HOUSE OF COMMONS

Health Committee

Oral evidence: Childhood Obesity Strategy, HC 465
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Watch the meeting

Members present: Dr Sarah Wollaston (Chair); Dr James Davies; Maggie Troup; Dr Philippa Whitford.

Questions 168 - 212

Witnesses: **Professor Susan Jebb OBE**, University of Oxford, **Dr Peter Scarborough**, University of Oxford, **Dr Alison Tedstone**, Director of Diet and Obesity, Public Health England, **Dr Emma Boyland**, Institute of Psychology, University of Liverpool**, Professor Simon Capewell**, Vice President, Faculty of Public Health **Dr Colin Michie**, Chair of Nutrition Committee, Royal College of Paediatrics and Child Health, **Dr Jeanelle de Gruchy**, Vice-President, Association of Directors of Public Health

Q168 Chair: Good morning. Thank you for coming to give evidence today. Could I start by asking all members of the panel to set out whether they have any relevant interests, either for themselves or for the organisations they are representing today, and to give those following the debate outside this room an idea of what their role is? We will start with Dr Boyland.

Dr Boyland: I am a lecturer at the University of Liverpool, in the department of psychological sciences. My institution has received no funding for any food marketing work, but we have accepted funding from Weight Watchers International for weight management work with adults.

Dr Scarborough: I am Pete Scarborough. I am a university research lecturer at the University of Oxford, in the Nuffield department of population health. I have no conflicts of interest to declare.

Professor Jebb: I am Susan Jebb, professor of diet and population health at the University of Oxford. I am chair of the responsibility deal food network. My research is almost entirely funded by public funds, although in 2007 we did a trial that was funded by Weight Watchers around weight management in adults. In two publicly funded trials that we currently run, the intervention is provided free of charge by one of the commercial weight management providers.

Dr Tedstone: I am Dr Alison Tedstone. I am from Public Health England. I am the chief nutritionist there and also the national lead for diet and obesity.

Chair: Thank you.

Q169 Dr Davies: Thank you for attending this morning. I will start by referring to the Prime Minister's comments over the summer in respect of the forthcoming childhood obesity strategy. He said that we should be concentrating on primary children first and foremost because, in his words, 10% were arriving at primary school obese and 20% were leaving primary school obese. Are we focusing on the right cohort of children there? Could Susan Jebb answer first, please?

Professor Jebb: Of course. Children matter—there is no doubt about that. Clearly primary school is a time when many children are gaining excess amounts of weight, so of course that is important; I would not possibly dispute that. However, if we want to tackle obesity as a whole, it is not enough. It is absolutely not enough. We cannot ignore the huge increases in body weight that occur in teenagers, for want of a better word, and the fact is that most of the health burden is experienced by adults. If we want to make resource savings and immediate impacts on health, those will come more quickly if we also work on adults. It is not an either/or, but I would absolutely and firmly say that just to pin this entirely on primary school-aged children is insufficient.

Q170 Dr Davies: Okay. Of course, the strategy is focusing on children first and foremost and I suppose it looks at how early decisions impact on later life.

Professor Jebb: I hope that it will, but the reality is that we have precious little evidence of what the impact of interventions in children is on later life. It is largely an act of faith. It is one that I share, as I genuinely and absolutely believe that it is vital that children have the best possible start in life, partly through education but especially through the environment they are exposed to; it would be a no-brainer to say otherwise; but I do not think it is enough.

If you go back to the foresight report in 2007, we made it very clear that you need to take a life-course approach. Indeed, we did some modelling that looked at the impact of just focusing on children and really showed—you can look those data up—the impact on health consequences of doing that. Let us imagine that glorious day when no child leaves primary school overweight. I do not believe we will have solved the problem of obesity, because most people gain weight later in life.

Q171 Dr Davies: Alison Tedstone, could I ask you for your thoughts on the same issue?

Dr Tedstone: They are broadly the same as Susan's. What we need to acknowledge is that the biggest risk factor for being an overweight child is living in a family where one of your carers is overweight or obese. That is the biggest risk factor. I absolutely support the idea of focusing on primary school-aged children, but we have to think of the drivers of excess energy consumption and low levels of physical activity, which are primarily environmental. Those may be the environment we live in—if you walk down any high street, there are constant nudges to consume more food—the home and society more broadly.

The acknowledgment that you will not solve an obesity problem by focusing on that primary school-aged child alone is quite important. There is also a bit of a danger that too

much of a focus on primary school-aged children puts the focus on schools. We know that schools have improved immensely. Most schoolchildren in England now do not have access to unhealthy food while at school. A lot is being done. Children now learn to cook. They learn to cook savoury food as well as sweet food. Diet is embedded in a whole-school approach. There are lots of advances. There is some room for improvement, but very little extra. So I think it is a starter.

Q172 Dr Davies: Yes. Does the panel have any view on the role of infancy and the impact that diet then can have, although it may be that quite a limited range of foods are being given?

Professor Jebb: Absolutely. Early infancy is a critical time. We know the impact of breast versus bottle feeding. Breast feeding seems to protect against later obesity. The introduction of complementary foods is a really difficult moment. Many parents struggle to know how to wean successfully, appropriately and healthily. There are issues in relation to protein intake. The protein intake of very young children is extraordinarily high. We know that that is associated with increased risk of excess weight gain.

There are lots of issues in early infancy. The statistics that you pointed out earlier show that many children are arriving at school already overweight and obese. We absolutely have to look at those early years at home, when lots of their taste preferences and their understanding about food are already shaped. We are asking school to pick up the pieces, when actually we could be doing much more in the early years, both through health visitors and early years support through the healthcare system and through childcare settings. I was involved in developing the voluntary guidance for pre-school years on food, but that has not had anything like the kind of oomph behind it that we have put in relation to food that is served in schools. As more children have more childcare outside the home, there are probably opportunities to intervene there. This is a life-course approach.

Dr Tedstone: Can I add a few points? We have calculated energy excess for children. We see adults consuming too much energy. We also see children consuming too much energy at all life stages. That tells us that there is something wrong with children's diets. We see that in the national diet and nutrition survey, including for the pre-school age group. The diets of the very young, unlike the rest of the population, have improved over the years, but they are still far from ideal and there are too many calories. That is talking about things like portion size and weaning practices that could be better. By the time you get to about two, you are consuming roughly the same kinds of foods as an adult, so it is the same kind of food mix that you and I are probably having. We are missing consistent national guidance on pre-school.

There is one other thing for me to add. We have done a review of the effect of advertising on food preferences and food choices, as part of the evidence package on sugar that PHE has done. Our very young children are exposed to advertising.

Chair: We will come on to that very specifically later. Thank you very much, Dr Tedstone. I am not trying to cut you off, but we are trying to go through all of this.

Q173 Dr Davies: Having said that, clearly if there are regulatory policies in place there is a challenge, isn't there, in ensuring that they apply to the right target group? Do you

see any issues in terms of designing appropriate regulatory procedures for the targets we are seeking for children?

Professor Jebb: That really depends on what particular regulation you are talking about. For the most part, these will be whole-population approaches. There are very few things that specifically and only relate to children. One of my concerns when people say, "We must take action on children's foods," is what on earth do we mean by children's foods? As Alison said, children eat the food that you and I eat. With the exception of just a couple of weaning products, there is no such thing as children's foods.

If we go down that route and apply regulations, whatever they may be, just on children's food, we will impact on a tiny, tiny bit of the market. I would say to the Government, through you, that we made real mistakes with the restrictions on TV advertising. First, we acknowledged that there was an impact from that advertising, so we acknowledged the risk, but then we partially addressed it by setting tight restrictions around children's viewing hours, completely missing the point that most of children's viewing occurs at other times. If we go down the route of saying that there should be regulations on children's foods, we will make the same mistake twice.

Q174 Dr Davies: You have addressed the kinds of issues I was referring to there. Are there any other views on that matter?

Dr Scarborough: I agree entirely with what Susan has said. If you have a population-level approach, that is the kind of approach that will be effective in terms of improving people's diets. You will affect children and all sorts of people within this society. It is adults who buy the food, so if you are trying to target things that look at the type of mix of different foods that are brought into the house, you will have to address that to adults anyway, in terms of population, in order to have an effect on children's health.

We did some work some time ago now—about 10 years ago—around restrictions on advertising children's foods. As part of that, we were originally looking at a target group of older children—aged 11 and upwards. We looked at how we would have done this differently if we were aiming it specifically at younger children. After looking through the evidence on how we would possibly have done things differently, as the decisions that we made were focused specifically on the fact that we were dealing with older children, we found that it would have made no difference whatsoever. With most of these steps—definitely if you are talking about population-level approaches—if you try to focus just on children, you will miss the whole raft of foods that are actually consumed by children, which are just consumed by the population.

Q175 Maggie Throup: I want to explore the evidence base in support of a tax on sugary drinks. My first question is specifically for Professor Jebb. Could you explain why you support a tax on sugar-sweetened beverages?

Professor Jebb: We have tried all sorts of ways, policies, education, encouragement, information and advice to get people to reduce their intake of sugar, particularly of sugary drinks. There has been a bit of success. The UK has one of the highest proportions in the world of people consuming low and no-sugar products. However, we are pretty stuck. A lot of people are still consuming sugary drinks. We need to look at new policy options, and that would appear to be one that is promising. Price works very well in reducing

consumption in alcohol and tobacco. In fact, we see it in food as well. When things are discounted people buy more, and when the price goes up they buy less. I have little doubt that it would impact on consumption. What would be the magnitude of the effect? It is a bit hard to judge, but it would probably be positive.

The other reason—and, for me, the reason for supporting it—is that it is not about raising money. It is not even about penalising people who choose sugary drinks. It is to encourage people to change their behaviour and to switch into the low or no-sugar options—or, indeed, just water—by producing a clear price differential at the point of choice. It is incredibly important if this policy is going to be effective that people are offered that differential choice, so I have been a bit concerned to hear people beginning to suggest that we should introduce a similar tax on the low-sugar options as well. Of course I would prefer people to have water—mostly I do not drink these products myself at all—but the fact is that it is a huge behaviour change to take people from a full-sugar beverage through just to water. Right now, giving them a staging post of being able to go to one of the low-sugar or no-sugar diet drinks is probably a good idea.

The other reason for supporting it is that, if we want industry to take seriously the importance of voluntary agreements, we have to demonstrate that we are prepared to take tougher action if those voluntary agreements are not proceeding fast enough. I have always said that throughout the responsibility deal. I think that this is one of the chances to do it. It is a very easily definable category. It is strongly supported by quite a lot of the public, and we see that support increasing. Nobody out there really thinks that sugary drinks are good for you. While they may not like it, once introduced it would meet reasonable public acceptability standards.

Q176 Maggie Throup: You mentioned tax on other substances. Some of our witnesses last week argued that cigarettes and tobacco, for example, have a tax of 700%, yet the proposal is for just 20% on sugary drinks. Do you think that it will have the impact that you really want?

Professor Jebb: I have not seen any specific Government proposals to introduce it at any level, so we will wait and see what they might set it at. Clearly, the bigger the price increase, the bigger the impact will be. I do not think that we have sufficient data to be able to be precise about how that will work out. With tobacco, of course, we have ratcheted it up over time. There would be no reason not to do that if you started to see it having some benefits.

Q177 Maggie Throup: Dr Scarborough, can I bring you in on that? Do you have any evidence that this would work?

Dr Scarborough: The evidence is there from looking at similar sorts of taxes that have been introduced in France, Finland, Hungary and Mexico. All of those taxes are levied at rates lower than 20%, yet we have seen a measurable impact on sales of sugary drinks. We do not yet have data that look at how that works out distributionally within society, so we do not know exactly which levels of society are lowering their consumption or their purchases less than other places. That will be on its way. There is some work on the Mexican tax that will start to look into that, but it has not got through the peer-reviewed literature yet. However, we know that we can measure an impact of these taxes on sales of

these products. I think the suggestion that a tax of just 20%, which is larger than the taxes that are out there at the moment, would have no measurable impact on sales is just not supported by the data.

In the hearing last week, there was a suggestion that it will not have an impact because essentially people will move from branded products down to non-branded products. Again, there are no data particularly to support that. I am sure that there will be some moving within category, but there is very strong evidence that people move outside category. We have good pricing data—good economics data—from the living costs and food survey in the UK, which has looked at how people change their purchases based on small natural price fluctuations. It shows that diet drinks are a good substitute for non-diet drinks. When prices change, people move to diet drinks—they move out of that category. There are good data and evidence to support that, so there is a good suggestion that that could be successful.

Picking up what Susan was saying about why the suggestion is that there should be a sugary drinks tax, rather than a carbonated drinks tax, like they have in France, there is some work by health economists who have looked into the effect that you have in terms of the benefits to different kinds of society. In some societies, diet drinks are complements to non-diet drinks; in some societies, they are substitutes. It depends on how they are seen by society and on how people change their behaviour when drinks are taxed. In the UK, it is very clear that they are substitutes, so if you tax diet drinks at the same time as you tax sugar drinks, you negate some of the effect on the tax on the sugar drinks, because you are removing some of the chance for people to move away from them to a natural substitute. There will be some advantages, because you are getting some sort of benefit in terms of dental caries and moving the whole sector down, but if we are focusing particularly on childhood obesity—obesity tactics and looking at getting calories out of the diet—including diet drink tactics is probably not very good economics in that regard.

Professor Jebb: It would also not be good in terms of the evidence of the effectiveness on obesity. The randomised controlled trials that we have in children where full-sugar drinks were replaced either with water or with diet drinks showed clear benefits in terms of children's weight, so I think that we can be confident. There is no strong evidence, certainly from the trials, that consuming the non-nutritive sweetened drinks is disadvantageous for weight.

Q178 Maggie Throup: I wonder whether Dr Tedstone could come in on that as well.
Dr Tedstone: We now have clear public health advice from the Scientific Advisory Committee on Nutrition, which all UK Health Departments have accepted, that sugary drink consumption should be minimised. That is because of the large body of randomised controlled trials, not just from children but also from adolescents, that high-sugar foods, particularly sugar-sweetened drinks, are associated with health risk. For that reason, we gave very clear advice to parents, which consumer-tested very well, that sugary drinks have no part in children's diets. People quite like those slightly nanny-state messages.

PHE has reviewed the evidence on fiscal measures. We have looked at two types of evidence. We have looked at the experimental data, which are data using things like supermarkets and canteens, changing prices and seeing what happens to purchases. We have also reviewed the country data. Five countries have produced—I would not say

published because, with the exception of Mexico, nothing has appeared in the peer-reviewed literature—evidence on impact. Universally, all of those assessments, which are of variable quality, show that a tax does change purchases.

Q179 Chair: Decrease purchases.

Dr Tedstone: Yes—decrease purchases. There are no long-term data.

One question that comes up is whether an incentive to buy fruit and vegetables, say, would help in achieving an overall balance of the diet. At the moment the experimental data do not support that. There are things that you do not predict would happen. Some of the supermarket data, for example, show that when vegetables are discounted, yes, people do buy more vegetables, but they also use the money that they have saved to buy more of the things that do not fit in line with a healthy balanced diet. However, on the basis of our assessment of the fiscal data, PHE does see that there is a role for a fiscal approach in trying to reduce sugary drink consumption.

Q180 Maggie Throup: You have just answered the next question that I had for you. We appreciate that. Have you any evidence of the impact that a 20% rate of tax would have?

Dr Tedstone: As Peter said, broadly the evidence shows that the higher the tax increase, the greater the effect. However, most of those data come from modelling studies that PHE have not reviewed; we have just taken a general sense of the modelling studies. What we do not know—Jamie talked about this yesterday—is how transitory the effect is. Everybody acknowledges that the moment of introducing that kind of tax has a big health halo effect. We do not know how long that is sustained.

Q181 Maggie Throup: What are your opinions on whether people change from branded to unbranded if the pricing differential is—

Dr Tedstone: We do see movement around category, as Peter said. That is an established thing that happens when price changes. However, one presumes that if there was a tax it would happen on the unbranded and branded categories. You would expect to see some movement, but there is also brand loyalty that goes on with these things. The retailers are very used to changing prices. Another part of our review, which I suspect I will talk about later, is the work that we have done on the effect of promotions in stores. Regularly 30% is taken on and off products in stores. That leads to changes in the purchasing of those products. That happens in the branded and non-branded categories. That is everything that I know on that point.

Q182 Maggie Throup: You have touched on the international evidence of fiscal measures. Can you expand on that?

Dr Tedstone: We have seen data from Mexico saying that, on average, this tax has led in the first year to a 6% reduction in sugary drink purchases. There are very little data yet, but the impact has been greater on the most deprived in society. Of course, Mexican society does not match our society, so it is difficult to know what the differential effect would be here. One thing that came up from the Committee earlier was that this is imposing additional costs on the least advantaged. That is not the point of the tax. The point of the tax is to nudge people away from purchasing those things towards purchasing

things that are more in keeping with a healthy balanced diet, but there are no data applicable to the UK on—

Q183 Maggie Throup: Is that reduction in purchases of sugary drinks sufficient really to tackle the problem of obesity?

Dr Tedstone: Oh no, absolutely not. PHE would rank three other interventions above a tax intervention. We think that there could be bigger impacts from, for example, getting a handle on promotions and on the deep, consistent advertising our children are exposed to for unhealthy foods. We also believe that there is great scope for reducing the sugar content of the food that we buy in our supermarkets and corner shops and that is served in cafes and restaurants.

Q184 Maggie Throup: You wanted to come in, Professor Jebb.

Professor Jebb: I totally echo what Alison is saying. None of us can put all of our eggs in one basket on this. I go back to foresight and the system map. This is a big, complex system. There are lots of people out there who are not consuming any sugary drinks at all and still have a problem with their weight. We have to think much more holistically. Taking action in one area does not mean that the job is done. It would be a huge mistake to think that. We need to construct a portfolio of policies that work in different ways and that ultimately will begin to shift the entire system. That is incredibly important. One of the slight worries is that the focus on sugary drinks sometimes makes it feel as though, if we did that, it would be job done and Ministers would be able to say, "Haven't we done well?" Yes, that would be good, but it won't be enough. I come back to the point that I made at the start. We have to wake up to the scale of the challenge. It is huge. We have to have a proportionate response. That means far bigger, bolder steps than we are talking about right now.

Q185 Maggie Throup: Dr Scarborough, do you want to come in on the international evidence again, to see what we can learn?

Dr Scarborough: There is not a great deal of international evidence, because it has not rolled through the peer-reviewed papers. As I said, what we really have is some information on what has happened to overall sales in different countries. We can get that from sales monitoring devices. What we have seen is that you get a slightly smaller percentage size impact than the size of the tax. If you put on your tax at 10%, you get a reduction in sales of about 8% in general. Mexico suggests that it might even buck the trends, because in Mexico tax was put in at 10% and from early results it looks like there was a reduction in sales of up to about 12% by the end of the first year. That is reduction in sales. We do not know what has happened in terms of reduction in consumption. We do not have a very good idea of what is happening in terms of which elements of society are reducing their consumption more than others, to get a distribution of older versus younger and everything like that. That will start to come through, because the data from Mexico have good panel data and we will start to see that, but we do not have a good idea about that from France, Finland and Hungary yet.

With the modelled exercises, we are on to modelling data, but those are based on evidence of looking at how people react to price fluctuations within the UK. Of course, if we look

into the international evidence, we are assuming that people in the UK will behave in the same way as people in Mexico behave. Looking at the way people in the UK behave, if we take small fluctuations in price, extrapolate those out and say, "What would happen if you put a 20% tax on sugary drinks?", we can get an idea about which sectors of society it will impact on more. We know that it will have a bigger impact on people in the lower income bracket and we think that it will have a bigger impact on younger adults, as opposed to older adults. The younger adults thing is going on largely because younger adults are where the majority of sugary drinks are consumed; there are not many in older adults. With the lower income group, you get a bit of a double whammy, in that more sugary drinks are consumed in lower income groups, although the differential between lower and higher income groups is perhaps not as strong as you would think. There is also higher price sensitivity within lower income groups.

If you take it that those effects will play out when you get to a 20% tax level, you can extrapolate up and see what impact that would have on obesity rates. Our paper in *The BMJ* a couple of years ago thought that it would reduce obesity by about 1.3% of the obese population. It is based on modelled data, so this is not observed data, but it is using data on sugary drink consumption from the national diet and nutrition survey that we know underestimates sugary drink consumption, basically because of the way in which the national diet and nutrition survey collects data. When you compare it to data on overall combined sales of sugary drinks in the UK from, say, tax receipts or industry records, the difference between the total amount of sugary drinks sold and the total amount consumed, according to the national diet and nutrition survey, is fourfold. There is a massive difference in that recording. If we are estimating our changes based only on calories that we have removed as recorded in the national diet and nutrition survey, we are probably underestimating the effect that it would have.

Q186 Chair: If you look at the McKinsey obesity report, they reflect on the fact that it is very difficult to gather experimental data on obesity. They argue that we should experiment with solutions and try them out, rather than waiting for perfect proof. Would that be the panel's opinion as well? Would you share that strongly?

Professor Jebb: I would strongly support that view. With many big population-level interventions, as academics we cannot do these experiments until the system is introduced, so absolutely. Of course, if you are trying to introduce something where you do not have clear evidence that it will work, you need to put some careful procedures in place to ensure that you introduce it in a way that enables you to measure what happens, to think very hard about what the unintended consequences might be and to mitigate those risks, wherever possible. However, we cannot let the perfect be the enemy of the good. We really have to start making some progress and to learn as we go along, in a kind of action learning, which we do in lots of other spheres. I sometimes worry slightly that as academics we have been hung by our own petard in saying, "We have to have evidence on which to base policy." I think that we have to have evidence to inform policy. That is incredibly important. Then evidence has to be marshalled to evaluate policy. That is how we will make the most progress.

Dr Scarborough: We are not going to get a step change in the level of evidence around something like sugary drinks taxation, because you cannot do a sugary drinks taxation randomised controlled trial. The only improvement on the evidence that we have at the

moment will be when it comes out from panel data from countries that have already implemented a sugar drinks tax. We will start to get evidence like that from Mexico reasonably soon. However, we will not get good evidence about whether or not sugar drinks taxation would be effective in the UK before that is put in place in the UK, because you cannot implement it in that way. It would be a pity if the decision on it was put aside along the lines of saying, "We haven't got good enough evidence yet," because we are not going to get good enough evidence. This is it. The identification of the association between sugar drinks and health outcomes is as strong as it is ever going to get, and it is very convincing.

There is good evidence that if a tax is put on in different countries you are reducing sales. That is about where it is going to get. If you want to know how it will affect different levels of society and different people within society, it will have to be introduced. There are all these things that affect and intervene on how effective the implementation would be. There are things like pass-on rates—if you put on the tax, how much do the manufacturers actually pass it on to the consumers? We know that that varies in different places. In France, Finland and Hungary we saw that pass-on rates were all above 100%—they all passed on more than 100% of the tax. In Berkeley, a study has just come out that showed that the pass-on rate was about 50% of the tax, so quite a lot lower than the tax that was put on. We do not know what will happen until it is put in place in the UK.

Q187 Chair: So it is in the UK context.

Dr Scarborough: Yes.

Dr Boyland: I know that we will come on to marketing shortly. However, in that sphere, the fact that we have regulations on television is an acceptance that marketing does play a negative role in children's diets. I do not think that we can afford to wait until we have the same strong body of evidence for all of the other different avenues in which marketing can be applied. We have to use a precautionary principle here and say that we know that marketing has an impact and therefore, in a rapidly changing media environment, research will never be able to keep up. We need to adopt the principle that, yes, it is negative and we need to tackle it on the many different platforms and in the many settings in which children are exposed to it.

Q188 Chair: Thank you, Dr Boyland. Can I turn to Dr Tedstone? You have carried out a very detailed evidence review. I understand that it is entitled "Sugar reduction: responding to the challenge". Is that correct?

Dr Tedstone: No. The first document that PHE produced in June 2014 was "Sugar reduction: responding to the challenge", which set out the work programme that PHE would undertake to inform Government's thinking on sugar. The new document is entitled "Sugar reduction: the evidence for action".

Q189 Chair: "The evidence for action"; okay. Is that evidence review a review of all of the studies that we have—all of the international evidence on a range of different measures?

Dr Tedstone: Yes.

Q190 Chair: Or is it specifically advice to Government? Is it in a form where it could easily be separated out between the evidence review and the advice? Could you talk us through the document?

Dr Tedstone: Shall I talk you through the structures?

Chair: That would be very helpful.

Dr Tedstone: There is an overarching summary that knits together the technical annexes that have been produced to inform the document. It is quite hard to see the technical annexes as stand-alone. We have used many years' experience to knit together the themes that are coming out of the technical annexes, because there is quite a degree of overlap. There is the overarching summary, which is about 50 pages long, and there are a number of individual annexes. I think that there are about seven in total.

We have commissioned or done within PHE a number of deep dives into the evidence on, for example, the effect of marketing. We have used a systematic review approach to assess the evidence out there and then to quality-control it, before drawing evidence from those conclusions. For example, for the marketing review we identified over 500 references through the initial searches. Those were then funnelled down to 45 that were included in the final document. We were at great pains to make sure that what we were talking about was based on the totality of the quality evidence.

The document is not a think-piece. It is not drawing particular evidence in a way that is driving what PHE is saying. We have tried to take a cold, hard look at the evidence. For the fiscal review, fewer studies are included that made it through the quality control; there were only 11.

Both the fiscal reviews and the marketing reviews were also informed by a series of stakeholder interviews. With the taxation side, we thought very much that there would be data that countries had or that academics were privy to that had not yet appeared in the peer-reviewed literature. On the marketing side, one of the things that industry has always said to us is that they know how to do it and that, if we were just to listen to them, we would know how better to deliver health messaging. For that review, the conversations were again with international experts, but also with industry in closed, private ways. PHE did not do those; we commissioned a research organisation to do them. We hoped to get things that were not yet in the published literature. For both of those reviews, the peer-reviewed literature was triangulated against the interview data. Broadly, the interview data did not provide anything that the experimental data did not provide.

Q168 Chair: One of the challenges we have found in this inquiry is that you have two panels—one from industry and one from campaigning organisations—both contesting each other's evidence and the value of it. We felt it would be helpful for people to be able to see the quality evidence that the Government are going to be using for their reference so that we can all have many eyes on it and say, "Do we agree that that is the right evidence base and can we all have access to the same data?" Do you think there would be merit in that evidence being available to all those groups so that everyone can see what evidence you are using and relying on, as well as actually seeing what your conclusions are?

Dr Tedstone: Obviously Duncan spent a lot of time answering questions on this yesterday. I am really sorry that the evidence is not available for the Committee to see and for everybody to test that evidence. I was heavily involved in the salt work from the FSA and I know that we will go through a testing period if lots of stuff on sugar finally emerges in the obesity strategy. It will be tested very deeply. The Food Standards Agency have ended up in quasi-legal processes through the Advertising Standards Agency, for example, because the industry challenged everything that the FSA was doing. That robust evidence base was incredibly important in maintaining the direction of travel of the policy.

Q169 Chair: But do you still feel that at the moment you are not in a position to let us see the evidence base?

Dr Tedstone: I am not empowered to do that. I can talk to you in a lot of detail about the evidence, but I can't give you the evidence.

Q170 Chair: The trouble with being able to talk about it in detail though is that it does not give us sufficient detail for those who might wish to look deeper into it and challenge it.

Dr Tedstone: I completely understand and sympathise with the Committee about that. It is an unfortunate situation.

Q171 Chair: Thank you very much for clarifying that. In other words, there is structure to the report. Perhaps you could send the Committee a note as to how that structure is carried out.

Dr Tedstone: Yes.

Q172 Chair: Are you in a position to talk in further detail about this; you mentioned earlier that there were three measures that ranked above fiscal measures. Obviously we want to talk in detail about each of those groups, but perhaps at the end of this session you could talk us through in more detail about the order, and how you came to the judgment about the order in which they should be placed. I do not want to tread on the toes of colleagues who are covering other areas, so I am going to come to Philippa next.

Q173 Dr Whitford: I am going to talk about promotions and then advertising, because in a way they are about how you get people to take things and how much you get them to take. Professor Jebb, in your position as chair of the Food Network and the responsibility deal, you felt that progress on price promotions had been limited. Obviously you saw it as very important in the alcohol issue. Could you tell me your thoughts with regard to sugar?

Professor Jebb: First of all, it is very important to say that from the very outset of the responsibility deal it was made absolutely clear that there would be no discussions explicitly on price. That was outwith our remit. This was about voluntary measures. If there were to be price interventions, it would have impinged on the Competition Commission and so forth. That would have been a decision for Ministers. We did not specifically discuss price and we were never going to.

What we did talk about were promotions. I accept that there is a fine line, because promotions work in many ways by altering price. We had lots of discussions to see whether we could come up with collective voluntary agreements around various aspects of changing the promotional environment in its widest possible sense. I deeply regret that we made so very little progress on that. There were a few commitments by individual companies, with Lidl, Aldi and Tesco taking sweets off the check-out, for example. I say "for example", but there are not many other examples, frankly. We could not get the kind of collective agreement that we have been able to achieve with things like reformulation or labelling. It is very frustrating.

However, the positive bit from that is that, if we want to move to taking harder policy measures in this area, it is absolutely right and proper that one gives a proper go at trying to do it through voluntary means, and I think we have now done that. We spent a good year in discussions. The minutes from our meetings are on the website, and it is very clear to me that this cuts to the heart of business competitiveness. It is extremely difficult to do it in a voluntary way. There are lots of people who are not part of the responsibility deal and who were not going to be affected by it. There is a real risk with promotions that whoever goes first is disadvantaged by that, which makes it really very difficult and calls for broad action that will affect everyone equally and will not penalise the most progressive companies, but it has been an important process to go through.

Q174 Dr Whitford: That was something that came from the representative of the retail organisations themselves last week—at the point they were at, they would actually find regulation easier because it affects everybody. Dr Tedstone, what was the particular view of promotions in the PHE evidence?

Dr Tedstone: I have two sources of evidence that talk about this. I have the work that PHE commissioned with Kantar Worldpanel, the company which collects for retailers data on food purchases from a panel of 30,000 households across the UK. We commissioned them to look at what is going on in promotions and how it is affecting food purchases. They used two years-worth of data, so that is looking at what is going on over time. We also asked them to compare the UK with other countries. We have a highly promoted retail market in the UK—this is just about price promotion; I can talk more in a minute about place and things like that. Forty per cent of the food we take home—all of us, independent of social class—is on promotion. The next highest little group of countries in Europe are all around 20%, so it is a very big differential. You will hear retailers—we heard them last week—talking about having promotions on fruit and veg as well as on other foods. We have looked at the balance of promotions in UK stores and they are heavily weighted towards high sugar foods. When we hear about these things, one of the important points that I always think you need to think about is volume, not just numbers. In volume terms, the promotions are weighted towards high sugar foods, with the exception of bags of sugar—the commodity—and things that are naturally high in sugar, or rather medium in sugar, like fruit and veg that have sugar within their structures. Our analysis shows that promotions do not just lead you to swapping one brand of biscuit for another brand of biscuit; they lead to an expansion of the category. Over time, promotions lead to a 20% expansion of the category, which means that overall they lead to us buying more food.

You could argue that that is about value to the customer, but our analysis supports the notion that it is actually leading to people buying things that they would not otherwise intend

to buy. Say biscuits are on promotion and say you normally buy one packet of biscuits a week; they are on promotion, so you buy two. Some would argue that the next week you would not bother buying a packet of biscuits because you have two packets of biscuits already and you have left one in the cupboard. Our analysis shows that that is not true and that you continue buying biscuits at the same rate whether they are on promotion or not. One would surmise, but our analysis does not show this, that that has led to more food consumption. We have also estimated that that 20% figure, the uplift in the category which is happening because of promotions, is responsible for an addition of about 6% to sugar coming out of retail. That is quite a lot.

Q175 Dr Whitford: So actually these promotions do not necessarily save money, in that, if it is two for one, we still buy two for one, and then we go back the next week and buy another two for one. The argument is always, "We are helping people to save money," whereas you are suggesting from your evidence that that is obviously not true.

Dr Tedstone: They lead to us buying more food and spending more money, independent of social class. That is what our analysis shows. We all respond to promotions. We respond differently according to which group in society we are. Not all of us have the time to chase down promotions in one particular retailer, although some will, but we are all sensitive to the ones going on in store.

In the review of marketing, which I mainly talk about when we talk about advertising, we looked at evidence on place within supermarkets. The evidence is about the end of aisles, which have a big impact on place, but most other place locations within the supermarkets have not been researched in a way that met our quality control criteria. We also talk about pack size, because that is a way of promoting food; pack size drives greater consumption. Because of that, PHE are advising that promotions need to be reduced and rebalanced if you want to reduce sugar consumption.

Professor Jebb: I totally agree with what Alison is saying there. Last week, we published the Cochrane review about package size, showing that large packages increased overconsumption, and also work on end of aisles showing that with beverages on the end of the aisle—carbonated drinks—you get an uplift in sales equivalent to a price discount of about 22%. We should not underestimate the importance of placement.

The question for me is not whether promotions make a difference; of course they do. The challenge is how we can take action. It is dead easy to say that we need to rebalance promotions, but do we mean we need to increase the healthy and decrease the unhealthy, or do we genuinely mean that we should shift the balance? That might actually raise the whole level of promotions. Secondly, if you were trying to write some legislation what would you write? Through the responsibility deal discussions, I have to say that I was really struggling to think what it was, in a very precise, targeted way, that one would need to do, which would not lead to compensatory actions by manufacturers elsewhere. If we again take a too narrow, scalpel-like approach to this, there is so much variability in the promotional spend by companies that we might just squeeze the spending somewhere else and not affect things overall. I do not know how much evidence we have, or whether PHE have been able to work out where those pinch points are.

Q176 Chair: That is what we are very interested to hear—the evidence and what PHE concludes.

Dr Tedstone: In PHE, there is very little evidence on ways to control promotion, as Susan says. Because we have taken a peer-review look at the evidence, that has been difficult. We need to reduce overall numbers if you want to see an impact; you cannot just uplift the healthy side of it. We already have a tool for limiting the advertising of foods to children. PHE are recommending that that tool needs to be looked at and refreshed because it is quite old. Something like that would possibly be a basis for thinking about promotions.

There is one other thing I would like to add to the promotions side. There are new things happening in promotions in store. One of the biggest shifts that we are seeing is high sugar foods being promoted through non-traditional retail routes. You never used to be able to buy bags of sweeties in dress shops. Now they are heavily marketed along the checkouts of dress shops. They are heavily marketed in some of our newsagents, and we know from behaviour change research that it is very difficult to resist that "Would you like a kilo of chocolate with your newspaper, Madam?" type of thing. It requires our will not to buy that very cheap bar of chocolate.

Q177 Dr Whitford: That comes back to what you opened with, which is that the whole environment out there is a bit of a nightmare, and therefore there is not going to be one silver bullet. One of the things that came up last week when we were talking about taxes was that the low sugar versions of sugary carbonated drinks are actually cheaper to produce, because they have less sugar in them and sweeteners are less expensive than sugar; yet they are marketed at exactly the same level, meaning there is more profit. W**e put it to the food and drinks group from last week that obviously they, without that much pain, could simply drop that margin, which, before you reached tax, would mean that the diet versions were cheaper. What would you think of that as a way of dealing with it?**

Dr Scarborough: In the absence of any other techniques for putting in a price differential in that way for diet drinks over sugar drinks, I suppose it would be better than anything—

Q178 Dr Whitford: I do not think we mean just anything.

Dr Scarborough: I do not want to say that it would be a bad thing, but I just think it is not a very good idea compared with what else you could do. The problem is that if you are just reducing the price of diet drinks and leaving the price of sugar drinks overall, the whole category of diet drinks plus non-diet drinks just increases in size. That is terrible for dental caries. If you do it, presumably the same argument applies; they have set these price levels at a level that is optimised for their profit levels. All the arguments that the industry like to put out—"It would affect our industry, our profits and jobs"—are going to happen if you are doing that; you will get all that bad side but you do not get any of the plus side of actually generating some revenue for the Government that they can then use for health promotion activities. I do not see that it is particularly positive action.

Q179 Dr Whitford: But is it not similar in a way to tax, which is that we were wanting to create a differential between the two?

Professor Jebb: The difference would be much smaller than you could get if you were to go down the tax route. That is the point Pete is making.

Dr Scarborough: People respond to the differential, but it is also the absolute price. If you attack this by saying, "Right, to make the differential we will make diet drinks cheaper," rather than saying, "We will do it by making sugar drinks more expensive," you expand the size of the total market rate. If you go at it the other way, you reduce it but you get the differential effect as well. I just do not see that it is an entirely good idea.

Professor Jebb: Just to broaden this out, the PHE work stemmed very much from the Scientific Advisory Committee on Nutrition report on sugar, so there is a stronger focus on sugar. But it is not just about sugar. Fat in the diet is a big source of calories and we are all consuming too many calories. Let us just keep in mind in all these discussions around promotions in particular that it is much broader. Apart from sugary drinks, most other things are a combination of fat and sugar: confectionery, chocolate, biscuits, cakes and so forth. We should not leave them out of our thinking. The focus on sugary drinks is absolutely justified, and for tax they are a very definable category, but when we are thinking about promotions, please let us look across the breadth of foods that are of concern.

Q180 Dr Whitford: I want to come back to Dr Tedstone. Obviously you have the evidence and we do not. Before we move from promotions to marketing, which is obviously just a slight difference but the same approach, do you have any evidence in your document that would suggest what the best approach is to limit these two-for-one promotions?

Dr Tedstone: No, because there have been very few interventions on promotions. The PHE analysis of two years of Kantar data is a really valuable addition to the evidence base, because it shows the depth, breadth and effect of promotions. People have researched advertising. Emma has done that extensively, and I am sure we will talk about that. With the exception of a few things on promotions, it has not been researched that extensively. End of aisle has been and price has been a little bit, but not so extensively.

Q181 Dr Whitford: It is just because you mentioned that you would put it higher up, near the top.

Dr Tedstone: It is based on an analysis of the Kantar data and the stark reality that 40% of the foods we buy are on promotion and they are balanced towards the unhealthy end of the market, for sure.

Q182 Dr Whitford: Dr Boyland, last week we were told by one of the panels that advertising was just about market share rather than about recruitment. I would like to ask your opinion on that.

Dr Boyland: That is experimentally absolutely not true. It has been shown time and again that marketing affects product choice, not just at brand level—choosing between two alternative brands of, say, a soft drink—but at the category, beyond brand, level, to the extent that somebody would be more likely to choose a soft drink per se. I have just done a meta-analysis on that, and we can also confirm that marketing makes children eat more. It is not at all about shifting brand preference. That argument was used for tobacco advertising. It was not true then and it is not true now. Food marketing makes children overconsume and it makes them overconsume the least healthy items.

Q183 Dr Whitford: Dr Tedstone, is this part of the PHE evidence?

Dr Tedstone: We agree. PHE have looked at the studies. Broadly speaking, we found that the evidence consistently shows that marketing in any form we have looked at affects food choices, food preferences and, where available, food consumption. That literature is heavily weighted towards children because, of course, children are the most vulnerable in society.

Traditional TV advertising is still affecting food choices. We see that TV is still the predominant medium where children are exposed to advertising, but of course there is a huge growth in internet and social media advertising. The evidence is consistent and now quite large that advergaming affects food choices, and so do things like brand promotion. Sometimes it is argued that brand promotion is somehow neutral, because you are not actually promoting a product. Our evidence base shows that it absolutely is not. I am quite interested in sponsorship, because we are seeing a lot of food companies moving into sponsorship. There is very little evidence to say what the effect of it is, but the only evidence we have suggests that it affects food preferences and food choices. The notion is that sponsoring a physical activity event with food company branding is a neutral thing; our evidence is support that it is not.

We have taken a look at possible means of getting a handle on promotion, because PHE is of the view that in order to improve the diets of children they should be exposed to fewer adverts in terms of number, and that the controls that currently exist are not deep enough. We have the nutrient profile for the control of food advertising within children's TV alone. The reality is that a breakfast cereal that is 22.5% sugar passes that nutrient profile. As a public health nutritionist, I am really uncomfortable with that. We also see in our evidence review that things like cartoon characters can be used to drive the food choices of children. The current legislation says that branded cartoon characters cannot be used to advertise to children. Dumbo cannot be used, because that is a branded character, but things like the Coco Pops monkeys can. Yet the evidence shows that things like the Coco Pops monkeys engage children and affect food preference and choice. The other thing that comes out quite clearly from the review is spokespeople. People such as our sporting heroes promoting unhealthy foods affect the food choices of our children.

Q184 Dr Whitford: The promoting person or event connecting something utterly unhealthy with something that we think of as healthy is a newer direction. I want to focus a little bit on the television side. Obviously certain foods are not marketed directly to children, but we know that until mid-evening children are watching the same things on a Saturday night as their parents. The list that we were given last week from the food and drinks body included crisps, chocolate, crackers and pizza, but these were not specifically aimed at children and they therefore considered that that was all right.

Dr Tedstone: This is coming back to the definition of children's food. This is why perhaps a focus on children's food is not helpful. Children eat pizza. That is what our national diet and nutrition survey clearly shows; children eat pizza, chocolate and crisps. Children are exposed to unhealthy food advertising in family TV schedules that is not captured within the current legislation.

Dr Boyland: Children respond at both a neurological and behavioural level to palatable food cues—the appearance of a palatable food—and also to brand imagery. Something

like a brand logo develops activation of motivated areas of the brain and causes children to shift food choice and food consumption. Whether or not the ad is specifically targeted at a child, it will contain elements that are appealing to children. Those adverts often also contain persuasive techniques that appeal to children. A certain crisp manufacturer might include a celebrity endorser in their adverts who has a comedy villain persona that very much appeals to young people and engages them with the advertising. It is very much the case that even adverts that are more broadly of appeal to the entire population will also affect children and change their food choice in an unhealthy way.

Q185 Dr Whitford: The Committee has been informed by the Broadcast Committee of Advertising Practice that in actual fact they are not planning to review or change that. What is your reaction to that, Dr Boyland?

Dr Boyland: It is really important that we take hold of food marketing regulation at this point. The television food advertising regulations are an acceptance, as I said, that this advertising plays a negative role in children's diet. As has already been alluded to, there are severe problems with that. The biggest one is the use—nonsensical, in my opinion—of audience indexing, which means that family shows like "The X Factor", and so on, are missed out. As I mentioned before, it is also inappropriate to wait for a full body of evidence before we apply these sorts of rules to other forms of marketing as well. I thought the previous CAP report—the review of online food marketing—was very weak and poorly constructed. I just hope that the upcoming review takes a step over the point at which we are gathering evidence and starts to consider more seriously how we are going to implement marketing regulations on online marketing. Let us stop delaying and talking about the nuances of how it operates, the underlying processes and the role in children's lives, and actually say that we need to be precautionary and bold and we need to tackle this.

Q186 Dr Whitford: They say that they are not particularly planning to change TV advertising, whereas we have just talked about the fact that up to 9 o'clock or whatever children are watching.

Dr Boyland: A 9 pm watershed is really the only logical way forward at this point. It shuts down that massive loophole—the fact that marketers can still advertise unhealthy products to children during family viewing that is watched in much greater numbers than the dedicated children's programmes that are currently targeted.

Q187 Dr Whitford: Can I bring you in, Dr Tedstone? Does the PHE evidence speak to this at all?

Dr Tedstone: PHE have concluded that the evidence supports broader and deeper controls on advertising. Family viewing is clearly part of that. I was involved in the scientific side of the first controls on advertising that came in, which were absolute landmarks across the world. My sense then was that some stakeholders expected an unrealistically high level of evidence: a randomised control trial that linked advertising directly to childhood obesity—I am exaggerating slightly. As Susan explained, that kind of evidence is never going to be available. How could you do it in an ethical and practical way living in our society?

Q188 Dr Whitford: Would you also support the idea of a 9 o'clock watershed from the television point of view?

Dr Tedstone: PHE would support controls on family viewing, for certain.

Q189 Dr Whitford: Do you have any suggestions from the evidence on non-broadcasting? You touched on sponsorship, but we have heard about advergames and all the online things. Was there anything from the evidence that would suggest an approach to take?

Dr Tedstone: There are various steps that could be taken. The first obvious step would be to apply the current controls as they exist on broadcast media to non-broadcast media; not being able to use cartoon characters to encourage a preference for those products and being very careful about branding. There is a whole scope for doing things on the internet. People often talk about it being too difficult; I am not convinced, at least for UK-based companies, that controls could not be brought in. Advergaming is shocking in the way it sucks children in and in the way it is set up as a game by what it says on the label. The advertising bit of it is quite low profile, as opposed to the fun of engaging in the game. As Emma says, all that drives brand recognition and children's food choices.

Q190 Dr Whitford: Professor Jebb, do you want to come in?

Professor Jebb: I come back to the scale of the task we face and the need for a portfolio of policies. Frankly, I do not think we have the luxury of being able to pick and choose and say, "Well, we prefer not to do something on that. I don't think we will look at that now." Wake up. We have to focus on all of these and we have to take action across a whole breadth of areas. It is far too casual to think we can just park this on the sidelines as something we are not going to look at right now.

Q191 Dr Whitford: Dr Boyland, you have already talked about non-broadcast advertising, but do you want to add any other suggestions that you think are appropriate actions?

Dr Boyland: I agree that we need to shut down advergaming. That is one prime example. Food marketing is very well established now across the internet, so we have things like commercial websites for the brands that children visit. They very deliberately muddy the water as to what is advertising content and what is information about products. We need clear boundaries as to what is allowed on that front.

There is also a massive issue around social media and online video-type exposure to marketing, which has very strong effects on children. Online social media platforms can very quickly engage children in peer group action, whereby particular individuals in a peer group will be able to express their brand preferences through things like social media. That can be very influential, particularly for adolescents. It is a complex issue to deal with when you start talking on that global scale, but things like exposure to adverts on Facebook from friends, who are particularly influential and admired in adolescence, has a big impact on their brand preferences and choices. We need to be tough in tackling that.

Q192 Dr Whitford: Is there anything else that you want to add?

Dr Tedstone: To add to Susan's point, we have evidence that for certain parts of the internet we need quality control criteria for saying, "Something needs to be done about

this," such as the advergaming. As Emma says, there are many areas where we have less evidence, but it makes sense that, if advergaming is affecting food choices, things like video on demand, where you are getting ads as part of that, are probably affecting food choices as well. There is a kind of logic model in this which is sometimes missing.

Q193 Dr Whitford: It is also the sponsorship that you talked about—the story being told that drinking all these things is hydration to do with sport. That is really quite an undermining thing if parents are trying to help their children to be healthy.

Dr Tedstone: Yes, and the idea that we are all elite athletes so we all need to drink lots of sugar just to be able to run fast is not helpful.

Q194 Chair: I want to come to another area that you touched on earlier, Dr Tedstone, which is reformulation. You ranked it as No. 3 in your list earlier. We had a demonstration yesterday of the different levels of sugar per 500 ml in various products. If we are going to apply a reduction, should there be absolute targets? How do you see that we should do that? Should it be a percentage reduction but people are starting from different baselines, or should there be absolute levels of sugar included in products and a step-down as a mandatory requirement? Could you talk us through where you are on reformulation?

Dr Tedstone: PHE is not ranking reformulation as No. 3; we are ranking it in the top three. We equally rank three things. Salt has been a highly successful model, and you heard Graham MacGregor talking about that. It used a target approach across 60 food groups and that has been successful. Bread now contains 40% less salt than it did 10 years ago and most of us have not noticed that that has happened, until we go abroad and realise that the bread is saltier. PHE is of the view that a targeted approach would be very helpful.

One of the lessons from the salt work is that the out-of-home industry has been slow to step up to the table in all this work. We now consume 20% of our food out of the home. The notion that eating out of the home is a treat is probably unhelpful; most of us, and many children, are doing it every day, and not just at school. They are eating food regularly in the evenings from takeaways. This is Susan's point about the whole diet; fat is an important component of this. The out-of-home sector has things it could do. One of the lessons from salt is to make sure that the out-of-home sector fully embraces this work. It does not make sense that a pizza you buy from a popular chain will contain much more salt than the pizza you buy in supermarkets. What we learned from salt was that challenging industry to move to lower levels within a food category was a successful approach.

The thing that really needs thinking about is how quickly reformulation should take place. We know that if you take the salt approach, which is an adaptive model so that as a nation we all gradually adapt our taste buds, that is quite a long-haul thing. If, however, you were to accept that artificial sweeteners are a useful component of this, you can take much bigger steps. You can quite easily take out substantial amounts of sugar using artificial sweeteners.

Professor Jebb: A bigger challenge with the issue of whether you should have targets or should you encourage people to change is also whether it is going to be a voluntary or mandatory process.

Q195 Chair: That was going to be my next question.

Professor Jebb: Certainly with the responsibility deal, on the reformulation agenda we have had pretty good engagement from most of the main manufacturers and retailers. Yes, there is a lot further to go, and we are miles further behind than we were on salt, but the salt programme has been running for 10 years, so give it time. Getting everybody to come to the table in a voluntary scheme is very difficult. You are always going to have a coalition of the willing, and we have really struggled to engage the out-of-home sector. I would probably exclude contract caterers from that. Contract caterers have been doing quite good work, but even when you get the high street chains and the coffee shops—we are not there with them—in the out-of-home sector there are so many independents, one-man bands and so forth, and, although they may not be contributing much at a national level, of course for individual communities, for individual families, they are incredibly important. We have to work out how we spread the reformulation agenda right across the whole food chain, and that is extraordinarily difficult.

Q196 Chair: Just to be clear, are you saying—coming back to you, Dr Tedstone—that we should go for a mandatory approach and that it should apply across all sectors? Is that what you are recommending?

Dr Tedstone: I would like to see a voluntary approach more thoroughly tested. One of the problems with the RD—the responsibility deal—is that it has been piecemeal, and it has not always been entirely clear what is going on. Salt worked such that if a retailer took salt out of product x you knew it would not be added back to product y because all the categories were moving downwards. On the responsibility deal model, we do not know what is happening. It is also very hard to know what the matrix means. I know, as a nutritionist, what it means if you take x amount of grams out of x amount of products, but you do not know when they report things as tonnes. I do not know what 200 tonnes of sugar coming out of sugary drinks means to the food chain. I have got slightly lost on what the question is, I am sorry.

Q197 Chair: It is about voluntary versus mandatory.

Dr Tedstone: It is worth giving voluntary a jolly good shot.

Q198 Chair: A jolly good shot is quite vague. I am sorry.

Dr Tedstone: What worries me about a mandatory approach is that we have seen in some mandatory work—I suppose that has been largely seen in the EU on some of the food-based things—that you have ended up in a worse place than you wanted to be, because more compromise seems to happen on the road towards setting legislation. You may end up with higher targets than the lower ones you would have liked, but I am not certain.

Professor Jebb: It is difficult to know. I share Alison's concern. On the mandatory things, we might end up agreeing, for example, that a 5% cut in sugar in sugary drinks was the right kind of level, or maybe we could even get to 10%. We probably would not get any further than that if it was going to be mandatory, because for very small companies that would be a huge ask, and so on. Yet with the voluntary approach we are getting 30% in some cases. We might set a target for cereals, but at whatever level you set it, if it is a

mandatory thing, you automatically then license one gram below that as being okay. Actually, it is not okay. I do not want to see 20 grams or even 15 grams. If you can really get more traction in voluntary it is probably a better approach, but, as Alison says, there needs to be a much more comprehensive system, and one should not underestimate the time and the resource needed from Government officials and also from companies themselves in a voluntary system.

Q199 Chair: What do you do, though, if you have a voluntary system and one part of the sector just undermines it and then becomes the preferred brand?

Professor Jebb: It is a problem. I am not pretending that voluntary solves all the problems. What both Alison and I are saying is that there are issues with mandatory and there are issues with voluntary, and we have to work more carefully to find the optimal mix. It comes back to being absolutely clear, and being prepared to act, and acting, when the voluntary action does not come up to the mark. That has also been absent. There has not been much stick around. To reflect on the responsibility deal, we have to ask what the incentives are for companies to take part; frankly, there were very few. What are the disincentives for those who stay out of it? Frankly, there were none at all. We have to work that bit through much harder.

Q200 Chair: We have to work through what the disincentives are for not taking part.

Professor Jebb: Yes.

Chair: Dr Scarborough wants to come in and then I will come back to Dr Tedstone.

Dr Scarborough: On reformulation.

Chair: Yes.

Dr Scarborough: I do not really have anything to add.

Q201 Chair: I am sorry, I thought you were saying you wanted to. Dr Tedstone.

Dr Tedstone: As well as reducing the amount of sugar in products, the other important part of making the food chain better is portion size control. I am very worried that we are beginning to see practices that we commonly see in the States coming into the UK; for example, we are now seeing bottomless cups in some restaurants. We are seeing the default offer for portion sizes of sugary drinks in the out-of-home sector becoming bigger and bigger. There has been some success with voluntary systems on that, but very little. Portion size is part of the mix, things like bags of crisps. A single bag of crisps now is substantially larger than 15 years ago, and I do not think many of us leave those few crisps at the bottom of the packet. We need to think about the portion size thing hand in hand with the reformulation part of it.

Professor Jebb: Portion size is really important, because there are some products that it is very difficult to reformulate. If you are thinking about chocolate, for example, it is very hard to take fat or sugar out. You can do little bits, but you cannot make that much difference to the overall calorie content of the bar. But if you take 5 or 10 grams off the size of the bar you really start eating into the calorie count. For some products in

particular, portion size is going to be the best option, but right across the board I am totally with Alison. You have probably seen our review showing just how important portion size is in driving overconsumption.

Q202 Chair: Does that need to be mandated or can that be voluntary as well?

Professor Jebb: It is the same arguments as before. There are pros and cons to each approach. There is a lot more we could do with voluntary. One of the issues that struck me the other day is that manufacturers will certainly tell you that most bags of crisps are sold in multipacks—we can debate multipacks—which are about 25 grams per bag. Yet if you are at the railway station or the newsagents the individual bags you buy are 35 grams, 40 grams and sometimes even 50 grams. If most crisps are being sold in 25-gram bags, why aren't they all 25-gram bags? There is a whole raft of products where, if we were really clear about what the ask was, we could perhaps start marshalling more support around that. It still has the caveats for voluntary that I expressed before, but we could do more. The fact that, with single bars of confectionery, the three big chocolate manufacturers have all committed to them being fewer than 250 calories shows we can make these stepwise changes.

Q203 Chair: Dr Tedstone, do you have anything further to add?

Dr Tedstone: I absolutely agree. One of the difficult things is the value-for-money part of it, which sometimes can be used to undermine this type of approach. We know that what is contained within those bags is not a large contributor to the price. The marketing, packaging and brand development are all major contributors to the price. I have felt saddened that some manufacturers have been attacked for reducing portion sizes when actually that is the right thing for public health.

Q204 Chair: What about the super-sizing issue, when you go out, for example, to cinemas? Are you recommending that those kinds of—

Dr Tedstone: We would really like to see that reduced. One of the things I always think about is that in the standard portion size tables that were produced by the then MAFF, many years ago, this small cup was the standard portion size for a drink. That is pretty hard to buy anywhere now. New York experimented with this and they lost it through legal challenge, but it is clearly a road to consider. There are also things about differential pricing. There can be a price driver, because why wouldn't you have a big cup when it is only a very small amount of money more than the small cup, so it makes financial sense? PHE are commenting on that kind of differential price driver.

Q205 Chair: You are commenting on that in your review.

Dr Tedstone: Yes.

Chair: Thank you. We come next to the issue of labelling.

Q206 Dr Davies: Labelling does not feature within the top three categories that you are keen to target as Public Health England. Does that reflect the fact that you feel that

sufficient progress has already been made, or that there is little more that can be done on a voluntary basis at this stage?

Dr Tedstone: PHE have not reviewed the effect of labelling; it was not in the mix of things we looked at. I have been involved in labelling reviews in the past. I was involved in the development of traffic-light labelling some years ago. The research generally shows that people who are engaged in labels, who are health-seeking, are interested and use the label. They use front-of-pack labelling in almost any form it is in, but the reality is that the research shows that most people will not engage with that type of information. I see it as a really important platform, but better and better food labels are unlikely to deliver the population-level changes that are needed to address the obesity crisis. That said, front of pack has been a huge step forward. We now have it on 75% of products, which has been a success of the responsibility deal. On things like calorie information in restaurants, I was very struck when I was in the States recently to see that they have excellent calorie labelling in fast-food restaurants, but I asked my son, "Have you ever noticed that?" "No." It is the engaged who use those labels, and the research shows that in the States calorie labelling in restaurants changes food choice for people who are reading it but not for those who are not interested.

Professor Jebb: The other addition about labelling—again, we do not have good evidence as it gets very difficult to collect—is that it has supported, if not stimulated, some reformulation. There is almost no research on that—it has tended to focus on consumer behaviour—but we are in a good place with labelling. It would be great if we could grow that a little bit more. It hinges a little bit on the decisions in Europe, which I think are making it hard for us to push companies more strictly on labelling.

Q207 Dr Davies: If we look at labelling that already exists, yes, there is only a relatively small proportion of the population who perhaps take an interest in it, but isn't there still some confusion over exactly what people are looking out for, whether it is fat, calories or sugar? Do you think there is any need for guidance from above on what the public need to be looking out for, or is that where the traffic-light system comes in and anything that is red is bad—"Avoid it"?

Dr Tedstone: Yes. Different people have different things that they are particularly interested in, and the attempts to produce a composite score have been difficult and subjective. Peter may be able to talk more about that. I think you heard Graham MacGregor talk about what it should be. The traffic-light labelling is based on 100 grams, which people do not always understand. When traffic-light labelling was developed, there was testing on portion sizes and on 100 grams; 100 grams tested better in consumer testing. The other thing is that what constitutes a portion can be a bone of contention with the industry. There is a very famous case of a leading sugar manufacturer having a portion as one teaspoonful, which means that a bag of sugar ends up being thought of as low sugar, which is nonsensical. Portion sizing can run you into problems. With labelling, just like everything else, there are always compromises.

Professor Jebb: Australia has just introduced a health star system which gives products a one to five rating. I was over there last week, and certainly their Government are doing some evaluation of that, and it would be worth seeing how it comes out. It would in theory get over the confusion that some people have about whether they should be worrying about calories, fat, saturated fat or sugar.

Dr Scarborough: Indeed, in some stores in America they have a very limited system where something that I think is called NuVal scores foods from 0 to 100, the idea being to put all things on to one scale. With traffic-light labelling focusing on the four nutrients that are there, inevitably you are giving people information to make their own decision and then it is confusing to know how people make that decision. We do not really know how people deal with that sort of information; we do not have great understanding about it. If you have a food with two reds and two greens, is that better or worse than a food with four ambers? It is not very clear. We have done some research—it is not published yet and we are in the late stages of putting it through—to look at what is the effectiveness, what is actually happening, what is driving those decisions. What comes out is that the red marks are much more important than the green marks, and the nutrients that are of importance seem to come out as saturated fat and salt, which we were quite surprised about. A lot of the information that people have been talking about for the last few years has been about sugar, but it seemed to be saturated fat and salt in our research. Comparing that with what other people have done in similar ways, because groups in different parts of the world have considered putting in traffic-light tables and have done traffic-light label monitoring, people tend to find that they get biases towards the nutrients which are on the side—it is just a kind of sight reference or whatever—and they are the ones that drive things. We did not find that in our research, but it is a common finding in most other research. It is complicated because of the fact that diet is multifactorial. Jamie Oliver's evidence yesterday—the labelling on bottles of drink—is an indication that different things might work in different products. With sugary drinks all of a standard size, something that just said, "This is the amount of sugar within that product" might work quite well. But I agree with Dr Tedstone that if you are talking about doing things on a per portion level, when you start looking at foods, it can get really complicated. I think per 100 grams is the best level, where we deliver the information in most cases; it is not going to be in all cases, and the example that Jamie showed yesterday was one where it is much better to be completely frank: "This is how much sugar is in this bottle." It does not work everywhere. For example, it does not work particularly well for a big box of breakfast cereal to say, "This is how much sugar is in this," when it takes you two weeks to eat the whole box. If you allow them to say, "We will do this per portion size," what is a portion of breakfast cereal? They can say it is an extremely small amount of breakfast cereal to get a small amount of sugar.

Q208 Dr Davies: Jamie Oliver's point was that specifically for sugary drinks, which is obviously his key interest area, putting the number of teaspoons of sugar on the pack was a good way of engaging people.

Dr Scarborough: It can work in certain restricted areas, but that does not mean that it would then work across the entirety of the food chain. It was a good example. In terms of sugary drinks, it works well.

Dr Tedstone: I think Jamie's idea is worth testing, but, as a little aside, there have been unbelievable amounts of argument about what constitutes a teaspoon and what constitutes a sugar cube. I would rather avoid spending a year of my life arguing about the size of teaspoons, because, even though it is jokey, it will happen. It is one of those unintended consequences.

Q209 Dr Davies: Finally, in terms of labelling, we have discussed takeaways and the fact that many people eat away from home. You referred before to certain menus having nutritional content, but that is certainly not widespread in this country. Do you think that is something we should be looking to enforce?

Professor Jebb: In the responsibility deal there is a pledge on menu labelling. On the high street, there has been some progress. Again, we are really slightly caught up by EU rules, because the law says that you have to provide calories and kilojoules. Most UK consumers find kilojoules very difficult to deal with, and if you have both numbers on the menu it becomes even more confusing. That is not an excuse, but it is a practical problem in going down this route. The other big practical problem would be getting this happening in all of the little local one-man band outlets. On the other hand, with the food information regulations, they are required to have much more information about the food they are serving. We could get over that problem, but we should not underestimate the challenge. We could do it, but we need to resolve this calories/kilojoules issue, I think.

Q210 Chair: Just as we come to the end of the session, returning to you, Dr Tedstone, you mentioned that in your top three—you said they were of equal importance—you would place promotions, deep, consistent advertising and reformulation. Could you explore what else is on the list and in what order or what groups you place them and why, and then we could perhaps ask the rest of the panel whether they agree?

Dr Tedstone: In the reformulation part, we have included Government food procurement because that has a big influence on the food chain, and if you think about the NHS most of us work in the public sector. Clearly, getting a handle on public food procurement has the potential to be a great lever on the food chain and on our health. Also on the list we have education for those who are procuring and providing food for us; we already have some education of health professionals on nutrition, and we feel that better standards are needed for the education of our caterers, those procuring and selling our food. The leisure industry, where an awful lot of food is sold, often sends out mixed messages: "Go to the gym, burn a lot of calories, come out of the gym and buy more calories from a vending machine." That is a worrying thing. What else? Training. Can I just think for a moment?

Q211 Chair: Would it help to have a piece of paper to jot it down? Where you are grouping things and in what priority is very important to us. Would it help to have something to refer to?

Professor Jebb: Do you want the rest of us to chip in while you are waiting?

Q212 Chair: No. First of all, I would like Alison to set it out, because it is really important; people are very interested to hear what the basis is and why you are making these recommendations. We are quite keen to know what you are basing that on. You have set out that you are disappointed that you cannot share the evidence with us, but it is very key for us and for the wider public to know where you are placing these in order, and why?

Dr Tedstone: We have also included making sure that five a day and the eatwell plate are aligned with public health messaging and guidance to institutions on the better provision of food. We have also included local authority action. We have to remember that, as well as the national part, there is also a local part of this. We have piloted some work with East Sussex on a sugar champions project, because local authorities at the moment are not part

of Government food procurement, but they obviously have a big influence over what is procured locally. They have some influence over planning, for example, and we feel that there are opportunities for them to do more. I have been very heartened to see what Brighton & Hove have been doing recently to champion sugar reduction in their population. The Sussex work also considers schools, particularly the environment around schools. There is a very interesting piece of work, which is not yet evaluated, on children's routes to school and what they are buying on their route to school. This is picking up on Jamie's point about how the environments around schools affect our food choices. We have on the list education of those who procure our food; the nutrition instruments, such as five a day and what counts for five a day; the eatwell plate, which is one of the key tools that health professionals use to guide people; and more opportunities within local authorities.

Q213 Chair: Am I correct in thinking that you have grouped promotions, deep and consistent advertising and reformulation alongside Government food procurement in your top three of equal value?

Dr Tedstone: Yes.

Q214 Chair: Then am I right in thinking that you have put fiscal taxation-type measures in as No. 4?

Dr Tedstone: Yes.

Q215 Chair: Are you able to say why you felt that should be lower down the list, and what evidence you based it on?

Dr Tedstone: It is purely based on a rough calculation of the effect it would have on sugar consumption. A sugar-sweetened beverage tax is exactly what it says on the tin—it is on one product—and we know, if we use the Mexican example, that it would have an effect on the purchase of sugar-sweetened drinks. When you drill down, you realise that has an effect on sugar consumption, but it is on a relatively small level, probably about a gram a day, per individual.

Q216 Chair: Because it is only targeting a relatively small part of the food chain.

Dr Tedstone: Yes. We know that promotions are adding to the amount of sugar you buy by about 6%, so that is quite a big impact. We estimate that it would have a bigger impact in terms of sugar reduction. We have done some back of the envelope scenarios in terms of the effect of reformulation, and we think it could be larger than a tax—quite significantly—because sugar-sweetened drinks are only one of the foods that we would consider to be part of that.

Q217 Chair: Are there some things you recommend that we ban outright? For example, you referred to the selling of chocolate bars when you buy a newspaper. Are there some things you are saying that you think should absolutely stop?

Dr Tedstone: We are not using that kind of language, but we would really like to see that discouraged.

Q218 Chair: Is there anything you would like to add, Dr Tedstone, before we ask the rest of the panel?

Dr Tedstone: No. The rest of it we see as supporting. One thing I forgot is that we think it is important that health marketing continues, that five a day continues. It is very important that people are given the tools to do it, but that is an underlying plank; it is not a key recommendation.

Q219 Chair: Thank you. Professor Jebb?

Professor Jebb: I totally agree with all Alison has said, but I want to broaden it out in one area. We have talked entirely this morning about preventative actions. Prevention will, of course, help people who are already overweight or obese, whether they are adults or children, but we have to recognise that a quarter of adults and large proportions of children are overweight already, and they are going to need more support to be able to reduce their weight. I urge us to see that in a genuine obesity strategy we have to include treatment as well. I will not talk about the treatment options for adults; I think what we can do is very clear and we have good evidence, which I am happy to provide to you.

For children, treatment is much more difficult. We have much less good evidence of what can be done, but I do not think we should underestimate the importance of treating adult obesity, not only for adults but also for children, for a number of reasons. If we got health professionals much more engaged, they would provide strong opinion-leading messaging. Part of the tobacco reduction was about health professionals being incredibly clear that smoking is bad for your health. I do not think we have health professionals consistently giving out those messages around food yet, so we would have some progress there. Secondly, if you engage overweight adults in managing their own weight, one might hope that that begins to change the micro-environment in the family home, which will benefit the children. Finally, when adults, or indeed children but particularly adults, start recognising the cognitive effort it takes for them to manage their weight, they start to become much more acutely aware of how unsupportive the environment is. They become much more concerned about having to make their way through rafts of confectionery when they buy their petrol, or whatever else it may be. Building a group of people who are actively trying to manage their own weight may be one of the steps towards building greater public acceptability for some of the other policy actions that we have talked about today. It is incredibly important that treatment is seen absolutely as an integral part of an obesity strategy. That does not in any way underestimate the importance of all the prevention stuff we have done today, but it is another issue that has to be in there, particularly if we are talking about obesity, because that is fundamentally about treatment. Most of the other issues have been about prevention, and I am not sure how helpful it is to frame that totally in obesity. It is about healthy behaviours, a healthy diet and physical activity, which we have not touched on much.

Q220 Chair: We have not touched on it. We looked at it in our previous inquiry. Obviously, physical activity is independently extraordinarily important, but would you agree with the conclusion that we felt that it would be a mistake to send a message that this is all about activity? We felt it was absolutely—

Professor Jebb: It is absolutely not all about that.

Chair: We felt it was independently important whatever your weight.

Professor Jebb: Both of these are very important. They both contribute to a healthy weight, and they both have other independent health benefits aside from weight. That is why we should be thinking, when we talk about prevention, not just about preventing obesity but about the importance of a healthy diet and physical activity for good health overall. I slightly worry that, if we pin it all on preventing obesity, first, the impact is smaller because there are other benefits, but also, particularly for some parents whose children are not currently overweight, it is quite hard to engage in a discussion about preventing obesity because they think their child is fine, and they do not perhaps recognise the long-term risk, whereas every parent wants a healthy child in a much more general sense. Prevention for me, particularly in children, is about healthy behaviours, and obesity is about providing support to people who have an established problem. Certainly with adults, we know what to do; we are just not delivering that terribly well through the health services.

Q221 Chair: Thank you. Dr Scarborough, do you want to add anything?

Dr Scarborough: I certainly do not have anything to add. It was a long shopping list, and Professor Jebb added some more things that are certainly well worth considering. I definitely would like to reinforce the idea that what is needed is a whole raft of different things simultaneously. There is no reason why any of these should be done at the expense of the other; they are all completely different kinds of interventions working on different mechanisms where obesity has laid the foundations, so I would encourage them all. It is very hard to judge on the basis of the kind of prioritisation system that has been presented, because we have not seen the actual review. We have not seen the evidence, so it is difficult to make a judgment about that. I am surprised that the fiscal measures are not in the top raft of high prioritisation, because they have some obvious advantages. Saying they are only going to take one gram per day, per person out of the food chain is not really painting the full picture, because that is an average across the entire population, including a whole bunch of people who never drink sugary drinks. Actually, when you target it on people who drink sugary drinks, we know from the evidence that sugary drinks are related to obesity and diabetes; there are some people at high risk of obesity and diabetes and the effect is much larger in people who drink a lot of sugary drinks. That is not a fair way to package it. The fiscal measures are the only ones that have revenue-raising potential, which then allows for some money to be directed towards other incentives and interventions.

My only other comment about the prioritisation is on reformulation. Reformulation can be extremely important if delivered correctly. The salt action by the FSA in the mid-2000s was fantastically useful for public health in this country, and if we could do something similar that would be great. The problem sometimes with reformulation—I have not seen the report so I have no idea if it goes down this route—is that it can end up focusing on a single nutrient. If you focus all your powers on a single nutrient with reformulation, what happens with the other nutrients? Does it gets squeezed in different directions? You have to be careful to make sure that you do not allow that kind of unintended consequence of reformulation.

Q222 Chair: Thank you. Would you like to be able to see the report so that you can comment on it?

Dr Scarborough: I would love to, yes, if possible.

Q223 Chair: We all would. Thank you. Dr Boyland.

Dr Boyland: I absolutely agree that we need a holistic approach that tackles all of those different facets. I hope that there will be a whole-Government approach and engagement from the Department for Culture, Media and Sport in some of the elements that fall under their remit. At the moment, our food environment is very difficult even for somebody who is engaged and able to use all the measures we have, such as traffic-light labelling. It is very difficult to maintain a healthy weight in that sort of food environment, so I am pleased to see that the emphasis is not on individual responsibility, although education and all those things are very important underpinning elements. It is very critical that we tackle the food environment as a collective responsibility and make it easier to make those healthy choices. All the measures that are being proposed will go some way to doing that.

Chair: Thank you all very much for your time today. It has been really interesting to hear from you. Thank you very much. I propose that we have a five-minute comfort break, so we will stretch our legs before the next panel. Thank you for coming today.

Examination of Witnesses

Witnesses: **Professor Simon Capewell**, Vice President, Faculty of Public Health, **Dr Colin Michie**, Chair of Nutrition Committee, Royal College of Paediatrics and Child Health, and **Dr Jeanelle de Gruchy**, Vice-President, Association of Directors of Public Health, gave evidence.

Q168 Chair: Thank you very much for your patience and for coming this morning. As with the first panel, could I start by asking you to introduce yourselves and also to declare whether you have any relevant interests, either personally or for your organisation, perhaps starting with Dr de Gruchy?

Jeanelle de Gruchy: Hi; I am Dr Jeanelle de Gruchy. I am director of public health for the London Borough of Haringey and vice-president of the Association of Directors of Public Health. I do not have any interests to declare.

Professor Capewell: Good morning. I am Professor Simon Capewell. I am vice-president for policy for the UK Faculty of Public Health and a professor of clinical epidemiology at the University of Liverpool. I am a trustee for the UK Health Forum for Heart of Mersey and I am a founder member of Action on Sugar, with Graham MacGregor having presented their case last week.

Dr Michie: Good morning. I am Colin Michie. I am a paediatrician from Ealing Hospital. I also chair the nutrition committee for the Royal College of Paediatrics and Child Health. I have no conflicts to declare.

Q169 Chair: Thank you. Could I start by asking you each to respond to what you heard from Dr Tedstone at the end of the last session—were you all here listening to that session—particularly the point that having the sugary drinks tax proposal is not in the top three, and what you feel about that list that we heard her talking about? Perhaps Dr de Gruchy can start.

Jeanelle de Gruchy: I can start. Clearly, I am speaking from more of a local government perspective; certainly we need a lot of national work to take place to support us at local level. The Association of Directors of Public Health supports the sugar tax proposal, but we would absolutely see the importance of all the other elements that she was suggesting are key. We would want action to be taken on those other elements—the promotion, advertising and reformulation. We would see those as key as well in terms of the food environment.

Q170 Chair: She specifically refers to local authorities' action as well.

Jeanelle de Gruchy: Yes, and I can talk more to that point if you would like me to.

Q171 Chair: Yes, if you want to quickly refer to that point—what you would like to see from what she recommends for local authorities.

Jeanelle de Gruchy: Yes. I do not know, obviously, what is in the report in terms of local authorities, but, certainly from our point of view, local authorities now have a responsibility for public health and play a key role at a local level in terms of leading in the system: that is both place shaping, so the nature of the place in which people live, as well as people and people's behaviour who live in those places. The first session focused a lot on food and the food environment, and absolutely local authorities would have responsibilities around things like planning and licensing. I can talk more about perhaps the hot food takeaways planning work that we are trying to do. There are also the things that local government does in terms of increasing walking, cycling and people's physical activity. I know you focused on that previously, but it is all of that together; it is the place shaping and influencing the way that people behave within those places.

Q172 Chair: Thank you. Professor Capewell?

Professor Capewell: Yes. From the Faculty of Public Health perspective, we have been pushing for some time for the sugary drinks tax. We have been pushing for some time for a ban on advertising of junk food and sugary drinks to children, at least until the 9 o'clock watershed, and also, to promote physical activity, a 20 mph speed limit.

Like you, we are desperate to see the evidence on which these recommendations are made. The idea of ranking them on the basis of benefit to the population is clearly very attractive. We would certainly like to work through the arithmetic. We absolutely endorse the statements made last week and this week that it is an obesogenic environment. The structure of our society is making children fat and therefore the response has to be a comprehensive strategy. There is much to be learned from the success with tobacco and alcohol control, and thinking about the frameworks used: the 3As—the A for affordability, the A for acceptability and the A for availability. When you consider that four out of five men were smoking during the second world war and now it is less than one in five men

and women, that does not represent any single magic bullet. It represents equal contributions from getting the price up, controlling advertising, making smoking unacceptable and limiting the availability to a fewer and fewer number of retailers, with no shiny promotions and no single cigarettes being sold to children. We think that the 3As framework might usefully be applied here.

Chair: Thank you.

Dr Michie: I thought it was really very interesting and full of positive findings. Just to emphasise two of them, the idea of staying with the five-a-day programme is very important, sticking with our educational messages that we know have worked so far—and that is a rather important one, although whether it is five portions a day or more is another point—and the eatwell plate does merit a comment. An eatwell plate has been very helpful to schools and preschools. It is a very useful framework from which to work with healthy children's diets. The problem is that it does not have any fluids on it; the eatwell plate does not come with a drink. That has been one of the big gaps in the use of it throughout our educational system. So I would add that caveat, but certainly I thought there were some very positive messages. As was emphasised, the College is very concerned about marketing and promotions that involve children. We have good evidence to show for many years that this has a powerful influence on what happens within families and it is a complex thing, because it is not just the children that are being influenced—they influence their parents and the parents then purchase the foods too. There is a complexity there. But, clearly, marketing is crucial to any intervention that is taken centrally and nationally.

From the point of view of the tax position, the College thinks that it would be of great advantage to tax sugary drinks. A big problem that we have is that we face large numbers of patients in clinics, and Susan Jebb touched on it at the end. The problem is not in trying to prevent something that is coming at us; it is in our clinics already. We have a problem with treatments and we cannot see a way out of treatments without doing something fairly immediate. I am sorry but we are doctors and we want to do something now, and we cannot see any of these interventions which are slightly more nationally directed and perhaps slower in timeframe. We would like to do something fairly urgent and that is why we are a little bit biased toward the idea that a Pigovian tax would be the way to sort this out fairly swiftly for children.

Q173 Chair: Thank you. I note that Dr de Gruchy wanted to come back in.

Jeanelle de Gruchy: Yes. Could I come back on two things that were spoken about earlier? The first was around sponsorship. Absolutely, we see that playing out at local level. One of the sugary soft drinks companies is sponsoring park activities for children. You see that happening and that has been taken up by lots of councils, so it is going into local areas to do that. The concern we might have is that, as councils' budgets are reduced, they will be looking at other ways in which we can improve health and you get into this quite conflicting area again of the sponsorship with the branding of particular drinks or food companies linked to kids being physically active. I absolutely echo the concerns that were raised about that in the earlier panel.

Likewise we are doing work with local businesses; they were mentioned. As well as the big national chains there are a lot of local businesses, and certainly there will be a lot of small businesses. When you talk about the big national reformulation and the voluntary

schemes, we are doing that at local level. We have things like a healthier catering commitment and are working with a lot of the independently owned fast-food takeaways to improve their offer. But again that is very labour-intensive work; it takes up a lot of time and capacity at a local level to do that. It is reducing—

Q174 Chair: We are probably going to explore in greater detail local action in a minute, so thank you. Professor Capewell, you have already indicated that you would like to see the report. Would other panellists also like to see the report?

Dr Michie: Most certainly, thank you.

Jeanelle de Gruchy: Yes.

Q175 Chair: Thank you very much. Can I focus on one area to start with—the reformulation aspect? We heard some differences of opinion on whether it should be voluntary or regulatory. Do any of the panel want to expand on whether they feel it should be voluntary?

Professor Capewell: Yes. The lessons from tobacco control are very clear. Over 10 years ago Mike Daube wrote a paper entitled "Voluntary agreements" with industry: "designed to fail". When the structure of the responsibility deal for food was laid out five years ago, *The BMJ* had a cartoon with fat representatives of the different companies sitting around the table and there were analogies with Dracula being put in charge of the blood bank. Voluntary deals do not work. The Department of Health itself commissioned extensive evaluation of the responsibility deals—alcohol, physical activity, workplace and food. They were consistent in demonstrating lack of effect. As Susan said in the earlier session, the industry vetoed the effective interventions. So price was off the table and advertising was not discussed. The formulation was discussed but nothing actually happened. Most of the much-vaunted pledges from the industry were already happening or due to happen. The evaluation and the reporting was patchy and the quality was poor. There really was no evidence of health gain. There were similar conclusions from the evaluation of the alcohol, physical activity and workplace RDs.

In contrast, mandatory regulations have been demonstrated to work around the world for tobacco, alcohol and food. As Susan and Alison were explaining, the major successes with salt reformulation happened before the responsibility deal started, and they happened because the industry reps were dragged into the office of the Minister and the Minister made it quite clear that either they could do it the easy way or they would do it the hard way with regulation. This was, effectively, soft regulation. The reductions in salt were dramatic—more than a gram and a half per person per day by 2011—but, when the responsibility deal came in, that reduction slowed. Graham MacGregor published a paper in *The BMJ* less than a year ago suggesting that the slowing had resulted in 6,000 additional deaths because the previous reductions had not been pursued.

So the Faculty, and indeed I think the vast majority of the public health community, would argue strongly for mandatory approaches. My group and other research groups have looked at the potential benefits from voluntary versus mandatory. Mandatory are consistently more powerful by a factor of five, 10 or 20-fold, and also they are more equitable, so they work particularly well in the disadvantaged groups that have the bigger burdens of disease. I hope that is helpful.

Q176 Chair: From the earlier panel we heard the comment that you could achieve greater reductions with voluntary arrangements; also the point made earlier was that you would give an impression that that is acceptable at that level and it does not encourage people to go further. How would you respond to those points?

Professor Capewell: They were fine statements. I am sure they were well intentioned. I would love to see the evidence because the evidence from the UK, and indeed across the world, is very much in the other direction. Mandatory is far more powerful. It is just a very simple matter of thinking about the companies who did not come to the table for the responsibility deal. Of those that came, the pledges they pursued were mostly activities they were going to do in the first place. They are companies and their single statutory obligation is to maximise profit for shareholders. The one thing they are not going to do is pursue any activity that reduces sales and reduces profits. The public partnership approach is such a naive concept. Mandatory is far more powerful.

Dr Michie: If I could join in on that particular bandwagon, paediatricians have many years of experience in dealing with the milk formula companies, and trying to agree with them on any voluntary arrangement is a very frustrating business. There is a great history to this, the consequence of which is that this country now has the lowest exclusive breastfeeding rate in Europe. We have shelves full of unnecessary products in every supermarket and there is a continual business in trying to fight the advertising from these companies to promote their products very surreptitiously or very obviously in every possible part of the media. Paediatricians would never buy a voluntary arrangement with a large company for precisely the reasons that Simon has just outlined. They are in this as a business, they are extremely good at doing what they are doing and the voluntary arrangement is only ever a very temporary one. The consequence of this infant feeding has been a disaster and history will write it down as such because of this problem that we have with trying to defend breastfeeding in the face of this barrage from companies, from industry.

Q177 Chair: Are you concerned about things such as, for example, proxy advertising of infant formula with follow-on formulas and things like that?

Dr Michie: Precisely. Follow-on formulas are not necessary for human beings, but it would not seem so if you watch television. They problem is we are all very convinced by the stories. There are other issues that have parallels for what was said earlier in that the milk companies sponsor education, training, events and an awful lot of professional activities, which again does exactly, to our minds, what we heard it does to infants' minds: when we see brand names, we equate certain things with them. It is an insidious business that we know enough of to be very wary of. For this reason, we would be extremely worried about any voluntary arrangements with big companies.

Q178 Chair: Thank you. My final question is this. How strong do you feel the evidence is that you have seen around the other measures we have talked about—a sugary drinks tax—but also marketing and advertising? Would you like to talk about what you feel should be the priorities there?

Professor Capewell: In terms of the evidence, the issue before us, and indeed before Ministers shortly, is whether the evidence is sufficient to move from the status quo. The status quo, I think we recognise, is appalling, with one fifth of children arriving in

reception already being overweight or obese and a third of them when they move up to high school. If we were waiting for absolutely perfect evidence, we would still be waiting for the randomised controlled trial to prove that smoking causes lung cancer. This is clearly absurd, although the industry would love to prevaricate, and we saw some prevarication last week. We think that the evidence is very strong for a sugary drinks tax. There are empirical data from a number of countries now showing a rapid benefit—a substantial benefit. The evidence for reformulation is very strong for salt and we have heard no opposition from the industry saying it would not work. We have heard that it will reduce the bulk, which might be a good thing, and we need to try. We have also heard from industry very clearly last week that they want a level playing field. I did not mention this with the mandatory versus the voluntary, but, as discussed earlier in this session, the industry are rather weary of pioneers being picked off by doing pro-health interventions and their competitors making money out of philanthropic mistakes by the pioneers. A level playing field is very important and would be welcomed by the industry. It would certainly be welcomed by the public. There is big public support for sugary drinks taxes and for reformulation. The parents, in particular, want something to be done.

Q179 Chair: Thank you. Do you have anything to add?

Dr Michie: I have a brief comment on the business of advergaming. There is a great—although not as vast as we have been hearing this morning—research interest in gaming to treat children with neurological problems and we have discovered that gaming has profound effects on the human brain, especially when you are three, four and five. Certainly very large groups like Wellcome and the MRC are recruiting gamers to try and get gaming introduced for little three, four and five-year-olds to help them when they have a neurological problem. The only difficulty is that the foods industry—and the baby milk industry—are ahead of us in this; they have already developed these gaming techniques. They are very important. We can use them as treatments and these folks are using them for advertising purposes. Just to add one specific observation about that, it is a sinister thing for our children and we need to try and control this.

Chair: Thank you. Now we come on to James.

Q180 Dr Davies: Physical exercise is the topic of my question. Clearly no one would deny the general health benefits that physical exercise brings, but how important would you say that it is in terms of tackling childhood obesity?

Professor Capewell: The UK Faculty of Public Health would like to see more physical activity in schools—at least another two hours per week. As emphasised before the break, physical activity brings many benefits. We would therefore promote active travel and think it would be of particular benefit to children as well as adults. Clearly you need the national policies, supporting structures and the local implementations. Maybe Jeanelle would like to comment.

Jeanelle de Gruchy: We see both physical activity and food as equally important in a very complex way. Physical activity is never going to balance out the high calorie intake of children; it is just never going to do it. As to any of those messages coming out from industry such as, "If we can be a bit more physically active, that will counterbalance it and it will be fine," we do not think that is the case at all. Certainly we are very keen locally to

increase active travel—active travel to schools. That is where the Department of Transport is important in terms of roads, road safety, cycling routes for children, 20 mph speed limits—and quite a number of councils are now putting those in place—and play areas. Are we ensuring that children have places to play, that the car is not supreme in terms of car parking spaces rather than playgrounds in new estates and so on? It is amazing how children's play and physical activity has been planned out of the way we live—out of a lot of our public and home spaces—nowadays. We are very keen to look at ways to do that, obviously through local government influences, but you need the national Government legislation to support that.

School is another key area. There are things like healthy schools. We have a very strong programme in London, but it is variable across the country. Many schools are looking at how they can encourage children to be active, not just in formal sports but certainly specifically during lunch hours, after-school activities and things like that. Absolutely, being physically active is so important, both for your healthy weight but also your emotional health and well-being.

Dr Michie: My colleagues have covered the nuts and bolts here but, just to give an example, we heard this morning that certain sportsmen were advertising foods as part of their day-to-day work, as it were, and a normal part of their activities. To put the opposite spin on that, there is a chap in Canada called Pierre Lavoie, who was a Canadian Ironman. After two of his children died of a metabolic problem, he set himself a challenge to cycle a certain distance. He now has virtually the whole of French-speaking Canada cycling on what he calls "Le Grand défi"—the great challenge—as part of exercise. Although there are no figures, the obesity figures in Quebec have fallen pretty steadily, and a lot of folk there attribute this to the activity of the great challenge and getting everyone of all ages to get out and cycle. They collect little cubes of energy which they save from their schools and communities, and they get prizes and sponsorship for local developments based on this activity. Exercise can change communities, and it can change the whole health of a community and, as a consequence, one will then see obesity resolved.

Q181 Dr Davies: We have already touched on the role that schools can play, but do the panel feel that schools are, in general, involved sufficiently in this agenda, and what more might they do?

Jeanelle de Gruchy: There is always more we can do. It is a real shame that the healthy schools programme went, leaving the much more variable ad hoc way that schools have approached a whole-school environment in terms of healthy weight and food and physical activity. We would like to see a healthy weight environment in schools coming into the Ofsted framework so that when schools are inspected that is something they absolutely want to know about. How is this school promoting healthy living for the children? I know Alison said there have been changes. I would probably be a little bit less positive about that. It is extremely variable across the country and there is a huge amount more we can do, but I do agree with her point that it is before children get to school, both in terms of their age but also in the mornings on the way, eating fast food on the way to school and so on, and then after school when they come back eating fast food or sugary drinks or whatever, and then coming home to the meals at home.

Professor Capewell: I would echo all of those statements and point out that, at the moment, guidance on healthy food—lunches, for instance—only applies to state schools. It does not apply to academies. Why on earth not? This is putting on a huge pressure, making a big assumption about parental responsibility, and surely parental responsibility should be reinforced and supported for the children who go to academies as well as to other schools.

Dr Michie: Alongside that, there is not a requirement for everyone in all schools, particularly academy schools, to have a PHSE session for their children, and that is crucial in order to teach people about their health and healthy eating in secondary school. Although the obesity rate goes up a lot in primary schools, it is also increasing in secondary schools; so we need to be able to have some national recommendation on PHSE in all schools.

Q182 Dr Davies: Is it felt that the school food standards, where they apply, have been successful or are sufficiently stringent?

Jeanelle de Gruchy: I am not sure I can comment on that.

Professor Capewell: They were recently relaxed. I think most people in the public health community regret that they were relaxed.

Dr Davies: Okay.

Q183 Chair: Can I follow on from that with a point that Jamie Oliver made yesterday about the fact that school foods standards do not apply to lunch boxes? Therefore, it is very difficult for teachers to say, "That is inappropriate to have." Do you feel, in addition to saying that it should apply to academies, that it should cover the other foods that are supplied to the children?

Professor Capewell: Absolutely. Clearly, there are ways of doing this. It is a learning opportunity. It could be integrated into lessons. There could be discussions in class. Rather than a Draconian "This school does not accept cheese burgers coming through the gates" that gets into the tabloids, it could be turned into a very positive development for the children as part of a broader and deeper education in health and nutrition.

Jeanelle de Gruchy: I totally agree with that. We have seen in London, where we have a very good healthy schools London programme—we have about 1,600 of the schools signed up to that—that the school takes responsibility for its food policy, and that will include the lunch-box policies, what kind of break-time snacks the children have and so on. Also, if the school sees that healthy eating and being physically active improves not only the emotional well-being of the child but also the educational attainment, which it does, then they have a vested interest in it. Putting time into, say, the midday supervisors and training them so that they get children more physically active would also help in terms of what they are bringing into school in their packed lunches.

Q184 Chair: When you say "help", do you mean they have an ability to send a note back home to say, "Please don't supply this in your child's lunch box"? How does that operate?

Jeanelle de Gruchy: It is probably quite variable in how it is implemented, depending on the schools, but some do, although certainly not all of them.

Chair: Thank you.

Dr Michie: It is a really important issue, but the only problem is that sometimes it causes quite a lot of friction and it comes down to the observation that has been made today that overweight and obese children very often have overweight and obese parents who do not necessarily know what to put in the lunch boxes. One has to do it sensitively, as Simon has said, but it is not always easy.

Q185 Chair: You would support it being a voluntary—
Dr Michie: Yes, I think it is a voluntary thing, but it is an important educational step for a family and it really takes someone like Jamie Oliver to do that in a way that would not get everyone frightfully embarrassed and fighting with the teachers, which is not what we want to start.

Q186 Chair: But he was very clear that he felt it was an impediment that there were not standards. Would you agree with him?
Dr Michie: There are not and there should be.

Professor Capewell: Yes, we would agree, particularly because it takes the onus off the teachers. Teachers are busy people and they want to build relationships with parents. They do not want to be pointing the finger in a Victorian fashion. If there are national guidelines and there is strong messaging coming out from Public Health England and other respectable sources saying, "This is what a healthy lunch box looks like; this is what an unhealthy lunch box looks like, and it is promoting a risk of obesity and future ill health in a child. Would you like to think again?", that will save an awful lot of teachers' time and stress, and of course it will be a much more powerful comprehensive strategy.

Q187 Chair: So an eatwell plate and an eatwell lunch box—
Dr Michie: Absolutely. One of the charities that does eatwell plates has tried to do a lunch box but they could never float it; it did not get funding to support it. But there is an eatwell lunch box plan already drawn up.

Chair: Thank you. I am now going to come on to the child measurement programme.

Q188 Dr Whitford: If I could start with Dr Michie, what do you think the impact has been of the national child measurement programme?
Dr Michie: It has been critical because it has outlined the size of the problem we face. It is very limited—it is two time points—but it has shown that there is a big problem with children when they are coming into reception at school. Twice as many as one expected are obese. By the time they have got to the end of their primary school the problem has got worse, and, over time, this has not really changed except to get mildly worse. We do have a big problem. It indicates, crucially, how big a problem we have in front of us and what we need to do to sort it out. There are problems with it in that it only starts off at the

beginning of primary school. Crucially, you would like to know what two or three-year-olds are doing because a lot of infant feeding probably contributes to this. Indeed, a mother's health during pregnancy probably contributes a lot in many cases to the development of obesity, but we do not really have good national data on that. Whereas we have wonderful data for what is happening in primary school, we could do exactly the same if it were extended. The IT is here, the GP link-ups are there, and we could do this and extend it a little bit. We could do more measurements later on to look at secondary school likewise, but it is a crucial instrument and it is very high-quality data. This has a very high take-up rate and is terribly useful.

Q189 Dr Whitford: I was going to come on to how you think it needs to be improved and you have already touched on that. Obviously babies are measured right at the start, so is it around two or three? How would you go about it—linking it with one of their vaccinations?

Dr Michie: Yes; at two or three is quite an opportune point at which to check on development and measurement. I gather my colleagues in the Royal College of General Practitioners are quite interested in that. We do have an issue—and there is another reason for giving that age—in that we do not have BMI charts for anybody under two—BMI starts at two—partly because body composition is changing quite significantly and quickly. Because of the population scatter, it might not be a good idea to do BMI any younger than that, but certainly starting at two we do have good population data that would allow you to make some reasonable conclusions on their nutritional state at that point.

Q190 Dr Whitford: I do not know whether you would want to add anything.

Professor Capewell: The programme is absolutely essential. We are talking about all sorts of fundamental interventions here. We need to gauge the effect. We need to gauge the effect quickly. The advantage of focusing on children is that we will see benefits very rapidly, particularly if, as Colin says, we are measuring at three. We heard before coffee about the life course analysis—pre-pregnancy, pregnancy, early life and the first 1,000 days. Effective interventions will reduce obesity in children over a couple of years very quickly. The programme is absolutely essential, both to measure the scale of the burden and to assess and evaluate those interventions rapidly.

Jeanelle de Gruchy: Yes, it has been critical and certainly I am sure has supported this work today in terms of what is happening in those two groups, who represent, in a way, a population of children. It absolutely needs to continue, it is mandated and we at local authority level fund it and make sure it happens, is done properly and has that quality and high uptake by the schools. I would be quite hesitant, though, about extending that. I do not know if that is what you were asking.

Q191 Dr Whitford: I am just asking how you think because your suggestion was extending it—

Jeanelle de Gruchy: Just as a survey, it provides us with the information with which to look at policy both nationally and locally. Certainly we absolutely use it locally with local politicians. It is really important in galvanising action and support locally. Whether adding

another year here or there will make any material difference in that task, I am not sure. I would have to—

Q192 Dr Whitford: Do you not think, if you are trying in the coming decades to see what works, that you need a little bit of linear information rather than just a time point? If we are intervening in primary school but actually we do not know what is happening to the children when they are 15, we do not know whether what we did worked. I would have thought that you do need a little bit of linear extension at both ends.

Jeanelle de Gruchy: Obviously there are different cohorts going through, so you will start to see the cohort that is measured at reception year coming through to year 6. So you do have some trend with the different cohorts that come through. You will see over time the different cohorts. I suppose it is just that, when we are looking at our budgets locally, does the benefit of knowing that bit extra justify the money that we would have to put in, which we would have to take from somewhere else? We need to be assured of that.

Q193 Dr Whitford: Particularly for girls, often their weight starts to change in their teenage years. That is why I was talking about trying to link it to something else. If you are vaccinating the child, is it a big deal to weigh them, whereas when you are doing it as an individual thing I realise that is quite a big commitment?

Professor Capewell: It is worth mentioning that the Health Survey for England does do young people, but it starts with adult life. These are random surveys that are representative of the wider population. One of the potential criticisms of the existing programme is that it is 100%. Does it need to be? No. So long as it is representative, you will probably still get value for money.

The other thing that Jeanelle and I discussed was the precarious nature of the programme in some local authorities because it is supported by school nurses. Local authorities are being exposed to extreme cuts—40% last year. The Chancellor has proposed that another £200 million is taken away from local authority public health budgets this year. That is clearly a false economy. It is going to cause all sorts of additional burdens for the national health service and, in addition, if school nurses are taken away from some local authorities that will just demolish the measurement programme at a stroke.

Q194 Dr Whitford: I totally take the point that if you are looking at it epidemiologically you do not need to get all the children, but if you are trying to do it as an intervention on those children then you do, and that brings us to the next question as to what you do with it. You touched on speaking to parents, but if you are identifying in reception that you have a child who is overweight or on the way to obesity what do you currently do with that?

Professor Capewell: If you do a national programme, then a representative national survey will show you whether those interventions are working. You do not have to measure all the children.

Q195 Dr Whitford: From an epidemiological point of view, I am talking about the individual child, spotting that wee Johnnie is way above the line and are we speaking to wee Johnnie's parents?

Dr Michie: That is the elephant in the room, if we can shine a light on him, and, as Susan Jebb said this morning, the whole problem is that there are no treatments coupled or linked to the NCMP. Basically, we find out about children, but quite often the parents do not get the measurements or the interpretation of them back, and, if they do, in the vast majority of cases there is no treatment or treatment plan, or even advice to provide, that goes with that. It is a stand-alone system that is very helpful epidemiologically, but from a clinical perspective it is not very helpful at all. What you have just alluded to is exactly what we would like to have so that a GP or a parent who has a little Johnnie whose BMI is too high at three, four, five or 10 knows what to do and can refer them in to do something appropriate. Right now there is a disjunction, mostly because of cuts in funding as there are not many local services for obese and overweight children that link with the measurement programme.

Q196 Dr Whitford: It was always envisaged more as a survey rather than a tool for individuals.

Dr Michie: Yes.

Q197 Dr Whitford: It is also a difficult conversation. You were talking about the lunch boxes, but equally that conversation with parents, who, as you say, may be overweight themselves, is not an easy conversation either.

Professor Capewell: One point worth emphasising from before the coffee break is that we are stuck with treatments. Treatments are not very effective. Very few obese children will turn into adults of normal weight, and that is with the best will in the world and the best clinical care—and it is expensive. The idea of prevention, of structural change that creates the healthy environment so that children never get overweight in the first place, is immensely more attractive and it is cost saving—substantially cost saving. That is an important point to make. This is very much first aid; it is accident and emergency services dealing with a disaster that should not really have happened in the first place.

Q198 Dr Whitford: That is to try and change things for the future, but it still leaves us with 70 years-worth of people who have finished primary school, so we maybe cannot afford to wait all that length of time.

Professor Capewell: That is true, but Susan Jebb's systematic reviews have demonstrated that, even in adults, the weight loss programmes are frustratingly weak in effect, that the adults in the best RCTs will lose 4 kg or 5 kg, but, after the intervention stops, if you follow them later—as most people in this room will know if they have tried dieting—it creeps back. We really have to put more emphasis on prevention and take the scales from our eyes in terms of weight-loss management. It is really a weight-loss industry.

Q199 Dr Whitford: The Prime Minister has focused on the BMI within the primary school years and we have touched on whether we should be looking at younger and older. Do

you think that that is something that would be helpful? Your comment was more just to stick with primary school.

Jeanelle de Gruchy: Are you talking about the NCMP?

Q200 Dr Whitford: No. He has said that, generally, we have to change the BMI of primary school children. In the previous panel we were talking about 10% of kids actually arriving at school with a problem, and then, as I commented, often it would evolve later.

Jeanelle de Gruchy: We have to take a comprehensive approach. Focusing on children is absolutely right because we need to protect children and their health. The way in which we do that is by looking across the life course. Overweight or obesity in pregnant women, which is becoming an increasingly big problem, means their infant is more likely to be overweight themselves. Breastfeeding is absolutely critical in terms of a healthy weight later and then it starts from there. However, I have already mentioned the mother. It is already the parents; it is the family and the family context. I suppose when Alison and Susan were talking they were talking about the family, the family home, the family food, who does the shopping, who does the cooking or whether they all go out together. That is an important concept. Certainly children at the younger age are very dependent on parents and family. The problem we have with young people is, of course, that off they go and can access fast foods quite easily without any parental guidance. As they get older, the issue becomes how those children can access extra cheap calories elsewhere.

Dr Michie: There are many interventions that are coming up to deal with pregnancy and the first few years of life—the first 1,000 days. There is a lovely one at King's called UPBEAT, for their pregnant mums. They have developed a programme to help them lose weight. It is effective. It works very well at that point and, in terms of life span, might really influence things. If we had an earlier measuring point at two or three years, we would be able to measure those interventions and their effects, but right now we are a little in the dark and reliant on individual studies because of that.

Professor Capewell: We also have to recognise that, in responding to your question, there is the issue of scientific evidence about what works and there is the issue about practical politics. Jamie Oliver emphasised yesterday that we have a duty of care to our children and this is the message that we think Mr Hunt and Mr Cameron will be able to sell to colleagues in Parliament and the wider country. There will be a push back about the nanny state, but let's get real. The nanny state means that drinking water is safe and that we are sitting in a room that is not full of cigarette smoke. I could go on and on. We are alive today and our families are healthy because of the nanny state, so let's do the appropriate thing to the proportionate scale, as Malcolm Clark was emphasising.

Dr Whitford: Thank you very much.

Q201 Chair: Before we move on to our final group of questions, can we follow on from Philippa's to draw on the health inequality aspects that have been identified by the child measurement programme with the very large differences between the lowest 10% and highest 10% in advantage terms? Would you like to see greater focus within the child measurement programme in high-risk areas? Given that it cannot be afforded everywhere, would you like to see—

Jeanelle de Gruchy: The child measurement programme is everywhere.

Q202 Chair: What I mean is this. You were saying that it is difficult to fund an increase in the number of measurements taken. If you know you have, for example, a school that has a higher prevalence of obesity, do you think you could argue that you could do more measurements within certain communities that are going to be at a higher risk or not?

Jeanelle de Gruchy: No. We would probably go for an all-school approach. In some of our schools 60% of the children are overweight and obese in the two bands that we measure. So I suppose you make the assumption—

Q203 Chair: No, I am not suggesting that you would target certain individuals within a school, because clearly that might feel stigmatising, but if you know within a local authority area that you have some schools that have a higher prevalence overall, do you think there would be a case for saying that you can look more intensively at some communities if resources are short?

Jeanelle de Gruchy: Yes. We have the data from the child measurement programme and some schools, as I say, have very high levels and others have lower, so the amount of energy and effort you can put into supporting those schools or advocating that they have a healthy whole-school approach, whatever that might be, is variable across the country. It is about looking at the whole environment and working with those schools, but in some of those areas we have very high levels of fast-food takeaways or a lack of play areas or green spaces. You can target areas and look at the kinds of environment that are creating a lot of the overweight and obesity, and make big changes there. We can target in that way. In areas where there is a lot of regeneration work going on, absolutely we have to get walking and cycling and the place shaping done more in a healthy way.

Q204 Chair: In other words, you would see more focus on the response than the amount of monitoring you do. That is my question.

Jeanelle de Gruchy: If I am looking at the limited resources of my team, which it often comes down to, I would rather they were out and doing that than doing another year's survey.

Chair: Thank you; that was my question.

Q205 Maggie Throup: You have touched already in some of your responses on the role of local authorities with the responsibility of public health being transferred to local authorities. I want to explore that a bit further and your views on the role of local authorities in tackling childhood obesity. I want to know—and probably both questions are targeted at yourself, Dr de Gruchy, but I would like the others to input as well—how local authorities are spearheading efforts to tackle childhood obesity at the local level.

Jeanelle de Gruchy: I have spoken a bit about that and my last answer probably covered some of it. They are doing that by influencing the places where people, where children, live, so walking and cycling, planning around fast-food takeaways, 20 mph speed limits and looking at play areas and green spaces. There is a lot that local authorities do to influence in terms of those. I could speak to each of them, but certainly there would need to be quite a lot of intensive local work, officer time and local councillors' time, going into each little positive improvement in those things. Take the 20 mph: that takes quite a lot of

time, energy and effort to implement in a local area. It is the same with walking and cycling schemes.

As to planning, we are having to put a lot of energy and effort into that. There are a lot of steps one has to go through to try and limit the proliferation of hot-food takeaways in a local area. We have to put things into planning documents. I will not go into all the detail, but it takes a lot of processes and steps and you do have representation. Last week we tried to do that in my borough. We had representations from KFC and McDonald's, a lot of very legalistic documents that need officer time at a local level to address. As to the evidence base, as we have heard this morning, it is quite tricky to prove if a hot-food takeaway is directly linked to childhood obesity and so on. If the legislation was done differently at a national level it would make it a lot easier for us at a local level to try and address some of these issues, such as a proliferation of hot-food takeaways. I am happy to provide more information on that.

There are quite a lot of things where national legislation is very helpful, but it is also about how it gets implemented and, looking at some of the challenges that we face locally, how we could make it more effective and make it more effective across the country. So it is this variability.

Q206 Maggie Throup: Do you have some examples where local authorities are doing it really well and other local authorities could learn from those?

Jeanelle de Gruchy: Yes, absolutely. There are a lot of examples where they are doing well. The important thing in a local authority is its local system leadership. It is championing a lot of partners to try and address obesity in the different ways that I have mentioned such as the design of environments and how developments can happen. Certainly in the east of London, with the growth boroughs around the Olympic bid, there was a lot of work and effort put into those areas so that you have play areas, walking, cycling and those kinds of things. You can also influence where staircases are sited in a building—they are small things, but massively important—and whether people use the staircase or whether there are lifts. Our planners and people working in regeneration will be influencing all of that design.

Then there is the food environment. There is system leadership at a local level. We also are working with our schools, with the hospitals, the hospital trusts and the GPs. There is a lot that still happens in a hospital trust environment that you would want to question such as the vending machines and the kinds of foods available. It is just remarkable that you still have those. It is a bit like selling cigarettes in the past. As you go into hospitals, you can buy chocolates and crisps and all of that. With our leisure centres, we are trying again to influence the offer, such as vending machines.

Q207 Maggie Throup: Do you think the local authorities are taking all this on board?

Jeanelle de Gruchy: Absolutely, increasingly they are, and certainly now with having the responsibility for public health. I have seen a change in the last few years. It has helped that the childhood obesity agenda has gone up nationally. But at a local level childhood obesity is now much more a priority in the health and wellbeing strategies, certainly in ours. You will find that across the country health and wellbeing boards are providing that

local leadership to ask what we are going to do about the rise of childhood obesity in our local populations, because, of course, they have the data from the national child measurement programme for their own populations in schools.

The problem we are coming into now is a reduction in funds and funding. We do not have a lot of money in public health, certainly. I have noted that there is money across local government in these other areas, but generally, at a local level, trying to address obesity is led by public health teams with the director of public health sitting in the team. So it is about how we galvanise that money and bring it together.

Q208 Maggie Throup: It is more than just a pot for public health.

Jeanelle de Gruchy: If you look at our budgets, there is no big pot that says "obesity" in the way there is for sexual health and drugs. There is not. It is a very small amount of money so it is about influencing and implementing what is done nationally, making sure it happens locally. It is about providing that system leadership, making the join-up. We need people to do that. The in-year public health cut of £200 million has impacted badly in terms of that. I would be quite concerned that people are talking about school nurses and weight management programmes going. We do not have that in my borough. Again, that would be variable across the country. There is some great innovative work happening on that front, but that is all in jeopardy now.

Q209 Maggie Throup: Do you think there should be a pot labelled "tackling obesity" as there is for sexual health?

Jeanelle de Gruchy: Do you mean new money?

Q210 Maggie Throup: I am not saying that—just a pot.

Jeanelle de Gruchy: If it was new money. I think nationally and locally there is money in the system that could be joined up. I mentioned some of the departments that do do work that influences the environment. Could that money be put together? We have mentioned the rise of sponsorship of physical activity by certain companies. They all want their branding on it and actually could, conversely, be fuelling childhood obesity, could they not? If they are concerned about the health of our children, could they be putting that money into a blind pot? Why is there sponsorship attached to that? Are there other ways? What would we do with the money? I think some of it is really about leadership and having the capacity to do that, but if you take even that one example I gave you about planning and the fast food, that is a member of my team having to work with the planning officers. That post is jeopardised, so it really does come down to that at a local level; we are really trying to influence. If there was more ability at a national level to join that up but also locally to have the capacity to do some of this work, that would be great.

Q211 Maggie Throup: You talk about building in the systems to stop fast foods being placed near schools. What can be done retrospectively, because there is an awful lot there already?

Jeanelle de Gruchy: Do you mean the fast-food takeaways?

Maggie Throup: Yes.

Jeanelle de Gruchy: You talked earlier about national reformulation and at a local level we are working with businesses—a lot of them are just family-run businesses—to make their offer healthier: not healthy but healthier. There is quite a lot that you can do with fast-food takeaways to make them healthier. It is not without its challenge, but a lot of those local-level owners are happy to have the conversation to look at ways that they can tweak things to not put so much salt on, to not put a lot of sauces on, to use different chip oils and to use thicker chips rather than thinner ones. There are things that they can do. When you think of how many of our young people or families eat fast food, small changes can make quite a big difference. We are also doing that kind of work with the local businesses—that is quite important—with those that are already there, but there are just too many and too many near our schools.

Q212 Chair: Thank you. Finally, would you like to see a change in the legislation so that you can have health as a consideration in planning?

Jeanelle de Gruchy: Yes, we would, very much.

Chair: Thank you. Unfortunately, we have run out of time. We could have carried on a lot longer—I am conscious of that—but thank you very much for your time today. I appreciate you coming to give evidence.