recommend that Public Health England backs this up with a campaign to explain and reinforce this scheme to the public to assist them in using the new labelling to make healthy food choices.

Reformulation

108. Professor Jebb also mentioned the front-of-pack labelling scheme, but highlighted the limitations of labelling, arguing that its impact assumes people will “get to the point where they are interested enough to look at the label.” She went on to argue that “within any food category there is a whole range of fat and salt content. Let us take sausages. Not all sausages are the same; some sausages have far more fat and salt than others. What can we do to ensure that the rest are as good as the best, so that we have a much healthier sausage market in general? The same applies, of course, for every other category of food.”¹²⁸

109. As discussed above, work on salt reduction has been described as a success; however, Which? argues that saturated fat and calorie reduction pledges “have not had such wide take up” and have been “more limited in scope”. Discussing this further in oral evidence, our witnesses told us:

126 Which? [\(IDH0097\)](#) para 14

127 Q100

128 Q53

We think, as you say, that the salt-reduction targets have been very positive. There was a bit of a delay and we had them in 2010, 2012 and then 2017, but at least it means that the whole approach, which is about gradual reduction so that you are lowering salt across the whole of a product category so that people's tastes adjust and they are not aware that they are eating less salt, is continuing. It is important that those manufacturers and retailers that are not signed up commit to it. We would like to see a similar approach for sugar and saturated fat. We recognise that it might not be as straightforward as it has been with salt, but the key thing is to look at those product categories that make the most significant contribution with sugar and saturated fat to people's diets—things like soft drinks, for example—and then look at the scope for reductions, but again setting targets so that you have the whole industry acting together so that consumers are getting gradual reductions rather than tasting one product and thinking, "That tastes much better. I am going to buy that rather than that product." We have to be careful. If it is done too quickly and it puts people off the food, then it will be counterproductive.

The salt reduction programme has shown how it can be achieved and the importance of gradual reductions to maintain taste with salt. With sugar and fat, there are some technical issues about how they act together in certain products, particularly baked products. If you reduce one, the chances are that the other may rise. When we are talking about some of the discretionary foods that are high in sugar and fat—the cakes and the biscuits—the messaging is more about how much is appropriate to eat rather than simply tinkering round the edges and making them least worst. As to foods where people are not expecting to find sugar—for example, in ready meals—clearly there is a good argument that there should be reformulation, as well as making the sugar transparently clear on the label but also to reduce that. People are not expecting to find sugar in ketchup, in ready meals, pasta dishes, curries and sweet and sour dishes—or maybe yes in sweet and sour dishes, but they are very high in sugar sometimes.¹²⁹

110. Dr Mike Knapton of the British Heart Foundation highlighted sugary drinks as a "relatively simple area that you could make a big difference on"¹³⁰ Dr Alison Tedstone of Public Health England agreed, describing reformulation of fizzy, sugar-sweetened drinks as "low hanging fruit". Sugar is not as easy as salt in some respects, because it has functionality in some foods. In fizzy drinks, it is just sweetening the drinks."¹³¹

111. While we welcome the changes to labelling we have heard about during the course of this inquiry, as one of our witnesses told us, the effectiveness of labelling depends on "people [being] even interested enough to look at the label." Reformulation—altering the composition of foods to make them healthier—offers significant potential to improve diet, and progress has been made in lowering the salt content of foods. Lowering saturated fat,

129 Q107

130 Q107

131 Q253

sugar, or overall calorie content are all further ways in which foods could be reformulated. **We recommend that Public Health England should take the lead by introducing clear targets for reductions, and the Government should use regulatory measures to enforce this, if voluntary approaches do not yield swift progress. The Committee strongly recommends that the first focus of this work should be on reducing the sugar consumed by children in sugar sweetened drinks.**

Marketing and promotion of foods to children

112. An area that was frequently raised in our written evidence was the marketing and promotion of unhealthy foods to children. The UK Health Forum and the British Heart Foundation both call on the Government to:

Address unhealthy food promotion in the retail environment and extend restrictions on TV advertising of high fat, sugar and salt (HFSS) food and beverages to children up to the 9pm watershed. Strengthen restrictions on all forms of HFSS food marketing and promotion to children in non-broadcast media.¹³²

113. Which? gives further detail:

Ofcom restrictions limit TV advertising for unhealthy foods (foods high in fat, sugar or salt or HFSS) during programmes of particular appeal to children up to 16. The Broadcasting Code of Advertising Practice (BCAP) places some additional restrictions on the content—and the Committee of Advertising Practice (CAP) Code which covers non-broadcast techniques includes some restrictions for younger children. Several companies have also signed up to an EU Pledge on food marketing to children. Despite these initiatives, many gaps still remain in terms of the media used, age of the children protected and nature of promotions considered to be targeted to children. This therefore needs to be addressed in order to ensure that food marketing to children complements rather than undermines education initiatives and healthy eating advice.¹³³

114. Dr Tedstone gave further explanation of these problems:

We know that, when Ofcom introduced regulations around the control of advertising of foods to children in children's programmes, it meant that for a while children were exposed to fewer ads, but they moved outwards. What happened was that they moved further away. Those Ofcom controls worked in terms of what they were intending to do, but the industry was ahead of them. That was some years ago. We should think more broadly about the lessons learned from that to take it more broadly.¹³⁴

132 UK Health Forum ([IDH0081](#)) p1; British Heart Foundation ([IDH0050](#)) para 10

133 Which? ([IDH0097](#)) para 17

134 Q271

115. The evidence we have received has also called for wider restrictions on promotion of unhealthy foods to children—in both broadcast and non-broadcast media, particularly social media. We recommend that the next Government takes steps to stop the marketing of unhealthy food and sugary drinks to children.

Portion size

116. The British Heart Foundation raises the issue of portion size:

Variation of portion size also presents a significant challenge to individuals trying to maintain a healthy diet. As demonstrated in the BHF report *Portion Distortion*, portion sizes have increased dramatically between 1993 and 2013. The UK Government has not updated its information on typical portion sizes for 20 years and there is currently no legislation on this issue. We would like to see an urgent review of this by the Government.¹³⁵

117. Developing this in oral evidence, Dr Mike Knapton told us that “we basically think that there should be a review to inform both consumers and industry about the production of food and what sensible portion sizes are to have a healthy diet in terms of calories and nutrition intake.”¹³⁶ Sue Davies of Which? added that

You have the problem at one end where sometimes you will get a really unrealistic portion size to make the labelling look better. Something that you might think is one portion, when you actually look at the small print, is two portions. Then there is also the situation, particularly when you are in the out-of-home sector, as you mentioned, that when you are at service stations or train stations you often only get the large portion when you actually want a smaller portion¹³⁷

Price promotions

118. Which? was also among many organisations that called on retailers to use price promotions responsibly and make it easier for consumers to choose healthier options, noting that food promotions was the area where there had been least action.

Food promotions stand out as the area where there has been the least action. This has always been a difficult area to tackle through voluntary commitments alone and the Responsibility Deal has initiated very little action. A few retailers have made commitments to take sweets off checkouts, but the majority still continue with this practice. Supermarkets, with the exception of Sainsbury’s and The Cooperative, do not have policies for the balance of healthy and less healthy foods they include within price promotions.¹³⁸

135 British Heart Foundation ([IDH0050](#)) para 11

136 Q104

137 Q106

138 Which? ([IDH0097](#)) para 16

119. Sue Davies gave further detail on this in her oral evidence:

There are a huge amount of products that are on promotion at the moment. When we asked the supermarkets if they had policies for what they included in those promotions, only the Co-operative and Sainsbury's told us that they had actual targets, and their targets were only for about a third of the products on promotion to be healthy. The others would not give us them or they did not have them. That is a really important area to tackle given that so many people are drawn to them.

It is probably about getting more of a balance, because sometimes people will want to buy particular treats and at the moment it is too much weighted towards the unhealthy food. Perhaps ruling them out completely on unhealthy promotions might be difficult, but there are certain areas such as the slightly iconic things like the sweets at check-outs where quite a few of the supermarkets seemed to make commitments about 10 years ago but have gone back on those. Also, a lot of other types of outlets promote chocolate at the check-out, when you are buying a newspaper and that kind of thing as well. That whole area is another one that can easily be tackled.

When we have asked people, the majority say that they think they should stop sweets at check-outs and the majority of people say that they want more promotions on healthier products. We have not specifically asked them if they should be ended altogether, but there is definitely a lot of support for changing the balance and using the price promotions to help them make healthier choices.¹³⁹

120. Professor Theresa Marteau provided further detail of research on position of products in her written evidence:

Availability is ranked third in the recent McKinsey report (Dobbs et al 2014) for cost-effectiveness at reducing the burden of obesity. We recently completed the first study aimed at estimating the effect size of placing of products on aisle ends in supermarkets (Nakamura et al., 2014). End-of-aisle displays are often used by supermarkets to promote sales. We used data from one supermarket in the UK (derived from 43,000 trolleys) to establish the effect of displaying different types of drinks on aisle ends (Nakamura et al., 2014). Placing products on end-of-aisle displays substantially increased sales of drinks, to the extent that altering these displays may have as much impact as some pricing interventions currently being considered by policy-makers.¹⁴⁰

121. Professor Susan Jebb, in her Chair's blog on progress of the Responsibility Deal on food, highlights food promotion as an area where now stronger measures are needed:

Another important lesson has come from our failure to agree a generic commitment on responsible promotions. I recognise these are tough

139 Qq108-111

140 Professor Theresa Marteau ([IDH0073](#)) p3

economic times for businesses and that promotional activity goes to the heart of business competitiveness. But nonetheless 80% of consumers are looking for a healthier diet and a collective pledge would have sent a strong signal that food businesses in England are putting health at the heart of their business strategy. However, I do welcome the individual examples of companies using their marketing resources to support other pledges within the RD, such as the promotion of products with less saturated fat, sugar or salt. I am also pleased to see that the movement towards sweet-free checkouts is building, but the lack of a collective pledge is disappointing.

But the effort to find a deal on promotions has not been in vain. I firmly subscribe to the view that regulation should only be deployed when other approaches have failed. We have given voluntary agreements to control the promotion of unhealthy options the best possible opportunity to fly, but we now need to look to harder policy options to secure progress. The challenge for public health is to identify the very precise aspects of marketing which can be controlled in a way which leads to public health benefit.¹⁴¹

122. The area on which we have heard the least progress has been made, but one which has the potential for a significant impact on diet and health, is retail price promotions on food. Voluntary agreements have been tried, but now we need to look to harder policy options to secure progress. We recommend that the next Government commissions either Public Health England or NICE to review policy options in this area as a matter of urgency.

Fiscal policies

123. We also received a considerable number of submissions calling for the introduction of fiscal policies to promote healthier diets, notably taxes on sugar, or specifically on sugar-sweetened drinks. Using taxation to influence food choices is controversial. As an earlier Health Committee noted in its 2004 inquiry on obesity, the notion of taxing unhealthy foods is fraught with ideological and economic complexities.¹⁴² However, the written evidence we received suggests that there is a strong interest in at least exploring the possibility of using fiscal measures to incentivise healthier food choices. Professor Nick Wareham cited the example of Mexico:

There is evidence from countries like Mexico of a 10% taxation on sugar-sweetened beverages giving rise to a 10% reduction. I am not suggesting that these are instant fixes or that the evidence base is perfect, but at least it ought to be talked about.¹⁴³

124. Fiscal policies can have an impact beyond taxation; the possibility of introducing subsidies for healthy foods could also be explored, and, as Professor Wareham pointed out,

141 Susan Jebb, [New Year message](#), Responsibility Deal blog, Department of Health website. Accessed 18th March 2015.

142 Health Select Committee, 2004, "Obesity: Third Report of Session 2003-04", Volume I, HC 23-1, pg 113

143 Q73

there is a need to look at the impact of a broad range of policies on food pricing and availability:

We have to move beyond the label, up the food chain and right back to the source of the foods. There is a really important illustration of that right now in that we are all concerned about sugar, but the European Commission, through the CAP, is regulating sugar within Europe through the import tariffs, price guarantees, production quotas and export subsidies. They are about to make changes which they themselves estimate will increase the amount of high-fructose corn syrup threefold and will drop the price of sugar. While it is very important for us to talk about education and labelling, we do have to think about these market influences which are going to have a major impact on the constituency of food in Europe.¹⁴⁴

125. We have received evidence from organisations supporting the introduction of a tax on sugar-sweetened drinks. We look forward to the publication of Public Health England's review of the evidence base for introducing a sugar tax, which is expected later this year, and we do not seek to pre-judge its outcome. We welcome the fact that Public Health England is carrying out this review. Given the scale of the public health challenge and growing health inequalities we urge the next government not to shy away from difficult decisions around proportionate regulation if these are supported by the emerging evidence.

Conclusions and recommendations

Physical activity—a priority in its own right

1. For too long, physical activity has been seen merely in the light of its benefits in tackling obesity. However, there is compelling evidence that physical activity in its own right has huge health benefits totally independent of a person's weight—in fact research recently published suggested that increasing physical activity levels could have greater impact on reducing mortality than reducing weight. The Chief Medical Officer's guidelines recommend levels of activity which will help people derive the greatest health benefits; but even small increases in activity levels can have a dramatic positive impact on health. (Paragraph 25)
2. Diet, obesity, and physical activity all have important impacts on health. However, it is vital that the importance of physical activity for all the population—regardless of their weight, age, gender, health, or other factors—is clearly articulated and understood. We recommend that the Government, Public Health England and health professionals, in particular GPs, take urgent action to communicate this crucial message to the public. (Paragraph 26)

Individual and population level interventions

3. It is clear from the evidence we have heard that interventions focused on encouraging individuals to change their behaviour with regard to diet and physical activity need to be underpinned by broader, population-level interventions. Individual interventions include provision of information about the health benefits of exercise, workplace incentives, or referral to a lifestyle weight management scheme. Broader measures include pricing and availability of unhealthy foods, and redesigning environments to promote physical activity, which aim to make the healthy choice the default choice. Population-level interventions have the advantage of impacting on far greater numbers than could ever benefit from individual interventions, and may also be more effective at tackling health inequalities than individual interventions. (Paragraph 32)

NICE guidance on what works

4. NICE has produced a comprehensive raft of guidance on cost-effective interventions that can be introduced, either by the NHS or by local government, to improve diet and physical activity. These have included interventions on an individual level—changing individual behaviour, and weight management, and also more 'upstream' environmental interventions, such as changes to the local environment that may improve access to healthier foods or encourage active modes of transport such as walking and cycling. (Paragraph 35)
5. While we welcome NICE's guidance, it is disappointing that there has to date been little assessment of how far these guidelines are being implemented. We have heard that NICE's forthcoming Quality Standards will produce a clear framework against which progress towards implementing NICE guidance can be measured. We recommend that the next Government shows its commitment to improvements in

this area by auditing progress against Quality Standards in the areas of diet and physical activity across the country to allow benchmarking and drive progress. (Paragraph 36)

Local authorities—key to improving public health

6. There is a danger that the current financial pressures on local authorities will lead them to deprioritise all but the mandated public health services to the detriment of prevention and health improvement. We recommend the next Government prioritises prevention, health promotion and early intervention and provides the resources to ensure it happens. (Paragraph 43)
7. We also heard that local authorities need more powers to limit the proliferation of outlets serving unhealthy foods in some areas; Public Health England told us that they too had concerns about this. We recommend that the next Government works closely with the Association of Directors of Public Health and the Local Government Association to ensure local authorities have the planning powers they need for the control of food and drink outlets and for the preservation of open spaces for physical activity for public health purposes. (Paragraph 44)

Workplaces

8. One commentator told us that in her view, it is "at best anomalous and at worst negligent" that that NHS properties continue to serve foods high in sugar, fat and salt, with some hospitals even having fast-food outlets on their premises. The NHS should lead by example and manage its estate in a way that stops promoting the over-consumption of energy dense nutritionally poor food. (Paragraph 53)
9. Beyond the NHS, workplaces are where working age people spend the majority of their time and as such can represent a powerful resource for health promotion. We urge the next Government to work with NICE and Public Health England to find the best options for achieving this in a range of workplaces, including the use of financial and other incentives. (Paragraph 54)
10. While local authorities now have the lead public health role, there is an ongoing need for the NHS to provide both prevention and treatment services but greater focus needs to be given to discussing inactivity or overweight. The NHS is this country's largest employer and has a crucial role to play both in terms of promoting the health of its workforce, and in setting a wider example. More broadly, there is clearly potential for other workplaces to do more. We recommend that Primary Care takes the lead, as it has does for smoking cessation, in promoting physical activity and preventing obesity—these topics should not be off limits during consultations. (Paragraph 55)

Cross government working

11. While there now is widespread recognition of the health impacts of diet, obesity and physical activity, and the scale of the problems we now face in these areas, these problems are not "owned" by a single Department or agency. A successful strategy for tackling these problems needs to mirror the successful strategy on tobacco, and be multi-level, spanning national and local government down to every citizen. A successful strategy may need to incorporate elements as diverse as public education, regulation, fiscal measures, legislation, messaging and campaigns, evidence based behaviour change, changes to the school curriculum, and changes to planning arrangements. (Paragraph 59)
12. Given the breadth of these issues, it is essential that the strategy must be cross-governmental and integrated laterally and vertically, and given the importance of these issues, led from the very top of government. We call on the next Government to introduce a co-ordinated government-wide programme to tackle poor diet and physical inactivity; this programme should be given the resources and authority necessary to secure collaboration with all relevant Departments and bodies, and should report at regular intervals on health improvements to the Prime Minister, and to Parliament. (Paragraph 60)

Physical activity—a key health priority in its own right

13. We have heard the hugely positive message that increasing physical activity has significant health benefits and does not necessarily mean playing organised competitive sport three times a week—it encompasses a diverse range of activities, including everyday activities such as walking. The point was made that raising heartrate was the most important thing, but any increase in activity is beneficial. (Paragraph 69)
14. For some people it can be easier to fit physical activity in if it is “a means to an end” rather than an end in itself. The key message from witnesses was to “just do more”, in a way that fits with your lifestyle. (Paragraph 70)

Promoting physical activity in clinical encounters

15. NICE has clearly recommended that offering brief advice in a primary care setting is a cost effective way of getting people to increase their levels of physical activity. It is clear that clinicians have a crucial role to play in promoting physical activity. Better undergraduate and postgraduate education is now required, both to ensure clinicians’ understanding of the medical benefits of physical activity, and to teach them how to promote physical activity to their patients in an effective way, particularly when some patients may be sceptical of such a “low tech” approach. We recommend that the next Government works with the royal colleges and Health Education England to achieve this. (Paragraph 81)
16. In relation to NHS Health Checks, we heard of a “tick box” approach to physical activity, with clinicians carrying out Health Checks lacking the skills to support people in actually changing their behaviour. We recommend that, given the considerable investment of public resources in NHS Health Checks, NICE should be tasked with assessing their clinical and cost effectiveness. (Paragraph 82)

An environment that promotes physical activity

17. We have heard that the physical environment can have a significant impact on activity. Open spaces are needed for recreation and play, and the built environment, including road infrastructure and speed limits, all impact on how easy or attractive it is to walk or cycle. We call on the next Government to make a clear commitment, together with appropriate long term funding, to significantly increase the levels of cycling and walking. (Paragraph 86)

Engaging different groups in physical activity

18. Physical activity must be seen in its totality, and a flexible and inclusive approach is needed to enable individuals to choose a way to increase physical activity that is right for them. Nowhere is this more important than in promoting physical activity amongst groups of people who seldom take part. The most obvious is the disparity between men and women, but inequalities in physical activity levels exist between other sectors of society too, and children fare worse than adults in terms of meeting physical activity recommendations. (Paragraph 93)
19. Fear of judgement is a key barrier preventing women from being more active. Some barriers may be quite simple such as the lack of availability of sports clothes in larger sizes or mixed changing rooms. The Government-wide programme on diet and physical activity should include a specific workstream focused on identifying and tackling inequalities in relation to physical activity, and it should begin with work to examine how women, those with disabilities and overweight people, can be encouraged and supported to be more active. (Paragraph 94)

NHS prevention and treatment services

20. According to Public Health England, there is an unmet population need for support for weight loss and sustaining a healthier weight. NICE have recommended cost-effective interventions in this area and we recommend that these are funded and implemented as a matter of urgency. The Committee regards it as inexplicable and unacceptable that the NHS is now spending more on bariatric surgery for obesity than on a national roll-out of intensive lifestyle intervention programmes that were first shown to cut obesity and prevent diabetes over a decade ago. All tiers of weight management services should be universally available, and need to be well integrated. (Paragraph 99)

Reforming the food environment

21. We have heard that the Government's Responsibility Deal has achieved some successes, but should be seen as a complement to regulation rather than a substitute for it. We agree with the UK Health Forum, that we cannot hang all our expectations in terms of all the things we need to achieve in public health on voluntary pledges. (Paragraph 105)

Labelling

22. Progress has been made on introducing a traffic light nutrition labelling system. We recommend that Public Health England backs this up with a campaign to explain

and reinforce this scheme to the public to assist them in using the new labelling to make healthy food choices. (Paragraph 107)

23. We recommend that Public Health England should take the lead by introducing clear targets for reductions, and the Government should use regulatory measures to enforce this, if voluntary approaches do not yield swift progress. The Committee strongly recommends that the first focus of this work should be on reducing the sugar consumed by children in sugar sweetened drinks. (Paragraph 111)

Marketing and promotion of foods to children

24. The evidence we have received has also called for wider restrictions on promotion of unhealthy foods to children—in both broadcast and non-broadcast media, particularly social media. We recommend that the next Government takes steps to stop the marketing of unhealthy food and sugary drinks to children. (Paragraph 115)

Price promotions

25. The area on which we have heard the least progress has been made, but one which has the potential for a significant impact on diet and health, is retail price promotions on food. Voluntary agreements have been tried, but now we need to look to harder policy options to secure progress. We recommend that the next Government commissions either Public Health England or NICE to review policy options in this area as a matter of urgency. (Paragraph 122)

Fiscal policies

26. We have received evidence from organisations supporting the introduction of a tax on sugar-sweetened drinks. We look forward to the publication of Public Health England's review of the evidence base for introducing a sugar tax, which is expected later this year, and we do not seek to pre-judge its outcome. We welcome the fact that Public Health England is carrying out this review. Given the scale of the public health challenge and growing health inequalities we urge the next government not to shy away from difficult decisions around proportionate regulation if these are supported by the emerging evidence. (Paragraph 125)

Formal Minutes

Tuesday 17 March 2015

Members present:

Dr Sarah Wollaston, in the Chair

Rosie Cooper
Barbara Keeley
Charlotte Leslie

Grahame M. Morris
David Tredinnick
Valerie Vaz

Draft Report (*The Impact of Physical Activity and Diet on Health*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 125 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Sixth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned to a day and time to be fixed by the Chair]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the Committee's inquiry page at www.parliament.uk/healthcom.

Tuesday 3 February 2015

Question number

Professor Gillian Leng CBE, Deputy Chief Executive and Director of Health and Social Care, NICE, **Professor Susan Jebb OBE**, Nuffield Department of Primary Health Care Sciences, and **Professor Nick Wareham**, MRC Epidemiology Unit and Centre for Diet and Activity Research

[Q1-86](#)

Sue Davies MBE, Chief Policy Adviser, Which?, **Dr Mike Knapton**, Associate Medical Director, British Heart Foundation, **David Stalker**, ukactive, and **Jane Landon**, Director of Policy and Deputy Chief Executive Officer, UK Health Forum

[Q87-145](#)

Tuesday 10 February 2015

Professor John Wass, Academic Vice-President, Royal College of Physicians, **Dr Janet Atherton**, President, Association of Directors of Public Health, **Dr Jane Moore**, Director of Public Health and Professor in Public Health at Coventry University, **Dr Dagmar Zeuner**, Director of Public Health, London Borough of Richmond-upon-Thames, and **Kay Thomson**, Health Lead, Sport England

[Q146-214](#)

Jane Ellison MP, Parliamentary Under-Secretary of State for Public Health, Department of Health, **Professor Kevin Fenton**, Director of Health and Wellbeing and **Dr Alison Tedstone**, Director of Diet and Obesity, Public Health England

[Q215-282](#)

Wednesday 25 February 2015

Dr William Bird MBE, GP and CEO of Intelligent Health, and **Professor Dame Sue Bailey**, Chair, Academy of Medical Royal Colleges

[Q283-343](#)

Julie Creffield, blogger and campaigner for Too Fat to Run?

[Q344-371](#)

Published written evidence

The following written evidence was received and can be viewed on the Committee's inquiry web page at www.parliament.uk/healthcom. IDH numbers are generated by the evidence processing system and so may not be complete.

- 1 2020Health ([IDH0071](#))
- 2 Ab Sugar ([IDH0044](#))
- 3 Academy of Medical Royal Colleges ([IDH0038](#))
- 4 Advertising Association ([IDH0066](#))
- 5 Ajinomoto ([IDH0057](#))
- 6 Aleksander Cox ([IDH0084](#))
- 7 Alspac, University of Bristol ([IDH0036](#))
- 8 Amateur Swimming Association ([IDH0054](#))
- 9 APPG on a Fit and Healthy Childhood ([IDH0017](#))
- 10 Arthritis Research UK ([IDH0088](#))
- 11 Association for Nutrition ([IDH0011](#))
- 12 Association of Directors of Public Health ([IDH0061](#))
- 13 Breakthrough Breast Cancer ([IDH0080](#))
- 14 British Association for Applied Nutrition and Nutritional Therapy ([IDH0040](#))
- 15 British Heart Foundation ([IDH0050](#))
- 16 British Masters Athletic Federation ([IDH0099](#))
- 17 British Soft Drinks Association ([IDH0074](#))
- 18 Britvic ([IDH0012](#))
- 19 Bupa UK ([IDH0039](#))
- 20 Cambridge Weight Plan ([IDH0060](#))
- 21 Cancer Research UK ([IDH0082](#))
- 22 Croydon Council ([IDH0085](#))
- 23 Cycle East Sussex ([IDH0086](#))
- 24 Cycle to Work Alliance ([IDH0068](#))
- 25 Dairy UK ([IDH0096](#))
- 26 Department of Health ([IDH0078](#))
- 27 Diabetes UK ([IDH0076](#))
- 28 Dieticians in Obesity Management UK (Domuk) ([IDH0046](#))
- 29 Dr Angeliki Papadaki ([IDH0002](#))
- 30 Dr Dagmar Zeuner ([IDH0103](#))
- 31 Dr Dianna Smith ([IDH0089](#))
- 32 Dr Katrina Wyatt ([IDH0013](#))
- 33 Dr Sebastien Chastin ([IDH0016](#))
- 34 Dr Simon Sebire ([IDH0008](#))
- 35 Dr William Bird MBE ([IDH0104](#))
- 36 English Outdoor Council ([IDH0033](#))
- 37 Faculty of Dental Surgery, Royal College of Surgeons ([IDH0025](#))
- 38 Food and Drink Federation ([IDH0041](#))
- 39 Greater London Authority ([IDH0094](#))

- 40 Greg Atkinson ([IDH0009](#))
- 41 Institute for Food Brain and Behaviour ([IDH0059](#))
- 42 Institute for Sport and Physical Activity Research, University of Bedfordshire ([IDH0029](#))
- 43 International Centre for Lifecourse Studies in Society And Health (Icls), UCL ([IDH0031](#))
- 44 Jack Winkler ([IDH0079](#))
- 45 Lawn Tennis Association ([IDH0015](#))
- 46 Lighterlife ([IDH0058](#))
- 47 Living Streets ([IDH0087](#))
- 48 Local Government Association ([IDH0022](#))
- 49 London Borough of Camden ([IDH0056](#))
- 50 London Health Commission ([IDH0052](#))
- 51 Macmillan Cancer Support ([IDH0062](#))
- 52 Marks and Spencer ([IDH0095](#))
- 53 Men's Health Forum ([IDH0045](#))
- 54 Mrc Epidemiology Unit / Centre for Diet and Activity Research ([IDH0069](#))
- 55 Mrc Epidemiology Unit / Centre for Diet and Activity Research ([IDH0070](#))
- 56 Mrc Unit for Lifelong Health and Ageing at UCL ([IDH0019](#))
- 57 Mrc-Aruk Centre for Musculoskeletal Ageing Research ([IDH0007](#))
- 58 Newcastle University ([IDH0004](#))
- 59 NHS England ([IDH0101](#))
- 60 Nice ([IDH0098](#))
- 61 NIHR Leicester-Loughborough Diet, Lifestyle And Physical Activity Biomedical Research Unit ([IDH0030](#))
- 62 North Lincs Council/ School Sports Partnership ([IDH0077](#))
- 63 On Behalf of The Association of Play Industries ([IDH0028](#))
- 64 Prof Jane Moore ([IDH0102](#))
- 65 Professor Alison Avenell ([IDH0027](#))
- 66 Professor Russell Jago ([IDH0003](#))
- 67 Professor Theresa M Marteau ([IDH0073](#))
- 68 Public Health England ([IDH0063](#))
- 69 Purely Nutrition Ltd ([IDH0023](#))
- 70 RCUK (For Mrc, Esrc and Bbsrc) ([IDH0093](#))
- 71 Richmond Group of Charities ([IDH0042](#))
- 72 Robert Blundell ([IDH0010](#))
- 73 Royal College of Physicians ([IDH0043](#))
- 74 Royal College of Physicians of Edinburgh ([IDH0021](#))
- 75 School and Nursery Milk Alliance ([IDH0047](#))
- 76 Sibylle Kranz ([IDH0018](#))
- 77 Slimming World ([IDH0024](#))
- 78 Sport and Recreation Alliance ([IDH0051](#))
- 79 Sporta ([IDH0067](#))
- 80 Sugar Nutrition UK ([IDH0065](#))
- 81 Sustrans ([IDH0001](#))
- 82 Tam Fry ([IDH0032](#))

- 83 The Breastfeeding Network ([IDH0026](#))
- 84 The British Psychological Society ([IDH0005](#))
- 85 The Ramblers ([IDH0014](#))
- 86 THSG ([IDH0048](#))
- 87 Tom White ([IDH0055](#))
- 88 UK Faculty of Public Health ([IDH0083](#))
- 89 UK Health Forum ([IDH0081](#))
- 90 Ukactive ([IDH0053](#))
- 91 University of Bedfordshire ([IDH0072](#))
- 92 University of Bristol ([IDH0035](#))
- 93 University of Oxford ([IDH0100](#))
- 94 Weight Watchers UK ([IDH0034](#))
- 95 Which? ([IDH0097](#))
- 96 World Challenge Expeditions ([IDH0006](#))
- 97 Youth Sport Trust ([IDH0064](#))

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the Committee's website at www.parliament.uk/healthcom.

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2014–15

First Report	2014 Accountability hearing with the Health and Care Professions Council	HC 339 (Cm 8916 and HC 731)
Second Report	Managing the care of people with long-term conditions	HC 401 (HC 660)
First Special Report	2013 accountability hearing with the General Medical Council: General Medical Council's response to the Committee's Ninth Report of Session 2013–14	HC 510
Second Special Report	2013 accountability hearing with Monitor: Monitor's response to the Committee's Ninth Report of Session 2013–14	HC 511
Third Report	Children's and adolescent's mental health and CAMHS	HC 342 (HC 1036)
Fourth Report	Complaints and Raising Concerns	HC 350
Fifth Report	End of Life Care	HC 805

Session 2013–14

First Special Report	2012 accountability hearing with the Care Quality Commission: Government and Care Quality Commission Responses to the Committee's Seventh Report of Session 2012–13	HC 154
Second Special Report	2012 accountability hearing with Monitor: Government and Monitor Responses to the Committee's Tenth Report of Session 2012–13	HC 172
Third Special Report	2012 accountability hearing with the Nursing and Midwifery Council: Government and Nursing and Midwifery Council Responses to the Committee's Ninth Report of Session 2012–13	HC 581
First Report	Post-legislative scrutiny of the Mental Health Act 2007	HC 584 (Cm 8735)
Second Report	Urgent and emergency services	HC 171 (Cm 8708)
Third Report	After Francis: making a difference	HC 657
Fourth Report	Appointment of the Chair of Monitor	HC 744
Fifth Report	2013 accountability hearing with the Nursing and Midwifery Council	HC 699 (HC 1200)
Sixth Report	2013 accountability hearing with the Care Quality Commission	HC 761
Seventh Report	Public expenditure on health and social care	HC 793
Eighth Report	Public Health England	HC 840

Ninth Report	2013 accountability hearing with Monitor	HC 841
Tenth Report	2013 accountability hearing with the General Medical Council	HC 897

Session 2012–13

First Report	Education, training and workforce planning	HC 6-I (Cm 8435)
Second Report	PIP breast implants: web forum on patient experiences	HC 435
Third Report	Government's Alcohol Strategy	HC 132 (Cm 8439)
Fourth Report	2012 accountability hearing with the General Medical Council	HC 566 (Cm 8520)
Fifth Report	Appointment of the Chair of the Care Quality Commission	HC 807
Sixth Report	Appointment of the Chair of the National Institute for Health and Care Excellence	HC 831
Seventh Report	2012 accountability hearing with the Care Quality Commission	HC 592
Eighth Report	National Institute for Health and Clinical Excellence	HC 782
Ninth Report	2012 accountability hearing with the Nursing and Midwifery Council	HC 639
Tenth Report	2012 accountability hearing with Monitor	HC 652
Eleventh Report	Public expenditure on health and care services	HC 651 (Cm 8624)

Session 2010–12

First Report	Appointment of the Chair of the Care Quality Commission	HC 461-I
Second Report	Public Expenditure	HC 512 (Cm 8007)
Third Report	Commissioning	HC 513 (Cm 8009)
Fourth Report	Revalidation of Doctors	HC 557 (Cm 8028)
Fifth Report	Commissioning: further issues	HC 796 (Cm 8100)
First Special Report	Revalidation of Doctors: General Medical Council's Response to the Committee's Fourth Report of Session 2010–11	HC 1033
Sixth Report	Complaints and Litigation	HC 786 (Cm 8180)
Seventh Report	Annual accountability hearing with the Nursing and Midwifery Council	HC 1428 (HC 1699)
Eighth Report	Annual accountability hearing with the General Medical Council	HC 1429 (HC 1699)
Ninth Report	Annual accountability hearing with the Care Quality Commission	HC 1430 (HC 1699)
Tenth Report	Annual accountability hearing with Monitor	HC 1431 (HC 1699)
Eleventh Report	Appointment of the Chair of the NHS Commissioning Board	HC 1562-I
Twelfth Report	Public Health	HC 1048-I (Cm 8290)
Thirteenth Report	Public Expenditure	HC 1499 (Cm 8283)
Fourteenth Report	Social Care	HC 1583-I (Cm 8380)
Fifteenth Report	Annual accountability hearings: responses and	HC 1699

Sixteenth Report	further issues PIP Breast implants and regulation of cosmetic interventions	HC 1816 (Cm 8351)
------------------	--	-------------------