



Health Committee

Oral evidence: [Impact of physical activity and diet on health](#), HC 845

Tuesday 10 February 2015

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Written evidence from witnesses:

- [Association of Directors of Public Health](#)
- [Department of Health](#)
- [Professor Jane Moore](#)
- [MRC Epidemiology Unit](#)
- [Public Health England](#)
- [Royal College of Physicians](#)
- [Dr Dagmar Zeuner](#)

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Members present: Dr Sarah Wollaston (Chair), Rosie Cooper, Barbara Keeley, Charlotte Leslie, Grahame M. Morris, David Tredinnick

Questions 146-282

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

Q146 Chair: Good afternoon and welcome to the Health Committee. Could we start with you introducing yourselves for those who are following the debate from outside this room, perhaps starting with Professor Wass?

Professor Wass: Thank you very much for inviting us. I am the academic vice-president at the Royal College of Physicians. I am in charge of public health issues at the Royal

College of Physicians. I have the chair of endocrinology in Oxford and I was responsible for the report that the Royal College of Physicians did last year on “Action on obesity”, which concentrated largely on management of obesity.

Chair: Thank you.

Dr Atherton: I am Janet Atherton. I am president of the Association of Directors of Public Health, which represents directors of public health across the UK, and I am director of public health in Sefton on Merseyside.

Dr Moore: I am Jane Moore. I am director of public health for Coventry and I have a visiting chair at Coventry university. I am also the vice-chair of the Association of Directors of Public Health West Midlands.

Dr Zeuner: Hello. I am Dagmar Zeuner. I am director of public health in Richmond, which is a south-west London borough. I am also the children’s lead on the London directors of public health group.

Kay Thomson: Hello. I am Kay Thomson. I am the health lead at Sport England.

Q147 Chair: Thank you. This is our second session on diet and physical activity, and their impact on health. Could I start with a question for Janet, Jane and Dagmar, please, about the impact of public health budgets? Are you able to achieve what you would like to do within your budgets and how does having certain aspects of that budget constrained affect how you are able to deliver what you would like to be able to deliver?

Dr Atherton: First, we have a ring-fenced public health grant going into each local authority, but when you are looking at the challenge of directing physical activity you need to look beyond that public health grant to the whole of the budget that the council spends, what the private sector is spending locally and what the NHS is spending locally, because it is a societal issue rather than something that you can deal with through very focused programmes, for instance, around weight management. We need to be looking much more broadly than the public health grants specifically, I would say.

Dr Moore: In terms of budgets, there have been some real benefits and synergy of having the ring-fenced grant within councils. It has allowed us to look much more broadly at how we use resource, but I would echo Janet in that some of the real value has been where we have created the partnerships and it is not about what public health does. A lot of this has been about leverage: how do we use the leverage of public health to get a lot of other parts of the system delivering change on our behalf? For example, I could use the work we have been doing with the police in Coventry—they have done a lot of work with us around working with communities and how we engage people in different ways in sport—and some of the work we have done with workplaces, where in fact we have not put in any resource. They have put a lot of time and resource in from the workplace to really deliver change and work with us, and in some cases have offered the financial incentives around some of the work we do related to events that we have not therefore had to find the funding for.

Dr Zeuner: Can I come in on a slightly different angle? I completely agree with my colleagues that we have been very crafty with rather humble money, and our position in

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

Q148 Chair: Do you feel that handing public health to local authorities has overall been a positive thing for delivering on some of the targets that we are interested in?

Dr Atherton: It certainly gives us many more opportunities to work right across all the different functions of the council and have better relationships with things like the business sector than was possible from within the NHS, for instance. But I would agree about the overall financial situation of councils being our major challenge rather than challenges around the ring-fenced grant specifically.

Q149 Chair: Just looking at the evidence, because of the prioritisation of NHS Health Check, for example—which we will talk about in more detail later on—I can see that the biggest loser has been physical activity in children. Do you see that, directly as a result of having certain areas mandated, it has meant that other areas have lost out?

Dr Atherton: When you focus down purely on the public health grant you only see part of what local authorities do. If you look overall at local authority spend on leisure services and the influence they have on schools, for instance, on children's physical activity and things like transport policies, that will not show when you are looking at the public health grant.

Q150 Chair: In other words, this kind of data is not very helpful.

Dr Atherton: It gives you part of the picture, but only a small part of the picture.

Dr Moore: I would reiterate that being in the council has been incredibly valuable and it is exactly the right place. It has allowed us to look at it in a much wider way, linked to the whole issue of deprivation and inequalities. It has allowed us to look at very different interventions to try and change those inequalities, but the timing is wrong in the face of councils having to make difficult decisions about how they protect core services. We cannot be immune from that; we have to be party to it. We can add value in how we generate the maximum benefit and outcomes for our population within the resources that are available and how we try and find other ways of doing things involving communities in different ways that are not about large injections of public sector funding.

Dr Zeuner: If I can just add, in a way, wherever you sit, you find some things easier and you create new boundaries. Now that we are outside the NHS, we have to work particularly on our relationship back into the NHS. For me, we are where we are and we make the best out of it, but the crux of the matter is that it is neither the local authority nor the NHS; it is a whole societal issue if we want to get prevention embedded.

Q151 Chair: Thank you. As a final point before I hand over to my colleague Barbara, would you like to see the public health spending categories having prescribed and non-prescribed areas? Would you like to see that change so that you had more flexibility about how you spent that money, or do you think having prescribed functions is a useful thing?

Dr Atherton: It is the first time probably that there has been any real transparency about spend on public health programmes, so that is absolutely welcome. In practice, we perhaps find some of the categories—the types of things we are now able to do through local authorities—a bit constraining and quite traditional in the way things are divided up. Also, when you are looking at prescribed and non-prescribed, the prescribed things tend to be those that have a clinical element, such as sexual health services, for instance, and we will always need to spend a decent amount of money on those services to be able to deliver a decent quality of service. So it is difficult. In general, local authorities would look for more discretion or the ability to have more discretion and scope to spend, but having more focus on the outcomes that are being achieved, rather than the amount of money that is spent on specific things.

Chair: Thank you.

Dr Zeuner: It allows us to learn a bit. At the moment it is pretty new territory, so I do not mind. Although the categories are clearly a little arbitrary, for me the principle is that one could track and look at whether mandated services survive longer, are better, flourish or otherwise, or whether it triggers disincentives and distortion. For me, it is quite useful as an experiment.

Chair: Thank you. Barbara.

Q152 Barbara Keeley: I have a question about what level of priority the two issues we are looking at of obesity and physical activity get in your areas specifically, and in local authorities more generally, but it would be useful if Dr Moore and Dr Zeuner told us, for context, what the situation of funding has been in your local authorities. Richmond is described as “affluent...healthy, safe and rich in assets...extensive parks and open spaces, high levels of volunteering”, all of which sound brilliant for physical activity, for instance. Could you say what the funding situation has been? Have you had substantial cuts? My local authority has had £100 million-worth of cuts since 2010, which means that the cuts are larger than the amount we take in in council tax. Is your position similar, Dr Moore?

Dr Moore: Yes. As with all the urban metropolitan councils, we are facing significant issues. Coventry has planned well so that we are still managing within budget, but the cuts have been significant. We will have lost 46% of the budget between 2010 and 2016. That is a significant element to manage. That has real consequences and is now into conversations about very different models—about leisure centres. But there is a big discussion about how we use that to our advantage, around growth, getting people into the city as well. So it is not just a “cuts” conversation on some of these items, but it does flavour the whole conversation about what we do and how we do it.

Q153 Barbara Keeley: Has it actually changed the priorities? We have seen, I think, the end of free swimming. Has that been a cuts decision that local authorities had to make?

Dr Moore: It has invested in its leisure centres, particularly in swimming. In the last couple of years it has opened a new centre, which has increased considerably the number of people swimming, and is looking to create a new city-centre one as a sort of anchor around a whole leisure offer. But the aim is that these are financially self-sustaining.

Q154 Barbara Keeley: For instance, you did not have free swimming before.

Dr Moore: We have what we call a Passport to Leisure for the most deprived, which is available for people on low incomes. That is how we have done it.

Q155 Barbara Keeley: But you did not have free swimming for all children, for instance, or older people.

Dr Moore: No.

Q156 Barbara Keeley: To finalise on that—because these are two contrasting authorities, which is quite interesting—do you detect any shift in priorities? You seem to be saying that physical activity has become more of a priority.

Dr Moore: It has been more about seeing it in the round in terms of this. It has been a combination of how we use our leisure facilities in different ways that are going to reduce the financial burden on the council but enable more people to use them, and also looking at innovative ways of working. We work with Sport England and ukactive—a whole group of people—and try and get funding in from a whole range of things to try and support this in different ways. Therefore, there has been a real prioritisation—a partnership—and working with people, and not looking just to use the council funding to deliver these services.

Q157 Barbara Keeley: I understand. Dr Zeuner?

Dr Zeuner: In contrast, it is absolutely right that we are at the other end of the spectrum. We are not very dependent on grant; so the pressure is a little less, but nevertheless it is all pervasive. I do not think there is a single local authority now that can escape the reality of—

Q158 Barbara Keeley: Could you say, as Dr Moore said, what the change has been? You are not dependent so much on the grant, but what cuts have you seen?

Dr Zeuner: In the public health arena our approach has been to be more targeted.

Q159 Barbara Keeley: Is it possible to know the situation of the local authority? Have there or have there not been cuts? What is the scale of the budget cuts you have seen if you have seen any?

Dr Zeuner: We have to produce savings of several million—£30 million—over four years; so substantial savings and efficiencies have been introduced.

Q160 Barbara Keeley: £30 million over four years.

Dr Zeuner: Yes. The approach is obviously an absolute attempt to preserve front-line services. A lot is happening behind the scenes in terms of back-office functions because that is one of the big attempts. The other issue is: can we lever money in? So, like my colleagues, I look at other options of bringing money in. Then, from a public health point of view, we are moving away a little bit from a service model that offers one-to-one services, which is very expensive in a way, to thinking how we can work together with our colleagues in the environment, for example, to find options that are possibly reaching more people and are less costly.

Q161 Barbara Keeley: £30 million does not seem like a very high level of cuts to me, particularly if you are not dependent on grant, but has there been any shift in priorities around the two issues of obesity and physical activity that we are looking at? Has it caused anything to end or change?

Dr Zeuner: No. The fact of the matter is that we are starting from a relatively low point. Richmond is in a very fortunate position in that it has a lot of assets already. Therefore, we did not have to go into cuts. For me, some of the issues are around early years and children's services, for example, and longer term the question is how we can prevent further erosion.

Q162 Barbara Keeley: Do you have anything to add more generally than our two examples?

Dr Atherton: Certainly. In terms of Sefton, our level of cuts is very similar to Coventry. We have taken out £110 million over the last two years, with another £55 million to come out over the next two years. Inevitably, when you have challenges about the acute needs around social care, they are the same sorts of issues we face within the NHS where the needs of hospital-based care and urgent care often take priority over the longer-term prevention agenda. So we do have to look at other ways to make sure that that prevention agenda gets protected in a tough financial environment.

Dr Moore: Can I add one thing because I think it is really important? It has given us a big impetus to do some of the things around engaging with our communities in a different way. You talked about swimming. We know, because we have been doing some values and behaviours work with our communities, that only about a third of them would even vaguely consider doing sport activity, and there is about a third who would not do it even if you paid them. So we are trying to take different approaches which work from where people are, from their communities. Again, a lot of our communities are very insular; they do not go outside their immediate neighbourhood. We are trying to work on approaches that build within communities, build on people's lives, building on activities that are not seen as being about health, often, but about enabling people to have a better quality of life. A lot of those approaches are not high cost and we are trying to aim for them to be

sustainable by getting a much more diffuse leadership. We are not trying to drive all those initiatives. We are providing small bits of funding, resource and support to enable those communities to develop their own initiatives. That is starting to show real fruit in some of the communities we have been working with in Coventry.

Q163 Rosie Cooper: Before I go on to the question, Janet, you just said that you are subject to local authority pressures in the cuts that there are and to pressures in the health service. My initial out-of-the-box question would be, why is it better with you than it was in the health service, and is this just a name—is this just a game? The quote you just used was “other ways to protect this work”. What are they—real stuff, not namby-pamby stuff?

Dr Atherton: While a lot of us were in joint post before the transition in 2013, the general experience I am picking up from directors of public health right across the country is that they are finding being within local authorities is a much better environment from which to influence the things that we need to be influencing, such as transport policies and whatever. You may well have had reasonable links with the transport planners in your local authority, but being part of the same team makes a huge difference to being able to change the way that things are delivered. That is certainly one thing.

I can give a number of different examples of things that we are doing differently as a result of working in Sefton. For instance, we have done a lot of joint work around the local plan to make sure that health is absolutely built into that, cycling and walking being prioritised, safe routes to schools, 20-mile-an-hour zones and those types of things, which have all come in over the last couple of years through being able to work more closely.

Q164 Rosie Cooper: Why did you not do it before?

Dr Atherton: It is quite interesting how different it is being part of the same team as opposed to being a partner.

Q165 Rosie Cooper: So why don't we just dump the health service into local government? Is that what you are saying?

Dr Atherton: It is not what I am saying. That is a bigger issue than I could possibly answer.

Q166 Rosie Cooper: I would not recommend that at all, by the way, but if we are almost saying that geography, where you are located and who your colleagues are make a difference to the outcome—and I do not believe that either—then perhaps we should be looking at a more structural agenda, if that is what you are really saying. I am happy that it moves and I am not asking why it is different, but what I do not get from all this is why is it better, and if it is not better—

Dr Zeuner: I think it is early days to say whether it is better or not. We have not been in local authority that long, but it is fair to come back to the austerity point that we were talking about and what the solutions are. We have really tried, and I think up and down the country there are masses of examples of really crafty attempts to make the most out of

what is very little. Looking back at the NHS, I see Simon Stevens making it absolutely clear that we are turning the NHS round but saying that we need £8 billion, and he doesn't make a secret out of that. So why don't local authorities turn round and say, "Actually, we have tried our very best and we will continue, but we have very little. We need more."

Q167 Rosie Cooper: I am leading into the real questions, which are, what are the challenges in making use of NICE guidance on public health matters in a local setting? I hear austerity, but what else would you say the challenges are? What support do you think Public Health England has given you on your health promotion activities? Has it been useful? Then the big one, which comes to your final point, is what support would be most helpful? That is a long list, but it is about your challenges and how you would deal with them.

Dr Moore: I will start. The issues about healthy weight and physical activity are wicked problems. These are not going to be easily solvable and would not be even if we were not in the situation we are in with the restraint on public sector funding. Though the NHS has not had the same degree of pain as local authorities, we are working very clearly across those boundaries. That makes for real challenges in encouraging people to think differently about how we solve problems and how we look at maximising the benefit. It gives us challenges about sometimes changing the language to help people understand why this is important.

Some of the conversations—going back to business and to our growth—have been about the need for good growth and why that is important, and therefore why we need to look at health inequalities and some of the things like physical inactivity as being really limiting for our population. I will give you one example. The average age for a man in Coventry at which they will have substantial health issues that are limiting their life is 59 years. It is 70 in Richmond. That means, on an economic level, that we have a whole group of people who are economically inactive because of their health problems, who are not contributing to the economy in Coventry. So we have changed some of the story to reflect some of those challenges.

The biggest challenge is that you can see, in terms of inequalities and the gap between my health outcomes, that a lot of what we have been doing over the past 20 years has improved health overall but it has not narrowed that gap. One of my big challenges even in this situation is that I need to be doing something different, because doing more of the same is not going to improve health outcomes for people in Coventry—and I really need to be doing that. So I have got to think differently; I have got to think outside the box; and I have got to look at different ways of solving the problem, which is why I come back to it being a wicked problem. That is why we are using a lot from behavioural science and psychology—a lot of work with our communities to engage them so that we really understand what works for them—rather than just coming up with neat programmes. It requires you to do a lot more of a lot of different things rather than one big thing. That is challenging and it means that you are building things piecemeal from a different resource, from different bodies, and it requires a lot more time and effort to make sure that things are getting put in place.

Q168 Rosie Cooper: I will move on to the other side in a second, to Dagmar, if I may. I hear what you are saying, but you have NICE guidelines, you know what they are and you talk about finding different solutions for different bits of the problem. The problem that you outline is very large. What help and support do you get from Public Health England? How does this all work for you, to contrast it across?

Dr Moore: I absolutely beg, borrow and steal any help I can get from anybody. I am completely unashamed about that. When we were looking at healthy weight, Public Health England helped us around the evidence base because of their function around intelligence. We have worked across the system on how we learn within the West Midlands around some of these wicked issues. In terms of other bodies, again, it has been about creating dialogue, and that is why I am saying one of the challenges for us in public health is that it becomes much more about managing relationships. Getting out there and forging partnerships often is key to our delivery of effective public health rather than just the programmes that we deliver ourselves.

Q169 Rosie Cooper: How will we measure it?

Dr Moore: We are measuring it in a whole range of ways. Would you like me to talk about some of the ways we are trying to measure the effectiveness of what we do? Okay. Some of this is quite challenging because we are using things like social media, which are very difficult to measure. We have a whole range of ways we do it. In Coventry, we continue to do a household survey. In that we measure a whole series of indicators around public health, one of which is physical activity, and we also measure well-being. It is really interesting because there are very clear associations between physical activity, social isolation and well-being, so we are also comparing that. It allows us to look in detail. For every single public health programme, or where we are working in partners, we agree a series of metrics. Each of them has metrics which are quantitative in terms of measures that could be around weight or reaching people from our most deprived quintiles, and it can be qualitative around changes in people's perception, around the degree to which they are positive about their ability to change their behaviours. We also measure the high-risk behaviours, and we can actually say in Coventry that we are seeing a reduction in the number of people with those behaviours around drinking, smoking, physical inactivity and poor diet, and in the number of people who have multiple behavioural challenges around those. So we are monitoring that.

Finally, we are looking at how we use other measures to ensure that we understand how this is changing in the context of other things we are very keen on. We look at things like well-being and at the impact this is having on things like social networks. There is a whole range of ways that we evaluate and try to make sure that we understand the impact, but it is completely built in. For anything innovative that we try, we will build in an evaluation to ensure that we are getting the maximum learning from that piece of work.

Q170 Rosie Cooper: Thank you. What about the contrast, Dagmar?

Dr Zeuner: It is not necessarily a contrast. First of all, coming back to your specific questions of whether NICE guidelines are helpful, yes, they are; they are absolutely helpful. But we also have to be realistic and say that NICE guidelines, particularly relatively specific ones on some individual interventions, are not going to stem the tide of

obesity in this country. The causes of that epidemic are multifactorial and bigger than even the best NICE guidelines can fit. So, as to the NICE guidelines, absolutely, we work with them, we use them and they have good implementation tools associated with them, but we have to be realistic. What we have set them up to do they do very well, but we have not set them up to change the world completely.

What about Public Health England? Yes, Public Health England is a very important player in what we call the whole public health family and the public health system. It is, obviously, relatively new on the block and still finding its feet, but it has been immensely helpful to make the arguments. We need local democratic mandates to do our activities, our interventions and our priorities, and, for that, Public Health England is very helpful in fuelling us with the evidence base, the epidemiology and the trends so that we do not just talk about our hunches but—as far as we understand it—the science that underpins them.

Dr Atherton: Public Health England has a really important role in supporting us in our local action and also in terms of its influence on national policy. Our ability to be effective at local level is hugely influenced by national policy and that is where Public Health England, in terms of a voice at that national level, is really important.

Q171 Rosie Cooper: I have great admiration for Duncan. My final question to you is what more support would be helpful?

Dr Zeuner: Shall I start? Possibly the balance between what we call individual approaches to lifestyles and population approaches is a little bit too tilted towards the individual, so in the end it is choice and individual responsibility. Actually, I think population-based measures, such as regulatory approaches, promotion and product design—population-based approaches—are generally faster, cheaper and they are universal. That means they help us with inequalities. At the moment I find that the balance is a bit tilted. That would be one of the helps we could get.

The second is, “Local knows communities really well.” Allow local people to do their job well. That sometimes requires a little bit more devolution of power. You might remember that Simon Stevens talked about devo-max. Where there is a democratic mandate, allow local places a little bit more room for manoeuvre. Just to give you an example, planning legislation is one of the areas where a little bit more help would get us quite a long way: for example, getting exclusion zones around schools for fast-food outlets.

Dr Moore: I would reiterate the first point. There has been too much emphasis on the individual particularly around weight when we know the food environment is incredibly important. There is a lot more we could be doing about how we use planning around the location of fast-food outlets, about the need to give nutritional and calorie information. Knowing how many calories there are in something has a big influence at the point at which people eat things, about whether they eat or not.

Q172 Chair: We are going to return to that later. Just on a final point, would you agree that there needs to be more population versus local?

Dr Moore: Absolutely—more population.

Q173 Charlotte Leslie: All the evidence shows—and it has become quite a well-known thing—that there is a massive difference between the amount of physical activity that women and girls do and boys and men. First, I will ask this of Sport England but then to everybody. What can be done to address this? What are the main factors for this that you have identified and what can be done to address this?

Kay Thomson: We have been concerned about the gender gap for a long time and we have some good examples of offers that can be implemented locally to close the gender gap or increase participation in women. Most of our focus up until now has been on the supply side, such as working with people to develop appropriate offers when delivering to women. However, we also know that we can build the best sports centres, the biggest swimming pools and provide sessions at the appropriate times for women, but unless they have the confidence to become more active and to take that first step they are going to have limited impact.

You might be aware of or have seen our recent campaign called “This Girl Can”. I am not sure if Committee members have seen any of that in the recent month or so, but, when we did the insight behind “This Girl Can”, we looked at what the barriers were to women participating more. We know there is a gender gap and it is widest when people are younger. Even though participation is higher when people are teenagers, that is when there is the biggest discrepancy between men and women. But we also know that more women want to be physically active. About three quarters of women want to become more active but something is stopping them. When we looked beneath those barriers a bit more, we found out that it was emotional as well as practical. Overwhelmingly, when we talked to women of all ages across the country, we identified a fresh insight about a fear of judgment, essentially. That could have been judgment about appearance when exercising, ability to be active, confidence to turn up to a session or feeling guilty about going to be physically active or doing something when you should have been spending more time with your family or things like that. Often, that fear of judgment could outweigh the confidence of people to become more active. So we are trying to work on this programme in our new campaign, which is about liberating women from that fear of judgment and giving them the confidence and ability to go and be active. But then the offer has to be right as well. I am happy to talk about some of those examples if the Committee members are interested or if others do not have comments.

Q174 Charlotte Leslie: Does anyone else want to speak?

Dr Atherton: One of the issues as well is about the focus around sport to get people engaged. Certainly one of the things we would be promoting is about building physical activity into daily life, for instance about how people get to work, to the shops or whatever. Some of the evidence there is around women having more complicated journeys to make, which often are not very easy to do with public transport. Those types of barriers are important, but certainly I would say that the “This Girl Can” campaign has absolutely been successful in terms of the impact it has had through social media and in terms of my social groups picking up people just talking about it, which you do not often get with a lot of health promotion campaigns.

Q175 Charlotte Leslie: Have you had any hard evidence back on how successful it is? I know it is still going, but is there any hard evidence yet as to how it is impacting?

Kay Thomson: It is early days in terms of hard evidence. We can talk about the reach of the campaign and the conversations that it has started. In terms of views and the conversation on social media, it has had over 13 million views on YouTube and Facebook alone. That is only awareness.

We are measuring the impact of the campaign in lots of other ways. In future iterations of our Active People Survey—which is our participation survey—we will be able to look at women’s participation. We are looking at stakeholder engagement. The campaign is the first step to liberate people from that fear of judgment, but we are working really hard with our partners, stakeholders and colleagues at the table here, the local authorities, directors of public health and national governing bodies, to make sure they have the appropriate resources and tools to be able to deliver the sessions appropriately. We will look at partner engagement, media effectiveness and participation in the long term, but in terms of awareness we had something like 10 days of back-to-back national coverage, with the full range of breakfast TV slots, and I think something over 90% of all of the coverage has been really positive. It is early days in terms of the other measures.

Dr Moore: From our perspective, the key thing is about getting people active, particularly as there is this imbalance with women often being less active. We have been very keen to take a number of approaches and have been working with Sport England on a thing called “#YouCan”, with groups who are not usually active in sport, which has been women but also some of the people from our more deprived community. We have been working with the Sky Blue Trust—which is, for those who are not into football, our football club, the Sky Blues, Coventry City—which has done a very innovative programme which encourages girls to be engaged in physical activity around music and dance as well as some of the more traditional ways. We do have some evidence now coming out that that is encouraging girls to be more active.

We have a strong strand which is working with our schools, not just about getting the children, particularly at primary school, active, but also encouraging their families to be active. We have badged it “Happy Hour”, which is basically ways that parents and children can do activities themselves. We are not badging this as being about being healthy; we are badging it as active socialising, a way to have a good time with your children and at the same time to get the benefits of being physically active. We started running that in primary schools and are now starting a similar programme with secondary schools around how we encourage that form of activity at the end of the school day.

The third strand has been in working with our communities around what helps people to be more active. There is a lot of emphasis on walking, cycling and on things that people can do in their locality. For example, we are trying to get people out by making the environment more conducive just to walk around it and to have walking guides that have nice things to say such as, “Did you know this about this place on your walk?”—all of which are about ways of trying to get people, and particularly women, to be more active.

A key message that we got from girls particularly was that we need to work on things that make it attractive to their peer group. For women, once they get into their 20s and beyond and with families, we need to make sure that what we are planning, in creating opportunities for them to be active, is family based, because, even if they do not care about

being active themselves, they want to do the best for their children. If we create family-based activities, they are much keener on participating in them.

Dr Zeuner: Can I emphasise the importance of schools? When we think about where we could ask for some help, kids spend lots of time in school, and the statistics are that they get fatter from reception to year 6; normally, the obesity rates double. That is quite shocking, and it even happens in leafy Richmond, although from a lower base. So there is something of an opportunity that I really think we should grasp. For me, also, the stereotyping of some of the gender differences could be counteracted in schools. There is more that could be done in building physical activity not only into the PE lessons—one question to the panel, or to you, might be that it is quite astounding how little PE is now in the curriculum, and I leave that with you—but also into learning activities. If you look at schools and their pressures, a conversation with Ofsted might be helpful to allow schools the room to take that forward and really build it in.

Professor Wass: Can I say a couple of things which are pertinent to that discussion? One is that it is evident that education is absolutely key to this whole issue, and getting in there when the person is young is absolutely key as well. That makes the more general point that, at the moment, there is a complete lack of any co-ordination between various Government Departments in this whole issue of obesity such that we need a healthy environment in the health service; we need to educate our children; we need to grow healthy food; we need to have healthy transport with bicycles; and Work and Pensions need to take on all of this as well, just to mention a few Departments. If there was somebody—perhaps a Cross Bencher in the House of Lords who had experience of inter-governmental responsibilities and action—who could be put in charge of a co-ordinated Government programme, it seems to me that we would run the serious risk of being the first nation on the planet to solve the problem.

Q176 Chair: Kay, you wanted to come back on that point.

Kay Thomson: Yes. It is on Dagmar's earlier point about schools—though I am not in a position to comment on curriculum or school policy as those are matters for the DFE—and something Jane said earlier about needing to think differently and do something bigger and better. I would completely agree in terms of our broader work, but, also, in terms of participation, sometimes it is something really simple that makes a difference. Looking at some of the programmes that we have implemented in different areas, an example would be a school in Hull that has equal participation between girls and boys, which we have described as quite unusual. When we asked the school how they managed that, they said they spoke to the girls and asked them what they needed in order to do more PE and be more physically active. Their answer was really simple: they wanted 10 minutes after their PE lesson and some plugs for their hair straighteners to make themselves look nice again. Sometimes if you start where the girls are or where the people are in general, whatever group you want to speak to, it can make a difference as well.

Chair: Thank you, that is lovely. Barbara, I know you have a supplementary before coming back to Charlotte again.

Q177 Barbara Keeley: I cannot, I am afraid, let that point go. It is not an original idea that you are putting to the Committee about cross-party work. Certainly, Charlotte Leslie and I worked for a long period of time on this and presented to the Minister who is going to be with us later the need to have a cross-party focus, but the Departments are kind of resistant to this; so it is not like it is not being suggested. I co-chair a group on women's sport and fitness here with Baroness Grey-Thomson—and she would be excellent—but it needs a bit more push than that for it to happen. It is not just a matter of suggesting it; it is a bigger thing to make it happen.

Professor Wass: It is a very desirable objective, though.

Q178 Barbara Keeley: Yes, indeed, and we have made that very clear on a cross-party basis.

Could I say that “This Girl Can” is amazing, and perhaps we ought to watch it, Chair, before we finish this work? I stood on my local station platform on Sunday looking at one of the adverts. I have seen it a lot of times and I went to the preview before it was first aired. It is actually quite emotional. Quite a lot of people in the audience felt weepy about it because it gets to the heart of the issue. If the barriers are emotional, the answer is emotional too.

I do not know if Sport England has given any evidence to this Committee, but for this inquiry we really do need those statistics. We do not have it in our briefing today, but I understand that the gap is 2 million between the number of women who take part in sport and the number of men. In fact, we have today some figures from Coventry that show 11,000 boys not reaching the recommended physical activity levels but 31,000 girls. So there is a gap in Coventry of 20,000 between the boys and the girls, which is enormous. I just tried to work it out, but if that played up to the rest of their lives and all across the country it would be a 5 million gap, and that is very serious.

Chair: Barbara, is there a question that the panel could mull over, because we are going to get some physical activity ourselves while we go and vote in the Division? Perhaps we can leave you with the question while we are away.

Barbara Keeley: There is. I would like to know why—from the evidence last week—there is a gap between what you know in Sport England about this and all the barriers, and some of the people that we have had talking to us. We had some quite expert witnesses last week who did not understand this issue. When we asked them about the gap they did not know. It seems to me that it is quite a specialised cache of people that understand this issue of the gap and are trying to work on and explore it, and then the whole world of local government, which does not seem to understand it at all. There are leisure centres that do not understand it and sports centres that do not understand it. The question is: why is there such a gap, because there are specialised organisations like Sport England and lots of other that do understand why women and girls are not doing sport, and then the whole world of leisure centres that do not understand it and seem to do nothing about it, and in fact do wrong things that make it worse such as having mixed showers and mixed changing, for instance, in swimming, which I have seen in my local authority and in Manchester?

Chair: That is the question to mull over and you can do lots of star jumps while we are out of the room, please. Thank you very much.

Sitting suspended for a Division in the House.

On resuming—

Q179 Barbara Keeley: I asked the last question because, for instance, after the Commonwealth games, the Aquatics Centre in Manchester—a wonderful building—had mixed showers. You talked about barriers. Then my local authority decided to introduce that into our leisure centres and our swimming pools, because they had seen it at the Commonwealth games centre. Those things are crazy. How come people can do that when there is a group of people that understand these things? Maybe it is how you can get the message out to the people who need to understand.

Kay Thomson: There are always different variations locally in those types of examples. I think—or I hope—we are seeing them less and less with the information and the insight that we now have. The stuff around “This Girl Can” and the fear of judgment is new insight for us as well; it has only come to light as part of our campaign preparations, and we will be publishing on our website later this week a summary of the insights. As the expert body in this area, we want to make sure that we share it with all our stakeholders and partners.

We have had some examples in the last month or two where we have tried to do that. About a month ago we brought the eight core cities—that is, the biggest cities population-wise—together who are all doing work around sport and wider physical activity, and we shared all the messaging, the insight and the information from “This Girl Can”. Each of those cities has taken back that information. I know Bristol, for example, are planning a host of activities around International Women’s Day on 11 March to do that. So they are starting to take on board the insight and information that we are sharing with them.

We have really good examples from some of the national governing bodies. A good one would be the Lawn Tennis Association. Just last summer, in 2014, they ran a programme called “Tennis Tuesdays”. It was focused on a targeted age range—post-university pre-mums—and they wanted to get them participating more in tennis. They started by talking to the girls to ask them when they were more likely to participate. The girls said, “Thursdays and Fridays are going-out nights; the weekends are times we want to spend with our families or our partners, but Mondays or Tuesdays are pretty good days for us to be active, so why don’t you put something on on a Monday or a Tuesday?” So the concept of “Tennis Tuesdays” was born. People can book online, it is pay as you go, you can turn up, the equipment is provided and you can have a go. The two areas that piloted it last summer showed an increase in participation in the latest Active People Survey in both London and Leeds. All of that insight is becoming much more integral to the work that both we and our partners are doing. As to your example about changing rooms, that kind of example is fairly common as well.

Q180 Barbara Keeley: It was mixed showers that were the real problem.

Kay Thomson: We know that, for women, the quality of the changing room is a real barrier to being active, and we have seen, once again, examples of that. We run a programme in Bury called “I Will if You Will”, which is similar in concept to “This Girl Can”, so it is about providing the right offer for women as well as the social marketing and media campaign around that. One of the really simple things they have done is to improve the lighting in the changing rooms, for example. It is not even mixed showers but looking at the lighting and the offers that are put on for women. We saw just two weeks ago with our Active People Survey that participation by women in Bury had gone up by 2,500 in the last 12 months. We will do our best to share the insight and information that we have. We know our partners are keen to take it on board, and we are happy to write to the Committee if they would like some information on that.

Chair: Thank you. That would be great.

Dr Moore: Can I add something on one of the things you said about the gap in Coventry? Actually, we had worked with our leisure colleagues around the development of the new sports strategy and that is our data, and it fed into, “What was the priority?” The priorities in the strategy are to encourage more women into sport, and the other one—and we are not talking enough about this—is that both weight and physical inactivity are much greater in our deprived population. So another big strand has been to get people from deprived communities into sport. We have another good story, again with the Lawn Tennis Association—

Q181 Charlotte Leslie: That is just what I was going to say. Obviously you have the gender divide, and I do not know whether it is bigger or not, but it is certainly extremely significant in social and economic deprivation. What can be done about that in a broad sense and how upstream—I hate this phrase—or how far back to causality do you need to go before you start to solve those differences in obesity, life expectancy, levels of physical activity, smoking habits, alcohol and things like that?

Dr Moore: I will start because we are doing a lot of work around this. Two things are really important which link to the Marmot agenda, where it has been very clear that one of the most important things is around early life, giving every child “the best start in life”, as Marmot puts it. We have a strong focus around pregnancy, particularly first-time mums, because at that stage we are most likely to see changes in behaviour, and around influencing breast feeding. We have education programmes that work with our health professionals, midwives, health visitors and the children’s centres, on a very clear message around both healthy eating and activity. We are trying to think about where those communities are and find that what might seem like quite perverse behaviours start to make sense sometimes when you talk to communities about their values.

We are trying to work around things that can be incorporated into people’s lives that are not about huge cost. There has been a lot of work around walking and cycling. We got funding through our integrated transport authority around “Cycle Coventry” to develop a whole series of cycle routes. Initially, they were going to go into our most affluent areas because they were the ones that already cycled most. We enabled a change to that agenda to get them into the most deprived areas, and public health has funded resource around enabling people to get training, how to do cycle maintenance, how to access cheap cycles and so on.

You have had an example that we have also worked with the Lawn Tennis Association. One of our big focuses has been in working with these governing bodies. Coventry had a very strong focus around the south of Coventry, which is the most affluent part, and we engaged with the Lawn Tennis Association, who have now started to develop a facility in the north which is much more holistic; it is not just about elite sport but about how we encourage women and people from groups in the population who normally would not see tennis as an activity they want to take part in. They have come back to us saying that they want now to learn from this holistic approach that we have worked with them on and take it into the next developments that they are looking to do.

Professor Wass: Can I mention another aspect of health inequality, which is people with mental illness? They have a hugely increased risk of having physical illnesses, and patients with schizophrenia, as you probably know, live a significantly shorter life than those without. This is another issue which we are trying to take on. We have a group at the Royal College of Physicians where I work and the Royal College of Psychiatrists trying to address this issue, trying to make sure that people in long-term mental institutions are being looked after from a physical health point of view, and we are trying to introduce a means whereby we can force people in health authorities and so on to observe these things such that their physical illnesses are attended to properly, which currently are not so well done. That is a really important issue in terms of health inequality in that particular group of patients.

Q182 Charlotte Leslie: Picking up on that, is there any evidence or have you done any work on people with mental health issues who are slightly less at the hard end of the spectrum, who are in the community, often in functioning or slightly dysfunctional lives, and the symbiotic relationship between mental health and physical activity and lifestyle choices? It often strikes me that, when people eat too much, drink too much and smoke when they know it is bad for them and do not take any activity, it might be both a symptom and a perpetuating cause of a mental health issue.

Professor Wass: That is an interesting thought. I do not think there is any particularly good work that is done on it, and certainly none that I am aware of, I am afraid, but it is an interesting point because there is that spectrum, I agree. At the moment we are trying, in bite-sized chunks, to look at people who are in mental institutions in the long, medium or short term rather than people who are out in the community.

Dr Atherton: There is quite strong evidence, though, around improvements in mental health associated with physical activity in open spaces, for instance. So there is some evidence around it that would be worth looking at.

Q183 Charlotte Leslie: I do not know if you have any evidence on whether when people's mental health conditions improve—perhaps when they find a different job or their situation with their partner changes—there is any difference in uptake of physical activity, whether confidence levels rise and things like that. I would be fascinated to know.

Dr Atherton: Certainly, we found with our local programmes that building in a component around emotional well-being to physical activity and diet programmes has made a big

difference to people's continued engagement in the programmes and their outcomes. On a local level, we certainly have that information.

Q184 Charlotte Leslie: As a final thought, women and men both suffer domestic abuse and abuse at home. Is there any correlation between women who are being abused and difficulties in getting physical exercise? The reason I ask is that I do quite a bit of boxing, and there is some evidence to suggest that girls who have been abused find boxing a very good way of reclaiming their bodies if they can be encouraged to take that step of confidence to be able to go out and do something like that. It is just a thought for the panel.

Dr Moore: I do not know, but there is evidence in relation to those who experience abuse that they are more likely to be socially isolated so they are less likely to take part in activities outside the house. But I do not know if there is any evidence that relates specifically to different forms of physical activity.

Q185 Charlotte Leslie: Thank you, and I am sorry for the deviation.

Dr Atherton: On the issue of inequalities overall, it is important to emphasise the importance of population-based approaches for tackling inequalities, because often one-to-one interventions tend to be taken up by people who have more ability to take those up. Sometimes that can widen inequalities, unless you are really careful about how you target those interventions.

Q186 Chair: Can we come now to children and young people and start perhaps with Professor Wass looking at the impact of the child measurement programme, which has been very effective at highlighting the inequalities and the doubling of obesity from reception to year 6? Do you feel, Professor Wass, that we could be doing more to use the data from the child measurement programme? Do you feel that we should be carrying out those measurements at another stage, perhaps targeting children who we can see are slipping towards obesity? In other words, is there more we could get of value from this programme, and also could you tell us a little bit about what you feel about the way parents are informed? We are interested to hear your views.

Professor Wass: Those are very interesting and hugely important questions.

First, children are measured at birth and then at one. Then they are not measured routinely until they are five. There is a time then when you could be picking up things if they were being routinely measured at two, which they are in some places but not always. Then they are not measured until they are 11, and again there is a gap because the data are that quarter are overweight when they come in and a third are overweight by the time they are 11. So, again, there is a gap there, and then they are not measured routinely in secondary school at all. For my money, it really is important that they are measured more frequently. That is the first thing which is absolutely key.

The second thing—and I have talked about this with Public Health England, who I know are working on it—is that the liaison between the measurements that are made in school and in general practice, and you will know about this, are not terribly robust and so the

GPs do not always get to hear about these measurements. That is something which, in principle anyway, would be quite simple if you used the NHS number. The trouble is that simple things may be more complicated to introduce, but certainly that is a simple concept, which I would have thought could be used, and that would be useful.

The last thing you mentioned was parents, and, as you know, 75% of parents do not recognise when their children are overweight. I have just been looking at a survey from Russell Viner, who is at UCLH. He confirms that the parents may be informed of this but then do not get any support, which they could get from their general practitioners if he or she was so minded to do it. The issue there is in trying to empower the parents to understand what the problem is, and that could be helped by the GPs.

Q187 Chair: Once you have identified children who are in this bracket, could you give us some guidance about what you feel the best evidence interventions are, both for reducing obesity and separately for increasing physical activity? The focus of this inquiry is that we want to take a “what works” approach.

Professor Wass: Exactly.

Q188 Chair: Could you be very clear about what works and, also, what is currently being done which we should ditch because it does not work? Do you have a view on that?

Professor Wass: There are three questions there. The first is: what works? For my money anyway, seeing parents and interceding would be useful, but in fact there is not that much data because it does not happen that much and has not happened in a systematic way.

Q189 Chair: Do you think that is something that we should definitely do?

Professor Wass: That is an important piece of research which needs to be done, in my view.

Q190 Chair: Right, so that is as to how we interact with parents.

Professor Wass: Yes, how we interact with parents. Some work has been done on telling parents if their children are overweight, but in the community anyway that is something which needs to be better done, I would say.

Q191 Chair: What is the impact of just informing parents that their child is overweight? Some people have argued that maybe that is stigmatising. Is it your view that it is a good thing or are there unintended harms?

Professor Wass: There are issues there. It has to be done sensitively. There are people with whom I have talked in general practice who are trying to empower other GPs to talk about it in a sensitive way. Something has been produced by a lady called Rachel Pryke, who is a GP in Gloucestershire, for the Royal College of General Practitioners. So there

are people working on that and trying to make it so that it is done in a more empathic way and, therefore, hopefully, more effectively.

Q192 Chair: What is the impact of just sending parents the data? At the moment some parents are just sent the data. There is a range of responses around the country, is there not?

Professor Wass: Yes, absolutely.

Q193 Chair: Is anyone evaluating what the power is of those different approaches?

Professor Wass: I would be very happy to send you the data that I have, which I was reading in the last few days, because Russell Viner, who is a transitional endocrinologist at UCLH, has just been evaluating the impact of the National Child Measurement Programme, both in terms of pre and after measurements. He has looked specifically at the impact of telling a parent that their child is overweight and then following them up. I would be very happy to send you that after this meeting.

Q194 Chair: That would be helpful. Are you in this context able to give us an overview of what it shows?

Professor Wass: Yes, certainly. It did show that it was important that there was strengthening of the discussion for parents whose children were overweight and that this was helped by having somebody in the community to do that.

Q195 Chair: In other words, just sending them the information was not as powerful as following it up.

Professor Wass: That is exactly right, absolutely.

Q196 Chair: In your view, would it be important that children who are identified as slipping into the overweight category have more frequent measurements as part of the child measurement programme?

Professor Wass: That would be an ideal, but at least if it is picked up then something can be done to help deal with the problem.

Q197 Chair: Thank you. In terms of other “what works” approaches, what would be your key messages for this Committee in what works for children, both for obesity and for physical exercise?

Professor Wass: I am not so expert on physical exercise, and you can talk to the other members of the panel about that, but in terms of obesity what would work would be more frequent measurements, better liaison between the measurements and the general practices, and an empowering and probably wider application of general practitioners to engaging with the problem. With all the other things, I recognise that is a very difficult

thing for them to do because they are very busy, but somehow getting that message across to the parents through a health professional in the community would be the best way of dealing with it.

Q198 Chair: So those would be individual approaches.

Professor Wass: Yes.

Q199 Chair: At a population level, stepping away from the child measurement programme, what would be your key messages as far as children and reducing childhood obesity goes?

Professor Wass: There is not a magic bullet, I would say, and this is one of the things we were talking about earlier with having lots of different people involved. It is a question of trying to encourage healthy eating and education, and obviously physical exercise is key. As many things as we can possibly introduce should be utilised to try and decrease the rate of child obesity that we have in this country. I do not think it is a single thing. Today it is butter, yesterday it was sugar, and the day before it was probably something else. There is not just one single thing. It is a question of an overarching policy of healthy exercise, healthy eating, education and all the other things we have been talking about.

Q200 Chair: Thank you. Would other members of the panel like to come in, maybe, Kay, starting with you on physical exercise and a key message for children? I know you have talked a bit about girls and boys, but, overall, if we want to do something, what would be your key points?

Kay Thomson: I have to be honest and say that I am not an expert on children and young people. Most of my work is with adults, but I would refer to some of the work that Public Health England has done lately in terms of the “what works” guidance that it has produced. Kevin might be speaking about it in the next session, but, alongside the publication of “Everybody Active Every Day”, they produce another document, which is what works in terms of increasing physical activity, and there are a number of promising programmes and interventions in there alongside NICE guidance on improving physical activity in children and young people. But I am not expert enough in children and young people.

Q201 Chair: That is fine. Dr Atherton, would you be happy to come in?

Dr Atherton: There is some reasonable evidence about targeted programmes around physical activity and diet for children that focus on the family, things like the “Move It” programme, for instance, which can produce good outcomes but on a very small scale in terms of the numbers of children who are able to be supported through those routes. We need to be looking more at whole-school approaches around things like that, so physical activity policies—PE—within schools and things like free school meals. The free school meals for infant children will have made a big difference to the quality of food which children are eating day in, day out now. Also, if you look at things like the journey to

school, certainly one of the key barriers to children and parents taking more active routes to school through cycling and walking is the perception of safety. We certainly welcome the inclusion of cycling and walking in the Infrastructure Bill. That needs now to be followed through with investment, which will enable things like safe routes to school to come into place, because those population-based approaches will have the biggest impact overall. We focus on the outcome of the lack of physical activity and the impact of poor diet being around obesity, but everybody needs to be active every day and everybody needs to be eating healthily every day, so we do need to have those population-based approaches.

Chair: Thank you.

Dr Zeuner: I would add that there is a good evidence base from the “Health Behaviour in School-aged Children” survey, which is an international survey, supported by the WHO but the UK is very much involved. There is Professor Fiona—I have forgotten her second name, but I can send it to you—who represents important UK participation. There is increasing international evidence about the way societal defaults and norms are set such that it is really difficult for families and kids to live healthy lifestyles. For me, therefore, the idea is that, if you really want to go to the root causes of the problem, you have to have, clearly, programmes for an obese child identified in our measurement programme, but it has to be augmented by much wider societal changes in order to make it easier for families.

We have not mentioned at all that the way youngsters live their lives now with digital devices and media has fundamentally changed the way they spend their time. The survey I mentioned picks this up and tries to do work with children, and understand with them how, rather than working against the devices—because I think we have passed that—we can engineer ways to use the devices to help them to live healthy lifestyles.

Q202 Chair: Thank you. I know we are slightly pressed for time, so I am going to ask you to make one very brief point.

Dr Moore: We have not talked about the environment, which is hugely important. In the food environment, we have food deserts in our major cities where eating healthily at a reasonable cost is really difficult because it is very difficult to access that food using public transport or whatever. There is a real issue about our more deprived communities, with less access to green space and it being more difficult to get outside the home in ways that people feel safe about, and that is at both ends of the age spectrum.

The other key area is that, because we get into these issues about stigma and it becomes about the individual, we need to think about different ways of working with professionals and how they approach this, which is not about, “This is as an individual,” but in the wider context. We are doing work with food banks and other organisations in Coventry about how we help people in the context of what are often very difficult things. Saying to people, “Eat healthily,” when you are getting an unhealthy bag of food from a food bank is very challenging. We are trying to change that conversation as well and recognise that people have to be seen in their context.

Chair: Did you want to make a brief point, David?

Q203 David Tredinnick: Just on the food deserts in the centres and what you do about it, is the answer to try and encourage a single outlet to produce healthy food and advertise it as such? What strategy do you have for putting oases in the desert?

Dr Moore: There is a variety of things, such as food co-ops. We are trying to encourage people to use spaces and “grow your own”. You may have heard of things like guerrilla gardening that has happened in various parts of the country. We are trying to get people to be able to grow their own, yes, and working with various organisations, including supermarkets and fast-food organisations, around how we can create more healthy options in those areas. So it has to be all of them.

Chair: We are going to come on to more of that in a minute. Barbara, over to you.

Q204 Barbara Keeley: We have touched on this, so it might be that we do not need to spend too long on this question. We heard that any and all forms of physical activity need to be promoted and I think the members of the panel have touched on that, including things like dancing, active travel and simply walking; you have said those things. Can you give us your view on that in the round a bit more—we have had some examples in other things that you have been answering—and maybe how to broaden the offer, because, of course, not everybody likes sport. So those other things are important, are they not?

Kay Thomson: I will start if the other panel members are okay with that. It is obviously hard to single out one particular type of activity because one of the things we know about individuals is that they want a range of choice and a range of things to participate in. I often say to people that the word “sport” for me is one of the most unhelpful parts of my job as the public health lead at Sport England because there is a perception around the word “sport” that it can be too offputting or competitive and things like that. But, in actual fact, when I am talking about sport I am talking about mainly the things you have just mentioned, such as dance, going for a run, swimming and cycling. They are all types of activities that we would count or fund in the broader range.

Sport plays a valuable role in the context of wider physical activity, and we are about providing as big a range of opportunities as possible for people to participate in to get them active. It is possibly more about the surrounding support around the programme than the particular activity or choice that people have. We should provide that whole range, from everyday activity to active travel, walking to work or activities you might do in your lunch break. We have seen a real rise in things like gym and fitness and conditioning through our Active People Survey, as well as activities like Zumba. There is walking football or a whole range of different activities now. It is hard to single out the activity, but the types of programmes and support systems around them are what are important, I think.

Dr Zeuner: Maybe one important point I am sure you have come across in all the submissions is that a big challenge is not just the physical activity and in how much physical activity we do, but shifting people who really do not move at all to even move a little bit. It is the move towards moving sedentary people; it is quite a different concept. One area that we have not touched on yet is the workplace. As we spend a long time at work, that is another setting where one can really focus not so much on the sporty end but

on how, even when we look around now, do we have a break, do we get up and can we stand up a little bit?

Q205 Barbara Keeley: Perhaps you could advise the Committee.

Dr Zeuner: Absolutely. I thought that shows us how important it is to really build it into everyday life.

Barbara Keeley: It is not built in, though; it is accidental here.

Chair: I am conscious that we are keeping our second panel waiting. Unless someone has something pressing that they want to add, I am going to come on to Grahame for the next question.

Q206 Grahame M. Morris: You have covered some of the ground already, particularly Dr Moore, about the issues around environment and planning, and I mean the physical environment. How important are environmental factors in promoting physical activity, and how are you working across local government to address these issues? Perhaps we also might ask—because I know you are Coventry, Dr Moore, and Dr Zeuner may be able to answer from the perspective of the Richmond great parks and the vistas of opportunity that are presented for engaging in physical activity—what we could do in the older industrial areas like mine that do not have such outdoor facilities to encourage it.

Dr Zeuner: I think you are absolutely right. One of the reasons why Richmond fares so well on a number of the indicators is that we are very fortunate in the assets that are there. The importance of the physical environment is huge, and if you have not got it what can you do? That is your challenge. I guess make the most of what you have. One of the issues is that in new design NICE, for example, in their guidance around physical activity looked quite a lot at environmental new design. It is particularly helpful when you do new things, because retrofitting is much harder but it can still be done.

We are, for example, working very closely now with the Town and Country Planning Association. Just last week London directors of public health and their planning colleagues had a big conference in London. We understand, by bringing the two professions together, that that is one of the good examples of being in a local authority. We can learn from each other what can be done in our given frameworks. But, as we have the panel of you around, there are also areas where some more regulatory freedoms would help us to push agendas further.

Q207 Grahame M. Morris: Forgive me for interrupting, but that leads me on to the next point, particularly in relation to what local authorities can do. You are calling us the panel, but you are the panel; you are the expert panel and we, as a Committee, are looking to draw down your expertise to formulate some recommendations to Government. Do you think local authorities have enough powers? I was thinking of section 106 planning agreements, for example, not just in terms of creating play areas where there are new developments but in closing off some of the proliferation of fast-food outlets and so on around parks—the East Durham Heritage Coast in my case.

Dr Moore: It certainly does, and not just that but how do you design in environments particularly so that people feel safe walking? We know with the elderly, in particular, that it is very simple things around street architecture and lighting that make a big difference as to whether older people will come out. You talked about deprived communities with not a lot of green space. We have been working with our parks and green spaces team around how we reclaim green spaces in some of our most deprived areas. It is by working with the community and getting them to do it, so it is them taking back some of the spaces that there are. Even in those most urban areas there are usually green spaces that are not being utilised, often because people do not feel safe and there is not a sense of community ownership of those spaces. So we have been working very heavily with our parks and green spaces team in five of our most deprived areas to identify areas and work with the communities about how they can use those.

The other thing for me, even in those most urban areas, is how you create a sense of how people can be more active within that urban environment. We have been working with some of our colleagues who are very interested in the wildlife around urban opportunities, which again is not about it being, “This is really healthy,” but about, “This is good for you, you will feel better and you can get out and enjoy nature even in these urban areas.”

Q208 Grahame M. Morris: Organisations like Natural England and so on working with schools is great, but can you answer that specific question? Do you think local authorities in particular have sufficient powers currently and they are not exercising them? I do not want to put words in your mouth, but what is your recommendation to the Committee?

Dr Zeuner: I would say local authorities could do with some more devolved powers. I am not an expert—because I would have to have an environmental planner with me and I have not—but the work around fast-food outlets is a good example. Of the knowledge I have around London boroughs, some have had more appetite than others to actually—

Grahame M. Morris: No pun intended.

Dr Zeuner: —use planning tools, but, for example, when you have the fast-food outlet and it even changes hands, you cannot do anything around it. Health is not yet a really strong material factor. Lots of appeals have happened. If you think, we have talked about austerity; so what is the appetite of local authorities to face the appeals? There is even a judicial review. More powers, yes—details.

Q209 Chair: Dr Atherton wants to come in as well.

Dr Atherton: I wanted to make another point, but certainly making health an explicit requirement around planning and licensing applications would be absolutely critical to us being able to be more effective at local level. There is this bigger issue about the concentration of unhealthy retail within most deprived areas, such as fast-food outlets, off-licences and whatever.

Chair: I am very conscious that we are overrunning very badly. Did you have any other points?

Grahame M. Morris: No. That is good.

Chair: We will move on to David Tredinnick about obesity treatment services.

Q210 David Tredinnick: Yes, indeed. Thank you, Chair, and I am sorry I was not able to be here for some of the earlier parts. A lot of these questions overlap but I am going to ask this one anyway. We have heard that, despite having good evidence on the best ways the NHS can help people who are overweight and obese to lose weight, there are still large unmet needs for those services. Is that really the case, and, if so, why is it the case?

Professor Wass: Can I answer that?

David Tredinnick: Yes.

Professor Wass: We have done a survey of the tier 3 services. You will probably know that tier 1 is prevention; tier 2 is the community and GPs looking after this; tier 3 is usually a district hospital with a physician and a multi-disciplinary team trying to help both people in the hospital and the community; and tier 4 is bariatric surgery. That is the apex of the triangle, if you like. One of the most important things of this is to get linked-up care between tier 1 and tier 4 because they are all under the aegis of different people; it is local authorities, CCGs and NHS England. That is one of the absolutely key things and it is in danger because of the recent splitting up, which we talked about earlier.

Q211 David Tredinnick: It has similar problems as with mental health services.

Professor Wass: Indeed. You then ask about the services that there are. In London we have just finished a survey, and in each of the district general hospitals in the country there really should be somebody who has a special interest in weight and weight management who leads a team of people, which includes a dietician, a physiotherapist, a psychologist or someone like that—a multi-disciplinary team—and he or she will interact with the community and be responsible for the hospital staff as well as patients.

David Tredinnick: It is interesting you should say—

Professor Wass: Basically, the bottom line of that is that this is something which is present in four out of the 32 CCGs in London. We are just finishing a survey for the rest of England, Northern Ireland and Wales, but the generality is that there is a hugely missed opportunity because tier 3 services simply do not exist. Then you say, “Why is that?” It is probably related to lack of enthusiasm sometimes, lack of money often, and for various reasons. Trying to be proactive, we have taken a discussion with the various people who are responsible for potentially setting up these services and we are going to get them to the Royal College of Physicians to try and help and encourage them in that way. We are taking a proactive approach but at the moment it is not perfect. I am sorry to go on.

Chair: That is fine. Janet wants to add some brief points. We are very over time for our next panel and I know the Minister has to leave.

Q212 David Tredinnick: I am sorry. Do you think that one of the ways forward is to look at exercise as a medicine in a hospital context so that somehow patients can be addressed and told, “Either you can have some drug or you can get on an exercise machine”? Are we not missing a trick here?

Professor Wass: Yes. The answer to that is yes, but it is just what I said earlier. It is not one silver bullet. You can prescribe exercise 30 minutes five times a week for a patient—I have done it myself many times—and that is something which is very important. Yes is the answer to your question.

Dr Atherton: I would like to say that, when you are looking at the sheer scale of the challenge around obesity in the population, in our local set-up we have capacity within weight management services for exercise on referral for 5,000 people and we get some great results through that; but we have 150,000 plus who are overweight and obese, and, if you look at the total population, 280,000 who need to be physically active and eating healthily. Having an approach that focuses largely on one-to-one interventions and exercise referral will never on its own be enough. We simply will not have the capacity to deliver that on the scale that is needed.

Q213 Chair: Am I right in thinking that NICE came down against exercise on prescription? Is that correct?

David Tredinnick: I am not sure.

Kay Thomson: There is a variety of guidance. In the guidance it talked about exercise on referral for certain population groups is recommended, such as long-term conditions, but for exercise referral on its own there are a couple of different recommendations. It is not a complete no on exercise referral but just certain situations where the evidence is stronger.

Q214 Chair: So it was nuanced. Right; thank you.

Professor Wass: Can I quickly add that it is not a question of either/or prevention or treatment; I think we have got to do both, and that is—

Chair: That is a very good point on which to finish and I am sorry to have rushed you, but thank you very much for coming this afternoon and for all your evidence; it has been very helpful. Thank you.

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

Q215 Chair: Thank you for coming this afternoon and apologies for keeping you waiting. Would you mind starting by introducing yourselves to those who are following the debate outside this room, starting with Professor Fenton?

Professor Fenton: Good afternoon, everyone. I am Professor Kevin Fenton. I am the director of health and wellbeing at Public Health England. I cover PHE's prevention programmes or health improvement portfolio and I also cover health inequalities and health care public health.

Jane Ellison: Hello. I am Jane Ellison. I am the Public Health Minister.

Dr Tedstone: I am Alison Tedstone. I work with Kevin Fenton. I am the chief nutritionist at Public Health England and also the national lead for diet and obesity.

Q216 Chair: Thank you. Could I start with Professor Fenton and Dr Tedstone? Could you perhaps set out for the panel—because we are trying to take a “what works” approach to this inquiry—what you feel have been the greatest successes that you have been able to support so far?

Professor Fenton: Thank you very much to the panel for focusing on this issue, which is a priority for us in Public Health England. Many of you are aware that in our “From evidence into action” priorities document last year we have clearly identified tackling the obesity epidemic as one of the key areas that Public Health England would like to focus on. As you have heard from other members of the panel, both today as well as previously, this is not an easy problem: in fact it is a wicked problem. It is a reflection of the social, cultural and structural environment changing and engineering physical activity out of our lives, but also changing the way we relate to food—our diet—and obviously generating the epidemic of obesity.

As we think about what works, we in Public Health England are very clear that we need multiple approaches addressing the multiple determinants; it has to be sustained over time and there has to be strong leadership on this issue. In terms of what Public Health England has been able to bring to the table so far in our 18 months of existence, we have been clear in focusing on national leadership on these issues, raising the profile of obesity and physical activity, both strategically as well as in our work. We have been able to think about ways in which we bring the evidence to bear on local authorities, and you heard from the DsPH today about work that we are doing in translation of evidence into action. We have been able to focus on specific programmes such as, for example, our work on sugar, and more recently we are beginning work on our diabetes prevention programme in partnership with the NHS, as concrete drivers of the epidemic or the consequences and what we can actually do. Finally, it is thinking about sharing and facilitating the dissemination of best practices across local government and ensuring that we are listening to and hearing about what works, and facilitating that as well. Those are some of the things at a macro level that we have focused on in Public Health England.

Q217 Chair: Dr Tedstone, did you want to add to that?

Dr Tedstone: I will add a couple of things. Going slightly wider than PHE but something that PHE have been actively involved in is the improvement in schools in terms of diet. We now have new standards for school food. We have schools taking a whole-school approach to physical activity and diet, so now we have cooking embedded in the national curriculum again. Our children for some years have not been able to buy fizzy drinks.

There is thinking going on about the environment around schools. That has all been great progress and some of that Public Health England has supported. For example, we worked very hard with DFE to help get good standards out there for school food underpinned by standards for food procurement. It is one thing saying you can only have, let's say, lasagne once a week, but it is very important that that lasagne is healthy.

The other thing where we have seen a great deal of success is that our ideas about how to do marketing have greatly moved on. Change4Life, which is the big platform for marketing to families, has evolved over the years and in recent years has been very successful in terms of bringing about differences. This time last year we were running a campaign on smart swaps, with a lot of focusing on sugar. At that time we saw a big reduction—an 8.6% reduction—in the purchases of sugary drinks. Building on that kind of thing is really important. We know some things about what works. I will come back to weight management later; I suspect you are going to ask about that.

Q218 Chair: Carrying on from Change4Life, is not one of the problems about education programmes of course that they are relatively short?

Dr Tedstone: Yes.

Q219 Chair: In other words, how often do you have to keep repeating these messages for them to have any long-term benefit? You say it has evolved over the years. What kind of things are you now satisfied just do not work on a population level, and perhaps Professor Fenton can come in as well on that one?

Dr Tedstone: McKinsey wrote an interesting report quite recently on obesity and they said some interesting things about marketing, which I very much believe, that health marketing is important for giving individuals information, for helping to galvanise the system and the leadership. I worked for some years on the salt-reduction programme that the FSA were running—now it is with the Department of Health—and key to that was working with industry, but also raising the issue through campaigning helped individuals. Health campaigning can never match the industry. Change4Life spends about a tenth of what industry will spend on food advertising. We can never do that. It is important that we do it but it must only be part of the approach. It comes back to what Kevin has said: we need myriad things at scale to deliver change in the population. Marketing can only be part of it.

Professor Fenton: May I share three areas where our marketing and Public Health England have evolved over the past 18 months? The first is the movement from raising knowledge and awareness towards driving behaviour change. Alison has mentioned the work in sugar swaps. Last summer we ran our public physical activity campaign in partnership with Disney. We were able to really look at this public private partnership to get physical activity much more embedded for children and we were able to generate more than 100 million additional minutes of physical activity in children during that summer period. That was measured and evaluated. This behaviour change is important.

Secondly, the campaigns themselves drive engagement with families and individuals. We now have more than 2.7 million people who are connected to Change4Life or online

platforms who are engaged with online conversations with social and digital media, and this gives us an opportunity to take people along with that journey.

Finally, all of our campaigns are supported by a variety of digital tools such as apps, as well as other innovative ways of keeping people connected. We are moving away from simply pushing information out to being there along with individuals and families as they are journeying towards health and well-being so that when they need us we can be there. That is a key part of the shift that removing—

Q220 Chair: In other words, just telling people that having too much sugar is bad for them is less effective than something that drives behaviour change.

Professor Fenton: Exactly. It may be the entry point, but what you need to move towards and what we are committed to doing is getting to that behaviour change and measuring and demonstrating it as well.

Dr Tedstone: Can I add to that? There is a wealth of literature on health promotion and it kind of shows that, if you just give people knowledge, they can repeat it back to you but they find it hard to enact. We base a lot of Change4Life research on focus group research with socially-deprived C2E families, families of low socio-economic status, and they tell us that they need things that fit into their lives. They tell us that they want simple like-for-like changes. One of the biggest things is really hearing what people want and how it can help them change.

Chair: Thank you. Charlotte has a very brief point before we move on to David.

Q221 Charlotte Leslie: Yes, very quickly. In our last panel we heard about the radical idea of Government working cross-departmentally to make sure that physical activity was something that every Department looked at in all the areas that each Department covers. Obviously this has been talked about and tried and has been recommended many times. How practically could this happen? For example, we have equalities impact assessments and things by which Departments and Bills have to demonstrate that they have met certain requirements in terms of equalities. Could we have a physical activity impact assessment whereby each Department has to demonstrate that its policies promote physical activity and may have to report to someone who is a cross-departmental figure before any Bill went through? What practically could we do?

Jane Ellison: Can I lead off on that if that is okay? I can come back to the Committee with some thoughts on the impact assessment—I have not specifically thought about that—but I do want to give the Committee the assurance that we are working across Department and have been certainly in the time I have been in this post. That is not to say that we should not have been doing it for longer and I very much hope it continues into the future, but I can give the Committee absolute assurance on that. I chair a ministerial subgroup on physical activity which is itself a legacy committee to the Olympics as well, and that has lots of different Departments around the table. I was at a ministerial roundtable with Helen Grant this morning looking at outdoor recreation and physical activity. We have begun to embed that idea—you are absolutely right—of it being everybody's business. In fact, the "Moving More, Living More" document, which was an attempt to capture everything that

was going on across Government on physical activity, then very much led on to and specifically fed into Public Health England's work on "Everybody active, every day", which is a far more all-encompassing framework than just looking at traditional sport or promoting it from a health point of view. It does look at all aspects right across local government in particular. So we are very conscious of that; it has been happening; it needs to keep happening; and it needs to be embedded in as many different ways as we can think about it. But we have established the principle.

Chair: Barbara wants to ask a quick supplementary on that point.

Q222 Barbara Keeley: I do not know if you were here, Minister, when the previous panel was touching on planning, but there were some very strong points made about planning and the struggle that local authorities have. The policy pressure is actually to build more homes on green open spaces and green belt land—it is true in my constituency, as I am sure it is true everywhere else—which removes walking, running and cycling, all of those possible activities. That is the pressure. There are two sets of pressures on local authorities—financial but also this planning one—and that plea from the last panel was a very strong one. What influence can you have over DCLG and the planning inspectors to make them take this into account, because that really is not there at the moment and it is quite clear that, faced with a £0.25 million bill to wrestle with a planning appeal, a local authority will just give in and let people build on green belt?

Jane Ellison: I have heard that too, obviously, and I did hear that previous evidence, and we have had those discussions. DCLG are around the table at ministerial subgroups on physical activity and I do not really recognise the description of—

Q223 Barbara Keeley: But are they shifting on this issue?

Jane Ellison: You would need to ask a DCLG Minister on that. We look at the evidence. I do not really recognise the picture of new development necessarily building out all potential for exercise, but obviously I will—

Q224 Barbara Keeley: It is in my local area.

Jane Ellison: I am very happy if the Committee want to pass me—and I am sure Public Health England will be interested to see—evidence of specific developments where that has happened. Really, all aspects of national planning guidance do point to having to build in potential for exercise.

Q225 Barbara Keeley: They don't, actually.

Jane Ellison: As I say, I am very happy to look at any specific examples the Committee wants to send us. Kevin might want to comment further.

Q226 David Tredinnick: I am going to be able to develop Barbara's theme, which I also wanted to address, on the whole motivation of local authorities in the NHS and whether we have the right measures in place. NICE has produced many guidelines over a period of time about physical activity and obesity, identifying effective and cost-effective ways to address these issues. But how convinced are you that you have got it right now, given that these guidelines have changed so much over periods of time?

Dr Tedstone: Do you mean the NICE guidance has changed? I think it probably has.

Q227 David Tredinnick: I will go wider. Do you think we have the right incentives in place to get local authorities to commit to addressing these problems, particularly at a time when we have some financial constraints?

Dr Tedstone: We know from our analysis—I think the previous panel talked about this already—that we have seen an increase in spending on obesity through the public health grant, but that is only the thin end of what local authorities are spending, as the previous panel explained. We also know through that work that the local authorities with the highest prevalence of obesity are spending the most money. I think, though, they are wrestling with difficult problems—and planning is a good example of that. Public Health England has been working, for example, just recently with the Town and Country Planning Association to produce guidance on planning and physical activity, and the food environment. The food environment is a very important part of this, but we recognise that the levers are difficult. There are challenges in planning. We have many communities asking us to help them with getting fast-food restaurants under control, for example. I have seen data recently from Cambridge and Gateshead where there is an exponential rise in the number of fast-food outlets.

Q228 David Tredinnick: When you say “under control”, do you mean the number of outlets or what they are actually marketing?

Dr Tedstone: Those are two different things. The Gateshead data showed me quite clearly that, when you have a very high density of fast-food restaurants, they compete just on two things: price and portion size. Reformulation within that kind of environment, when you look at what is being provided, will not take you very far because it is just so energy dense. Changing the oil will reduce saturated fat, but when people are competing like that it is very hard. Reformulation—things that restaurants do—can be helpful. We have seen, for example, more restaurants doing calorie labelling, and that can be helpful, but it can only be part of an activity. Labels do not always drive change.

Q229 David Tredinnick: I have in my head as I am asking this question a pizza which I had to eat the other evening—I was late and I was tired—and it was absolutely overloaded with cheese. It was quite obviously the wrong food, with no vegetables on top, and I thought, “I should not be eating this at this time in the evening. It will probably keep me awake at night as well.” Portion size is another issue, but I wanted to ask you, sitting next to the Minister, are you convinced that the central levers—the levers of Government—are being applied properly when you are talking about what is happening on the ground?

Dr Tedstone: Are you talking about the Responsibility Deal really?

David Tredinnick: Yes.

Dr Tedstone: The bottom line is that, as a nation, we are consuming too many calories. Public Health England estimate that the average man is consuming 300 calories per day more than he needs, so that is like an extra meal. The food environment, the retail environment, our homes, schools and where we work are all part of that. It is all part of that.

Q230 David Tredinnick: I raised this a couple of sessions back and I said, “I am thinking on my feet: what about having a food traffic-light system where you can actually warn people that the portion they are buying is a portion for two and somehow try and link that into other traffic-light systems?”

Jane Ellison: The front-of-pack labelling scheme, which is a voluntary scheme, now covers around 70% of the market. That is a big chunk and it is expanding all the time. I would add that that is a voluntary scheme, and the reason it is voluntary is because you cannot make it compulsory under EU law, but it is a voluntary scheme around which large parts of the industry have coalesced in the recognition that we want to make it easier for people. We want to see that go further so that people do have consistent nutritional information.

Q231 David Tredinnick: Moving on slightly, we have also heard that the services to help overweight and obese people lose weight are often unavailable. Why are local bodies not commissioning these evidence-based interventions more widely?

Dr Tedstone: There is variability in access to weight management services across the country. We have said that in our written submission; it is absolutely clear. We are working with local authorities to try and help them to commission services. For adults, we know what works. We know that we have guidance from NICE, and we know, for example, that many commercial providers do work. Achieving more at-scale access to service is one of the important things for treatment.

Q232 David Tredinnick: Are you confident that you are getting better at identifying and scaling up promising and innovative local practice? Are you buying into new ideas well enough?

Dr Tedstone: That is a big part of Public Health England’s job. We are an expert agency. We have to provide evidence into the system and evidence to Ministers. One of our strengths is that we go round the country all the time and we can identify good practice. For example, Lambeth has seen some very positive changes in terms of childhood obesity; it is not perfect, in that it has not always gone in the same direction, but from our analysis of what has gone on there we can see a holistic, systems-based approach that has really unpicked the problem and has not gone for single projects. This comes back to Professor Fenton—

Jane Ellison: We had Lambeth in to present to the obesity review group, which I chair, precisely to showcase that work. One of my challenges to Public Health England has

always been to say, “How can we accelerate excellence where we find things are working? How can we make sure that we give them that broader platform?” That is a challenge to which PHE have responded, and, not least, “Everybody active, every day” on the physical activity front was a successful attempt to capture a huge number of things going on all over the country and boil it down to something that every local authority could take away as a framework to look at their own situation and obviously judge it depending on need. Your constituencies are all very different and we need things that people—whether yours or Grahame’s local authority—can pick off, things that will work for them just as they would for you. That has always been one of my big challenges to PHE and they are very much rising to that. Alison has picked a good example with this Lambeth work with children where we have seen evidence of what they are doing. I would say that often this takes time. Particularly politicians are often seeking the silver bullet that can be fired during a five-year term, or whatever.

Q233 David Tredinnick: That is because we have general elections.

Jane Ellison: Yes. The reality is that I have seen no evidence that there is a single silver bullet in either of the areas you are looking at. I have seen more and more evidence that you are talking about a set of tiered interventions, one thing on top of another.

Q234 David Tredinnick: So are NHS Health Check and Change4Life a silver bullet or a copper-bottomed bullet? What sort of a—

Jane Ellison: It is part of the solution.

Q235 David Tredinnick: How do you rate those?

Professor Fenton: It is really a part of the solution and, as I am sure you have heard throughout this inquiry, you need multiple interventions working at different levels, targeting people across the life course to be effective. So Change4Life, whether with our start well, living well or healthy ageing programmes, is really engaging members of the population, families and individuals in their journey towards health and well-being. NHS Health Check is a much more systematic way of engaging people between 40 and 70 years and providing that moment in time where we can actually engage in their health and well-being. Then that wraps around with other programmes locally as well.

Dr Tedstone: Can I add something? One of the challenges for Public Health England is to maximise those opportunities. For example, on Health Check we have seen an improvement in uptake and referral into the service, but we still have work to do on maximising that opportunity. For example, in the diabetes prevention work that we are now working on with NHS England, the Health Check really works as a way of getting people into the service.

Q236 David Tredinnick: That is all very fine, but are you not also being undermined by other environmental factors very often so that you have an inconsistent

landscape? What exactly is Public Health England's strategy on tackling wider environmental factors, Professor Fenton?

Professor Fenton: This is a key element of our work. As you heard from the previous panel, the tendency over time has been to focus on the individual. The key aspect of looking at the environment is first of all looking at the built environment and ways in which we are working with local authorities and their work in thinking about active transport, the ways local towns are designed, and looking at retrofitting the design of our towns and villages to build in active cycling, walking and travel within the design of towns. We are actively participating with that.

Another aspect of the built environment is looking at how we use spaces—open spaces, green spaces—and again some of the work with local authorities, with NGOs working in this space to think about making our green spaces health-promoting spaces. This is part of the work we are doing.

Finally, we are doing a lot of work in looking at the evidence on what works in addressing the built environment, ensuring that we are looking at guidance from NICE and others and ensuring that we are working with our partners locally to bring that evidence into—

Q237 David Tredinnick: I am glad you mentioned NICE because, for most people, NICE is about approving or not approving drugs, and you get some sensational headlines. Do you think there is a role for NICE as an organisation—independent of Government, of course—to evaluate evidence and make recommendations to Government about these wider issues?

Professor Fenton: Absolutely. We work very closely with NICE—between Public Health England and NICE—in terms of helping to identify what are the priority issues that need to be reviewed by NICE so that the evidence which is provided for public health practice is both appropriate and acceptable at national level as well as locally. But also we work with NICE to think about how, when the evidence is finalised, we help to translate that into action. So, with NICE colleagues, we have developed evidence into practice symposia, a seminar series, over the past couple of years where we are really looking at NICE guidelines as they are prepared, working with our local partners to see what this means for local practice, what we do differently and how we hold ourselves accountable moving forward. This translation of evidence into action is a unique space that Public Health England occupies, but we cannot do that without our academic partners, without NICE and without colleagues who are working on completing that evidence.

Q238 David Tredinnick: So a multi-agency approach is what you are saying.

Professor Fenton: A multi-agency approach, yes.

Q239 David Tredinnick: Are you happy about the co-ordination between all these organisations?

Professor Fenton: Honestly, it has been a fantastic partnership with NICE. We meet top tier to top tier with NICE on a regular basis to look at our strategic priorities. We also have

technical teams, members of Alison's team, who would work on the guidance reviews and evidence reviews with NICE. So we are looking at ways in which we can work more effectively together to ensure that evidence into practice is a key hallmark of the new system.

David Tredinnick: That is probably quite an upbeat moment at which to finish because we have a lot to ask.

Q240 Chair: Can I follow on from that point about evidence? We heard earlier—and we have seen in our evidence—about how much of public health budgets is going into NHS Health Check. How clear is the evidence base for NHS Health Check, and how do you avoid ending up inadvertently widening health inequalities, because Health Checks tend to be taken up by people who are already accessing and interested in their health? In other words, is there an unintended consequence here and how clear are you about the evidence base? Is it the best way to use that money?

Professor Fenton: The reality of the NHS Health Check is that we have a number of effective interventions which are packaged as one and provided to individuals every five years. So whether it is checking their blood pressure, their weight, screening them for cholesterol or having a conversation with them—

Q241 Chair: Yes, sure; I can see that it seems like a good idea, but is it actually leading to changes in behaviour? You talked about behaviour change earlier. Where is the evidence that it actually changes outcomes and how do you make sure it does not widen health inequalities?

Professor Fenton: With the Health Check programme, we know that individuals who are identified with any of the conditions—for example, high blood pressure—would be linked in to effective treatment and care services which are available within general practice or within the local community. So the effectiveness and impact of health checks is a direct consequence of the onward referral and onward management systems which are currently in place, and we know that there has been a lot of working with primary care and local authorities to strengthen that referral pathway, strengthen that pathway for risk management, and of course evaluate the impact. There have not been any randomised controlled trials of the NHS Health Check programme, but we do know that the Department of Health has commissioned two national evaluations of the Health Check programme. They are going to be reporting this year. Local authorities have also been doing their own evaluations of the offer, the uptake and the impact of the programme, and over time we will get more information. Finally, Public Health England is committed to building the evidence around the NHS Health Check. We have just completed our research strategy for Health Check and we will be working with research funders to ensure that we are building the pipeline of data and evidence to underpin the programme.

Q242 Chair: In other words, it is too early to say whether it is changing outcomes. In terms of the health inequality issue, is that something you are looking at?

Professor Fenton: We are looking at this and we are working with our partners locally who are implementing the programme to look at the data on who is taking up the Health Check and whether or not it is having the unintended consequences of widening inequalities. The evaluations which have been done locally and which have been reported suggest that local authorities have either been targeting the Health Check programme, so it is offered to everyone—

Q243 Chair: Targeted universally.

Professor Fenton: Exactly, but you actually enhance the programme in more deprived areas or with communities which are disadvantaged; you are using the programme to engage those who are disadvantaged far more effectively. That is an opportunity to really address the inequalities challenge.

Chair: Thank you. That is very clear. Barbara.

Q244 Barbara Keeley: In the recent publication “From evidence into action”, you set out Public Health England’s top seven priorities for the next five years, but they do not specifically include physical activity. Instead, actions for that are listed under “tackling obesity”. We have heard that physical activity has substantial health benefits, regardless of weight, and that physical activity in isolation is not a useful strategy for tackling obesity. First, do you think that conflating the two things in this way risks sending out mixed or confusing messages?

Professor Fenton: No. The PHE priorities document provides an opportunity for us to focus on a few things, to do them well and to bring them to scale and demonstrate real impact. At the same time, Public Health England also produced our physical activity framework—the Minister spoke about it—which was “Everybody active, every day”. That had broad cross-sector engagement and lots of cross-sector support. We are now working on implementing that framework.

In the priorities document, it is very clear that the seven priorities will be supported by cross-cutting activities focused on mental health and well-being and on health inequalities. The physical activity work will integrate as well, because it has an impact on our dementia priority, our early years priority, and even some of the other priorities such as tobacco and alcohol.

Q245 Barbara Keeley: I find that confusing. In your evidence and the Department of Health’s evidence, there is very substantial evidence around the benefits of physical activity. It just seems like an enormous good. It is good for mental and musculoskeletal health and reduces the risk of mortality by a third. It seems an enormous thing to list all of those benefits and then not have it as one of your priorities. Our reading—certainly my reading here—is that that suggests that you do not think it is important.

Jane Ellison: To some extent, perhaps, those priorities are a victim of not wanting to put physical activity into a single silo. As Kevin said, it feeds into an awful lot of the priorities.

Q246 Barbara Keeley: Indeed. It is clear from the evidence.

Jane Ellison: I am also very conscious as a Minister that, if we make physical activity solely the priority of the health world, we will not embed it right across other parts of Government and local government. It needs to be a whole-society response. Obviously, at the end of the day you cannot have everything as a priority, but physical activity feeds into all of those. When we were discussing the document and PHE was drafting it, that was a question that I asked. Because it feeds into many of those priorities and we are very committed to making physical activity everybody's business, in all parts of Government and local government, I understand why it is not one of the seven.

For too long, getting more people physically active has sat in a silo marked "health", which has allowed everyone else—planners, transport people and so on—to ignore their own responsibility for it. One of the things that we have tried to do with this inter-ministerial working group is pull it firmly out of the health silo and say that it is everyone's business. There is no point in our running health campaigns if someone has not built the physical infrastructure for walking and cycling. From my point of view, that is one of the reasons why I felt that I could understand that.

Q247 Barbara Keeley: It might be good to take on board that it does appear to send a mixed message. I will come on to it a bit more in a moment, but, if one read only the evidence that you have submitted to this Committee, it sends mixed messages and could be rather confusing. There is a strong case, given those health benefits, for making it clearer that it is a real priority.

Professor Fenton: If I may take you back to two years ago, before Public Health England was created, we entered an environment where there was no national strategy on physical activity. There was not a national approach. In the last 18 months, we have had the cross-Government "Moving more, living more" approach to physical activity. We have had Public Health England entering the space, with the framework, and being clear about what we would like to see the system do to ensure that we have a step change on physical activity. Our partnership with local government and academic institutions—for example, the National Centre for Sport and Exercise Medicine—as well as with NGOs across the country, is really changing this environment. It is a priority for us in Public Health England. I want to reassure you that it is my commitment that we will continue to advocate this moving forward.

Q248 Barbara Keeley: Perhaps the evidence should have stated it more clearly. Let us move on from that, as those sorts of things are not necessarily evidence in themselves. Minister, you have commissioned Public Health England to produce an awareness campaign about physical activity similar to the five-a-day campaign, which does now appear to get through to people. Whether we do five a day or spend our time eating burgers, people understand the five-a-day thing, don't they? Is it because you think that the messages around physical activity are not well understood? We seem to have taken a long time to come around to this. One of our witnesses last week said to us that he thought people overestimated how

physically active they and their children were. If people don't get it and are misreporting it, how can we deal with that?

Jane Ellison: All of those are problems. I will explain the work that I have commissioned. There are two strands of work going forward. One of them is around the chief medical officer bringing together an expert group to look at how they translate the guidelines and make them more accessible for health professionals. You have said that no one knows. There was a survey of GPs in which a minority knew what the CMO's guidelines on physical activity were, so I don't think there is any dispute that it is not widely understood how much exercise people should be doing. There is a piece that is health professional-facing.

I have also asked PHE to work on something that is not quite a campaign but is about finding a metric—something like five a day. That may or may not be possible—these things sound simple when you ask for them—but we can get a lot closer than we are at the moment, where there is very little understanding. As you say, although not everyone does five a day, most people understand that that is the aspiration. I would be amazed if you could stop anyone in the street and get them to say how much exercise they should be doing a week or whatever.

The second part of the challenge is about coming up with something that could be used in public-facing communications, as an extension of the work that Alison and Kevin have spoken about on Change4Life and so on, so that we begin to use something that embeds in people's minds the idea of what they should be doing and the sorts of activities that feed into that. I do not yet quite know what that will look like. I have a bit of a sense of where that work is going—Kevin could probably give you more of a sense of it—but I think that we need it.

Until we have a better understanding across the population of what the ideal is, our progress will be slowed down. Kevin mentioned the campaign from last summer that PHE did jointly with Disney, in which we piloted 10-minute shake-ups. There was fantastic take-up among families. Packaging it up and making it easy for hard-pressed mums and dads to get children moving in that way gave us a bit of a clue to the future.

Q249 Barbara Keeley: That links into the next question, in a way; perhaps Kevin could answer it, too. The initiatives described in the Department of Health's written evidence really relate to sport—things like the primary school PE and school sport premium, school games and Change4Life sports clubs. We have heard that it is crucial that we avoid a narrow focus on sport itself—notwithstanding anything else, because girls and women do not always relate, as you know, to sport—and that we place emphasis on just increasing activity levels overall, through dancing, cycling, getting off the bus earlier, parking the car earlier and walking a bit at the end of a journey. What are you doing to promote those other types of physical activity? Do you think that this is what makes a new link?

Jane Ellison: That is exactly the reason why I want us to have something that enables people to put all of that in some context. When you get off the bus a stop early, what percentage of your recommended daily activity is the distance that you walk? People do not have a sense of that. I would not say that they have a universal sense with food. However, with good labelling, people can now know, for example, what percentage of

their recommended calorie intake something that they eat is. We are nowhere near that on physical activity. That is one of the reasons why I am pushing that.

I could not agree with you more about being broader than just sport. This morning our ministerial round table on outdoor recreation kicked off with a walk around Richmond park, because I am passionate that walking is the most accessible way into exercise for the vast majority of people, particularly older people. There is an understandable focus on the young, which is quite right, as we know that good habits start young, but the least active group are older people. There is a real link with social isolation there as well, so I am passionate about championing forms of activity that can get older people more active.

Q250 Barbara Keeley: Is there a fear that if we move away from the 150 minutes people will drop off what they do? In fact, we seem to be getting evidence that even a move from inactivity to a moderate level of activity is beneficial, particularly for older people, and that we should do that, instead of insisting on levels of activity that people are not achieving anyway as the measure.

Jane Ellison: It is funny that you say that. It leads perfectly into what Kevin may say about the early thinking on this work. Absolutely—the whole point of taking a title like “Everybody active, every day” was that the title is the message. There is no downside to being more active. Wherever you start, there is an upside to being more active. We know the issues around bone strength and the wider social issues. That is the key message. Perhaps Kevin can say a word about where the thinking is going on that.

Professor Fenton: We could not agree with you more that the objective is to get everybody moving more every day. The people who have the most to gain from this are people who are currently inactive. As you know from the data, we are among the most inactive in the OECD countries, so we need to think about how we shift the population curve.

The focus on 150 minutes per week, however, is important, because that is where you gain the maximum health benefits from physical activity. We really want to encourage people who are maybe just below that to do more, so that they can truly benefit from all of the outcomes that you mentioned. However, the data are now absolutely clear that you will gain benefit from any additional physical activity that you do. We are trying to democratise the process and to encourage people to think about activity in its broadest sense, whether it is gardening, dancing, walking, cycling or walking the dog; getting out and being there is really important.

It is also important that it is not expensive. There are things that we can all do that are within our budgets and can build social capital and relationships that have become part of this approach.

Q251 Grahame M. Morris: We touched on this a little earlier, in a question from David about the traffic-light system. It boils down to the philosophical argument between nudge and universal paternalism—what do we do? David was talking about portion size, while Alison was talking about the content of the food. In terms of influencing people’s

choices and behavioural change, what do we know about the efforts that have been made to reformulate foods to reduce fat and salt content? Is that voluntary code—the agreement with the industry—a success?

Jane Ellison: Can I say a word and then ask Alison to provide the expertise? What I said earlier about the multi-tiered approach was best captured by the McKinsey Global Institute report, which you have probably looked at in your evidence. It talked about the split between conscious and unconscious health choices, which I thought was really interesting. It said that people need help to make the right decisions, but interventions that rely less on conscious choices by individuals are very effective. The message from that report, which I think was very credible, was that you need that holistic approach.

Yes, we need to give people information and options for better choice, but there is more and more evidence, particularly interestingly, looking at what consumers tell the supermarkets. A good example is taking sweets off checkouts. Yes, we definitely promoted that agenda as part of the Responsibility Deal, but one of the most interesting things was that in customer surveys customers said to the supermarkets, “We would really like you to do this.” That was probably the tipping point; people said, “Make it easier for us to be healthy.” It is a mixture of both conscious choices based on information and other interventions around things like reformulation. We have clear information and data that those interventions are both popular and effective. Alison can say a bit more about that.

Q252 Grahame M. Morris: That works both with physical activity and with diet, doesn’t it? The default option in a restaurant when you have your burger may be that you get salad rather than chips. If that is the default option, but you can ask for what you want, that is healthy choice. With exercise, you could have a sign pointing to the escalator, rather than one saying that the stairs are there. Although you are not forcing people, you are nudging and encouraging them to do it.

Dr Tedstone: Even better than a sign is having the stairs in the middle of the building and having the escalator somewhere hard to find, because that will nudge us towards taking the stairs. Making the default option healthy is really important. We have learned through the schools work that changing school menus helps to improve kids’ diets. There is a great opportunity to do some of that in the workplace. We already have Government buying standards for food, which set minimum criteria for the nutrition offer.

That is only about Government Departments at the moment. There is an opportunity to get it rolled out across the public sector. You were talking about leisure services in parks. At the moment, that café in the park and that vending machine at the swimming pool will not be vending particularly healthy stuff. Some will—some councils pick it up—but often you go for your swim, overestimate the amount of calories that you use and come out and buy more from that vending machine. People do two things. Not only do they overestimate their physical activity but they underestimate how much food they are eating. It is a bit of a lethal combo.

Really pushing forward on public sector food procurement and offers within public buildings is very important. The NHS is part of that agenda. We have had Simon Stevens signal clearly that he wants to see NHS facilities get into better shape, because they are not that healthy at the moment.

Q253 Grahame M. Morris: Alison, that is fine; I agree with you. It does not matter whether I agree or not—that is your opinion—but where are we going with food reformulation?

Dr Tedstone: We have seen really good stuff on reformulation, particularly in terms of salt. The nation's salt intake has been reduced by 15%. We have seen some positive signs on other things. I am really pleased to see that if you go into a sweetie shop all the chocolate bars are smaller sizes. That is through the Responsibility Deal. We have seen Tesco and some of the industry take sugar out of drinks. That has been a good start, but Public Health England's sense is that we could go deeper with reformulation. We could think about using the approach that has been used on salt on a broader range of nutrients.

Q254 Grahame M. Morris: I know that we are short of time. Professor Fenton, could you tell us what you think about that?

Professor Fenton: I could not agree more with Alison. We need to go further and faster. The evidence and the focus that we are putting on sugar at the moment will enable us to begin thinking about strategies really to push on this. As you know, we are ingesting far too much sugar across the entire life course, but it is particularly problematic for children and teenagers. Whatever we can do with reformulation, working with manufacturers and retailers, to help to reduce that will be key to addressing both problems with tooth decay in children and the obesity epidemic. That will play a really important part.

Dr Tedstone: There is a low-hanging fruit here, which is around fizzy, sugar-sweetened drinks. Sugar is not as easy as salt in some respects, because it has functionality in some foods. In fizzy drinks, it is just sweetening the drinks. There is an opportunity to work on reformulation with the drinks, in particular.

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

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

Q255 Chair: You mentioned resetting the default. Some of the chocolate bars may have got smaller, but the bags of crisps have got considerably larger. When you go to the cinema, there is a supersize culture. Do you really think that there is evidence that we have

reset the defaults? Equally, you now get share packs of many bags of sweets and chocolates. I agree that the bars themselves look smaller, but everywhere else it seems that the default may be going in the other direction.

Jane Ellison: My general point is that we need to reset the default and to start challenging on this.

Q256 Chair: Yes, so should that be done in legislation?

Jane Ellison: There is a good example. In cinemas—

Q257 Chair: Just to challenge you, Minister, yes, these things are all voluntary, but are voluntary default sizes working? They may be for small chocolate bars, but do we now need to have regulation to give that teeth? Has the time come to shift that?

Jane Ellison: As I said, we are beginning to address this issue. No one would pretend that we are there. I will give you an example on the point of cinemas. Major cinema chains are now offering sugar-free Pepsi Max as the default. If someone goes up and asks for a Pepsi, that is what they are given; they have to ask for the full-sugar version. There are things that we can do through that. There is more that we can do through voluntary action; there is a lot that can be achieved through that. I would not underestimate the complexity of legislation in this area, particularly in areas of EU competence. It is very complicated.

Q258 Chair: Are you saying that it would be illegal?

Jane Ellison: Voluntary partnership with industry will always be really important and a big part of what we do.

Q259 Chair: Are you saying, Minister, that it would be illegal to have a default size for sweetened sugary drinks? Would it be illegal under EU law to limit that with regulations?

Jane Ellison: I would need to write to the Committee with the detail of that. All that I am saying is that experience that we have had in other areas has indicated that this can be quite a complex area in which to legislate. I am happy to write specifically on that one.

Q260 Chair: You can make it the easy thing to do in terms of things like cinemas having a default non-sugary option, but do you yourself feel that there is a case for introducing regulation for default sizing now, if it is permissible do it?

Jane Ellison: I am not persuaded of that. At the moment, that is not the route that we have taken. Any Minister needs to be open to the evidence that is presented to them, but that is not my personal position.

Q261 Chair: Could I bring in Professor Fenton? Is there evidence that we should now be moving further, if we want to drive behaviour change, on changing defaults and reformulation? In your view, has a voluntary arrangement gone far enough?

Professor Fenton: In my view, a voluntary arrangement is important. It is an important part of the range of tools that we have to use to get and to encourage companies and industry to change behaviours.

We need to understand when and how best to apply legislation and regulation, as the Minister said, understanding what the evidence says. We know about other areas that have tried to use regulation—for example, on soda size. We know very well the story from New York City, for example, and how problematic that was in terms of public acceptability as well as for industry. Really understanding how best to apply legislation and regulation in this space and what impact it is likely to have will be critical.

We should also think about other ways in which we may use legislation and regulation. It may be not only on the size of the products. There may be other opportunities for us to think about when we use that approach to help us in this journey towards better health and well-being.

Q262 Chair: In terms of other measures, such as fiscal measures, we now have various international examples of those—sugar taxes and fat taxes, albeit that those were withdrawn in Denmark. What is your view of the evidence from the time that they were in place or from countries that do now have a price differential? Should we be moving down that route? Does the evidence support our moving down a fiscal route?

Professor Fenton: I will ask Alison to respond on the detail of this. We have been asked by the Department of Health to assess the evidence on the effectiveness of fiscal measures in our journey towards reducing the population's sugar intake. As you rightly say, there are examples where fiscal measures have been used in other industrialised countries or other parts of countries. We need to understand what the impact of that has been and what the return is—how those resources are used and how best to leverage that approach.

Q263 Chair: Are you in a position to update us on where you are with that evidence?

Professor Fenton: We are currently undertaking the review of the evidence. The plan is for that to be available by June this year. That will provide evidence to support decision making by Ministers regarding what options should be on the table for addressing the high sugar intake that we have. We are absolutely clear on collating the evidence and making that available to Ministers.

Q264 Chair: Dr Tedstone, do you want to add to that?

Dr Tedstone: No. Kevin has described it very well. We are midway through the review. It is very important that PHE looks very carefully at what people mean by evidence that fiscal measures change consumption, because sometimes they do not mean consumption. Sometimes they mean that they raise awareness; sometimes they mean that they change sales. It is a complex picture, so we are trying to look at it really analytically.

Can I add another point? Another part of PHE's evidence review is around promotions.

Q265 Chair: I was going to come on to that next. We heard from the Minister that what you are spending on Change4Life is a tenth of what the industry is deploying. There is such an unequal balance here. Do you feel that voluntary arrangements around promoting, particularly to children, go far enough? Is it now time for us to step in and be more muscular in our approach to marketing, particularly to children?

Dr Tedstone: I heard what Susan Jebb said at this Committee. Last week Advertising Standards came out with a review of the evidence, which broadly says that there is an awful lot of marketing to children through an awful lot of platforms. Children are not always in a position to understand that they are being marketed at, but they felt that there was not enough evidence for action. From PHE's point of view, that is a bit disappointing. I do not yet know what our review is going—

Q266 Chair: How independent do you feel that that report was?

Dr Tedstone: They used published literature, so clearly it is independent, and they have published their whole systematic review. That is their job. We are doing our own review. We are going broader than the published literature, because we know that scientific published literature in this area is very difficult. Essentially, the industry moves so fast that the academics cannot keep up, so we are augmenting it with key informant interviews from around the world on the effect of promotions.

Q267 Chair: The sense that I get from the panel is that the jury is out on all of this—price, availability and marketing—and that you are not really in a position to say that you think we should go down a regulatory route. Would that be fair?

Dr Tedstone: Susan Jebb has clearly said that the voluntary approach to promotions has not worked.

Q268 Chair: We are interested in your view as a panel. Do you feel that it is time for us to move—

Dr Tedstone: I think that it is an area to consider seriously.

Q269 Chair: Is that a yes or a no?

Dr Tedstone: It is a yes.

Q270 Chair: We are asking you what you are seriously considering, not whether you think that we should consider it.

Dr Tedstone: When you have brands on the internet—on gaming sites and through social media—being very heavily pushed, that is a worrisome area.

Q271 Chair: So advergames—that kind of thing.

Dr Tedstone: All of that kind of thing.

Q272 Chair: Right. So we will be making recommendations after you have finished your review of this area.

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

Q273 Chair: Do you think that there is a case for insisting that companies that use marketing for children's products should be required to give at least the same amount to those programmes that are involved with public health?

Jane Ellison: That is really a policy decision. It is absolutely right that PHE is looking at the evidence on this. Ministers should remain open-minded, to receive that evidence and then act on it. Most Governments—certainly this Government—have demonstrated that, with regard to areas affecting children's health, one should tend towards the precautionary principle. I think, therefore, that it is a case of Ministers being open to the evidence presented to them and seeing the best way forward.

As I know only too well in other areas of my portfolio, any policy decision always has to be balanced against all of the other factors that go into things, whether those are economic or legislative. Ultimately, it is a policy decision, but it is absolutely right that a body like Public Health England feels that it can look at the evidence and present that unflinchingly to Ministers. Then it is up to us how we act on it, looking at everything in the round.

Q274 Grahame M. Morris: Through the Chair's questions, we have looked at what can be done upstream in terms of influencing diet—taxes on sugar, fat and so on. What can we do upstream in terms of influencing physical activity? Is that a stupid question?

Professor Fenton: No, not at all. We have been thinking quite a bit about that as well. In our approach to physical activity, "Everybody active, every day", we are very clear about the things that we need to do with the built environment, through Government policy promoting cycling, active transport and thinking of open spaces. It is really important for us to begin thinking about how we restructure the environment.

We also need to think about the social environment—the ways in which we use communications, health marketing campaigns and the way in which we use social networks to support individuals and communities around how they engage and how the demand for health and physical activity is generated. That is why campaigns such as Change4Life or new live well campaigns that we are now looking at developing for 40 to 60-year-olds will be really important.

Finally, at the community level, we must think about ways in which we really look at the assets within communities—community classes, community walks and health, walking

and cycling clubs within communities—and begin to use the power of community, to meet communities where they are at and to provide the space and resources to support that. That helps to change the environment as well. We need to challenge the tendency for us to go immediately to individuals and to think about what policy can do, what the built environment can do and what communities can do.

Q275 Barbara Keeley: On a number of occasions, we have touched with our witnesses on the inequalities in healthy lifestyles. One glaring one is the inequality in terms of physical activity—the lower levels among girls and women than among boys and men. In fact, a witness we had earlier from Coventry said that the gap between numbers of boys and girls was 20,000, in terms of meeting physical activity levels.

Could you give us an overview of what you think are the most significant inequalities and what you are doing to address those? Clearly, there is that girls and women point, but there is another issue I feel quite strongly about. I have my own interest in this area, being an MP in the north. The most marked gap is between northern regions—the north-west and the north-east—and the south-east. Coventry has its issues, but I am afraid that ours always feel worse. That is why I feel quite strongly that we need activity. Is that an inequality that you really see? Exactly what is going to happen to try to close those gaps?

Professor Fenton: First, I confirm that it is an inequality we are very concerned about. The data suggest that the drop-off that we see and the difference start very early and are cumulative across women's lives. A campaign such as “This Girl Can” from Sport England is fantastic because it is really looking at women's perception of the barriers to activity and sport and addressing it in a very creative and innovative way. I am looking forward to the evaluation on that.

As part of developing our programme on physical activity, Public Health England held engagement sessions across the country about what we should be doing as a nation, but specifically about what we should be doing on inequalities. We are concerned about girls and boys and about the low levels of physical activity among people who are disabled. You have heard about mental health issues.

Q276 Barbara Keeley: Could I stop you there? You will not be able to close all of those gaps by just listing them. You will need very specific and different actions with those different groups, won't you?

Professor Fenton: Exactly. First, it is about recognising that it is a problem. That is why one of the things that we are doing is leveraging the data that we have and presenting those data to our local authority colleagues to say, “Here is the magnitude of the problem.” We are currently working on developing resources for health professionals to help them to think about physical activity, as well as addressing inequalities in physical activity. We have partnered with BMJ Learning to develop e-learning modules for health professionals to understand what the opportunities are for tackling inequalities. We are also doing systematic reviews of the evidence on what works to address issues such as the disparity for people who are disabled—

Q277 Barbara Keeley: I am asking just about girls and women, because that is the biggest one.

Professor Fenton: For gender. We are looking across a range of inequalities and at the evidence on what works. We will be presenting toolkits and resources to help local authorities to know where to focus.

Finally, as I mentioned at the beginning, one of the really exciting spaces that Public Health England can occupy is learning about what works in different parts of the country and helping to disseminate that evidence far more quickly than we have been able to do in the past. Through our regional networks and forums, we are bringing people together to speak about physical activity. We are sharing that best practice and helping to learn from one another. Those are some of the things that we are committed to doing—and are doing at the moment.

Dr Tedstone: Can I add another point? The Committee has picked up very strongly on adolescent girls falling off in terms of physical activity. They also fall off in terms of diet. Adolescent girls stand out as a population group for really having poor diets. The diet as a whole for all groups in the population is pretty poor, but adolescent girls are stand-out poor. There are various health behaviours that are worse in adolescent girls than in other groups, so clearly they are a group that needs particular attention. Some of the upstream things that have been themes in this Committee are really important as part of the solution to the health inequalities issue. Those adolescent girls know the messages, but if their default option is to go to the takeaway it is difficult, isn't it? I just wanted to mention diet.

Q278 Grahame M. Morris: My colleague Barbara Keeley raised the issue of the disparity between boys and girls, but Professor Wass on the previous panel highlighted people with learning disabilities and mental health issues. Is that a targeted area for an intervention?

Professor Fenton: Professor Wass mentioned the issue of mental health. I could not agree more with what he said about the importance of helping people with mental health issues to become much more physically active and to focus on diet and so forth. Our mental health programme in Public Health England is looking at opportunities for integrating the approaches to physical activity as well. We are working with our partners on thinking about the best evidence.

Q279 Grahame M. Morris: So there is nothing specifically targeted in that regard. It is part of an encouragement to integrate with the mainstream.

Professor Fenton: Exactly. It is thinking about the physical well-being of people with mental health issues.

Q280 Barbara Keeley: I wonder whether the Minister can see any point in differential funding. I was at a conference last week where this issue was discussed extensively. One group of academies that were represented there said that they had decided that the only way to close the gap was to overinvest in girls' sport. Somebody else there

asked us about the Title IX funding that they have in the United States, where there has to be equality of funding on sport and physical activity. Clearly there is not in this country, because we have such enormous gaps. Is there any thought or suggestion of shifting—

Jane Ellison: I have not looked at that specifically, but it sounds very interesting. I would be very keen to look at that, particularly the evidence of that weighted spending having an effect. Yes, I would be very interested to look at that. I have not given it any specific thought to date, but you can see from things like “This Girl Can” that there is, in a sense, a disproportionate communications exercise going on. Hopefully, that is a demonstration of the fact that the message is definitely received by everyone that this is a challenge and we need to do more about it.

In all of these things, it is a question of looking at what evidence we have of what works, but not believing it is any one thing. As Alison said, diet comes into it. Some of the work in other areas for young people that Public Health England does is around general resilience and being ready for all that life throws at you as you hit adolescence. All of those issues come into this. There is body image, which I know you have done a lot of work on before.

Chair: Thank you very much for your forbearance and patience. David, do you have a final comment?

David Tredinnick: It is on workplace issues. When Duncan Selbie was in front of us, we talked about financial, company and business incentives to get people to shed weight and look after themselves. He volunteered that he himself had been working in the United States and had lost 3 kilos.

Chair: You meant Simon Stevens.

Q281 David Tredinnick: Did I say Duncan Selbie? I am very sorry; I meant Simon Stevens. Forgive me—I have been talking to Duncan recently. Thank you, Chair, for helping me out of a major hole. I could have been in terrible trouble. I would have had to invoke parliamentary privilege to save myself from difficulties.

In front of this Committee, so it is on the record in *Hansard*, he said that he had been with a company in the United States and had lost weight through a scheme where the company offered incentives—financial incentives, perks, holidays, freebies, whatever you like—to get their employees fit. There are obvious benefits to that. Minister, I wonder whether you have thought about the possibility of that taking off in the UK. Is that an aspect that we should be driving?

Jane Ellison: I can recommend being Public Health Minister as a good way of losing weight, as I have lost 2 stone doing this job.

Q282 David Tredinnick: We all run around the House from one Division to the next, don't we?

Jane Ellison: I was really interested in what Simon Stevens has been saying about that. We should look at it really carefully. I thought that it was very exciting to hear. It is also exciting to look at how you can involve companies in that incentivisation. Although in

America there are different dynamics and the health care system is set up differently, in reality it is the same equation. There is a massive incentive for companies here to have a healthier population, a healthier work force and all of those things.

We have some really good examples of work that we have done through the Responsibility Deal with big companies like GlaxoSmithKline AstraZeneca, Morrisons and Heathrow. They have all done things like subsidised gym membership, walking groups and programmes for minority groups within their work force. We already have some really good examples, but it is an area we need to look at a lot more openly. I welcome the fact that Simon has been talking about it. It is something we need politically to respond to and to give further thought to.

Professor Fenton: It might be worth while mentioning that, if you think of the local economy, the biggest employers tend to be the NHS, local authorities, universities, schools and, of course, small and medium-sized enterprises. As we are thinking about workplace programmes, it is not just about the big companies. We also need to look within the health and social care sector to see what more we can do as well. There is really good evidence on great programmes that can be implemented and scaled that can help people in the work force to be healthier.

Dr Tedstone: Can I add a specific? At the moment, in PHE we are piloting a weight management programme for staff. We are also programming it with the NHS, with the Imperial Trust. That is new and innovative. What we are very keen on in this is that people who turn up are not just the people who would go anyway. We are working hard to try to incentivise everybody to go. We will evaluate that. If it works, I hope that it is something that the NHS will pick up for a lot of people.

Chair: On that healthy note, we will say thank you very much for your patience. I am sorry that we kept you waiting to give evidence.