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Submitted to **A healthier future - action and ambitions on diet, activity and healthy weight**
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Transforming the food environment

Promotions

1 Are there any other types of price promotion that should be considered in addition to those listed above?

Yes

Please explain your answer.:
The Royal College of Physicians of Edinburgh is an independent clinical standard setting body and professional membership organisation, which aims to improve and maintain the quality of patient care. Founded in 1681, we support and educate doctors in the hospital sector throughout Scotland and the world with over 12,000 Fellows and Members in 91 countries; covering 54 medical specialties and interests. The College has worked to improve public health for nearly 350 years and promotes health and wellbeing for all.

The focus in terms of price promotions is understandably on the promotion of food and drink which is high in fat, sugar and salt. However, the alternative approach is to facilitate promotions of healthy choices – both unprocessed foods (eg. fruit and vegetables; poultry or fish) and processed but in a more responsible way. College Fellows suggest that without a radical change in cooking habits, the popularity of ready meals, or components of these, will continue. The convenience food revolution from the 1950's onwards will only be reversed by attitudinal change – education both in what to eat, how to cook it and a change in time priorities: ie. making time to prepare food.

Frequently foods which are not nutritionally balanced not only taste good but are easy and quick and require no thought or cooking skills to prepare. The promotion of cooking clubs that make meal preparation a family event and fun would be positive. The encouragement/incentivisation of supermarket promotions of foods produced by companies who adhere to low fat, low sugar etc should be considered to make these a popular choice in terms of cost and 'reward' the companies in terms of sales for responsible production. If this goes alongside food and health education in schools, there may be a longer term, sustainable change.

Fellows also suggested that promotions through loyalty/reward card points and price reduction coupons should be considered. These promotions often apply to large packs sizes or nutritionally unbalanced foods and may encourage over-purchasing.

2 How do we most efficiently and effectively define the types of food and drink that we will target with these measures?

Please explain your answer.:
This is a complex area, for example foods that are high in fat and marked by one of the traffic light systems as "bad" may be healthy if taken at low volume and in the context of the rest of the dietary intake. The current warning systems need to go a stage further and improve the way they present information such as "% of recommended daily intake". One solution is to provide the consumer with ideal daily/weekly diet component/intake cards that they can use with food labelling achieve a balanced diet. Once there is familiarity with a balanced diet, it is likely that the choices will become ingrained and the natural selection of the consumer.

Fellows believe the main focus for promotional measures should be discretionary foods. The lay public can easily grasp the concept of foods that are "treats" (desserts, snacks, sweet drinks which are largely taken between meals or unnecessary addition to meals) rather than an integral part of the diet. There may be foods that are high in sugar or saturated fat but which may contribute essential nutrients to the diet and the key is to avoid confusing the public. For example, macaroni cheese is high in saturated fat but if you include broccoli, cauliflower or kale in the recipe the cheese and macaroni can be a way of encouraging children to include vegetables in their diet. Thus, picking foods high in a specific nutrient (eg saturated fat) may risk penalising foods that do contribute to the diet, whereas a focus on foods and drinks that do not contribute any essential nutrients (treats, snacks, desserts) will probably be better understood by the public than a more complex nutritional model.

Advertising

3 To what extent do you agree with the actions we propose on non-broadcast advertising of products high in fat, salt and sugar?

Strongly agree

Please explain your answer.:
The College is of the view that obesity is not inevitable; it is a crisis by design. Advertising is a powerful lever: potent; pervasive and refined by years of commercial research. Extending advertising restrictions is likely to reap benefits by reducing the exposure of particular groups to targeted advertising. The restriction of advertising on public transport; public buildings and near schools should be examined further.

However, it is also important to consider that advertising campaigns can be used in a positive way: for example, to demonstrate the harms of being obese, and could be implemented in same way that has been done successfully for tobacco and alcohol. In order to have the required impact, action on advertising needs to be combined with education and reinforced by parental education – there is little point in children being informed about a healthy balanced diet if their parents fill their packed lunch box with treats.

Out of home sector

4 Do you think any further or different action is required for the out of home sector?

Yes

Please explain your answer.:
What is proposed is good in terms of information, more emphasis so that the consumer is aware of how many calories and adverse food sources are in out of home foods would also be helpful. Calorie capping may be a good way of promoting better industry practice.

Consideration should be given to food and other retail/entertainment promotions, such as the purchase of a cinema ticket plus sweets/drink/popcorn.

Thought should be given to taking positive action to support and/or reward out of home outlets serving healthier foods/labelling informatively rather than have only punitive options. There could be encouragement on reducing unnecessary additions to prepared foods, such as mayonnaise on sandwiches, sauces on restaurant dishes, dressings on salads etc. On a menu, instead of low fat or reduced fat listed on sauces or dressings, direct the consumer to lower fat as standard and label others as full fat or high fat as the exceptions.

Planning system and the food environment

Labelling

5 Do you think current labelling arrangements could be strengthened?

Yes

Please explain your answer.:
It is vital that the public can make informed choices about food. The colour coded nutrition labelling scheme is well known and easily understood. Any food labelling must be straightforward and more complex labelling may be confusing. However, information could be made more prominent, so it can be easily read on packaging. Ensuring higher uptake of the labelling code and extending it to out of home sales would be useful, combined with more education of the consumer as to what intake is required/what is excessive.

In food labelling more emphasis could be given to the protein content, as this is particularly important for satiety and for children's growth and health.

Fellows have suggested that particularly for "treat" foods, there could be posters in the aisles in shops or labelling on packaging to illustrate, for example, one chocolate bar = however many minutes of walking/running etc to burn off the calories. This is again offering consumers more information and enabling them to make educated choices about food.

Reformulation and innovation

6 What specific support do Scottish food and drink SMEs need most to reformulate and innovate to make their products healthier?

What specific support do Scottish food and drink SMEs need most to reformulate and innovate to make their products healthier?:
There must be incentives for SMEs to "buy into" these initiatives, with positive marketing rather than wholly negative instruments. SMEs could be offered access to research and innovation (for example, alliance with industry and academia/universities and food science related grants) if not already available.

A gradual process of change is also likely to be most effective, underpinned by there being a clear rationale and evidence for the suggested changed, positive alternative models and financial support if necessary.

Food and drink levies

Living healthier and more active lives

Developing a positive relationship with food from birth to adulthood

7 Do you think any further or different action is required to support a healthy weight from birth to adulthood?

Yes

Please explain your answer.:
There is a good overall program; however increased focus on effective delivery will be important. Point 2.10 raises the importance of engaging with, informing and supporting women before their first pregnancy to ensure they start their pregnancy at a healthy weight. At present, many do not start pregnancy at a healthy weight, resulting in increasing numbers who develop gestational diabetes mellitus (GDM), a temporary form of diabetes in pregnancy. Developing GDM is associated with an increased risk of developing type 2 diabetes in future. This high risk group is seen fortnightly in pregnancy once their diabetes is diagnosed. There is an opportunity to educate these women about future weight loss and reduced risks of future permanent diabetes. But dietetic support for these clinics is scarce. Investing in education for these women would potentially reduce their future risk of permanent type 2 diabetes as well as targeting a high risk group for education on how to maintain a healthy weight for their child.

Targeting pre-school children and their parents (using multiple strategies) is crucial here, given that if a child starts school already obese it is far harder to change trajectory. Whole family eating should be the focus for improvement. There should be education on correct eating choices for children at every opportunity – starting with antenatal classes, then nursery, pre-school, primary school, etc. Person centred, positive intervention is essential in this regard: it is important to focus on the person not their weight in obesity control programmes especially for children. At school, introduce puddings or treats only as balanced by activity levels, not with every meal e.g. no routine pudding after school dinners. Play areas should have free water access for active children and consideration should be given to incentivising activity further for young people. For example, make walking to school and work more attractive options for children and young people – give them "walking fares" instead of bus fares.

Access to subsidised exercise is important for those who cannot afford it. While children will have access to physical education at school, some will leave school before the age of 18 and be unable to access private gyms. While there is subsidised exercise available, there have been reductions in access recently due to pressure on budgets. However, this is very much investment in the health of the population and preventative spending and so reductions in provision are essentially false economy. The College also views it as important that access is maintained across all health and social care partnerships to avoid a postcode lottery.

Living healthier and more active lives also requires a broader commitment to how we plan our cities and towns and will involve cross departmental working: health and sport cannot tackle obesity without collaborative action from education; planning; economy; housing and others. As an example, many European cities encourage active travel and are designed to make this easy and accessible. Scotland could learn much from examples around the world of best practice in this regard.

There appears to be a vital theme missing in the consultation on the psychological factors behind issues with weight. Weight is not simply a physical issue and without addressing the mental health issues behind an individual's relationship with their body, long term sustainable lifestyle change is highly unlikely. Consideration should be given to providing psychological support for weight management. As an example, the Lothian weight management programme recognises the existence of disordered eating (as opposed to eating disorders such as anorexia or bulimia). Examples would include binge or comfort eating in response to stress or anxiety. Dietary support alone is insufficient unless the person is given the skills to recognise triggers that lead to unhealthy eating (eg stress) and alternative strategies to deal with these issues.

Supported weight management

8 How do you think a supported weight management service should be implemented for people with, or at risk of developing, type 2 diabetes - in particular the referral route to treatment?

How do you think a supported weight management service should be implemented for people with, or at risk of developing, Type 2 Diabetes - in particular the referral route to treatment?:
Significant improvements are needed here focusing on those recently diagnosed with type 2 diabetes and those with pre-diabetes (including women who have had gestational diabetes). There are some ongoing initiatives but uptake to DESMOND (Diabetes Education and Self-Management for Ongoing and Diagnosed) is at best patchy and many patients with type 2 diabetes being looked after in primary care get no proper dietetic input at any stage. Consideration should be given to whether DESMOND is the best tool (and whether a wider range of options need to be made available). Current access to Tier 3 services is too restrictive and if a patient fails to keep just one appointment they will be excluded, which is very restrictive.

However it is vital to look downstream: perhaps a major public health campaign about what diabetes is and how to prevent it would be more impactful–there is concern among College Fellows that with increasing numbers of overweight/obese and diabetics that it is becoming the 'norm' and therefore accepted. Fellows are concerned that many people do not realise how devastating diabetes can be if there is a public perception that you can simply "take a pill" and the problem will go away. Patient educators are potentially more successful than health care professionals in this regard.

Healthy weight advice should be offered at all health contacts, with an emphasis on friendly, useful advice which is relevant and is tailored to the individual's understanding of healthy eating and their circumstances. For example, this could be how to make "quick and easy swaps", such as swapping a large whole milk latte coffee for a large filter coffee, which could reduce consumption by over 200 calories (for example, see Starbucks Caffe Latte- Grande- Whole Milk- 228kcal; Starbucks Fresh Filter Coffee- Grande- 3 kcal https://globalassets.starbucks.com/assets/C188769C64A54E49AE1D467978F60E8B.pdf)

Lothian has a tiered weight management service (Lothian Weight Management Service – LWMS), which includes community based group education, psychology support for disordered eating (not eating disorders, but behaviours that might fall within the spectrum of 'comfort eating' in response to anxiety of stress) , group exercise and bariatric surgery. The principles behind this pathway are sound, although a few improvements could (and have) been made. When the LWMS was set up, referral was only via primary care, leading to a situation where those at greatest risk (people with existing diabetes and spiralling weight gain) could not be referred directly from the diabetes clinic and needed a separate GP appointment to obtain a referral. Patients did not always take this additional step and referral opportunities were lost. Thankfully, the pathway was changed some time back so that both primary and secondary care could refer in. This is key in the climate of joint working between health and social care and increasing cooperation between primary and secondary care; referrals to any successful weight management pathway must be allowed via a range of sources.

Lothian has already had some success with reversal of diabetes via its participation in the DiRECT study and it seems sensible for weight management programmes across Scotland to offer programmes in line with the evidence from DiRECT for suitable individuals, particularly those within the first 5 years of diabetes.

For those at high risk of the complications of obesity (ie those newly diagnosed with type 2 diabetes) special efforts must be made at the time of diagnosis to embed healthy living habits, particularly now that there is data to support the fact that intensive lifestyle change can push diabetes into remission. There is insufficient provision for structured (and other forms of) education at the time of diagnosis of type 2 diabetes. There is also insufficient resource to educate high risk groups such as women who have had gestational diabetes and are therefore at risk of developing type 2 diabetes in future. Focusing resources on these high risk groups is likely to yield significant health dividends. However, supporting sustainable lifestyle change involves much more than just education. Programmes will need to explore the provision of psychological support at this crucial time to give people the skills to adjust to their diagnosis in a proactive way that supports sustainable change.

Healthy living and other interventions

9 Do you think any further or different action on healthy living interventions is required?

Yes

Please explain your answer.:
The College outlined our policy priorities in Health Priorities 2017 (http://www.rcpe.ac.uk/sites/default/files/files/rcpe_health_priorities_2017.pdf): in this document we call for the Scottish Government to “renew and prioritise the obesity route map”. Our Fellows have commented that there are many positive and evidence-based initiatives in the 2010 strategy which have not yet been brought to fruition: the College would like to see the new strategy encompass the aspects of the 2010 strategy which are yet to be realised, including significant cross-portfolio cooperation prompting fundamental change in environmental, social and cultural circumstances in Scotland, and leading to the normalisation of healthy weight and physical activity.

Learned behaviours were discussed by the College’s Fellows and Members as contributory factors to obesity: the familial environment, unintentional harm and eating habits. Comparisons were made with second-hand smoke. Obesity has become normalised in society: clothes are readily available in extra-large sizes. In the past it was abnormal to be overweight, whereas now it is abnormal - statistically - to be a healthy weight. Fellows have highlighted that instead of preventing obesity we are finding solutions to the consequences of obesity, further consolidating its normalisation.

College Fellows were keen to change the perception from “going on a diet” to making a “lifestyle change”. A diet is temporary and short term but behaviour doesn’t change in the long term. Psychological issues for eating problems and difficult relationships with food also need to be addressed. Societal change is needed to make it easy and attractive to be fit and healthy: exercise and activity should be normal and encouraged.

The status quo has not worked, the focus on obesity as a disease for surgical or dietician involvement needs to change and a radical re-education of the expectation of population around food exercise and health consequences needs to be undertaken.

Living healthier and more active lives will also require a sustained broader commitment to how we plan our cities and towns. Adding cycle lanes or pavements to busy roads would help encourage a more active approach to getting around, rather than an automatic reliance on cars. The College notes that this is referred to later in section 2.33, with the appointment of an Active Nation Commissioner. To be effective, this role must work across government departments and have considerable influence.

Clinicians need to have time to have conversations with patients about obesity. Clinicians can be uncomfortable about weight conversations, and have limited time to introduce the topic into discussion. College Fellows support medical students being trained more widely in health and wellbeing, and importantly in how to have these more difficult conversations about obesity with their patients as well as treating patients.

Whose remit is it to discuss weight with patients? The weight of NHS staff themselves sometimes acts as a barrier to open discussions (see Obesity and NHS Scotland staff briefing: Obesity Action Scotland
http://www.obesityactionscotland.org/images/pdfs/briefings/NHSScotlandStaffWeb.pdf).

Clinicians need to find time to have conversations with patients about obesity. Clinicians are often uncomfortable about weight conversations, but need to have courage and accept they won't always have the answer. A study on brief interventions published in The Lancet (Lancet 2016; 388: 2492–500 http://thelancet.com/pdfs/journals/lancet/PIIS0140-6736(16)31893-1.pdf) , found that 8 in 10 overweight or obese people thought it was appropriate and helpful for their GP to suggest that losing weight would be good for their health.
The College's primary training responsibility is to develop and oversee the specialty curricula within medicine. We do this jointly with our sister Colleges, through the Joint Royal Colleges of Physicians’ Training Board (JRCPTB https://www.jrcptb.org.uk/). All UK medical trainees must be enrolled with JRCPTB. There is a considered view among Fellows that medical students should be trained more widely in health and wellbeing, and importantly how to have these more difficult conversations about obesity with their patients as well as treating patients. This is part of a wider need to move from curative medicine to preventative medicine.

Physical activity

10 How can our work to encourage physical activity contribute most effectively to tackling obesity?

How can our work to encourage physical activity contribute most effectively to tackling obesity?:
The College agrees that removing the barriers to physical activity is important to get adults and children moving more and feeling better. Initiatives such as The Daily Mile, where primary-and nursery-aged children run, jog or walk outside in the fresh air each day at school, are needed to improve children’s fitness, concentration levels, mood, behaviour and general well-being. There is a danger of children feeling valueless and vulnerable: a child needs to feel valued and feel that they are taking responsibility for their actions. Initiatives such as the daily mile are helpful and positive in this regard.

The College supports fully embedding physical activity for health (The Scottish Academy of Medical Royal Colleges and Faculties, Pledge on Physical Activity. http://www.scottishacademy.org.uk/documents/pledge-on-physical-activity.pdf
) into primary care, secondary care, social care and health education, as well as in the health and social care workforce and workplace. This would include ensuring secondary care staff provide guidance on the recommended minimum levels of physical activity for health, offer brief advice and brief intervention, and signpost to community resources fully supporting the aims of the Health Promoting Health Service.

Work to encourage physical activity needs to take place across the whole spectrum of society, but probably needs to focus on those at greatest risk of developing complications of obesity in order to make the most efficient use of resources. This includes targeting areas of social deprivation where people have less access to leisure facilities and focusing on high risk groups such as those recently diagnosed with type 2 diabetes, where we know that intensive and sustained lifestyle change can push the condition into remission. Women who have had a diagnosis of gestational diabetes are a further high risk group where resources should be focused, particularly as these women will probably focus on their child’s health rather than their own.

In schools, continue the work outlined to make walking to school the norm. Consider drop off exclusion zones around schools – make drop off further away with safe routes to walk to school. There should be more focus on walking and being active than having to attend the gym or looking to an elite athlete as a role model (i.e. activity as part of normal daily life).

Leadership and exemplary practice

Leadership

11 What do you think about the action we propose for making obesity a priority for everyone?

What do you think about the action we propose for making obesity a priority for everyone?:
It is absolutely vital that this is seen as everyone's issue. If this is seen as an issue for just one sector of society to solve (be that government, the NHS, schools or parents) the problem will remain endemic. College Fellows have stated that we must rapidly get away from the increasing perception that obesity is the 'new norm' and associated acceptance of this. The College feels that all concerned - healthcare workers, teachers, policy makers and the public have to overcome our diffidence in discussing not just obesity but also being overweight as a life-threatening illness.

What is proposed is laudable and deliverable but needs to have a wider reach and an aspiration to be much more.

12 How can we build a whole nation movement?

How can we build a whole nation movement? :
This will take time and commitment must be sustained. Government needs to build cross party support for this so that any measures put in place are guaranteed longevity and sustainability.

The College feels that one component of building a whole nation movement is the ability to have a frank conversation about the issues. Although the word obesity has acquired pejorative connotations, health professionals in particular have to be able to use it. Many people who are obese do not realise just how overweight they are, partly because discussions skirt round the issue and professionals feel uncomfortable. The real issues around obesity are not aesthetic, but health-related. People need to understand that obesity is linked to a range of complications, such as cancer and erectile dysfunction for men. There is a lack of insight from many patients, a sense of denial and reluctance to acknowledge the consequences of their actions. There is also disassociation. For example, telling people that their BMI is too high does not help, as people say that they "feel ok".

Individuals also need to take ownership and personal responsibility as there is only so much that health policy, education and legislation can do. However, an excellent example of changing perceptions is the smoking ban in public places, which has significantly changed public acceptance of smoking and we need to build momentum so that it is no longer acceptable to be significantly overweight.

How can we help people change their behaviour? Personal choice will always remain but we need to create an environment where people have a wider range of options to help them make healthy choices. As an example, cardiology is dominated by obese patients and the general theme is "it's 20 years too late" for these patients to make effective change. If patients had lost weight earlier, a lot of problems could have been prevented.

Obesity needs to be "all of our business" and, rather than working in silos, we should learn from each other. Being obese doesn't give a good quality of life: someone is "alive but not living". Societal movements such as the Park Run and the #thisgirlcan campaign are very useful in making contributions. Patients and the public need to "buy in" to programmes and want to be a part of them if they are to be successful.

Every setting needs to be included: homes; workplaces; shops etc. Hospitals should encourage physical activity more – people are told to stay in bed, or a chair. Activity can help improve muscle mass and lead to less falls. A sustained approach is needed, and an example could be a shared gym for hospital staff and patients.

Evidence-based improvement

13 What further steps, if any, should be taken to monitor change?

What further steps, if any, should be taken to monitor change?:
The proposed plan is good, but a wide range of performance indicators is needed both from national demographics and indicator diseases. It is important to be aware that change will not be seen overnight, and change must be seen in terms of an ongoing, long term movement. Data, in terms of morbidity and mortality, should be easy to demonstrate in the long term.

14 Do you have any other comments about any of the issues raised in this consultation?

Do you have any other comments about any of the issues raised in this consultation?:
Fellows have commented that the obesity epidemic is without doubt the single biggest health threat facing Scotland. Mobilisation of resources to tackle it should be on a significant scale. Lessons that can be taken from addressing tobacco and alcohol use should be learned and integrated into the new obesity strategy.

There are some key areas where the College would like to see further detail:

• Obesity and type 2 diabetes are linked to social deprivation and the College would like to see a focus on health inequalities and how these can be tackled in the strategy.

• The College would also like to see greater emphasis placed on the psychological side of issues with weight and eating, which affect many people. The issues around weight are not solely physical and in order to have a successful and effective strategy which makes a measurable impact it is vital that a holistic, whole person view is taken.

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Are you responding as an individual or an organisation?

Organisation

What is your organisation?

Organisation:
Royal College of Physicians of Edinburgh

If you are responding on behalf of an organisation, please tell us the type of organisation for which you are providing a response.

Other (please note in the text box provided)

If other, please specify.:
Medical Royal College

The Scottish Government would like your permission to publish your consultation response. Please indicate your publishing preference:

Publish response with name

We will share your response internally with other Scottish Government policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for Scottish Government to contact you again in relation to this consultation exercise?

Yes

Evaluation

Please help us improve our consultations by answering the questions below. (Responses to the evaluation will not be published.)

Matrix 1 - How satisfied were you with this consultation?:
Slightly satisfied

Please enter comments here.:

Matrix 1 - How would you rate your satisfaction with using this platform (Citizen Space) to respond to this consultation?:
Slightly satisfied

Please enter comments here.: