THE NATIONAL OBESITY FRAMEWORK

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# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page No:</th>
</tr>
</thead>
<tbody>
<tr>
<td>THE ALL-PARTY PARLIAMENTARY GROUP AND THE WORKING GROUP</td>
<td>4</td>
</tr>
<tr>
<td>EXECUTIVE SUMMARY</td>
<td>5</td>
</tr>
<tr>
<td>PREGNANCY: A HEALTHY WEIGHT BEFORE, DURING AND AFTERWARDS</td>
<td>7</td>
</tr>
<tr>
<td>EARLY YEARS: LAYING THE FOUNDATIONS FOR LIFELONG HEALTH</td>
<td>12</td>
</tr>
<tr>
<td>THE ROLE OF SCHOOLS: A WHOLE SCHOOL STRATEGY TOWARDS FOOD AND NUTRITION, INCLUDING PRE-SCHOOL</td>
<td>17</td>
</tr>
<tr>
<td>THE FAMILY: SUPPORT, ADVICE AND ENCOURAGEMENT TOWARDS HEALTHY LIFESTYLES</td>
<td>24</td>
</tr>
<tr>
<td>THE VIRTUOUS CIRCLE: MOVEMENT, PLAY, PHYSICAL EDUCATION AND SPORT</td>
<td>27</td>
</tr>
<tr>
<td>INDUSTRY: IT’S ROLE IN ENCOURAGING HEALTHY LIFESTYLES INCLUDING ADVERTISING AND PR</td>
<td>30</td>
</tr>
<tr>
<td>TRADITIONAL AND SOCIAL MEDIA: THEIR ROLE IN ENCOURAGING HEALTHY LIFESTYLES</td>
<td>40</td>
</tr>
<tr>
<td>A FIT AND HEALTHY UNITED KINGDOM: GOVERNMENT FRAMEWORK STRATEGY</td>
<td>44</td>
</tr>
</tbody>
</table>
THE ALL-PARTY PARLIAMENTARY GROUP AND THE WORKING GROUP

The Working Group that produced this Report is a sub-group of the All-Party Parliamentary Group on a Fit and Healthy Childhood.

The purpose of the APPG is to promote evidence-based discussion and produce reports on all aspects of childhood health and wellbeing including obesity; to inform policy decisions and public debate relating to childhood; and to enable communications between interested parties and relevant parliamentarians. Group details are recorded on the Parliamentary website at:

http://www.publications.parliament.uk/pa/cm/cmallparty/register/fit-and-healthy-childhood.htm

The Working Group is chaired by Helen Clark, a member of the APPG Secretariat. Working Group members are volunteers from the APPG membership with an interest in this subject area. Those that have contributed to the work of the Working Group are listed on the previous page.

The Report is divided into themed subject chapters with recommendations that we hope will influence active Government policy.

The Officers of the APPG are:

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EXECUTIVE SUMMARY

‘My relationship with food had always been one of ‘love’ and even at school I got bullied because I was bigger than the other girls. Shortly after moving schools, rumours started that the reason I’d moved school was because I’d had a baby and given it up for adoption – all because some nasty girls had seen my stretch marks when getting changed for PE. So I ate more because I was bullied.’ (Alana Morris, Killamarsh, Derbyshire 2015)

This statement from a woman who has been overweight for most of her life serves to epitomise the physical and mental damage resulting from the condition and also the difficulty of conquering it once it has established a grip. There was a happy outcome for Alana Morris, who eventually lost four stones with the help of her local group of Slimming World, but for every Alana, there are many others trapped in a vicious cycle of ill-health, susceptible to a range of chronic illnesses and with every chance that their family now and in future generations will repeat the same pattern. The UK is facing a health crisis related to poor diet and inactivity. One third of our children, two thirds of adult men and just over half of adult women are either overweight or obese (Department of Health HSCIC. Statistics on Obesity, Physical Activity and Diet).


Public recognition of the severity of the issue is not in doubt because barely a day goes by without a mention in traditional and new media of the scale of the obesity epidemic. In 2014, figures released by Public Health England revealed that:

‘Overall, 64 per cent of adults in England are overweight or obese – with a body mass index (BMI) of 25 or over.’ (The Daily Telegraph, 4th February, 2014)

This statistic is certainly shocking, but many adults and adults caring for young children in the UK do claim to be aware of the importance of consuming nutritious food and being physically active as part of a healthy lifestyle. There is increasing awareness too of the potentially detrimental health consequences of obesity and its contribution to a range of illnesses including cardiovascular disease, type two diabetes, some forms of cancer, nutritional deficiencies and dementia. Over £5bn is spent by the NHS each year dealing with health problems associated with excess body weight (Department of Health and Jane Ellison MP. Reducing obesity and improving diet, https://www.gov.uk/government/policies/obesity-and-healthy-eating) and cardiovascular disease remains the biggest cause of death in the UK (British Heart Foundation, Heart statistics).

However, research shows that public awareness alone does not predicate beneficial changes in lifestyle and there is a need to consider a range of issues beyond improving an
individual’s perception of cause and effect. The fact remains that whilst it is widely understood that children who become overweight and obese are at a higher risk of obesity throughout their lives (Viner RM, Barker M. Young people’s health: the need for action BMJ 2005; 330:901) resources to address the matter are decidedly inadequate. To illustrate the point, the UK spends £10 billion per annum addressing the ills of diabetes which may be triggered by obesity (McKinsey Global Institute, 2014 Overcoming obesity: An initial economic analysis McKinsey and Company) but less than £638m a year on obesity prevention programmes. If money talks, Government needs to raise its voice.

In fairness to the Conservative Government, elected as a majority administration in May 2015, it has made a public commitment to do just that. Shortly after his reappointment, Health Secretary, Jeremy Hunt declared that tackling the mounting obesity epidemic and type two diabetes were top governmental priorities. He announced that the Government would tackle the problems head on by means of a National Obesity Framework. Prime Minister, David Cameron reiterated the intention and announced his personal leadership of the proposals; also adding that the solution was not merely a case of persuading adults to eat less unhealthy food and take more exercise but by starting in childhood where a toddler carrying excess weight can all too quickly become an overweight child and thence an obese adult with the attendant health problems and a propensity to pass these on to successive generations.

This news was welcomed by the All Party Group on a Fit and Healthy Childhood. We have consistently argued via our four published reports (‘Healthy Patterns for Healthy Families’, ‘The Early Years’, ‘Food in School and the Teaching of Food’, ‘Play’) that such a strategy must be child-centred and holistic. In addition, we have stressed that negative behaviours/habits learned in very early childhood usually prevail into adulthood where they become entrenched. Talking about obesity and poor fitness levels in children will always be more effective than taking up the gauntlet in adulthood, when obesity has taken a much firmer hold (4 million adults now have type two diabetes). This report on a potential National Obesity Framework will build upon this approach and hope to influence the Government’s thinking so that its own policies to combat obesity will be comprehensive, credible and capable of encouraging productive partnerships between national and local institutions, industry, public services and the family unit.

Yet if the Government is serious about tackling the nation’s obesity crisis, it must deploy all of the effective weapons in the policy armoury. Past ‘stand alone’ or ‘silo’ programmes have failed to reduce the numbers of overweight children simply because they have failed to address all of the key factors influencing child nutrition and inactivity, which are:

- An excess intake of low nutrient, high energy food/drink encouraged by an obesogenic environment
- A lack of understanding of the role and importance of physical fitness
- Increasingly sedentary behaviour
- A massive reduction in the ability and opportunity for children to play freely and actively
- Excessive consumption levels
- Insufficient sleep
- Insufficient fruit, vegetable and fibre consumption
- Early introduction of solid food
- Maternal smoking during pregnancy
- Insufficient formal physical activity

(In addition to all of the above, new findings about possible triggers for obesity are emerging – one being the role played by bacteria in the gut known as the microbiome. Recent research suggests that it may be a key determinant in general health with links to obesity. The microbiome is extremely sensitive; for example, a single dose of some antibiotics may have adverse effects whilst extra fibre consumption is positive. Managing the health of the gut is likely to be significant in managing weight and general health but more research is needed before all the implications can be properly calibrated.)

**What is required from Government is a holistic approach, propelled by a cross-cutting and properly funded strategy, overseen by a Cabinet Minister with sufficient authority over all policy areas relevant to child wellbeing to ensure that the necessary changes in policy, budgets and guidance actually happen.**

The only way that real progress in addressing child (and thence adult) obesity across the UK will be realised is by investing in all relevant aspects of every child’s life, from the portion sizes of the food and drink that they consume to the way their school encourages vigorous, sustained daily movement through provision of a better cultural and physical environment and from the way their local authority thinks about their movement needs, to the way more formally organised and delivered provision is offered to their family.

Truly collaborative action is essential if we are to combat the detrimental human and economic costs of obesity so that the UK can thrive as a fit, healthy and truly productive nation. It will not be easy and progress will be steady rather than immediate - but it is a worthy goal.

**PREGNANCY: A HEALTHY WEIGHT BEFORE, DURING AND AFTERWARDS**

We know that what happens to children in their earliest years, and even before birth, is critical to health in adult life.

**A nutritious diet during pregnancy** is essential for the health of both mother and baby and the consequences of becoming obese during pregnancy or of conceiving while obese include:

- gestational diabetes
- pre-eclampsia
- caesarean section
- macrosomia (delivery of large infants >4000g birth weight)
In addition to the above, the obese pregnant mother may encounter certain obstetric difficulties; for example there are considerable limitations of the foetal ultrasound due to the impaired acoustic window. Rates of caesarean section are increased.

Maternal obesity in the UK is rising (Public Health England. Prevalence of obesity in females in females aged 16-44 years during the period 1993-2010 https://www.noo.org.uk/NOO_about_obesity/maternal_obesity/uk_trends ); around 16% of women are obese and 50% of women are overweight at the start of pregnancy (NICE. Weight management before, during and after pregnancy, http://www.nice.org.uk. October 2014). However, pregnancy is a key time of change in women’s lives, when targeted interventions can have many positive outcomes. More information and specialist support is needed to help women prevent excess weight gain during pregnancy and improve the outcomes of women who start a pregnancy with a high BMI.

It is worth here, at the outset, adding a qualifying note about BMI – an estimate of body size which is widely used in health, medical and sports science contexts. As a result of its ease of calculation (body mass in kg divided by height in metres squared), BMI is often used as a substitute for measuring body fatness; with BMI score of 18.5 – 24.9 suggesting a person is normal weight, one of 25-29.9 indicating a person is overweight and a score of over 30 defining someone as obese. Despite its widespread usage, and the continued popularity of the measure, (new studies continue to report BMI as a reference against previous research) there is clear evidence that the measure is flawed in its role as an estimate of body fatness. For instance, females of the same BMI as a male and older people with the same BMI as a younger person tend to have a higher body fat percentage than their counterparts. Likewise, a commonly cited example is that of athletes who can have a high BMI, one that might put them in the overweight category, but in reality, they often have a low body fat percentage. Their high BMI (a false positive) is in fact, the result of their higher muscle mass resulting in their BMI score providing an incorrect estimate of their body fatness. For children, their level of maturation, as one example, can affect the accuracy of BMI as an estimate of body fatness.

‘One of the most vocal critics of BMI is Dr Margaret Ashwell, a leading obesity and nutrition researcher at City University London. She believes that the best – and simplest - way of assessing health is to work out your waist-height ration’ (The Daily Mail, 15th September 2015).

As a widely accepted and easily calculated measure of body size/fatness, BMI will in all probability continue to be used, however, readers should view with caution the results of this particular approximation.

While levels of weight gain can be monitored during the antenatal period, quite often this is too late. Therefore, the best way forward is to encourage women of childbearing age to attain a healthy body weight. Certainly there is work to be done here with latest figures showing that over half of women in the UK (57%) are overweight and one fifth (23%) obese ((HSCIC) Health & Social Information Centre, 2015, Statistics on Obesity, Physical Activity and Diet http://www.hscic.gov.uk/catalogue/PUB16988/obes-phys-acti-diet-eng-2015.pdf ).
Also, the highest rates of unintended pregnancies are found amongst UK women aged 20 – 34 years (62.4%), as reported by the third National Survey of Sexual Attitudes and Lifestyles (NATSAL-3) survey – the first to measure rates of unplanned pregnancies since 1989 (Wellings K et al, 2013, The prevalence of unplanned pregnancy and associated factors in Britain: finding from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3) Lancet 382(9907): 1807-1816).

Women are more likely to adopt healthier behaviours if they receive advice from healthcare professionals, particularly before conception. Unfortunately, current provision of support during this critical window of opportunity is insufficient, partly because the frontline professionals are struggling to cope with an increasing number of complex births (Parliament UK. NHS midwives shortage remains despite increasing numbers - Maternity Services Report) many of which are related to maternal obesity. Mothers (particularly young ones) say that they need more nutritional advice during pregnancy. The Infant and Toddler Forum continues to champion this cause (Infant &Toddler Forum, early Nutrition for Later Health: Time to Act Earlier, November 2014) but makes the point that many healthcare professionals are unable to offer the assistance necessary about the importance and the principles of good nutrition during pregnancy due to their own lack of training. They therefore have neither the resources nor practical guidance to help expectant mothers in this way and 45% of those who responded to an Infant and Toddler Forum poll said that they would welcome training in behavioural change specific to nutrition and lifestyle in pregnancy.

Current NHS guidelines advise pregnant women to eat a variety of foods from all food groups including fruit, vegetables, proteins and carbohydrates. They also point out that the familiar adage ‘eating for two’ should not be adhered to and that while women may feel hungrier during pregnancy they should choose healthier snacks such as fresh salad vegetables and soups (http://www.nhs.uk/conditions/pregnancy-and-baby/pages/healthy-pregnancy-diet.aspx). The Infant & Toddler Forum’s factsheet is also a practical source of clear and informative nutritional advice (Infant & Toddler Forum. Healthy Eating in Pregnancy Factsheet, 2014).

However, no amount of reading or research in isolation can be a thoroughly satisfactory alternative for advice given in person to the expectant mother by an appropriate professional. Health and education professionals often have unique and well established relationships with families based on trust and respect. For example, GPs and practice nurses meet individual family members at different stages of their lives; midwives work with women before, during and after pregnancy, health visitors get to know children soon after they are born and teachers support children throughout their school careers. During a family’s lifetime, its members will interact with some or all of the following professionals:

- Midwives
- Health visitors
- GPs
- Practice nurses
- Clinical specialists
- Mental health professionals
• Social workers
• Teachers
• School nurses

During pregnancy, women need advice on healthy eating as well as meal content and energy requirements (dependent upon the individual’s height, weight and activity levels). There are currently no UK evidence-based recommendations on appropriate weight gain during pregnancy unlike in the USA where guidance is supplied by The American Institute of Medicine (IOM). Most UK women do not receive any guidance on appropriate gestational weight gain depending on their pre-pregnancy weight.

There are other issues that can be raised in person by a trusted professional. The link between smoking and low birth weight is widely known beyond the medical community, but far less women will be aware that epidemiological evidence suggests it is also increasingly acknowledged to be a risk factor for the incidence of childhood overweight and obesity, based on the consistent positive associations reported among studies [http://ehp.niehs.nih.gov/1205404](http://ehp.niehs.nih.gov/1205404).

One explanation for excess weight in those children whose mother smoked during pregnancy is the production of leptin and its link to weight gain. Another important ingredient in maintaining health during pregnancy is physical activity and here again a conversation between the healthcare professional and expectant mother can establish that while current NHS guidelines advise that those who are active during pregnancy are less likely to experience problems in later stages and during labour, people who are unused to it would be unwise to take up any strenuous activity for the first time during the antenatal period ([http://www.nhs.uk/conditions/pregnancy-and-baby/pages/pregnancy-exercise.aspx](http://www.nhs.uk/conditions/pregnancy-and-baby/pages/pregnancy-exercise.aspx)). Many leisure centres offer pregnancy-specific classes such as prenatal yoga or water-based classes. However, they are frequently held during the day or early evening and are therefore not always accessible to women who work full time. Leisure centres (including those run by local authorities) could be encouraged to make the times of classes more flexible.

Personalised advice (particularly in the area of nutrition, portion sizes and physical activity) given by supportive and sensitive professionals is especially important for those people who are difficult to engage. According to Marmot, families in low income households are more likely to eat less healthily and be less physically active than those with higher incomes ([Marmot M, Bell R, Fair society, healthy lives. The Marmot Review, February 2010](http://www.marmotreview.org/)). There are various reasons for this, including food and leisure opportunities, lower educational attainment and the cultural dietary preferences of different ethnic groups. Women experiencing disadvantage (low SES, ethnic barriers, domestic violence etc.) do not access antenatal and neonatal services with regularity ([Row,R.E.& Garcia,J.O.2003, Social class, ethnicity and attendance for antenatal care in the United Kingdom: a systematic review, Journal of Public Health,25(2),113-119](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC5783458/)) and often have lower trust in healthcare professionals ([Doescher MP, Saver BG, Franks P, Fiscella K. Racial and ethnic disparities in perceptions of physician style and trust. Arch Fam Med 2000;9:1156-1163](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1916261/)), so steps must be taken to try to maximise communication channels within the community. There are also gender divides – in women, the risk of obesity rises steadily with falling household income.

Social factors pose a significant challenge for healthcare professionals because people most in need of dietary guidance and support may be the most disenfranchised and difficult to reach. There is also no escaping the fact that many people feel uncomfortable in both raising and discussing the matter of body weight. Society’s view of overweight is generally very negative and many professionals (who might, in addition, be struggling with their own weight) may worry that raising this subject could be interpreted as a personal slight on an individual that might irreparably damage the relationship. Guidance published by NICE in May 2014 considered how lifestyle weight management programmes focusing on diet, activity and the way people live their lives (behaviour change) can help people who are overweight or obese to lose weight and to keep it off. It is vital that healthcare professionals are properly aware of the risks of excess weight gain during pregnancy and support women to manage their weight healthily. So that they are enabled to approach the task with confidence, government should recommend and support a national training programme for professionals in raising the issue of obesity and weight management at this time in ways that are sensitive and respectful. This is especially important (and challenging) as the perception of judgemental attitudes by health professionals can prevent weight loss in patients and cause alienation and lack of trust in the healthcare system in the next generation (Gudzune, K.A., Bennett, W.L., Cooper, L.A. % Bleich, S. N. 2014 .Perceived judgement about weight can negatively influence weight loss: a cross-sectional study of overweight and obese patients. Prevention medicine, 62,103-107).

Post birth, healthcare professionals should be encouraged to ensure that support and guidance is ongoing and includes:

- Continuing advice to the mother on lifestyle and weight monitoring to ensure that after she discontinues breastfeeding she works towards a healthy weight, as retention of any excess gestational weight gain is a risk factor for her own obesity and that of any subsequent offspring
- Advice and support on best practice for breastfeeding (which will also help the mother to return to her pre-pregnancy weight) and for those not choosing to breastfeed, guidance in the preparation of formula milk and responsive feeding
- Advice to ensure that a mother’s mental health needs are addressed and information about how a routine of eating well can promote positive mental health

Nutrition and lifestyle guidance pre, during and post pregnancy should be a public health priority. This early life focus should be the foundation of a life-course approach to optimising nutrition and lifestyle so that families are empowered to make healthy choices that offer their children the best start in life.

We recommend

- Leadership from Government in up-skilling healthcare professionals in obesity prevention and weight loss support and patient-centred approaches including
instruction on how to effectively communicate messages about healthy nutrition and lifestyle

- Updated and personalised pregnancy weight gain guidelines
- All pregnant women (not just high risk) should be weighed regularly during antenatal visits and given appropriate and supportive advice
- As many pregnancies are unplanned, broad healthy lifestyle strategies (diet and activity schemes) targeting women of childbearing age are needed
- Greater emphasis within primary care to guide all parents-to-be on nutrition, lifestyle (including evidence-based portion sizes) and ideal personalised pre-pregnancy weight
- Dietary assessment, advice and body weight measurement to be integral components of the first midwifery visit with regular follow-up reviews throughout the planned visits
- To continue encouraging mums to stop smoking, advising of the additional links to obesity in later life and the associated risks

EARLY YEARS: LAYING THE FOUNDATIONS FOR LIFELONG HEALTH

The early years are crucial when it comes to establishing healthy patterns of weight gain and eating habits, and the importance of ensuring that mothers and their babies are well-nourished is widely recognised. A child’s diet during the early years impacts upon their growth and development and is linked to the incidence of many common childhood conditions in addition to childhood obesity including iron deficiency, anaemia, tooth decay and vitamin D deficiency. It can also affect the risk of developing conditions such as coronary heart disease, diabetes and obesity in later life.

Breastfeeding is considered to be the gold standard for feeding babies, particularly in terms of preventing excess infant weight gain, especially in children from economically disadvantaged families who are at increased risk (Gibbs BG & Forste R, 2014 Socioeconomic status, infant feeding practices and early childhood obesity. Pediatr Obes 9(2): 135-46). Alongside this, research has shown that lowering the protein content of formulas, so it is just above that of human milk may help to support normal infant growth (Haschke F et al, 2014 Fast growth of infants of overweight mothers: can it be slowed down? Ann Nutr Metab 64 Suppl 1:19-24). Latest statistics that have pooled figures from 89 local authorities show that 43.4% of women breastfeed at 6-8 weeks after birth (Public Health England, 2015 Breastfeeding prevalence at weeks 6-9 after birth 9 by local authority https://www.gov.uk/government/statistics/breastfeeding-at-6-to-8-weeks-after-birth-2015-to-2016-quarterly-data), indicating that over 56% are bottle feeding.

Concerning weaning, women should be guided about responsive feeding including introducing solid foods, progressing through the food textures and reducing milk feeds. The British Society of Paediatric Dentistry encourages parents to wean their children from the bottle at 12 to 14 months, advising that early drinking from a cup will develop motor skills alongside preventing the pooling of beverages around the teeth which may lead to an increase in dental caries. One meta analysis found the early introduction of solid foods
before 4 months of age to be a risk factor for childhood overweight (Weng SF et al, 2012 Systematic review and meta-analyses of risk factors for childhood overweight identifiable during infancy. Arch Dis Child 97 (12):1019-26) and differences in cultural beliefs may also come into play with some mothers seeing a chubby infant as a healthy infant (Gross RS et al, 2014 Maternal infant feeding behaviours and disparities in early childhood obesity. Child Obes 10(2):145-52).

As many parents are in full or part-time employment, the responsibility for what their children eat and how they are fed does not rest with a single person. Play group, pre-school and nursery staff, grandparents and other child minders share a key role in caring for toddlers and feeding them. It is important that everyone realises that wherever young children are fed, those involved have a responsibility to effect positive improvements in their diets and lifestyle. In order to embrace the role with confidence, they require clear and practical guidance about what foods and portion sizes to offer and what behaviours to instil. Children tend to model their parents’ and carers’ intake and beliefs about food and if their parents adopt unhealthy diets and food behaviours it is likely that their children will follow suit.

It is acknowledged that external and internal non-hunger stimuli can affect food intake. Children aged 3–4 may respond to external cues to eat when they are not actually hungry. Like adults, they may eat because others are eating, or to imitate the eating habits of others. The desires to ‘comfort eat’ and finish what is left over (empty plate syndrome) are interactive behaviours that can also lead to over-eating. Research shows that although parents and caregivers are reasonably adept at recognising a baby’s hunger, they are slower to notice signs of fullness. Ongoing feeding even after full cues are given is common practice among parents who thereby disregard their baby’s natural instinct to stop eating. Longitudinal data provides evidence that poor responsive feeding patterns exhibited by caregivers, including controlling and indulgent feeding styles and providing excessive portion sizes, can supersede this internal regulation and may contribute to childhood obesity (Engle PL, Pelto GH Responsive Feeding: Implications for Policy and Program Implementation. The Journal of Nutrition, 2011,141 (3): 508-511).

Parents who are above their own optimum weight level often have children who are overweight and perinatal programming and lifestyle choices are influential (Whitaker RC, Wright JA, Pepe MS, Seidel KD, Dietz WH, 1997, Predicting obesity in young adulthood from childhood and parental obesity, N Engl J Med. 337:869-873). To give children appropriate role-modelling and encourage them to trust their own intuition, caregivers need targeted support in dealing with their own attitudes toward food, psychosocial triggers for eating such as boredom or comfort, body image and physical activity. Parents and caregivers need consistent evidence-based, non-judgemental and family-centred support to help them and their children to achieve and maintain a healthy weight. The message should widen from an emphasis on body weight to physical, mental and social health and wellbeing, including self-care, trust in child-led feeding and play/physical activity. Attention should also be paid to how young children eat and drink:

‘Choosing an open cup means that you are allowing your child to develop a healthy sipping habit. Spouts and no-spill valves that mean a child has to suck, rather than sip, contribute to
poor facial and dental development. A young child’s teeth, jaw and muscles are still growing so it’s a crucial time.’(Dr Derek Mahony BDS(Syd) MScOrth(Lon) DOrthRCS(Edin), Orthodontist)

Health visitors are best placed to provide advice, practical suggestions about how much food to offer, the correct behaviours to encourage and the appropriate weight for a child’s height. Growth checks (height and weight) are advocated but not necessarily undertaken as routine procedures in the first years of life. While growth faltering after birth in the early years is clearly an important issue, typically identified by healthcare visitors using World Health Organisation Growth Charts, rapid weight gain in the first year should also be identified and discussed with parents. New strategies are not needed, as this can also be identified using the same growth charts; the focus should rather be upon emphasising the risks associated with rapid weight gain to healthcare visitors alongside the support needed for babies who are not gaining weight as they should.

Growth checks would pick up children gaining excess weight and consequently at risk of overweight and obesity in this critical period. The Infant and Toddler Forum has produced resources with evidence-based portion sizes for 1-4 years (More J.A. Emmett P.M.2015 Evidence-based practical food portion sizes for pre-school children and how they fit into a well-balanced nutritionally adequate diet. Journal of Health and Dietetics, Apr:28(2):135-54) which can be used to halt rapid weight gain through overeating in young children.


The average UK diet is poor and is not in line with the advice that is available (Bates B LA, Prentice A, Bates C, Page P, Nicholson S, Swan G. (Eds). 2014 National Diet and Nutrition Survey: Headline results from Years 1to 4 (combined) of the rolling programme from 2008 and 2009 to 2011 and 2012, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/310995/NDNS_Y1_to_4_UK_report.pdf). This is partly because most food choices are habitual and automatic; we exert little self control over what and how much we eat (Wansink, B., & Sobal, J. 2007. Mindless Eating the 200 Daily Food Decisions We Overlook. Environment and Behaviour, 39(1), 106-123). In addition, even the improved nutrition information on food labels (Food Standards Agency. Front of pack labelling research http://food.gov.uk/healthiereating/signposting/), Department of Health, 2013. Guide to creating a front pack (FOP) nutrition label for pre-packed products sold) has had a limited influence on dietary improvement because the labels are generally ignored unless people are trying to lose weight or interested in ingredient avoidance for a particular health issue
When parents and care-givers are deciding what to feed a pre-school child, the labels are unhelpful because they contain information that is adult-appropriate and not applicable for young children. However, even very young children can influence what their parents buy through feeding behaviours and ‘pester power’. As children grow older, they will also be influenced by what their peers eat and this particularly applies to the pre-school age group. Peer influence and modelling behaviour observed in very young children could offer an unexpected environmental, long term health benefit by improving dietary behaviours and food choices in 3-4 year old children as part of the free nursery hours policy proposed in The Childcare Bill (The Childcare Bill, Policy Statement https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/465446/childcare_Bill_Policy-statement.pdf).

Physical activity and play combine with nutrition as part of a ‘virtuous circle’ enabling young children to maintain a healthy weight as well as establishing the groundwork for mental wellbeing and key personal development. The government announcement that even more small areas of council green space are to be built upon does not help to combat children’s lack of informal exercise close to home; in fact it worsens an already unsatisfactory situation. Most pre-school children will readily engage in active play but opportunities can be curtailed by their housing situation, local environment and facilities and established practice at early years’ settings. Children’s fundamental right to play is enshrined in Article 31 of the United Nations Convention on the Rights of the Child and the Association of Play Industries (API) is amongst other bodies considering that this right is being eroded in the UK. API research (nowhere2play campaign, autumn 2015) amongst parents found that 98.5% of parents think that it is important that their children are physically active but 56% are unhappy about the lack of facilities in their local area. 23.4% said that their nearest playground is in a poor state and 38.1% are worried that playgrounds in their local community are at risk of closure. 67.5% say that they see no improvement in local play facilities with 15.1% reporting a decline. In addition, young children and toddlers spend much time in front of a screen when parents are otherwise engaged in the home. UK Active (2015) has called for a comprehensive approach to build activity back into children’s lives, contending that healthcare professionals, educationalists and parents need support to make movement and play integral to both early and later childhood. It is the time between the ages of 5-11 when children are being failed. Beneficial patterns developed in this most influential period have a good chance of sticking for life. A poor standard of play provision (time, places and quality) is one of the key factors still being missed by government policy as it stands now. The consequent health benefits extend far beyond weight management and include improved physical and mental health and higher academic attainment.

The causal processes involved in the development of obesity are complex and combine social, environmental and biological influences. There are multiple influences on early child health and development and recent work (Goisis A, Kelly, Y, Why are poorer children at higher risk of obesity and overweight? A UK cohort study) using data from the Millennium Cohort Study on over 10,000 children considered the contribution of potentially modifiable
risk factors in relation to the likelihood of obesity, analysing the extent of social inequalities in the risk of overweight and obesity throughout childhood.

Key findings from the study include:

- Substantial inequalities in the risk of overweight and obesity during childhood; these worsen as childhood proceeds
- At five years old, children in the 20% poorest homes were twice as likely to be classified as obese compared to their richer peers
- By 11 years of age, the income gap had widened substantially – the poorest children were three times likelier be obese than children from higher income backgrounds.

Following the same children over time (longitudinally) from 5-11 years of age revealed:

- Sufficient sleep and fruit consumption (three or more portions per day) protected healthy weight five year olds against becoming overweight or obese
- Sufficient sleep and fruit consumption among overweight/obese five year olds was linked to their movement to healthy weight
- Mother’s smoking during pregnancy and early introduction of solid foods (before four months) was linked with healthy weight five year olds becoming overweight or obese by age 11.

Social and economic inequalities are the most stubborn factors standing between a child and a healthy body weight. A child born into socially disadvantaged circumstances is likely to be exposed to a series of social and material adversities (parents/carers with poor mental health, none or few qualifications, unemployed carers, living in poverty, poor housing and deprived residential areas). These increase the risk of exposure to adverse behaviours (smoking during pregnancy, not being breastfed, early weaning before 4 months, poor dietary intake, physical inactivity, poor sleep routines) that impact directly on the risk of developing unhealthy weight.


Ultimately, the environments in which people live ‘get under the skin’ because social circumstances interact with biology to shape health, wellbeing and risk of mortality. It is therefore essential that all strategies to prevent overweight and obesity from taking a grip in the very early years of a child’s life must be thoughtfully planned, considered and audited bearing matters of social and economic equality always in mind.

We recommend

- National nutritional standards and portion size guidance for children aged 1-5 years
• Mandatory rather than voluntary food or nutrient standards for nurseries, preschool settings and childminders
• The 30 hour childcare nursery places to be fully funded to include appropriate food and portion sizes
• Start4Life and Change4Life to develop clear evidence-based messages on healthy eating and lifestyle for the toddler age group, using like-for-like tools such as a toddler eatwell plate and NHS Choices website
• To ensure that all healthcare professionals with responsibility for 0-5 year olds have the necessary knowledge and skills to assess nutritional status and provide consistent advice on dietary behaviour
• The Integrated Review of all two year olds should include statutory measurement of height and weight as part of the National Measurement Programme data; annual measurements between two years and five years to identify at risk children
• Health and Wellbeing Boards commissioning local services to signpost local facilities for physical activity and play for under 5s e.g. parks, playgrounds, toddler activity/movement groups
• Children’s centres, early years settings and schools to be encouraged to share information with parents about physical and play activities that families can replicate at home
• Government to embed childhood nutrition indicators into key developmental checks and frameworks measuring child poverty and health inequalities (such as the Integrated Review)
• Department of Health and Public Health England to build the evidence base on effective interventions to improve early life nutrition and provide information and guidance on nutrition/movement/play to Health and Wellbeing boards and other local commissioners
• Health and Wellbeing boards to have a statutory duty to commission local services to provide age-appropriate and consistent advice for parents on breastfeeding, the introduction of solid foods, dental health and toddler feeding
• EYFS guidance on play (e.g. The Characteristics of Effective Learning Through Play) be extended to cover all primary school ages (Northamptonshire County Council example)
• Children’s centres and nurseries to share good practice on building community hubs of expertise and support for all parents, particularly on early life nutrition and the role of physical activity and play in creating a healthy lifestyle from pregnancy to pre-school.

THE ROLE OF SCHOOLS: A WHOLE SCHOOL STRATEGY TOWARDS FOOD AND NUTRITION, INCLUDING PRE-SCHOOL

A child’s right to adequate and appropriate nutrition is stipulated under Article 6 and 24 of the Convention on the Rights of the Child. However, in 2015, national surveys show that the nutritional requirements of children in the UK are being short-changed. A whole school approach towards food and nutrition approaches food and nutrition alongside wider health issues such as physical activity, movement, play and emotional wellbeing. Strategies should
engage all the groups within school communities: teachers, support staff, parents and pupils are all integral and essential.

The UK obesity epidemic stems from the earliest stages of life and food provision within early years’ settings is very important. The number of early years’ providers, including childminders, nurseries and children’s centres totals 78,286, caring for around 1.3 million under-fives (Ofsted, Department of Education, Early Years Annual Report:2012/13, September 2014). The need to ‘get it right’ is illustrated by the fact that some children eat all three meals on five days in these settings and the latest figures from the National Child Measurement Programme show that 22.5% children presenting in Reception year at primary school (4-5 year olds) were already overweight or obese (Health and Social Care Information Centre, national Child Measurement Programme 2013-14, 2014). With the extension of free childcare for three and four year olds to 30 hours per week (Department for Education, 2015 Children Care Bill: Policy Statement, https://www.gov.uk/government/publications/childcare-bill-policy-statement) early years’ settings provide a fresh opportunity to help young children learn about and practice healthy eating as well as to encourage families to establish healthy eating patterns at home.


There are no statutory requirements on meals, drinks and snacks or nutrient content provided in these settings. Decisions regarding children’s nutrition are usually taken by early years’ managers and in-house cooks or chefs although some providers outsource catering services. In 2010, the Department for Education (DfE) commissioned the School Food Trust (now the Children’s Food Trust) to manage a multi-disciplinary Advisory Panel on Food and Nutrition in Early Years (‘the Panel’). Evidence received suggested that many early years’ settings were supplying food suited to older children or adults, leading to an under-provision of energy, carbohydrate, iron and zinc, and over-provision of added sugar and salt. The minimal training on nutrition for early years’ practitioners means that the overall quality of nutritional provision varies. Some chains of settings such as the Pre-school Learning Alliance (Alliance) have developed (with support from experts) in-house guidance while other groups use online or hard copy information from providers including:

- Infant & Toddler Forum (ITF)
• British Nutrition Foundation (BNF)
• Caroline Walker Trust (CWT)
• First Steps Nutrition
• Local Authority Public Health Services
• Private consultants and nutritionists
• The Children’s Food Trust

However, in the absence of a statutory requirement and no inspection of food provision by Ofsted in early years’ settings, some settings simply develop their own menus. Investing in early years’ healthy food provision training and guidance is essential because the foods that under-fives are offered are the foods that they become familiar with and learn to like, thus shaping their food and drink preferences and influencing long-term health outcomes. Early years’ settings play a vital role in educating both the children in their care and their parents on healthy lifestyles and feeding habits, but standards will continue to fluctuate in the absence of mandatory guidance.

In 1999, the Labour Government introduced a voluntary National Healthy Schools Programme (National Healthy Schools Programme: archived https://en.wikipedia.org/wiki/National_Healthy_Schools_Programme) as a component of the strategy described in the Department of Children, Schools and Families Children’s Plan (DCSF 2007) and in the Department of Health’s Healthy Weight, Healthy Lives (DH 2008). The four themes, each with particular criteria are:

• Personal, Social and Health Education
• Healthy Eating (including healthy and nutritious foods being prepared in school canteens and available in schools as well as enabling young people to make informed decisions about healthy food)
• Physical Activity – enabling young people to undertake physical activity as well as being afforded opportunities to be physically active.
• Emotional Health and Wellbeing (including bullying, how to express feelings, build confidence and emotional strength).

The Programme was curtailed for financial reasons but some councils including Leeds (Healthy Schools Leeds – www.healthyschools.org.uk) continued to help schools to achieve Healthy School status. In 2013, the London Mayor launched the Healthy Schools London Awards and staff from Mytime Active work directly with schools in the three London boroughs to achieve Bronze, Silver and Gold Awards. A major milestone in the process is to have a credible whole school food policy.

A whole school approach is the framework that guides the development of a healthy food culture in schools and shapes the school’s whole school food policy. The approach is endorsed by the head teacher, embedded in the school development plan and permeates the entire school experience. Consistency is the watchword: what is taught about food and healthy eating in lessons is reflected and reinforced in the daily life of the school, with the dining room as an extra classroom. Pupils are encouraged to help guide the programme which extends into the wider community (Food for Life website: http://www.foodforlife.org.uk/what-is-food-for-life/whole-setting-approach).
The Schoool Food Plan, (School Food Plan: Henry Dimbleby and John Vincent, 2013 http://www.schoolfoodplan.com/checklist/) introduced a whole school approach towards food culture in schools (Schabas L., 2014. The School Food Plan: putting food at the heart of the school day. Nutrition Bulletin, 39(1), 99-104). This included funding for breakfast clubs for schools with over 35% pupils eligible for free school meals. There have been concerns raised about the nutritional quality of some breakfast foods offered in school (‘... the food served at our kids schools for breakfast ... surpasses the government guidelines for sugar. My kids get fed spaghetti hoops and jam sandwiches at after school club too. Feeling like they are doomed.’ Infant school parent, Kent) and restricted access for some pupils, but the benefits of reducing breakfast skipping and promoting social health opportunities have impacted upon pupil performance, early habit formation and metabolic health (Graham, p. L., Russo, R., & Defeyter, M. A., 2015 The advantages and disadvantages of breakfast clubs, according to parents, children and school staff in the North East of England, UK. Name: Frontiers in Public Health, 3 156).

The Plan has increased the uptake of nutritionally balanced school meals and reduced the reliance upon the frequently unhealthy lunchbox in children from low-income and socially deprived homes. Other strategies are designed to encourage children to eat a wider range of foods. For example, canteen layouts and health-promoting stickers can lead to a significant increase in the uptake of plant-based foods (Ensaff, H., Homer, M., Sahotoa, P., Braybrook, D., Coan, S., & McLeod, H. 2015 Food choice architecture: An intervention in a secondary school and its impact on students’ plant-based food choices. Nutrients, 7(6), 4426-4437) and is also recognised that lunch break duration and portion size (Birch, L., Savage, J.S., 7 Fisher, J.O. 2015 Right size prevention, Food portion size effects on children’s eating and weight. Appetite, 88, 11-16) impact upon child weight levels although further research and attention is warranted here.

The introduction of the universal infant free school meal offers an opportunity to evaluate the impact of investing in healthy food interventions in school. A rigorous evaluation of the current policy of offering a free school lunch to all children in Reception, Year 1 and Year 2 at school in England must be completed so that its effect and future potential for children’s public health can be assessed. Findings from two randomised controlled studies undertaken by the Children’s Food Trust showed that children are likelier to concentrate and be alert in class after a healthy school lunch eaten in an appealing environment (Golley R, Baines E, Bassett P, Wood L, Pearce J, Nelson M. School lunch and learning behaviour in primary schools: an intervention study European Journal of Clinical Nutrition 2010,64(11), 1280=1288 http://www.nature.com/ejcn/journal/v64/n11/full/ejcn2010150a.html, Storey HC, Pearce J, Ashfield-Watt PAL, Wood L, Baines & Nelson M. A randomised controlled trial of the effect of school food and dining room modifications on classroom behaviour in secondary school children, European Journal of Clinical Nutrition 2011 65, 32-8). Recent analysis of school lunch take-up data at local authority and school level suggests a link to improved attainment at secondary level (Nelson M, Gibson K and Nicholas J. 2015 School lunch take up and attainment in primary and secondary schools in England http://journal.frontiersin.org/article/10.3389/fpubh.2015.00230/pdf ).
Compulsory national standards for school food have also achieved an improvement in school food culture and the quality of food provided. The standards restricted less healthy foods high in fat, saturated fat, sugar or salt and became mandatory in January 2015 for all schools including academies set up between September 2008 and September 2010 and after June 2014. However, academies set up between September 2010 and June 2014 do not have to comply with national school food standards because they have a different funding arrangement. Therefore over 3,800 schools are offering technically unregulated food, although they can sign up voluntarily to the standards (http://www.schoolfoodplan.com/school-food-standards/).

The Children’s Food Trust is a strong advocate of compulsory food standards and a growing body of opinion supports its contention that the ‘academy’ loophole should be closed so that all children can derive benefit from them.

The British Society of Paediatric Dentistry is another supporter of the improved standards and further suggests that for all children, encouraging oral hygiene practices (tooth brushing with age appropriate fluoridated toothpaste after meals at school) will encourage good oral health and help to reduce the incidence of dental decay. For pre-school children, this will require supervision. However, it is important to remember that the health of children is not simply about food, but also about physical activity. The rise in obesity and the lack of fitness in children can be attributed to a decline in physical activity and opportunities to play as well as to dietary habits.

A whole school approach towards food and nutrition will therefore only be accomplished if it contains corresponding initiatives to promote physical activity, sport, movement and play. Physical activity and PE are highly unusual within the UK curriculum in that pupils are not subject to standardised testing. This results in a number of adverse outcomes:

- Children (and their parents and teachers) have no clear idea if they are adequately physically literate and fit
- Without assessment, there is no defined educational mechanism to teach children why physical fitness and health are important
- The schools themselves cannot judge the effectiveness of their PE teaching and programmes.

In the USA, The President’s Challenge (http://pyfp.org/about/index.shtml) measures the fitness of children and provides programmes to help them improve. There is an increasing awareness of the potential of testing to assist the development of children in physical education and the forms of testing such as the development testing undertaken in the Netherlands and Wales, along with fitness testing as conducted in countries such as Singapore as well as the USA should be analysed to ascertain the most appropriate methods to support learning and physical activity participation. It is anticipated that the All Party Parliamentary Group on a Fit and Healthy Childhood may research this important issue in due course with a view to making evidence-based recommendations.

Equally essential is the role of play in an effective whole school approach; playtime is 20% of the school day, in primary school a child will spend approximately 1680 hours outside at
playtimes and with proper training for all appropriate school staff, every school can deliver a high quality play environment capable of engaging all children – not just those perceived to be ‘sporty’. The rules and competitive nature of sports do not suit every child and it is important to provide children with varied ways of being active (such as dance). The play team should be led by a trained Play Leader/Coordinator with a direct line to senior management and should examine ways in which children’s active free play (which is not dependent upon expensive equipment) can be best facilitated. Continuation of funding for sports initiatives should be extended to support active playtimes and active learning across all areas of the curriculum. The National Curriculum should contain guidance about active playtimes and specific CPD programmes should be available to enable staff to deliver positive outcomes outside the classroom. An Ofsted report (Learning Outside the Classroom, 2008) stated that:

‘When planned and implemented well, learning outside the classroom contributed significantly to raising standards and improving pupils’ personal, social and emotional experiences.’

At the same time, the trend of shortening lunch and break times – even keeping a child inside to ‘finish work’ should be reversed. In The Crucial Role of Recess in School, The American Academy of Paediatrics comments:

‘Recess is a crucial and necessary component of a child’s development and, as such, it should not be withheld for punitive or academic reasons’ (Paediatrics: January 2013, Vol 131, issue 1). Ideally these times should be lengthened.

A whole school strategy towards food and nutrition including pre-school is one in which beneficial food and nutrition policies are complemented by a positive approach towards play, physical development and fitness, sport, movement and emotional wellbeing. The recently launched Nuffield Health Head of Wellbeing Pilot at Wood Green School in Oxfordshire centres upon a new post of Head of Wellbeing, responsible for uniting all existing school practices that relate to health and wellbeing (2020 Health, a Head of Wellbeing; An essential post for secondary schools?).

In this pilot programme (http://www.nuffieldhealth.com/health-topics/childrens-health/school-pilot) existing strategies to combat childhood obesity are extended to include the health and wellbeing (both physical and mental) of staff as well as pupils and efforts are made to engage parents in the agenda via information evenings with external experts, guidance at parents’ evenings and anonymous questionnaires. Ultimately, a whole school strategy towards food and nutrition including pre-school will focus in the ways advocated above and on preventative health measures so that children derive the greatest long-term benefit. If parents and teachers are encouraged to think more about their own health and wellbeing, it is likely that positive patterns and behaviours can be transferred to children. Teachers here will take on the role of health ambassadors.

Schools have the potential to play a very important role in helping to educate children and young people about their health and wellbeing and these issues should no longer be marginalised. If improvements are to be made and sustained, a proper evaluation process
must be embedded into every stage of the process. For this reason, a whole school approach towards food, nutrition and other aspects of health and wellbeing will be incomplete unless pupil health, physical development and wellbeing assessment is added to the traditional forms of testing required by the National Curriculum to take place in all school settings.

We recommend

- Statutory requirements on meals, drinks and snacks for all settings including standardised portion guidance
- Qualified nutrition specialists to oversee food provision, menu planning etc. in all settings, in addition to up-skilling staff in nutritional knowledge
- The impact of voluntary food and drink guidelines for early years settings to be properly evaluated
- School foods standards to be statutory for all settings to include early years
- Teeth brushing and dental health to be embedded into the whole school approach to food and nutrition to include pre-school
- Implement minimum standards for physical literacy at primary school level
- Introduce a National Framework for physical development assessment in secondary schools
- Emphasize a broad range of physical activity in school PE lessons
- Re-frame the Sport Premium as the Sport, Movement, Physical Activity and Play Premium to encourage schools to adopt a holistic approach that extends its reach and ambition beyond sport
- School nursing teams to work with partners including health and social care teams, teachers and youth workers to deliver the evidence-based public health interventions as outlined in the Healthy Child Programme (5-19) and using the core principles of Making Every Contact Count for intelligent, opportunistic interventions
- Implement minimum standards for Play Provision Quality in all existing and new build primary schools, using the 18 criteria OPAL baseline measurement tool to identify and address all gaps in provision
- Ensure that all appropriate school staff receive proper training in play
- Pilot and evaluate innovative posts such as a Head of Wellbeing in schools based on the Nuffield Health model to include health and wellbeing assessment tools
- Introduce a National Framework in schools and early years for ‘whole child health’ encompassing nutrition, play, movement and sport and providing useful lifestyle resources that children can learn in school and cascade to the rest of the family
- Pupil health and wellbeing to be assessed as part of the National Curriculum
- Physical activity to be built into every aspect of school life including the National Curriculum
- Improved provision within teacher and learning support training to build confidence and competence in introducing physical activity in all aspects of school life.
THE FAMILY: SUPPORT, ADVICE AND ENCOURAGEMENT TOWARDS HEALTHY LIFESTYLES

Parental/carers commitment in helping children to develop healthy habits to treat and prevent obesity is crucial. Parents serve as role models and change agents to mould their children’s eating and activity patterns and home environments influence lifestyle choices. Persuasive evidence shows that behavioural treatment is more effective in children if parents are involved as the primary mediator of change (NICE evidence report, 2006, Golan and Crow 2004). Long term studies by Epstein and co-workers (1994) following up families after 10 years, show that parental involvement is more effective in long term weight loss and maintenance than child-only strategies. Healthy lifestyles and healthy families must be on the agenda beyond the school gate, especially in environments consisting predominantly of young parents and vulnerable groups. Parents and carers need advice on matters from diet/nutrition to play and leisure pursuits both inside and outside of the home. One relevant issue is the amount of screen time to allow. A 2014 study compared food intake by boys aged 9-13 while playing computer games, watching TV and computer screens. The food intake was significantly higher than in non-screen conditions (in hour long sessions they consumed about half of a day’s calories) and TV watching produced the highest food intake. (Samantha Marsh et al, Comparative effects of TV watching, recreational computer use and sedentary video game play on spontaneous energy intake in male children. A randomised crossover trial. Appetite, Vol 77, June 2014, p 13-18). The importance of addressing family behaviour rather than isolating the child in behaviour change programmes can be further illustrated using the TV example because in the UK 68% of evening meals are eaten by children and their families in front of the TV and eating is thereby regarded as contingent upon viewing (Sigman, A. 2015 We Need to Talk Screen Time in New Zealand. Media Use: An emerging factor in child and adolescent health. Report to Family First New Zealand).

Attempts to regulate a child’s behaviour alone will fail unless the whole family is enabled to embark upon lifestyle change that is holistic and encompasses a range of behaviours, habits and activities.

Various methods of engagement have been found to be effective. Community-linked projects involving whole families in practical cooking sessions, economical food use and promoting youth interest in food provenance and sustainability are highly valuable. For example, farm-to-school projects develop nutritional education within the school environment, but also create educational responsibilities and opportunities beyond school and within the locality (Valiantos, M., Gottlieb, R., & Haase, M.A., 2004. Farm-to-school strategies for urban health, combating sprawl, and establishing a community food systems approach. Journal of Planning Education and Research, 23(4), 414-423). A holistic, cross-cutting approach is best placed to reach families. Healthy lifestyle education would be strengthened by a natural progression through antenatal groups, health visitor involvement, nursery, pre-school and then into school with a clear route for family engagement at each stage. Sports clubs and broad extra-curricular activities should also include raising awareness of the importance of balanced diets and healthy choices within their programmes.

Partnership working amongst health professionals is essential to engage families about all aspects of feeding and a good example of this is in the area of dental health. It is imperative
that healthcare professionals, paediatricians and paediatric dentists work side by side with health visitors to ensure that a consistent and correct message is conveyed to families with young children and newborn babies. On-demand feeding at night (bottle/breast) should be discouraged from 12 months onwards with the introduction of a free-flowing cup at 6 months. Encouraging collaborative patient care should be supported and encouraged and health visitors should promote the first visit of the child to the dentist upon the eruption of the first tooth.

A number of organisations have developed broad-based projects with like-minded partners that are specifically crafted to encourage healthy choices within the family. Examples are HENRY (Healthy Exercise for the Really Young (http://www.henry.org.uk/homepage/), Trim Tots and MEND (Mind, Exercise, Nutrition, Do It).

Trim Tots Community Interest Company aims to tackle obesity through the delivery and national roll out of Trim Tots Healthy Lifestyle Programme. This programme has been developed by a team of child health professionals from the Institute of Child Health together with a team of community artists, experienced in delivering educational art workshops to young children. The focus is on prevention rather than treatment of obesity by promoting a healthy lifestyle both in pre-school children, aged between one and five, and their carers. It is the only evidence-based intervention programme with two-year follow up data. (http://www.trimtots.com/evidence.html)

The MEND programme was originated by a partnership of UCL Institute of Child Health and Great Ormond Street Hospital for Children NHS Trust and since 2012 has been part of Mytime Active. It is a multi-component, community-based programme aiming to provide families with a foundation for feeling fitter, healthier and happier throughout the life course and MEND’s published evidence-based testing has shown that to date it has benefitted over 45,000 families. Children leave MEND with improvements in waist circumference, self-esteem, dietary intake, cardiovascular fitness and physical activity levels. Improved dietary outcomes include increased fruit and vegetable consumption and eating together as a family. Anecdotally, MEND also helps children concentrate and do better academically and parents and children have reported an upturn in family relationships after they have participated in the programme.

The programme (developed to be delivered at scale in the community by a wide range of professionals including non-specialists) is delivered face-to-face in a group context and involves direct participation by all children and their parents or carers. At least one parent or carer is required to attend all sessions as they are the primary mediators of behaviour-change in a family setting. The groups are held in local community locations several times a week and are age and stage appropriate. They include fun-based, multi-skills physical activity sessions, interactive nutrition sessions and behaviour-change workshops, designed to empower parents to adjust their own and their children’s physical activity and nutrition behaviours.

Positive role-modelling is used to promote a healthier lifestyle for the whole family. Whilst sessions are open to any family member, MEND asks that the constant family member is the regular care-giver who is the nucleus for making key nutrition decisions such as shopping...
and physical activity choices e.g. leisure time pursuits for the family. Families are encouraged to work together on health behaviours, engaging in discussion to determine personalised (SMART) goals and rewards and working towards weekly nutrition and physical activity targets. Parents can often feel distressed or to blame for a child’s weight status and emotional health (many of the children attending MEND sessions are bullied) and the programme offers direct support to parents/carers via dedicated parent/carer workshops where communication, role-modelling, consistency, problem solving and relapse prevention strategies are all worked through to support positive, long term parenting techniques and sustainable health behaviour change. Parents engaging in the programme often lose weight themselves.

In July 2014, a NICE draft quality statement (Family involvement in lifestyle weight management programmes) stated that children and young people are likelier to achieve a healthy weight if the whole family is involved. Slimming World was started 45 years ago from a conviction that the burden carried by overweight people is two-fold: the burden of excess weight itself and the more onerous burden of shame, self criticism and low self-esteem. Responsible weight loss organisations give regular and consistent weight management support to diverse communities throughout the UK; with high take-up in low income areas, especially those pursuing a model of established support groups at the heart of communities. Families should ideally be able to access training to support changes in behaviour as a family to improve their children’s health and fitness levels ‘Support’ should include positive parenting strategy and is most effective ‘when it is delivered with genuine warmth, compassion, empathy, respect and understanding.’ (Carolyn Pallister; Public Health Manager at Slimming World: 27th May 2014)

Slimming World’s confidence-boosting programmes and evidence-based approach continue to succeed in encouraging all family members to be physically active and eat healthily by setting achievable patterns for adults to adopt and children to follow. However, the wider picture encompassing education and health professionals is less encouraging. Mentioning sensitive issues of overweight and obesity requires skill, delicacy and empathy and those who raise the issue require specific training to ensure that advice given is at all times, respectful, non-judgemental and free from blame and stigma. As yet there is a training shortfall for health and education professionals, many of whom will have unique and long standing relationships with families at different stages in their lives and are therefore ideally placed to refer those in need of help to responsible weight loss organisations. Until the training needs of the relevant professionals are fulfilled, many children and their families will continue to slip through the net and therefore continue to incur health problems now and in the future.

We recommend

- Government to recognise and promote the importance of involving the family in healthy lifestyle programmes and provide evidence-based guidance to Local Authorities and Health and Wellbeing boards
- Government to develop and implement mandatory national training for all professionals who interact with families to equip them with the skills to raise the issues of obesity and weight management with sensitivity
- Government to recognise the role that responsible commercial weight loss organisations can play in supporting families to adopt new healthy lifestyles and reduce the prevalence of obesity and to encourage health and education professionals to signpost to such organisations that are evidence-based.
- Providers of lifestyle weight management programmes and family-based health and wellbeing programmes to monitor and evaluate these and supply evidence-based data to commissioners and those responsible for referrals. All data to be published and readily accessible.
- Early years settings, pre-schools and schools to embed family and community-centred initiatives into their health and wellbeing programmes.
- Lifestyle weight and health and wellbeing programmes to ensure that the publicity material they use to raise awareness of their programmes is culturally sensitive and available in a variety of languages and formats as appropriate to the community.
- Recognition by national and local government and professional bodies that those working in the health and education sectors have a duty of care to their patients, pupils and students who are at risk of suffering physical or psychological harms due to being overweight or obese.
- Government to provide clear information and guidelines using evidence-based research so that parents are equipped to make choices about the amount of screen time to allow their children.

**THE VIRTUOUS CIRCLE: MOVEMENT, PLAY, PHYSICAL EDUCATION AND SPORT**

Sport is predominantly considered by policy makers as the all encompassing ‘go to’ solution in tackling physical inactivity in children and its attendant ills of overweight and obesity. Increasing participation in sport undoubtedly has a role but will not alone end the negative cycle of obesity and sedentary behaviour which leads to isolation, under-productiveness, illness and in some cases, early death. As stated above, the rigid rules and rituals of school sport alienate many children who may be labelled (or label themselves) as ‘non-sporty’. This then discourages participation in physical activity in later childhood and sets a pattern of inactivity into adulthood that is likely to remain a habit for life. What is required is a ‘virtuous circle’ of complementary policies, aligning sport with PE, movement, play and positive initiatives towards food and nutrition.

Physical Education or PE, especially in England has lost its way in terms of curriculum development and has failed to keep true to what is implied by its name. The core purpose of physical education should be to educate children about the physical and to give them educational experiences from early childhood through to leaving school that will enable them to find their own pathway to a lifelong love of, and engagement with, movement and physical activity.

A gulf between the opportunities and facilities for PE in private schools and state schools in the UK has long been acknowledged with the state sector at a disadvantage. This is not so in Amsterdam where there are no private schools and all (state) primary schools have a dedicated gym, and in many cases, two gyms (specialised for infant and junior children) for
physical education. Their primary school PE teachers are specialists who deliver what is regarded as a core curriculum area. The strategy has made a significant difference in areas of inequality within a city that now has PE facilities comparable to any private school in the UK. The city council has collaborated with one of the city’s universities to measure outcomes, focusing not on measuring fitness but on measuring children’s motor development in partnership with schools and teachers. The results of the testing are shared with the school and its PE teachers so that they can prepare individualised programmes for each child to enable them to maximise their potential.

Professor Sheila Wigmore, Emeritus Professor at Sheffield Hallam University has highlighted a lack of curriculum innovation since 1942 in UK physical education. Research findings show that many adults had a negative school experience of physical education resulting in the creation of barriers to physical activity in adulthood. It is also known that many females are switched off from physical education due to a poor secondary school experience; many primary school teachers neither enjoyed nor found success in physical education during their own schooldays and received little or no time on the subject during professional training. As a consequence, their own confidence levels are low which impacts detrimentally upon the experience for their learners – a vicious rather than virtuous circle. Yet despite this knowledge and a welcome growth in the variety of sports and physical activities since 1942, there has been little change in the subject and approaches to teaching it. What is required is the development of an innovative curriculum befitting the needs of 21st century learners and government championing that will enhance the experience and open up opportunities for future generations. Every school should have a dedicated physical education space along with specialist teachers, strengthened by ongoing CPD and equipment to deliver a high quality educational experience. Physical education must emerge from the shadow of sport to take its rightful place as a central component in the virtuous circle of health and wellbeing.

Sport’s other poor relation is play. Whilst the Government speaks of an obesity crisis, few policy-makers mention that this has gone hand-in-hand with a play crisis over the same period, most deeply affecting almost exactly the same group of children, as well as most other children to a lesser degree. According to the National Trust’s 2012 report Natural Childhood; since 1970, the radius of activity for children (the territory around their homes in which they can freely move) has shrunk by 90%. Dr Joe Frost in his A history of children’s play and play environments; Toward a contemporary child-saving movement (2010, New York, Routledge) concludes that American children have become less active; they prefer indoor virtual play to active outdoor play and succumb to junk food with catastrophic consequences. The situation in the UK is similar. Play deprivation has become a child welfare issue and ‘nature deficit disorder’ has come to signify all the consequences of play deprivation; lack of outdoor play, lack of outdoor education, lack of any time at all spent outdoors.

In October 2015, the All Party Parliamentary Group on A Fit and Healthy Childhood decided that the neglect of play and its potential benefits was sufficient to merit a single report in its own right and it is not proposed to reproduce the minutiae of that argument here. However, it is important to state that children’s free, active play is a significant factor in combating sedentary behaviour, slowed development and poor fitness. To improve the
quality and scope of play provision across the country, it is not simply a case of designating certain locations as being ‘for play’. It is about ensuring that children can make choices about where they play with a wide variety of experiences on offer. Ideally, these will be within walking distance of home, without necessitating negotiating busy roads. This can be readily achieved as large new housing estates are built – provided that those responsible for development and design have been given the correct advice. If there are trained staff around, they can further enrich the play environment through their knowledge and experience. Playwork is rooted in an understanding that children learn and develop while they are playing, and a belief that there are many instances in modern society where the process of play is interrupted or impaired. In effect, to modify the journalist Richard Louv’s well known phrase regarding children and nature, modern developed societies are characterised by a ‘play deficit disorder’ (Louv, R. 2008 Last Child in the Woods: Saving our Children from nature-deficit Disorder. Chapel Hill, NC: Algonquin Books of Chapel Hill).

Playwork rests on the assumption that adults have a responsibility to address this deficit (Brown, F. 2014 Play and Playwork: 101 Stories of Children Playing. Maidenhead: Open University Press). It therefore makes perfect sense to include the Playwork approach as part of the solution to the problem of childhood obesity. All forms of play have benefits and all local authorities should be identifying their areas of weakness so that investment is wisely targeted. Simply by properly co-ordinating the broad ‘play offer’ available across a geographical community area between 1) the ‘fixed equipment’ of parks, 2) the ‘street play’ and Home Zones experiences that a single street of parents can organise with local authority support and 3) the supervised ‘loose-parts’ play that only schools and Adventure Play provider (free access Adventure Playgrounds, not the fee-charging commercial enterprises claiming the same description) can specialise in, would mean that every child has easy access to all the play-based developmental experiences that they need for their health and wellbeing.

Prior to investment in physical features, there should be firstly an investment in training and education for:

- Local authority parks, housing, planning and Health and Safety staff
- Local CCGs and their GPs plus other health providers including school nurses
- All school staff
- Parents (via better information, not training)

Only once the vast majority of people can understand what play is and how it works can there be rational, sensible investment in physical provision in public spaces, schools and other venues.

Play is essentially a smarter way for government departments including the Departments of Health, Culture Media and Sport, and Education to jointly invest increasingly limited amounts of money. Compared with the burden on the NHS and with many other recent child obesity programmes, remarkably little investment is required by play provision per child to achieve a better long term result. This is especially relevant when trying to reach the 15-40% (depending on regional variations) of children with the greatest health and wellbeing needs. Research has already shown that play, especially in combination with
nutrition, movement and physical education can deliver the same or better benefits than sport alone and it can do so for longer each week on average because it happens at every given opportunity (it does not need the constant attendance of an expensively qualified adult in supervisory role), so pound for pound it is efficient for government to invest in play as a key part of a whole child solution. Play is ‘natural’ (not forced upon children who may be unwilling) so there are greater behavioural wellbeing benefits and once the right environment has been created, can be permanently self-sustaining.

Taking a decision to include play as a key component of strategies to combat overweight and obesity and promote health and wellbeing is not enough on its own. All adults involved in school and pre-school settings must be trained in quality play provision (using successful programmes such as that provided by OPAL) risk-benefit assessment and parental engagement. Architects and school builders also require guidance both in the design of new-build or upgrading existing structures. Reversing decades of decline in the delivery of play opportunities and physical education programmes will take time, consultation and a governmental mindset that will recognise the value of bolstering change by the use of pilots and evidence-based research but it will not necessitate the abandonment of a commitment to include sport in health and wellbeing strategies. Rather, the holistic ‘virtuous circle’ of nutrition, play, sport and physical education stands a better chance of overcoming the ills contingent upon overweight and obesity than any of these elements if pursued exclusively.

We recommend

- Professional training and ongoing CPD for all health and education professionals to include a holistic approach to health and wellbeing with equal value given to nutrition, play, physical education and sport
- Review, revision and upgrading of the physical education curriculum so that it is properly appropriate for 21st century needs
- All schools to have a dedicated physical education space together with equipment and specialist teachers
- All early years and primary settings required to have a clear Play Policy supported by a structured improvement and implementation plan
- All school staff/break-time supervisors to be given professional training on the benefits of active play and providing access and opportunity for disabled children
- All local authorities to audit their play space and provision prior to the adoption of a localised Play Strategy
- Training in play to become part of standard teacher training, including use of a baseline gap assessment tool (such as that developed by OPAL)
- DCMS, DfH and DfE to develop a holistic ‘virtuous circle’ approach to health and wellbeing, pooling resources as necessary
- Virtuous circle strategies for child health and wellbeing to be included in the audit process for local authorities.

INDUSTRY: IT’S ROLE IN ENCOURAGING HEALTHY LIFESTYLES INCLUDING ADVERTISING AND PR
The widespread recognition that the UK is in the grip of an entrenched obesity epidemic has meant that its population has been increasingly bombarded with messages to reduce the sugar content of food, tax sugary beverages and reformulate recipes with attention to portion control. The food industry has come under intense scrutiny - in the words of Professor Kelly Brownell 'is the food industry a trustworthy ally or troubling adversary' (Brownell K and Horgen K, 2002, Food Fight: the Inside Story of the Food Industry, America’s obesity crisis, and what we can do about it. Contemporary Books, McGraw-Hill Company) but the answer to this supposedly simple question is both less than easy and decidedly complicated.

Comparisons are frequently drawn between the food and cigarette industries when the possibility of a sugar tax is raised. Speaking on BBC Radio 4 (11th December 2015), Chief Medical Officer, Professor Sally Davies said:

'I think (sugar tax) is a runner. With smoking it took 20 years for the public to believe (a tax) was needed. I think we’re at a tipping point. I think industry is on notice. If it doesn’t deliver, then we’ll have to look at a sugar tax.’

However, the comparison is not straightforward. The food industry does not consist of a small number of companies. It is immense and everybody has to eat. It is vast, powerful and driven by commercial forces aimed at maximising financial profit and hence consumption. It represents a spectrum of stakeholders yet is central to the successful development and implementation of future nutrition and public health programmes to encourage healthy lifestyles. One challenge within the industry is that it is rife with oligopolies – a handful of international companies dominate the market. The task for policy-makers, therefore, is how best to unleash the good forces in these industries.

The link between unhealthy food and non-alcoholic beverage marketing is unequivocal and there is consensus on the need for beneficial change, particularly as an ever increasing number of voluntary agreements are being developed. The industry is endeavouring to position itself as part of the solution to obesity as opposed to the cause but again the picture is complex. Its messaging emphasises devotion to health and wellness and it works assiduously to build influential allies in the field but it also creates conflicts of interest amongst potential critics and finally protects corporate interests. The McKinsey Report (2014, Overcoming obesity: An initial economic analysis. Discussion paper).

In recent months, those pressing for a sugar tax have become increasingly vocal. Chief Medical Officer, Sally Davies states (above) that it may be considered if the food industry fails to ‘deliver’ but the cross party Health Select Committee, chaired by Dr. Sarah Wollaston MP has gone further, advocating in a recent report, the imposition of such a tax amidst a range of ‘bold and urgent’ measures to tackle child obesity. Campaigning chef, Jamie Oliver also supports a tax on sugary drinks, ‘the single most important change that could be made.’

Pressure is being exerted upon the Government by a mix of professional bodies and charities in the form of a letter urging the Prime Minister to impose a sugar tax. The letter has been signed by 15 professional and charities including Action on Sugar, the Royal College of Paediatrics and Child Health and the National Obesity Forum. It states: ‘The
Government has a unique opportunity to produce a coherent, structured evidence-based plan to prevent obesity, type 2 diabetes and tooth decay – conditions which are preventable if the food environment is changed. Current policies are ineffective and we urgently require policies that work. Sugar tax must be put back on the table before it’s too late.’ (The Daily Mail, 22nd January 2016).

Other organisations including the Children’s Food Trust have adopted a nuanced approach, citing evidence-based research to argue that using price to make junk food less appealing to the consumer and healthier choices easier beyond the school environment could play a role in improving children’s diet (Mylon et al, 2012: Taxing unhealthy food and drinks to improve health http://www.childrensfoodtrust.org.uk/childrens-food-trust/our-research/). The Trust suggests that government should consider trialling a sugary drinks tax.

At the time of writing, the Government’s own stance on the viability of a sugar tax may be shifting and it may yet be included in some form in the imminent National Obesity Framework:

‘A tax on sugary drinks is being considered by ministers in a u-turn after evidence showed that the measure would help to tackle the obesity crisis.....one Whitehall source said: ‘We want to learn the lessons from examples such as the sugary drinks tax in Mexico. This does not mean a tax on sugar - your bag of Tate & Lyle isn’t about to become more expensive. And there are still lots of arguments against. But we have not ruled anything out and no decisions have been made.’ (The Times, 7th January 2016)

Perhaps predictably, food industry representatives are unconvinced. Ian Wright, Director General of the Food and Drink Federation considers the Health Select Committee report on Child Obesity to be ‘disappointing’ and has alleged that the proposed tax would penalise the consumer:

‘No-one seems to have considered the hard-pressed consumers in all this. Consumers already pay billions in VAT on food and drink. As a result of the arbitrary new tax recommended by the committee, which, if introduced would inevitable be increased year-on-year and extend to other foods, would leave consumers paying significantly more, every week, for the products they love.’ (BBC Online 30th November 2015).

Writing in the Financial Times (7th December 2015) Gavin Partington, Director General of the British Soft Drinks Association takes issue with the paper’s stated editorial opinion (3rd December 2015) that the case for a British sugar tax is ‘compelling’. He is not persuaded by the figures:

‘The UK tax campaigners claim it would cut four calories a day from the average UK diet, which hardly seems likely to have an impact on levels of obesity. Soft drinks contribute just 3 per cent of calories in the average UK diet and consumption of regular soft drinks in the UK is already falling fast – down by more than 20 per cent between 2010 and 2013. Consumers are choosing instead the low or no-calorie varieties which our industry is producing and promoting.’
He argues that product reformulation and portion size reduction as featured in the McKinsey Global Institute report are ‘far more effective in reducing calorie intake than a sugar tax.’ The All Party Group on a Fit and Healthy Childhood agrees with the Children’s Food Trust that government should proceed via commissioned evidence-based research and studying the outcomes of selected localised trials/pilots (such as the new ‘NHS sugar tax’) before deciding whether to impose a UK–wide tax on sugary drinks. It is also important to research further into sugar substitutes/sweeteners and alongside ongoing discussions of sugar taxes it would be prudent to consider supporting consumer choice by subsidising healthy food. There are, in any case, other measures that are being proposed as part of the solution to the child obesity epidemic. A Commons Early Day Motion (782, Sugar Labelling In Spoonfuls In Food And Drinks) notes that:

‘The maximum amount of added sugar the World Health Organisation recommends per day is six teaspoonfuls for women and nine for men’ and ‘calls on the Government to support food and drink labelling that expresses added sugar in teaspoonfuls, and to restrict the advertising of high sugar products as low fat products.’

A further initiative has been launched by Change4Life and Public Health England (PHE) in the form of a free smartphone app; a device that enables people to scan product barcodes to reveal the sugar content both in grams and sugar cubes. The move has been backed by companies Weetabix, Flora, New York Bagels and Aldi, Tesco, The Co-operative Food, Asda, Tesco and Morrison’s are amongst UK supermarkets that have also expressed support.

The British Society of Paediatric Dentistry is amongst organisations contending that the present ‘traffic light’ system of food labelling is confusing due to the number of grams being utilised as a measurement tool. It advocates the teaspoon method of labelling as a clearer way for individuals to note (and make purchasing choices in accordance) how much sugar is present in many items with ‘hidden sugars’ such as fruit juices and other items penned as ‘healthy foods’. A dual win would then be possible; combating obesity whilst at the same time reducing the incidence of dental caries. However, there is also a school of thought contending that the jury is still out on traffic lights; that when these are prominent, consumers do understand them and that even to assess whether they are effective or not is extremely difficult because they had not been fully implemented in a consistent way. The interest of supermarkets in the scheme has been largely diluted by a lack of enthusiasm by producers. Whilst this is the case, the impasse seems set to remain.

The UK has developed a new voluntary front-of-pack nutrition labelling scheme and it is encouraging that food companies (accounting for two thirds of food on sale in the UK) have signed up. One in three meals sold on the UK high street now display calorie labelling but there is room for improvement and evaluation is variable. The messages themselves can be misleading e.g. a claim that there is less than 1% fat on a high sugar product like sweets where fat was never a significant component. Calorie values should also been printed clearly on the containers of alcoholic beverages including alcopops and there is a pressing need for a comprehensive public education campaign. Smoothies, for example, have a healthy image; what is not so widely known is that they also contain high calories levels. Other measures such as calorie labelling in restaurant menus (successful in the US) could be adopted more actively in the UK, but again, the matter is less than straightforward. Many
labels are difficult for the customer to notice and in some cases well-nigh impossible to read! Labelling can be unhelpful because some products give sugar levels per portion size while others print levels according to the total size of the pack. Adopting the spoonful alternative might provide more clarity and have the potential to assist the consumer in making healthier purchases.

McKinsey’s contention that reducing portion size would have a significant impact upon obesity levels is echoed by a Cochrane review (2015 Portion, package or tableware size for changing selection and consumption of food, alcohol and tobacco, September 15th 2015 http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD011045.pub2/abstract):

‘The evidence is compelling that actions to reduce the size, availability and appeal of large servings can make a difference to the amounts people eat and drink... hopefully these findings provide fresh impetus for discussions on how this can be achieved in a range of public sector ad commercial settings.’

The ubiquity of large portions may also thwart the body’s ability to regulate and this especially applies to food eaten away from home where calorie intake can be greater, based on the perverse logic that the food has been paid for, it represents good value for money because of its generous size – so therefore eat everything! However, this type of ‘reasoning’ is not easily dislodged. More research is needed regarding the size, appeal and availability of larger-sized portions alongside further work investigating the sizes of crockery, cutlery and glasses.

Whilst these are some initiatives that have been suggested as tools to combat overweight and obesity, there is no simple road map for delivering potential change levers for healthy food choice/lifestyle. Self-regulation and political involvement is desirable but companies may also require a clear pull from consumers, creating the opportunities for competitive advantage based on healthy food choice. For the food industry, rising obesity rates present a health conundrum. Companies have a duty to their shareholders to make money (and many unhealthy products are very profitable) but they do not wish to attract opprobrium from causing obesity. Yet even as they develop nutritious products, the persistent marketing of fizzy drinks and crisps continues.

In a Com Res poll of more than 1,000 parents for The Children’s Food Trust (2012) the advertising and marketing of less healthy foods to children was one of the key points explored with parents. 65% said that they would support a 9pm watershed on the advertising of junk food before 9pm. Research by Ofcom found that television advertising has a modest direct effect on children’s food preferences, consumption and behaviour, and that indirect effects are likely to be larger (Ofcom, 2006, Television Advertising of Food and Drink products to Children: Options for new restrictions: A consultation, para 1.8). Yet research by Newcastle University has highlighted that existing regulations banning advertising of foods high in fat, sugar and salt during children’s television programming have failed to have the desired effect (Adams J., Tyrrell R., Adamson, AJ., White M. 2012 Effect of Restrictions on Television Food Advertising to Children on Exposure to Advertisements for ‘Less Healthy Foods’: Repeat Cross Sectional Study, Plos one http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0031578).
In the UK, there is no junk food advertising on channels aimed at children but no policing of adverts during Coronation Street and The X Factor, for example. Neither do the current regulations include evening viewing by children around sporting events.

Meanwhile, the ever-burgeoning use of the internet by children has prompted concern at the lack of legislation governing advertising of foods high in fat, sugar and salt to children online (British Heart Foundation, 2011 The 21st century gingerbread house. How companies are marketing junk food for children online) amid research showing that the boundaries between advertising and other content may be more difficult for children to distinguish online (University of Strathclyde, 2003. Review of research on the effects of food promotion to children). Action on Sugar and The Campaign for Action on Salt Health are two of the organisations that continue to highlight confusing claims made by products marketed for children (Consensus Action on Salt and Health, 2015. Parents Being Misled into Buying So Called ‘Fruit Snacks’ Not Permitted in Schools http://www.actiononsalt.org.uk/actiononsugar/Press%20Release%20/156530.html).

With the role of advertising in urgent need of further scrutiny, The Academy of Medical Royal Colleges has recognised that global marketing needs to be regulated and has supported the Australian Sydney principles (International Association for the Study of Obesity, 2007, The Sydney Principles http://www.iaso.org/iotf/obesity/childhoodobesity/sydneyprinciples) for achieving a substantial level of protection for children against the commercial promotion of foods and beverages.

Their 7 robust principles by which regulation should be assessed include:

- 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 inefficient
- Take a wide definition of commercial promotions
- Guarantee commercial-free childhood settings, such as school and children’s centres
- Include cross-border media such as the internet
- Be evaluated, monitored and enforced to ensure that it is effective.

Children have a right to grow up free from commercial pressures to buy or pester for unhealthy food choices with little or no understanding of the future detrimental consequences for their health. Marketing is being used to exploit children’s basic needs and sadly, unless action is taken, they will remain in the front line.

Food companies invest considerable resources in devising elaborate public relations campaigns to improve their image and pro-active public relations strategies are used to create a dialogue with the consumer, highlighting brand and frequently underlined by celebrity endorsement. The approach diverts criticism, interacts with the media and disseminates messages. It may also be used to convince the consumer that their product promotes health even when it clearly does not!
PR companies are endeavouring to change the image of industries fighting regulatory control related to obesity. In 2007, the Health Ministers of 52 European Nations convened in Istanbul and agreed to ban the marketing of junk food to children. This has yet to be achieved and it was only in May 2012 that Chile became the first nation to ban junk food marketing to children (Lustig R., 2014 Fat Chance: The hidden truth about sugar, obesity and disease. Fourth Estate. London). Fast food companies are becoming increasingly linked with sports to counter-balance an unhealthy image and evidence from systematic reviews looking at the relation of sugar-sweetened beverages with weight gain or obesity was ‘five times more likely to present conclusions of no positive association’ if the research had been funded by industry (Gornall J., 2015 Sugar’s web of influence: biasing the science. British Medical Journal; 350:h215).

Whilst there is no room for complacency for the food industry in the fight against overweight and obesity, The UK Responsibility Deal represents a step forward with regard to calorie reduction. Food labelling, portion control, advertising and PR are key areas in the Deal. According to Public Health England, some of the approaches deployed by the food industry to reduce calories under the Government’s deal include:

- Activity to inform and educate: consumer-friendly websites promoting healthy lifestyle
- Reformulation: recipe changes to reduce calories whilst maintaining product quality and appeal
- Portion sizes: new smaller pack sizes and formats, increased use of re-sealable packages
- Development of lower calorie options – voluntary calorie caps
- Encouraging consumers to choose healthier options, influencing the type of advertising spend

Since 2011, over 70% of the fast food outlets and takeaway meals sold have calories clearly labelled. Many companies have signed up to the calorie reduction pledge including Coca-Cola, Mondelez International (formally Kraft Foods UK) and Nestle and Professor Susan Jebb has highlighted the positive actions of some committed Responsibility Deal partners including:

- Subway: serving 2.5 million customers every week with calorie featuring menu boards
- Morrison’s: delivered a calorie reduction of 35% in own brand products by removing saturated fat
- The Co-op: removed 1.5 billion calories by taking added sugar out of its own brand fruit juices
- Waitrose: reformulated their Good-to-Go range with 5000 lower calories
- AG Barr: pledged to reduce the average calorific content per 100ml of their drinks portfolio by 5%by 2016
- Britvic: pledged to increase their packaging mix to include smaller sizes and a new range J20 in 250ml slim-line cans.
The Responsibility Deal serves a purpose because at the very least, it does put companies under pressure to consider future food policy and reformulation but, as an initiative of the former Coalition Government, there are some signs that it may be losing an element of momentum with a decrease in the number of businesses signing up. However, big name companies are taking (and building upon) some major initiatives, including Tesco and ASDA. In 2015, Tesco removed 2 billion calories from its juices and 600 million calories from its Finest and Everyday Value ranges. On 11\textsuperscript{th} December 2015, the company announced an intention to roll out sugar reduction targets to its own-label suppliers in new categories of food and drink in early 2016, following earlier success in healthier reformulation of children’s soft drinks. ASDA too, has made significant progress along this pathway. In January 2015, the company announced a new voluntary commitment to reduce the added sugar in a wide range of soft drinks by 22\%, equating to 814 tonnes of sugar and 3.25 billion calories removed from the food chain each year. This commitment was fully realised in May 2015 and the sugar reduction activity has been stepped up in a range of other products, including cooking sauces, juice drinks, yoghurt drinks and breakfast cereals; removing more than 290 tonnes of sugar from own-label cereals. The company has developed its thinking further and now advocates UK-wide sugar reduction targets:

‘We believe that this significant contribution from industry, which is in line with recent recommendation from Public Health England and the UK Health Select Committee would deliver the required pace and scale of product reformulation to reduce the UK’s sugar intake and help to improve public health’ (Alan Edwards, Senior Director; Public Affairs and Corporate Responsibility, ASDA, 4\textsuperscript{th} December 2015).

ASDA remains aware that the proposed targets will only deliver beneficial change if they win support from a significant number of businesses and hopes that by going public itself, others will be encouraged to follow suit. The British Retail Consortium (BRC) has gone a stage further, advocating mandatory rather than voluntary measures:

‘The BRC’s Andrew Opie said: ‘We believe we’ll make the most progress by having targets for reducing sugar from those categories contributing the most to excessive consumption by children, as part of a wider reduction strategy. To be effective, they need to apply to all food companies, which is why they need to be mandatory.... It means we see change across the board and these companies that are more progressive in removing sugar are not penalised.’ (The Daily Mail, 4\textsuperscript{th} January, 2016)

Waitrose has also shown proven commitment to reduce the sugar content of its products. To date, a total of seven tonnes of sugar have been removed from chilled juices and 14.6 tonnes removed from own label yoghurts. In addition, the company has reduced the sugar content of undiluted juices, cordials and squashes by between five and 15\% without the use of sweeteners and by 10 and 30 \% for fizzy drinks. In January 2016, Waitrose announced new plans to reduce sugar in its range of breakfast cereals during 2016 by stripping out more than 7.5 million calories (nearly two tonnes) in the coming year. The commitment will involve a 15\% sugar reduction in cornflakes and significant sugar reduction in other popular products including honey nut cornflakes and choco pops. These further measures mean that by the end of 2016, Waitrose will have removed nearly 25 tonnes of sugar from its own label products across a variety of product categories. Waitrose will combine the on-going
sugar reduction programme with plans to add healthier ingredients which have nutritional
benefits into the own label range such as wholegrains, vegetables and fruit.

In March 2015, the Responsibility Deal had a total of 800 partners signing up across 43
pledges. Billions of calories have been removed from soft drinks, lower sugar cereals are on
the shelves and no-sugar drinks are being served as the default in leading cinema chains
plus the appearance of guilt-free checkouts. However, frustration remains that not
everybody has signed up and that a fully co-ordinated response from industry may work
better (Gornall J., 2015 Sugar’s web of influence. Why the responsibility deal is a ‘dead duck’

Beneficial change has not matched the optimism of predictions and many in the public
health sector view the idea that the food industry can police itself with scepticism; noting
that progress has been patchy and piecemeal. Doubts will continue unabated as long as
some companies stubbornly insist on bucking the health and wellbeing trend – epitomised
perhaps by WH Smith, a company that has achieved its first increase in checkout receipts for
six years by the sales of snacks at airports and railway stations. Their confectionary special
offers are actively encouraged by till staff and Dunkin Donut machines are now in many of
their shops.

Food promotions like those adopted by WH Smith can have a malign effect on health and
wellbeing goals. Many such ‘offers’ are weighted towards high sugar, high fat choices and
Dr Alison Tedstone of Public Health England regards the need to address this issue to be a
higher priority than formulating and imposing a sugar tax (Public Health England, 2015
Sugar Reduction: the evidence for action. Department of Health. UK). The ploy of increasing
pack size and buy-one-get-one-free offers which usually involve a discreet price rise, tends
to reduce the bargain but not the extra calories! There is also the challenge of under-sizing
where the nutritional information on a ‘typical’ portion is open to misinterpretation and in
addition, the persistent positioning of fast food outlets near schools, children’s play areas,
sports facilities, museums and even hospitals needs immediate action. There is also
considerable concern from the public health sector about the strong ties and influences that
Big Food companies have on national governments. However, it remains true that that
engagement is still viewed as part of the solution in tackling rising obesity rates.

The physical activity and health industry has itself an important part to play in promoting
healthy lifestyles although more needs to be done to combat the growing number of health
and wellbeing issues affecting children and young people. One way forward is for
organisations to partner with schools, thus assisting with investment in much-needed
resources and funding for health and wellbeing initiatives. Nuffield Health holds
partnerships with over 20 schools and colleges across the country and this involves working
with schools to create first-class fitness facilities and health services that are not only
available to pupils and staff throughout the school day but accessible to the local
community in the evening and at weekends. The self-sustaining facilities afford young
people ready access to opportunities that may not otherwise be available to them and the
school benefits from the support and advice of the Nuffield Health experts who can assist
with talks and lessons on how to lead healthier lifestyles. An industry partnership to
encourage healthier lifestyles can also take the form of two organisations working in
tandem. Nuffield Health has partnered with the Amateur Swimming Association (ASAS) in order to boost swimming numbers amongst children and young people and have reached their pledge for 2015 of helping to teach 10,000 children to swim through the ASA Learn to Swim programme at Nuffield sites.

The industry in general can be seen to portray a misleading image of what may constitute as ‘healthy’, especially in relation to body image. Sport England’s excellent ‘This Girl Can’ campaign is an example of a more positive message championing women of all ages that have taken up exercise. Nuffield Health’s own ‘small victories’ initiative was also successful in encouraging people to make small but positive lifestyle changes that can make a big difference. However, there remains much more to do. Using different platforms including more positive health and wellbeing messaging on social media could be a way of countering negativity and contributing to beneficial change.

Overall, industry, whether food, physical activity and health or advertising and public relations has a responsibility to help customers make healthy choices. The food industry is not a monolith and should never be considered as all good or all bad. By eliminating misleading labelling, reducing portion size and controlling false health claims that are specifically designed to hoodwink customers, it can build trust and advance the future health of the population – alongside complementary action from other industries and a mix of appropriate voluntary and statutory measures undertaken by government.

In 2011, UN Secretary General Ban Ki-Moon called for a collectivist approach towards achieving health and wellbeing goals:

‘I especially call on corporations that profit from selling processed foods to children to act with the utmost integrity. I refer not only to food manufacturers, but also to the media, marketing and advertising companies that play central roles in these enterprises’ (2011, Remarks to the General Assembly meeting on the prevention and control of non-communicable disease. Geneva).

The organisation WHO, recognising the global nature of the food companies in particular, has stated that international collaboration is vital (WHO, 2015 Interim Report of the omission on Ending Childhood Obesity. Geneva). However, those who are searching for a single solution to the problems of overweight and obesity (such as a fiscal measure) are likely to be disappointed. The agenda is vast and obesity is clearly in the ‘hard-to-do’ box.

In the words of The Royal College of Physicians:

‘To tackle these problems in the future, there needs to be strong regulatory framework and concerted action across government and industry to work on the prevention of health harms arising from obesity and poor diet.’(The Royal College of Physicians, 2015 Press Release 17th July. Welcome for the SACN Report).

As Liverpool councillor, Richard Kemp puts it:
‘...if we have a city of people that waddle, we will have a city of people that dies early.’ (BBC, 2015 28th October).

Whatever approach (or rather, combination of approaches) is used, one thing is therefore certain. Failure is not an option.

**We recommend**

- Government to deploy UK representative trials and pilots (such as the new ‘NHS sugar tax’) and publish the results before taking any decision about the imposition of a tax on sugary drinks
- Government to open discussions with the food and drink industry about the adoption of ambitious UK sugar reduction targets as have already been delivered successfully on salt
- Local authorities to encourage restaurants and fast food outlets to adopt a system of calorie labelling for their products and menus
- Government to replace ‘traffic light’ food labelling with a new system prioritising consistency, readability and clarity; launched by means of a national public education campaign
- Sugar content to be measured in spoonfuls rather than grams on all food labels
- Government to commission research into portion size and impact of tableware, cutlery, cups and glasses in encouraging people to eat more in settings outside the home
- National review/revision of screen advertising regulations to include the internet; no junk food to be advertised on any channel before 9pm watershed
- Government to adopt the Sydney principles in order to protect children against the aggressive commercial promotion of foods and beverages
- Government to explore ways of forming positive partnerships with industry on a health and wellbeing agenda, prioritising international co-operation, collaboration and coherence
- National audit of the Responsibility Deal; Government and industry to work together to increase uptake, publishing examples of best practice
- Local authorities to re-visit planning policies, discouraging the placement of fast food outlets in the vicinity of schools, hospitals children’s play areas and ‘family’ venues such as museums
- Physical activity and health industries to explore partnership working on health and wellbeing issues with schools nationwide
- Government to explore ways of promoting healthy body image messages using positive advertising and methods such as the ‘This Girl Can’ campaign.

**TRADITIONAL AND SOCIAL MEDIA: THEIR ROLE IN ENCOURAGING HEALTHY LIFESTYLES**

Traditional media influences people’s beliefs and patterns of behaviour. Mass media has a far-reaching impact upon social learning/comparison, the translation of social norms and plays direct and indirect roles in the formation of identity. A relatively new development is
that traditional media communication channels (including print, radio and TV) are increasingly acquiring digital and social counterparts and a recent survey found that 72% of adults now consume news brand and/or magazine content via PCs and mobile devices (National Readership Survey, 2015. Print and Digital: News brands and Magazines, http://www.nrs.co.uk/latest-results/facts-and-figures/market-total/). These formats allow audiences to access, engage with and create news content (e.g. through comment sections and sharing). Media distribution within the Web where content can easily be generated by users offers both opportunities and challenges for collective health intelligence and communication (Kamel Boulos, M.N. & Wheeler, S. 2007. The emerging web 2.0. social software: an enabling suite of sociable technologies in health and health care education 1. Health Information & Libraries Journal, 24(1), 2-23).

Whilst mass media campaigns have impressive potential for changing health behaviour, through prompting public discussion and calling for policy change; day-to-day reporting styles related to health issues have caused controversy. For example, exposure to mass media depictions of health-related ideals (such as being thin and/or muscular) has been linked with body image disturbances (Grabe, S., Ward, L. M., & Hyde, J. S., 2008. The role of the media in body image concerns among women: a meta-analysis of experimental and correlational studies. Psychological bulletin, 134(3), 460). Meanwhile, pictures of overweight or obese children and adults accompanying news stories are significantly more likely to have heads cut out of the frame, leaving shots of abdomens and lower bodies in isolation. Overweight or obese people are also likely to be shown in the act of eating or drinking (Huer, C. A., McClure, K. J., & Puhl, R. M. 2011. Obesity stigma in online news: a visual content analysis. Journal of health communications, 16(9), 976-987). They are less likely to be seen wearing professional or well-fitting clothes in the pictures and are likelier to be engaging in sedentary behaviour than people depicted who are not overweight (Puhl, R.M., Peterson, J. L., DePierre, J. A., & Luedicke, J. 2013 Headless, hungry and unhealthy; a video content analysis of obese persons portrayed in online news. Journal of health communication, 18(6), 686-702).

Exposure to stereotypical images and over-representation of ethnic minorities increases negative public perceptions, to include increased ratings of laziness, social distance and dislike of overweight or obese people and the danger of reinforcing prejudice and discrimination has implications for short and long term damage to the psychological health of overweight individuals. This sets a negative pattern, leading to barriers to dietary change and lasting residual distress and low self esteem post weight loss (Levy, B. R., & Pilver, C. E., 2012. Residual stigma: Psychological distress among the formerly overweight. Social Science & Medicine, 75(2), 297-299). Reducing weight stigmatisation and discrimination in society has been identified as a route to mediate the severity of depressive symptoms in overweight individuals and their consequent association with adverse health outcomes including further weight gain (Konttinen, H., Kiviruusu, O., Huure, Y., Haukkala, A., Aro, H., & Mattunen, M. 2014. Longitudinal associations between depressive symptoms and bodily mass index in a 20-year follow up. International Journal of obesity, 38(5), 668-674).

There is an increased role for social media in matters of weight management. A growing number of young children use the internet at home (Ofcom, 2009. UK children’s media literacy. 2009 interim report, http://stakeholders.ofcom.org.uk/binaries/research/media-
and many young people access it throughout the day using mobile devices (Office for National Statistics, August 6th 2015. Internet Access - Households and Individuals, 2015h [http://www.ons.gov.uk/ons/rel/rdit2/internet-access---households-and-individuals/2015/stb-ia-2015.html]). Blogging and vlogging has soared in popularity; approximately 6 million parents are users on Facebook and younger generations regularly interact online. It is therefore important to examine the role that social media platforms play in cascading health messages; particularly as health-related information is one of the most popular search terms on the internet (Fox, S. 2011. The Social Life of Health Information. Pew Research Centre). A recent Mumsnet campaign for NHS support for miscarriage is a powerful example of combined shared experience shaping health policy (Griffiths, F., Dobermann, T., Cave. J.A., Thorogood, M., Johnson, S., Salamatian, K., & Goudge, J. 2025 The impact of online social networks on health and health systems: a scoping review and case studies. Policy & Internet).

However communication must be approached with care. Despite the proliferation of bloggers/vloggers, the health messages they give may not be evidence-based. Also, despite the rise in social media applications, very few studies have quantified the efficacy of these as a tool for weight management (Chang T et al, 2013, The role of social media in weight management: systematic review. J Med Internet Res 15(11):e262). The participation of physicians, health professionals, thought leaders and academic experts is an excellent opportunity for communicating evidence-based health information but the media space is becoming increasingly crowded. A programme of public education about how to find, and when to trust, health information (particularly on high-participation topics such as diet and physical activity) would potentially safeguard online users from making poor health decisions.

Social mediums have the potential to play a role in active discussion and health empowerment. They are increasingly used within integrated health interventions because they are low-cost and accessible (Dahl, A.A., Hales, S. B. 7 Turner-McGrievy, G. M. 2016. integrating social media into weight loss interventions. Current Opinion in Psychology, 9, 11-15 {ePub ahead of print}).

However, there is scope for more to be done. Other work, collecting information from 1110 tweets showed that few government or educational tweeters were disseminating information about childhood obesity (Harris J.K.et al. 2014 Communication about childhood obesity on Twitter. Am J Public Health 104(7):e62-9). A recent quantitative analysis of selected weight-related media posts on Twitter and Facebook (Chou et al, 2014 Obesity in social media: a mixed methods analysis. Transl Behav Med4 (3):314-23) produced disappointing findings. These platforms are predominantly characterised by derogatory, prejudicial attitudes towards obese and overweight people (blog and forum comments were more nuanced). It is therefore important that mass media prioritise directing the public attention towards content promoting positive change, such as online support groups, networking and blogs in order to disrupt media ‘spirals’ which contribute selective and detrimental messages to the cultural obesity identity (Slater, M. D. 2007, Reinforcing spirals; The mutual influence of media selectivity and media effects and their impact on individual behaviour and social identity. Communication Theory, 17(3), 281-303).
Mass media communications combined with health-product distribution (e.g. promotions and free samples) have good potential for promoting healthy behaviours, especially if they are community-based (Robinson M. N., Tansil, K. A. Elder, R. W., Soler, R.E., Labre, M. P., Mercer, S. L. & Community Preventive Service Task Force, 2014. Mass media health communication campaigns combined with health-related product distribution: a community guide systematic review. American journal of preventive medicine, 47(3). 360-371). Social media may be useful to regenerate interest in such schemes, and afford opportunities for participation within specific geographical areas, for particular demographic groups, or for segmented health behaviour (e.g. diet within a weight management campaign). However, interventions based on social media alone do not yield significant health outcomes and should be accompanied by mass social marketing to increase engagement and prevent information misuse or misunderstanding (Williams G., Hamm, M. P., Shulhan, J., Vandermeer, B., & Hartling, L. 2014. Social media interventions for diet and exercise behaviour; a systematic review and meta-analysis of randomised controlled trials. BMJ open, 4(2), e003926). Also, localised health news releases could be used to improve the quantity and quality of health-promoting information for groups experiencing disparities in health care access such as people living in rural areas.

The role of advertising in social media in the communication of health messages needs scrutiny. Recent years have seen the rise of the social media ‘celebrity’ as well as many celebrities using social media to promote themselves, their products and being paid to endorse products for others. Online celebrity vloggers create videos specifically for the internet and their endorsement of a product, (particularly if the endorser is a young person) may be seen as more reliable and honest than perhaps it is. At present, anybody promoting a brand or giving an endorsement need not state that they have received payment. In the case of traditional media, such as newspapers, many stringent rules apply to paid advertising and the Advertising Standards Agency will not permit untrue claims. Businesses can be fined for false advertisements and their adverts banned. Adverts also have to look like adverts; for example if someone has paid for an ‘advertorial (part advertisement, part editorial), it must be clearly labelled as an advertisement feature. Facebook has strict rules for the advertising and monitoring of posts and such rules should apply across other online advertising.

Whilst traditional media formats are currently preferential avenues of health information and dissemination, social media may be better suited to gauging response and estimating public health changes. It could also be used to collect antecedent data such as health-information engagement patterns, public language use and emotions toward health issues such as obesity to help optimise mass reporting to promote good health behaviours (De Choudhary, M., Counts, S. & Horvitz, E., 2013, May. Social media as a measurement tool of depression in populations. In Proceedings of the 5th Annual ACM Web Science Conference (pp. 47-56). ACM).

Used wisely, social media has a key role to play in encouraging and embedding healthier ways of life. Government nationally and locally has a duty of care to educate the public in the most advantageous use of it.
We recommend

- The media has a responsibility to disrupt body image stereotypes; guidelines for appropriate reporting standards regarding the portrayal of overweight people should be enforced
- Newspapers to monitor incoming stories relating to weight/body image and where possible, add critique from an independent source
- Media formats have segmented purposes: mass media should harness social media for participation and research
- Health campaigns across traditional and social platforms should partner with healthy products to promote the visibility and accessibility of healthy lifestyle solutions
- National awareness campaign to drive the dissemination of evidence-based social media feeds on health and wellbeing led by government, education or health professional bodies
- To support the reporting and removal of social media applications that are deemed inappropriate and potentially harmful to health
- A regulation system for online advertising to be developed similar to that in place for TV advertising
- Government to prepare a public education campaign on the use of social media to increase knowledge about healthy lifestyles.

A FIT AND HEALTHY UNITED KINGDOM: GOVERNMENT FRAMEWORK STRATEGY

Such is the ingrained nature now of the child obesity crisis, which has been allowed to grow almost entirely unchecked over several decades, that the impact of any programmes initiated in 2016/17 will require more than a generation of sustained delivery before the first signs of meaningful improvement are likely.

The current (2011) UK physical activity guidelines for children and young people have been expanded and changes from the previous guidance include:

- Inclusion of vigorous physical activity in recognition of the additional benefits that this can provide; the previous guidelines focused on moderate intense activity
- Emphasis that the 60 minutes a day is a minimum with the addition of the statement ‘and up to several hours each day’
- Frequency of activities to strengthen muscle and bone has increased from two days to at least three days a week
- There is no guideline relating to flexibility
- The addition of a new guideline relating to reducing the amount of sedentary behaviour.

However, despite the fact that the improved guidance has now been in existence for four years little has really changed in the lifestyle of those overweight and inactive children in the greatest need, even with the additional support from the London 2012 legacy–funded
sports programme in schools. Sedentary behaviour has not been effectively addressed in
the home or at school, physical activity levels remains stubbornly poor for a large
percentage of children, physical fitness and literacy is on average far worse than ever
before, dissemination of good practice in nutrition and food consumption is poor and no
programmes currently exist that reach directly into the daily lives of all children.

In recent years, most government departments have operated in time-honoured style;
delivering their own policies largely in isolation from other departments. Typically they use
only their own funding allocation, even when delivering a programme which is on the
premises of a site predominantly overseen by another department, or even when the
benefits are equally in the interests of another department. However, if the entrenched
obesity crisis is to be addressed with lasting effect, smarter, more cooperative and
collaborative ways of working must be devised. A National Obesity Framework that will
produce a meaningful improvement in child weight statistics and wellbeing, therefore
reducing the future burden on the NHS which must have collaboration rather than
isolationism as its lodestone.

**We recommend**

The All Party Group on A Fit and Healthy Childhood recommends that the Departments of
Health, Education and Culture, Media and Sport should jointly take the National Obesity
Framework Lead Role as a fully resourced ‘taskforce’ with sufficient authority, expertise,
funding and crucially, the full and continued backing from the Prime Minister and the
Secretary of State for Health (who have both already committed themselves to this
initiative) to deliver greater child health, fitness and wellbeing over and above all other
government programmes which are known to have a potentially negative impact upon child
health, e.g. transport schemes, housing design etc. The taskforce should be supported as
required by other government departments such as Transport and Communities and Local
Government who might otherwise unintentionally place barriers in the way of safe access to
facilities specifically or largely intended to promote child health (such as new roads,
railways, housing developments, community facilities, policing, child care, etc.).

Above all, its Duty of Care should be to promote the wellbeing and healthy development of
all children inside and outside of the home and ensure that adults entrusted with their care
are equipped with advice and training that is comprehensive, relevant and appropriate.

The taskforce and all other departments must now combine their child obesity-related
health, learning, mental wellbeing and physical activity objectives and budgets in one
holistic whole child programme, overseen by a Cabinet Minister for Children with sufficient
authority to ensure that any and all barriers to programme delivery are removed. It should
target every early years’ and primary school child and the delivery programme should go
hand-in-hand with the recommendations in our preceding reports and be viewed in the light
of a long-term effort rather than a quick fix. If all government departments were to make a
contribution to a joint budget as of now and commencing in April 2016, an effective
programme could begin almost immediately.
Funding streams should be targeted at a generational scale, whole child programme initially. It should focus on play, movement, fitness and nutrition in schools, early years’ settings, local communities and children’s centres from Day 1 but within several years should widen to also cover targeted advice for parents at pre pregnancy/antenatal stages and the programme should then move into those universities who deliver teacher, early years and school design/architect training. The advice and formal guidance programme should include public health (encompassing everything from GP surgeries to prisons and hospitals), food and drink products, policy-makers and anyone else with a direct influence on child health, weight, nutrition and activity. In the same way, it should be a formal requirement that all ‘external’ organisations (e.g. Sport England, Military Ethos https://www.gov.uk/government/news/new-funding-for-military-ethos-projects) working with schools to promote health via physical activity should also cease working in isolation and instead, fully partner and co-ordinate delivery in each school with those other organisations best placed to advise, train and support the new initiatives in school nutrition, fitness and play.

Similarly, as it is known that mental health can be affected to a significant degree by body image, self-confidence, social development/relationships, influenced by daily contact with nature, the All Party Parliamentary Group on a Fit and Healthy Childhood proposes that a significant proportion of the Department of Health’s mental health budget should be targeted at schools, not as another separate and isolated government programme, but as yet another aspect of a combined, holistic whole child wellbeing approach, aimed at benefitting every child according to individual need and whatever their personal circumstances.

In conclusion, in the current debate about the nation’s health, the topic of weight/obesity has dominated discussions and commandeered headlines sometimes on a daily basis. As a consequence, emphasis on the population’s health has focused upon weight to the extent whereby aesthetic issues (such as size) have become conflated with judgements about health and fitness.

The holistic strategy for the Framework that we propose, involving inter-departmental and inter-sector co-operation and collaboration, cascading information and good practices and where required, pooling resources, is designed to help the population to distinguish between what is relevant to health and what represents an unhelpful detour resulting from adverse pressure in society.

It is designed to help everyone, wherever they live and whatever their age, ethnicity, gender or socio-economic status to understand what the words ‘fit’ and ‘healthy’ really mean. A generation ‘lost to obesity’ is moving closer - and unless action is taken in our time, it is the all too likely alternative.

Helen Clark: January 2016