HOUSE OF COMMONS

Health Committee

Oral evidence: Impact of physical activity and diet on health, HC 845

Tuesday 3 February 2015

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Written evidence from witnesses:

- NICE
- Prof. Susan Jebb OBE (Univ. of Oxford)
- Which?
- Professor Nick Wareham
- Professor Nick Wareham – further evidence
- Ukactive
- UK Health Forum
- British Heart Foundation

Watch the meeting

Members present: Dr Sarah Wollaston (Chair), Andrew George, Robert Jenrick, Barbara Keeley
Charlotte Leslie, Grahame M. Morris, David Tredinnick, Valerie Vaz

Questions 1-145

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

Q1 Chair: Good afternoon. Thank you very much for coming. For those following this debate outside the room, could you introduce yourselves, perhaps starting with Professor Jebb?

Professor Jebb: Hello. I am Susan Jebb, professor of diet and population health at the University of Oxford. I also chair the public health Responsibility Deal food network.

Professor Leng: I am Gillian Leng, deputy chief executive at NICE and director of health and social care, which now includes the public health function that Mike Kelly has retired from.

Professor Wareham: I am Nick Wareham. I am director of the MRC's epidemiology unit and the UKCRC Centre for Diet and Activity Research at the University of Cambridge.

Q2 Chair: Thank you for coming. This is our first session on the impact of diet and physical activity on health. Perhaps I could start with you, Professor Leng. Drawing on the body of guidance that NICE has produced, we are interested to know what you think are going to be the most effective measures we should be recommending to our successor Parliament—and what we should be focusing on not only for Parliament, but for local authorities and individuals—for both obesity and physical activity. Perhaps you could set out what would be on your key wish list.

Professor Leng: There are a number of points in response to that. First, we have set out already a number of pieces of guidance that cover obesity and physical activity, and shortly we will be producing quality standards for those topic areas that will very much highlight the key areas of activity. One thing that I would like to leave you with is the impact that we might have from using the quality standards, because they provide a measurable way of tracking progress.

In terms of what we have set out, there is sadly no easy answer. For any sort of behaviour change across a population, you need to have a wide-ranging strategy that draws on a range of different initiatives and is tailored to the population. That also includes things that you might do at a national level, things that we would then advise local government to do and others working at an organisational level, as well as things the individual might do. That is a very long answer without giving you a single initiative because you need to have a range of things. One of my favourite quotes is, "Change is not made without inconvenience, even from worse to better." That is very much the situation with a population that is growing—literally growing—in terms of the levels of obesity.

We have set out in the guidance, in particular, things that we know are effective in terms of slimming programmes, and Susan can elaborate on that more than I can. We have set out initiatives that encourage physical activity that you might want local government to do, that make it easier for people to take exercise and for children to exercise at school. There is a range of things. I have not been responsible for our public health programme for that long, but I have been responsible for NICE's implementation programme for many years. The thinking around the mechanisms that you might use to trigger changes in behaviour is something that we might want to reflect on. The levers to encourage change at organisational level, particularly the sorts of things that we might want local government to do, are really important.

Q3 Chair: How far do you think there is a problem of all parts of the system not working together? Do you think that is an issue that needs to be addressed?

Professor Leng: Absolutely. It is difficult to change behaviour. If you do not have all the various systems driving in the same direction, that can be a barrier to change. In my own way of thinking about the approach that NICE has used around implementation, there are three things. The first is knowing what needs to change; raising awareness with individuals might be an example of that.

Then you need to make it easy for people. What sort of support can you provide to help people develop what they need to do to change? That might be making it easy for an individual to cycle to work, or it might be providing local government, as we do, with advice on the return on investment to make it easy to work out what they are going to save.

The third strand is motivation. What are the incentives in all this? Some of us are motivated much more readily by just being provided with the information, and for others it might be peer pressure or money. But it is about working out, through all those factors, what is going to drive change across a whole population, and that means you need to have that systematic, multi-factored approach.

Q4 Chair: One thing that has been highlighted by the National Audit Office is the variation in the amount that local authorities—one key part of the system for public health—are spending in focusing on this. Do you think that is an issue—that there is variation in how much is being done within different local authorities?

Professor Leng: Possibly. Without knowing the detail of the challenges that those local authorities are facing, it is hard to know whether there is a definite correlation with the spend, because part of the strategy for changing the population is tailoring it to your local population. In some areas, I suspect—not I suspect; we all know, don't we?—that the challenges are bigger than others. So there is no straightforward answer.

Q5 Chair: Before I move on, I would be interested to hear from each member of the panel—absolutely accepting that there is no magic bullet here and that there are many things that need to change across the whole system—the points from which you feel we would get the greatest gain. In terms of obesity, and separately from physical activity, could you say what your key asks would be? Perhaps, Professor Jebb, we could start with you.

Professor Jebb: You have to think about prevention and treatment as slightly separate things. They are absolutely two sides of the same coin and one will benefit the other, but what needs to be done is different in those two areas.

In relation to treatment, we have quite a lot of evidence about what works, and we are simply not investing, incentivising and activating the system to deliver that. That is a question of getting on and doing it—resourcing health service delivery systems. In particular, we hear a lot about bariatric surgery. There is definitely a place for that—it is not suitable for everybody—but it is not the whole of obesity treatment. We are failing to roll out much cheaper services that can be done at the kind of scale that might start delivering a public health impact. But that is only part of it.

The other side is absolutely prevention, recognising that if we take action to improve the quality of the diet and reduce excess calorie intake, as well as getting people to be more physically active, we will help to prevent not only obesity, but a whole raft of other diseases. I am really encouraged that the Committee are thinking of those things as underpinning behaviours that are going to have widespread health outcomes.

We have done a lot to motivate and make people aware of the issue. It is important that that continues, but it is probably not where I would put the issue. With the Responsibility Deal, we are doing some things to change the products—a lot of work on reformulation and portion size. There is more to do, but that ball is rolling.

Where we are absolutely not taking any action at the moment—and this is crucial—is on the sheer availability of food and the prompts, primes and cues to eat. It is astonishing. They are absolutely everywhere. It is so important, and the reason I am putting such emphasis on it today is this particular audience. It will take very clear-sighted political leadership to address such an issue as the sheer availability of food. I am a nutrition scientist, so I will stick to a food example and leave physical activity to Nick.

Chair: Thank you.

Professor Wareham: Following on from what Susan has said, my key message for the Committee, as you embark on this journey of accumulating evidence, is to think about the nature of the evidence in relation to different challenges in individual approaches to prevention and ones that are collective. The individual approaches to prevention are amenable to evaluation by trials, and we have very strong evidence of what does and does not work, but at the other extreme, when we think about interventions that, as Susan says, might have really big impacts on how we eat and how physically active we are, it is very difficult ever to countenance randomised control trials of such things. The evidence you might hear at that end, if we took a very naive view about the hierarchy of evidence, is likely to be considered to be less, but it is actually as good as we can get. We need to put in place not only systems that allow us to act on that evidence, such as it is, but proper evaluations of policies and changes as they occur, either by design or naturally in the form of natural experiments.

Professor Leng: Reflecting on what I was saying before, the key point is not a recommendation that you will find specifically in NICE guidance, but it draws on that. It is the "make it easy" bit. It is difficult to change behaviour, so everything we do has to make it easy to exercise—whether that is in public places, and there is NICE guidance on that, such as accessing buildings, using stairs rather than lifts, or encouraging people to walk to school—and easy to access healthy food and smaller portions. I agree with Susan that we live in an environment where calorific food is readily available in most places. You notice the difference when you go to France, where it is not like that. So make it easy not to eat large portions.

Chair: Thank you. Over to Barbara.

Q6 Barbara Keeley: Physical activity can be overshadowed by the debate around diet and obesity. I understand that research has been published—it has been widely

reported—suggesting that physical inactivity may in fact be more harmful to health than obesity. There are two questions on this. First, is that an accurate reading? Is that the case?

Professor Wareham: I think that you are alluding to our paper that came out a week or two ago, which studied nearly a third of a million people in Europe and quantified the impact on all-cause mortality of participation in different levels of physical activity. About 23% of people in that study—and there was a large group of people in that study from the United Kingdom—were in the category of being totally inactive; they had a sedentary job and did no recreational physical activity at all. That group had the highest mortality risk. If you look at the difference between that group and the moderately inactive, there was about a 20% reduction in mortality risk. Switching from being totally inactive to moderately inactive would require the equivalent of walking 20 minutes extra per day, which is a totally feasible public health transition. We estimated that, if everybody who was in that totally inactive category could move up to the next category, the impact on mortality would be of the order of 7%. That was greater than the impact of the avoidance of obesity. The important thing for the Committee is that that impact of physical activity was independent of obesity. So within the strata of whether someone is obese, overweight or a normal weight, the effect of physical activity was the same. While obesity is tremendously important and a very important public health problem that we need to deal with, we need to think of the behaviours, as Susan said, as independent and important factors that we need to worry about and try to change. It is very good that the Committee is focusing on physical activity and diet. Obesity is obviously important, but it is not the only issue.

Q7 Barbara Keeley: Are there any further comments?

Professor Jebb: Let me say one general thing. When we are thinking about dietary interventions, it is really important to remember that it is not just about obesity. There is a whole mass of public health policy around diet on issues that are quite separate from obesity. We know from the Global Burden of Disease studies that dietary risk factors are the single biggest risk in terms of disability-adjusted life years. But that is way beyond just obesity. As with physical activity, improving diet benefits a whole range of things, including obesity.

We need to take action on all these fronts. If we start saying, "Is it one or the other?", we tie one hand behind our back. Coming back to the earlier comment on what we should do, sometimes I think that we should just focus on doing the doable things. There are lots of things that are really hard, so let us just start by doing the obvious—doing the doable—and then we will progress up. Some of those relate to physical activity and some relate to diet. I hate it when we get into a competition between the two. We should all be recognising that they have independent health effects and that, together, they will help prevent obesity.

When it comes to treating obesity, in terms of actual weight loss it is clear that dietary control or restriction is the single most important thing to do. But losing weight is just the first step in a long-term journey of weight management, and we know that for keeping the weight off physical activity becomes incredibly important. Why do we want people to lose weight? I don't worry what people look like; I worry about their health. I want people to lose weight because losing weight improves their health and—surprise, surprise—physical activity improves their health too. So they all have—

Q8 Barbara Keeley: Yes, but it sounds as if physical activity—

Professor Jebb: —to be part of the same thing. The fortunate thing is that the messages are not different. To prevent obesity and a whole raft of other ill health, be more active. To reduce the risk of obesity, eat less saturated fat, less sugar, less energy-dense and less calorific food. So let us just get on and take action and not divvy it up between us.

Q9 Barbara Keeley: I think there is a difference, though. We might move on to talk later about the difference between men and women as far as this is concerned, but there are real substantial barriers that prevent some people taking exercise, and being big is one of them. It is very important that a message goes out—if it is the right message—that it is important to do exercise whatever size you are and that—

Professor Jebb: I completely agree.

Q10 Barbara Keeley: —it does not matter if you are big. That in itself is a barrier because, of course, people suffer—or worry about suffering—abuse if they are taking exercise and they are bigger. It is currently the subject of a marketing campaign by Sport England to try to get girls and women used to the notion that, however big they are, they can get out there and exercise. But separating them is quite important because you might be more successful with the diet, possibly, if you got people active to start with and starting to think of themselves in a different way; as someone who does take exercise, is not sedentary and, whatever they look like in Lycra, is going to get out there and do something.

Professor Jebb: Separate them, absolutely, because the way you get people to do these things may be different. Some elements are the same because some principles of behaviour change cut across. At one level of course, yes, separate them, but let's not lose sight of the fact that changing both those behaviours is about improving health, and in the end we need a very holistic approach to it.

Q11 Barbara Keeley: The second point, which I think you have already mentioned, is that physical activity has a large range of health benefits, whatever a person's weight. It may not be the best thing for weight loss, but it does have separate health benefits. I want to come back to Professor Wareham and ask this. The figures you gave from your study do seem astonishing. In many ways we ought to be recommending physical activity as a medicine, ought we not, given the reductions in mortality you talked about?

Professor Wareham: As medicine and as public health, it is very important that we are talking about physical activity, of which exercise and sport are a subset, and a subset for some people. We also have to remember that physical activity is the totality of what we do. For people for whom sports and exercise may be not their thing, there is active travel. There are many opportunities in life to re-engineer physical activity back into our lives. One of the characteristics of the past 50 years is that physical activity has been engineered out of our everyday existence.

Barbara Keeley: That is probably important for us, given our hugely sedentary occupation.

Chair: Thank you.

Q12 Robert Jenrick: I want to ask you about your opinion and expertise on the trends in physical activity levels. We have had conflicting evidence. Public Health England has told us that the percentage of adults achieving the recommended levels of physical activity has increased over the past 15 years—it gave us figures of as much as 43% for men and 32% for women. But in written evidence we have heard that the figures could be as low as 6% for men and 4% for woman. What does your experience tell you about levels of activity?

Professor Wareham: Maybe I should answer that one. Physical activity is an extremely difficult thing to measure, particularly with questionnaires. With questionnaires, we are very good at quantifying the things we do regularly that have a beginning and an end and that we maybe use special equipment for. Physical activity questionnaires work very well for sport, but they do not capture the totality of activity in our everyday lives. To do that, one needs objective ways of measuring physical activity, be that accelerometry or other methods. The figures you were alluding to—6% and 4%—are from studies that used the more objective ways of measuring physical activity.

Q13 Robert Jenrick: That is right.

Professor Wareham: I don't think that there is controversy between what Public Health England has said and that other evidence; it is just that they are talking about different things.

Q14 Robert Jenrick: Are you saying that the accelerometry, for example, is the objective figure that we should all be referring to?

Professor Wareham: Yes.

Q15 Robert Jenrick: The Public Health England figures are pretty misleading for lay persons, such as myself, if we are talking about as little as 6% or 4% of the public reaching recommended levels.

Professor Wareham: That is recommended levels of participation in circumscribed recreational activity, but it is possible to accumulate beneficial physical activity in small bouts which may not be easily quantifiable by those methods. People can get a lot of health benefits from parking their car a little bit further away from where they are going, and from using the stairs rather than the lift. All that sort of activity is very difficult to capture in physical activity questionnaires.

Professor Leng: There is some general evidence that shows that people set a pattern of physical activity in their late teens and early 20s, and that tends to stay with them. One of the pieces of guidance we will shortly issue is very much about triggering a change in that

behaviour in your 50s, because we know that if you can make a change in mid-life it does impact on your health. As you grow older, it impacts on your risk of dementia and so on. I do not want to argue with Nick, because it clearly is difficult to measure time trends, but in general we know that people do have fixed patterns and that they need a bit of a kick-start to change that as they get into adulthood.

Q16 Robert Jenrick: Just to tackle it, there are two different sets of figures: one is very objective and is primarily about participating in active sports, for example; and the other might encompass everything that one does in life, such as walking upstairs and so on. What is your view on the trends? Public Health England's figures suggest that activity is improving, potentially quite significantly. Is that your view?

Professor Wareham: If you take a longer time trajectory, going back over maybe 50 years or so, time-use trends suggest that the major declines in physical activity in everyday lives happened well in the past and were due to alterations in work, where people would previously have expended a lot of energy, and then in travel. Over the past 20 or so years things have been relatively stable. The danger is that we may be arguing about small fluctuations in a very low base rate of physical activity without stepping back and saying, "How are we compared with how we used to be, and how are we compared with other places?" I am not sure how fruitful it is to think about short-term time trends without taking a step back and seeing the bigger picture.

Q17 Robert Jenrick: Professor Jebb, what dataset would you use if you had to point the Committee towards one? What is the most useful?

Professor Jebb: For physical activity, I defer to Nick, but I would say that we are all agreed that people are less active than is good for their health. I am much less interested in measuring it than I am in trying to encourage people to be more physically active.

Q18 Robert Jenrick: Understood. We talked earlier—my colleague Barbara Keeley mentioned this—about the difference between men and women, and young boys and girls. What is your impression of the trends there and the explanation that might be behind them?

Professor Jebb: I honestly think that Nick is going to give you much more detailed information on physical activity than me.

Professor Wareham: One of the important things to worry about is that as we look at the transition from childhood through to adolescence and into adulthood we see a major decline in physical activity. It is particularly pronounced in girls.

Q19 Robert Jenrick: Why is that?

Professor Wareham: I don't think we really know. Probably, to some extent, a decline in physical activity as children get a little bit older is a natural thing, but the question is whether we can do anything to alleviate the reduction that we see in girls. Can we explain it? The natural assumption is to think that it is all about what goes on in school, about PE and the school environment, but much of that decline is actually happening out of school

hours and at weekends. One has to worry about girls' participation in active sports, the wider environment that our children live in and the extent to which we are permissive of them being free and active in the environments around their homes in a way that maybe we were when we grew up as children. Also, there is some evidence that a permissive environment, plus strong family support, does predict whether children are active and mitigates that risk. We need to look at the totality of the issue.

Q20 Barbara Keeley: Other organisations do think they understand why girls and women do not take part in sport. There are a number of reasons. It has tended to be things like too much concern about appearance, lack of confidence, body image and that kind of thing, but I am sure that it ties in with the points you have made about strong family support, because strong family support would overcome that, would it not? If parents were doing a lot themselves and encouraging you to do a lot, then you might not worry so much about what you looked like. But if it is entirely about peer pressure, then whole groups of you would worry about what you looked like, and that is the thing. In years gone by it was probably at age 14 or 15 that girls started worrying so much about what they looked like and their appearance and confidence, but it is getting younger because of the pressures, is it not?

Professor Wareham: The whole issue of active travel is also an issue for children.

Q21 Barbara Keeley: But that is mostly a safety fear on behalf of parents, is it not?

Professor Wareham: We need to distinguish between the perception of safety and safety, which are not exactly the same thing. But there are issues. For example, 30% of children who live within 2 km of school are driven to school. That is a major opportunity to intervene and do something about the issue. Our study found that 47% of children cycled or walked to school, but 53% did not, and the ones who were active in travel to school were active overall; it was not the case that they substituted and were less active for the rest of the day. This is a major lever, and I agree with Susan that we should be looking actively for levers to encourage change.

Q22 Chair: That is active travel. In terms of within the school environment, do you feel there is an issue about the types of sport that girls get to do, for example netball, compared with those that boys have traditionally had the opportunity to do? Is there any evidence about differences in the kinds of energy level expenditure that you get with traditional girls' sports and traditional boys' sports?

Professor Wareham: I am not an expert on girls' sports, but we have to find ways of promoting participation in sports, exercise, dance—anything that is physically active. In a sense, it is much easier for boys because we focus on specific sports, and maybe that is less amenable for girls. I do not know whether Gillian wants to come in.

Professor Leng: In terms of barriers to girls in doing any sort of sport, the evidence suggests that there should be a choice of activities, because getting girls to do anything is better than nothing. I appreciate that there may be lower energy expended, but if that is going to help drive some physical activity, the choice is an important factor in overcoming some of the barriers.

Chair: Thank you.

Q23 Robert Jenrick: We hear a lot in the media about the correlation between income levels and obesity, but we hear less about the same correlation with physical activity or inactivity. What is your impression of that and what the drivers might be behind that?

Professor Wareham: There is certainly a significant income and socio-economic gradient as it relates to obesity. The same is certainly true of dietary intake, and Susan can add to that. It is less steep for physical activity. If one assesses the totality of physical activity, it may have something to do with the socio-economic nature of the physical activity energy expenditure of some manual work compared with sedentary occupations. So it is maybe a more complicated picture than we paint for diet and obesity. Susan, I do not know whether you want to add to that.

Professor Jebb: I think that on diet the data sources have their limitations. I am sure that you have had chapter and verse on that in your written evidence. If we look cross-sectionally, diet is less socially patterned than many people imagine. It certainly is for fruit and vegetables; without doubt there is a clear association between consumption of fruit and vegetables and social class or education, or however else you want to categorise it. There is also a gradient in relation to sugary drink consumption. Beyond that, it is much less clear-cut. If you take something like saturated fat, for example, intake is pretty consistent across different groups. The sources of that saturated fat are very different in high SES groups compared with low, but the absolute intake is quite similar. We perhaps need to move away a little from this very nutrient-based approach and think much more about a food-based approach. That is certainly going to be more helpful when we start talking to people about changing their behaviour. Nobody goes into the supermarket to buy 35% of fat, 10% of saturated fat and 6 grams of salt; we go in to buy foods. If we want people to change the way they shop, we need to think much more holistically about the dietary pattern, about the types of foods that are more or less consistent with achieving a healthy diet, and particularly focusing on those foods that add a lot of extra calories and few extra nutrients, and really being much clearer that those foods should be occasional items. If we could address consumption of those foods, we would cut fat, saturated fat, sugar, salt and calories all in one go, and we would not need to debate the ins and outs of fats versus sugar.

Q24 Robert Jenrick: Yes, I understand. Going back to physical activity, it seems perverse in some respects that there should be any correlation between income and level of physical activity. It is a reversal of what it might have been in a different generation when, as you say, people on lower incomes might have been doing more manual work. Is it that we are too fixated on luxury sports, the need to join expensive gyms and to have the right equipment these days to take part in sport, and that we perhaps underplay the kinds of activities that are free or very inexpensive and that 20 years ago would have been the norm?

Professor Wareham: I totally agree. We should be promoting physical activity—the totality—however people choose to do it. It need not be expensive; it need not cost anything to walk more or to cycle. That is not to say that we should not also be promoting, for those who want it, sports and exercise, but they are subsets. The public health issue is the totality of physical activity.

Professor Leng: These comments are really illustrating the complex picture that we have, and we have not even talked about how ethnicity impacts on that and the types of diet that might bring in. It goes back to the message of thinking about how you change things and the need to look at your local population and the barriers they might have. Years ago I worked in the west of Scotland, where the diet was not good, and we were running cookery classes—that was the plan—until it became clear that the barrier there was that people were not given a cooker. They were given money to buy a cooker, but it did not buy a cooker—it bought something else. That is just an illustration of how you very much need to tailor what you do to your local situation.

Q25 Robert Jenrick: Can I ask one more question very briefly? I know that we want to move on. I am looking at a graph here entitled "The lazy man of Europe", which shows that levels of physical activity in the UK are among the worst not just in Europe, but in the world. It seems to break some of the stereotypes or impressions that members of the public might have, for example that Australia is very sporty, because, by comparison, Germany has more activity than Australia, and northern Europe versus southern Europe and so on. According to these figures, in the Netherlands the proportion of the public who do not meet the recommended levels of physical activity is 18%, compared with 63% in the UK. I do not know whether you have experience of what the reasons are behind that, but could you pick out a few reasons why a country such as the Netherlands is so dramatically better at meeting physical activity than the UK is, despite having climates and populations that are not too dissimilar?

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

Chair: Thank you very much.

Q26 David Tredinnick: Staying with my colleague Robert Jenrick's point, I looked at that chart too and was astonished to see that our figure was 63% and that the United States of America's was 41%. They were two thirds of us on this laziness graph. I find that extraordinary, as I thought it would be the other way round.

I want to start by asking Professor Jebb about the overall trends relating to obesity and overweight, which we have touched on already. I was struck by one figure in the briefing here where you said, "…the rise in the prevalence of obesity in younger adults is much lower than in older adults." If that is the case, do we have something here which is just disappearing naturally, because there is a trend? That seems a fairly stunning figure, a stunning statement, to me—forgive the alliteration?

Professor Jebb: First, let us be very clear that we are talking about differences in the rate of increase in the prevalence of obesity; we are not talking about reductions. There is no population group where this is consistently and significantly going down. If you look at all the data from the Health Survey for England, which is a repeated cross-sectional survey done each year of different people—around 15,000 to 18,000 people each year—and you divide that up by decades, among adults in the 18 to 45 age range, I think it is, you see that the lines are relatively flat over time, whereas in the over-55s the increase in the prevalence of obesity is much more marked. That is an interesting difference. It perhaps parallels the difference we see if we look at children, using the NCMP data, which is a much more extensive dataset, where we have seen that the increase in prevalence has attenuated in recent years, particularly in the younger children. That is an interesting observation. I am not sure where it takes us in terms of knowing what to do about it, but I certainly do not think that we should interpret it as somehow, "It is business as usual. If we just leave things as they are, this will sort itself out." There is no consistent sign of that whatsoever.

I do think, though, that we should recognise that the rate of increase is attenuating. I heard a comment in the media that we had just reached saturation point and that was the reason it had plateaued. I do not really buy that argument, because some countries, notably the United States, have much higher prevalences than we do, and it is hard to imagine why we would have plateaued at a different point if this reflected some biological susceptibility. It does indicate that some of our efforts are beginning to pay off and that we are beginning to make some inroads into this, but I strongly caution against complacency, because the rate of change is slow and, crucially, the health inequalities remain and are potentially getting larger. Particularly if we look at the data in children, the fact that we are seeing relative improvements in children—i.e. it is not going up so quickly—is largely being driven by a plateauing in the children in the highest SES groups, and we are continuing to see very worrying increases in children in low SES families.

Q27 David Tredinnick: That leads me neatly to my next question, which was coming anyway, which Professor Gillian Leng talked about, and that is about ethnicity. "Obesity and related conditions vary according to ethnic group, socioeconomic status and geography." Would you like to expand on that? I have in mind that one of my Leicestershire colleagues, who is himself Asian, has very successfully had a big campaign here about diabetes in that particular community. Could you tell us how important the ethnic factor is here?

Professor Leng: As you say, there is certainly an association between certain ethnic groups and the prevalence of diabetes, and between other groups and stroke. There are clear differences in risk factors, diet and levels of exercise. The evidence recognises that in some of our recent guidance on the way we should be identifying people from an ethnic background as being at risk in terms of their body weight as a lower threshold than the rest of the population.

Q28 David Tredinnick: It is always difficult dealing with these issues—they are very sensitive—but are we targeting different groups in specific ways to deal with their specific problem?

Professor Leng: We do need to if there is a clear—

Q29 David Tredinnick: NICE has guidelines, does it not?

Professor Leng: Yes, we have definitely done that, and taken that approach in our guidelines where there is a clear link between ethnicity, socio-economic status or hard-to-reach groups—however we define it—and tailored the approach that the group needs.

Q30 David Tredinnick: Moving back to something that we have touched on, body image has changed dramatically over the centuries. If you look at some of the great painters from a couple hundred years ago, you see a totally different shape of body, particularly the female body, which appealed at the time—much larger actually. To what extent do you think this is influenced by, shall we say, the "doll" culture, meaning very thin dolls, without naming any brands? Should we be looking at the toys children play with?

Professor Leng: It is not an evidence base about which I can talk as an expert, but clearly it is a factor, because if you watch things that were made back in the 1970s, when I was young, you think, "Gosh, the normal body size back in the 1970s was far different from that which we see today." We know that various clothing companies have resized things and that there is a normalisation of being a different weight, a different body shape, than we used to be. It is not an area that NICE has been asked to consider, but I am always happy to.

Q31 David Tredinnick: I have raised in this Committee on other occasions the cheating in labelling in women's clothes now, where size 10s are actually size 12s, or whatever it is, and in fact it is impossible to buy some of the smaller sizes now as adults, so adults who are that size now have to shop in children's shops, which has the benefit of not having to pay VAT. There are problems there. Are you proposing to come up with guidelines to get companies not to cheat on sizing?

Professor Jebb: Let me jump in. We really need to raise our game here. Resizing clothes is not going to be the answer to preventing or treating obesity. Without doubt, overweight is now the average, the typical, the normal. But I do not believe personally that that is making the problem worse. The reality is that most people who are overweight would like to lose weight. There are a few who profess to be very happy the way they are, but the vast majority of people who are overweight would like to lose weight. We need to support and enable them to do that. One thing that we do know is that people respond much better to a supportive structure than they do to criticism, discrimination and so forth. I worry that we are just getting down to the minutiae and missing some of the bigger issues that are going on here.

Q32 David Tredinnick: Right. So being able to deceive yourselves in the shops because the sizing has changed is minutiae, is it?

Professor Jebb: I don't think—I think people who are overweight—

Q33 David Tredinnick: I am shocked to hear that.

Professor Jebb: —for the most part are very aware that they are overweight, and I do not think that that has to do with the size of their clothes.

Q34 David Tredinnick: Professor Leng went back to some of her earlier experiences when she was younger. When I was in school we had compulsory games. There was not an issue about whether you played games or not; you had to play them and there were sanctions against you if you did not play them. Do you think that is a good thing? It is true.

Professor Leng: In general, in terms of behaviour change, you have facilitators and barriers, and sanctions are your sticks, if you like. I think most people would prefer these days that there are incentives rather than sanctions, but certainly something that drives a behaviour change when you are young—

Q35 David Tredinnick: Obviously while you are at school there should be incentives, surely. There might be some prize or some extra hours in which you can do something you like.

I have one last question, Chair, if I may crave your indulgence. Mixed changing rooms came up as one of the reasons for stopping girls playing games at school and elsewhere. Do you think we should have a policy on this? Do we have a policy? Is there some advice issued to schools about this issue? Presumably, girls do not necessarily want to change in front of boys, particularly as teenagers. These are basic issues and we have to tackle them. We are not here to dance around issues. These are core issues. What do you think about it, please?

Professor Wareham: It seems self-evident that boys and girls should change separately.

Q36 David Tredinnick: But it is not happening everywhere, is it?

Professor Wareham: I am not aware of what is happening, but it seems a very bad idea if it is happening.

Q37 David Tredinnick: Right. Let us get that on the record.

Professor Leng: I would agree. I suspect it is happening—

David Tredinnick: It is a very bad idea and that is one of the reasons children are not playing sport in schools. We were briefed on that earlier. Okay, Chair, I have finished. Thank you very much.

Chair: I know Charlotte has a quick supplementary question as well.

Charlotte Leslie: I am sorry if this was covered when I had to nip out of the room. One of the things we risk doing when talking a lot about young people is ignoring older people, and I am going to get very personal for a second. My mum started swimming when she was 40, having never done anything. She won't thank me for saying this, but now she is 65 and world triathlon champion in her age group.

Chair: Hear, hear. Congratulations.

Q38 Charlotte Leslie: One of the things she has worked on with friends is saying, "Even if you have not done any exercise and you are 60 or above, you can still build significantly on where you are," and that people who have not done that much exercise in the past can build quite a good level. What can we do to get this message out more to older people who may want to exercise, or even do more physical activity, but feel that once they are over a certain age that is it—opportunity closed?

Professor Wareham: It is important to have positive role models, and your mother is clearly in that category.

Q39 Charlotte Leslie: It makes me feel very old.

Professor Wareham: The message I was putting across previously—that the key thing is to make changes in physical activity, whatever is suitable for that individual—is very important as we get older. We have to find ways of people being active in a manner that is conducive not just to their lives, but to their abilities, which change as we get older. The other thing, particularly for the elderly, is that the focus has to move a little bit away from obesity and towards body composition. A very important aspect of physical activity as we get older is the preservation of muscle mass. That is really important as we get older, because if we lose muscle mass as we get into our 80s and beyond, we lose balance and stability, and that leads to falls and their consequences. The promotion of physical activity in older people as a benefit over and above the importance of obesity is an absolutely crucial public health issue.

Q40 Charlotte Leslie: Many people who are getting older worry about being a burden on those who are going to care for them. Is there a case to be made that if you retain muscle mass and end-of-life fitness—if there is muscle mass and you are a fit person—you are going to be less of a burden on those who have to care for you than if you do not have any muscle mass at all?

Professor Wareham: That is true, but the predominant burden comes from conditions such as dementia, and there are the beginnings of an evidence base that suggests that there is a link between physical activity in mid-life and dementia in older life. If that evidence base can be substantiated and strengthened, that would be very important.

Professor Leng: These things are very much addressed in a piece of guidance that NICE is shortly to issue and that we have been affectionately calling "Fit at 50", which is about encouraging change at that time of life and thinking about initiatives that will encourage a

change, such as socialised walking groups or cycling clubs. Those sorts of things that kick-start a bit of behaviour change are really important.

Q41 Chair: We are about to have a vote. After we come back we are going to lead off with some questions from Barbara, but can I just clarify one bit from Professor Jebb? You talked about people knowing that they are overweight. Is there evidence that some parents do not realise that their children are overweight because we have had a normalisation of obesity? Are you able to expand on that? People often make the point that parents always know when their children are overweight, but I understand that there is evidence that says they do not.

Professor Jebb: Thank you very much. That is an important clarification. I was very much talking about adults. You are absolutely right that parents find it very difficult to judge their child's weight. Actually, health professionals find it quite difficult to judge a child's weight. Of course we have seen obesity increase in children, but we have seen the whole population distribution change. When I go back and look at my old school photographs, I think, "Gosh, we all look like quite skinny little wretches." I look at my child's class and they are just a different shape. Because we have such a high prevalence of overweight and obesity in our schools, the overweight and the obese child is not just the fattest child in the class; there is actually quite a group of them.

The NCMP programme, as you know, gives feedback to parents on the weight status of their child, and that is quite an important step in beginning to help re-frame the public understanding of what is overweight, not just in terms of the letters that go to individual families, but we have seen a number of media reports where suddenly this is a discussion which people are having. Is it reasonable to be able to see the ribs on an 8-year-old? Yes, actually, that is quite normal. It is a recognised problem that people fail to recognise overweight and obesity in children. We are beginning to try to address that, but it is very difficult. But mostly we do not want to single out these overweight and obese children. We need a supportive environment where every child has a better chance of eating better and being more physically active to prevent obesity, rather than having to identify them. When we start coming to identify them as individuals, we are really getting into a much more individual-level treatment approach. Most people can identify those children who are at the extreme end of the distribution, so I do not think that is the problem.

Q42 Chair: They do not see the ones that are—

Professor Jebb: They do not see the ones in the middle, so parents do not realise that their child is developing a problem.

Chair: I am sorry, but we are going to take a quick vote.

Sitting suspended for a Division in the House.

On resuming—

Chair: Before we kick off, David wants to make a quick point.

David Tredinnick: I must make a quick correction about the children's changing rooms point. It was swimming pools.

Valerie Vaz: Right; it is not your—

Chair: That clarifies it.

Valerie Vaz: Do you know something that we don't know?

Chair: Thank you for correcting that, David.

Barbara Keeley: However, I was going to add that this was an issue. The Commonwealth games aquatic centre at Manchester was built with mixed showers, which really did not suit, and then my local authority copied it, so we had swimming pools with mixed showers and they started to have all kinds of problems.

Grahame M. Morris: I was not aware that there was—

Barbara Keeley: So you are not too far out.

Chair: Thank you very much.

David Tredinnick: It was intended to be a serious point, but on the grounds of "The dinosaur does not know what he is talking about."

Barbara Keeley: Yes, you can run into it.

Chair: Thank you, David. We come now to Barbara's question on focus.

Q43 Barbara Keeley: We had a way into this question with what Charlotte just said about her mother doing the triathlon in her 60s, but our question is the other way round really. Recent research that we have been given suggests that current guidelines on physical activity may be too difficult for some people to meet and that efforts would be better directed at encouraging people, particularly older people—although clearly if they can do triathlons we should not limit what we say—to make modest increases.

Professor Wareham, perhaps it goes back to the point you made about moving people up a scale, from inactivity to moderate inactivity. Is that the case? Would that be better? The current guidelines quote figures that probably seem quite steep to people, don't they, at 150 minutes and so on?

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

achieve; it is within the realms of possibility—"can have serious health benefits," is a much more positive message.

Q44 Barbara Keeley: Do you think—both you and Professor Leng—that the 150-minute-a-week target seems like too far away to people and that we would be better to set a lesser target and get people achieving it?

Professor Wareham: My own view about all public health guidance and targets is that there is a merit to consistency and stability, and constantly changing what is good for people and our aspiration is a bad thing. I fully support the CMO's previous guidance, which talks about that 150 minutes, with this added rider that more is better, and that we should be encouraging additional activity in every way.

Q45 Barbara Keeley: I do not know, but in your experience, from the studies you have done or seen other people doing, do you think it is well understood that it is 150 minutes or how to break it down into chunks that might be worth doing?

Professor Wareham: I am on a WHO expert committee right now that is considering the challenges of bringing together surveillance information about physical activity with our public health guidance and our understanding about the relationship between physical activity and health endpoints. Those camps have tended in the past to be slightly different scientific groupings, and there would be a value in bringing them together. But the key thing is that our public health messages are consistent, simple and achievable. That is what the CMO is doing.

Professor Leng: In general, targets should always be realistic and achievable, but if we sit back again and think about the population approach, as a population we want to try and shift everybody to be doing more. It goes back to what we can do in the environment and across a whole range of different strategies—as set out in various bits of NICE guidance—to drive that change in everybody.

Q46 Barbara Keeley: As well as the focus on 150 minutes, should there possibly be a separate campaign or a separate target to get people to minimise the time they spend in a sedentary situation? Should that be talked about more as well—not just, "Do more in these sorts of chunks to this sort of time," but, "Don't sit for four hours," as we do in debates in this place or in Committees? Should we not do this?

Professor Wareham: A focus on diminishing sedentary time is an important additional public health target. There is some evidence—it is slightly controversial whether it has or does not have a separate effect in the absence of physical activity—but it is an important public health message, because unfortunately most of us have sedentary occupations. An important additional factor is that there is some evidence that, given a total amount of sedentary time, if you break it up every hour by getting up and moving around, so that it is not a consistent, uninterrupted bout of sedentary time, that has some benefits, particularly on glucose metabolism.

Professor Jebb: If I can add to that, I am currently chairing a committee for NICE about developing guidance on maintaining a healthy weight. That has been out for consultation and we are just finalising it, but within that we talk very specifically about being more active and reducing sedentary behaviours as two very distinct areas where people can make change. For some people, working on spending less time watching the television may be a better place to start than thinking, "I need to go out for a run three times a week."

Chair: Thank you.

Q47 Valerie Vaz: I want to take a number of strands that all three of you have touched on. Although this heading is "Behaviour Change", I have to confess that I switched on my pedometer on the first day but forgot the second day. There is evidence that you have to do things for 21 days to build them in to become part of the pattern of your life. But I did stand up when I read this brief. Picking up on your point, there is evidence suggesting that we should now be standing up at our desks, not sitting down. If you put that to anyone—maybe people who work here—they would say, "No, it costs more money," but it is a very simple solution and, as you say, it does have an effect on glucose metabolism, does it not?

Professor Wareham: Yes. We do need to do further studies, and we are just embarking on one in children. In the school environment we would need to think about the impact of standing desks not only on health and metabolism, but on behaviour and learning. There are the beginnings of an evidence base suggesting that there are actually beneficial effects on those factors as well.

Q48 Valerie Vaz: Yes, moving around, and outdoors as well.

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

Q49 Valerie Vaz: It is crucial, and you all touched on that, but schools are at the centre of it. You talk about children being driven to school. I think that people have found that that is part of the choice mechanism—that they do not go to their local school where they used to walk. Certainly, when my daughter went to her primary school we used to walk to school. Schools do "Walk to School Week" so there is that built in, but there is also the issue about playing fields. I have a number of schools in my constituency—at least two—that do not have playing fields. That is another issue that needs a macro look at everything.

Professor Wareham: When we talk about active travel, sometimes we polarise it and say, "It is use the car or walk or cycle," when, increasingly, because of the way societies are

being built and where people can afford to live, what we are talking about is travel that is mixed modality. People will drive for a portion and then cycle or walk. That mixed modality travel can have major impacts on health-related physical activity. There is one study where people who were using offsite car parks got another 12 minutes of walking and 17 minutes of cycling if they parked a little bit further away and used that more healthy type of transport for the last bit. We should not polarise it as either/or, but accept that we should be encouraging this mixed modality. For most people the car is not an option—they will have to use it for a portion of the journey—but is there a part that could be healthier at the end or at the beginning?

Professor Leng: Active travel, the physical space, schools and diet are all things that we have looked at in NICE guidance. So if there is anything that you might be able to consider around the mechanisms for ensuring that schools or local authorities are incentivised to look at those, perhaps reporting against some of the standards that we will be issuing over this year and next, that might be an important mechanism for getting some of this evidence into play.

Q50 Valerie Vaz: In terms of behaviour, when I looked at the list of the NICE guidelines, I was quite exhausted and thought, "I can't do any of it." That was the first thing, which is a bad thing to think—that I can't do something. So I found that exhausting. When I heard about the evidence that said, "You just have to do 20 minutes extra and then you will live longer, and you can break it up within two lots of 10 minutes," I thought that is certainly achievable every single day. So that helps. How do we build that into the kind of behaviour that will enable us to do that? This is to the exercise people.

Professor Jebb: Can you re-phrase your question, please?

Q51 Valerie Vaz: The guidelines are quite difficult to comprehend. Even someone like me, on a Health Select Committee, did not know about all these guidelines, but because it was presented to me I looked at it and said, "There is a heck of a lot of stuff out there." I suppose what I want to ask you about, Professor Leng, is that also you talk about quality standards. Is that a much more accessible way? Could you give us an example of a quality standard?

Professor Leng: Yes. There are a couple of bits in terms of messages and the fact that the guidance can be quite complex, but they are probably aimed primarily at organisations such as local government and public health professionals, rather than individuals. In terms of that, we often need to work with other organisations that will re-present clear messages. We will look at the evidence and say, "These are the important things and we need people"—whether they are charities or, increasingly, Public Health England—"to take and reposition some of the messages for the public." That is important. The other bit around quality standards will also make the guidance focus down into a handful of five to 10 clear statements in a particular area about the most important things that we think should be taken forward. That is not to say that you do not need the whole guidance, but a few focused things that can be measured because, like it or not, measurement drives change, and if we can encourage our colleagues in local government to start tracking improvements, that would be really important.

Just as an aside, we have recently looked at all the information we have about uptake of NICE guidance, and there is quite a lot of stuff. A lot of it comes from national audits or commissioned research, but there is a minuscule amount about what has happened to the public health recommendations. That is not because they have all been ignored by any means, but it does mean there is not that culture of data collection, and data drives change. That is really important.

Professor Jebb: I completely agree with Gill. Targets are things that we need in terms of a set of policies, and we monitor against them and so on, but they are not always the best way of communicating with individuals. They rather assume that it is going to be a very reflective, knowledge-based decision: "Oh, my goodness, I have only accumulated 110 minutes of exercise today. I need to do something else." We have to recognise that a lot of our choices—they are not even choices actually—about physical activity, and the same applies for diet, are not really active choices; they are just the default. We do the thing we have always done because that is our habit. We do the thing the environment encourages us to do, and less of this is about reflective thinking than just automatic choices. That is where changing the default is so very important in all of this.

Q52 Valerie Vaz: In terms of behaviour, how do you change, for example, for food? There are mixed messages coming out about food. Certain saturated fats are not good. We are at the level where we know what we are talking about, to a certain extent, but you know more than we do. For example, olive oil is better than whatever the butter equivalent is in a margarine. In previous times it said, "Eat margarine," but that is not as good as having olive oil.

Professor Jebb: I come back to the comment I made at the start, which was talking about overall dietary patterns and the way we eat. We have to try to avoid prompting the behaviours we do not want people to have. We need restaurants, public procurement and public institutions to choose the healthier options so that the foods you are served here, or when you are having an official lunch, are the healthiest that they can be. That is an important part of it.

Q53 Valerie Vaz: Then there is the labelling. Certainly now, with calories and the content, you can look at something and see that it has sugar and it also has high fructose corn syrup, which is the same thing, only worse, and those are the top two ingredients. How do we change people's behaviour about looking at that and knowing that it is okay sometimes to have 400 calories for a sandwich if you have slightly less at another meal?

Professor Jebb: We have made some progress with the front-of-pack labelling scheme and something like two thirds of the packaged food market has now signed up to that consistent colour-coded front-of-pack scheme. It is early days, so we now have to work on helping people to understand that and use it to make healthier choices. But, again, that is assuming that they get to the point where they are interested enough to look at the label. So there is another piece, which is really the public health piece, about saying that within any food category there is a whole range of fat and salt content. Let us take sausages. Not all sausages are the same; some sausages have far more fat and salt than others. What can

we do to ensure that the rest are as good as the best, so that we have a much healthier sausage market in general? The same applies, of course, for every other category of food.

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

Q54 Valerie Vaz: I want to touch on the girl issue and the behaviour. I went to a school where I ended up as school hockey captain; hockey was available. I am happy about that and familiar with exercise, but we are still having this discussion now about "sweaty girls", and we heard recently in the Australian tennis that we are still having the issue about that. How do we change that when we have, for example, Maria Sharapova, who is a millionaire because of her endorsements, but Serena Williams—the better tennis player, in my view—who does not have as many endorsements? How do you change those kinds of attitudes and behaviours?

Professor Wareham: For a start, people are talking about it. That whole debate about Heather Watson's defeat was very encouraging. There is, as you say, this advertising media campaign going on at the minute. These are very positive things and a start, but I agree with you that they are not the end of the discussion—just the beginning of it.

Q55 Valerie Vaz: In your view, do you think there is a role for Public Health England to pull together all these different strands—the exercise strand and the food strand—to start another public awareness campaign, including your NICE guidelines, in a much more simplified way?

Professor Leng: I am always happy for anybody to support the uptake of NICE guidelines, and we are working very closely with Public Health England, so that is very positive. Perhaps we need to know a bit more about the barriers to why girls are not undertaking exercise at school. I do not know what the evidence says to date, but I do have two daughters and there is this issue about appearance. You do not get long at school and perhaps girls need a bit longer to do their hair and put their make-up back on. This is why I am saying we need the evidence for this. I am just making it up, but we need to be clear for any behaviour change what the barriers are to it, and then you address the barriers. That is the approach the evidence says you should take and I do not know enough about the barriers.

Q56 Valerie Vaz: Also women's football is now taking off, so they are seeing whether it is about role models or not.

I have one last question in terms of incentives and behaviour. We have seen a huge change in that pharmacies will tell you that 90% of people they see are there because they want to stop smoking. They have had that wonderful impact. Is that something that pharmacies can do? I notice that NHS England in their written evidence said, "Exercise is available on prescription." How would you put that on a prescription? Could they go to the pharmacy and could the pharmacy monitor them?

Professor Jebb: There are a couple of things built in there. There is a scheme which works through primary care, not through pharmacists, as far as I am aware, which is a so-called exercise-on-referral scheme. We recently reviewed that for NICE. Although it is a very attractive option, people like the idea of it and it does have some very strong advocates. Our evidence reviews showed that its effectiveness in increasing people's physical activity was extremely modest and that, given the very high cost of those schemes, it was not something that we felt was cost-effective simply for the benefit—"simply" is the wrong word, but just for the purposes—of getting people to be more active. It may be appropriate in other slightly more clinical situations, but we did not conclude that that was a cost-effective mechanism just to get people more active.

Can pharmacists be more involved in health promotion in general, whether that is increasing physical activity, dietary change or encouraging people to take steps to manage their weight? One would hope so. They should absolutely be part of "make every contact count". There is relatively little evidence of the effectiveness of pharmacists in providing that advice. We know less about that. There is one study that I am aware of which looked at pharmacists providing advice for weight management. This was a behavioural intervention on diet and physical activity advice. It was a study conducted by my colleague Paul Aveyard, who looked within a routine service at what happened if people were referred to either the commercial providers, to an NHS dietician-led group or to pharmacists. I am afraid it showed that the pharmacists were ineffective in supporting people to lose weight. There is definitely an opportunity, but we would really need to work out how that would happen, what the mechanics would be and what the programme would be that they would be following. But, just at a basic level, they can be part of the background noise which says that these things matter; they are very important.

Q57 Valerie Vaz: Of course local government now have a role in this, do they not? Did you want to add anything?

Professor Wareham: No. Susan is quite right. One of the areas where we can do more is in the promotion of physical activity in a clinical encounter. That sometimes gets given lesser importance than dietary change or obesity. I know from my clinical work where we are treating people with diabetes that, if we want to focus on the behaviour, even the provision of a pedometer to people in a diabetes clinic is extremely difficult, and yet we know from trials that providing a pedometer and making people aware of their own level of physical activity does promote beneficial change. There are things we can do in a clinical encounter as well as, more broadly, in a public health arena.

Professor Jebb: I would absolutely reinforce that, and, again, going back to smoking, we now have a situation where the GPs or practice nurses of most patients who smoke will talk about their smoking in their consultation. That is not happening in relation to people who are inactive or people who are overweight. We really need to look at the opportunities

in opportunistic clinical encounters to start opening up those conversations, particularly with something like health checks where you have potentially the so-called teachable moment. If we identify a new condition, we have to ask how we are using that moment to make an individual effort to motivate that person to adopt a new behaviour, whether that is becoming more active, changing their diet or thinking about losing some weight. There is a real opportunity to do something there.

Professor Leng: Indeed, shortly, the quality standard on physical activity is about encouraging activity in people in contact with the NHS. One of those statements will be about adults having their health check. At that point they are given brief advice about how to increase physical activity—just a clear statement. That is a line in the sand; that advice is given, and hopefully somebody measures against it and tracks when it is being done.

Valerie Vaz: Thank you all very much.

Chair: Charlotte wants to take a follow-up point on that.

Q58 Charlotte Leslie: Very briefly, I have one thing. It would be a relief if we could point out that things are not necessarily healthy because they are brown. Things like All-Bran, Bran Flakes and Special K market themselves as ever so healthy because they have bran in them, but they are stuffed full of sugars. So, yes, it is not just the label but the branding as well.

Professor Jebb: Absolutely.

Q59 Charlotte Leslie: Moving on, one of the most striking examples I have seen of previously sedentary, physically inactive people becoming physically active and then moving on to exercise as well was on Ashley Banjo's "Big Town Dance" and "Secret Street Crew", which was on Sky, where he got a whole lot of people who had never thought of dancing before to dance. In one of them he got a whole town dancing. It struck me that a key thing in that was not so much that you had a celebrity doing dance but that he made people feel good about themselves. To what extent do you think physical activity, obesity and a bad lifestyle are symptoms of a much deeper sense of powerlessness, or maybe some occasionally mild or more severe mental health difficulties? I know for myself that if I am feeling bad about myself I am more likely to have a beer than go for a run. Are we missing out on tackling the root cause of many of these things and at risk of just tackling symptoms?

Professor Wareham: The evidence base says there is a bidirectional relationship between mental health conditions, and indeed general wellbeing, and physical activity and obesity, and it can work in both directions. I do not think there is a simple answer that is the root cause. It is certainly true in some individuals that physical inactivity can be a cause of diminished wellbeing, but the reverse is also true. You are right that we have to consider these issues in the round, but the evidence is that it is bidirectional.

Professor Jebb: We absolutely need to recognise that when we talk about obesity, we mean a family of obesities and there are many different routes to something which actually ends up looking like the same condition. At least one of those is people who overeat as a consequence of using food as a reward mechanism when they are feeling very stressed,

very sad or at particular circumstances—the so-called emotional eaters. We definitely need to start further research because we do not have the answer to this yet, for sure, to understand whether interventions which are better tailored to deal with their relationship with food may be more effective than what tend to be just knowledge-based things, learning about calories and so forth. There is definitely a subgroup of people for whom emotional eating is a significant cause of their overweight and we need to at least research into more effective treatment options for that group.

Chair: Thank you. I am conscious that we probably need to move on, so, Grahame, over to you next.

Q60 Grahame M. Morris: I have a couple of questions in relation to interventions for improving physical activity. I think you have covered some of the ground already, so I do not want to go over that. I want to clarify a particular point that came out in your answers to the earlier questions, particularly Professor Leng and Professor Wareham, in relation to public health principles and your public health remit. Your submission, Professor Wareham, very much focuses on cycling and sport as the physical activities that are to be encouraged. I visited a school in my constituency last week, Dene community school, and had a chat with some of the PE teachers and so on; I visited the facilities there. Some of the youngsters were very enthused about this sport called free running—which is a kind of mixture of gymnastics and running and is an incredible discipline really—and dance as well. There were quite a number who do particular dance classes—Zumba, and so on. Do you think that there are horses for courses? Do you think we should be looking at a broader range of physical activities? Should we be looking at different physical activities for different age groups, between children and older people and between men and women?

I also want to touch on the issue of class or, rather, socio-economic subclasses. There is a huge issue there about health inequalities and the difficulty of engaging with particular groups and stressing the importance of physical activity. How can we move the public health curve to the left that benefits everybody but particularly gives us a big win with those who would benefit the most?

Professor Wareham: I completely agree with you. The public health issue is low physical activity, and the solution is to promote the physical activities, of whatever type, that are most conducive to that individual or that group. I was in no way proposing cycling as some cure-all solution.

Q61 Grahame M. Morris: Cycling is a good thing, but it is not for everybody.

Professor Wareham: Cycling is good for some people. It is perfectly easy to cycle in places like Cambridgeshire where it is flat, but in other places in the country it is less easy. We are not promoting a single solution. We are promoting any type of physical activity that we can promote in different groups, and you are quite right that schools can promote novel types of activity that the children want to do. We are just embarking on a trial where we are evaluating the impact of children and peers suggesting those ideas, and then doing what they want rather than what we tell them to do. You are quite right about dance. So we are in agreement.

Professor Leng: It goes back to the "no one thing works when there is behaviour change", so you do need a range of strategies. I talked earlier about what the incentives are, and for some that would be competitive team sport because that drives them. For others it would be social activity like the dance example or some other things NICE has recommended around group walking. Just having the group support and the enjoyment drives change as well. Making it easy to not be sedentary is what we are looking for.

Q62 Grahame M. Morris: Professor Leng, your colleague Professor Jebb gave us an indication of what the most cost-effective interventions are in terms of tackling obesity. Can I ask you what are the most cost-effective interventions in terms of encouraging physical activity? In my area—it is a coal-mining area—we made a big investment in the former miners' welfare halls and community centres of gymnasiums, cardiovascular centres and encouraging GPs to make referrals, particularly of older people, partially to socialise and interact. Healthworks in Easington is a terrific example, bringing a bit of mental health into it as well. Is that a cost-effective intervention in terms of encouraging physical activity?

Professor Leng: The guidance draws upon a whole range of cost-effective activities and I cannot give you a definitive list right now, but clearly some of those things, like brief advice to take more exercise, will work for certain groups. Walking groups and those things are cost-effective, and if you want some further information I am very happy to send that through.

Grahame M. Morris: If you could just indulge me, we are trying to formulate some recommendations to take forward as policy recommendations to the next Government, whichever complexion it is. So it would be quite helpful if we had some information about what is a cost-effective intervention. If you could send that, it would be helpful.

Q63 Chair: Although it has been very clear that you feel that changing defaults and making it easy is the best way forward, in terms of the complexity of NICE guidance and the fact that it tends to be directed towards health professionals, do you think there is a case to make guidance for individuals as well because there is so much confusing advice out there? I absolutely take on board your point that advice is lower down the list but it is somewhere in the list. Is there a case for having clear guidance from NICE that individuals can look at?

Professor Leng: It has not been our role to date to do that translation, clearly to do direct health promotion to the public, but it certainly is something we would be happy to take forward. There are resource constraints around doing that, of course, and I do not want to bring budgets into this, but at the moment we are looking at the evidence, we know what messages need to be put out and we are working with other organisations to help communicate that. If we had further resources to do that directly, that would be—

Q64 Chair: Communication with people is so important. We discussed with your predecessors how NICE is working on informatics that tell people what the risk is of certain types of medication or what the chances are of success, presenting things in an easily understandable format. Do you feel there is a case for doing the same in terms of diet and exercise, with those kinds of charts that say, "If you take 20 minutes more exercise a week,

you are less likely to suffer early disability," and putting that in a clearly visual format alongside consistent advice, because if people turn to the internet they get so much conflicting advice? What is your view on that?

Professor Leng: It would be great to be able to do that. It would be really positive and I want to be absolutely clear about that. Because at the moment we are not able to do that, we are looking at things like health apps, at third-party resources and we have recently started to endorse them to say, "This is in line with the guidance." So we are working with others to do that but do not have the capacity and resource ourselves to generate those messages.

Q65 Chair: You see your role as being almost a kitemark for others producing that guidance so that people can have confidence in it.

Professor Leng: We very much do see ourselves as providing that kitemarking activity at the moment because, within the resources that we have, that is the most effective way of being sure that the messages being put out are in line with our guidance and our evidence base. But to do it ourselves is also an option.

Q66 Chair: That was the kind of clarity I was looking for; that is where you see your role. I know that Professor Jebb wants to add something.

Professor Jebb: Of course there is quite a lot of messaging out there already. We have Change4Life, which is very much trying to go direct to consumers, particularly to families, and is trying very hard, and with modest success, to target some of the most deprived and vulnerable communities. There is also NHS Choices. The NICE guidance very much feeds into that and informs a lot of the information which is available on NHS Choices. In the new piece of work that we are currently doing about guidance for maintaining a healthy weight, we reflect in that document that this will also be of interest to individuals, and we have been having discussions within the implementation team in NICE about how we can bring that to life for individuals. It is happening through other channels, as Gill says, but it is certainly something that is on the agenda.

Chair: Thank you.

Q67 David Tredinnick: I want to ask a couple of questions about individual weight management and start with referring to something Public Health England acknowledge, that there is "an unmet population need for weight loss support", and the Academy of Medical Royal Colleges calls for an investment of £100 million per year for the next three years to increase provision of weight management services so that they can mirror smoking cessation services, which we have already touched on. Do you think there is an unmet need for these services? What interventions are the most effective and which are the least effective, please?

Professor Jebb: I can take that. There is most definitely an unmet need. When we do research studies we send a letter out, through the GP surgeries, to the patients in the practice who are identified as being overweight or, indeed, sometimes obese. Very typically, 10% of people respond to that letter and say, "Yes, I would like to take

advantage of that service." They go into the treatment programme, and we have shown that we can achieve clinically significant weight loss. So there is definitely an unmet need.

We are currently running a trial in which doctors make opportunistic interventions in the sort of "while you are here" moment at the end of a consultation, offering people who are overweight and likely to benefit from weight loss the opportunity to take up a weight management service. We will obviously have the results of that in due course. There is no doubt that there is an unmet need.

It is also very clear that there are interventions, most specifically referral to some of the commercial weight loss providers, which achieve significant weight loss and achieve greater weight loss, and more cheaply, than we have seen in terms of interventions delivered by primary care teams. That is not going to be the answer for everybody, but it is one effective intervention.

Q68 David Tredinnick: I hate to interrupt you, but, according to our briefing, the Faculty of Public Health argues that there is "strong evidence that weight loss programmes do not achieve useful long-term weight loss, as most recently demonstrated by the new Systematic Review commissioned by NICE".

Professor Jebb: We did that systematic review for NICE, which shows that—

Q69 David Tredinnick: I am sorry, as we say in the House here, to pull the pin and hand you the grenade, but—

Professor Jebb: Essentially it shows that at one year on an intention-to-treat basis—that is, taking everybody who went into it and assuming that those who dropped out did not lose any weight, so it is a very conservative estimate—we showed that people lose, I think it was, 2.89 kilos at one year. That clearly is an important health benefit at the population-level scale we are talking about.

Professor Leng: We set out the parameters for what makes a good weight-loss programme because clearly they vary, but that is all set out in the guidance.

Professor Jebb: That is for adults. For children it is much more difficult. We are struggling to know what to do for children.

Q70 David Tredinnick: I was driving down to my Leicestershire constituency last Friday week in the morning listening to Professor Dame Nancy Rothwell on "Desert Island Discs", listening to her arguing in favour of bariatric surgery in specific cases. She seemed very well informed on the subject. Do you agree with her? Do you agree with bariatric surgery? What weight should we give to it in terms of further treatments?

Professor Wareham: Bariatric surgery is effective in some groups of individuals, and, given the problems of obesity and its co-morbidities, we definitely need better facilities for provision of bariatric surgery for certain individuals. It needs to be set in the context of an overall approach which has treatments for people with obesity and co-morbidities, but also individual disease-prevention programmes. One of the problems at the minute is that

things like the health checks are raising and identifying individuals at risk, but possibly with a disconnect from them getting on and doing something about that. It is about seeing these issues in the round and it is not a question of treatment or prevention. It is an integrated system of treatment, high-risk prevention and population approaches, and too often they have been polarised.

Professor Leng: NICE has recommended for a number of years bariatric surgery as a cost-effective option. It was one of the earlier things that we looked at and it is not a first-base treatment option. One has to be clear that the individual concerned has tried other regimes first. But when you get to that point it really does make a difference.

Professor Jebb: There is absolutely a place for bariatric surgery, for sure, as we have heard, and I am not going to continue that theme. I would also remind you that weight losses of maybe 20 kilos in an individual really makes you sit up and take notice, and that would be very typical after bariatric surgery. But that is one individual and we should not underestimate the benefit of having 10 people who all lose 2 kilograms because, again, at a public health level, that is going to bring similar health benefits. So we need a mixed economy and we need these tiered kinds of services where we are intervening earlier, before problems get more serious, with some of these less expensive, more behavioural interventions, which hopefully achieve some weight loss but, crucially, if they are following good practice, because they are founded on getting people to improve their diet and to become more physically active, will have the other independent health benefits that come from changing those fundamental behaviours. We have to see what I call behavioural weight management programmes as being that hybrid of preventing chronic disease associated with obesity but also treating the early stages of overweight and obesity. I think they are much underused.

Q71 Valerie Vaz: I have a brief question to pull it all together. What do you think are the most cost-effective interventions that can be made today?

Professor Jebb: To achieve what?

Q72 Valerie Vaz: What you want to achieve—what we want to achieve. Presumably we want a healthy population. We want people to feel comfortable in their own skin, happy, healthy and have proper wellbeing.

Professor Jebb: NICE does cost-effectiveness work for every single piece of guidance, so you could look at that and pick the one which gave you the cheapest. I think we need to take a more nuanced approach, which is to think about the portfolio of things which are going to come together and drive change. On the treatment side, I absolutely do think we are missing opportunities to intervene earlier with behavioural weight management programmes. Linking it into health checks is an absolutely prime opportunity to do that.

On the prevention side, there is a lot of work going on around diet in terms of information for people, but we are not changing the environment. We have absolutely got to look at some of those more fundamental structural measures, and I come back to the issues I raised at the very start about looking at the sheer availability and accessibility, and one

might also add the affordability, of food. In spite of recent price rises, the reality is that food today is very cheap.

Professor Leng: I am not going to give you a direct answer because I want to remind everyone again about the importance of quality standards, because they will very much do that task of, "What are the most cost-effective interventions?", and also identify areas where we know there needs to be change and we know they will make a big difference if these things are put in place. It is more of a reminder to encourage use of those as they come out in public health topics over the next few years.

Professor Wareham: I chaired the NICE committee on prevention of diabetes at the community and population level. We concluded that there is not a single intervention that is the most cost-effective but we should be proposing multi-component interventions, which are very cheap but which can be applied to whole populations and large numbers of people. In the end, if it is very cheap and the benefits are accumulated across large groups of the population, that is the way to get population benefit and eventually public health cost-effectiveness.

Q73 Valerie Vaz: You have said it from your point of view, but in terms of, say, labelling, marketing and that kind of thing, are those effective? Do you always have to put that in the mix?

Professor Wareham: Sure; of course. The one thing we have not talked about this afternoon is fiscal measures and the possibility of at least having a discourse about subsidies and taxation. These are important issues that do have an impact, particularly on dietary behaviour. There is evidence from countries like Mexico of a 10% taxation on sugar-sweetened beverages giving rise to a 10% reduction. I am not suggesting that these are instant fixes or that the evidence base is perfect, but at least it ought to be talked about.

Q74 Valerie Vaz: What about subsidised fruit and vegetables?

Professor Wareham: Yes.

Professor Jebb: Increasing fruit and vegetables is probably a good thing to do, but I do not think we should fool ourselves that increasing fruit and vegetables is going to tackle obesity. It may have other health benefits which we want to encourage, but that would not be where I would first focus if I was trying to change diet in order to tackle obesity. It is very easy to promote the positive, and that is marvellous, but we have to accept that people are eating too much of foods which are high in fat and sugar and we have to cut down on their consumption.

Q75 Valerie Vaz: But you have to give them something else to eat which does the same thing for their bodies.

Professor Jebb: It is not a natural substitute.

Professor Wareham: If you tax the sugar-sweetened beverage, people switch to water.

Professor Jebb: Or they switch to the no-sugar options, which does not even have any detrimental business effect. The companies do not really mind whether they sell you a full-sugar or low-sugar option.

Q76 Valerie Vaz: I fear a kind of rift between the two in the sense that—
Professor Jebb: No, not at all.

Q77 Valerie Vaz: No, not a rift. Maybe rift is not the right word, but there is this element, which you brought in at the end, of the commercial aspect of it and we are thinking about companies more. But you should just encourage companies to not put in the high-fructose corn syrup—not do that.
Professor Jebb: Absolutely.

Q78 Valerie Vaz: Then you have to tell people not to buy it. If they don't buy it—for example, you do not have the juices, which have more sugar—you have the apple, and we want our children to know that apples do not grow in Tescos; they actually grow on trees. It is that kind of education; it is much more.
Professor Jebb: I totally agree.

Q79 Valerie Vaz: The shift of the balance is more towards, "You need to do something quick and fast," and you are slightly worried about the commercial aspect.
Professor Jebb: No, I am not. I was simply making the point that you could move people from consuming sugary drinks to the low or no-sugar drinks, and that would be a public health win. I would be delighted if people had water; that is absolutely the first call. I have also said very clearly that I would prefer people to eat their fruit rather than drink it. Please do not interpret my comment as being to protect some commercial interests. We have to remember, of course, that the food industry is a big player in the economy, but I am absolutely persuaded that it is perfectly possible to reconcile good health with good business.

Q80 Valerie Vaz: Yes, and we force them to make things that people should eat.
Professor Jebb: The question should be: what are the policy levers which are going to make that happen? That is an incredibly important discussion to have, about how you drive change within the food industry.

Q81 David Tredinnick: Just coming in on Valerie's point, is not the biggest problem really with the colas, which have huge advertising campaigns encouraging people to use them, and they have very high sugar content? But is it not true that, despite that advertising, the demand for them has come down and people are switching to low-sugar

drinks or even bottled water, particularly in the middle-class areas? There was a reaction to that whole cola culture. Is that not right?

Professor Jebb: There certainly has been, over time, a decrease in consumption of sugar-sweetened drinks in favour of the low and no-sugar options, or indeed water. That is certainly true, but there are an awful lot of people who are still drinking an awful lot of sugary drinks.

Q82 David Tredinnick: But that is the biggest problem. My last question—thank you, Chair—relates to another group problem, which is the issue of burgers containing far too much fat. That is also linked to portion size, but I want to focus on the content. If we address the whole burger culture, would we not be tackling a large part of the problem?

Professor Jebb: There are two issues there. One is the absolute content of the burger. If we look across a range of different burgers—I had a sausage example earlier, but the some applies to burgers—some are healthier than others, and we should be encouraging and finding policy levers which move us towards those healthier options. The issue of burger culture is a more fundamental one. How do we change the food culture in society? That is going to go way beyond burgers and is much harder to do at a policy level.

Chair: I am conscious that we are probably running into the time for the next panel. Is it possible for you to write to us with where you are on the evidence base for various fiscal measures—whether that should be banning promotional three-for-two type offers, loss leaders, changing loss leaders or adding sugar or fat taxes—and what the evidence is internationally? It would be very helpful to us to be able to present what your views are on what works and what does not work. Barbara has a last question for you and then we must invite our next panel whom we have kept waiting rather a long time.

Q83 Barbara Keeley: We have ranged across wide groupings and different aspects, but could I ask a simple question? If we want to talk about the most effective ways of promoting physical activity for children and young people, clearly that is not going to be the same as adults because they cannot necessarily decide how they are going to get to school themselves and they cannot do the mixed transport mode thing. We are looking for the most effective ways that we can come up with as recommendations as a Committee of promoting physical activity for children and young people.

Professor Wareham: The problem is that your question is in a way premised on what is the single most—

Q84 Barbara Keeley: Or five things or 10 things, whichever.

Professor Wareham: In our submission, which I can certainly happily reduce to a list for you afterwards—

Q85 Barbara Keeley: That would be good.

Professor Wareham: We were trying to stress that there is no single silver bullet—

Q86 Barbara Keeley: There is no magic bullet.

Professor Wareham: Probably to continue to strive for it might be a mistake, rather than thinking of a whole range of interventions on the way to school and at home. That is what we were stressing in our evidence.

Professor Jebb: Of course children matter and we all care desperately about giving them the best start in life, but parents are unbelievably important in determining what children eat and what they do, because they control the microenvironment and because they are role models and set the culture in the family. We should not underestimate the importance of engaging with adults, because if you create healthy, aware, motivated adults then the children will reap the knock-on benefits of that.

Professor Leng: Again, the answer—

Barbara Keeley: It would be valuable if you sent us that list of points, however few or many you want to provide.

Chair: Thank you very much for coming this afternoon.

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

Q87 Chair: I am sorry we have kept you waiting. Can we start by you introducing yourselves to those following the discussion from outside this room, perhaps starting with you, David?

David Stalker: I am David Stalker, chief executive of ukactive, a non-profit health body focusing on trying to see how we can get more people more active more often.

Sue Davies: Hello. I am Sue Davies, chief policy adviser at Which?, the independent not-for-profit consumer organisation.

Jane Landon: Hello. I am Jane Landon, director of policy and deputy chief executive at the UK Health Forum, which is a charitable alliance and centre for policy development and advocacy on the prevention of non-communicable diseases.

Dr Knapton: Good afternoon. My name is Dr Mike Knapton. I am associate medical director at the British Heart Foundation, but also a GP one day a week in Cambridge.

Q88 Chair: Thank you. We have heard quite a bit about the NICE guidance, and, as an opening, could you all tell us what difference you think NICE guidance has made to

obesity, diet and the level of activity in the population? Perhaps each of you could give us your view, as an overview, of what we should be focusing on—what you feel is the strongest evidence for making a difference—perhaps starting with you, Dr Knapton?

Dr Knapton: The first thing is that NICE, certainly from a clinical point of view, is a credible organisation that metabolises an enormous amount of evidence which is very difficult for a jobbing clinician to get across. It provides credible summaries of the current state of the evidence in terms of informing our, or my, work in general practice, practice nurses and so forth. In terms of what we do, it is the best source of credible evidence to inform the advice we give to our patients. That applies similarly now to the public health output from NICE, which Gillian is in charge of.

In terms of the outcomes, though, as to whether or not you can credit the NICE guidance with a causal link to the changes in levels of physical activity and obesity, which I think were the two outcomes you were interested in, that is very difficult. We at the British Heart Foundation have invested over £10 million in our Hearty Lives programmes, working at a local level trying to address these sorts of things. It is very difficult—and Nick Wareham referred to this—to demonstrate that, while it is a good summary of the evidence, the application of that evidence in the field has a causal effect because there are so many other variables going on at the same time. What you need to do, or what I think NICE and others—BHF will contribute to this—need to do, is to think about the methods and approaches to evaluation and real-time evaluation of these sorts of interventions to improve our confidence that there is a causal relationship between the guidance and the outcomes you are looking for.

In terms of the trends, obesity, as you have heard already, was a flat line, so that might be a good thing, but I do not think NICE in and of itself did that. There are many other factors at play.

Q89 Chair: Thank you. If you agree with that, there is no need to say the same other than just yes.

Jane Landon: It is very clear that there is good evaluation of the impact of the clinical guidelines that NICE has produced. We have been discussing very much the public health guidance that they produced over recent years. What is clear is that there is not such robust evaluation for the reason that it is quite difficult to know what to count, but, if we talk to people in local authorities, we know that having recommendations which are evidence based and which are from an authoritative source are invaluable in terms of factoring those policies into their local public health planning. It would be very useful to have some further investment so that NICE could do more systematic evaluation precisely of that follow-through from NICE guidance into local practice. What NICE is not directed to do is to provide advice to Government, and quite a few of the things that we have been touching on in some of the discussions earlier are about what Government can and should be doing which is effective and cost-effective. This is an area that could be developed further. NICE is able to assess the evidence, to look at those international examples and to bring the full evidential review into focus so that we can make those kinds of recommendations. While they are not directed to do so, clearly they have the capacity and the expertise to do so.

Q90 Chair: Thank you.

Sue Davies: Our focus has been slightly different in that we see the NICE guidance as being really important, but, as a consumer organisation, we focus a lot more on making healthier food choices easier for people. There, the evidence is coming from a variety of different sources. Obviously Public Health England now has an important role to play; the Food Standards Agency did a lot of work in that area. There is a lot of consistent evidence showing where action is needed on things like product reformulation, access and affordability of products, looking at things like promotions and consistent labelling. That is something, through the Responsibility Deal, on which there have been some discussions, but our concern is that the pace of change and level of action across the board have been far too slow given the scale of the problem that we are facing and need to tackle.

Q91 Chair: Thank you. David, do you want to add something?

David Stalker: It is a very small point in terms of yes, I agree, on the NICE guidelines being extremely important, but, on a physical activity point of view, I am not entirely sure that we can see any evidence of the results or the delivery of them. What I would like to see is a way of tracking what was happening.

Q92 Grahame M. Morris: In relation to the Responsibility Deal for people who are serving on the steering committee, can you tell us how that is working in your view? There is a bit of scepticism about whether it is delivering what it set out to. Sue?

Sue Davies: Which? does sit on the steering group. We felt that it was important to be sitting on it and to try and influence the pledges. We found it quite a frustrating process. It has achieved some things. Some of the areas where it has achieved change are things that were already in train to some extent. The salt-reduction work has been really positive and there have recently been some 2017 salt-reduction targets published. But there are still quite a few big players, particularly on the manufacturing side, that have not committed to those targets yet. There has also been some progress on things like removing trans fatty acids and out-of-home energy labelling in things like fast food restaurants, but on some of the more contentious issues the Responsibility Deal has found it hard to make progress. There is a calorie-reduction pledge, but that is a very vague, woolly, toolkit-type approach. What we wanted to see was more specific targets around reducing sugar and saturated fat in products, recognising that that probably was not as straightforward to do as reducing salt, but making clear what were the key product categories where there needed to be more reformulation. The really big issue still is tackling promotions, both in terms of promotions to children but also promotions within supermarkets, whether that is about product positioning or price promotions. Because that is such a contentious and difficult issue for the food industry, it is very difficult to make any progress through the Responsibility Deal-style mechanism.

The other positive thing I should mention is the roll-out of traffic-light nutrition labelling, which, as Susan Jebb said, is a significant step forward. Hopefully, by the end of this year it will be very visible. Some of those that have committed have not actually put it on pack yet but it will be very clear with two thirds of the market providing it. That was something

that was sparked by a regulatory initiative—the review of the food information regulations at EU level—rather than necessarily being through the Responsibility Deal.

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

Q93 Grahame M. Morris: That is in relation to the diet side of things—reducing salt and saturated fats. Can the Responsibility Deal do anything in terms of encouraging physical activity or tackling inactivity? Is that linked in any way?

Sue Davies: There is a group looking at physical activity. We have not been involved with that, so colleagues on the panel might have a better view of whether that has made any progress.

Q94 Grahame M. Morris: You cannot make any assessment of that. Maybe David could answer that.

David Stalker: The chair of that group is our chair and it is the aim of ukactive to get physical inactivity as a public health real core area, but there is no point in that becoming a core area if businesses are not looking at it from their own point of view. We have seen it as very valuable because it has brought people around the room to talk about physical inactivity and the differences it can make and, out of that, the pledges that have come. So there have been big benefits from that area for us.

Jane Landon: With the physical activity dimension to the Responsibility Deal, it has done quite well to showcase and increase activity around existing activities and diet initiatives, but I am not sure that it has necessarily brought forward anything that is additive to what is already going on.

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

Q95 Grahame M. Morris: How do we measure the success of the Responsibility Deal? One of my colleagues earlier quoted the graphs of doom about levels of inactivity in the UK compared with other European countries and other countries across the Atlantic. How are we measuring—David says it has been a real positive—success in this regard?

Sue Davies: There is an independent evaluation being carried out by the London School of Hygiene & Tropical Medicine, so that is the independent all-encompassing evaluation. From our point of view, we assess its impact in terms of whether or not it is achieving

change in some of the key areas that our research shows people want help in: that is about reducing fat, sugar and salt levels in foods, about responsible marketing, consistent labelling and helping to make healthier options cheaper. As I mentioned, there has been some progress in those areas, but not on the scale and not by as many companies as you would want.

Dr Knapton: From the BHF point of view, we have never been a signatory to the Responsibility Deal because we felt that the evaluation was not robust enough, and the sanctions, if the industry did not deliver on its pledges, were not strong enough. We think you can achieve these changes through other means, which we might come on to later in the questioning.

Q96 Valerie Vaz: I want to ask you about labelling. You said there has been some significant progress. Could you just expand on that?

Sue Davies: Yes. Which? has been campaigning for consistent front-of-pack nutrition labelling, including traffic-light labelling, for several years. The research that we did testing different labelling formats with consumers and the research that the Food Standards Agency did showed it worked best for consumers because it was simple and clear; you have the red, amber and green highlighting the levels of the key nutrients that most people are concerned about. There were a lot of different schemes on the market for a while, which just made it confusing. There was a big breakthrough when all of the supermarkets agreed that they would put traffic-light labelling on and use the scheme that the Department of Health has worked with them on. Also, what was really encouraging was that several of the big manufacturers who had previously been quite resistant to traffic-light labelling did a U-turn and committed to doing that. That is why we will see widespread traffic-light labelling across the board. That is a huge opportunity because it means that you can have much more consistent messages, whether it is in schools or Change4Life; you can tell people what to look out for. Those retailers who have already been using traffic-light labelling for a while have also said that it has a positive impact in that it encourages reformulation. For those who are developing the recipes, particularly on things that it is intended for such as ready-meals or sandwiches, it is an incentive to them to try and get more ambers from reds and more greens from ambers. We hope that by the end of next year people will be familiar with it and will be using it more widely.

Q97 Valerie Vaz: What sort of effect is it having on people's choices and buying? How are you measuring that?

Sue Davies: It is really difficult. Unfortunately, there has not really been any kind of independent evaluation of it. There is anecdotal evidence from those retailers who have been using it for a while. They say that it does influence people's choices and that it may also depend on the buying occasion or the day of the week, but generally people like it and are using it. The Department of Health is looking at how to evaluate the scheme now that it is in place and will be looking at purchasing data to see what kind of impact there is and how purchases have changed before and after the introduction of the scheme. That will be really important to have a kind of independent measure of the impact. The research that we have done—in just asking people about it and, also, as I said, testing it before—shows that people do like the scheme.

Q98 Valerie Vaz: You are asking the supermarkets, for example. What about the manufacturers? Are you getting any feedback from them?

Sue Davies: It is only recently that the big manufacturers have committed to it. There were a few smaller manufacturers like McCain; they are obviously fairly big, but they were one of the only ones that committed to it. But now that we have Mars and PepsiCo, some of the big players, on board—and Coca-Cola now as well—it will be interesting to see what sort of impact that has on their products. But even though two thirds have signed up, there is still obviously a third that is not doing it and it is going to become very visible to consumers. If you take something like breakfast cereals, where we have done a lot of studies looking at the high sugar content, particularly for children, you will see that the own-brand product will have the traffic-light labelling on but the Kellogg's one, because they have not committed, will not have it on. Hopefully, the customers will then be asking the manufacturers, "Why are you not being transparent about what is in your products?"

Q99 Valerie Vaz: Did you want to comment on that?

Dr Knapton: BHF supports and has supported traffic-light labelling as a hybrid system for many years. We support voluntary action by the retailers and manufacturers and are frustrated at the pace of change. If people are going to make informed choices about what they buy, they need to know what is in what they buy. It seems obvious to me. The Food Standards Agency did also look at buying behaviour with and without labels and showed that it did move people towards healthier choices. If people are making healthier choices, the manufacturers and retailers will want to respond to that consumer pressure. But it is only a proportion of the products that are labelled and I suspect it is those products that are not as red; I suspect it is the green ones. I do not know, but I suspect that is the way—

Q100 Valerie Vaz: I have seen lots of greens.

Dr Knapton: I realise there are difficulties at a European level in terms of bringing this on, but for me it is about enabling people to make informed choices about what they are buying and then they can balance off. We should not underestimate the degree to which individuals are able to do that; they are not stupid. They will choose some reds and they will offset that with some green, and I think human behaviour is such.

Jane Landon: We have also researched and advocated for the traffic-light scheme over many years. The piece that is still missing probably is that we need a public campaign behind the labelling scheme. One of the objections raised by some of the non-adopters is that the labelling colours are misunderstood. That could be addressed through a public campaign and I believe that Change4Life will incorporate some aspects of the traffic-light labelling in some of their forthcoming campaigns. Public educational campaigns are your best bang for your buck when they are supporting other initiatives and helping to drive home the understanding of something that is working across the whole population.

Q101 Valerie Vaz: Mr Stalker, in terms of your organisation and these so-called energy drinks, which are not really energy drinks—they are just sugar, aren't they?—what is your view about the traffic-light system? I will come on to labelling in a minute and other ingredients.

David Stalker: I am rather taken aback because, to be perfectly honest, we steer very clearly on talking about inactivity and activity, and we believe wholly and totally that it has to go hand in hand with good nutrition and good diet, so we are very supportive of any scheme like that. But in terms of saying, "We have an opinion on those drinks," obviously we are never going to support high-sugar consumption or anything like that.

Q102 Valerie Vaz: You are talking about the traffic-light system. What about the other system, because there was resistance earlier about saying what is in the product—for example, sugar and then high-fructose corn syrup and various other things further down—and it is now standard, is it not, in most foods? What is the efficacy of that? What is the evidence that that actually works?

Sue Davies: There are minimum requirements now under the EU food information regulations so some manufacturers are still putting the front-of-pack nutrition labelling on. They can do it on a voluntary basis; they can either put energy or all of the five nutrients on the front of it. Some have decided just to do that, but obviously the national scheme that has been developed includes the traffic-light labelling scheme. In a way, that should have sorted out any problems because everybody needed to move a little bit. Those who were just using traffic lights but not percentage reference intakes are now putting those on, and some of those manufacturers who were just doing percentage reference intakes have put the traffic lights on. In that way everybody can compromise a bit, but, from a consumer point of view, you then end up with a single scheme and everybody knows what it is.

Q103 Valerie Vaz: Does anybody else want to comment?

Dr Knapton: We have supported a hybrid scheme so that those who want to can look, and those who, like me, do not have the time can just shove it in the basket and get out of the shop as quickly as possible. But the information is there for people to make a choice if they want to use it.

Q104 David Tredinnick: I want to move on to portion size, but, before I do, can I offer a personal insight on cereals? It is very hard indeed to get a low-sugar cereal, in my experience. In my household, we have bought the separate ingredients and put them together. If you do that, you end up paying less than for a packet of cereal and you do not have the sugar. I know that for a fact; I have tested it many times. No comment needed.

On portion size—this is for you, Dr Knapton—the British Heart Foundation has argued that portion size can have a significant impact. You suggest that "an urgent review" of policy in this area is needed. Could you give us a little more detail on this, please?

Dr Knapton: Yes. As I understand it, the Government information on portion sizes was last looked at 20 years ago. There has been considerable change in the way in which

people approach food and portion sizes. You can see that in terms of what retailers sell, what people sell through takeaways and restaurants and how people eat in their own home. We commissioned a review ourselves, which was called "Portion Distortion: How much are we really eating?" to try and get a sense as to what has been happening. We basically think that there should be a review to inform both consumers and industry about the production of food and what sensible portion sizes are to have a healthy diet in terms of calories and nutrition intake.

Q105 David Tredinnick: Would it not be possible to introduce a traffic-light system for portion sizes which would fit alongside the traffic-light system we have already been talking about? If people can buy portions that say on them, "This is for four," can we have some indication that that is a suitable portion for four, or two or one? I am just thinking on my feet, as we say here—although I am sitting down—but do you think that is a possible idea?

Dr Knapton: It would be difficult. I have no doubt that it would be possible. We are looking at more health promotion and health education advice. Some slimming products do control the portion size in terms of controlling people's calorie intake, but most of my patients, when they use those, will eat two rather than one because they do not think they are getting enough.

Q106 David Tredinnick: I do think it is sad at a time when we have food banks in certain areas—and I have one in my own constituency, which I am going to visit very soon—that we should also face at the other end of the scale the problem with just too much food on a plate. Having been around a bit longer in this life than some, I well remember the smaller portions that we used to eat. Every time I go into a canteen, I still have in my mind the size my mother served that we used to get a very long time ago. I do not see how people can control their diet if their norm is just the wrong amount of food on a plate.

Sue Davies: That is definitely an issue. Portion sizes have to be responsible and realistic. You have the problem at one end where sometimes you will get a really unrealistic portion size to make the labelling look better. Something that you might think is one portion, when you actually look at the small print, is two portions. Then there is also the situation, particularly when you are in the out-of-home sector, as you mentioned, that when you are at service stations or train stations you often only get the large portion when you actually want a smaller portion. The whole area of portion sizes and being more responsible is an important area to tackle.

Q107 David Tredinnick: There is an offer issue here, is there not, and a distribution issue, that perhaps there should be some regulation on the sizes that are put out in the marketplace? Maybe what is being offered is not suitable to the recipients, so they are getting too big a portion and they have no option but to buy it. Maybe that is something we should look at. I think, Dr Knapton, you are nodding.

I know we are a bit pressed for time and I want to move on to reformulation of foods. Much of our evidence has highlighted salt reduction as a great success. Have there been any drawbacks to the voluntary approach adopted for this? Should this approach be extended to

sugar, fats and calories? Would you envisage any difficulties in doing this? I am thinking of representatives of the UK Health Forum and Which? to answer those questions first.

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

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

Dr Knapton: We, also, are pleased with the progress of the reformulation with regard to salt, but I would not say it was "job done". I think we are down to about 8.1 grams; we are aiming for 6 grams, so there is still, on average, too much salt in our diet, which is a risk factor for blood pressure, which in itself leads on to kidney disease and stroke—two very significant problems that I deal with at the British Heart Foundation. We have been working quite closely with CASH—the campaign for action on salt—to look at niches within the food chain where salt is still unregulated, such as food out of restaurants and takeaway foods. They do periodic surveys on the salt content of these products and have found very significant levels of salt. At the moment that is not even labelled so people would not know. With regard to the others, I agree that it is more complicated, except when it comes to sugary drinks. That is a relatively simple area that you could make a big difference on.

Q108 Chair: Thank you. Could I come on to the area of advertising, marketing, promotions and, obviously, placement, and perhaps start with you, Sue Davies, if that is all right? Could you say, from your point of view within the organisation you represent, what you feel would make the biggest difference, and also, crucially, what do you think would be

most acceptable to consumers? Is this something that consumers want to see happen? Do people want to see an end to these placements on the ends of supermarket tills? Are we missing a trick here?

Sue Davies: It is an area, from our surveys, that people want to be tackled. People get frustrated by the amount of marketing of unhealthy foods to children. Although we have had restrictions that have come in, such as the Ofcom TV advertising restrictions, and also there was a review of the code of advertising practice which deals with some of the non-broadcast techniques, there is still an awful lot of marketing to children that goes on. That is because the restrictions do not cover all of the times that children are watching television. There would still be promotions in family viewing times, for example, and we think we need to be looking more at how children are interacting with different media, including television, so looking at on-demand services, making sure that is covered as well.

But on the non-broadcast side, there is still a whole range of different marketing techniques, from sponsorship to use of packaging, to a variety of digital media, some of it user-generated content as well, which is quite difficult to keep track of. The restrictions and voluntary pledges that the food companies have made generally only deal with the younger children and do not deal with the full range of promotions. That is an area that definitely needs to be tackled and is something, from our surveys, that people, whenever we ask them whether they want it to be tackled, strongly support. It also comes up when we do more qualitative research as well.

The other area you mentioned is the supermarket promotions. There are a huge amount of products that are on promotion at the moment. When we asked the supermarkets if they had policies for what they included in those promotions, only the Co-operative and Sainsbury's told us that they had actual targets, and their targets were only for about a third of the products on promotion to be healthy. The others would not give us them or they did not have them. That is a really important area to tackle given that so many people are drawn to them. The research we have done more generally on price promotions shows that people find them frustrating and do not really trust them, but then it does make them buy things.

Q109 Chair: So they are effective. If they were not effective, they would not be used.

Sue Davies: Yes. I think there is real scope to tackle that area and make sure that they are used responsibly.

Q110 Chair: When you talk to consumers, are they telling you that they would like to see an end to promotions on unhealthy foods? Would that be a popular thing to introduce?

Sue Davies: It is probably about getting more of a balance, because sometimes people will want to buy particular treats and at the moment it is too much weighted towards the unhealthy food. Perhaps ruling them out completely on unhealthy promotions might be difficult, but there are certain areas such as the slightly iconic things like the sweets at check-outs where quite a few of the supermarkets seemed to make commitments about 10 years ago but have gone back on those. Also, a lot of other types of outlets promote

chocolate at the check-out, when you are buying a newspaper and that kind of thing as well. That whole area is another one that can easily be tackled.

Q111 Chair: I am trying to gauge from you if that is something that consumers would like to see end. In other words, if you want to try and control your diet and avoid those impulse situations—if you have to pass through a chicane as you get to the check-out—is that something that you are being told by consumers they would like supermarkets to stop doing?

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

Q112 Chair: So that would be a popular move with customers. Do you think also that the use, for example, of terms like "Designed with children in mind"—I have seen one recently for Kinder—should be banned outright? In what way is Kinder designed with children in mind, if you are looking at their health?

Sue Davies: Yes, and sometimes there are still these implied health or nutrition claims suggesting that something is better for you than it is. That crops up as well where sometimes you get reduced sugar products and people think, "I will buy that because that must be good for me," and actually it is still loaded with sugar. In some of the surveys we have done as well people see something with low fat, think that is good and then realise when they look at the small print—or maybe they don't—that they are just eating a load more sugar and perhaps even more calories than they were getting if they had bought the standard product. There have been rules that have tightened up the proof behind the claim, but you can still get away with putting in a vitamin or mineral or something and then still have a lot of fat, sugar and salt in products. That is an area—

Q113 Chair: Do you have a concern about the marketing of sports drinks to children? A lot of people feel there are no circumstances in which a child would need a high-calorie sports drinks. Do you think we should stop marketing those to children altogether?

Sue Davies: It is not something we have looked at specifically, but a lot of them are just high-sugared drinks that are targeted at children and the same rules should apply in general. They should be caught when we are looking at restrictions on the way that products are marketed to children.

Chair: Thank you; that is very helpful. We will move on to Grahame.

Q114 Grahame M. Morris: We have talked about voluntary codes and the efforts that are being made to persuade the industry to participate voluntarily. Can we look at fiscal policies? I think you heard the evidence of the earlier panel and Professor Wareham talked

about taxes on unhealthy foods. In fact, Sue, you are an advocate of it, are you not, starting with sugary drinks, beverages that—

Sue Davies: Not as Which? actually. We have not called for it, just because we have not done the research ourselves. The UK Health Forum has advocated for that.

Q115 Grahame M. Morris: What is the general view on that in terms of applying a tax policy to influence people's behaviour?

Jane Landon: The view from where we are is that this is something that is well worth exploring based on our experience of how taxes on tobacco and alcohol are demonstrated to reduce consumption, and they are a key pillar, for example, to tobacco control and alcohol harm reduction. With food taxes, we have evidence in terms of natural experiments in other countries. France introduced a tax on soft drinks a few years ago; Denmark introduced a tax on saturated fat, which lasted a year before it was repealed, but even within the 12 months that it was in place there was evidence that, as prices rose in response to the tax, consumption dropped on the taxed products. Modelling evidence also shows that we can predict what sort of elasticities apply in different product categories and what kind of effects we might see. The frequent argument against them is that they are regressive, but the argument I would come back with on that is that, although, yes, people on lower incomes may be harder hit by the taxes on, say, a soft drink, they are more likely to be responsive to the tax, and the effects of drinking the soft drinks are more keenly felt in the groups where they have the highest health problems. So the health impacts are progressive even where you may have a regressive—

Q116 Grahame M. Morris: Dr Knapton, do you have a view on that from the British Heart Foundation?

Dr Knapton: Yes. We are not supporting a sugar tax.

Q117 Grahame M. Morris: You are not.

Dr Knapton: We are not, but we are reviewing that position, so, like the others, we are looking at it. One of the additional reasons why we are cautious is that we think it pushes us away from Susan Jebb's view, which we agree with, that you should look at the whole diet. We talk about a balanced diet and—this is a strong word—this would be demonising one nutrient, because sugar is a source of energy and in moderation is part of a healthy diet. We want to talk about a whole balanced diet, as to how people eat. As Susan Jebb said earlier on, people do not buy fat, sugar, salt and all the rest of it; they buy meat, veg, milk and butter. While what I have said about food labelling stands—labels allow those who wish to choose to choose—most people buy food, eat food, cook it and do what they do with it. So at the moment we are not supporting a sugar tax.

Q118 Grahame M. Morris: Or salt.

Dr Knapton: Or salt.

Q119 Grahame M. Morris: Very quickly, Mr Stalker, are there some fiscal incentives that could be used to encourage physical activity then?

David Stalker: Yes. I would think there are enormous incentives in terms of usage of facilities, private, public and the rest of it, and corporate opportunities where it does not become part of a declarable extra. The difficulty if you start giving those benefits is in measuring that people are using and completing the activity. That is the challenge. There is more of a need for us to look at the lowest common denominator in terms of those people who are doing the least and seeing how we get those people moving.

Grahame M. Morris: Thank you.

Q120 Valerie Vaz: I want to pick up on your point about sugar because sugar is not; it is naturally occurring. It is the added sugar that makes us want to keep on buying the products, which is why it keeps going into them. So you do need some sort of incentive not to put the sugar in.

Dr Knapton: That is absolutely right, but sugar is a part of our diet.

Q121 Valerie Vaz: There is naturally-occurring sugar, but we are talking about sugar that is added into—

Dr Knapton: Added sugar is empty calories and does not do—

Q122 Valerie Vaz: How do you stop people doing that other than, to pick up my colleague's point, on a fiscal basis?

Dr Knapton: The other approach would be not to tax the food but to create incentives through the common agricultural policy and so on in promoting the growth of fresh fruit rather than sugar beet and what have you. I know that was quite successful in Finland in shifting the diet and outcomes there.

Q123 Valerie Vaz: We heard that adding the tax on seems to have worked in Mexico as well.

I want to move on to physical activity. In your evidence, you say that that is slightly overshadowed by diet and nutrition. Could you explain that?

David Stalker: Yes. It is absolutely overshadowed and I think, almost, sitting at this table I feel overshadowed by nutrition people. But let us understand that this Committee is dealing with both and I welcome the opportunity for physical activity and inactivity to be on that agenda. It is overshadowed largely because, as an industry, we probably do not have the concrete evidence yet of the differences that are made by physical activity in a normal surrounding. We have plenty of evidence from what happens in university studies and the rest of it.

Also, when we look at those NICE guidelines and at recommendations for 20-odd lifestyle diseases, physical activity plays a key part, but I am not entirely sure that in any, or

in many, GP surgeries there is really an understanding or a comfort in passing people on to physical activity to deliver on those changes, and we have seen with smoking and things like that referring people to those who are experts in that. What I would like to see is a physical activity counsellor—in my wildest dreams—in every GP surgery, where it was not just about exercise referral, because it is not about that, but it is about counselling, understanding and your mindset. It would be a valuable service for them to be part of a GP set-up. But we need to get more evidence. We looked, in the work we did with Public Health England, and there were 900-odd things out there, different campaigns and things that have happened, and it is just too much. We need to start finding things that actually work and see how we can take those forward. Public Health, when we did our first "Turning the tide of inactivity" report, gave 2% of their spend to physical inactivity in a year. It has increased to 4%, so we are going the right way, but it is a long way off what is happening in sexual health or areas like that, which are important, but, for us, physical inactivity needs to go up the agenda. The colleague who was at the table earlier—the Cambridge report—said it for me entirely: it is a top-tier concern so we would like to see it go that way, working in partnership with people on food and diet absolutely, but inactivity in its own right is now absolutely crucial.

Q124 Valerie Vaz: And it promotes these endorphins, which helps people to feel good.

David Stalker: Absolutely.

Dr Knapton: To reassure and to remove the shadow that you felt was cast on you, the only reason I have not talked about physical activity thus far is—

Valerie Vaz: Because you weren't asked.

Dr Knapton: —that these guys have not asked us about it. We fund the National Centre for Physical Activity and Health in Loughborough, which is an evidence-based outfit. Elaine McNish runs that. That provides us with the assurance that the advice that we give as the British Heart Foundation on physical activity is robust both in the outcomes and what works in promoting physical activity. We have just published our BHF supplement on physical activity this month, which sets out the current state of play with regard to physical activity in the round, both in children and adults, with a particular focus on heart patients and the role of prescribing and providing physical activity as part of a package of care called cardiac rehabilitation following a heart attack or a heart operation. That is a very effective way of increasing it. Not only do you promote physical activity, but you can show that intervention increases levels of physical activity in those patients who access cardiac rehabilitation and also there is this very new concept, which is an emerging concept, around sedentary behaviour as a risk factor in and of its own right. I have been rather persuaded that that is an important thing to look at, because the CMO's guidance, which recommends either 150 or 60 minutes a day, or whatever the target is you want to look at, only accounts for three or four hours a week, and there are 168 hours in the week. Even if you fulfil the CMO's guidance and then spend the other 100-odd waking hours sedentary, you are still putting yourself at considerable risk because of the relationship between sedentary behaviour and a range of diseases—cancers, heart disease and what have you.

We are very keen to do something, but at the moment we have not set a target for reducing the amount of sedentary behaviour that we have experienced this afternoon, for instance, because at the moment the evidence is not there. So our call is to work with our partners in the research community to say, "Okay, what is the impact of reducing sedentary behaviour and what is the dose relationship?", if you can get to that point.

Q125 Valerie Vaz: I think the evidence is out there. Michael Mosley does some excellent programmes about diet and activity, so it is just a question of getting the evidence out to the right people. That is what Mr Stalker's point is and the key point is in a GP surgery, where you are likely to be there.

Dr Knapton: My GP surgery—

Q126 Valerie Vaz: Oh, no, we are not personalising this at all.

Dr Knapton: No, but it is mixed. Some surgeries are good and others are not. We have a "Walk2Go" programme, which is a referral programme; we have exercise on referral. Our practice manager does a walk round the local city park in Milton, and that is the most popular thing because I do not get involved; keep the doctor out of it.

Q127 Valerie Vaz: It is a guided walk, is it, for your patients?

Dr Knapton: Yes. It is a guided walk for anybody actually, but people with high-risk cardiovascular disease, people who just want to get fit or people who have retired and want to maintain their fitness. That is extremely popular. I would say the biggest advocate for primary care involvement as a way of promoting physical activity is probably Dr William Bird, who has done a lot of work in his surgery in Reading to promote physical activity through primary care.

Q128 Valerie Vaz: I have one quick thing before I move on to the others. What do you write on a prescription for physical activity, because apparently you can write a prescription for exercise? What would you write on it—I am fascinated—while you are here? What would you say? Where would they take it?

Dr Knapton: Some people would get referred to the local authority exercise referral scheme and they get money off the swimming pools, the gyms and all that sort of thing. Actually, what I would do is negotiate with my patient and say, "What sort of level of physical activity would you wish to achieve? What would be realistic?" Then I would say, "Are you really sure?", and we would agree that. It is probably formalised mostly in the management of diabetes, where you set annual objectives, but there is no reason why it could not be done for anybody—high-risk patients—and certainly in cardiac rehabilitation it would also be done in that formal way to set realistic targets. For some people it would be taking up—what was it?—swimming and becoming a triathlon leader. For most of my patients it would not be, but they may want to take up cycling, dancing or whatever it is. It would depend on the patient.

Jane Landon: It would be well to avoid the trading off of diet against physical activity because clearly both are very important. Looking back over the 30 years that have led to the current situation we are in, the Foresight report refers to the fact that there are systemic problems in the food environment and the physical environment that have led to where we are now. It will take some time to resolve that, but we will not tackle systemic problems by just focusing on individuals. While these are necessary for people coming into Mike's surgery who have particular problems, if we are really going to shift the curve, in terms of overweight and obesity, and also other diet-related illness, we need to recognise that the responsibility—the accountability, actually—for these problems rests across Government. We need not just to talk to individuals but to local authorities because they have capacity. Our focus is on how we create healthy places—healthy people follow in healthy places—and what could constitute a health-creating economy. What would that look like? It would probably look rather different from how it looks at the moment.

We have the tools available to us; we have dietary guidelines; we have CMO physical activity guidelines. We are only really using them when we talk to the individual, but these should be perhaps guiding decisions and policy decisions across Government Departments, whether it is transport, business and trade as well as health. We are kind of reframing some of the discussions. One of the things we are not doing is any kind of health impact assessment on Government policy; we are not looking at the impact on the food environment or the physical environment when we make decisions across Government as routine. This could be something that could be much more effectively carried through and we would start to pick up those pressure points when things start to go wrong, which they have done over the last 30 years, and respond to those at the time that new policies are being put in place because it is very difficult to retrofit.

Chair: Thank you.

Q129 Valerie Vaz: I have one last question. There is the campaign for "five-a-day". What would you have as your campaign for physical activity, just briefly in one sentence? I will go down the line, though you do not have to answer if you do not want to.

Dr Knapton: Just do more. If you want it in one sentence, just do more. If you are an elite sportsman you can do more, and if you are a completely sedentary person—and we heard from Nick Wareham—walking 20 minutes a day will improve your prospects with regard to long-term conditions.

Jane Landon: I understand that an amendment to the transport—

Chair: The Infrastructure Bill.

Jane Landon: The Infrastructure Bill is going to put a duty on future Governments to make a long-term investment plan for walking and cycling. I would argue that we should make at least 3% of transport budgets available for supporting those long-term plans.

David Stalker: In light of the danger of being at the end of the line, I agree entirely with Mike: "Just do more"; absolutely.

Valerie Vaz: Thank you very much.

Q130 Chair: Thank you. Can I quickly follow up on a point? We heard from the last panel that NICE did not find any support for exercise on prescription. Can we just clarify whether you feel it is different for those who are recovering from myocardial infarctions? We need to be clear about what the evidence is. Do you agree with NICE's position that exercise on prescription, as a generality, is not effective, but would you argue that there is a different evidence base for people who are—

Dr Knapton: I am not in a position to argue with NICE. They have looked at the evidence in more detail than I have, so I am not going to argue with that. I do not think this is an alternative to what Jane was talking about, which is creating an environment in which physical activity is promoted—I think they go hand in hand; but, in dealing with people at an individual level, there is good evidence that promoting physical activity in the right way, through a motivational interview-type approach, looking at what that individual feels is realistic and likely and they are motivated to do, works. I tend to use it where I think it is going to have the most difference, which would be for those with pre-existing cardiovascular disease, cancer and some musculoskeletal conditions, and it has an impact on mental health problems, and probably also high-risk individuals as identified through JBS3 guidelines for the assessment of cardiovascular risk, for instance. So that is targeting it on those who are most likely to benefit.

Q131 Chair: Thank you. Could I come to David Stalker, please, just to return to an issue we raised with the previous panel on the difference between uptake for physical activity between boys and girls? What is the best evidence that you as an organisation would like to put to the Committee on how we can increase uptake of physical activity in girls?

David Stalker: Yes. We do not have a view. We recognise it as a serious problem. We do see things like the Sport England "This Girl Can" campaign that has just come out as, at last, looking at physical activity being for everybody. With girls—having a daughter of my own—and listening to them, we need to spend more time listening to why they are not doing it as opposed to taking a wild guess. I think it is going to be in variation. It is about finding all kinds of options from yoga to Zumba to walking, and so on, but at last a campaign such as "This Girl Can" is giving people the feeling that they can get involved in activity.

Q132 Chair: Has Which? undertaken any research in this area?

Sue Davies: No, I am afraid we have not. We have not really focused on physical activity, not because we do not think it is important—we recognise it is vitally important—but it is just that our expertise is, we feel, better focused on the food side. We do look at things where it is helpful. We have just done a review in the magazine looking at apps to help you do exercise, for example, but we have not got involved in the wider policy debate on it.

Q133 Chair: Can you maybe comment on the apps that you have reviewed? What makes a good app?

Sue Davies: Could I send you the report separately, if that is okay?

Q134 Chair: Yes, certainly. I wonder whether, Jane Landon, you want to comment on that.

Jane Landon: The discussion about engaging girls in physical activity reminded me of someone who was working in the educational field, who said that his view was that sometimes it is hard to keep very young children still. Your difficulty is not getting them active—it is keeping them still. The question is: what happens over time? He says, "You go with the natural grain of what they are already doing," and his view was, "In the school yard, don't ban it, whatever it was they were doing. Organise it and provide some infrastructure around the sorts of things they were already interested to do." I thought that was quite a good way into thinking about keeping young girls, particularly, active from school age through that period when we know it goes off a bit of a cliff in their mid-teens.

Q135 Chair: Perhaps for older patients—the patients who are contacting the British Heart Foundation—do you still see a difference between older men and women in uptake of physical activity, or are there any techniques you have seen that have been most effective in encouraging people to move a bit more afterwards?

Dr Knapton: I am not sighted on that gender difference right now, but I can go back and find out.

Q136 Chair: I just wondered if it was something you had noticed.

Dr Knapton: Certainly I do recognise the fall-off particularly in teenage girls and why that is so. We put a call out two years ago for some focused work through our Hearty Lives programme—and we have six programmes running at the moment—where we asked local authorities, who were then the lead for public health, to look at physical activity and obesity in children. We did not specify which subgroups, and actually three or four of them, interestingly, went for looked-after children. They felt that looked-after children were particularly disadvantaged in this regard. It reminds me to say it is not just gender; there are other inequalities that need to be attended to. Those will be reporting next year in terms of their findings.

Chair: Thank you. Finally, David has a question.

Q137 David Tredinnick: Yes, I have the last couple of questions, you will be relieved to hear. I want to ask you about workplace-based initiatives. How useful are workplace-based initiatives for improving diet, obesity and physical activity?

Dr Knapton: We supported a Health At Work programme, which was evaluated by Fiona Bull, who was then in charge of the centre in Loughborough. They found that it was very popular. They have had some interesting findings about how to do it well. In terms of the bottom line—persuading the finance director to invest in these sorts of things—we were unable to demonstrate increases in productivity. However, we continue to support Health at Work, and we have 7,900 workplaces working with the BHF Health at Work

programme at the moment. So there is clearly something in it for employers and their staff. I suspect it is the softer stuff around feeling good at work, feeling rewarded and looked after. I remember I was at a meeting with Dame Carol Black, speaking about her work, and she said that no amount of access to physical activity, Zumba and boxes of fruit will compensate for the fact that you have a poor line manager. So Health at Work is also about good policies within the workplace.

Q138 David Tredinnick: But finance directors are unlikely—not necessarily, perhaps I should say—to be experts on health care. For a finance director to say that he could see no merit or no benefit from having fit people in the office seems to me, frankly, absurd. If you are not falling asleep over your desk because you are carrying 4 extra kilos, you are likely to have a better output, be sharper, make better decisions and likely to be more able to manage your life and the life of the company.

Dr Knapton: I agree. The feedback we got was that the finance directors were happy to have a fit and healthy work force, but until you showed a real move in the bottom line they were not going to invest heavily in it. We at the BHF do invest in Health At Work in our work force. We put money into it and provide resources, pay for showers, changing rooms and all of that. That is what I am getting at, getting the finance directors to invest in Health At Work rather than just accepting that a healthier work force is going to be a happier and more productive work force.

Jane Landon: In addition to that, you have to recognise that a lot of people are employed in small and medium-sized enterprises. Therefore, the calculations are going to be much trickier for them than for the big companies. Maybe because it is difficult to discount the benefits, it is necessary to give some incentives. There should be some central incentives to encourage, particularly small and medium-sized companies, to provide these sorts of services and provision. It could be concessions on employer contributions to national insurance, for example, because they will be contributing to a healthier work force and will gain benefits, but there will be some global benefits as well in terms of the overall work force.

Q139 David Tredinnick: In a previous inquiry—and we will finish on this—we had no less a person than the chief executive officer of NHS England, Simon Stevens, telling us of the company he worked for in America that offered inducements—I imagine financial, but you will have to read the minutes—to lose weight. I think he told us he lost several kilos and was very proud of it. If we were going to recommend anything, I thought that this was one of the things we probably should be recommending, where you get into the workplace and try and encourage people there to take more pride in themselves and make it part of the company culture. Making it no longer acceptable to take no personal care is what it boils down to. It is personal respect, personal care.

Dr Knapton: At the risk of trespassing off the topic, it seems to me that he is in a very good position to do that with the NHS work force.

Q140 David Tredinnick: We could not have a better advocate in a better place, could we?

Dr Knapton: Yes, exactly.

David Tredinnick: He is running the show. Chair, thank you so much.

Q141 Chair: Are there any final points that any of you would like to make before you go?

Sue Davies: I would like to comment on one point that Jane made. It may be going slightly too broad, but looking at diet and physical activity is a huge area in its own right, and one of the things we have put in our manifesto for the next Government is that we need a joined-up food policy in that we are often talking about issues around improving diet and then issues around improving sustainability, challenges around food security and trade policy. There is no joined-up approach across Government Departments, so a longer-term issue is about making sure that there is consistency and clear priorities that go across all Government Departments.

Q142 Chair: So you would agree with the previous panel, who said that we need a strategic overview with all those areas that are responsible for putting in place a policy working together.

Sue Davies: Definitely, yes.

Q143 Chair: Thank you.

Dr Knapton: In terms of contributing to the debate, I do not know if we put this in our evidence, but the Richmond Group of Charities towards the end of last year produced a report responding to the WHO "25 by 25", which is the notion of reducing the prevalence of long-term conditions by 25% by the year 2025. Our recommendations are set out in that, and, in line with what I think you have just said, the scale of the prevention challenge means that all political parties should make this a priority and we feel it should be led by the Prime Minister. It should have that level of priority for lots of reasons, not only the health of the citizens but also because the NHS is not going to cope with the burden of long-term conditions. So we started at that point and the WHO recommendations are a 10-year horizon. We think that is a realistic thing to crystallise our thoughts around in terms of approaching prevention.

Q144 Chair: Thank you very much. Jane, you had one final point.

Jane Landon: We have talked a lot about some of the barriers, difficulties and costs attendant on making some of the changes that we need to make, but we should also be bearing in mind that there are huge co-benefits because the sorts of policies and interventions that will be beneficial around our food environment and our physical activity environment will also support environmental protection, sustainable development and will help to tackle climate change. Seeing these things in isolation, we lose some of the big levers. Another lever just to leave you with is the Government's own purchasing power.

We could see much more in terms of better use of purchasing power and standards in terms of commissioning foods in all publicly-funded institutions. That would be a very good place to start.

Q145 Chair: Thank you very much. Did you want to add anything?

David Stalker: I want to go back to the point that, from my point of view, physical inactivity has to be considered a top-tier health issue, working with everything else; it really needs to be.

Chair: That has come across from both panels today, so thank you for closing with that important point. Thank you very much for your time.