



House of Commons
Health and Social Care
Committee

Childhood obesity: Time for action

Eighth Report of Session 2017–19

*Report, together with formal minutes relating
to the report*

*Ordered by the House of Commons
to be printed 23 May 2018*

Health and Social Care Committee

The Health and Social Care Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health & Social Care.

Current membership

[Dr Sarah Wollaston MP](#) (*Conservative, Totnes*) (Chair)

[Luciana Berger MP](#) (*Labour (Co-op), Liverpool, Wavertree*)

[Mr Ben Bradshaw MP](#) (*Labour, Exeter*)

[Dr Lisa Cameron MP](#) (*Scottish National Party, East Kilbride, Strathaven and Lesmahagow*)

[Rosie Cooper MP](#) (*Labour, West Lancashire*)

[Diana Johnson MP](#) (*Labour, Kingston upon Hull North*)

[Johnny Mercer MP](#) (*Conservative, Plymouth, Moor View*)

[Andrew Selous MP](#) (*Conservative, South West Bedfordshire*)

[Derek Thomas MP](#) (*Conservative, St Ives*)

[Martin Vickers MP](#) (*Conservative, Cleethorpes*)

[Dr Paul Williams MP](#) (*Labour, Stockton South*)

The following Members were members of the Committee during the Session

[Dr Caroline Johnson MP](#) (*Conservative, Sleaford and North Hykeham*)

[Maggie Throup MP](#) (*Conservative, Erewash*)

Powers

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the internet via www.parliament.uk.

Publication

Committee reports are published on the Committee's website at www.parliament.uk/hscocom and in print by Order of the House.

Evidence relating to this report is published on the [inquiry publications page](#) of the Committee's website.

Committee staff

The current staff of the Committee are Huw Yardley (Clerk), Seth Roberts (Second Clerk), Laura Daniels (Senior Committee Specialist), Lewis Pickett (Committee Specialist), Juliette Mullin (Clinical Fellow), Cecilia Santi O Desanti (Senior Committee Assistant), Ed Hamill (Committee Assistant), and Alex Paterson (Media Officer).

Contacts

All correspondence should be addressed to the Clerk of the Health and Social Care Committee, House of Commons, London SW1A 0AA. The telephone number for general enquiries is 020 7219 6182; the Committee's email address is hscocom@parliament.uk.

Contents

Summary	3
1 Introduction	5
The problem	5
Our work	7
2 A whole systems approach	9
Local and national government collaboration	11
Political leadership	12
Clear expectations	13
3 Marketing and advertising	15
Broadcast media - the evidence	15
Broadcast media – the solutions	16
Non-broadcast platforms	18
4 Price promotions	19
Product placement	20
5 Early years and schools	22
Early years	22
Measurement	23
Schools	24
6 Takeaways	26
7 Fiscal measures	28
Expansion of the Soft Drinks Industry Levy	28
Use of the revenue from the levy	29
VAT	30
8 Labelling	32
9 Support for children living with obesity	33
Conclusions and recommendations	34
Formal minutes	39
Witnesses	40
Published written evidence	41
List of Reports from the Committee during the current Parliament	43

Summary

Current estimates suggest that nearly a third of children aged 2 to 15 are overweight or obese in the UK and younger generations are becoming obese at earlier ages and staying obese for longer. Obesity rates are highest for children from the most deprived areas and this situation is getting worse. Children aged 5 and from the poorest income groups are twice as likely to be obese compared to their most well-off counterparts and by age 11 they are three times as likely. The case for stronger action on this unacceptable and widening health inequality is compelling.

The Government is expected to publish shortly a refreshed version of the childhood obesity plan first published in summer 2016. This report outlines the following key areas which demand attention as a matter of urgency by the Government before the next chapter of the plan is finalised:

- **A ‘whole systems’ approach**—an effective childhood obesity plan demands a joined-up, ‘whole systems’ approach. Government must change the narrative around childhood obesity, to make it clear that this is everyone’s business. A Cabinet-level committee should be set up which reviews the implementation of the plan, with mandatory reporting across all departments. We call on Government to set clear and ambitious targets for reducing overall levels of childhood obesity and the resulting health inequalities.
- **Marketing and advertising**—We endorse the calls for a 9pm watershed on junk food advertising. The next Government childhood obesity plan should include a ban on brand generated characters or licensed TV and film characters from being used to promote HFSS (high fat, sugar and salt) products on broadcast and non-broadcast media, and Government must align regulations on non-broadcast media with those for broadcast media.
- **Price promotions** —We call on Government to regulate to restrict discounting and price promotions and on removing confectionery and other less healthy foods from the ends of aisles and checkouts which responsible retailers have requested, through statutory measures
- **Early years and schools**—We recommend that the Government should put in place further measures around early years and the first 1000 days of life, including setting targets to improve rates of breastfeeding, to combat childhood obesity, and urge a full and timely implementation of all of the school-centred measures contained in the original 2016 Child Obesity Action Plan.
- **Takeaways**—The Government’s next childhood obesity plan must make it easier for local authorities to limit the proliferation of unhealthy food outlets in their areas. Local authorities also need further powers to limit the prevalence of HFSS food and drink billboard advertising near schools. Health should be made a licensing objective for local authorities.

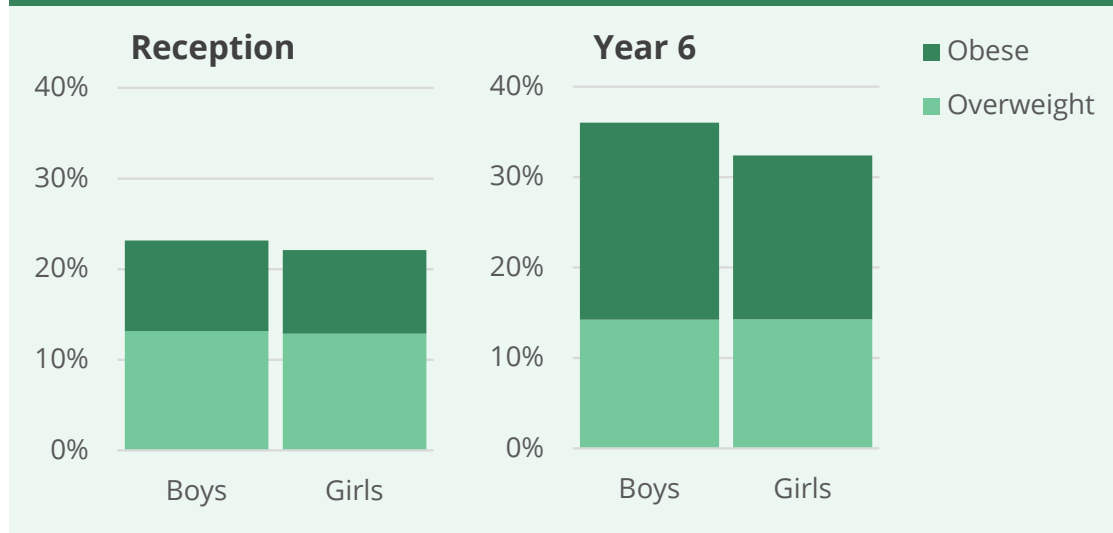
- **Fiscal measures**—We urge the Government to extend the successful soft drinks industry levy to milk-based drinks. The next Government childhood obesity plan must signal that further fiscal measures are being designed to encourage reformulation of products where targets are not being met.
- **Labelling**—Current progress on labelling in the UK is reliant on voluntary commitments and is therefore not universally applied. Calorie labelling at point of food choice for the out-of-home food sector would provide basic information to enable healthier choices.
- **Services for children living with obesity**—The government must ensure there are robust systems in place to not only identify children who are overweight or obese, but to ensure that these children are offered effective help in a multidisciplinary approach, and that service provision extends to their families. Throughout our report, we emphasise the need to focus on ‘healthy lifestyles’ rather than using stigmatising language.

1 Introduction

The problem

1. Current estimates suggest that nearly a third of children aged 2 to 15 in the UK are overweight or obese. These children and young people are becoming obese at an earlier age and staying obese for longer.¹ The personal cost for children living with a lifetime of obesity is immense and they are more than twice as likely to die prematurely as a result.² Obese adults are seven times more likely to develop type 2 diabetes than adults of a healthy weight,³ and are also at greater risk of other health conditions including heart disease, cancer and depression.⁴

AT AGE 4-5, 10% OF BOYS AND 9% OF GIRLS ARE OBESE. THIS RISES TO 22% OF BOYS AND 18% OF GIRLS BY AGE 10-11



House of Commons Library Briefing Paper: Obesity Statistics, Number 3336, published 20 March 2018

2. It was estimated that the NHS in England spent £6.1 billion on overweight and obesity-related ill-health in 2017/18. To put this in context, this is more than the Government spent on the police, fire service and judicial system combined.⁵

3. Childhood obesity is also a leading cause of health inequality. The burden is falling disproportionately on children from low-income backgrounds. Obesity rates are highest for children from the most deprived areas and the inequality gap has widened every year since formal recording began as part of the child measurement programme. Children aged 5 and from the poorest income groups are twice as likely to be obese compared to those in most advantaged decile, and by age 11 they are three times as likely to be obese.⁶

1 [Childhood obesity: a plan for action - GOV.UK](#)

2 [ibid](#)

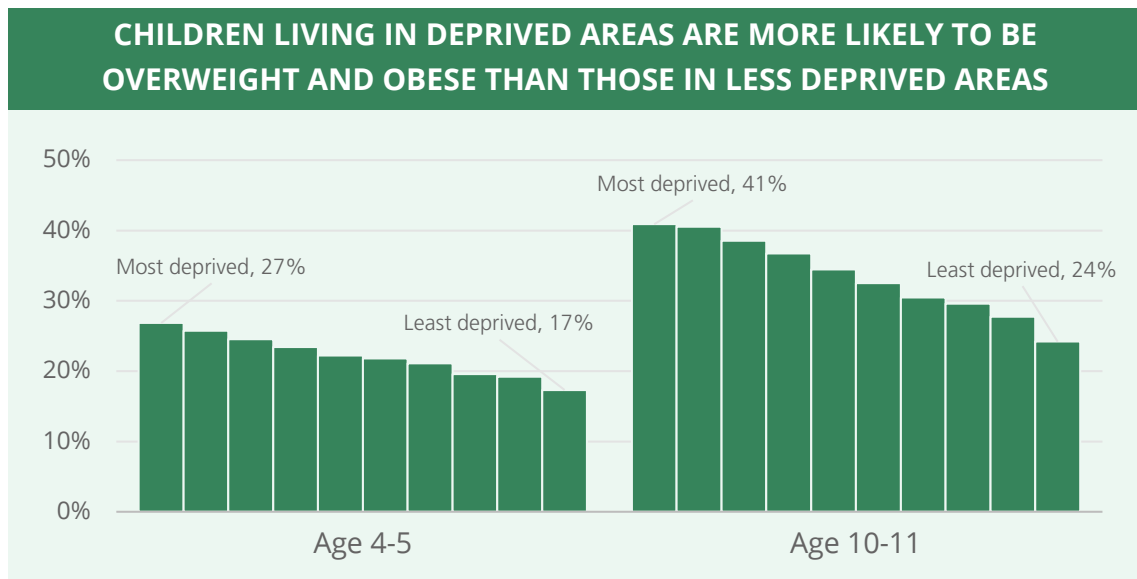
3 [ibid](#)

4 [ibid](#)

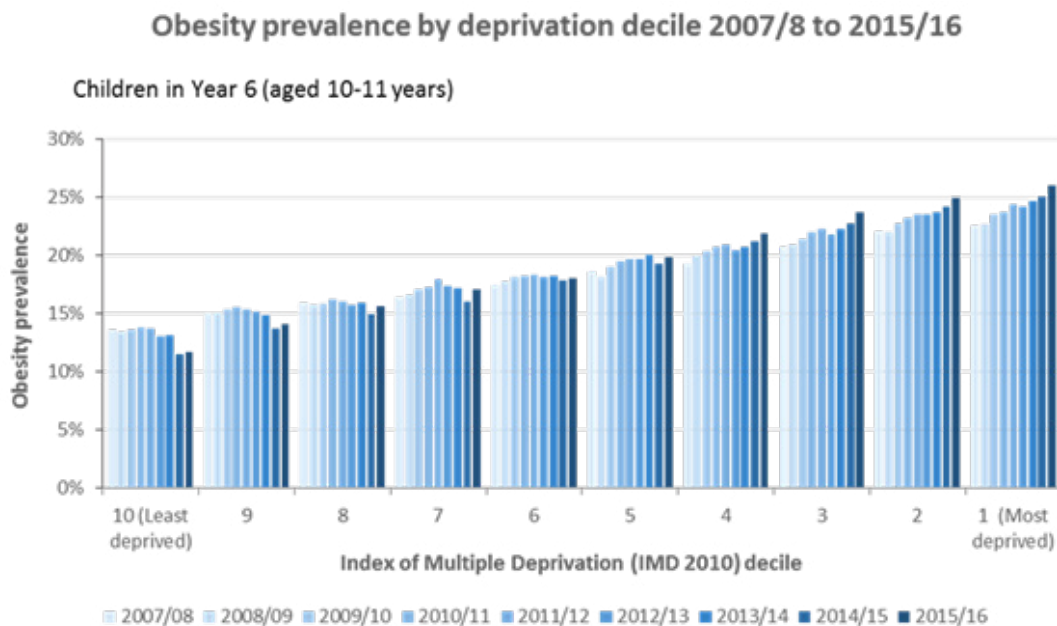
5 [Health matters: obesity and the food environment - GOV.UK](#)

6 [Childhood obesity: a plan for action - GOV.UK](#)

The importance of that point is illustrated starkly by the graphs below, which show the contribution of childhood obesity to health inequality—and the widening gap between those in the most and least deprived areas.⁷



House of Commons Library Briefing Paper: Obesity Statistics, Number 3336, published 20 March 2018



Source: National Child Measurement Programme 2007/08 to 2015/16 data

Child obesity: BMI ≥ 95th centile of the UK90 growth reference

4. The Government’s childhood obesity plan, which had originally been expected in autumn 2015, was eventually published on 16 August 2016. As our predecessor Health Committee observed in their last report on this subject, campaigners on childhood obesity were underwhelmed by its contents and there was widespread concern that the original draft strategy appeared to have been watered down.⁸ Whilst there was a resounding

⁷ House of Commons Library Briefing Paper: Obesity Statistics, Number 3336, published 20 March 2018

⁸ The Secret Plan to Save Fat Britain: Channel 4 Dispatches, 31 Oct 2016

welcome for the sugary drinks levy, evidence to this inquiry has been clear that the next round of the Government's plan needs to be far more comprehensive and to be far bolder if it is to make an effective contribution to tackling childhood obesity and in particular to the unacceptable and widening health inequality which results.⁹

Our work

5. Our predecessor Health Committee conducted a brief inquiry into childhood obesity in September and October 2015. Their report, *Childhood obesity—brave and bold action*, was published in November 2015.¹⁰ Dissatisfied with the Government response to this report, the Committee launched another short inquiry—*Childhood obesity: follow up*—which made recommendations in a variety of areas:¹¹

- Setting clear goals for reducing overall levels of childhood obesity as well as goals for reducing the unacceptable and widening levels of inequality.
- Extending the soft drinks industry levy to milk-based drinks which have extra sugar added.
- Urging the Government to set out the policy proposals which it is prepared to implement if the voluntary reformulation programme does not go as far or as fast as necessary to tackle childhood obesity.
- Regulating to further reduce the impact of deep discounting and price promotions on sales of unhealthy food.
- Re-examination of the case for further restrictions on advertising of high fat, salt and sugar food and drink.
- Change to planning legislation to make it easier for local authorities to limit the proliferation of unhealthy food outlets in their areas, and the inclusion of health as a material consideration in the planning system.

The Government response to the report stated:

The plan marks an important step forward in tackling childhood obesity, but it is not the final word. As part of this ongoing process ... we are continuing our conversations with industry, schools, experts and the public sector on how we can further tackle childhood obesity.¹²

6. In accordance with our predecessor's declared intentions,¹³ we launched a further inquiry into childhood obesity, to evaluate progress since the 2016 childhood obesity plan, and contribute to the "continuing conversations" on childhood obesity.

7. Our inquiry into childhood obesity received over 50 submissions. We heard oral evidence from a range of groups including the food and drink, catering and retail industries, Government, campaign groups, activists and academics. We heard powerful

9 [Jamie Oliver Group \(COY0044\)](#) p.2

10 Health Committee, *Childhood obesity—brave and bold action*, First Report of Session 2015–16, HC465

11 Health Committee, *Childhood obesity: follow-up*, Seventh Report of Session 2016–17, HC928

12 Government Response to the House of Commons Health Select Committee report on *Childhood obesity: Follow-up*, Seventh Report of Session 2016–17, Cm9531

13 Health Committee, *Childhood obesity: follow-up*, Seventh Report of Session 2016–17, HC928

evidence on the personal cost to individuals as well as the wider costs and scale of the problem. We also heard about the work being undertaken in a number of settings to tackle this issue. We travelled to Amsterdam to meet representatives from the Amsterdamse Aanpak Gezond Gewicht (Amsterdam Healthy Weight Programme) and Jongeren Op Gezond Gewicht (Young People at a Healthy Weight) programme and we visited a number of school-based and community programmes across the city. We wanted to understand the measures that have been taken at local and national level that have contributed to their success in tackling childhood obesity and the health inequality gap in recent years. We are grateful to all those who gave us evidence. We would also like to thank the Parliamentary Academic Fellows Dr Oliver Mytton, Honorary Specialty Registrar, UKCRC Centre for Diet and Activity Research, University of Cambridge School of Clinical Medicine, and Thijs van Rens, Associate Professor of Economics, University of Warwick, for their assistance throughout this inquiry, particularly in assessing the available academic evidence on what works in tackling childhood obesity.

8. The Government has indicated that a refresh of the Childhood Obesity: A Plan for Action will be published shortly.¹⁴ We have heard compelling evidence which we hope the Government will take into account before setting out its next steps. This report sets out the key messages we have heard from witnesses during the course of our inquiry. It is necessarily brief, so that we can publish it in time to influence the Government's refreshed plan. We intend to return to the subject following the publication of the plan to assess its adequacy against the weight of the evidence we have heard during this inquiry.

9. In this report we outline a number of key areas which we consider must be included in the next chapter of the plan. All the components are important and excluding any of the elements would make for a less effective plan and, in some cases, miss important opportunities to narrow the gap between the most and least disadvantaged children:

- i) Leadership and a whole-system approach to changing culture and the obesogenic environment
- ii) Marketing and advertising
- iii) Price promotions
- iv) Takeaways and powers for local authorities and communities
- v) Early years, schools and wellbeing
- vi) Taxation and fiscal measures
- vii) Labelling
- viii) Support for children living with obesity

2 A whole systems approach

10. Arguably the most consistent message we heard throughout our inquiry was that implementation of an effective childhood obesity plan demands a holistic, joined-up, ‘whole systems’ approach with clear and effective leadership.¹⁵ This approach needs to encourage joint working between national and local Government, families and communities, third sector groups, schools, healthcare professionals, industry and academia, in order to deliver the results necessary to tackle childhood obesity in England. We need to change the narrative of childhood obesity to being ‘everyone’s business’, rather than just that of the health and social care sector.¹⁶ Leeds Beckett University explained in written evidence:

A whole systems approach corrals expertise and enthusiasm from across all sectors to develop a shared understanding of what causes obesity (locally or nationally), and then to identify points in the system where stakeholders can work collectively to change how the system functions. Such an approach takes time, continued engagement from all stakeholders, and for many, involves a new way of thinking and working.¹⁷

11. The 2007 Foresight Report on Tackling Obesity¹⁸ argued that a wide range of factors affect the distribution and occurrence of obesity across England, and that tackling obesity requires a ‘joined-up’ approach, where each of the various determinants can be addressed in a multi-sectoral manner. So far, however, joined-up working to resolve childhood obesity has been limited.¹⁹

12. In late 2017, the Centre for Social Justice published “Off The Scales: Tackling England’s childhood obesity crisis”,²⁰ a comprehensive report on the state of the nation with regards to childhood obesity, and the actions necessary from Government and other stakeholders in order to address it. In the introduction to this report, the point was made that:

No single sector is fully responsible or will make much difference in isolation from other factors. Only when all key departments and sectors take ownership and recognise their responsibility will we have a society and culture conducive to good long-term health ... moving from a fragmented to a collective, whole-systems approach ... [is] essential for the Government to end childhood obesity.²¹

13. This focus on the necessity of a ‘joined-up’ or ‘whole-systems’ approach was reiterated through our inquiry. The Health Action Campaign’s written evidence looked at international examples of successful childhood obesity schemes, and concluded that there are now at least three programmes known to reduce childhood obesity.²² We heard evidence during our visit to Amsterdam on EPODE in France, JOGG in Holland, and TCOCT (The Children’s Obesity Clinic Protocol) in Denmark. The Health Action Campaign argue that:

15 [Off the scales - The Centre for Social Justice](#), December 2017, p.18

16 [Ibid](#) p. 14

17 [Leeds Beckett University \(COY0048\)](#) p.2

18 [Tackling obesities: future choices - GOV.UK](#), 17th October 2007

19 [Off the scales - The Centre for Social Justice](#), December 2017 p. 37

20 [Ibid](#)

21 [Ibid](#) p.12

22 [Health Action Campaign \(COY0007\)](#) p.3

Each of these successful initiatives has adopted a sustained, systematic, joined up approach, rather than separate ad hoc initiatives, either in a community or a clinical setting. Each has reduced levels of childhood obesity, including in socially disadvantaged groups, thereby helping reduce health inequalities.²³

14. Evidence to our inquiry demonstrated that there are also a number of programmes being undertaken across England to tackle childhood obesity. We heard written and oral evidence about the successes of schemes including, but by no means limited to, NHS Champ in Manchester, HENRY and the Croydon Food Flagship programme in reducing childhood obesity at a local level.²⁴ However, we echo the arguments made in the Centre for Social Justice's report '*Off The Scales*', that

[While] There are numerous whole-systems programmes and effective childhood obesity projects being delivered across England... unlike in Amsterdam where efforts are joined up and politically led, the current system in England remains fragmented.²⁵

15. We strongly believe that, in order for the important local examples of best practice relating to tackling childhood obesity across England to fulfil their potential, it is essential that they are 'joined-up' in a whole systems approach. We saw this demonstrated by the example of the Amsterdam Healthy Weight Programme (AAGG). We heard that AAGG committed to identifying and connecting different schemes that already existed in the city. Once that had taken place, the AAGG was able to recognise and 'fill in the gaps' where service provision was lacking.²⁶

The 'Sand Bag' analogy

During our visit to Amsterdam, the AAGG's approach to tackling childhood obesity was described in terms of using sandbags as a flood defence.

Childhood obesity is a river, which has burst its banks. To protect society, we put in place sand bags, with each sand bag representing a specific policy to combat childhood obesity, such as a 9pm Watershed on junk food marketing, or increasing education in schools on healthy eating.

In isolation, each sandbag is unable to stop the flooding, much like, in isolation, no single specific policy can successfully tackle childhood obesity. It is only when we have a large collection of sandbags, which are effectively joined together, do we have a flood defence which works. Only when we have a variety of different evidence-based policies, and a joined-up system which connects them all, can we hope to tackle childhood obesity effectively.

16. The implementation of an effective childhood obesity plan demands a joined-up, 'whole systems', collaborative approach driven by effective leadership and ambitious targets.

23 [ibid p.8](#)

24 [HENRY \(COY0037\)](#), [NHS CHAMP Project \(COY0053\)](#), [Croydon Council \(COY0059\)](#)

25 [Off the scales - The Centre for Social Justice](#), December 2017, p.37

26 [ibid p.41](#)

17. **Local leadership will be essential in identifying areas of greatest need and in drawing up action plans which can start by drawing on existing good practice and focus on joining up existing services by identifying community, school, local government and neighbourhood-led projects that already exist, and ‘filling in the gaps’ where service provision is lacking.**

18. **Alongside this, there needs to be a concerted effort at both national and local level to change the narrative around childhood obesity, to make it clear that reducing the personal cost and inequality is everyone’s business.**

Local and national government collaboration

19. We heard that national and local Government collaboration and co-operation will be integral to the success of a whole system approach in England.²⁷ In 2015, Public Health England (PHE) commissioned Leeds Beckett University to create a toolkit that enables local authorities to produce a whole systems approach for tackling obesity. Leeds Beckett University argued that the initial results of the pilot had been extremely promising. However, they reinforced the importance of national and local Government co-operation, stating:

Local authorities have levers available that can change how the local system functions—including how to create a healthier local environment. However, local authorities work within geographical and political boundaries. They cannot change all elements of their local systems, some require action and support from national government ... national government must be seen by local authorities to be doing their part, obesity cannot be tackled by local authorities alone.²⁸

20. Evidence to our inquiry suggested that to allow local authorities to act effectively on childhood obesity, greater awareness was required of the priorities of different sectors to identify where ideas around obesity fit in with their existing work, to encourage cross-sectoral commitment.²⁹ While local authorities can do this up to a point, the oversight and ‘big picture’ vision afforded to national Government is an essential supporting measure to inform local decisions.

21. **The next round of the Government’s childhood obesity plan must include a dedicated discussion of the role and responsibility that local government has in reducing childhood obesity, and the specific ways in which the Government intends to support local government to achieve that aim. We heard that many local authorities feel that their influence can only go so far. National Government must give them the levers they need to be able to tackle the obesogenic environment and to provide an effective range of support services. We therefore urge national Government to listen to local authorities and give them greater powers to reduce health inequality at local level.**

27 [The Local Government Association \(COY0011\)](#) p.3

28 [Leeds Beckett University \(COY0048\)](#) p.2

29 Q13 Dr Nobles

Political leadership

22. The Obesity Policy Research Unit's report '*What can be learned from the Amsterdam Healthy Weight programme to inform the policy response to obesity in England?*' highlights strong political leadership as critical to the success of the Amsterdam AAGG. This is reiterated by the Centre for Social Justice's '*Off The Scales*' report, which states,

The resounding emphasis from experts connected to or involved in AAGG is that the political leadership—most notably the leadership, vision and commitment to overseeing the project by Alderman van der Burg—has been integral to its success in being city-wide and effectively holding every sector to account. [Van der Burg] “understood the gravity of the problem and propelled childhood obesity to the top of the city’s agenda”. In doing so, other key politicians formally committed to introducing the programme in 2013 and, in publicly signing up to the long-term vision and ambitions, are now fully accountable to ensuring its success.³⁰

We met Mr Van Der Burg ourselves during our visit to Amsterdam, and were impressed by his drive and commitment to the policy area of childhood obesity, and the long-term vision he adopted when attempting to devise solutions to the problem.

23. The Centre for Social Justice report goes on to recommend,

The first step the Government, and specifically the Prime Minister, must take to end childhood obesity is to commit to doing so, secure the cross-party, cross-departmental and cross-sector commitment to support this and set out a bold, long-term, target-led, non-partisan strategy. The Government should focus on area-based targeting: start in areas with the highest proportion of childhood obesity and then roll out interventions proportionate to an area's childhood obesity rates.³¹

24. In England, political leadership on Childhood obesity prevention has been lacking, despite the Government's 2016 Plan. In written evidence, Sustain, a charity focusing on better food and farming, stated:

... leadership on sugar reduction efforts shown by Public Health England and the NHS has not been matched by other Government departments, or from Number 10 itself. The Childhood Obesity Plan has remained primarily within the remit of the Department for Health, rather than high level cross-government leadership from the Prime Minister personally and by the Cabinet Office ... Whilst there is a committee of civil servants from across relevant departments which meets quarterly to look at the progress on implementing the Childhood Obesity Plan, this is very different from the high level ministerial—and indeed prime ministerial—leadership and coordination of policy that was originally envisaged. Meanwhile there is little evidence that departments such as DCMS, DEFRA or DexEU/Trade are integrating public health or the Obesity Plan appropriately with their own strategies and plans.³²

30 [Off the scales - The Centre for Social Justice](#), December 2017, p.39

31 [Off the scales - The Centre for Social Justice](#), December 2017, p.56

32 [Sustain the alliance for better food and farming \(COY0024\)](#) p.5

25. **The revised government Childhood Obesity Plan should be championed by the Prime Minister. A cross-department Cabinet-level committee should be set up which reviews and evaluates the implementation and effectiveness of the plan, with mandatory reporting across all departments on the implementation of the childhood obesity plan every six months. Tackling childhood obesity effectively will take time, and political leadership will be needed to bring decision-makers together with a shared mandate to create and sustain healthy food and activity environments for children.**
26. **Whilst leadership at national level is important, it should also be reflected and driven at local level. We urge local authorities to identify named individuals to do so.**
27. **The Government must ensure that future trade deals do not negatively impact on childhood obesity by worsening the obesogenic environment.**

Clear expectations

28. The Obesity Policy Research Unit's report also highlights that clear expectations were critical to the success of the Amsterdam AAGG. They state,

There is a recognition that eradicating child obesity is a long term project. However, to ensure there is continued buy-in, and to mitigate against the disruption caused by electoral cycles, the AAGG has established shorter term goals along the way (see programme description). The potential effect is if it can be demonstrated that the milestone goals are being achieved this may encourage continued buy-in from different sectors and across election cycles. This will then facilitate the achievement of the AAGG's long-term goal.³³

29. In 2016, it was suggested by Channel 4's *Dispatches* programme that the Government's Childhood Obesity: A Plan for Action had been significantly diluted from its original draft.³⁴ The programme claimed that the draft contained a pledge to halve childhood obesity by 2026 to 800,000 cases. However, when the full strategy was released, that had been changed to a pledge to "significantly reduce" the number of chronically overweight children.³⁵ Evidence to this inquiry suggested that this change had been detrimental to the success of the Government's plan, and that the next round of the Government's plan must redress this failure. In oral evidence, Kieron Boyle of Guy's and St Thomas' Charity stated:

... we need a road map. Everybody recognises that this is a complex issue. To have a genuine 10-year plan, we need to say what we hope to see after years 1, 3 and 5. Year 1 need not be that ambitious if we know that it is pointing toward where we need to be by year 10.³⁶

As the Jamie Oliver Foundation observed in written evidence, "what gets measured gets done".³⁷

33 Obesity Policy Research Unit (OPRU): Rapid response briefing paper - What can be learned from the Amsterdam Healthy Weight programme to inform the policy response to obesity in England?, 18 December 2017 p.10

34 The Secret Plan to Save Fat Britain: Channel 4 Dispatches, 31 Oct 2016

35 [Childhood obesity: a plan for action - GOV.UK](#) p. 4

36 Q17, Kieron Boyle

37 [Jamie Oliver Group \(COY0044\)](#) p.6

30. We fully endorse the conclusion of our predecessor Committee in its 2017 report– Childhood Obesity: Follow Up - that “Vague statements about looking ‘to further levers’ if the current plan does not work are not adequate to the seriousness and urgency of this major public health challenge.” We repeat its call for the Government to set clear goals for reducing overall levels of childhood obesity, as well as goals for reducing the unacceptable and widening levels of inequality.

3 Marketing and advertising

Broadcast media—the evidence

31. Public Health England, in 2015, concluded that,

Available research evidence shows that all forms of marketing consistently influence food preference, choice and purchasing in children and adults.³⁸

Subsequently, our predecessor Health Committee called for broader and deeper controls on advertising and marketing to children in its 2017 (follow up) report, specifically:³⁹

- Restricting the advertising of all high fat, sugar and salt foods until after the 9pm watershed
- Extending current restrictions on advertising to apply across all other forms of broadcast media (e.g. social media, cinemas, posters)
- Tightening loopholes around the use of non-licensed cartoon characters and celebrities in children’s advertising
- Changing the nutrient profile model to ensure that high sugar cereals are included within the products not suitable for advertising to children.

32. The Government’s response to these recommendations, whilst appreciating the salience of the points raised, was light on action. The formal Government response stated,

The Government recognises that marketing in all forms affects food preference and choice. Although evidence regarding the extent of increased consumption by children as a result of advertising and the knock-on effect on obesity levels is mixed.⁴⁰

33. We find that response wholly unsatisfactory. We heard evidence during this inquiry that the relationship between advertising and childhood obesity is well established.⁴¹

34. Calls for greater restrictions on marketing and advertising have continued to be voiced by health groups. The BMA argued in written evidence,

One of the BMA’s primary criticisms of the Childhood Obesity Plan was the failure to include any measures to strengthen controls on the marketing and promotion of unhealthy food and drinks to children. We know that junk food adverts are very influential on children’s eating habits, and children are heavily exposed to marketing of unhealthy products in broadcast and non-broadcast media.⁴²

35. In evidence to this inquiry, the Jamie Oliver Food Foundation stated:

38 [Sugar Reduction: The evidence for action](#), PHE, 2015

39 Health Committee, *Childhood obesity: follow-up*, Seventh Report of Session 2016–17, HC928 p.26

40 Government Response to the House of Commons Health Select Committee report on Childhood obesity: Follow-up, Seventh Report of Session 2016–17, Cm9531 p.6

41 Q108, Dr Emma Boyland, Professor Russell Viner

42 [British Medical Association BMA \(COY0014\)](#) p.2

When the government published their child obesity plan in August 2016 ... there was a glaring omission of policies to protect children from the marketing of foods and drinks high in sugar, salt and saturated fat... companies invest in advertising because it works. Junk food marketing is a totemic issue that must be given the due attention in the next government childhood obesity plan.⁴³

36. In response to these arguments, Stephen Woodford of the Advertising Association argued:

We have in the UK some of the strictest rules in the world. As an example of that, in the UK we define children as under-16s. Those rules have been in place on broadcasting since 2010, and in July last year they were extended to cover all media.⁴⁴

37. However, we heard convincing evidence that this was not the case. Dr Emma Boyland Senior Lecturer in Psychological Sciences at the University of Liverpool told us:

There is a strong argument that these regulations can be effective and a useful policy lever, but independent monitoring of the Ofcom regulations from 10 years ago showed that there was not a significant reduction in food advertising that children see.⁴⁵

38. Professor Russell Viner agreed, adding:

[...] advertising is most powerful in those who need it least. It is most powerful in deprived communities. Some research quoted again in our “A ‘Watershed’ Moment” pointed out, from a survey done with teenagers, that those from deprived communities were 40% more likely to recall junk-food advertising than those from less-deprived communities.⁴⁶⁴⁷

Broadcast media—the solutions

39. Evidence to this inquiry on marketing was almost unanimous on the need for implementation of the recommendation of our predecessor Health Committee, and Public Health England, to restrict all advertising of high fat, salt and sugar (HFSS) foods and drinks to after the 9pm watershed. Our predecessors’ most recent report noted:

The Royal College of Paediatrics and Child Health told us that “previous research by Ofcom showed that [a ban on the advertising of HFSS food and drink before the 9pm watershed] would reduce the amount of HFSS adverts seen by children by 82 per cent compared to just 37 per cent for the current regulations.”⁴⁸

43 [Jamie Oliver Group \(COY0044\)](#) p.1

44 Q93

45 Q115, Dr Boyland

46 Q115, Professor Viner

47 The Potential Cost-Effectiveness and Equity Impacts of Restricting Television Advertising of Unhealthy Food and Beverages to Australian Children, Brown et al, May 2018

48 Government Response to the House of Commons Health Select Committee report on Childhood obesity: Follow-up, Seventh Report of Session 2016–17, Cm9531 p.28

40. As the Royal College of Paediatrics and Child Health argued in written evidence to this inquiry:

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.⁴⁹

41. We fully endorse the calls for a 9pm watershed on high fat, sugar and salt (HFSS) food and drink advertising, and expect to see this measure included in the next round of the Government’s childhood obesity plan. Failure to implement this restriction would leave a worrying gap and call into question the commitment to serious action to tackle one of the key drivers of demand for high fat, sugar and salt food and drink.

42. We heard clear evidence that restrictions on advertising and marketing should not be limited to a 9pm watershed. Sustain, in written evidence, argued:

As with tobacco and alcohol, the Government should investigate ending sponsorship by brands overwhelmingly associated with HFSS products of sports clubs, venues, youth leagues and tournaments. Campaigns are currently calling on sports associations to disassociate themselves from junk food brands, but if sports associations will not act, the Government must step in.⁵⁰

Sustain also argued that the next round of the Government’s plan should:

Extend regulations governing use of child-friendly cartoon characters (either brand generated characters or licensed TV and film characters) beyond advertising to include HFSS product packaging and in-store promotions.⁵¹

Both of these recommendations were supported by the Jamie Oliver Food Foundation, who argued that they should be backed up with “meaningful sanctions for non-compliance.”⁵²

43. The next round of the Government’s childhood obesity plan should include a ban on brand generated characters or licensed TV and film characters from being used to promote high fat, sugar and salt products. The plan should also include a commitment to end sponsorship by brands overwhelmingly associated with high fat, sugar and salt products of sports clubs, venues, youth leagues and tournaments.

49 [Royal College of Paediatrics and Child Health \(COY0028\) p.4](#)

50 [Sustain the alliance for better food and farming \(COY0024\) p.4](#)

51 [ibid p.4](#)

52 [Jamie Oliver Group \(COY0044\) p.4](#)

Non-broadcast platforms

44. In 2016, Ofcom's report on Children and Parents: Media Use and Attitudes revealed that children's internet use has reached record highs, with young people aged 5–15 spending around 15 hours each week online—overtaking time spent watching a TV set for the first time. Even pre-schoolers, aged 3–4, are spending on average eight hours and 18 minutes a week online, up an hour and a half from the previous year.⁵³

45. In the Committees on Advertising Practice's 2016 amendment to the advertising code, regulations around non-broadcast ads were aligned with the stricter broadcast rules regarding HFSS advertising. However, submissions to this inquiry suggested that regulations around non-broadcast media remained ineffectual. Dan Parker of Living Loud, a health campaigner who previously worked in the marketing industry for companies including Coca-Cola, suggested in written evidence that,

The extension of this advertising ban to digital effectively excludes Facebook and Google, which alone account for 50% of online advertising. It also effectively excludes social media and video channels such as YouTube ... These bans cover but one small aspect of marketing junk food to children.⁵⁴

In oral evidence, Parker made the argument that

This code is a masterpiece in that it has banned something that never really existed. The interesting question is: what advertising that did exist has stopped existing because of these codes? There are no compliance breaches because it does not exist. More specifically, it goes out of its way to exclude the most effective tools in the junk-food marketer's box—packaging, promotion, sponsorship, retail media, all specifically excluded because those are the things that they use to market to kids, even more so than TV advertising. It is a shocking sham—the whole piece of regulation.⁵⁵

46. We heard consistent evidence that current regulations around non-broadcast media marketing to children are ineffectual, and fail adequately to appreciate the dynamics of children's non-broadcast media consumption. We urge the Government in its next childhood obesity plan to tighten regulations around non-broadcast media to bring them in line with broadcast media restrictions, and to ensure that sites such as Facebook and YouTube amongst others are taking responsibility for helping to reduce exposure of children to inappropriate advertising and marketing, including advergames. The regulator should play a pro-active role in investigating breaches and taking enforcement action.

47. Furthermore, just as for broadcast media, the next round of the Government's childhood obesity plan must include a ban on brand generated cartoon characters or licensed TV and film characters from being used to promote high fat, sugar and salt products in non-broadcast media.

53 Children and parents: media use and attitudes report 2017, Ofcom, 2016

54 [Living Loud \(COY0025\)](#) p.2

55 Q125, Dan Parker

4 Price promotions

48. In PHE's 2015 report "Sugar reduction: the evidence for action", addressing price promotions was the first recommendation that a successful sugar reduction programme should include:

1. Reduce and rebalance the number and type of price promotions in all retail outlets including supermarkets and convenience stores and the out of home sector (including restaurants, cafes and takeaways).⁵⁶

49. Evidence shows that price promotions are more common in the UK than in other European countries and that they are most common for unhealthy foods and snacks. Research has indicated that promotions are the most salient form of marketing for young people. The Association of Directors of Public Health in written evidence argued

Price promotions increase the amount of food and drink people buy by one-fifth (22%) and around 6% of total sugar purchased (equivalent to 7.4g per individual per day) could be prevented if promotions on higher sugar products did not occur.⁵⁷

50. NHS Scotland's 2017 rapid review paper '*The impact of promotions on high fat, sugar and salt (HFSS) food and drink on consumer purchasing and consumption behaviour and the effectiveness of retail environment interventions*' argues that price promotions increase the volume of food or drink purchased during a single shopping trip and do not lead to a reduction in the frequency of purchasing at subsequent trips. The report also suggested that increases in the volume of food and drink purchased on promotion did not result in reductions in purchases of other high fat, salt and sugar foods and drinks.⁵⁸

51. Despite this, Government action on the regulation of price promotions has so far remained entirely voluntary. In its 2017 (follow-up) report, our predecessor Health Committee concluded:

We are extremely disappointed that the Government has not regulated to provide the "level playing field" on discounting and price promotions which industry representatives themselves have told us is necessary for the greatest progress. We urge the Government to follow the evidence-based advice from their chief public health advisers and to regulate to further reduce the impact of deep discounting and price promotions on sales of unhealthy food. Retailers who act responsibly on discounting and promotions should not be put at a competitive disadvantage to those who do not.⁵⁹

52. Evidence to this inquiry highlighted the need to distinguish between different types of promotions and their effects on health inequalities. Dan Parker of Living Loud stated in oral evidence,

Where we have to be very careful is that, generally, promotions ... have different reasons. Some will be for what is called reach, which is about

56 [Sugar Reduction: The evidence for action](#), PHE, 2015

57 [Association of Directors of Public Health \(COY0027\)](#) p.3

58 Rapid evidence review: The impact of promotions on high fat, sugar and salt (HFSS) food and drink on consumer purchasing and consumption behaviour and the effectiveness of retail environment interventions

59 Health Committee, Childhood obesity: follow-up, Seventh Report of Session 2016–17, HC928 p.25

getting more people to eat it; some are about frequency, which is getting them to have it more often; and some are about volume, which is getting them to eat more, consume more or buy more each time they go.

The interesting thing is that some discounts are just about shifting expiring stock. We have to be exceptionally careful not to stop the shifting of expiring stock, because for our poorest people it is the lifeblood of getting food on their table and it would add to food waste.⁶⁰

Dan Parker summarised this argument in written evidence, stating,

A blanket ban on promotions on HFSS products would disproportionately affect those on low income who often depend on them to make ends meet. We need to stop promotions which seek to increase the frequency and volume of consumption—HFSS products should be banned from using buy-one-get-one-free and buy-one-get-one-half-price promotions.⁶¹

53. We endorse the findings of our predecessor Committee in calling for Government to regulate to restrict discounting and price promotions on high fat, sugar and salt food and drinks, and particularly those that drive increased consumption, such as multi-buy discounts and ‘extra free’ promotions. Regulation ‘levels the playing field’ so that those who are doing the right thing are not disadvantaged.

Product placement

54. Feature and display promotions can create a nudging effect (defined as ‘any addition to or modification of the environment that influences consumers in a predictable way without changing economic incentives’).⁶² These promotions can change which products are the most visible for consumers and impact on product choice. One audit of supermarkets’ product positioning of snack products in eight developed countries found that the UK had the highest mean total aisle length dedicated to snack food including crisps, chocolate and confectionery, with snack food at over 70% of checkouts. The UK also had the second highest ratio (1.31) of snack foods aisle length to fruit and vegetables aisle length within the supermarkets sampled.⁶³ This salience of this issue to manufacturers was emphasised to us in oral evidence, where Dan Parker of Living Loud highlighted,

From that positioning—and not just gondola ends but things such as being at three quarter height or being near the check-out—Tesco makes £300 million per year from charging people for placement in store.⁶⁴

55. In 2015, Aldi and Lidl became the first high street retailers voluntarily to ban confectionery from their checkouts, a move subsequently followed by Tesco, Boots and Morrisons in their large stores. Confectionery and other HFSS snacks remain very prevalent at the checkouts in small outlets in a number of settings including garages and convenience stores, many with long chicanes lined by such products.

60 Q161

61 [Living Loud \(COY0025\)](#) p.3

62 Rapid evidence review: The impact of promotions on high fat, sugar and salt (HFSS) food and drink on consumer purchasing and consumption behaviour and the effectiveness of retail environment interventions p.12

63 Ibid p.12

64 Q163, Dan Parker

56. Sustain, a campaign group who provided written evidence to this inquiry, suggest:

The issue for food retailers has reached a tipping point and they know which way public opinion and hopefully the government are going on this.⁶⁵

57. In 2016 the British Dietetic Association published the results of a survey which shows that 75 per cent of the public found having junk food at checkouts ‘annoying’, 83 per cent had been pestered by their children to buy junk food at the checkouts, and 56 per cent of people would be more likely to shop at a supermarket which banned such food from their checkouts.⁶⁶

58. Despite all this evidence, Government action on point of sale promotions has been limited. Before our predecessor Committee in 2017, Chief Executive of Public Health England Duncan Selbie noted:

The argument was had. I have been before you and said that we can present evidence, but Parliament and the Government are there to make decisions. Being right is not sufficient; it is about what you decide to do.⁶⁷

59. We endorse the case made by our predecessor Committee, and by Public Health England, for removing confectionery and other unhealthy snacks from the ends of aisles and checkouts. We heard evidence that public opinion is in favour of Government action on product placement, and from retailers that they want a ‘level playing field’ on regulation. We also call on retailers to end the promotion of high calorie discounted products as impulse buys at the point of sales, particularly in the non-food retail environment. We understand that this cannot be achieved by voluntary action due to the fierce competition in the retail environment, and therefore we recommend that Government commit to regulation.

65 Boots to remove sweets and chocolate from all checkouts by next month, Mail Online, 11 March 2016

66 [British Dietetic Association \(COY0042\)](#) p.5

67 Health Committee, Oral evidence: Childhood obesity: follow up, HC 928 (2016-17), Q87

5 Early years and schools

Early years

60. The first 1000 days (from conception to a child's second birthday) are widely considered to be the most formative in a child's development, with health behaviours already heavily influenced. For example, the most excess weight gain before a child hits puberty occurs before children reach five years of age. Health Exercise, Nutrition for the Really Young (HENRY) argued in written evidence:

One of the key barriers to better prevention of child obesity is the current lack of focus and investment in obesity prevention in the early years. Attention is concentrated on obesity prevention and management with primary school aged children ... The early years (including pregnancy) provide a unique window of opportunity to prevent obesity before it can develop. It's much easier to establish healthy eating and activity habits early than it is to try break poor habits once they become routine. Additionally, the early years is a time when parents have more contact with health professionals and services and are more receptive to help and support.⁶⁸

61. In England each year 10% of children who start school aged 4–5 years are already obese, with a further 13% overweight.⁶⁹ Recent analysis by PHE found that of only 1 in 20 children who start school obese will have returned to a normal weight by the time they begin secondary school, and early childhood obesity disproportionately affects children from the most deprived backgrounds.⁷⁰ Despite this, the Government's first childhood obesity plan was troublingly lacking on early years provision, with the only action being to commission the Children's Food Trust to develop revised menus for early years settings which would be incorporated into voluntary guidelines for early years settings.⁷¹

62. The argument has also been made to us that, while much early years' service provision would, in an ideal world, be granted more central Government funding, there are best practice examples of cost neutral programmes which have revolutionised service provision currently underway in England. For example, NHS Champ in Manchester is a multi-partnership, collaborative approach committed to producing a digital growth chart for every child as a fundamental indicator of health and wellbeing as well as a predictor of future health and wellbeing. The scheme was able to provide additional measurement data for early years children whilst remaining cost neutral by harnessing technology in the way that children were weighed and measured. As they stated in oral evidence,

This means that school nurses, who already go into all 137 primary schools in Manchester, across the city, can weigh a whole school in the same time that they weighed and measured two classes before. That is why it is cost neutral: it is no more time and no more effort.⁷²

68 [HENRY \(COY0037\)](#) p.2

69 [ibid](#) p.2

70 [HENRY \(COY0037\)](#) p.2

71 [Childhood obesity: a plan for action - GOV.UK](#)

72 Q9

63. We recommend that the Government should put in place further measures around early years and the first 1000 days of life to combat childhood obesity. Such programmes should include:

- **Promotion and support for breastfeeding for all infants in all areas (including improved provision for mothers to breastfeed in the community), and further support and advice on appropriate and responsive bottle feeding for those cases where breast feeding is not appropriate.**
- **A ban on advertising and promotion of follow on formula milk as this has long represented a ‘back door’ route to advertising of formula feeding. There needs to be better enforcement of the existing rules around the promotion of infant formula milk.**
- **Improved early years education to inform and promote appropriate introduction of solids to infants’ diets.**
- **The strategy needs to set ambitious targets for initiation and maintenance of breastfeeding.**
- **Training and equipping the early years workforce, in both the voluntary and statutory sector, to effectively support parents and families to promote healthy eating and activity in their children. Evidence-based training should be made available and the long-term effectiveness of current national online training should be independently evaluated.**
- **A programme to ensure the widespread take-up of best practice, cost-neutral early years schemes such as the NHS Champ project in Manchester, and continued support to those already in operation.**
- **Government funding for local authorities to make available effective interventions to support families with pre-school children most at risk of obesity.**

Measurement

64. Further to early years service provision, Prof Russell Viner told us:

One key thing that we would argue for is expansion of measurement ... At the moment children are measured at birth by their GP at the six-week rate, but it is often not written down. They are often measured quite a lot through their early life and the data are not gathered in one place; it is not put together. They are measured exceptionally well by the national child measurement programme at four and at school leaving at 11, but between birth and four the data are in no particular place, sometimes in the parent’s red book, and after 11 there is no measurement.

The data systems should work together; it should be held by parents and by GPs. There should be systems that allow GPs to record and act upon that data purely through signposting. At the moment, our primary care systems are not designed to allow GPs simply to make every contact count.

We do not want a child to turn up at primary school at age four already overweight and obese. We want GPs, nurses or others to advise parents on when a child is going off trajectory, heading towards being overweight, and to guide them back.⁷³

65. We recommend that the next childhood obesity plan include specific measures to ensure that data on child measurement are able to flow effectively between different parts of the health and social care system to the child’s general practitioner, who should take on primary responsibility for co-ordinating appropriate weight management advice and services, and to the child’s parent. We recommend that consideration is given to including a further measurement point within the Child Measurement Programme, in addition to better collation of opportunistically gathered measurements. Early identification and targeted support is necessary to reduce health inequalities.

Schools

66. In the Government’s original childhood obesity plan, a large section of the recommendations focused on school-based measures, including updating the School Food Standards, introducing a Healthy Schools rating programme and running a campaign to encourage academies to sign up to the School Food Standards.⁷⁴ We heard no convincing evidence that any of these school-related measures had been implemented in an effective or holistic manner, and we retain significant concerns about the current approach of the Department for Education in making any significant contribution to the Government’s childhood obesity plan.⁷⁵

67. The focus on schools as an important element of an effective childhood obesity plan is demonstrated by the Amsterdam Healthy Weight Project. As the Centre for Social Justice’s ‘*Off The Scales*’ report states,

A critical element of the programme is the work in schools. The programme is based on the belief that children have the right to a healthy school environment in which they don’t eat unhealthy products and have sufficient, effective exercise. The programme states that all schools in Amsterdam promote health. All pre-schools and schools can get help achieving this through the Amsterdam school programme ‘Jump-in’. Jump-in supports all the primary schools in Amsterdam, but especially those where the percentage of children with an unhealthy BMI is higher than the average percentage for the Netherlands.⁷⁶

68. We were also interested in the focus on sleep in the Jump-in model, which sets “getting enough sleep” as one of the core eight targets for a school to be considered a ‘Healthy School’. We understand that the Government is working with the Obesity Policy Research Unit on this policy area in relation to the UK, and eagerly anticipate the publication of the findings from this work.⁷⁷

73 Q142, Q143

74 [Jamie Oliver Group \(COY0044\)](#) p.6

75 [Jamie Oliver Group \(COY0044\)](#), [British Dietetic Association \(COY0042\)](#)

76 [Off the scales - The Centre for Social Justice](#), December 2017, p.43

77 Q378

69. We urge the Government, and specifically the Department for Education, to review its performance in executing the measures contained in the Government's first childhood obesity plan relating to schools. We urge a full and timely implementation of all of the measures contained in their first Childhood Obesity Action Plan, including updating the School Food Plan to account for the updated dietary recommendations for free sugars and fibre. School Food Standards should be mandatory for all schools including all academies, as should the Healthy Rating Scheme.

70. We endorse the approach taken by the Amsterdam Jump In programme and in particular the culture change it drives around a healthy food and drink environment as well as the importance of wellbeing and physical activity. We look forward to the Government's publication of its appraisal of the role of sleep quality in tackling obesity and improving wellbeing. The Government should act on its findings and recommendations.

71. The greatest attention should be focused on schools with the greatest prevalence of obesity in order to reduce the unacceptable and widening health inequality of childhood obesity. Messages however should be positive and focus on health and wellbeing rather than stigmatise obesity. We also recommend that the Government commission research to find the messages that will be most effective within communities at greatest risk, for example on the need to reduce sugar to protect children's teeth.

6 Takeaways

72. According to the National Diet and Nutrition survey just over 1 in 5 children eat a takeaway meal at home at least once a week. This may under-estimate total takeaway food consumption by children, as it does not include takeaway food consumed outside the home.⁷⁸ Portion sizes of takeaways are often very large—in a recent study conducted in Liverpool, three quarters of takeaway meals (excluding side orders and drinks) studied exceeded 1125 calories, with a quarter exceeding the recommended daily intake for a boy aged 9–13 years (1800 calories).⁷⁹ In 2017, there were 56,638 takeaway outlets in England, a rise of 8% (4,000 restaurants) in the past three years, according to Ordnance Survey data. The takeaway industry has reported a 34% increase in nominal expenditure on takeaway food from £7.9 billion in 2009 to £9.9 billion in 2016. Annual growth of 2.6% per annum is forecast over the next five years.⁸⁰

73. Takeaways are likely to be contributing to inequalities in childhood obesity. Takeaway food can represent a very low-cost option to the purchaser, especially to children, who are highly price sensitive.⁸¹ Duncan Selbie, Chief Executive of Public Health England, told us that in some places £1 can purchase as many as 900 calories.⁸² There are 2–3 times as many takeaways in the most deprived areas of England compared to the least deprived areas, and children from lower socio-economic groups consume takeaways more frequently than other children. Takeaway consumption is associated with a greater increase in total calorie consumption for children in lower socio-economic groups than children in higher socio-economic groups.⁸³ PHE noted in written evidence:

National data show that children living in areas surrounded by fast food outlets are more likely to be overweight or obese. Evidence has demonstrated the associations between neighbourhood fast food takeaway density, consumption and obesity. Changing neighbourhood takeaway food environment may be particularly effective for groups of low socioeconomic status.⁸⁴

74. In March 2017, Public Health England published ‘*Strategies for Encouraging Healthier “Out Of Home” Food Provision*’, a toolkit for councils working with small food businesses, highlighting the importance of local authorities using licensing powers to influence the provision of healthier food.⁸⁵ However, evidence to this inquiry argued that, in order to implement the strategies effectively, local authorities need increased power to respond to obesity challenges in the realms of licensing, planning, and place-shaping.⁸⁶ The Association of Directors of Public Health argued:

Local authorities and communities need to be given more power and flexibility to respond. In ADPH’s most recent policy survey, 70% of

78 [Oliver Mytton \(COY0056\)](#) p.1

79 [ibid](#) p.1

80 [ibid](#) p.1

81 [ibid](#) p.1

82 Q252 Duncan Selbie

83 [Oliver Mytton \(COY0056\)](#) p.1

84 [MRC Epidemiology Unit \(COY0050\)](#) p.5

85 *Strategies for Encouraging Healthier ‘Out of Home’ Food Provision: A toolkit for local councils working with small food businesses*, PHE, 2017

86 [The Local Government Association \(COY0011\)](#) p.4

Directors of Public Health who responded said that amending licensing legislation to empower local authorities to control the total availability of alcohol, gambling and junk food outlets was one of their top five priorities. Action is needed to help local authorities tackle the proliferation of fast-food takeaways, particularly around schools.⁸⁷

75. Public Health England have built on this call, arguing:

Our experience from working with local authorities is that there are differences in interpretation about the extent to which existing powers can be used and enforced, and uncertainty surrounding best practice. Political and economic challenges also exist for local authorities. Although public health can be made a material consideration in planning decisions, it is sometimes a secondary concern. Local authorities can also lack information about how and where best to act on the food environment.⁸⁸

76. On top of this, evidence to this inquiry pointed out that councils' planning powers can do nothing to address the clustering of fast food outlets that are already in place. Planning experts point out that the planning system is currently not designed to deal with the detail of how a business is operated, but rather with how land is used.⁸⁹

77. We regret that the Ministry for Housing, Communities and Local Government declined our invitation to give oral evidence to this inquiry. We consider this response to be indicative of a lack of their own commitment to cross-departmental engagement on the subject of takeaways and childhood obesity.

78. We repeat the calls of our predecessor Health Committee, and argue that the next round of the Government's childhood obesity plan must, as a matter of urgency, include provisions for changes to planning legislation to make it easier for local authorities to limit the proliferation of unhealthy food outlets in their areas. The Government must also provide further clarity for local authorities on the extent to which existing powers can be used and enforced as we heard that planning inspectors do not take a consistent approach to appeals.

79. Local authorities need further powers to limit the prevalence of high fat, sugar and salt food and drink billboard advertising near schools. Currently, the only powers available to local authorities extend to the positioning of the billboards themselves, not the content of the advertising. Local authorities also need further powers to tackle the proliferation of existing takeaways.

80. We strongly support recommendations, including those which we heard from Public Health England in our most recent evidence session, that health should be made a licensing objective for local authorities.

87 [Association of Directors of Public Health \(COY0027\)](#) p.4

88 Strategies for Encouraging Healthier 'Out of Home' Food Provision: A toolkit for local councils working with small food businesses, PHE, 2017 p.42

89 [The Local Government Association \(COY0011\)](#) p.4

7 Fiscal measures

Expansion of the Soft Drinks Industry Levy

81. The Soft Drinks Industry Levy, which was announced by the Government in 2016 and came into force in 2018, is a welcome tool in tackling childhood obesity through a reduction in high consumption of this specific food group (Sugar-sweetened beverages (SSBs)). However, SSBs are not the only problematic foods in children’s diet, as they make-up only 13% of non-core food energy (foods high in fat and sugar that are surplus to requirements) eaten by British adolescents. In written evidence, Johnson et al from the University of Bristol argue that:

The remaining 87% of non-core food intake needs to be tackled as well, because a sole focus on a single food group (i.e. SSBs) will be insufficient to address the current obesity epidemic.⁹⁰

82. Thijs van Rens, a public health economist and one of the Parliamentary Academic Fellows working with us on this inquiry, argued in written evidence, “If the UK wants to be a front-runner on this issue, plans for expanding the tax measures need to be put in place now.”⁹¹ More specifically, the Jamie Oliver Food Foundation, in written evidence, argued that the Government should reconsider their decision not to review their exclusion of fruit juices and milk-based drinks in the SDIL until 2020, a point our predecessor Committee also argued for in their 2017 report.⁹²

83. The reaction to the SDIL was one of welcome rather than hostility. As PHE’s report of the first year of its reformulation programme shows, the levy has been a highly effective driver of reformulation. Such has been the effect of the SDIL that far less tax will be collected than anticipated as manufacturers have reduced sugar content to below the threshold levels.⁹³

84. We echo our predecessor Committee in welcoming the introduction of the soft drinks industry levy and urging the Government to extend it to milk-based drinks.

85. The next Government’s next childhood obesity plan must set out further fiscal measures which are under consideration to cover food groups such as puddings and chocolate confectionary, which the PHE sugar reduction and wider reformulation programme review has shown are not making progress in sugar and calorie reduction. We recommend that these measures should be implemented if there is not substantially faster progress on reformulation for these groups in the coming year.

86. In 2017, the then Minister Nicola Blackwood explained to our predecessor Committee:

[...] we put in the plan that this is the beginning of a conversation; it is not the end of the steps we will take. We also put in the plan that, if we do not

90 [Centre for Exercise Nutrition and Health Sciences \(COY0045\)](#) p.5

91 [Thijs van Rens \(COY0055\)](#) p.2

92 Health Committee, Childhood obesity: follow-up, Seventh Report of Session 2016–17, HC928 p.16

93 [School Food Matters \(COY0041\)](#) p.1

achieve the impact we want with the measures and steps, we will look to further levers. [...] We have been perfectly clear that this is not the end of the story.⁹⁴

87. The Government's new childhood obesity plan must maintain the pressure on industry to reformulate through the promise of concrete further action if there is not faster progress on reformulation.

Use of the revenue from the levy

88. The Government's childhood obesity plan says,

In England, the revenue from the levy will be invested in programmes to reduce obesity and encourage physical activity and balanced diets for school age children. This includes doubling the Primary PE and Sport Premium and putting a further £10 million a year into school healthy breakfast clubs to give more children a healthier start to their day.⁹⁵

89. Further correspondence from the Minister for Public Health sets out the detail of the Government's plans for the use of the levy:

- £160 million per year for primary schools for the primary PE and sports premium from September 2017;
- £10 million per year to expand breakfast clubs in up to 1,600 schools from September 2017, providing more children with a healthy start to their school day (£6m in Year 1, £10m in Year 2 and £10m in Year 3);
- £415 million through a new Healthy Pupils Capital Programme, to help pupils benefit from healthier, more active lifestyles. Primary, secondary and sixth form colleges will be able to use the funding to pay for facilities to support PE, after school activities and healthy eating. The money will be available to schools in the 2018/19 financial year: further details on the allocation formula, spending guidance and bidding criteria will be provided by the Department for Education in the summer.⁹⁶

90. In 2017, our predecessor Committee stated:

We commend the Government for responding positively to our recommendation that the proceeds of the soft drinks industry levy should be directed towards measures to improve children's health. It is particularly welcome that some of the proceeds will be directed to breakfast clubs, whose greatest benefit is to children from lower income families. We intend to follow up how the income from the levy is distributed in order to help reduce the inequalities arising from childhood obesity.⁹⁷

94 Health Committee, Childhood obesity: follow-up, Seventh Report of Session 2016–17, HC928 p.10

95 [Childhood obesity: a plan for action - GOV.UK](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/604277/Childhood_obesity_-_a_plan_for_action_-_GOV.UK.pdf)

96 Health Committee, Childhood obesity: follow-up, Seventh Report of Session 2016–17, HC928 p.18

97 Health Committee, Childhood obesity: follow-up, Seventh Report of Session 2016–17, HC928 p.18

91. Despite this, in a discussion over the ‘healthy pupils capital funding’ in a Committee of Public Accounts hearing in October 2017, Jonathan Slater, Permanent Secretary, Department for Education stated:

This was a capital budget that had not yet been allocated. It was a new thing, to be funded from the sugar levy—do you remember that? The decision that Ministers took was that rather than allocating it in the future to individual capital programmes in support of healthy pupils, schools would appreciate it more if it was baked into their core schools budgets for them to spend on an ongoing basis as they wished. That was the change.⁹⁸

92. We are extremely disappointed that the revenue being generated from the Soft Drinks Industry Levy has been diverted into core schools budgets. We reiterate our predecessor Committee’s argument that the proceeds of the soft drinks industry levy should be directed towards measures to improve children’s health, and specifically addressing health inequalities.

VAT

93. Taxation of food in the UK is not uniform. Food is VAT zero-rated, but there are some exceptions that attract standard-rate VAT of 17.5%, including food provided as catering, takeaway or in restaurants. Some countries have similar rules to the UK, applying sales tax to particular items. In France, sweets, chocolates, margarine and vegetable fat attract VAT of 20.6% whilst other foods attract VAT of only 5.5%. In Canada, sales tax applies to soft drinks, sweets and snack foods but other foods are free from sales tax. In oral evidence, Professor Jack Winkler of London Metropolitan University told us,

The next chapter in the childhood obesity plan should make clear an explicit objective not just to make the healthy choice the easier choice, but to make the healthy choice the cheaper choice ...⁹⁹

This was built on by Martin O’Connell of the IFS, who stated,

One point that has already been touched on by Jack is that the current system of VAT, as applied to food in the UK, is incoherent. A good starting point would be to sort it out. The fact that biscuits attract VAT and cakes do not, for example, has no real logical basis, either in terms of public health policy or simply on the principles of tax design. A very good starting point would be to focus energy on that.¹⁰⁰

94. This point was summed up by Dan Parker of Living Loud in oral evidence, who argued:

98 Public Accounts Committee, Oral evidence: Department for Education Annual, Report and Accounts 2016–17, HC 395, Q34, Jonathan Slater

99 Q73 Professor Winkler

100 Q90

What I find a little upsetting is the phrase that has been very popular in all of this—that we have to make the healthy choice the easy choice. That is not right. We have to make the healthy choice the cheapest choice because that is the only consideration for people who are on a very tight budget.¹⁰¹

95. We recommend that the Government undertake a consultation on the adjustment of VAT rates on food and drink after Brexit as a possible measure to tackle childhood obesity.

8 Labelling

96. The BMA has repeatedly called for a consistent approach to food labelling, and supports a mandatory traffic light approach to displaying nutritional information for all pre-packaged food and drink products.¹⁰² The use of traffic-light labelling is popular with the public, and accessible for children and young people, and evidence to this inquiry argued that the Government should make the front-of-pack labelling system mandatory in both the home and the out of home sector to provide a level playing field to both consumers and industry.¹⁰³ In written evidence, Diabetes UK argued:

Equipping consumers with nutritional information is an important step in helping people to be more informed about the food choices they make, wherever they choose to eat. UK government and the food service industry should introduce compulsory, clear and consistent nutrition labelling such as calorie labelling, with additional contextual information, at the point of choice in restaurants, cafes and takeaways. Over a quarter of adults and one fifth of children eat food from out of home outlets at least once a week. These foods tend to be higher in energy intake, fat, sugar and salt. Evidence suggests that calorie labelling on menus can reduce the number of calories per purchase. Polling conducted for Diabetes UK by ComRes indicates that three quarters (76%) of British adults agree that all cafes and restaurants should display calorie information on their menus so that consumers are informed about the calorie content of the food and drinks they buy.¹⁰⁴

97. This recommendation was supported, broadly, by industry in their submissions to this inquiry, with the British Soft Drinks Association arguing that in the next round of the Government's childhood obesity plan:

It would be further beneficial for parents to have clear nutritional front of pack labelling on out of home products, in line with the rest of the food and drink industry.¹⁰⁵

98. Efforts to increase awareness of healthy dietary behaviour must be supported in the next round of the Government's childhood obesity plan by measures to ensure consistent and clear labelling information for consumers. We also support a ban on health claims on high fat, salt and sugar food and drinks, in line with oral evidence from Public Health England. Current progress on labelling in the UK is reliant on voluntary commitments and is therefore not universally applied.

99. Calorie labelling at point of food choice for the out-of-home food sector would provide basic information to enable healthier choices. However, in light of evidence that current labelling tends to be less effective at changing choices in communities where obesity prevalence is greatest, we urge the Government to ensure that the effects are carefully monitored, in order to ensure that labelling is designed to make the healthy choice clear and straightforward.

102 [British Medical Association BMA \(COY0014\)](#) p.3

103 [Ibid](#) p.3

104 [Diabetes UK \(COY0015\)](#) p.3

105 [British Soft Drinks Association \(COY0033\)](#) p.3

9 Support for children living with obesity

100. We also heard concerns expressed during evidence that the Government's current childhood obesity plan fails to strike the correct balance between preventative measures and treatment services. In evidence to this inquiry, Dr James Nobles from Leeds Beckett University made the argument that:

There is a growing concern about how we help those who already have overweight or obesity, yet this was a notable omission in the August 2016 plan. Given that one in three children, and the majority of adults (>60%), are classified with overweight or obesity, there is a stark absence of support services available. A recent mapping exercise by PHE identified that 56% of LAs [local authorities] have a tier 2 weight management service for children and 61% for adults. These services are not intended to support individuals with complex needs. When looking at tier 3 and 4 services, service provision is bare. LAs are spending less and less on such services, year on year. This is not surprising given the emphasis placed on preventative approaches, however it is unlikely that these approaches will support those most in need.¹⁰⁶

101. He went on to argue that:

People with overweight and obesity face multiple biopsychosocial consequences. There is considerable evidence to suggest that weight management programmes can, and do, help individuals with obesity; not only in managing their weight, but also in improving their physical, mental and social wellbeing. Support services—similarly to smoking cessation services—must be available as part of a whole systems approach to tackling obesity. We cannot expect treatment programmes to be efficacious in the long-term if peoples' environments are not salutogenic. Nor can we expect a preventative approach to adequately support the needs of individuals already with overweight and obesity.¹⁰⁷

102. We heard evidence that resources such as the National Child Measurement Programme could, if effectively utilised, be a tool for referring people into weight management services. We also heard that, once children have been referred, these services must provide a multidisciplinary approach, covering mental health, physical health, educational and social needs.¹⁰⁸

103. We heard that signposting to appropriate advice, and where necessary, timely referrals for treatment was inconsistent for children living with childhood obesity. The Government must ensure there are robust systems in place not only to identify children who are overweight or obese, but to ensure that these children are offered effective help through a multidisciplinary, family-centric approach. This should include children identified by the National Child Measurement Programme. Addressing health inequalities must include providing help for those children who are already obese.

106 [Leeds Beckett University \(COY0048\)](#) p.4

107 [Leeds Beckett University \(COY0048\)](#) p.5

108 Q36

Conclusions and recommendations

A whole systems approach

1. The implementation of an effective childhood obesity plan demands a joined-up, 'whole systems', collaborative approach driven by effective leadership and ambitious targets. (Paragraph 16)
2. Local leadership will be essential in identifying areas of greatest need and in drawing up action plans which can start by drawing on existing good practice and focus on joining up existing services by identifying community, school, local government and neighbourhood-led projects that already exist, and 'filling in the gaps' where service provision is lacking. (Paragraph 17)
3. Alongside this, there needs to be a concerted effort at both national and local level to change the narrative around childhood obesity, to make it clear that reducing the personal cost and inequality is everyone's business. (Paragraph 18)
4. The next round of the Government's childhood obesity plan must include a dedicated discussion of the role and responsibility that local government has in reducing childhood obesity, and the specific ways in which the Government intends to support local government to achieve that aim. We heard that many local authorities feel that their influence can only go so far. National Government must give them the levers they need to be able to tackle the obesogenic environment and to provide an effective range of support services. We therefore urge national Government to listen to local authorities and give them greater powers to reduce health inequality at local level. (Paragraph 21)
5. The revised government Childhood Obesity Plan should be championed by the Prime Minister. A cross-department Cabinet-level committee should be set up which reviews and evaluates the implementation and effectiveness of the plan, with mandatory reporting across all departments on the implementation of the childhood obesity plan every six months. Tackling childhood obesity effectively will take time, and political leadership will be needed to bring decision-makers together with a shared mandate to create and sustain healthy food and activity environments for children. (Paragraph 25)
6. Whilst leadership at national level is important, it should also be reflected and driven at local level. We urge local authorities to identify named individuals to do so. (Paragraph 26)
7. The Government must ensure that future trade deals do not negatively impact on childhood obesity by worsening the obesogenic environment. (Paragraph 27)
8. We fully endorse the conclusion of our predecessor Committee in its 2017 report—Childhood Obesity: Follow Up - that "Vague statements about looking 'to further levers' if the current plan does not work are not adequate to the seriousness and urgency of this major public health challenge." We repeat its call for the Government to set clear goals for reducing overall levels of childhood obesity, as well as goals for reducing the unacceptable and widening levels of inequality. (Paragraph 30)

Marketing and advertising

9. We fully endorse the calls for a 9pm watershed on high fat, sugar and salt (HFSS) food and drink advertising, and expect to see this measure included in the next round of the Government's childhood obesity plan. Failure to implement this restriction would leave a worrying gap and call into question the commitment to serious action to tackle one of the key drivers of demand for high fat, sugar and salt food and drink. (Paragraph 41)
10. The next round of the Government's childhood obesity plan should include a ban on brand generated characters or licensed TV and film characters from being used to promote high fat, sugar and salt products. The plan should also include a commitment to end sponsorship by brands overwhelmingly associated with high fat, sugar and salt products of sports clubs, venues, youth leagues and tournaments. (Paragraph 43)
11. We heard consistent evidence that current regulations around non-broadcast media marketing to children are ineffectual, and fail adequately to appreciate the dynamics of children's non-broadcast media consumption. We urge the Government in its next childhood obesity plan to tighten regulations around non-broadcast media to bring them in line with broadcast media restrictions, and to ensure that sites such as Facebook and YouTube amongst others are taking responsibility for helping to reduce exposure of children to inappropriate advertising and marketing, including advergames. The regulator should play a pro-active role in investigating breaches and taking enforcement action. (Paragraph 46)
12. Furthermore, just as for broadcast media, the next round of the Government's childhood obesity plan must include a ban on brand generated cartoon characters or licensed TV and film characters from being used to promote high fat, sugar and salt products in non-broadcast media. (Paragraph 47)

Price promotions

13. We endorse the findings of our predecessor Committee in calling for Government to regulate to restrict discounting and price promotions on high fat, sugar and salt food and drinks, and particularly those that drive increased consumption, such as multi-buy discounts and 'extra free' promotions. Regulation 'levels the playing field' so that those who are doing the right thing are not disadvantaged. (Paragraph 53)
14. We endorse the case made by our predecessor Committee, and by Public Health England, for removing confectionery and other unhealthy snacks from the ends of aisles and checkouts. We heard evidence that public opinion is in favour of Government action on product placement, and from retailers that they want a 'level playing field' on regulation. We also call on retailers to end the promotion of high calorie discounted products as impulse buys at the point of sales, particularly in the non-food retail environment. We understand that this cannot be achieved by voluntary action due to the fierce competition in the retail environment, and therefore we recommend that Government commit to regulation. (Paragraph 59)

Early years and schools

15. We recommend that the Government should put in place further measures around early years and the first 1000 days of life to combat childhood obesity. Such programmes should include:
 - Promotion and support for breastfeeding for all infants in all areas (including improved provision for mothers to breastfeed in the community), and further support and advice on appropriate and responsive bottle feeding for those cases where breast feeding is not appropriate.
 - A ban on advertising and promotion of follow on formula milk as this has long represented a ‘back door’ route to advertising of formula feeding. There needs to be better enforcement of the existing rules around the promotion of infant formula milk.
 - Improved early years education to inform and promote appropriate introduction of solids to infants’ diets.
 - The strategy needs to set ambitious targets for initiation and maintenance of breastfeeding.
 - Training and equipping the early years workforce, in both the voluntary and statutory sector, to effectively support parents and families to promote healthy eating and activity in their children. Evidence-based training should be made available and the long-term effectiveness of current national online training should be independently evaluated.
 - A programme to ensure the widespread take-up of best practice, cost-neutral early years schemes such as the NHS Champ project in Manchester, and continued support to those already in operation.
 - Government funding for local authorities to make available effective interventions to support families with pre-school children most at risk of obesity. (Paragraph 63)

16. We recommend that the next childhood obesity plan include specific measures to ensure that data on child measurement are able to flow effectively between different parts of the health and social care system to the child’s general practitioner, who should take on primary responsibility for co-ordinating appropriate weight management advice and services, and to the child’s parent. We recommend that consideration is given to including a further measurement point within the Child Measurement Programme, in addition to better collation of opportunistically gathered measurements. Early identification and targeted support is necessary to reduce health inequalities. (Paragraph 65)

17. We urge the Government, and specifically the Department for Education, to review its performance in executing the measures contained in the Government’s first childhood obesity plan relating to schools. We urge a full and timely implementation of all of the measures contained in their first Childhood Obesity Action Plan, including updating the School Food Plan to account for the updated

dietary recommendations for free sugars and fibre. School Food Standards should be mandatory for all schools including all academies, as should the Healthy Rating Scheme. (Paragraph 69)

18. We endorse the approach taken by the Amsterdam Jump In programme and in particular the culture change it drives around a healthy food and drink environment as well as the importance of wellbeing and physical activity. We look forward to the Government's publication of its appraisal of the role of sleep quality in tackling obesity and improving wellbeing. The Government should act on its findings and recommendations. (Paragraph 70)
19. The greatest attention should be focused on schools with the greatest prevalence of obesity in order to reduce the unacceptable and widening health inequality of childhood obesity. Messages however should be positive and focus on health and wellbeing rather than stigmatise obesity. We also recommend that the Government commission research to find the messages that will be most effective within communities at greatest risk, for example on the need to reduce sugar to protect children's teeth. (Paragraph 71)

Takeaways

20. We repeat the calls of our predecessor Health Committee, and argue that the next round of the Government's childhood obesity plan must, as a matter of urgency, include provisions for changes to planning legislation to make it easier for local authorities to limit the proliferation of unhealthy food outlets in their areas. The Government must also provide further clarity for local authorities on the extent to which existing powers can be used and enforced as we heard that planning inspectors do not take a consistent approach to appeals. (Paragraph 78)
21. Local authorities need further powers to limit the prevalence of high fat, sugar and salt food and drink billboard advertising near schools. Currently, the only powers available to local authorities extend to the positioning of the billboards themselves, not the content of the advertising. Local authorities also need further powers to tackle the proliferation of existing takeaways. (Paragraph 79)
22. We strongly support recommendations, including those which we heard from Public Health England in our most recent evidence session, that health should be made a licensing objective for local authorities. (Paragraph 80)

Fiscal measures

23. We echo our predecessor Committee in welcoming the introduction of the soft drinks industry levy and urging the Government to extend it to milk-based drinks. (Paragraph 84)
24. The next Government's next childhood obesity plan must set out further fiscal measures which are under consideration to cover food groups such as puddings and chocolate confectionary, which the PHE sugar reduction and wider reformulation programme review has shown are not making progress in sugar and calorie

reduction. We recommend that these measures should be implemented if there is not substantially faster progress on reformulation for these groups in the coming year. (Paragraph 85)

25. The Government's new childhood obesity plan must maintain the pressure on industry to reformulate through the promise of concrete further action if there is not faster progress on reformulation. (Paragraph 87)
26. We are extremely disappointed that the revenue being generated from the Soft Drinks Industry Levy has been diverted into core schools budgets. We reiterate our predecessor Committee's argument that the proceeds of the soft drinks industry levy should be directed towards measures to improve children's health, and specifically addressing health inequalities. (Paragraph 92)
27. We recommend that the Government undertake a consultation on the adjustment of VAT rates on food and drink after Brexit as a possible measure to tackle childhood obesity. (Paragraph 95)

Labelling

28. Efforts to increase awareness of healthy dietary behaviour must be supported in the next round of the Government's childhood obesity plan by measures to ensure consistent and clear labelling information for consumers. We also support a ban on health claims on high fat, salt and sugar food and drinks, in line with oral evidence from Public Health England. Current progress on labelling in the UK is reliant on voluntary commitments and is therefore not universally applied. (Paragraph 98)
29. Calorie labelling at point of food choice for the out-of-home food sector would provide basic information to enable healthier choices. However, in light of evidence that current labelling tends to be less effective at changing choices in communities where obesity prevalence is greatest, we urge the Government to ensure that the effects are carefully monitored, in order to ensure that labelling is designed to make the healthy choice clear and straightforward. (Paragraph 99)

Support for children living with obesity

30. We heard that signposting to appropriate advice, and where necessary, timely referrals for treatment was inconsistent for children living with childhood obesity. The Government must ensure there are robust systems in place not only to identify children who are overweight or obese, but to ensure that these children are offered effective help through a multidisciplinary, family-centric approach. This should include children identified by the National Child Measurement Programme. Addressing health inequalities must include providing help for those children who are already obese. (Paragraph 103)

Formal minutes

Wednesday 23 March 2018

Members present:

Dr Sarah Wollaston, in the Chair

Luciana Berger

Johnny Mercer

Mr Ben Bradshaw

Dr Paul Williams

Dr Lisa Cameron

Draft Report (*Childhood obesity: Time for action*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 103 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Eighth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Tuesday 5 June at 2pm.]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

Tuesday 1 May 2018

Kieron Boyle, Chief Executive, Guy's and St Thomas' Charity, **Laura Flanagan**, School Food Improvement Officer, Croydon Food Flagship Programme, **Gill Heaton OBE**, NHS CHAMP, **Sarah Vince-Cain**, NHS CHAMP, and **Dr James Nobles**, Research Fellow, Leeds Beckett University [Q1–37](#)

Jamie Oliver, Jamie Oliver Group, and **Hugh Fearnley-Whittingstall** [Q38–69](#)

Professor Jack Winkler, Emeritus Professor of Nutrition Policy, London Metropolitan University, **Dr Laura Johnson**, Senior Lecturer in Public Health Nutrition, University of Bristol, **Martin O'Connell**, Associate Director, Institute for Fiscal Studies, **Professor Franco Sassi**, Director, Centre for Health Economics and Policy Innovation, and **Dr Peter Scarborough**, Associate Professor and University Research Lecturer, Nuffield Department of Population Health, University of Oxford [Q70–91](#)

Tuesday 8 May 2018

Dr Emma Boyland, Senior Lecturer, Psychological Sciences, University of Liverpool, **Shahriar Coupal**, Director of the Committees, Committee of Advertising Practice and Broadcast Committee of Advertising Practice, Advertising Standards Agency, **Stephen Woodford**, Chief Executive, Advertising Association, **Dan Parker**, Chief Executive Officer, Living Loud, and **Professor Russell Viner**, Obesity Health Alliance [Q92–151](#)

Andrew Opie, Director of Food Policy, British Retail Consortium, **Malcolm Clark**, Policy Manager (Cancer Prevention), Cancer Research UK, **Dr Jean Adams**, Programme Lead, UKCRC Centre for Diet and Activity Research (CEDAR), **Dan Parker**, Chief Executive Officer, Living Loud, **Susan Jebb OBE**, Professor of Diet and Population Health at the Nuffield Department of Primary Care Health Sciences, University of Oxford [Q152–173](#)

Councillor Richard Kemp CBE, Leader of the Liberal Democrats on Liverpool City Council, Local Government Association, **Chris Holmes**, Managing Director, Shift Design, **Maurice Abboudi**, Vice Chair, British Takeaway Campaign, and **Dr Burgoine**, Career Development Fellow, UKCRC Centre for Diet and Activity Research (CEDAR) [Q174–212](#)

Tuesday 22 May 2018

Duncan Selbie, Chief Executive, Public Health England, and **Dr Alison Tedstone**, National Director, Public Health England [Q213–272](#)

Steve Brine MP, Parliamentary Under-Secretary of State, Department of Health and Social Care, **Dr Alison Tedstone**, National Director, Public Health England, **Margot James MP**, Minister of State for the Department for Digital, Culture, Media and Sport, and **Nadhim Zahawi MP**, Parliamentary Under-Secretary of State, Department for Education [Q273–384](#)

Published written evidence

The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website.

COY numbers are generated by the evidence processing system and so may not be complete.

- 1 Advertising Association ([COY0046](#))
- 2 Advertising Standards Authority ([COY0013](#))
- 3 Appetite and Obesity Research Group, University of Liverpool ([COY0036](#))
- 4 Association for Physical Education ([COY0032](#))
- 5 Association of Directors of Public Health ([COY0027](#))
- 6 Bob Goodall ([COY0023](#))
- 7 British Dietetic Association ([COY0042](#))
- 8 British Medical Association (BMA) ([COY0014](#))
- 9 British Retail Consortium ([COY0008](#))
- 10 British Retail Consortium ([COY0061](#))
- 11 British Soft Drinks Association ([COY0033](#))
- 12 Cancer Research UK ([COY0012](#))
- 13 Cancer Research UK ([COY0063](#))
- 14 Centre for Exercise, Nutrition and Health Sciences ([COY0045](#))
- 15 CLOSER, the home of longitudinal research ([COY0043](#))
- 16 Croydon Council ([COY0059](#))
- 17 Department of Health and Social Care ([COY0054](#))
- 18 Diabetes UK ([COY0015](#))
- 19 Dr Emma Boyland ([COY0006](#))
- 20 Dr Eric Robinson ([COY0034](#))
- 21 Faculty of Dental Surgery at the Royal College of Surgeons ([COY0021](#))
- 22 First Steps Nutrition Trust ([COY0016](#))
- 23 Food and Drink Federation ([COY0047](#))
- 24 Guys & St Thomas' Charity ([COY0029](#))
- 25 Health Action Campaign ([COY0007](#))
- 26 HENRY ([COY0037](#))
- 27 Hugh Fearnley-Whittinstall ([COY0064](#))
- 28 Jamie Oliver Group ([COY0044](#))
- 29 Leeds Beckett University ([COY0048](#))
- 30 Living Loud ([COY0025](#))
- 31 Living Loud ([COY0060](#))
- 32 Living Loud ([COY0062](#))
- 33 MRC Epidemiology Unit, ([COY0050](#))

- 34 Mrs Rachel Henderson ([COY0001](#))
- 35 Nestle UK ([COY0039](#))
- 36 NHS CHAMP Project ([COY0053](#))
- 37 Obesity Action Scotland ([COY0010](#))
- 38 Obesity Health Alliance ([COY0009](#))
- 39 Oliver Mytton ([COY0056](#))
- 40 Oliver Mytton ([COY0057](#))
- 41 Professor Jack Winkler ([COY0051](#))
- 42 Professor Paul Kelly ([COY0035](#))
- 43 Professor Peymane Adab ([COY0026](#))
- 44 Public Health England ([COY0005](#))
- 45 Royal College of Midwives ([COY0002](#))
- 46 Royal College of Paediatrics and Child Health ([COY0028](#))
- 47 School Food Matters ([COY0041](#))
- 48 SDIL Evaluation Team ([COY0052](#))
- 49 Shine ([COY0058](#))
- 50 Sport and Recreation Alliance ([COY0040](#))
- 51 Sustain: the alliance for better food and farming ([COY0024](#))
- 52 The Daily Mile Foundation ([COY0018](#))
- 53 The Food Foundation ([COY0022](#))
- 54 The Foundation For Liver Research ([COY0004](#))
- 55 The Local Government Association ([COY0011](#))
- 56 The School & Nursery Milk Alliance ([COY0020](#))
- 57 Thijs van Rens ([COY0055](#))
- 58 UK Health Forum ([COY0049](#))
- 59 ukactive ([COY0019](#))
- 60 University of Hertfordshire ([COY0003](#))
- 61 University of Liverpool ([COY0038](#))
- 62 University of Southampton (LifeLab) ([COY0017](#))
- 63 Weight Watchers ([COY0030](#))

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the [publications page](#) of the Committee's website. The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2017–19

First Report	Appointment of the Chair of NHS Improvement	HC 479
Second Report	The nursing workforce	HC 353
Third Report	Improving air quality	HC 433
Fourth Report	Brexit: medicines, medical devices and substances of human origin	HC 392
Fifth Report	Memorandum of understanding on data-sharing between NHS Digital and the Home Office	HC 677
Sixth Report	The Government's Green Paper on mental health: failing a generation: First Joint Report of the Education and Health and Social Care Committees of Session 2017–19	HC 642
First Joint Special Report	Children and young people's mental health—the role of education: Government Response to the First Joint Report of the Education and Health Committees of Session 2016–17	HC 451