HOUSE OF COMMONS

Health Committee

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

Wednesday 25 February 2015

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Written evidence from witnesses:

- Academy of Medical Royal Colleges

Watch the meeting

Members present: Dr Sarah Wollaston (Chair), Barbara Keeley, Charlotte Leslie, David Tredinnick

Questions 283-371

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

Q283 Chair: Good morning. Thank you very much for coming and welcome to our final session on diet and physical activity, and their impact on health. Could we start perhaps with both of you introducing yourselves to those who are following this from outside the room, starting with Professor Dame Sue Bailey?

Professor Dame Sue Bailey: Good morning, everybody, and thank you for giving us the opportunity to contribute to this important work. I am a child forensic psychiatrist by day and chair of the Academy of Medical Royal Colleges—the role in which I am here today.

Dr Bird: I am Dr William Bird. I am a GP but I have been interested for 20 years in promoting physical activity in primary care. I am also CEO of Intelligent Health, a company I founded to get more people active and which uses technology to do so.

Q284 Chair: Thank you both for the evidence that you submitted to this inquiry, but, because some people will not have had the opportunity to read that in detail, could you set out for those following this debate, perhaps starting with you, Dr Bird, your views on the importance of physical activity and health, and your views on what your key messages would be to this inquiry?

Dr Bird: Thank you. My take on physical activity started back in 1995, when the evidence was coming out that moderate physical activity had as good an effect as vigorous activity; so walking was as good as actually going to the gym. That evidence was not really

accepted and taken forward at the time, but as a health professional myself I was trying to get the message across to my patients that they can go walking, hence I set up the health walk scheme, which was to try and get patients leading other patients. That is now a national scheme. The idea was that this was incredibly simple. It was not just that physical activity in its own physiological way was benefiting a patient; it was liberating a patient to help to connect to place or where they live, to enhance a community, increase voluntary work, increase socialisation and giving people purpose. It was those three aspects of "people, purpose and place" that were the foundation of where we get physical activity. It is such a huge area. It is almost that physical activity and life are connected together.

The medical profession, of which I am very proud to be a member and have been for 20 years, has a role—but it is only a small role—in liberating the knowledge and understanding to everyone else, giving permission to patients who have conditions that may concern them about their entry into physical activity, ensuring that the councils and the Government promote physical activity-friendly environments and policies, and also, therefore, that we fly the flag that physical activity is an extremely important aspect. This is not an option any more; it is not a "nice to have". I have been talking to councils across the country, and to the mayors and their chief execs, saying that if physical activity is looked at purely as a medical intervention they are only dealing with about 10% or 20% of its benefit. The rest of it is about community enhancement—that placement of health.

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

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

Q285 Chair: That is fantastic, and we will be returning to that in more detail shortly. Thank you very much for that. Sue Bailey, would you also like to give your pitch on the evidence for why it matters and where we should be focusing?

Professor Dame Sue Bailey: Yes. The Academy—which is an umbrella organisation representing all the Royal Medical Colleges—reaches out to 220,000 doctors. Our focus on exercise and physical activity stemmed from our inequalities forum, when we were looking at things that doctors needed to be able to do and promote. The important thing to do as doctors, working on an evidence base, was to bring together the evidence base. We have brought together over 200 separate pieces of research that show that regular exercise can reduce the risk, just as Dr Bird said, of a wide range of other diseases—breast cancer,

bowel cancer, dementia, stroke and heart disease—and prevent them in a significant way. It can also be a part of treatment for serious conditions.

Therefore, the emphasis of our report has been to help doctors in how to do this. You may ask why we have not done this before—that this was something that seemed obvious—but doctors, as part of society, have forgotten what it takes to stay healthy as we are leading increasingly sedentary lives. Doctors have a unique role to play in this because we are trusted and we are in a position beyond primary care to have the critical conversation with patients about the need for physical activity and the benefits it can bring to them, particularly in primary care. A primary care doctor may be seeing more than one member of a family and therefore the benefits to the family. It is important that we do have the ability, make the effort and speak from the health perspective as doctors and have continued contact with our patients so that we can follow through and encourage. We have tried to break it down into a way that is doable for everybody irrespective of their background, circumstance or stage of life. This is so important because it can bring really good health benefits. It fits with Simon Stevens's Five Year Forward View concept and document and is very critical to playing its part in public health overall.

Q286 Chair: Thank you very much. Looking at your own report, you talked about the big four causes, if you like, of preventable ill health. Of those, physical activity was the least well known. Why did you feel it was the least important of the four and how can we shuffle it up the list? Do you think that needs to happen?

Professor Dame Sue Bailey: The Academy has looked at the big four, and the others were the more current targets being talked about. Where doctors are involved with people who are already ill, they are the ones that more obviously are having an impact. Through the inequalities forum that I chaired, we said we were missing one of the really big issues here where there are more obvious and easier solutions, and these are things that can make a bigger difference over time.

Q287 Chair: Thank you. So it was not that you felt it was unimportant; it was an achievement to get it on the list and to start talking about it.

Professor Dame Sue Bailey: Absolutely not. This came from the basis of our inequalities work.

Chair: Thank you. Focusing more on the role of doctors, David Tredinnick is going to lead off on those questions.

Q288 David Tredinnick: Listening to this, I am very struck by your evidence, Dr Bird, about the division between obesity and exercise; I think that is something that people are not aware of. Would you agree with the notion that physical activity is a "wonder drug" and a "miracle cure"? Although NICE has recommended that referral to gyms is not a cost-effective intervention for promoting physical activity in the general population, do you agree that doctors and other clinicians should be promoting physical activity as a first-line treatment? Would you both answer that question?

Dr Bird: Thank you. Yes, I do feel that it is a wonder drug. It is a miracle cure, though perhaps not a miracle, because it is there already and the effects it has are quite well known. The effects, being clear, are right at the cellular level, at the very hub where all chronic disease comes from, which is chronic inflammation. Chronic inflammation is the basis of pretty much all long-term conditions. Physical activity is an anti-inflammatory. Whenever you have done some activity, you create an anti-inflammatory environment in the body. It is not surprising that it does cross-cut everything else in your body.

Q289 David Tredinnick: Do you feel that the health budget is completely out of balance and that we are spending a totally disproportionate amount of money on drugs, rather than on simple prevention such as getting people to walk?

Dr Bird: It is a question of whether that money could get people to walk. For example, giving a coronary stent to patients with stable angina or getting them to exercise for 20 minutes a day have exactly the same outcomes after one year, except that exercise is more effective. The question is whether the money could be used to promote walking, whether it is the health budget or the bigger budget of councils and a wider area.

Q290 David Tredinnick: Could you tell the Committee the difference in the costs of those two options, please?

Dr Bird: I will put that in writing, but there is a significant difference in cost and, of course, of hospitalisation afterwards. The hospitalisation—

Q291 David Tredinnick: I can help you, can I not, with the answer? Putting in a stent must have a certain cost and exercise has no cost.

Dr Bird: Exercise has no cost, except we are not getting people to exercise at the moment. You are absolutely right, of course, that going for a walk is entirely cost-free. The problem is that we do not have environments at the moment that encourage people to walk and we have to get over a kind of behaviour faction.

Q292 David Tredinnick: Following up on that, if walking is more effective or as effective as going to the gym, that is completely out of balance, because we should be encouraging the cheapest option and the one that is most readily available—Shanks's pony—walking.

Dr Bird: I totally agree.

Q293 David Tredinnick: You then do not have to go to a gym. We have a gym here and colleagues go to it, but actually the exercise that we get walking to and from the Division lobbies here, which is often walking all day long on a busy day, you would say is probably more effective.

Dr Bird: It is, and a first-line treatment is the same for a lot of conditions, such as mild hypertension; it could be walking to start with. I set up the health walks, and there are now

175,000 of these walks every year through every council. It involves very small amounts of money because it is all volunteers leading other volunteers. We have the evidence. I would totally agree that walking has to be the fundamental part of most interventions of long-term conditions, where appropriate. Sometimes it is not always appropriate.

Q294 David Tredinnick: About 20 years ago in this House there was a presentation which I attended at the Food and Health Forum by a professor, who said that we should be living the lifestyle of a stone age man—that is what our bodies were designed to do—which involved a lot of walking and very occasional running, stalking animals for food. Would you agree with that?

Dr Bird: I believe that we are still programmed to be hunter-gatherers.

Q295 David Tredinnick: Very good. Professor Dame Sue, what do you think about all that, please?

Professor Dame Sue Bailey: I have two examples. One is in the area in which I work, which is with children with childhood depression. There is evidence that exercise can help there, and, if that means we can use exercise and psychological therapies before we use drug treatments, that is what we should do; there is proven evidence of its efficacy. At the other end, the most striking thing that encouraged me to want to get this report out was from the author of the report, Scarlett McNally, who works in Eastbourne. She is as an orthopaedic surgeon, who found that just by a level of exercise that elders can do, strengthening bone density to prevent fractures, it seemed to be not only a great thing to do for elders, to prevent everything that comes after that and surgery, but it also hits to the heart of costs. Those are the two examples. The great thing about this is that it crosses the life span and there is the evidence base; and, yes, it is regrettable that the evidence has been there for some time and neither the public, politicians nor practitioners have gone with this sufficiently.

David Tredinnick: Thank you.

Q296 Barbara Keeley: There are possibly reasons for that, and separately in this inquiry we have seen people in public health and local government who say that austerity and cuts are probably having a real impact. I know that some of the venues where groups meet and possibly do the sort of exercise you have talked about are in buildings where, in my authority, they have just started introducing charges, which a lot of the groups can't pay or find it difficult to pay. So austerity and cuts in local government are probably hitting this just at the point where it could potentially move on. I feel very motivated to do something about this because I am an MP in the north-west, in a local authority which is probably the most physically inactive part of the country. I find it depressing and difficult that it is so hard to get anywhere with this.

You note that "fewer than a third of adults over the age of 65 do sufficient exercise". We have also touched in this inquiry on the difference between males and females, and we understand there is a very substantial gender gap in activity and wide geographical variations. I think the north and the north-west are very different from the south and south-east in this.

Could you tell us and the people following this inquiry what you think are the most effective ways of promoting physical activity for these different groups? We cannot talk about this as if it is the same. Clearly, if you live in a deprived estate—and I have some in my constituency—this idea of health walking is not going to be as easy for you to take up as it is if you live somewhere where there is a walk on your doorstep. There are distinct differences, are there not, in terms of the environment in which you live, in how readily you are going to be able to undertake this? What, in your experience, do we have to do to get over these differences?

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

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

Then there are the three things that I mentioned before. The first is socialisation. It is hugely effective, and in fact some of the evidence is now showing that possibly the socialisation of physical activity is more effective in depression than the actual physical activity itself—but both work. The second is to have a welcoming place. If a person goes to a sports centre, leisure centre or park, and it is clean and welcoming, they do not feel threatened at all. The third thing is giving them that purpose. Are they learning something that means something to them, rather than just doing something for the sake of it? If we can get those three things, we have shown that that can start to motivate the most deprived people who are having trouble in any way in just dealing with their everyday lives. The final thing is that the activity has to be absolutely local to the point of it having to be in that estate; it can't even be outside the perimeter of that estate.

The health walks are being set up everywhere. Macmillan and Ramblers, who have now bought the rights to it from the Department of Health, are trying to set it up in every single doctor's surgery and are trying to get it out to every single estate. It is incredibly cheap to deal with because they are all volunteers.

Q297 Barbara Keeley: I have one small question about that. Surely it is not as if there is no expense. If you are talking about people walking miles, they are at least going to need the right sort of footwear.

Dr Bird: No. It is 30 minutes maximum—no, 30 minutes to—

Q298 Barbara Keeley: But you are not going to recommend that a young woman who only has stiletto-heeled shoes walks two miles to anywhere, are you? So there is a question of having footwear in which you can walk miles, even if it is not specialised walking boots. There is a switch in lifestyle, is there not, to being able to start walking regularly? If you actually do not have any suitable shoes for it, that is going to get in the way. I do not think we should say there is no cost involved in walking because there clearly is.

Dr Bird: Okay, yes.

Q299 Barbara Keeley: You need outdoor-wear—if it is raining you need a waterproof—and if you do not have those things there is a bit of a cost implication.

Dr Bird: It would be a means to an end, again; if they feel it is worth it, they will hopefully do so, but, yes—

Q300 Barbara Keeley: Yes, but we need to acknowledge that, I think.

Professor Dame Sue Bailey: Pragmatically, it is doing what you do but doing it slightly differently. My example would be my daughter taking children to school pushing the buggy. There will be several of them doing that and on the way back they will come back at a quicker pace; they will go more rapidly; they will meet the criteria of this. Actually, they will have the socialisation and will physically feel better for it. That is almost without cost, I would say. So it is actually looking at the routine in people's lives and how they can alter their routine slightly each week on a regular basis. Taking children to school five days a week, here is the opportunity to do this. It is about having that conversation with people in the community and/or if you are the doctor in the surgery thinking of ways that it would be possible within the surgery. The practice nurses have meetings with young mothers and mothers-to-be, so there are opportunities right across the surgery to start having these conversations. The other thing is that health professionals themselves are going to have to join in and embrace this.

Q301 Barbara Keeley: Are there sufficient incentives? There are things like QOF indicators to incentivise GPs, but are there sufficient incentives at the moment? It sounds as if there are not, but could we explore that? The other side of that question is what are the barriers? Something is preventing, it seems, GPs promoting physical activities— possibly time available—but could you address that?

Dr Bird: Yes. I have done a lot of training of doctors—GPs—particularly around London, going to the practices and talking to the whole practice team about physical activity, and then getting feedback from them directly, which has been a huge experience and a great privilege. QOF came in and out again for physical activity. It was only there for hypertension for one year and then it was removed again when they did a cull of a lot of the public health aspects. I was pushing for it, but I do not think it made much difference in the end.

Q302 Barbara Keeley: Was it too small an incentive?

Dr Bird: Yes, it was too small and it uses the GPPAQ, which is the GP Physical Activity Questionnaire, which is not particularly popular. It is an official Department of Health questionnaire, but it does not include walking in its algorithm, which does not really make much sense.

Going back, there are three things that doctors feel will make it worth while. One is being a good doctor. Is the evidence there—is the clinical evidence right—for them to do with being a good doctor? Of course it is, but they need their colleagues and the higher colleges to show the doctors that this is good evidence. The second thing is cost-effectiveness. The CCG will tell the GPs that this is cost-effective. The third is the patients—the stories coming back from a patient. We get a lot of feedback from our patients. If you do something that makes a huge difference to their life, that really does reinforce it. What was happening was that the evidence was not being pushed out there, the cost-effectiveness was not very clear, and they still had not quite got that connection with the patient.

The biggest problem with the patient, going back to the example of the stent or physical activity, is that patients often were not ready to be told they had to go for a walk in the park when there was a nice shiny stent in a lovely brand new hospital down the road. They felt they were much more worthy to have that because that is where science and technology was at its ultimate and they were just being told to go for a walk. So the patients' expectations were not met and the doctor felt uncomfortable very often in promoting that because it was not what we had been taught to do and we had not got the confidence to do it.

Finally, the patients have a fear of physical activity. Most of them have never been out of breath because they have never exerted themselves to the point where they are actually going at 70% of their VO_2 max, which is a three-mile-an-hour walk. They are walking incredibly slowly, so to get to the point of being out of breath is quite scary. That is another aspect, when they come back to the doctor saying they cannot do this because it is too dangerous.

Q303 Barbara Keeley: There is the Sport England campaign "This Girl Can", which shows images of women taking vigorous exercise. Do you think that is a good idea? Clearly, the message in that campaign is that it is all right for women and girls to get sweaty, out of breath, go red and look terrible, if you like, and particularly to get over those barriers. Do most people need that message, that information?

Dr Bird: From the experience I was getting from GPs, yes, they do need it. That campaign is excellent and it has really raised the profile. It has been very effective in its pitching, in its reach to women. But we forget that barrier.

Professor Dame Sue Bailey: That is the very reason why in our report we have focused on the "how to" for doctors, which is the feedback Dr Bird has had from practices. We have focused on a very simple set or model of doctors' roles in changing behaviour and culture, how to do it themselves, how they can explain that to patients and the dos and don'ts of how to apply that. We have put in a quick guide to recommending physical activity because we know doctors across the whole field of primary and secondary care are very busy. This has to be embedded into our routine thinking and practice, and to do that we

have to feel confident in doing it. We are the people who are there and able to give appropriate advice about what a particular individual can do in terms of physical exercise. Therefore, there is a hearts-and-minds and training issue here that the Academy is very keen to address.

Q304 Barbara Keeley: Could I ask you about savings? There is a comment here from the evidence about savings and "the benefits of regular exercise". "The report highlights estimates that up to 15% of the NHS budget could be saved in costs of treatment and care if the population took appropriate physical activity…" That is a staggering amount. It would be very helpful to put a total figure on that, but, given Simon Stevens's push and the whole thought of what the funding gap is in the NHS, is it not surprising that there just is not a bigger push to be able to get those savings—that there seems to be a reluctance to embrace what you are talking about, and yet the savings that could emerge from it seem so substantial? This seems like a most peculiar gap to me. Here is something that is beneficial and financially it could be of great importance to the NHS in terms of savings.

Professor Dame Sue Bailey: Sadly, it is not unusual to encounter belief gaps where you have solutions that are simple. I work in the field of mental health where there is a belief gap that parity for physical and mental health will actually save money. It has to be fought, argued and evidenced. This is something we need to keep doing by attrition and demonstrate the benefits, not only the cost savings in this area but across the whole area of public health and public delivery of services.

Q305 Charlotte Leslie: I must apologise for nipping in and out; I have had a couple of urgent calls, so apologies for being so rude. Dr Bird, you mentioned in passing that walking was not part of the algorithm of the survey, which I detected that you found unfortunate. I am astounded. What does that say about the culture of DH and the systems we work in—that walking should not be part of the algorithm—when anyone with any common sense would have thought it was? Is that the point we need to target to try and get change, to perfuse throughout the system?

Dr Bird: It is a good point. The problem with physical activity is that it is hard to measure compared with BMI, smoking and other things, where we have nice figures and near-patient testing. So we are struggling a bit. The GPPAQ—a physical activity questionnaire—was taken from a massive study called the EPIC study, which was done on cancer around Norfolk, and it is a European study. They looked at what really made a difference on mortality from physical activity outputs, and it was actually work-related outputs, cycling and, I think, one other. Walking, housework, gardening and everything else did not fit in, but they asked the questions. You still ask the questions, but, when you look at the back end of it, it does not connect. GPs have told me that they find it very difficult when a patient is walking five days a week for an hour—as Professor Bailey's report said, that is where we should be going—for it to come out that the patient is inactive because of that. It is being looked at. A lot of CCGs are thinking about using a different measure and we are still in that kind of turmoil and trying to find out what the single measure is that we should be using—there are two or three out there—but which includes walking, because it is not really right at the moment.

Q306 Charlotte Leslie: Forgive me if you have already covered this when I was out, but are apps and things like that which you can use as pedometers changing the way that people can measure things? Watching and measuring progress for someone, particularly someone who perhaps has mental health issues, and watching that building and achievement is very good for mental health as well as physical health. Are those apps and pedometers helping?

Dr Bird: There is no evidence to show that apps change behaviour for physical activity, but they are very good at encouraging more behaviour in people who are already active. So, even though everyone has a smartphone right across the board, yes, they can be used and incentivised. There was a study of pedometers and Glasgow Rangers, where the middle-aged men were incentivised that if they got a certain number of points they went on the hallowed turf of Glasgow. That was hugely beneficial for the use of pedometers on that. In general, though, I do not think that is part of the issue and there is not enough evidence to show that pedometers can be used widely at the moment, but that may change.

Q307 David Tredinnick: Building on the points that Charlotte has made, I find it quite distressing to think that we now have a culture where patients prefer going to a shiny new hospital for a stent rather than taking basic walking exercise. Is not one of the core problems that we have with the health service that people no longer care for themselves? They believe they have an absolute right to pitch up at a doctor's surgery or an A and E and receive treatment of some kind which exonerates them from taking any action themselves.

Dr Bird: In the role of a doctor, there is very often a fear in patients. Although the internet has loads of information, often patients come with that information but do not want to take the full responsibility of it. They hand it to a doctor. The doctor—hopefully, if he or she is a good doctor—repackages that and hands it back to the patient in a format that they understand and can cope with. Therefore, I do not think it is wrong that patients come to us with fear and wanting to hand that responsibility on, because fear is a big factor in much of this. Our job is to have compassion and to be able to hand it back to them, having explained it. Then the patient continues that responsibility and moves forward.

Q308 David Tredinnick: To be fearful of taking basic exercise clearly has to be addressed, but, if you look at things at a macro level, much of the work of this Committee in this Parliament has been dealing with the so-called Nicholson challenge, coined by our former chair Stephen Dorrell—the inexorable increase in demand for services and scarce resources, and trying to find ways of bringing that together. What we are discussing today—basic exercise—could be a significant contributor to meeting the Nicholson challenge, in reducing costs. Surely the focus is far too much on increasing supply and far too little on cutting demand for services.

Professor Dame Sue Bailey: As doctors, we are in the business of values-based care and the second limb of that is value and cost, but this goes to the heart of what, as doctors, we need to do in conversations with patients. We add the advice beyond the evidence, and it is where we have to be able to help them choose wisely about their treatment path and what they are going to do in terms of self-care, self-help and what we can offer them.

Q309 David Tredinnick: Is there not, unfortunately, a built-in incentive for the medical profession to promote expensive treatments because it is through those treatments and the tariff system that people get paid? There is a disincentive to have the simple option of taking exercise.

Professor Dame Sue Bailey: As doctors, we are increasingly involved and must be involved in health prevention. Our duty is to help patients choose wisely.

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

Q310 David Tredinnick: The chief medical officer Dame Sally Davies, who has been in front of the Science and Technology Committee, which I also sit on, and in front of this one as well—there have been so many meetings this Parliament—wrote a book called "Drugs Don't Work", but, unfortunately, in the evidence that she provided, there are very few alternatives presented other than the need for more money to try and find antibiotics, which people should be using less, which is not a very attractive proposition for companies. Is it not absolutely critical that we roll this out on a wider scale to try and meet the problems that I have already described? I am asking you something you have to say yes to; you can hardly say no.

Dr Bird: No!

Q311 David Tredinnick: Maybe we should keep moving, but think about that, please. How helpful was the NHS Health Check in promoting physical activity? Can you tell us about that?

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

Q312 David Tredinnick: Professor Dame Sue, going on from that—you have touched on this—how well do you think the average NHS clinician understands the importance of physical activity?

Professor Dame Sue Bailey: We have a way to go and a way to travel, but we have a determination. We have a way of reaching 220,000 doctors and we need to ensure that this is bedded in, in terms of doctors, into medical education from the first day of medical school.

Q313 David Tredinnick: Is there not a problem with doctors' education in that there is far too little emphasis on prevention, and the training tends to focus on treating the specific conditions?

Professor Dame Sue Bailey: In the education, in the curriculum, there needs to be far more about prevention, understanding single conditions, and in fact most people have multiple conditions, both in terms of the functioning of the patient and the social context. The curriculum is changing and will continue to change, and an opportunity is going to be provided for that in the future Shape of Training.

Q314 David Tredinnick: Do you know offhand what time in the teaching schedule of doctors is allocated to issues to do with physical education?

Professor Dame Sue Bailey: No, but I can certainly find out. I suspect it will be that the training is spread across a range of topics within the curriculum. Maybe it needs to be recognised as an entity rather than just appearing in separate parts of different parts of medical curricula, but I can certainly come back to you on that.

Q315 David Tredinnick: I have a couple of final questions. What more do you think needs to be done to win the hearts and minds of physicians about promoting physical activity? Do you think medical training in this area needs to be expanded?

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

Q316 David Tredinnick: So it was an interface issue.

Dr Bird: It was. They were fascinated that physical activity had effects on the cellular part which was causing all these diseases. They then bought that; they owned it. Suddenly physical activity was owned by those doctors and you could see it happen very clearly. The way it is presented is quite important. Then those same doctors were talking about the school crossing almost 20 minutes later, because now physical activity was their responsibility. Doctors will accept that physical activity is not just prevention but treatment as well, so we have to explain that almost every condition can be treated. There

is a gap that we have probably not been very good at filling in getting that knowledge to GPs and all doctors, which is there, and I think they will accept it when it has been put in the right way.

David Tredinnick: Thank you.

Q317 Chair: Can I follow up on a couple of points that you have raised about issues like QOF, which are very process and tick-box driven? I know, Professor Bailey, you have touched in your evidence on how you have this unique opportunity in a health care setting to catch somebody just at the point when they are ready to change behaviour. If at that point they encounter somebody who, as you put it, Dr Bird, says, "I am meant to be talking about physical activity," that is not an inspirational moment. We have rather focused on incentives and tick boxes. How do we change this within doctors' surgeries to make sure that every contact really does count as we want it to? What do you think would make the biggest difference?

Professor Dame Sue Bailey: An overall approach would make the biggest difference. We have a way forward with this document and what we need is probably Dr Bird's scheme duplicated. As you do in all sorts of learning, you can always have the e-learning package. You then need some product champions who will go out and explain the benefit, not only to the patient but how it will make the whole functioning of the surgery better; it will make it a better, more positive place for not only the patients but the staff working in there. It is a hearts-and-minds thing, not tick boxes. It is action with intent, with evidence and with an attitude that this does work, it will work and we cannot afford not to do it.

Q318 Chair: In effect, it is having inspirational people going into surgeries teaching a whole practice team that this really does matter and that they are failing their patients if they are not capitalising on all these opportunities that they have to be leaders in driving change in people's lives.

Professor Dame Sue Bailey: I would term it that they can greatly benefit their patients. You have to frame things in a positive way if you want people to change behaviour.

Q319 Chair: You would say getting inspirational people into surgeries to change behaviour is the most effective way. It was a disappointment, I think, to many people that the NICE guidance came out saying that it was not cost-effective to have exercise on prescription. Of course, doctors are used to handing prescriptions to people; so it kind of felt like an alternative to using drugs or referrals. There was a lot of hope that that would be more successful or cost-effective. Do you feel part of the failure with that was just that it literally felt like getting a prescription—something handed over, a kind of, "I am meant to be talking to you about exercise"? Was that why it was not so successful? Do you feel there are ways we could still use this as an opportunity, as an alternative to referral?

Professor Dame Sue Bailey: The context in which advice is given is really important—that includes to doctors themselves—and how they understand the advice that we are giving. Far more work needs to be done on that. That will fit with whole-patient care and

will be caught in the future Shape of Training, but we need to do the catch-up with the current health care staff that we have.

Q320 Chair: Do you think that the future Shape of Training review is going to be a pivotal opportunity to change the way doctors are going to be putting these messages across?

Professor Dame Sue Bailey: The future Shape of Training at its core is about how we have conversations with our patients, how we understand whole-patient care, and how across the medical profession we look at the patient's whole needs and how this physical activity can be a pivotal part of that, which is going to give better care and better outcomes. It is a change of attitude and giving doctors the confidence in giving those messages and how to do it.

Q321 Charlotte Leslie: To what extent—and this is going to be a difficult question to answer, I know—do you think obesity is a symptom or a cause of mental health issues?

Professor Dame Sue Bailey: That is going to land with me, isn't it?

Q322 Charlotte Leslie: I need both your opinions.

Professor Dame Sue Bailey: We have two major challenges here. One is, whichever way we wrap this up, we know that the treatment we give to people with mental health problems leads to weight gain. We know that. But there is really good news from Australia and trials going on over here that we can now minimise that weight gain to no more than a woman going on the contraceptive pill. That is a major step forward.

Then you have the mental health problem itself where you become preoccupied with your thoughts, get withdrawn and stay in. You need to find comfort somewhere and eating is part of that. So it is both. It is like everything: it is both. It is about the approach you take with somebody with mental health problems from day one when you identify that. It is the attitude you take with them, how you try and help their sense of confidence and self-worth, and how you help also to support their carers. It is not just mental health problems. You look at the same sorts of things around dementia as well. So it is both. There is not a nice clean answer to the question.

Dr Bird: I feel nervous talking about psychiatry in front of Professor Bailey, but this is a symptom of a bigger epidemic of chronic stress where people really do not feel they have that well-being side of things. Of course, with chronic stress, as opposed to acute stress—which is quite healthy—you get the constant corticosteroids coming through, the glucocorticoids coming through, which are causing havoc in our bodies. Therefore, obesity is far more likely to occur in those people because you have cortisol going through, which creates weight gain. It is a way that the body survives. If you feel you are going to be stressed about a famine, war, earthquake or whatever, you want to conserve as much energy as possible; so you become more inactive and conserve more fat. We have this whole chronic stress issue which is underlying not just in the deprived areas but other areas as well. Obesity follows on from that. It is extremely difficult to undo that while you still have chronic stress. While people are still living in a bad environment, are isolated

and have no purpose in life, you have an almost impossible task in trying to change that obesity. This is where there has been a mismatch and people think, "It's so easy. You just have to go on a diet," or, "You just have to do this." But if you are in that state of mind, there is no way that is going to be effective and it is going to be difficult. If we are going to talk about the real problem, it is not just obesity and physical inactivity: it is inequalities and chronic stress.

Q323 Charlotte Leslie: It is rather like telling a depressed person to cheer up.
Dr Bird: Exactly.

Q324 Charlotte Leslie: If you feel inadequate talking about it in front of Professor Bailey, I certainly do. I am going to come to another question in a moment, but something I have not heard talked about—and I just wonder what your reaction to it is—is the sense of lack of control. In my constituency, which is very varied, I look at the communities that suffer from obesity. They are communities where individuals do not feel they have very much control over their own lives, and the community does not feel it has very much control over its destiny and its collective self-esteem is very low. I wonder whether eating—it often goes hand in hand with alcohol or substance abuse as well— is in some way taking control, even if it is in a negative way, in a world where you do not feel you have control over anything else, and whether a sense of self-esteem and autonomy is a valuable thing in terms of tackling the obesity epidemic. Does that make any sense?
Dr Bird: I could probably just say, yes, that lack of control obviously contributes to the whole aspect of chronic stress, as in the Whitehall studies where we heard that lack of control is one of the big risk factors for mortality. Of course, comfort eating and so on is very connected to the evidence to show that if you are chronically stressed you will want to take in more calories that are fat and sugar. There is no doubt that eating behaviour changes when you do not have that control because you have that chronic stress. There is a very strong relationship. Then, of course, physiologically in the body you have the double whammy of where that fat is laid down more, and in the area of inflammation, which we talked about as being the basis of all chronic disease, if you are stressed, you will create much more inflammation and chronic inflammation in the body. You have a pathway really of poor environment, isolation, no work, no job prospects and no control, chronic stress, chronic inflammation and disease. Inactivity and eating are the two drivers that keep it going.

Q325 Charlotte Leslie: It is very refreshing to hear you talk so much about causes and not just about symptoms. In our collective response to obesity, do you think we are concentrating enough on causes of obesity as opposed to the symptom that is obesity?
Professor Dame Sue Bailey: I would rather look at the solutions. You talk about communities that face adversity and exist in difficult conditions. They cannot see the point and they cannot see any exit point. This is fundamentally about how we build psychosocial resilience in communities. Communities that suffer chronic stress and adversity can be communities that are busy minding their own business one day and then suddenly an adversity hits them from left field. This goes to the heart of psychosocial resilience

building and how you build social scaffolding in communities. There is growing evidence that is coming from two fields, one of individual trauma from people who have been abused, and also from group trauma. The scientific evidence that is coming in from this, which is underpinned by the neurobiological evidence, suggests how we can build psychosocial resilience in communities. There is new work occurring on that and our college is about to write a book on it. You will all be the first ones to get a copy of the book when it comes out. But I think you go to the heart of a very important and large matter.

Q326 Charlotte Leslie: Do you think the way you are tackling it, which is very much, "Let's look at the root causes and see if we can help mitigate those," is prevalent enough in the way in which we look at our health services? Perhaps I have not been at the right meetings, but we have not had very many witnesses who have gone to the heart of the problem in the way that you seem to be doing, and it seems to me a shame that you should be unusual in that virtue.

Professor Dame Sue Bailey: I think life is at second base. We know what the problem is, we know what the causes are, and it is always the biggest hurdle to go to third base and to start action. That is what needs to start to drive across medicine now: action we can take that is simple, that can be done by doctors, by health and by communities, to reach fourth base, which is a healthier community in 2040 with good public health. We just have to keep at it.

Dr Bird: It is becoming much more kind of, I would like to think, mainstream—or perhaps not quite mainstream yet. For example, one of the things we have not touched yet is the environment, which I know has been dealt with before, but it is one of the areas of interest in another book that is coming out, the "Oxford Textbook of Nature and Public Health". You can all have it in July.

Q327 Chair: We do have a series of questions specifically on the environment.

Dr Bird: Okay, we will leave that. That is the way you can green and create an environment where that chronic stress is reduced. The evidence coming through on that in Chicago now is really quite strong. As to well-being, I am still a GP and have never moved into public health, even though a lot of what I have been doing on activity and the Met Office and other things have all been public health. The root cause and understanding of people has to come from seeing them day in, day out. They are my policy advisers; they are the people who guide me when I feel like—

Q328 Charlotte Leslie: Rather like being an MP.

Dr Bird: Yes, exactly. If you become dissociated from your constituents, from your patients, you have lost the plot completely. I feel that doing public health but on a grounding of general practice is a really strong place to be. One thing I have always tried to promote is that public health and primary care should come together in the same individuals so that there is continuity, so that we can talk about this higher level and second base—and even third base.

Professor Dame Sue Bailey: I am going to have to add even more reading. The Academy produced, through the work of the sustainability fellow at the Royal College of Psychiatrists, its report on waste and sustainability. The two main planks of sustainability are disease prevention and self-empowerment. It is that approach that will win through with time and effort.

Charlotte Leslie: Do you think perhaps one recommendation the Committee could consider in doing its report is a greater focus on things such as building psychosocial resilience and self-esteem to tackle the root causes of a lot of the things we spent a lot of money working on the symptoms of? I have gone on, I am sorry; it is very interesting.

Q329 Chair: Can we touch on a slightly related area? Something that concerns me is a suggestion that we, or the Government, might be looking at enforced referrals for people with conditions such as obesity as a condition of benefits. I know Dame Carol Black has been asked to look at this. I have great concerns about any concept of coerced consent or referral, but in terms of your thoughts about whether it would even be effective, could you share your views on those proposals? Do you share my concern about the idea of coerced consent and about whether it would be effective? Would you like to comment on that, Dame Sue?

Professor Dame Sue Bailey: It is a difficult area and I do not think we are even at first base, because we know from studies that you have patients who have obesity where GPs have sat in surgeries with them and have never even raised the issue with them for 20 years. Before we get to that point, we have things to do in our own house. Then we need to look at ways of engaging and I think we are a long way away from that.

Q330 Chair: One of the reasons for looking at it would be the theory that it is a way of at least engaging and forcing people to engage in it, but there are other issues around it, are there not, clearly?

Professor Dame Sue Bailey: I am hesitant as a forensic psychiatrist when I hear the word "coercion".

Q331 Chair: Yes, indeed. I do not know whether this is something you have been following, Dr Bird.

Dr Bird: No, I have not been following that. Going back to the exercise referral, where the evidence was shown to be inadequate and it kind of petered out, that did show, though, that that was very prescriptive in gyms. The evidence always takes so long to come through. A lot of work was done in the 1980s and 1990s. Newer work is showing that once you have the patient engaged—when you have had that "Anfield" moment, almost, with a patient, where they have got engaged and accepted it is going to be part of them—they will then change their behaviour. The medical profession has a really small but important role in perhaps initiating that change, but, after that, it has to be the patient enjoying it and feeling they have value. We sometimes overestimate what we possibly can do. Exercise referral was to throw someone into a gym, who probably hated the gym, and expect them somehow to go on for ever in doing something they don't like doing. Most normal people don't do that. So, from this, we have to accept what effect any kind of coercion referral

would have. If it gets someone to a place where they like it and they would not have done it otherwise, that is a good thing, but we can't make people do things that they don't want to do afterwards. It has to be a positive experience.

Chair: A positive experience, thank you very much. I do not know whether you want to add to that, Barbara.

Q332 Barbara Keeley: Can we come back quickly to local authority planning decisions and the idea of having a mandatory health impact assessment? The question from the Committee is what impact the environment has on people's ability and motivation to be physically active. Dr Bird, I think you were talking about some evidence that emerged in Chicago about the impact of open space on people's well-being. Is that what you were referring to?

Dr Bird: Yes.

Q333 Barbara Keeley: I have quoted that when I have been trying to appeal against building on green open space in my constituency and you get nowhere with it, unfortunately, at the moment because it is not part of the National Planning Policy Framework, but perhaps you could tell the Committee what you think on this issue.

Dr Bird: The environment has often been forgotten, particularly by the medical profession, and even in public health it is such a difficult area to get into because so much of it is obviously there and is expensive to change. But we have seen places even in New York where they managed to start to change the environment, temporarily initially, in order to get over the boundary. It got more people talking, walking and mixing, and suddenly the whole social cohesion came through and the health benefits have started to come through now with the measurement.

Even in an area where there are real barriers, there has been effectiveness. In Chicago, a million trees were planted by the mayor. Professor Kuo of the university of Illinois came up with some very good evidence to show that green space encourages social cohesion and gets people to become more active and less stressed, and therefore domestic violence goes down. Huge things that you would not even expect to be associated come through from very simple measures.

Physiologically now, we have all the PET scans to show that the brain changes when people look at green space. It actually does change for Alzheimer's patients. So there is a whole mass of evidence out there. The book I mentioned, going from Harvard to Stanford, shows that everyone is looking at this much more seriously. David Tredinnick would be pleased to know that this is now no longer just on the fringe. This is now mainstream medicine and goes right to the heart of planning. We have to have environments that are now conducive, with all the evidence we have. As to health impact assessments, I almost feel I do not like making that side of it mandatory. It is common sense and the planners should be so informed and empowered with this such that they should be doing it themselves.

Q334 Barbara Keeley: I agree, but, realistically, if it is not in the National Planning Policy Framework, if it is not mandatory, they are faced with legal challenges. In my experience, most local authorities are more worried about the six-figure legal bill that they are going to get if they are challenged. A builder who wants to build on green open space has that power. I would argue that is probably why it has to be mandatory.

Professor Dame Sue Bailey: The Faculty of Public Health, within the family of the colleges to the Academy, have a lot of evidence about this, particularly on work in Liverpool and Glasgow. It goes back to the heart of community engagement and finding a starting point.

Q335 Barbara Keeley: It certainly is my experience that we have targets for house building and road building but not targets for keeping anything, and certainly not for putting in more trees. We seem to be going in the opposite direction all the time. It is very depressing.

Dr Bird: We should be using green space as a health resource that has a health value. Therefore, that health value is removed when green space is taken away. That is the kind of mentality with which we should be looking at it.

Q336 Barbara Keeley: Is there any work going on with the planning establishment to do that—that you know of? This seems to me to be a big thing that is being ignored.

Professor Dame Sue Bailey: There certainly is if you look at the Liverpool Public Health Observatory. There is work going on with the chair of the Faculty of Public Health and across the universities there. There is currently work going on in Glasgow about making slight changes to green spaces that have been seen as not safe green spaces, just by the community bringing about slight changes. There then tends to be an acceptance by local government that some spaces can stay. But I would advise you to go to the chair of the Faculty of Public Health and I am very happy to give you the contact.

Dr Bird: Birmingham is trying to get the status of a biophilic city.

Q337 Chair: Can you say that again?

Dr Bird: It is biophilic—biophilia, the connection with nature. There is a kind of international way of making your city a biophilic city, by which green space is prioritised, and Birmingham is going through that process at the moment, so there will be another group to talk to.

Professor Dame Sue Bailey: There was a very good example at the Warneford hospital in Oxford where the local community and the mental health hospital came together. They have preserved the green space between the community and the hospital. Mental health and the community came together to retain that green space and the advantages that have been described. In Oxford, that was a very practical example.

Q338 Chair: Could we go on to the issue of the Responsibility Deal, changing the subject somewhat, and looking at the influences on diet that we can have through that? Have these voluntary agreements been successful, or do we need to go down a regulatory route? Would either of you have a view on that?

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

Q339 Chair: What would you feel about having a tougher regulatory regime, and what do you think would be the most effective of those measures?

Professor Dame Sue Bailey: If I had to go for one, I would have to say it would be having a tax on sugary drinks.

Q340 Chair: How about you, Dr Bird?

Dr Bird: I won't talk about diet so much because I have been working with the physical activity part of the Responsibility Deal. In many respects, that is slightly easier and less contentious because it does not have the alcohol or dietary impacts of industry. I don't know what difference it has made for the future, but from being there and looking at the companies who have been involved, who are making pledges about their own work force but also putting money into physical activity—and it is all the big names like Coca-Cola and others who are pushing forward—that discussion is good, and we should be talking to industry who use their ability to connect to people, in a way that we can harness it to connect to people in ways that we do not often do very well. As long as there is an absolute open discussion, it is very frank about what people want out of that deal and there is honesty at the table, those are the discussions we should be having. As I say, I do not know what effectiveness that has had so far on physical activity. I would expect very little, if none, but it is a way that perhaps that discussion has gone into some of the big industries in this country, which is probably not a bad thing and I think could be quite positive for the future.

Q341 Chair: Do you feel, Dr Bird, that there is a danger, when you see the promotion of sports drinks, for example, to children, which may have very high levels of sugar? Do you see any circumstance under which a child would need to have a sports drink? These are often sponsorship-type arrangements. Do you see that as a danger?

Dr Bird: In a very modest context, yes, sometimes children will need a little bit of additional energy, but certainly not to the extent and in the way that is being promoted—that you have to have this sports drink at the end of any activity you do. Activity can be 15 minutes, which is in no way going to compensate. It has been scientised and created into this great industry where you have to have all the gadgets, gear, nutrition and the drinking and so on to become active, whereas you don't need all of that—it is very simple. I would not want to say that you can't have a treat or anything afterwards, otherwise we are starting to be telling people that they can't do anything; but the way it is promoted is

probably overdone and perhaps even a barrier to people wanting to do activity because they feel they have to have all this apparatus around them.

Q342 Chair: Thank you. Looking at the obesogenic and low physical exercise environment that we have in our society at the moment, if both of you were going to take a "What works?" approach, what key messages would you want to come out from this inquiry? If we asked what should we really prioritise, what would you say they were, Dr Bird?

Dr Bird: First of all, the environment for physical activity. We did some work in Natural England. There were five generations of one family: the oldest member, the great grandfather, had a six-mile radius of being able to have free play at 8 years old, and the child now has less than 300 metres of free play. When I say "now", that was four years ago, but now a lot of children have zero because they can only be taken to places. So they have no more free play at all. That is having a major effect not only on children's ability to learn but also on them becoming active. Most of the activity is when they are outdoors doing free play and not sport; it is just free play. We have to have an environment that says that is just not acceptable. Also, there is the walking.

Another thing is that we need to understand the community and what people value to want to become active. The whole voluntary sector works on people being active. A whole community connecting together works on people being active. If you have an inactive society, you have a dead society; you have a dead city. We have to look at where environment and social meet together in housing estates, and so on, to improve that way of making it valued, to become active, to volunteer and to keep that cohesion of the community. Physical activity will follow as a secondary rather than being a primary.

Q343 Chair: Thank you. Professor Bailey?

Professor Dame Sue Bailey: I could not disagree with that and I think it is in the embedding of this and getting what communities actually want, what they would like to achieve, building the psychosocial resilience. The pragmatics that follow on from that are giving people awareness and education, giving them the facts, helping them to self-empower and following through with action, and, from the point of view of our report, getting doctors to better understand this and to realise what the impact of their actions could be if we are going to have a healthy nation in the future.

Chair: Thank you very much. Do either of you have anything you would like to add to that? Thank you for coming today.

Witness*:* **Julie Creffield**, blogger and campaigner for Too Fat to Run? campaign, gave evidence.

Q344 Chair: Hello. Thank you very much for coming. Could I start by asking you to introduce yourself to those who are following from outside the room?

Julie Creffield: Sure. My name is Julie Creffield. I would describe myself as a plus-size athlete and entrepreneur. I run a website called the "Fat Girls Guide to Running".

Chair: Yes. Thank you very much for coming today. First of all, I will hand over to my colleague Barbara.

Q345 Barbara Keeley: Perhaps you could tell us more about your campaign, because it is not just that you are involved in getting more people active; as you have said to us, you are specifically encouraging plus-size women to be active. Could you tell us how you started that and what you do?

Julie Creffield: Yes. I got into running when I was in my early 20s. I had put on loads of weight while at university and wasn't doing any regular exercise. I got involved in a fun run and it wasn't any fun because I was so unfit and overweight. A child shouted, "Run, fatty, run," and I just sat in my car and cried. I was really determined to change my health. I was not necessarily worried about being fat. It was more about the health implications of being overweight. So I started to run but I did it in secret at night. I didn't have any friends who ran, so I was completely by myself, and probably did that for three or four years, signing up for races, not training properly, having terrible experiences at these races, and I never really saw any progress. When I looked online for information, there was lots about weight loss and running but nothing about running just as an overweight person, the psychological aspects of that and how tough it is when you are constantly shouted at, laughed at and clothes in fitness stores don't fit you. It feels like the whole sport is not geared up for you.

The catalyst for me starting my blog was that I came last in a race. Not only did I come last but they had packed away the finish line. I felt incredibly embarrassed and thought that this must happen to other people—it can't just happen to me—and I started writing a blog. By that point I had committed to running the London marathon, even though I could not run really for more than 20 minutes at a time, but that was my goal. The blog was really to keep me accountable. Over time I realised that people were interested in what I was talking about and would say, "That happens to me. Could you tell me about this and what are your experiences of this?" Before I knew it I had an international following. Just recently I have been given the title of one of the world's leading plus-size fitness experts, and I never saw that coming. It has happened over a 10-year period. I would say it is separate now from my own journey and my own weight loss fitness goals, and it is much more about a campaign to challenge people's perceptions of overweight women and to encourage women to give it a go.

Particularly in terms of health, I went to my doctor in 2013 with some lower back pain which was caused by picking my daughter up. When I mentioned that I was due to run a marathon, he said I couldn't run a marathon—I was too fat. That really spurred me on to take what was a bit of a hobby—this kind of blog—to being a real campaign. I was so angry that that doctor, who wasn't my doctor but a locum, didn't want to hear that just the week before I had done 18 miles around Hyde Park and that I had been running for a long

period of time; this wasn't just something I had in my head. I was determined to run in that marathon to prove him wrong but also then to use that catch phrase "Too Fat to Run?" as a way of starting these debates with parliamentarians, the people who can make changes, because, ultimately, the people who were reading my blog were the people who needed help. I have struggled over the last few years to get my voice heard and to have discussions about health and what I have learned and experienced.

My background is working in local government. I worked as a project manager on the Olympics and I have done lots of work in culture and sport. I can work quite strategically as well as being a runner and giving practical advice.

Q346 Barbara Keeley: Could I go back to the attitude that you ran into not with your own GP but with a locum GP, because we have just been hearing—and you were with us, I think—Dr Bird talking about the difficulties of getting GPs to understand these issues? From the blog and the contact you have with other people who are going down this particular route, who are trying to take exercise, who are doing runs maybe or other forms of exercise, is that something you have heard other people encounter too? Do you think it is common? You have experienced it, so do you know if other people have experienced it too?

Julie Creffield: Yes. I am very connected to a lot of social media groups for overweight women, what would be described as "fat positive" groups. There are the experiences of women going to their doctors for advice about weight loss or health—you know, fitness—but also just going to the doctor for a sore finger and, before you know it, you are being told off about your weight. There is a lot of mistrust among overweight people and they think, "I am not going to go to the doctor about that niggling pain I have because I know he is just going to have a go at me about my weight again." I hear a lot that there is a mistrust.

Q347 Barbara Keeley: Do you think the NHS can cope with people who have not been active becoming active? That is an important part of what we have just covered—the whole notion of people moving from inactivity to activity. But if there are medical issues, you seem to be saying that people will ignore those because they don't want to be lectured about their weight.

Julie Creffield: Yes. I have a campaign to get a million fat women running, and if they all do it tomorrow then the doctors' surgeries might be bombarded with people with twisted ankles and shin splints and all those kinds of things. Of course there possibly will be an impact, but it is about a gradual introduction to the sport of running, not going full whack and signing up to a marathon. I have been developing a scale which could really help doctors. It is a scale that goes from non-runner to contemplator to beginner. We often talk about beginners, but a beginner could be somebody who was very active in a former life or somebody who has just had children and is coming back to it.

So I do not think the word "beginner" in running is very useful at all, which is why I have developed this scale, which talks about plodders, joggers and sloggers, because, again, we assume that overweight women are new to the sport. Actually, the research that I have done via my website is that there are women who have been enjoying running for 10 years and their weight is nothing to do with the reason why they run. They run for health and

happiness, not to lose weight. One of the reasons that I stopped talking about my own weight loss on my website was because I was sick of telling people whether I had lost a pound or not and it being linked to a sense of failure, or that I couldn't give advice if I was myself putting on weight. Now it is not about weight loss but about health and happiness.

Q348 Barbara Keeley: I have a final point about motivation. Clearly that seems to be coming out as an important issue. You seem to have made a lot of progress just on your own motivation, but how much do you think that is important with the people that you are talking to through your blog and through social media, having friends, having a network?

Julie Creffield: Yes. It is so important to have a network and it is easier for them not to be friends. It is easier for it to be people that you don't know. I run something called "The Clubhouse", which is a membership scheme, which is like a running club for fat people, basically, and we have members all over the world. They give each other that real practical support of, "Are you feeling rubbish? Maybe a walk today will make you feel a bit better." If you can't get that support from your immediate friends and family, which quite often you can't because, again, you feel you are going to get told off or they are on a different level, technology enables you to form really close friendships. Facebook for me has been a fantastic way of communicating with overweight women. I probably have 6,500 women on our Facebook page who interact every day.

I do something called "One Big Fat Run", which is a virtual race which happens monthly, and there are women who have done that for 18 months now and who have seen their weight come down; women have reported back that they have just left a job they hated because they have now got the confidence to go on. It is not just all about weight loss; it is about feeling part of a movement, a community of women who feel similar to you.

Q349 Charlotte Leslie: Do you have any male members?

Julie Creffield: We do—secret ones on the Facebook page—yes. "The Clubhouse" is the only thing that is exclusively for women. A lot of the feedback I get is that running clubs tend to be run by men and that is part of the problem. So "The Clubhouse", which is the only real paid-for thing, is women only. "One Big Fat Run" is inclusive—it is for anybody—and you don't have to be fat to do it; it is more of a mindset thing, about scale rather than dress size. We have a lot of overweight men who take part in that.

Q350 Charlotte Leslie: You said you worry about going to a GP because they will just have a go at you about your weight—I know how difficult it is to lose weight—but it is not something that is going to make you lose weight. It is going to make you go, "Stuff that. I am going to have cake."

Julie Creffield: Yes.

Q351 Charlotte Leslie: What do you think GPs can learn from how you have got people to overcome worries about their size?

Julie Creffield: I was so excited that Dr William Bird was here—I think I have a major crush on him—because what I say he says much—

Chair: I think we all did by the time he left.

Julie Creffield: —more eloquently than I can. He was the first doctor who said that you could be fit and fat. When I heard that out of the mouth of a doctor, I almost exploded. Just that phrase alone—for doctors to accept that that is a possibility—would be helpful. We make these assumptions based on things like BMI, and BMI is not an indicator of health, in my opinion and in my experience. I guess I don't know the ins and outs of the GPs and the way all that works in terms of their training, but I often think what I would say to 400 GPs. Do they have access to the imagery of things like "This Girl Can", which is a fantastic campaign, and what would they make of my campaign? I would love to have those conversations with those doctors because they do have a difficult time. I think about that doctor who had 15 minutes with me presenting with back pain and perhaps I would make that assumption, "Oh, a big girl." It is tough because, as human beings, we do make assumptions.

As to changing the terminology, it is why I use the word "fat". A couple of years ago, I would shudder myself at saying that, but what I have found through discussions is that the term "overweight" is not that useful because you are making a judgment about that person and saying that there is a sense of normal, when, for me, what I have here is normal; this is me. I am not that bothered about getting into a size 12 pair of jeans. I just want to be healthy and happy for as long as I can. So the terminology is useful as well. That is why I continue to use the word "fat" without shuddering any more.

Q352 David Tredinnick: Thank you. I apologise for being late, but I had a whole lot of phone calls to deal with this morning. I was fascinated by the presentation of the person you had a bit of a crush on, and particularly the disaggregation, to use a formal term, of heart disease from weight. He was saying that not only do you not need to go to the gym but you just need to walk and get your heart rate up, which I thought was fascinating and there are all sorts of cost aspects there.

Do you, as part of your work, talk about weight reduction where necessary and the possibility of diet? You have one or two closet men in the background in your group. I try and practise what I preach, so I have given up bread for Lent, which has been a fascinating exercise. There are a lot of issues about white bread anyway and I have just stopped eating it. I find I have lost—dare I say it?--a couple of pounds without doing anything, although Members of Parliament tend to walk a lot. This is a huge estate and we have offices in outlying buildings, and we get bells that say we have to vote within seven minutes so we are often running all over the place to get there. So we probably have an in-built advantage here with the Division system. What do you think about diet and advice on weight generally?

Julie Creffield: There are two things there. There is the idea of stress. We are bombarded in the media with what we should and should not be eating, both from the point of view of the number of calories but also in terms of diet. Should it be Paleo, should it be Slimming World, or should it be this? As a woman who wants to lose weight, who do you listen to? So you get majorly stressed about that. You might start something, it works for a little

while, then real life comes in and you stop. Then you feel like a failure rather than the diet being the failure.

I promote much more about mindful eating, listening to what your body needs from a nutritional point of view but also what it wants. When I want chocolate cake, I want chocolate cake and I will have chocolate cake. I am not going to get a chocolate cake that is pretending to be a chocolate cake which is not actually real food. I sometimes go into the supermarket and walk down all the aisles and think, "That's not real; that's not real; that's not real; that's not real. Where is the actual real food?" I talk a lot about eating real food, food that grew on trees and things like that, but if you do want a McDonald's, for goodness sake have one, because the stress created by abstaining from these foods that are morally wrong makes you live a life that is dreadful. That is one thing.

The other thing I was interested in is what you said about walking. I agree that walking is a very good form of physical exercise, but I think people need to walk like a runner; they have to walk with the mindset of a runner. It is not about speed; it is about intent. My mum, who is quite unhealthy and overweight, says, "I don't need to exercise. I walk. I walk everywhere. I walk every day." But she doesn't walk anywhere with intent. She pootles along and it does not have much of an impact on her health.

I always say to the walkers who are on my site, "Have a plan. Think about how you are fuelling. Look to increase either in mileage or in speed and get your heart rate up." There is a tendency for doctors to suggest something less vigorous than running, to try walking, but it is boring to just walk the same route every day. You have to have the mindset of somebody who is training for something. Walking is fine, but have the mindset of a runner to do that.

Q353 David Tredinnick: It is interesting because in the Army the standard marching pace is 120 paces to the minute and the Light Infantry have a faster rate than that. Part of the reason for that pace is to keep people in condition.

Julie Creffield: Yes.

Q354 Barbara Keeley: You have talked about the "This Girl Can" campaign, and we have touched on it a few times and looked at it. Clearly it is very important. But in terms of the input that you get from people from your blog and your whole network on social media, do you think there are specific barriers that we need to focus in on that are stopping women becoming active?

Julie Creffield: Yes.

Q355 Barbara Keeley: Out of all the things—I think there was a range of things researched and found to be barriers—which ones would you go for, if there are two or three?

Julie Creffield: I recently did a piece of research and three headlines came up. The first was fear of being ridiculed—feeling self-conscious and that everyone is looking at you.

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

The other point is about feeling that you are too slow as a runner. That is a real barrier and why I never joined a running club for all of those years. I did not want to be the one struggling at the back. We need to create clubs or events that are specifically designed for people starting at zero. That is what my "One Big Fat Run" virtual event is about. You can walk it or you can crawl it if you need to, and it is not about the time that it takes you to get round.

Q356 Barbara Keeley: The point about embarrassment, lack of self-confidence and feeling self-conscious about being last is quite important, and there is possibly something about the design of events. The first time I ran a half marathon there was a sweeper ambulance going alongside me all the time asking if I was okay, did I want to stop or did I need anything. I kept thinking, "Yes, I want you to go away and leave me alone." It is worth saying that I do not think the people who design these events understand how strong a feeling that is—that you do not want to be running along with the man dressed as a beer bottle. If you are doing half a marathon, you do not want to be with all the jokers doing it in fancy dress. Some events actually mix it so that you can see the fastest runners at certain points. Then you feel like you are part of the thing that they are doing. Otherwise it is you just jogging at the back.

Julie Creffield: Again, it is about being explicit with language. In "One Big Fat Run" people know what this is about. This is about fat people running, so they are much more inclined to take part because they know we are not going to be comparing speeds and that there is going to be someone probably slower than them. I am trying to take my virtual run and get some backing to roll it out across the UK.

Q357 Barbara Keeley: Could you explain how that works, because I do not think we have come across a virtual run before?

Julie Creffield: A virtual run is really simple. You say you are going to do it, you tell people on Facebook you are going to do it and then you do it. After you have done it, you tell everyone you have done it. So it is all done via social media. You have to make your mind up to do it and go off and do it on your own, or you can do it with friends. We have a lot of groups of runners all over the country that have it in their diary and they know the last Sunday of the month is "One Big Fat Run". They do it and then feed back via social media. The photos that I get of women doing it with buggies, with their dogs, in the snow and in the rain are fantastic. It would be good if, alongside the virtual run, there was the opportunity in your community to go to a certain park once a month and take part in

something really inclusive, which does not have a specific start and end point, because another thing people are really fearful of is lining up at the start line, and everybody goes off and you are left behind. The way that we are looking to design this event is that you turn up in the morning and there are a range of different start times. It is much more laid-back and inclusive.

Chair: David, you wanted to make a point.

Q358 David Tredinnick: Yes, I did. I was thinking of another issue that came up in earlier sessions—what I have called dress size deception. I don't think it applies to men, but the sizes of women's clothes have been adjusted to make people think they are slimmer than they are. Do you think that has any bearing on your work?

Julie Creffield: Yes, I do.

Q359 David Tredinnick: How do you feel about it?

Julie Creffield: As a plus-size runner I do not look at the labels; I look at the clothes and think, "Does it fit me?" Often, because obviously it is lycra, you can stretch into items. People will say that there isn't a problem with kit sizes because lots of big people do run. What they don't know is that they are squeezing into clothes that are too small for them. Some of the big brands such as Nike and Adidas have a responsibility to provide clothing. It borders on discrimination that they stop at a certain point. I don't know if that answers your question properly.

Q360 Chair: It is surprising considering that there must, presumably, be a market.

Julie Creffield: There is a demand for it. Not that I want to sell hoodies and T-shirts for a living, but I launched a range of hoodies and T-shirts with "Too Fat to Run?" on them, and they sold out. They were in large, extra large and extra extra large. But again it is impossible to get anything larger than an extra extra large, which is about a size 20 to 22, in small quantities. I am unfunded—I don't have any Government funding—and am doing it all from scratch as a start-up.

Q361 Chair: Do you see a definite need there and would you like to see more of the right clothing supplied?

Julie Creffield: There is a need, yes.

Q362 Chair: It is easier to run as a woman if you are wearing supportive clothing, apart from anything else.

Julie Creffield: Yes.

Q363 Chair: Can I ask a question? Clearly there is some amazing work you have done through social media and you have made the case why that is a very supportive network. Do you feel you would also like to be able to reach out to those women who don't use social media—those who are not connected through the internet? Have you had any ideas about what you might be able to do to reach out to those who don't use the internet?

Julie Creffield: Yes, and it is a big problem. Women say they saw me in a magazine but they don't normally use Facebook or Twitter. My idea for rolling out "One Big Fat Run" is the answer to that. The idea is that it would be led by the women in that community, so it would be larger, active women in their community volunteering to lead this event once a month. They are more likely to be the advocates and the ambassadors, and to go out and knock on doors to get people to that event every time. That is where you would not need to use social media and there would be something every month. When I first started out, if I did not have a race in the diary there was no urgency for me to go out and train. People tell me that knowing that this is coming up at the end of the month means that they do go out in the three weeks leading up to it and practise. It seemed like once a month was a reasonable milestone for people to work towards.

Q364 Chair: There are already schemes in place like Walk and Talk, for example, and Walking for Health. Do you think there is an opportunity to tap into those, which are not designed for, say, the Ramblers, which is a fantastic organisation, but which for people who are just starting out would be a bit offputting? Do you think in the same way you could tap into the possibilities of that?

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

Chair: Yes, thank you.

Q365 Charlotte Leslie: Do you think there is something very valuable about the explicit nature of your language "Too Fat to Run" and "One Big Run"? It is not euphemistic; it is just saying it like it is.

Julie Creffield: Yes.

Q366 Charlotte Leslie: Do you think people sometimes feel talked down to by all the euphemisms?

Julie Creffield: Yes.

Q367 Charlotte Leslie: Basically, we all know what the issue is—people are fat—but being talked down to through the euphemisms makes them feel even worse because people call it fancy stuff.

Julie Creffield: Yes. When somebody says "obesity", I think fat people think, "Oh, they're not talking about me; they're talking about those people we see on the news items." People don't relate to that word; it is a medical term. When you say "fat", we all know what we are talking about. Actually, there are a lot of slimmer women who are still fat. You could be a size 12 and still have quite high body fat. It is about self-definition. I don't go round calling women fat. I don't say, "You are fat. Come and join my club." That is not what it is about. It is about people self-identifying and thinking, "This is my tribe. These are the people that I want to train with, not the people in the running club who all look stick thin and are really active." Lots of money has been put into physical activity programmes specifically designed for fat people, but fat people don't know they are specifically designed for them because the imagery or the wording is wrong. We need to be explicit, but not in a "You must do this" way. It is about looking at the barriers and designing programmes that people want—things that people want.

Q368 David Tredinnick: Can I come in on this? Somewhere here—I am not sure I can articulate this quite as I want it to be in its final form—there seems to be a very important differentiation to me about somebody who can be large but internally in condition. Somehow there must be a message to get out that by walking, going back to Dr Bird's point, you reduce the chance of heart issues.

Julie Creffield: Yes.

Q369 David Tredinnick: We need to somehow convey to larger people that, if they exercise in a certain way, they are well within and they cannot be put into this overweight obese category. Somehow we need to break this out. I am not quite sure how we do it, but can you create a feeling of self-esteem through what you are doing that makes people who are larger able to say, "Yes, I am large, but, buddy, my ticker is in great shape and my digestion is regular," which of course is another thing that comes with proper exercise? Anyway, I leave that thought with you.

Julie Creffield: Ultimately, I don't really care whether the women who follow my blog lose or gain weight; that is not what I care about. I care about their self-esteem, health and happiness. We need to look at the wider picture and not necessarily just be ticking. A lot of these programmes that are designed for overweight people measure them, and success is about whether they have lost weight or not, and I just do not think that is—

Chair: That has been a very powerful message today and very well made.

David Tredinnick: It sure has.

Chair: As you said, this is about your health and your happiness, and you have been a fantastic advocate for it.

Q370 Charlotte Leslie: I would like to say thank you. When women try to lose weight, we all know that, if you go to the gym, you put on weight because you put on muscle and get bigger—but that is muscle.

Julie Creffield: That is right, yes.

Charlotte Leslie: And no one ever says it, so thank you.

Q371 Chair: It has been fantastic to meet you. It is really great that you came today. Thank you very much, Julie.

Julie Creffield: Thanks for having me.