

The recommendations

This report presents 10 key recommendations – an ‘action plan’ – of steps that we believe must be taken to make real inroads into tackling the obesity crisis in the UK.

The recommendations fall into three areas:

- Actions to be taken by the healthcare professions
- Changing the ‘obesogenic’ environment
- Making the healthy choice the easy choice.

Action by the healthcare professions

1. Education and training programmes for healthcare professionals:

Royal Colleges, Faculties and other professional clinical bodies should promote targeted education and training programmes within the next two years for healthcare professionals in both primary and secondary care to ensure ‘making every contact count’ becomes a reality, particularly for those who have most influence on patient behaviour

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

- #### 3. Nutritional standards for food in hospitals:
- Food-based standards in line with those put in place for schools in England in 2006 should be introduced in all UK hospitals in the next 18 months. Commissioners should work with a delivery agent similar to the Children’s Food Trust to put these measures into place

- #### 4. Increasing support for new parents:
- The current expansion of the health visitor workforce in England should be accompanied by ‘skilling up’ the wider early years workforce to deliver basic food preparation skills to new mothers and fathers, and to guide appropriate food choices which will ensure nutritionally balanced meals, encourage breastfeeding and use existing guidance in the Personal Child Health Record as a tool to support this.

The obesogenic environment

5. **Nutritional standards in schools:** The existing mandatory food- and nutrient-based standards in England should be applied to all schools including free schools and academies. This should be accompanied by a new statutory requirement on all schools to provide food skills, including cooking, and growing – alongside a sound theoretical understanding of the long-term effects of food on health and the environment from the 2014/15 academic year
6. **Fast food outlets near schools:** Public Health England should, in its first 18 months of operation, undertake an audit of local authority licensing and catering arrangements with the intention of developing formal recommendations on reducing the proximity of fast food outlets to schools, colleges, leisure centres and other places where children gather
7. **Junk food advertising:** A ban on advertising of foods high in saturated fats, sugar and salt before 9pm, and an agreement from commercial broadcasters that they will not allow these foods to be advertised on internet 'on-demand' services

Making the healthy choice the easy choice

8. **Sugary drinks tax:** For an initial one year, a duty should be piloted on all sugary soft drinks, increasing the price by at least 20%. This would be an experimental measure, looking at price elasticity, substitution effects, and to what extent it impacts upon consumption patterns and producer/retailer responses
9. **Food labelling:** Major food manufacturers and supermarkets should agree in the next year a unified system of traffic light food labelling (to be based on percentage of calories for men, women, children and adolescents) and visible calorie indicators for restaurants, especially fast food outlets
10. **The built environment:** Public Health England should provide guidance to Directors of Public Health in working with Local Authorities to encourage active travel and protect or increase green spaces to make the healthy option the easy option. In all four nations, local authority planning decisions should be subject to a mandatory health impact assessment, which would evaluate their potential impact upon the populations' health.

The start of a campaign

It is unprecedented that the medical royal colleges and faculties have come together on such a high-profile public health issue. We have done so because we recognise the huge crisis already happening and believe that current strategies to reduce obesity are failing to have a significant impact.

We are absolutely determined that this report doesn't just sit on the shelf and gather dust. In fact, it marks the start of our campaigning activity. The Academy and its members will be doing everything we can to push for these changes that we believe will have a positive impact on the UK's obesity levels and prevent generation after generation falling victim to obesity-related illnesses and death. But we will not achieve it alone. Only through the commitment and efforts of a wide range of organisations and individuals will these recommendations be achieved – and as healthcare professionals who experience and treat the effects of obesity on a daily basis, we are determined to lead the way.



1 INTRODUCTION

Obesity is one of the largest public health threats facing many of the wealthiest nations in the 21st century. Every day doctors treat people, young and old, who are facing the health consequences of being overweight or obese, such as high blood pressure, type 2 diabetes, heart disease, strokes, depression, and some major cancers. These illnesses are putting our nation's health – and the budget of the NHS – under strain, and the contributions of overweight and obesity are growing.

Such is the severity of the problem, with just over a quarter of men and women in the UK classed as obese, and almost a third of nine year olds overweight or obese – that we can ill afford to sit back and not take action.¹

Obesity is a thoroughly well documented problem. So the aim of this report is not to continue setting out the scale of the problem but instead concentrate on what we can do to resolve it.

That is why the UK medical profession has come together to speak out with one voice on the measures that we think society as a whole needs to take to prevent the obesity crisis becoming unresolvable. It is these measures that we set out in this report. We also recognise that these recommendations are not exhaustive, but are ones that we consider achievable, pragmatic steps towards tackling the problem.

While our belief that the obesity crisis needs to be averted is single-minded, the solutions we propose are multi-faceted. Obesity affects doctors and healthcare professionals in day-to-day clinical practice and costs the NHS an estimated £5.1 billion a year.² It has devastating effects on not only health, but also on quality of life. Because of these far-reaching effects, we suggest an approach that is society-wide, and our recommendations go beyond the clinical role that doctors themselves play, important as that is.

We are under no illusion that with today's obesity crisis, we are faced with a far more complex challenge, as shown by the now familiarly crowded, map in the Foresight report.⁷ The solutions proposed are so numerous that they could, as one commentator put it, represent a 'policy cacophony'.⁸ If there were a silver bullet solution it would have been found and fired by now.

Throughout our inquiry, we have heard evidence from a range of individuals and organisations and have been repeatedly reminded that there is no single answer. But we also, universally, took the view that the best must not be the enemy of the good.

Most obesity is the result of slow weight gain in adults over 20 to 40 years of age.⁹ Many of our proposed solutions are therefore long-term; some look to build on existing successful schemes for both preventing and treating obesity whilst others will require policy makers to be bold. But what the solutions have in common is that they require simultaneous, committed action on a number of fronts.

The obesity problem invites comparisons with campaigns against tobacco in the last century. It was the advocacy work of the Royal College of Physicians (RCP), and their presentation of the overwhelming evidence in *Smoking and Health*¹⁰ published in 1962, that provided a catalyst for the huge successes that we have seen in tobacco control and policy in the last fifty years. The wider population is reaping the benefits of those doctors' actions now.

Like those doctors who realised that smoke-filled homes and offices of the 1950s were creating a health time-bomb, we demand action today. Just as the challenge of persuading society that the deeply embedded habit of smoking was against its better interests, changing how we eat and exercise is now a matter of necessity.

This report represents the start of the Academy's goal to achieve change. Our hope is that we set down a clear position – this is what the UK's doctors' support – and prompt others to join us in implementing some of these measures.

2 A CAMPAIGN, NOT A REPORT

From the start, we have been clear that we want this report to be the start of a wider campaign, and, as the then Academy Chair, Professor Sir Neil Douglas, said, *'this won't be just another report that sits on the shelf and gathers dust'*.¹¹ This ambition will be demonstrated by the action that we will take, and encourage others to take, to achieve our recommendations.

We are very much standing on the shoulders of giants, in terms of the comprehensive and detailed reports that have preceded this publication. Given the breadth and depth of evidence that these provide, we believe that we needed to address the problem itself, rather than merely restate the extent of it.

Therefore what follows is not a comprehensive meta-analysis of the collected evidence on obesity, which numbers some 16,000 papers and counting. Neither can we state that the recommendations that we suggest have been tested in the crucible of randomised controlled trials. Indeed, it is in the nature of some of the recommendations that they cannot be tested in this way. We already have evidence-based guidelines for action, both clinical management and preventive measures, from the National Institute for Health and Clinical Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN). These recognise that randomised controlled trials are not the only source of evidence.

Health policy can be slow to emerge even when evidence is strong. The lobbying opposition to intervention can be well-rehearsed when commercial interests are at stake. However, from first principles, obesity is both correctable for every affected individual, and potentially 100% preventable. In the real world, no intervention is ever 100% effective, and as doctors we have to accept that a 10% or 20% benefit rate is worth pursuing.

Our recommendations are borne from a strong conviction that we cannot continue as we have before. That we need to implement and evaluate the recommendations. That absence of evidence is not evidence of absence. That we need to be bolder in our policy proposals, while testing their impact rigorously and in a timely manner. If they work, then we should identify the good practice, extend and share it.

2.1 The call for evidence

When the Academy embarked on a ‘call for evidence’, we invited individuals and organisations to ‘tell us what works’. We were clear that we wanted to hear from those who could recommend interventions and programmes that helped to either prevent or treat overweight and obesity. We structured this by asking for submissions covering five key areas: individual responsibility, action by healthcare professionals, environmental factors, economic measures, and educational influences. We received hundreds of interesting and helpful contributions which have helped shape the report. The oral evidence sessions that followed – drawn from particularly stimulating submissions – helped us to further focus our thoughts as we heard from experts across the field, including academics, clinicians, and weight management providers.

We acknowledge that doctors are sometimes not as sympathetic as they could be when listening to their patients. This also reflects a wider societal attitude towards those that struggle to maintain a healthy weight. To begin to address this, we ran a patient and public questionnaire, where we recorded the ideas, opinions, and, importantly, the emotions of those people. They talked of the personal battles that they have fought or are still fighting, in the hostile climate that is today’s obesogenic environment. Whilst writing this report, and continuing the campaign, we have kept their concerns and stories at the forefront of our minds. Details of those who submitted written evidence and oral evidence can be found at Appendices B & C. Appendix D has a copy of the questionnaire which patients and the public were invited to complete along with a breakdown of the responses for question 5.

Therefore we have concentrated firstly on what we as doctors can achieve. We know that we need to put our own house in order before we can be prescriptive about what action others should take. This means addressing the patchy provision of weight management services across the country. It means training doctors to treat those patients with weight problems in a more supportive and sensitive manner. It means ensuring that the workplace is targeted to address obesity and that hospitals provide high quality, nutritious food choices for patients and staff alike. It also means that the profession should acknowledge that many healthcare professionals are facing the same problems as their patients. Consequently, the NHS should be seen to lead the way in terms of supporting staff to address their own weight and health issues, in addition to helping patients do the same.

Equally we know that doctors and healthcare professionals more widely can only play a small part in addressing what is a complex and systemic problem. It is far preferable to build a strong fence at the cliff top, rather than depend on costly ambulances to wait for casualties at the bottom. So we have attempted to take both a life-course, and patient-centred approach. We looked at support available for parents in feeding their child from birth. We considered school food provision and the licencing of fast-food outlets near to these educational establishments. We looked at the wider environment that makes the rhetoric of individual responsibility as the whole solution (a false and fatuous claim)

such as the marketing of foods high in fat, sugar and salt, and the association of our nation's sporting events, and the athletes that compete in them, with such produce, to name just two examples. We looked at examples where the healthy choice could become the easy choice through the use of fiscal mechanisms, improved food labelling, and the design of a built environment that encourages rather than discourages good food habits, exercise, and active travel.

In short, we have produced a report with recommendations that we hope are clear, pragmatic, and achievable. Our aim is that what follows will build a coalition that can remove the barriers currently in place so that the UK can be a world leader in preventing, managing and treating overweight and obesity across the life-course.

2.2 What is the problem, and why did it happen?

Doctors should, by this point, hardly have to state why obesity is such a problem. We are arguably not in the position that the doctors of the 1950s were, facing a sceptical public who needed to be convinced of the health threat from smoking. Most obese people do not like being obese, and have made efforts to lose weight. The dangers of obesity are exhaustively documented, perhaps most comprehensively in this country by the Foresight review.¹² We know that obesity is a major risk factor for the development of type 2 diabetes, heart disease and some cancers. There are psychological causes and consequences of obesity. For example, unhealthy lifestyles are associated with depression and anxiety and severe mental illness; and with the physical illnesses that are associated with psychological distress. Furthermore, behaviour change requires that these emotional and psychological factors be understood and tackled, rather than neglected or minimised.

Tim Lang and Geof Rayner provide an eloquent narrative of the roots of the current obesity problem in the UK. They view this as the result of '*societal, technical and ideological change*'¹³ in the last half-century since the end of World War II when obesity as '*a medical condition appeared little more than as a curiosity*'.¹⁴ They are resistant to the temptation to glibly state that where the US 'leads', the UK follows. They nonetheless acknowledge that the present situation is at least partially a result of a culture in which highly calorific food is available at literally, pocket money prices. This, alongside technological advances that have made us a more sedentary nation, and '*the culture of clever and constant advertising flattering choice; the shift from meal-time eating to permanent grazing; the replacement of water by sugary soft drinks; [and] the rising influence of large commercial concerns framing what is available and what sells*'¹⁵ has powerfully contributed to the growing obesity problem.

Where Lang and Rayner succeed is in their even-handed approach. Whilst recent, engaging popular television series such as *The Men Who Made Us Fat*¹⁶ provide a useful social function in presenting the facts of the case to a wider audience, it is easy to slip into a scape-goat culture. In fact, the problem is far more systemic. Our ambition throughout this process has been to avoid the finger-jabbing inherent in such accusations and applaud areas in which the food industry or government have led on progress, but by the same token, uncompromisingly address ‘large commercial concerns’ where we feel they are distorting, hampering or in some cases deliberately undermining efforts to address the crisis.

But if the history of these creeping developments appears clear in retrospect then attempts to address them have been a far more muddled process. Lang and Rayner argue convincingly that the actions required to halt and reverse the trend must be committed over the long term. The problem, according to them, is that policy interventions thus far have been short-term, piecemeal and scattershot.

It is worth stating that as well as hearing from both organisations and individuals with expertise in the field, we have also been very struck, and influenced, by what patients and the public have told us. These latter groups have been vital to our thinking, not only because they have informed us of what they would find helpful and supportive in their private efforts but also because hearing from them has helped us gauge the limits of our work. What was most heartening amongst the responses that we received to our survey was the overwhelming support that the public gave to the advocacy role that doctors have sought to play. It is clear that patients see doctors in the same light as NHS Employers do: *‘The doctor’s role must be defined by what is in the best interest of patients and of the population served.’*¹⁷

It is also clear from our own survey that patients believe that doctors have a responsibility to speak as one where they can. This gives a popular mandate to push on the areas that we feel would be of most benefit to those patients who come through doctors’ doors each day, and also to all those who surely will without action across society. To this end, we have attempted to structure our findings and recommendations firstly from our own perspective, because it is from that viewpoint that we can speak with most authority and agency, and also from that of the patients who doctors see every day in their clinics and who have asked us to speak out on their behalf.

3 RECOMMENDATIONS

3.1 Action by the healthcare professions

Let us start with an admission. We have to acknowledge that some clinicians are insensitive, ineffective, and lack confidence when dealing with patients who have problems with their weight. With the increasing number of overweight people that pass through UK clinics and surgeries, doctors need to be better at providing the help that these patients want. However, part of this problem is the result of doctors simply not having the services available to refer people to. Compare the provision of weight management services with those of smoking cessation services and one begins to see the bind that many clinicians face. As an illustration of this, one weight management provider who submitted evidence to the inquiry is the largest provider of weight management services for children and young people, but had only ‘*secured funding to provide first line community-based treatment to 1 per cent of the UK’s obese child population*’.¹⁸

So what is the cause of this? While some of the larger commercial providers have had their efficacy assessed by means of randomised control trials and other evaluative methods, many smaller providers have no such formal evidence to support their interventions. Despite the best efforts of the National Obesity Observatory in producing both Standard Evaluation Frameworks and a database documenting the various weight management service providers¹⁹, there remains a panoply of providers without the necessary assurances available for commissioners to purchase them, with the resultant consequence that there is nowhere near enough provision throughout the UK. Given these difficulties, it is easy to see how doctors may be confused as to who to refer to patients to. Providers should be evaluated and accredited to make the ambition expressed by the NHS Future Forum of ‘*making every contact count*’²⁰ simpler for healthcare providers.

There are a limited number of well-designed fully evidence-based, effective and transferable weight management programmes, available for use in routine NHS primary care. Some are even economically ‘dominant’ (they will save the NHS more money than it costs to provide the service) to evaluate weight management services.²¹

This is corroborated by both a number of responses received to our patient and public questionnaire and also a number of published research papers.^{22,23,24} Many respondents to our call for written evidence urged us to revisit the recommendations of the RCP publication of 2010, *Training of Health Professionals for Prevention and Treatment of Overweight and Obesity*.²⁵ This report assessed the state of the healthcare profession’s general skills and confidence in this area as follows: ‘*health professionals either lack appreciation of the health and medical consequences of obesity or lack confidence and the ability to help [...and that...] too often health professionals ignore the obvious signs or symptoms of obesity or simply instruct the individual to go on a diet and lose significant weight.*’²⁶

This tallies closely with the impression that we have built up. The RCP's diagnosis likewise matches our own, that Royal Colleges and other providers of medical education and training need to look at addressing the collective shortcomings of the healthcare professions, but also acknowledges the different roles of the 'team'. In January 2013 the RCP published *Action on Obesity: Comprehensive Care for All*²⁷, which similarly calls for a multidisciplinary, integrated approach to obesity and overweight management, treatment and prevention. Different members of the team will need different training. For example, the role of the GP in an initial consultation differs greatly from that of the bariatric surgeon and his or her team assessing a patient's suitability for surgery. Different teams need different skills for different patients in different scenarios but healthcare professionals' education and training has arguably been slow to recognise this.

Evidence suggests that traditional methods of training are ineffective but that training in motivational interviewing shows some promise when treating children²⁸, and clearly further evaluation of training methods is needed. We urge education providers to be innovative in the way that training is provided, and to build the skills, knowledge and confidence of the practitioner.

Our **first recommendation** therefore is aimed squarely at the Academy's own medical royal colleges and faculties, with the acknowledgement that all health professionals should have some basic training in sensitive recognition and appropriate referral for overweight and obese patients.

Royal Colleges, Faculties and other professional clinical bodies should promote targeted education and training programmes for healthcare professionals in both primary and secondary care to ensure 'making every contact count' becomes a reality, particularly for those who have most influence on patient behaviour.

However, as noted earlier, 'making every contact count' on obesity will be little more than a platitude if practitioners do not have the appropriate services to refer on to. Weight management service provision is far too limited across the UK and, at the more severe end of the spectrum, there is evidence of Primary Care Trusts (PCTs) ignoring NICE guidance on bariatric services²⁹, while the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recently released a report critical of the inconsistency in bariatric provision.³⁰

Throughout our inquiry, much discussion focussed on the presence of indicators around weight management in the Quality and Outcomes Framework (QOF) for GP practices in England and the manner in which this might encourage or discourage certain referral patterns and clinical interventions. Clearly, these discussions with NICE need to continue, to ensure that primary care places a high priority on the needs of overweight and obese patients. However, we also heard that without the establishment of consistent provision of appropriate weight management services across the country, such adjustments to the QOF would not serve their intended purpose.

there was an initial dip in take up of school meals following Jamie Oliver's hugely successful Jamie's School Dinners campaign.⁴⁸ This was caused, argued Michael Nelson from the School Food Trust, not by children rejecting healthy meals but by the realisation on the part of parents just how poor the quality of food had been.⁴⁹ Since then, numbers have steadily climbed to their highest figure in 14 years.⁵⁰ The Children's Food Trust, and others, insist this shows children will embrace healthy food if it is made the social norm; something behaviour change specialists support.

On the benefits of healthy food, Nelson went still further citing evidence that where improvements were made to the food and dining environment children were 18% more likely to be engaged and concentrating in afternoon lessons.⁵¹ This is all very much to the good, and the efforts of all those agencies in making this happen should be applauded and be built upon. To this end, it seems to represent the most extraordinary own goal on the part of the current Government to exclude its wave of academies from the standards. Not a single submission to our inquiry supported this move and the Academy of Medical Royal Colleges considers that, on this issue, the Department for Education is surely mistaken.

Our **fifth recommendation** focuses on schools food:

The existing mandatory food- and nutrient-based standards in England should be applied to all schools including free schools and academies. This should be accompanied by a new statutory requirement on all schools to provide food skills – including cooking and growing – alongside a sound theoretical understanding of the long-term effects of food on health and the environment from the 2014/15 academic year.

Progress on the education and behaviour within schools on healthy lifestyles has been good, however, up until recently at least, the story at a local and community level really is a much more confusing and sometimes chaotic picture.

Using the example of school food we were told of the anomaly that existed within many local authority boroughs where licencing practices mean councils actually end up undermining their own efforts in the schools by allowing the expansion of outlets which sell food that is high in salt, sugar and saturated fats which in effect pull children away from healthy eating. Many times in the inquiry we heard about the valiant secondary school doing its utmost to put on high quality, affordable lunches for their pupils but being undercut by the local chip and chicken shop with its 'pocket money' prices. Older children understandably want the freedom of going off site at lunchtime but it is extraordinary that the local authority which is trying to encourage a child to have a healthy lifestyle in school allows an environment which nudges them to do precisely the reverse. We were told that many local authorities do not exercise the appropriate controls which can be placed on mobile food units which results in the paradox that burger vans,

once licenced, are in effect free to pitch up wherever they like so long as they do not infringe traffic regulations. Some local authorities have woken up to this and are taking decisive action to create a more level playing field. Councils such as Waltham Forest⁵² and Tower Hamlets⁵³ and cities like Liverpool⁵⁴ have introduced strategies to reduce obesity which include addressing obvious inconsistencies such as this.

Many people, practitioners and public, think that moving public health responsibility over to local authorities, which takes place in April 2013, is potentially, an insightful and valuable move. In transferring responsibility, notwithstanding the anxieties some contributors had about protection of 'public health' funds, there nonetheless exists the opportunity for local authorities to take more control over the entire gamut of policy decisions which effect the health of their local populations.

Our **sixth recommendation** is therefore:

Public Health England should, in its first 18 months of operation, undertake an audit of local authority licensing and catering arrangements with the intention of developing formal recommendations on reducing the proximity of fast food outlets to schools, colleges, leisure centres and other places where children gather.

Doctors understand that patients come to them looking for cures but that is not always possible – particularly if they have a complex, poorly understood illness or series of illnesses. Treatment regimens take time to work. Sometimes doctors can play the short game with a patient, sorting out the immediate, most vexatious parts of their illness and sometimes the long game, prescribing treatments and medicines which are required for months and years, if not permanently. In doing so there is a balance to be struck between what is possible and what is not. Doctors do their best to explain that to their patients. Treating and preventing obesity, is no different. But it is also dependent on the patients themselves making big efforts. People will face sources of conflict, or opposition to their weight management, through other people – family, friends, peers – who may unwittingly undermine efforts to control body weight, but also through the might of advertising and marketing, which is almost irresistible.

The Advertising Association told us that the advertising industry directly employs around 300,000 people in the UK and in 2011 total advertising expenditure was £16.1bn.⁵⁵ It cites qualitative research from Ofcom which showed that 'advertising ranks low on a list of factors influencing obesity'. It goes on to say that 'familiarity' and 'peer pressure' are, amongst others, more important influencing factors. That is, in our view, the nub of the problem. The Association made no mention of describing where it thought that peer pressure came from, nor what created familiarity of a given product in the first place. Presumably it would not be worth spending such vast sums of money on advertising a product if it made little difference to people's awareness of the product and

their likelihood to buy it? The argument is circular and advertising is only a small part of the marketing activities of the Food Industry which plays its part in subtly moulding our attitudes and beliefs about foods and our eating habits.

It is encouraging to note, as the Food and Drink Federation made clear, that *'advertising spend on products such as fresh fruit and vegetables has increased significantly since 2003'*.⁵⁶ However, that remains a drop in the ocean. How much more could be done if there was equal investment in promoting fruit and vegetables as there is for products high in salt, sugar and saturated fats? Could we reasonably expect that celebrities (whose endorsement seems capable of shifting large units of any product), be instead the image that people associate with the British Apple?

Probably not. But we should not be worn down by the world-weary fatalism in which we reject any measures that might curb the global reach of marketing. This marketing, increasingly through social media, promotes the eating of foods high in calories, fats and sugars. Nonetheless, we also have to be realistic within the bounds of what is currently politically acceptable and take a pragmatic look at what policy levers can be pulled. We cannot and do not wish to tilt against the deeply ingrained principle within UK society that consenting adults should be free to make their own choices, even if they are occasionally risky to themselves. However, we do think that most parents would want to shield their children and young people from exposure to foodstuffs damaging to their health.

Global marketing needs to be regulated by consistent global principles and we support the Sydney principles *'for achieving a substantial level of protection for children against the commercial promotion of foods and beverages'*.⁵⁷ These offer seven robust principles by which regulation should be assessed. It should:

- Support the rights of the child, by aligning and supporting the UN Convention on the Rights of the Child
- Afford substantial protection to children from commercial exploitation
- Be statutory in nature – industry self-regulation is ineffectual and insufficient
- Take a wide definition of commercial promotions
- Guarantee commercial-free childhood settings, such as schools, children's centres etc
- Include cross-border media, such as the internet
- Be evaluated, monitored and enforced to ensure that is effective.

The World Health Organisation has produced a comprehensive analysis for how a protective policy might be implemented, and the challenges of doing so. It cites Norway and Sweden, and the Canadian province of Quebec, as having comprehensive policy approaches that restrict the marketing of all foods and non-alcoholic beverages to children, or indeed the marketing of all products at children. Such policy approaches are based on the principle that *'children are best informed about healthy eating by parents, schools and health professionals rather than commercial entities and that children should grow up in commercial-free environments'*.⁵⁸

Food manufacturers globally spend vast amounts of money annually to advertise to children and young people. The evidence around the effectiveness of this investment is apparent both in the food manufacturers' profits and also in research studies. For example, a systematic review produced on behalf of the Food Standards Agency in 2003 concluded that there was *'sufficient evidence to show that food promotion can have and is having an effect on children, particularly in the areas of food preferences, purchase behaviour and consumption.'*¹⁵⁹ Furthermore, it concluded that these effects were probably understated by the studies' focus on television advertising and the concentration on direct influences on individual children rather than indirect influences such as *'promotion for fast food outlets [which] may not only influence the child, but may also encourage parents to take them for meals and reinforce the idea that this is a normal and desirable behaviour.'*¹⁶⁰ A further review of the literature found that *'the quantity of advertising on children's television appears to be related to the prevalence of excess body weight among children.'*¹⁶¹ It advises a precautionary approach to regulation of advertising activity, stating that *'Children require special consideration in respect of advertising as they are less able than adults to understand fully the intent of advertising or its persuasive techniques, and are thus less able to judge the advertisements critically.'*¹⁶²

Advertising of unhealthy food and drink products during children's television is currently restricted in the UK, but we agree with the Children's Food Campaign and other bodies who have argued that the current regulations are insufficient. These restrict advertising of food high in fat, sugar and salt *'during children's airtime and around programmes with a disproportionately high child audience'*¹⁶³ but do not include other programming that may be viewed by a large number of children such as soaps or sporting events.

Research from both the industry regulator OfCom, and independently from researchers at Newcastle University have found the current regulations on the advertising of unhealthy foods to be largely ineffective. Indeed, the latter *'found that exposure of children to advertisements for 'less healthy' foods was unchanged following their introduction',* arguing that the *'restrictions did not achieve their aim and this is likely to be because they only applied to a very small proportion of all television broadcast.'*¹⁶⁴ Meanwhile the OfCom evaluation of the restrictions found that the regulations reduced exposure to advertising of unhealthy food for children by 37%, and for older children (10-15 year olds) by only 22%.¹⁶⁵ While this can be considered a reasonable start, it does not go far enough.

We appreciate the political and commercial difficulties inherent in pursuing such a policy but the evidence suggests that restrictions are effective with regards to both direct and indirect marketing.

This is why our **seventh recommendation** relating to children's advertising calls for:

A ban on advertising of foods high in saturated fats, sugar and salt before 9pm, and an agreement from commercial broadcasters that they will not allow these foods to be advertised on internet 'on-demand' services.

3.3 Making the healthy choice the easy choice

Fiscal mechanisms

So far we have argued that the culture, circumstances and environment in which food and drink are available is predicated towards an unhealthy balance of foods high in sugar, fat and salt. We believe that alongside this, the cheap and abundant availability of highly calorific food, and the perceived relative expense of fresh fruit and vegetables provides strong financial disincentives to individuals pursuing a healthy balanced diet. This situation has resulted in a number of people, including the Prime Minister, David Cameron, talking about fiscal measures as a means of 'nudging' these consumption patterns.⁶⁶ This domestic interest is echoed by developments in continental Europe.

Hungary already has fiscal measures in place that tax foods high in salt, fat and sugar. The tax applies to foodstuffs with high sugar, salt, and/or caffeine content, although at levels that would best be described as peppercorn, for example, 10 Hungarian forints (approximately two pence) per litre of sugar-sweetened beverages.⁶⁷ Meanwhile France has very recently introduced a tax on soft drinks of approximately five pence per litre.⁶⁸ Denmark, which has long taxed sugary sweets, drinks, and banned trans-fats, has also tested a slightly broader programme. In October 2011 a tax of 16 Danish kroner (about £1.74) per each kilogram of saturated fat was introduced. New Scientist estimated that equivalent figures in US dollars would be an extra 12 cents (five pence) on a bag of crisps, and 40 cents (25 pence) on a burger.⁶⁹ This approach may later be re-introduced in a revised form.

There is now a considerable weight of modelling evidence around fiscal mechanisms and its effect on consumption of unhealthy food. Rayner et al's 2012 paper for the British Medical Journal offers a comprehensive summary of this evidence.⁷⁰ According to much of this evidence, the rates of taxation in Hungary and France may be too low to see much tangible effect on consumption but nonetheless it is a step in the right direction. The modelling evidence suggests that taxation of products high in fat, sugar and salt would not only result in reduction in consumption but also be an important cost-saving intervention. An Australian study calculated a saving of 559,000 disability-adjusted life-years on a 10 per cent tax, with an initial AU\$18m investment.⁷¹

Another policy response suggested by Sir Nicholas Wald amongst others has been the introduction of an excise 'SASS' tax on each gram of saturated-fat, alcohol, salt and sugar, rather than a VAT-style tax on just one or individual ingredients. Sir Nicholas suggests this approach would impact primarily on the manufacturer, who would be incentivised to adjust their price accordingly to promote healthier alternatives and smaller portion sizes. He believes that this approach *'influences the market, but preserves consumer choice'*⁷², and models the potential impact to suggest that a higher-fat burger meal would be harder hit by the taxation, adding on 39 pence versus nine pence for a lower fat chicken meal.

There have also been suggestions that taxation should be accompanied by subsidisation of healthier choices. An experimental purchasing study by Epstein et al suggests that the money that people save on lower-calorie foods is then spent on other high-calorie low-nutrient foodstuffs, so individuals' overall calorie intake wasn't reduced. By contrast, they found that taxation alone reduced individuals overall energy intake while reducing the proportion of fat and increasing the proportion of protein purchased.⁷³

While all of these developments should continue to be closely monitored, after careful consideration we believe it is too early for the UK to introduce these broad fiscal mechanisms. Concerns were raised about the price elasticity of different foodstuffs, and also the substitution effect. Furthermore, the political acceptability of fiscal measures around foodstuffs has probably been reduced following the furore around the proposed so-called 'pasty tax' in March 2012.

Nonetheless, we believe that we should look at the 'soda tax', now successfully implemented across many states in the USA and the measure introduced in New York to restrict the size of sugary soft drinks sold. The New York Department of Health and Mental Hygiene helpfully defines a 'sugary drink' as one that *'has greater than 25 calories per 8 fluid ounces [or 227ml] of beverage'*.⁷⁴

We therefore believe that a tax on sugary soft drinks, as a natural experiment, would be a bold and progressive policy move on the part of the UK government. Looking at Mytton et al's review of the evidence which suggests that increased taxation rates of 20% are needed to have sufficient impact on consumption.⁷⁵ Therefore we consider that a 'minimum price' increase of 20% on sugar-sweetened drinks, trialled for at least one year, would begin to give economists an indication of the possibilities of such fiscal mechanisms, and in the longer-term, provide an opportunity to assess the health benefits. Sustain estimates that a duty of just 20p per litre could generate revenue of approximately one billion pounds per year which, if hypothecated, could be used to provide weight management programs across the country.⁷⁶

Our **eighth recommendation** is that:

For an initial one year, a duty should be piloted on all sugary soft drinks, increasing the price by at least 20%. This would be an experimental measure, looking at price elasticity, substitution effects, and to what extent it impacts upon consumption patterns and producer/retailer responses.

Food and drink labelling

Much of the popular rhetoric around obesity centres on issues of individual choice and responsibility. We believe that this approach abnegates wider societal responsibility for the problem but also acknowledge that individuals should be given as much support as is possible in making healthy choices. One of the key ways we believe this can be achieved is through food labelling that provides clear and comprehensible information for the consumer.

We believe that consistency in the provision of information for both pre-prepared and out of home meals is desirable. In terms of pre-prepared meals, this means the universal adoption of ‘traffic-light’ food labelling. This should require both High-Medium-Low text and nutrient levels colour coding, with optional percentage of Guideline Daily Amounts. This is the system most easily understood and supported by consumers.^{77,78}

As we gathered evidence for this report, we were delighted that the UK government announced its support for standardised ‘traffic-light’ food labelling⁷⁹, following consultation, and we look forward to seeing the detail of the system and its appearance on packs in summer 2013.

Nonetheless, we believe that those retailers who already have ‘traffic light’ food labelling can further improve the information they provide. For example, both ‘per portion’ and ‘per 100g’ nutritional information is important for front-of-pack labels. Per portion declarations can help consumers see exactly what nutrients food provides enabling more informed decisions to be made about meals and snacks, according to the specific portion sizes that they, or their children, will consume. Per 100g data is equally important as it is a standard amount that allows for comparison between foods. Recommended portion sizes differ for children and adults, therefore per 100g information allows for relevant nutritional calculations to be made easily. Labelling size and design should also be considered. Nutritional information should be clear and easy to read, not hidden in small hard to read text.

People in the UK are also increasingly eating out, with an average £8.26 per person per week being spent on meals outside of the home, representing a quarter of total food expenditure.⁸⁰ While food labelling for pre-prepared food has gradually improved over the last decade, many consumers have little information

about food that they eat in restaurants, pubs, takeaways and canteens. A number of states in the US have introduced calorie information on menus and there is strong consumer support for such measures.⁸¹

This has led to a number of early adopters on the UK high street introducing clear calorie indicators on their menus. This is to be applauded and should be widely emulated by other convenience outlets, for example restaurant franchises with three or more premises could be obligated to provide this information. We appreciate that this is more difficult for small and medium sized businesses, which lack the economies of scale to standardise portions and commit to assessing nutritional content. However, we understand that the Department of Health is working with such companies to develop best practice and guidance for them.

Our **ninth recommendation** states that:

Major food manufacturers and supermarkets should agree by the end of 2013 a unified system of traffic light food labelling (to be based on percentage of calories for men, women, children and adolescents) and visible calorie indicators for restaurants, especially fast food outlets.

Town planning and the built environment

Throughout our gathering of the evidence, we repeatedly heard that whilst physical exercise is extremely beneficial, and can be helpful in maintaining a healthy weight, its impact on weight-loss without appropriate dietary restrictions is modest.⁸² There was also the repeated assertion that its importance had been overemphasised by vested interests, and we were reminded of high-street fast food outlets using athletes from the 2012 Olympic Games to promote their products. Consequently our recommendations have concentrated on policies that impact upon the availability of highly-calorific food and the individual's consumption of these products.

Nonetheless, despite this overstatement of its impact on weight-loss per se, clearly physical activity imparts many benefits on the individual⁸³ and should be encouraged alongside the recommendations already mentioned. As well as the easy availability of foods high in sugar, salt and saturated-fat, the current physical environment in the UK encourages a sedentary lifestyle.

The majority of adults spend substantial time at work. The workplace is therefore an ideal setting for raising awareness and providing information to help people lose weight and prevent them from becoming obese. A large number of people can potentially be targeted, particularly in large organisations. For employers the possibility of increasing productivity, while reducing costs through the reduction of sick leave and accidents, may also represent a strong incentive for the introduction of worksite programmes.

Recent studies⁸⁴ have shown the success of such workplace initiatives and following on from Professor Dame Carol Black's report⁸⁵, which aims to improve health and wellbeing in the workplace, Occupational Health clinicians are well positioned to encourage the promotion of healthy activities. For example, designing employer sponsored tailored weight management programmes, including nutritional and exercise advice for employees.

More widely, we live in a culture and transport infrastructure that encourages car use, and discourages active travel through the difficulty and danger created by a system that appears designed for exclusive use of motor vehicles. There is nothing more symbolic of this discouragement of physical exercise than the famous sign on walls across the UK that reads 'No Ball Games'. Without greater tolerance of a degree of risk from climbing trees and so on, we risk demonising normal childhood play and killing them with kindness. For all of our hero worship and veneration of elite athletes, we need a paradigm shift to encourage uptake of physical activity.

There is a prime opportunity then in the transfer of public health functions to local authorities in April 2013 to commission for co-benefits. Public Health England should provide leadership in this area by providing guidance and working with Directors of Public Health and Health and Wellbeing Boards in looking at how local areas' built environments can be adjusted as far as possible to encourage physical activity. The Chief Medical Officers make this point succinctly; *'For most people, the easiest and most acceptable forms of physical activity are those that can be incorporated into everyday life. Examples include walking or cycling instead of travelling by car, bus or train.'*⁸⁶

Furthermore, NICE already provides detailed guidance to commissioners and public health specialists on how to work with local authorities to encourage physical activity.⁸⁷ This may be through the improvement and creation of more cycle lanes, promotion of 20mph speed limits, so that pedestrians feel safer, or other ways that make the active and healthy choice the easy choice. To facilitate this ambition, and encourage local authorities to consider the built environment's impact upon health, we believe that health impact assessments should be a mandatory part of planning decisions.

Therefore our **tenth and final recommendation** states that:

Public Health England should provide guidance to Directors of Public Health in working with Local Authorities to encourage active travel and protect or increase green space to make the healthy option the easy option. In all four nations, local authority planning decisions should be subject to a mandatory health impact assessment which would evaluate their potential impact upon the population's health.



4 CONCLUSION

We have outlined what we believe to be a wide-ranging set of recommendations that have the clear objective of reducing the prevalence of obesity across the UK population. We have made the medical profession's responsibilities clear and we have also been realistic about limitations. We have looked at the obesity crisis from doctors' perspectives, and also from that of patients. We have thought about what has led over weight patients to doctors' doors, and how society might best help prevent patients coming through those doors in the first place. We have therefore identified where we think positive changes can be made to schools, workplaces, homes, restaurants and high streets. We have widely sought people's views on how these can be implemented either through encouragement, inducement or legislation, depending on what is most appropriate.

These suggestions may be wide-ranging but we have tried to avoid them being scattergun. At the start of this report, we said there was no 'silver bullet' but through our consultation we have discovered the many weapons in our collective arsenal. We also said that this is not just a report but what we hope will be the start of a campaign, where each party plays its part. In making these recommendations, we wish to build a coalition of the willing, and to that end these are not meant to be exhaustive. We are conscious that there are many more recommendations we could have made but the 10 in this report are meant as a sensible starting point. We can then honestly test them, review their effectiveness and then seek improvements based on the evidence. We hope that is a principle others can unite behind.

One comparison that was frequently made to us throughout the evidence gathering stage was doctors' advocacy on tobacco smoking. We aspire to the success that the medical profession achieved with tobacco control, by standing firm on the scale of the challenge and standing up to those vested interests which seek to obscure and distort.

Throughout this report, we have sought consensus, without diluting the strength or pragmatism of our recommendations. We do so with the best interests of our patients at heart. We now need to prove this principle in our advocacy and call upon all interested parties to work with us.



APPENDIX A

MEMBERS OF THE ACADEMY OBESITY STEERING GROUP

Professor Terence Stephenson (Chair)
Academy of Medical Royal Colleges

Professor Kam Bhui
Royal College of Psychiatrists

Professor Mitch Blair
Royal College of Paediatrics and Child Health

Professor Simon Capewell
Faculty of Public Health

Mr Vivek Chitre
Royal College of Surgeons of Edinburgh

Mr Peder Clark
Royal College of Paediatrics and Child Health

Mr Brian Dow
Royal College of Paediatrics and Child Health

Professor Mike Larvin
Royal College of Surgeons of England

Professor Mike Lean
Royal College of Physicians of Edinburgh

Dr Suzanne Lucey
Faculty of Occupational Medicine

Dr Aseem Malhotra
Trainee representative

Dr Rachel Pryke
Royal College of General Practitioners

Dr Shakila Thangaratinam
Royal College of Obstetricians and Gynaecologists

Professor John Wass
Royal College of Physicians of London

Professor Martin Wiseman
AoMRC Intercollegiate Group on Nutrition



APPENDIX B

WRITTEN EVIDENCE SUBMISSIONS

Below is a complete list of those individuals and organisations that submitted written evidence to the inquiry's initial call for evidence.

Aaron Grewal	Food for Life Partnership
Academic Unit of Paediatrics, University of Leeds	Fresh Produce Consortium
Advertising Association	Health Education Trust
Advertising Standards Authority	Healthy Weight Core Strategy Group
Ajinomoto	Heart of Mersey
Alcohol Concern	HENRY
Alexandra McGlynn	Jack Mulcahy
Amandine Garde, Neville Rigby	Jane Holland
Anthony Butler	John Furness
Association for Nutrition	Kevin Mousley
Association for the Study of Obesity	Kickin Kitchin
Association of Play Industries	Lighter Life
Barry Groves	Linda Hindle
Behaviour and Health Research Unit, Institute of Public Health, Cambridge	Living Streets
Big Lottery Fund	Macmillan Academy
Bjorn Hammerskjold	Margaret Beezhold
British Dietetic Association	Maria Garcia-Siñeriz
British Heart Foundation Health Promotion Research Group, Dept of Public Health, Oxford	Mark Benden
British Medical Association	Martin Kligman
British Retail Consortium	McDonald's
Cambridge Weight Plan	MEND
Chartered Society of Physiotherapy	More Life - Leeds Metropolitan University
Child Growth Foundation	National Heart Forum
Clare Gray	National Obesity Forum
College of Occupational Therapists	National Obesity Observatory
Counterweight	NICE
CPD Health and Fitness	Nicholas Grubb
David Boost	North West Obesity Track Group - ChaMPs
David Cooke	Paul Aveyard
Deborah Hunte	Penny Gibson
Department of Health (England)	Phil Thompson
Design Council	Philip Morgan
Dominic Leggett	Play England
domUK, British Dietetic Association	Population Health Sciences Research Network
Elspeth Webb	Raj Thamotheram
EPHA	RCGP
Erica Rose	RCOG
Eveque	RCP
Faculty of Public Health - Non-Communicable Diseases Advisory Group	Richard Whitaker
Fitness Industry Association	Robert Suchet
Food and Drink Federation	Rotherham Institute for Obesity
	Sandy Evans
	School Food Trust/Children's Food Trust
	Slimming World

Sport and Recreation Alliance
Stephanie Seneff
Sustain, Children's Food Campaign
Sustrans
Tavistock Centre for Couple Relationships
Tim Lang
Tina Bartley
Tom Buckley
Tom Harper
UNICEF
Weight Concern
Weight Watchers
Weight Wins
Women's Health Research Unit,
Barts and the London School of Medicine and
Dentistry, Queen Mary University of London
World Cancer Research Fund International
Zoe Harcombe

Key themes emerging from the evidence submitted to the Academy inquiry are summarised below. Respondent's full submissions can be accessed via the Academy website at www.aomrc.org.uk.

The role of the individual

- There was a general consensus that sustained but small weight loss and management for an individual is best achieved through community-based weight management programmes, provided in a supportive group setting
- A number of contributors suggested that the benefits of exercise in terms of weight loss had been overemphasised by vested interests. Physical activity, whilst an important factor in a healthy lifestyle for many aspects of health, was agreed to not have a significant effect on weight loss unless it is combined with appropriate calorie restriction
- Many commentators felt that although the individual has a role to play in their own health and weight management, collective efforts are needed to create an overall healthy environment that would facilitate the individual in taking responsibility for their own health.

The role of the medical workforce

- There was a consensus that doctors, nurses and other health professionals play an important part in the clinical treatment and prevention of obesity. However, this role is somewhat limited if the most effective services are not always available. For example, there was almost unanimous support for greater opportunities for GPs to refer patients to weight management programmes, yet provision of these across the country is far from comprehensive

- It was stressed that it would be more effective if more Quality Outcomes Framework (QOF) points were assigned to issues around weight management
- Many respondents also highlighted the significant role that health professionals have to play as advocates. For example, there was strong support for the medical community to come together to lobby against junk food advertising
- The group was repeatedly told that the health sector must lead by example: there should be a wide choice of healthy options in vending machines and hospital food outlets, and improvements in food quality for both patients and staff in health settings.

The role of education

- There was firm agreement that many improvements can, and should, be made to existing education in regards to developing healthy lifestyles. Many commentators said that parents and carers have the greatest influence in shaping the knowledge and behaviours of children, but teachers and schools also have an important role in providing the best information possible, informing children to make healthy decisions, and influencing good practices early on
- Many individuals and organisations highlighted the importance of schools in providing practical lessons and information on nutrition given the positive impact of nutrition on growth, behaviour and performance
- They suggested that the current curriculum is inadequate in most schools, from those that altogether lack any lessons on cooking or nutrition to those which do not provide the best information
- There were a considerable number of comments stating the Government should make free school and academy adherence to nutritional standards compulsory, as it does for maintained schools in England.

The role of environment

- Evidence from across the submissions placed significant emphasis on the environment, noting that currently the Government has placed too much focus on the individual, when further action could be taken to address the 'obesogenic' environment in terms of town planning, transport, licensing of fast food outlets and so on

- Many food and drink industry representatives however, stressed the role of the individual in making healthy food choices for themselves and that it was the role and responsibility of the industry to provide clear nutritional information to ensure individuals could make informed decisions. They highlighted industry progress on reformulation and salt reduction as examples of where their members have taken the lead
- A substantial number of respondents concluded that the Government's Responsibility Deal has proved largely ineffective in providing voluntary action from the food and drink industry to introduce measures that would reduce or prevent obesity. It was highlighted that there was a clear conflict of interest when it comes to the industry being asked to implement measures that would probably have a negative effect on their sales
- Support was shown for stronger regulation of marketing and advertising of food high in saturated fat, sugar and salt. Similarly, there were calls for clearer, more accessible nutritional information, such as better food labelling on packaging and in restaurants.

The role of fiscal mechanisms

- The inquiry heard about two types of fiscal mechanism: value added tax and excise tax
- Value added tax mechanisms to make foods high in sugar and saturated fat more expensive are currently being pursued by various countries across Europe including Denmark, Hungary and France. While some evidence was presented to support this, some commentators felt that the taxes in Hungary and France would act as revenue raisers rather than for health benefits, as the rate of tax was too low to impact sufficiently on consumption
- The inquiry heard that an excise tax would act as a supply side measure instead of demand. This could be calculated on the amount of sugar, salt or saturated fat that a foodstuff contained, rewarding food manufacturers for any reformulation, whilst also providing a pricing incentive if they passed the cost onto the consumer
- There was considerable support for tax to come in the form of a tax on sugary soft drinks, similar to the 'soda tax' implemented by a number of US states. It was reiterated that this would be relatively simple to implement, although there was much discussion about the political acceptability of these kind of fiscal mechanisms, especially given the recent controversy over the so-called 'pasty tax'
- The benefits of subsidisation of fruit and vegetables were also briefly discussed, although it was felt that more evidence on the effectiveness of such a measure is required.

APPENDIX C

ORAL EVIDENCE SUBMISSIONS

Paul Aveyard

GP and Professor of behavioural medicine
at the University of Birmingham

Penny Gibson

Consultant Community Paediatrician,
Blackwater Valley and Hart PCT

David Haslam

National Obesity Forum

Zoe Hellman

Weight Watchers

Susan Jebband Richard Cienciala

Medical Research Council
and Department of Health

Mike Kelly

Public Health Excellence Centre Director
for NICE

Jane Landon

Deputy Chief Executive at the National
Heart Forum

Tim Lang

Professor of Food Policy,
City University

Theresa Marteau

Director of the Behaviour and Health Research Unit,
Institute of Public Health, University of Cambridge

**Patricia Mucavele, Michael Nelson
and Jo Nicholas**

School Food Trust/Children's Food Trust

Alison Nelson

British Dietetic Association

Charlie Powell

Director of the Children's Food Campaign,
Sustain

Geof Rayner

Honorary Research Fellow,
Department of Sociology, City University

Harry Rutter

National Obesity Observatory
(speaking in personal capacity)

Paul Sacher

Chief Research and Development Officer,
MEND Central and Senior Research Fellow,
MRC Childhood Nutrition Research Centre,
UCL Institute of Child Health

Sir Nicholas Wald

Institute Director,
Wolfson Institute of Preventive Medicine



APPENDIX D

PATIENT AND PUBLIC QUESTIONNAIRE

ACADEMY OF MEDICAL ROYAL COLLEGES PROJECT ON OBESITY

Public participation invitation

Obesity is one of the major public health problems in the UK today. This project will produce a report and plan on what actions can be taken to tackle obesity. It will identify the role doctors can play in diagnosing, treating and helping prevent obesity amongst patients. It will also look more widely to identify steps for individuals, organisations and Government to ensure a joined up approach to tackling obesity.

Your views will be of great value in ensuring that issues are understood and addressed fully.

Please send your views by Friday 20th July

by email to

obesity@aomrc.org.uk

or by post to:

Academy Obesity Steering Group,
Academy of Medical Royal Colleges,
10 Dallington Street, London EC1V 0DB

What roles do you think doctors should carry out regarding lifestyle and obesity? For example, do you think doctors should:	Yes	No
Provide weight loss clinics		
Give healthy lifestyle advice		
Focus on prevention rather than treatment		
Focus on treatment rather than prevention		
Focus equally on treatment and prevention		
Screen patients for overweight/obesity		
Lobby government regarding lifestyle issues such as food advertising, labelling, sponsorship, service provision, etc		
Describe any other suggestions about the role of doctors:		
Please tell us of any further comments or suggestions you feel would be most helpful in the prevention and treatment of obesity.		

Thank you for taking part in this project.
Further information can be found at
www.aomrc.org.uk/item/obesity-steering-group.html

The invitation for public participation received over 200 responses, with a large amount from Slimming World customers. Below are the key themes from the responses as well as a table calculating the quantitative responses to Question 5.

Among factors that make it easy or difficult to achieve a healthy weight, many respondents wrote that ingrained habits (taught by parents, such as eating until a plate is cleared, or receiving junk food as ‘treats’ or ‘rewards’) and the low cost of ‘bad’ foods and higher cost of ‘good’ foods (and unhealthy foods being on offer) were major influences in diet. A lack of food awareness or nutritional knowledge, ads for junk foods, snacks and fast food, pre-existing health conditions or limited mobility and emotional eating (comfort foods, indulging cravings, stress eating, etc) were also common answers. Socialising, cooking for large families and having the time to cook also contributed to poor eating habits. Conversely, many respondents felt that regular exercise and support from friends and family (and peers such as a weight loss group) were helpful factors in weight loss. Meanwhile, respondents said that cheaper exercise classes or access to gyms, pools and leisure centres, cheaper healthier foods and more expensive junk foods and reduced costs for weight management programmes were thought would be very beneficial to maintaining a healthy weight, showing that financial factors rank fairly high in diet and exercise routines. Other recurring replies were that regular weigh-ins and the availability of 1:1 or peer help, menu planning and recipe help, food industry regulation, practical good cooking and eating skills and better emotional or psychological support would also be effective.

As far as the role of healthcare professionals, the overwhelming majority of respondents believed that GPs, who do not have the time in each appointment to thoroughly address obesity, should refer patients to other resources (weight management programmes, exercise). According to the respondents, some doctors did a good job of handling their overweight/obesity issues, while many commented that GPs were ill-equipped to deal with the problems. Respondents wanted to see doctors screening patients, treating the patient rather than individual symptoms and putting more of an equal emphasis on prevention and treatment (or more of an emphasis on prevention). The vast majority of respondents considered that healthcare professionals also needed to take a proactive role in lobbying Government for changes in the environment and lifestyle issues. A surprising number referred to inadequacies in mental health assessments when dealing with obese patients, and saw this as an important obligation for doctors, too. There was a 4:1 ratio of respondents who felt that healthy lifestyle services should be a higher priority for NHS funding.

Question 5 of the questionnaire asked a quantitative question the results of which are presented below.

What roles do you think doctors should carry out regarding lifestyle and obesity? Do you think doctors should...

What roles do you think doctors should carry out regarding lifestyle and obesity? For example, do you think doctors should:	No. of Yes responses	%age of total respondents (203)
Provide weight loss clinics	86	42%
Give healthy lifestyle advice	91	45%
Focus on prevention rather than treatment	52	26%
Focus on treatment rather than prevention	9	4%
Focus equally on treatment and prevention	74	37%
Screen patients for overweight/obesity	90	44%
Lobby government regarding lifestyle issues such as food advertising, labelling, sponsorship, service provision, etc.	9	44%



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