

Terms of reference

The Committee invites written submissions addressing the following two questions:

- What progress has been made with the measures contained in the plan published by the Government in August 2016?
- What should be the priorities for further action by the Government, given its commitment that the August 2016 plan was "the start of a conversation, rather than the final word"?

Introduction

The Royal College of Paediatrics and Child Health (RCPCH) welcomes the opportunity to respond to the Health and Social Care Committee Childhood Obesity Inquiry. Childhood obesity, and the government's approach to tackling it, rightly deserves continued emphasis and scrutiny, however the College would like to highlight the importance of coordinated action and shared learning, noting that there are two consultations currently covering this issue in England, as well as other further consultations across the four nations.

Despite the continued focus, rates of childhood obesity in the UK are not improving and for deprived groups there is evidence of further escalation. Between 2007/08 and 2016/17, the difference between obesity prevalence in the most and least deprived areas has increased from 4.5 to 6.8 percentage points for children in reception year and from 8.5 to 15 percentage points for children in year 6 in England.¹

The causes of obesity in childhood are multifaceted, and must address the obesogenic environment as well as look at genetic and epigenetic factors. Given this, effective obesity prevention requires a coordinated response across a wide range of stakeholders including parents, children, businesses and civil society actors, in addition to government.

Bold, innovative action is required. A lack of evidence for a particular policy/strategy should not be confused with a lack of efficacy. To tackle the obesity crisis we must experiment with testing interventions which exhibit face validity rather than waiting for clear evidence of what works, especially for low risk interventions. Valid actions should be considered, and where appropriate,

¹ NHS Digital. Statistics on Obesity, Physical Activity and Diet - England, 2018 .
<http://digital.nhs.uk/catalogue/PUB30258>

piloted and evaluated robustly.² Conversely, we must learn from research which challenges previously well-accepted approaches to preventing obesity, breaking the cycle of ineffective policy making.³

A recent evaluation of the effectiveness of school and family based healthy lifestyle programmes in the West Midlands found that schools are unlikely to have an impact on childhood obesity in the absence of wider support across multiple sectors.⁴ This highlights the importance of strengthening measures that tackle the obesogenic environment alongside what can be delivered in schools, specifically the availability and promotion of unhealthy foods to children. While the introduction of a sugar levy signals a positive step, the RCPCH believes that meaningful change requires tougher restrictions on advertising of unhealthy products to children and young people alongside a regulatory framework for reformulation. Further detail of the College's vision for tackling childhood obesity is outlined in Part 2 of this response.

Part 1: Progress of current obesity plan

The RCPCH would like to note progress in the following areas of the Childhood Obesity Plan:

Soft drinks levy

The RCPCH welcomes the introduction of the sugar levy, and is pleased to note that an evaluation been commissioned by the National Institute for Health Research through the Centre for Diet and Activity Research which was a recommendation in our 2016 [State of Child Health Report](#).

Sugar reduction

The RCPCH acknowledges that there has been progress with regards to reformulation, however we have called on Public Health England to outline plans for a regulatory framework for reformulation if the current voluntary sugar reformulation programme does not achieve one year target of a 5% reduction. Clear guidance on evaluation of industry reformulation and a specific timetable for implementation should also be published.

Making school food healthier

The RCPCH recommends that food standards are expanded to all schools and early years settings, i.e. making it mandatory for free schools and academies not just government schools. It is only fair that all CYP, regardless of the school they attended, have the same standard of healthy food available to them. Compliance with these standards should be monitored through Ofsted inspections.

² RCPCH. Tackling England's childhood obesity crisis. October 2015.

<https://www.rcpch.ac.uk/system/files/protected/news/Obesity%20Summit%20report%20FINAL.pdf>

³ Wake, M. The failure of anti-obesity programmes in schools BMJ 2018; 360 :k507

<http://www.bmj.com/content/360/bmj.k507>

⁴ Adab Peymane, Pallan Miranda J, Lancashire Emma R, Hemming Karla, Frew Emma, Barrett Tim et al. Effectiveness of a childhood obesity prevention programme delivered through schools, targeting 6 and 7 year olds: cluster randomised controlled trial (WAVES study) BMJ 2018; 360 :k211 <http://www.bmj.com/content/360/bmj.k211>

Food labelling

The RCPCH recommends mandatory food labelling be introduced for all processed foods. Mandatory food labelling will support families to easily compare products and make informed choices. Variation in the type of products labelled, coupled with variation in the way products are labelled only ensures that food choices remain complicated for families. Without mandatory food labelling, there is limited incentive for the food and drink industry to label food products where this may lead to an obvious decline in sales.

Enabling health professionals to support families

The RCPCH acknowledged progress in this area in our [The State of Child Health One Year On report](#), specifically the Public Health England resources to support health professionals in respect of child obesity including:

- a childhood obesity impact pathway
- 'Let's talk about weight' resources
- the 'All our Health' framework for England.

The RCPCH is also committed to strengthening capacity within the paediatric workforce for promoting healthy weight to CYP and families through continuing professional development opportunities at the College.

Part 2: Future priorities

The RCPCH set out several key actions to tackle childhood obesity in our 2017 [State of Child Health Report](#). In our recent follow-up report [The State of Child Health One Year On](#) we have undertaken an audit of actions against these recommendations, and while there has been some progress, significant further action is required.

Ban advertising to children and young people

Government should ban the advertising of foods high in saturated fat, sugar and salt in all broadcast media before 9pm.

Research demonstrates that there is a clear link between the food and drink adverts children see and their food choices and how much they eat. Current rules to restrict exposure to HFSS adverts do not go far enough in protecting children when they watch TV the most, between 6pm and 9pm, as this viewing period does not typically feature children-specific programming. A study by the University of Liverpool found that the majority (59%) of food and drink adverts shown during family viewing time (6pm-9pm) would be banned from children's TV however current restrictions only apply when children are over-represented in the audience, compared to the total viewing population, by 20%. Therefore while 27% of children's viewing takes place during children's TV where HFSS restrictions apply, 49% of children's viewing takes place in adult air time where HFSS restrictions do not apply, peaking between 7pm and 8pm. A 9pm watershed therefore is the most effective way to reduce children's exposure to food and drink marketing.

Reducing proximity of fast food outlets to schools, colleges and other places where children gather

Government should undertake an audit of local authority licensing and catering arrangements with the intention of developing formal recommendations on reducing the proximity of fast food outlets to schools, colleges, leisure centres and other places where children gather.

While the current obesity plan sets goals for making the school environment more health promoting, the wider environment cannot be neglected. An audit of local authority licensing and catering arrangements should be undertaken by government with the intention of developing formal recommendations on reducing the proximity of fast food outlets to schools, colleges, leisure centres and other places where children gather. The proposed ban by the Mayor of London to ban new fast food outlets being built within a 400m radius of schools should be adopted across the UK.

Improving monitoring and identification

Government should extend the National Child Measurement Programme to measure children after birth, before school and during adolescence

Mechanisms must be in place to identify CYP and families who are at risk or who are overweight/obese. This should begin with appropriate monitoring of CYP weight/BMI at regular intervals throughout childhood and adolescence, ensuring timely referral and access to additional services where required.

Infants and pre-school children are likely to be measured on several occasions as part of the Healthy Child Programme, however weight data is rarely captured consistently nor available to the wide range of health professionals who would benefit from seeing a child's full weight trajectory. In many cases, health visitors will record weight information in a child's [personal child health record](#) ('red book') which is not routinely accessed by GPs and other health professionals. The *Healthy Children: A Forward View for Child Health Information* sets out a vision for better digital collection and sharing of child health information. This should present opportunities to strengthen monitoring of childhood obesity at both the population and individual level.⁵ Efforts should be made to ensure data captured through the National Child Measurement Programme can also be accessed by appropriate health professionals, so action can be taken where required.

Furthermore, currently most GPs lack the skills and equipment to weigh and measure children - they lack the correct height measuring instruments and they do not have the IT systems to convert height and weight into a BMI centile necessary to judge if a child is overweight. There is no financial incentive for GPs to measure children – whilst measuring the BMI of an adult has long been an element of the QOF that provides additional payments to GPs. This is clear discrimination against children, and should be a priority for the NHS.

Improving weight management services for CYP

Overweight and obese children must have timely access and support to attend evidence-based programmes, via prescriptions or referrals from GPs.

⁵ <https://www.england.nhs.uk/wp-content/uploads/2016/11/healthy-children-transforming-child-health-info.pdf>

Whilst our majority response to childhood obesity must be prevention, this focus has led to a neglect of treatment of CYP already obese. Those who are significantly or extremely obese will be little helped by prevention efforts – prevention policies and interventions will not make those who are extremely obese become non-obese.

Obesity is a very difficult condition to treat – and this has led to a nihilism i.e. a belief that nothing works therefore nothing should be tried and that all efforts should be focused on prevention. This is an incorrect belief. Some obesity treatments – e.g. bariatric surgery – are extremely effective and cost-effective.

The NICE Guidance Development Group for weight assessment and management clinics (WAMC) recommends that CYP with a BMI greater than the 91st centile be referred to community tier 2 children's services or weight assessment and management clinics, with appropriate staff with expertise in child and adolescent health and development.⁶ Despite this recommendation there appears to be a mismatch between population burden and available data on service use in England, with many more CYP, particularly those from deprived groups, eligible for treatment than receiving it. Reasons for this are likely to be multiple but include a reluctance to seek help by families, lack of expertise among professional and accessibility of services.⁷

Moreover the NICE pathway is not sensible – as a simple analysis of the burden relating to the pathway identifies inconsistencies and illogicalities⁸ This is because the pathway currently is configured as a staged-care model (where an individual sits on a continuum, from an at-risk but asymptomatic state through to a persistent, chronic and unremitting disorder state), whereas a stepped-care model (where the least intensive intervention that is appropriate for a person is typically provided first, and people can step up or down the pathway according to changing needs and in response to treatment) is most sensible for very common problems such as obesity treatment.

There is confusion about whether the tier system commonly used in adult obesity applies to CYP. Whilst there are number of community (tier 2/3 services), there are very few specialist services for CYP obesity that manage and treat CYP with extreme or morbid obesity (equivalent to tier 3/4). Such services have only arisen due to interest and activism by individual professionals, and services exist in a commissioning vacuum – surviving only where individual trusts can 'turn a profit' or individual managers support the service.

About the RCPCH

The College is a UK organisation which comprises over 15,000 members who live in the UK, Ireland and abroad and plays a major role in postgraduate medical education, as well as professional standards.

⁶ Welbourne et al. 2017. Welbourn, R., Hopkins, J., Dixon, J. B., Finer, N., Hughes, C., Viner, R., Wass, J., and on behalf of the Guidance Development Group (2018) Commissioning guidance for weight assessment and management in adults and children with severe complex obesity. *Obesity Reviews*, 19: 14–27. <https://onlinelibrary.wiley.com/doi/full/10.1111/obr.12601>

⁷ Viner RM, Kinra S, Nicholls D, et al Burden of child and adolescent obesity on health services in England *Archives of Disease in Childhood* 2018;103:247-254. <http://adc.bmj.com/content/103/3/247>

⁸ Viner RM, Kinra S, Nicholls D, et al Burden of child and adolescent obesity on health services in England *Archives of Disease in Childhood* 2018;103:247-254. <http://adc.bmj.com/content/103/3/247>

The College's responsibilities include:

- setting syllabuses for postgraduate training in paediatrics
- overseeing postgraduate training in paediatrics
- running postgraduate examinations in paediatrics
- organising courses and conferences on paediatrics
- issuing guidance on paediatrics
- conducting research on paediatrics
- developing policy messages and recommendations to promote better child health outcomes
- service delivery models to ensure better treatment and care for children and young people

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