**The All Party Parliamentary Group on Obesity inquiry**

**Response submitted by the Royal College of Paediatrics and Child Health**

**March 2018**

## 1. Which option best describes your role?

The Royal College of Paediatrics 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.

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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## 2. Do you think that obesity is a disease?

Obesity is a medical condition but not classically a disease. It is associated with major contemporary and future morbidities, psychological and medical.

## 3. In your opinion, what are the barriers to better prevention of obesity?

The WHO Report on Ending Childhood Obesity 2016 emphasised the need for coordinated cross-sectorial action and a strong focus on actions in pregnancy and early life.[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

[1] http://apps.who.int/iris/bitstream/10665/204176/1/9789241510066_eng.pdf

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, 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 (see response to question 4).

**4. In your opinion, what are the barriers to better treatment of obesity?**

The RCPCH identifies the following as barriers to effective treatment of obesity in childhood:

1) Nihilism – a belief that there are no effective treatments
2) Focus on prevention
3) Stigma associated with obesity – leading to professionals not wanting to offer treatment (seeing it as the individual's fault) and individuals not seeking treatment
4) Identification issues – families and even health professionals not having the skills to identify who needs treatment
5) Lack of a useful pathway – the NICE obesity pathway for children lacks clarity and is not a coherent stepped pathway – it needs urgent revision
6) Absence of services to treat child and adolescent obesity – in part due to provider disinterest, in part due to commissioning failure.

**1 & 2) Nihilism and the focus on prevention**

Whilst our majority response to childhood obesity must be prevention, this focus has led to a neglect of treatment of children and young people (CYP) already obese. Those who are significantly or extremely obese will be little helped by prevention

[2] https://www.rcpch.ac.uk/system/files/protected/news/Obesity%20Summit%20report%20FINAL.pdf
[3] http://www.bmj.com/content/360/bmj.k507
[4] http://www.bmj.com/content/360/bmj.k211

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.

**3) Stigma**

Obesity suffers from significant stigma – and it should also be recognised that for health professionals, obesity is a 'low status' area to work in.

In a clinical sense, this also leads to health professionals 'ducking' the issue of obesity when being consulted about obese children for other reasons (e.g. asthma etc). Professionals perceive they lack the skills to have these 'difficult' conversations or perceive that they may cause harm by raising the issue of obesity with CYP and families. This can be particularly challenging where there is intergenerational overweight and obesity.

**4) Identification**

Mechanisms must be in placed 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 though 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

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

QOF that provides additional payments to GPs. This is clear discrimination against children, and should be a priority for the NHS.

### 5) Referral and the NICE pathway

Timely access to evidence-based weight management services are fundamental to early intervention and treatment of obesity in children and young people. 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 illogicalities.[8] 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.

### 6) Absence of higher tier services for children

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.

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[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

5. **What actions and resources are needed to specifically address the rising rates of childhood obesity?**

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.

1. **Her Majesty's Treasury should commission an independent and ongoing evaluation of the soft drinks industry levy.** The RCPCH acknowledges some progress in this area through the soft drink levy which will be implemented in April 2018, with an evaluation commissioned through the Centre for Diet and Activity Research.

2. **Public Health England should outline its plans for a regulatory framework for reformulation if the current voluntary programme does not achieve the targets set. Clear guidance on evaluation of industry reformulation and a specific timetable for implementation should also be published.** RCPCH acknowledges progress made in this area, dependent on the 5% reformulation target being met in March as identified through the PHE evaluation of voluntary reformation (or strong steps being taken by PHE if this target is not met).

3. **Government should ban the advertising of foods high in saturated fat, sugar and salt in all broadcast media before 9pm.** The RCPCH acknowledges no progress in this area. 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.

4. **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.** There has been no Government action in this area. At a devolved level in England, the Mayor of London has proposed a ban on new fast food restaurants being built within 400m of schools across the capital. RCPCH wants this initiative adopted across England and the UK.

5. **Government should extend the mandatory school food standards to all free schools and academies, and to early years settings. Compliance with these standards should be monitored through Ofsted inspections.** The RCPCH acknowledges no progress in this area.

6. **NHS England and professional bodies should ensure that all health care professionals make every contact count by empowering them to have the often difficult conversation with patients about their weight.** The RCPCH acknowledges some progress in this areas by NHS England and PHE.

7. **Government should extend the National Child Measurement Programme to measure children after birth, before school and during adolescence.** The RCPCH acknowledges no progress in this area (see response to Question 4)

In addition to those set out in our State of Child Health Report we also recommend the following actions specific to improving treatment of obesity in CYP:

8. **NHS England with Public Health England should ensure all GPs have the skills, equipment and incentives to weight and measure all children**. Additionally all primary care staff should be equipped to begin difficult conversations about obesity with families, and signpost families to appropriate services.

9. **NICE should examine recommending a stepped-care approach to childhood obesity management from primary through to tertiary care.**[9]

10. **NHS England should commission specialist (tier 3b/4) obesity services for children and young people to deliver highly specialist care, anti-obesity drug therapy and adolescent bariatric surgery**.

**6. What key resources/services would be required to effectively prevent and treat obesity? Please rank them in order.**

- Social prescribing such as use of cookery/nutrition classes - 1
- Dietary advice - 2
- Psychological/mental health support 3
- Specialist support 4
- Pharmacotherapy 5

**7. How does the funding of obesity services affect patient access?**

[9] A **staged-care model** is where an individual sits on a continuum, from an at-risk but asymptomatic state through to a persistent, chronic and unremitting disorder state. A **stepped-care model** allows for the least intensive intervention that is appropriate for a person to be typically provided first, and people can step up or down the pathway according to changing needs and in response to treatment.

The £200 million of public health funding cuts[10] has particularly affected children's services and as a result many local authorities have scaled down or scrapped their children's community weight management programmes over the past 2 years.

As noted previously, there is no attempt to systematically commission clinical services for CYP.

**8. What are the wider consequences of not taking action – i.e. if services remain as they are now, what is the likely impact of this in 5-10 years' time?**

Since the introduction of the National Child Measurement Programme in 2006, there has been little improvement in the number of children at a healthy weight on school entry, and a small increase (2%) in the number of children overweight or obese at Year 6 in England.

The obesity epidemic represents the one of greatest threats to both children and the UKs future.[11] Weight status in childhood is an important predictor of overweight, obesity, health and mortality risk across the lifecourse. It follows, therefore, that the lack of progress to date in reducing childhood obesity will translate to significant additional morbidity and mortality in the future adult population, placing increased social and economic burdens on future generations.

A continued failure to tackle the strong relationship between deprivation and obesity also poses a significant health, social and economic threat. Children living in the most deprived parts of the UK are more likely to be overweight and obese as well as experience a range of other health inequalities such as tooth decay and exposure to tobacco which will undoubtedly culminate in a substantial increased burden of disease in this vulnerable population as they grow.

**9. Are you aware of any services which have an established and successful pathway for a person with obesity? If so, please provide details.**

Successful high tier weight management services for CYP can be found at University College Hospital and at Kings College Hospital, both in London.

[10] https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Autumn_Statement_Kings_Fund_Nov_2016_3.pdf

[11] RCPCH. State of Child Health Report. 2016