

Potential scope of recommendations from the CPMC Summit on Obesity – 9 Nov 2016

Life course considerations

Infancy, childhood, youth, adulthood and aging

- Promoting the intake of healthy foods at all ages
- Weight management
- Preconception and pregnancy care
- Early childhood diet and physical activity
- Health, nutrition and physical activity for school aged children

Regulatory mechanisms

- Taxation on sugar
- Advertising restrictions
- Clear and specific food labelling
- Regulating sale of fast food in schools, sporting venues and other high risk locations

Lifestyle and behaviours

- Promotion of physical activity exercise and play
- Dietary guidelines freely available and distributed through multiple conduits
- Health professionals to provide opportunistic advice

Environmental considerations

Urban and regional planning initiatives promoting safe, inviting and proximate access to schools, shopping precincts, playgrounds and sporting facilities:

- Pedestrian pathways
- Cycle ways

Adjunctive therapies

- Surgery
- Medication
- Psychological support and dealing with stigma.

This involves identifying positive solutions across the social determinants of health:

- **Health professional education and training** (eg curriculum development, undergraduate education and continuing professional development)
- **Health policy, planning and translation** – local (medical colleges and health associations), COAG (political/policy recommendations to governments for action)
- **Community engagement** – partnering with patients and the community to ensure shared commitment
- **Effective therapies** - developing clinical advice to provide care to people (eg models of care, clinical pathways)

Commentary and recommendations from national and international obesity initiatives

From: Work of an Australian steering committee of public health experts: Draft - *Call for key components to be included as part of a national obesity prevention strategy* (2016)

Over the past year, with a steering committee of public health experts, we have developed a call for key components to be included as part of a national obesity prevention strategy. The elements of this national obesity prevention consensus have been derived from an analysis of the potential role of federal government from key national and international statements on obesity and chronic disease prevention. Through a process of deliberation and prioritisation the steering committee has identified eight federal government priority actions for obesity prevention:

Eight Priority Areas

Recommended action: Federal government to place a health levy on sugary drinks to increase the price by 20%.

1. Recommended action: Legislate to implement time-based restrictions on exposure of children (under 16 years of age) to unhealthy food and drink marketing on free to air television up to 9:30 pm.

2. Recommended action: Set clear reformulation targets for food manufacturers, retailers and caterers with established time periods and regulation to assist compliance if not met.
 3. Recommended action: Make the Health Star Rating System mandatory by July 2019.
 4. Recommended action: Develop and fund a comprehensive national active travel strategy to promote walking, cycling and use of public transport.
 5. Recommended action: Fund high impact, sustained public education campaigns to improve attitudes and behaviours around diet, physical activity and sedentary behaviour.
 6. Recommended action: Establish obesity prevention as a national priority, with a national taskforce, sustained funding, regular and ongoing monitoring and evaluation of key measures and regular reporting around targets.
 7. Recommended action: Develop, support, update and monitor comprehensive and consistent diet, physical activity and weight management national guidelines.
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From: “This is what the Government is Doing (And Spending) to Tackle the Nation's Obesity Crisis - More than \$180 million over the next few years”, *The Huffington Post Australia*, 6 October 2016

Making Healthy Food More Accessible

One of the most significant policies the Federal Government has recently implemented is the **Healthy Food Partnership** which was introduced in November 2015. The Government has partnered with a number of public health groups and food industry bodies to make healthy food more accessible and encourage food manufacturers to make positive changes to their products.

This collective approach helps increase knowledge around health and creates opportunities for Aussies to make healthier choices at the supermarket.

Of the dozen companies and organisations involved, the partnership includes names such as Coles, Woolworths, Dairy Australia, Meat and Livestock Australia, National Heart Foundation of Australia and Dieticians Association of Australia.

The Federal Government made an initial investment of \$600,000 to the Healthy Food Partnership.

Educating Australians

About \$12 million has been put towards the **Health Star Rating system** over the next three years which is jointly funded by the Federal Government and the states and territories.

The system has been running since 2014 and rates the nutritional value of packaged food throughout the country with a star rating from half a star to five stars. However, the system is voluntary so food companies have to agree to take part in the initiative which helps Aussies make a quick and easy decision about the quality of the food they're putting in their trolleys (and mouths).

The "implementation period" is between 2014 and 2019, which gives companies the chance to create healthier versions of their products.

More than \$12 million over three years has been put towards the Health Star Rating system.

Health Minister Sussan Ley introduced the **Healthy Weight Guide** in early 2016 which is a website helping Aussies achieve and plan for weight loss, and healthier lives.

The website is free to access, which gives all Aussies the chance to get healthier with an abundance of information and resources. Users can also login, set goals and track their progress on the site.

Promoting Exercise For Kids (And Specifically Girls)

In July 2015, the Federal Government launched the Sporting Schools Initiative which aims to get Aussie kids involved in different sporting activities across the country.

More than \$100 million has been put towards the initiative for primary school children, which will continue until June 2017.

In 2016, Health Minister Sussan Ley announced a \$60 million funding expansion of the program which will grow the initiative into secondary schools for 18 months. This is just for year seven and eight students across the country.

The health department has placed a particular focus on encouraging young girls to get involved in sport, introducing a **Girl's Make Your Move campaign** in February with \$10 million in funding behind it.

The campaign encourages young women from 12 to 19 to get involved in sporting activities, promoting the physical benefits as well as emotional ones.

The website provides a guide for women to find local events to explore and also apps helping young women find local activities.

What's Next?

The National Strategic Framework for Chronic Conditions will be introduced in late 2016 and is currently being developed with the cooperation of all states and territories.

The framework will provide a new foundation of advice to address chronic conditions in Australia. This will help all health professionals work together to deliver more coordinated care and responses to chronic conditions.

From: AUSTRALIA: THE HEALTHIEST COUNTRY BY 2020 - National Preventative Health Strategy – the roadmap for action, 30 June 2009, National Preventative Health Taskforce (Australia)

First phase (2010–2013)

- 1. Drive environmental changes throughout the community to increase levels of physical activity and reduce sedentary behaviour**

- Establish a *Prime Minister's Council for Active Living* and develop and implement a National Framework for Active Living, encompassing local government, urban planning, building industry, developers and designers, health, transport, sport and active recreation ☐ Develop a business case for a new COAG National Partnership Agreement on Active Living
- Conduct research into economic barriers and enablers, policies and tax incentives to inform a national active living framework and actions
- Australian and state governments to consider the introduction of health impact assessments in all policy development (for example, urban planning, school education, transport), using partnership models such as the *Health in All Policies* (HiAP) approach in South Australia

2. Drive change within the food supply to increase the availability and demand for healthier food products, and decrease the availability and demand for unhealthy food products

- Develop and implement a comprehensive National Food and Nutrition Framework
- Commission a review of economic policies and taxation systems, and develop methods for using taxation, grants, pricing, incentives and/or subsidies to promote production, access to and consumption of healthier foods
- Establish a Healthy Food Compact between governments, industry and non-government organisations to drive change within the food supply; develop voluntary targets
- Work with industry, health and consumer groups to introduce food labelling on front of pack and menus to support healthier food choices, with easy to understand information on energy, sugar, fat, saturated fats, salt and trans fats, and a standard serve/portion size within three years.

3. Embed physical activity and healthy eating in everyday life

Workplaces

Fund, implement and promote comprehensive workplace programs building on the COAG

Healthy Workers initiative:

- Develop a national accord to establish best practice workplace programs, including: protecting the privacy of employees, workplace risk monitoring, risk assessment or risk modification programs
- Establish a voluntary industry scorecard, benchmarking and award scheme for workplace health
- Establish nationally agreed accreditation standards for providers of workplace health programs
- Establish a national action research project to strengthen the evidence of effective workplace health promotion programs in the Australian context
- Establish a national workplace health leadership program and a series of resources, tools and best practice guidelines

- Commission a review of potential legislative changes to promote the take-up of workplace health programs, including options such as:
 - Changes to Fringe Benefits Tax Assessment Act and Income Assessment Act to provide incentives
 - Employer commitment to a percentage of annual payroll allocated to workplace health programs (similar to the former Training Guarantee Levy)
- Investigate the feasibility of rewarding employers – through grants or tax incentives – for achieving and sustaining benchmark risk factor profiles in their workforce

Schools

Fund, implement and promote school programs to increase physical activity and healthy eating:

- Establish a partnership with the education sector
- Incorporate Health and Physical Education (HPE) for all Australian children into the second stage of National Curriculum development Australian and state governments to establish a national program to support implementation of the new curriculum, including teacher curriculum guidance and professional development opportunities
- Education sector to encourage all schools to develop, implement and evaluate health, nutrition and physical activity policies
- Establish system to monitor the policy requirement of at least two hours of physical activity per week for all students K–10
- Expand the coverage of out-of-school-care health programs such as *Active After School* and *Eat Smart, Play Smart*
- Education sector to examine how to build the capacity of schools and teachers to promote health and resilience more effectively

Second phase (2014–2017)

- Implement the National Framework for Active Living, encompassing local government, urban planning, building industry, developers and designers, health, transport, sport and active recreation
- Use the Healthy Food Compact to continue to drive improvements within the food supply
- Implement measures agreed to under the Healthy Food Compact

Schools

- National implementation of the HPE curriculum for all Australian children as part of the second stage of National Curriculum development
- Monitor the policy requirement of at least two hours of physical activity per week for all students K–10

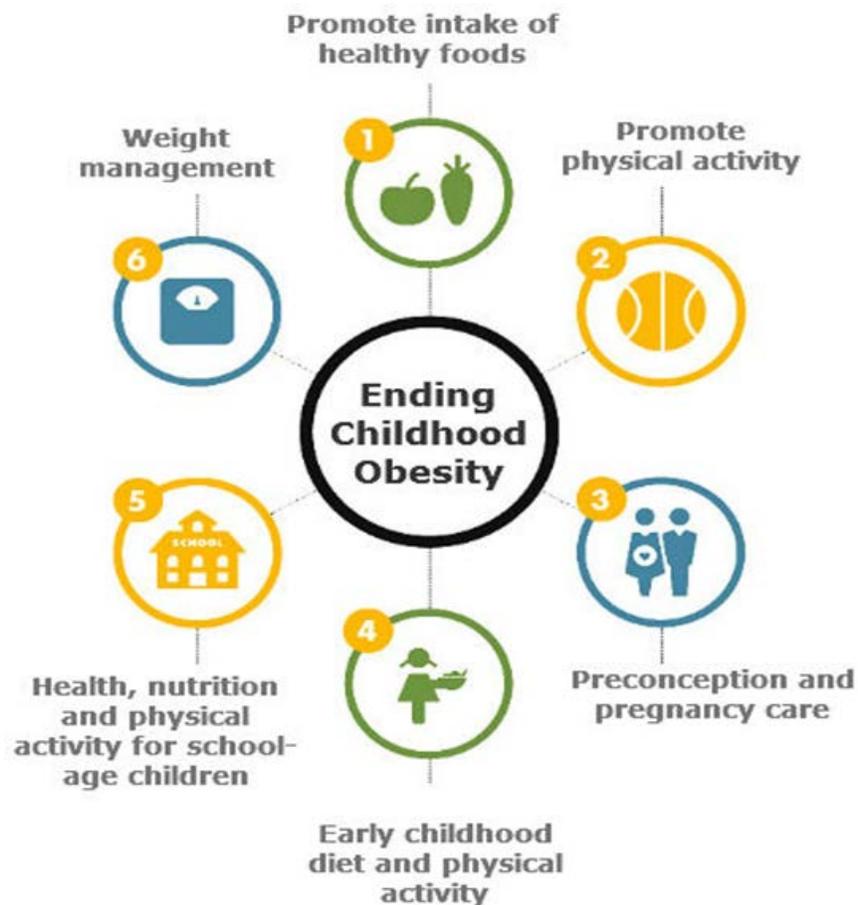
Workplaces

- Learn from best practice and promote effective workplace health promotion programs throughout Australia
- Implement recommendations of the review of potential legislative changes to promote the take-up of workplace health programs
- If feasible, implement a system to reward employers for achieving and sustaining benchmark risk factor profiles in their workforce
- Implement *Healthy Spaces and Places* planning guidelines through partnership with ALGA
- Implement new phases of comprehensive, sustained social marketing strategy to increase healthy eating and physical activity
- Continue to phase out food and beverage marketing to which children are exposed if self-regulation and co-regulation are demonstrated to be ineffective

Third phase (2018–2020)

- Monitor and report on progress with the implementation of the National Framework for Active Living
 - Monitor and report on progress with the implementation of measures agreed to under the Healthy Food Compact
 - Scale up school and workplace programs
 - Scale up community interventions across Australia according to results of national trials
 - Report on progress with the social marketing strategy to increase healthy eating and physical activity, and develop new phases as required.
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From: *Report of the Commission on Ending Childhood Obesity* World Health Organisation (2016)



RECOMMENDATIONS

1 IMPLEMENT COMPREHENSIVE PROGRAMMES THAT PROMOTE THE INTAKE OF HEALTHY FOODS AND REDUCE THE INTAKE OF UNHEALTHY FOODS AND SUGAR-SWEETENED BEVERAGES BY CHILDREN AND ADOLESCENTS.

- 1.1 Ensure that appropriate and context specific nutrition information and guidelines for both adults and children are developed and disseminated in a simple, understandable and accessible manner to all groups in society.
- 1.2 Implement an effective tax on sugar-sweetened beverages.
- 1.3 Implement the Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children to reduce the exposure of children and adolescents to, and the power of, the marketing of unhealthy foods.
- 1.4 Develop nutrient-profiles to identify unhealthy foods and beverages.

- 1.5 Establish cooperation between Member States to reduce the impact of cross-border marketing of unhealthy foods and beverages.
 - 1.6 Implement a standardized global nutrient labelling system.
 - 1.7 Implement interpretive front of pack labelling supported by public education of both adults and children for nutrition literacy.
 - 1.8 Require settings such as schools, child-care settings, children’s sports facilities and events to create healthy food environments.
 - 1.9 Increase access to healthy foods in disadvantaged communities.
- 2 IMPLEMENT COMPREHENSIVE PROGRAMMES THAT PROMOTE PHYSICAL ACTIVITY AND REDUCE SEDENTARY BEHAVIOURS IN CHILDREN AND ADOLESCENTS.**
- 2.1 Provide guidance to children and adolescents, their parents, caregivers, teachers and health professionals on healthy body size, physical activity, sleep behaviours and appropriate use of screen- based entertainment.
 - 2.2 Ensure that adequate facilities are available on school premises and in public spaces for physical activity during recreational time for all children (including those with disabilities), with the provision of gender-friendly spaces where appropriate.
- 3 INTEGRATE AND STRENGTHEN GUIDANCE FOR NONCOMMUNICABLE DISEASE PREVENTION WITH CURRENT GUIDANCE FOR PRECONCEPTION AND ANTENATAL CARE, TO REDUCE THE RISK OF CHILDHOOD OBESITY.**
- 3.1 Diagnose and manage hyperglycaemia and gestational hypertension.
 - 3.2 Monitor and manage appropriate gestational weight gain.
 - 3.3 Include an additional focus on appropriate nutrition in guidance and advice for both prospective mothers and fathers before conception and during pregnancy.
 - 3.4 Develop clear guidance and support for the promotion of good nutrition, healthy diets and physical activity, and for avoiding the use of and exposure to tobacco, alcohol, drugs and other toxins.
- 4 PROVIDE GUIDANCE ON, AND SUPPORT FOR, HEALTHY DIET, SLEEP AND PHYSICAL ACTIVITY IN EARLY CHILDHOOD TO ENSURE CHILDREN GROW APPROPRIATELY AND DEVELOP HEALTHY HABITS.**
- 4.1 Enforce regulatory measures such as The International Code of Marketing of Breast-milk Substitutes and subsequent World Health Assembly resolutions.
 - 4.2 Ensure all maternity facilities fully practice the Ten Steps to Successful Breastfeeding.
 - 4.3 Promote the benefits of breastfeeding for both mother and child through broad-based education to parents and the community at large.

- 4.4 Support mothers to breastfeed, through regulatory measures such as maternity leave, facilities and time for breastfeeding in the work place.
- 4.5 Develop regulations on the marketing of complementary foods and beverages, in line with WHO recommendations, to limit the consumption of foods and beverages high in fat, sugar and salt by infants and young children.
- 4.6 Provide clear guidance and support to caregivers to avoid specific categories of foods (e.g. sugar- sweetened milks and fruit juices or energy-dense, nutrient-poor foods) for the prevention of excess weight gain.
- 4.7 Provide clear guidance and support to caregivers to encourage the consumption of a wide variety of healthy foods.
- 4.8 Provide guidance to caregivers on appropriate nutrition, diet and portion size for this age group.
- 4.9 Ensure only healthy foods, beverages and snacks are served in formal child care settings or institutions.
- 4.10 Ensure food education and understanding are incorporated into the curriculum in formal child-care settings or institutions.
- 4.11 Ensure physical activity is incorporated into the daily routine and curriculum in formal child care settings or institutions.
- 4.12 Provide guidance on appropriate sleep time, sedentary or screen-time, and physical activity or active play for the 2–5 years of age group.
- 4.13 Engage whole-of-community support for caregivers and child care settings to promote healthy lifestyles for young children.

5 IMPLEMENT COMPREHENSIVE PROGRAMMES THAT PROMOTE HEALTHY SCHOOL ENVIRONMENTS, HEALTH AND NUTRITION LITERACY AND PHYSICAL ACTIVITY AMONG SCHOOL-AGE CHILDREN AND ADOLESCENTS.

- 5.1 Establish standards for meals provided in schools, or foods and beverages sold in schools, that meet healthy nutrition guidelines.
- 5.2 Eliminate the provision or sale of unhealthy foods, such as sugar-sweetened beverages and energy-dense, nutrient-poor foods, in the school environment.
- 5.3 Ensure access to potable water in schools and sports facilities.
- 5.4 Require inclusion of nutrition and health education within the core curriculum of schools.
- 5.5 Improve the nutrition literacy and skills of parents and caregivers.
- 5.6 Make food preparation classes available to children, their parents and caregivers.
- 5.7 Include Quality Physical Education in the school curriculum and provide adequate and appropriate staffing and facilities to support this.

6 PROVIDE FAMILY-BASED, MULTICOMPONENT, LIFESTYLE WEIGHT MANAGEMENT SERVICES FOR CHILDREN AND YOUNG PEOPLE WHO ARE OBESE.

- 6.1 Develop and support appropriate weight management services for children and adolescents who are overweight or obese that are family- based, multicomponent (including nutrition, physical activity and psychosocial support) and delivered by multi-professional teams with appropriate training and resources, as part of Universal Health Coverage.

From: *Obesity Stakeholder Group: Joint Policy Position on Childhood Obesity (2015)* UK

The Government should fully utilise all the policy tools at its disposal to deliver an effective strategy, including regulation. Progress must be routinely measured and evaluated to hold all those responsible to account for their progress.

Protect

Children are a vulnerable audience. Research shows that advertising of unhealthy food and drink can influence children's purchases, consumption and food preferences. Advertising practice on the TV, internet and in retail environments is skewed towards unhealthy products and is inconsistently regulated. In order to protect our children and support parents, the childhood obesity strategy should include the following interventions:

- 1) *The Government should introduce a ban on advertisements before the 9pm watershed for food and drink products that are high in saturated fat, salt and sugar. Alongside this, regulation governing on-demand services and online advertisements should be tightened to align with broadcast regulations.***
- 2) *Retailers should be set targets to improve in-store architecture to reduce the display of unhealthy foods in areas such as checkouts and end of aisle displays and increase price promotions of healthier alternative products.***
- 3) *The Government should take action to reduce the consumption of sugar- sweetened beverages (SSBs) by introducing a 20% tax on SSBs. The impact of this tax should be monitored and evaluated annually with revenue raised reinvested in public health promotion.***

Enable

Individual choice is a key element in determining whether an individual maintains a healthy lifestyle. However, the current obesogenic environment is making it difficult for people to make healthy food choices and be physically active in their daily lives. Action is needed across society to ensure that our environments, (e.g. our pre-schools, schools, communities, and workplaces) facilitate and encourage healthier behaviours. To do this the strategy should include the following:

- 4) *The Government should develop an independent set of incremental reformulation targets for industry, backed by regulation and which are measured and time bound. These targets should address salt, sugar and saturated fat levels. Compliance with these targets should be monitored and non-compliance should be backed by meaningful sanctions.*
- 5) *The Government should close the loophole exempting academies and free schools from the School Food Standards. Alongside this the Government should ensure the effective implementation of the cooking and nutritional education qualification into the curriculum.*
- 6) *The Government should commit to ambitious targets and sustained investment in active travel; this should be accompanied by guidance to Directors of Public Health on how to enable active travel at a local level.*
- 7) *The Government should commit to protecting ring fenced public health grants and future increases to enable local authorities to tackle obesity in their localities.*

Inform

To encourage healthier behaviours it is important that the risks associated with poor diet and physical inactivity are communicated to the public, for example, through public awareness campaigns. This must be presented in a way that is easy to understand by all age groups.

Parents and children must also be presented with easy to understand nutritional information of the products they are buying to help them make an informed healthy decision. To empower the population with the information they need the strategy should include:

number of products that feature the hybrid colour-coded front-of-pack nutritional labelling in the UK.

Support

With around 30% of children in the UK obese or overweight, we need to help more children and families lose weight and maintain a healthy weight. Children's weight should be measured regularly and families need to have timely access to the clinical support they need to reduce their weight in a safe and sustainable manner. Our medical professionals are at the forefront of interventions to reduce overweight and obesity. They should be equipped with the skills to identify those in need of intervention and have knowledge of the services to which to refer patients. To do this the strategy should include:

- 8) *Training curricula for all health professionals should include the role of nutrition and physical activity and obesity and the impact on health which should be examined. This should be alongside continuing professional development opportunities to skill up on counselling and coaching techniques.*
- 9) *The Government should commit to sustained investment to extend and increase the provision and quality of weight management services for families across the UK.*
- 10) *Alongside continued negotiations at an EU level to ensure the future of the hybrid system of front-of-pack labelling, the Government should approach, not just retailers and manufacturers, but also restaurants and cafes to expand the*

From: Measuring Up: the medical profession's prescription for the nation's obesity crisis, November 2013, The Academy of Medical Colleges (UK).

Action by the healthcare professions

1. Education and training programmes for healthcare professionals: Royal Colleges, Faculties and other professional clinical bodies should promote targeted education and training programmes within the next two years for healthcare professionals in both primary and secondary care to ensure 'making every contact count' becomes a reality, particularly for those who have most influence on patient behaviour

2. Weight management services: The departments of health in the four nations should together invest at least £100m in each of the next three financial years to extend and increase provision of weight management services across the country, to mirror the provision of smoking cessation services. This should include both early intervention programmes and, greater provision for severe and complicated obesity, including bariatric surgery. Adjustments could then be made to the Quality and Outcomes Framework, providing incentives for GPs to refer patients to such services

3. Nutritional standards for food in hospitals: Food-based standards in line with those put in place for schools in England in 2006 should be introduced in all UK hospitals in the next 18 months. Commissioners should work with a delivery agent similar to the Children's Food Trust to put these measures into place

4. Increasing support for new parents: The current expansion of the health visitor workforce in England should be accompanied by 'skilling up' the wider early years workforce to deliver basic food preparation skills to new mothers and fathers, and to guide appropriate food choices which will ensure nutritionally balanced meals, encourage breastfeeding and use existing guidance in the Personal Child Health Record as a tool to support this.

The obesogenic environment

5. Nutritional standards in schools: The existing mandatory food- and nutrient-based standards in England should be applied to all schools including free schools and academies. This should be accompanied by a new statutory requirement on all schools to provide food skills, including cooking, and growing – alongside a sound theoretical understanding of the long-term effects of food on health and the environment from the 2014/15 academic year

6. Fast food outlets near schools: Public Health England should, in its first 18 months of operation, undertake an audit of local authority licensing and catering arrangements with the intention of developing formal recommendations on reducing the proximity of fast food outlets to schools, colleges, leisure centres and other places where children gather

7. Junk food advertising: A ban on advertising of foods high in saturated fats, sugar and salt before 9pm, and an agreement from commercial broadcasters that they will not allow these foods to be advertised on internet 'on-demand' services

Making the healthy choice the easy choice

8. Sugary drinks tax: For an initial one year, a duty should be piloted on all sugary soft drinks, increasing the price by at least 20%. This would be an experimental measure, looking at price elasticity, substitution effects, and to what extent it impacts upon consumption patterns and producer/retailer responses

9. Food labelling: Major food manufacturers and supermarkets should agree in the next year a unified system of traffic light food labelling (to be based on percentage of calories for men, women, children and adolescents) and visible calorie indicators for restaurants, especially fast food outlets

10. The built environment: Public Health England should provide guidance to Directors of Public Health in working with Local Authorities to encourage active travel and protect or increase green spaces to make the healthy option the easy option. In all four nations, local authority planning decisions should be subject to a mandatory health impact assessment, which would evaluate their potential impact upon the populations' health.

From: Action on obesity: Comprehensive care for all - Report of a working party, January 2013, Royal College of Physicians (UK).

Recommendations

Current service delivery

1. In our hospitals there are few 'joined up' services for people who are overweight or obese; there is a need to develop and integrate weight management services with those healthcare services that manage the complications and conditions which arise from obesity such as coronary heart disease (CHD), diabetes, arthritis, sleep disorders and gynaecological disorders. Multidisciplinary teams have a proven track record in cancer care to promote quality by providing integrated services for patients, and we recommend that this model is translated to obesity.
2. The Royal College of Physicians (RCP) should oversee the development of multidisciplinary bariatric services to cover the population in the UK.
3. The RCP should promote the provision of these multidisciplinary groups by developing and providing courses that advise, encourage and train doctors (and other healthcare professionals) on their formation.

A multidisciplinary team approach to weight management and bariatric surgery

1. All members of the multidisciplinary team (MDT) should be trained and experienced in motivational interviewing and incorporate these techniques into their clinical practice.
2. Since type 2 diabetes is common among the overweight and obese population, and management of obesity may directly affect diabetes prevention and management, integration with diabetes services is recommended.

3. Adoption of the Edmonton Obesity Staging System (EOSS) will allow better 'phenotyping' of the individual patient and facilitate audit and outcomes review and research.
4. The primary care team has an important role in signposting to relevant services which are known to be effective. Many patients may contemplate commercial programmes, or increasingly such services may be providers of care within the NHS, and request advice from the primary care team. It is vital to ensure that patients attend services most suited to them.
5. The specialist MDT needs expertise in multiple obesity-related disorders. The MDT should include specialist consultant physicians, consultant surgeons, dietitians, nurses, psychologists and psychiatrists and exercise/physical activity professionals.
6. A particular issue amongst patients with extreme obesity is the increased prevalence of psychiatric disorders, including eating disorders, anxiety and depression. Thus, close collaboration with primary care and mental health services is required to assist patients with significant psychological trauma or psychiatric illness.
7. A growing number of patients within primary care will have had bariatric surgery (sometimes performed outside the UK), and links with the (hospital-based) medico-surgical MDT are essential.
8. Adequate administrative support to ensure that patients move smoothly through the MDT assessment is essential.

Care pathways, including post-surgery follow-up

1. In collaboration with the Royal College of Nursing, a specialist group of bariatric nurses who are trained in the specialist aspects of bariatric medicine and surgery should be established.

Audit, quality, research and monitoring progress

1. Within each multidisciplinary team, a clinical leader for audit for evaluating the quality and outcome of the service should be designated, and appropriate time allocated within that person's job plan.
2. Funding should be allocated, and bids from interested parties invited, to set up and run a central clinical audit system, facilitating regular comparison of outcomes between participating centres. All NHS and private providers in secondary and tertiary care settings should participate.
3. Clinical research should be encouraged and supported, focusing on long-term outcomes, health economics and quality of life from incorporating weight management within the treatment of patients being managed for obesity and its typical comorbidities.

Commissioning

1. Specialist physicians should take a central role in commissioning obesity services.
2. Commissioners should ensure that every NHS trust has a medical obesity spokesman or 'champion', who, amongst other things, can communicate with commissioners, providers and the community and contribute to the local development of effective care pathways.
3. The RCP should support these 'obesity champions' with career development and networking opportunities.

4. Commissioning of multidisciplinary services should use the term 'severe and complex obesity' not morbid obesity or bariatric surgery because management of these patients requires MDT input and medical supervision pre-, peri- and post-operatively.

The role of the GP and general practice team in weight management

1. Primary care has a core responsibility for obesity prevention, assessment of risk and morbidity in the obese, facilitating access to weight management support, and providing shared care in the long-term for patients who have been managed in specialist services.
2. GPs should, where possible and appropriate, deal with weight issues as part of their agenda to address risk factors. Each consultation provides a potential opportunity for this, although patient receptiveness also needs assessing for maximum effectiveness.
3. It is therefore important that GPs have training in a range of practical behavioural techniques such as in motivational interviewing. The effective application of these skills to weight management and obesity should be part of GP training and ongoing continuing professional development.
4. Inclusion of evidence-based targets for successful obesity management should be included in the Quality Outcome Framework (QOF) in order to support this practice.
5. A model for the commissioning of community services that integrates where required the specialist needs of patients should be developed.
6. The particular needs of some disadvantaged groups who find difficulty accessing community weight management groups should be addressed. These groups include people with learning disability, physical disability, mental health issues, those living in rural locations, socially excluded groups and those with severe degrees of morbid obesity.

Weight management for health service employees

1. Employers should encourage healthy eating among staff by:
 - implementing the National Institute for Health and Clinical Excellence (NICE) recommendations for obesity in the workplace (NICE CG43)
 - ensuring that healthy food is available in the workplace at affordable or subsidised prices
 - encouraging nutritional labelling to allow employees to make informed food choices
 - setting strict nutritional criteria as part of procurement contracts for food made available in food outlets and vending machines.
2. Employers should encourage physical activity by:
 - signposting to and encouraging the use of walking and cycling routes and stairs, including the provision of safe cycle storage areas
 - recommending the use of active travel methods to and from work, and provision of changing room facilities
 - working with local authorities to enhance access to health services by public transport

- considering the use of staff incentives such as discounted membership of fitness clubs.
3. Employers should encourage healthy behaviour change by:
 - developing a strategy for staff health and wellbeing
 - encouraging staff to take regular breaks to move around as well as sufficient time to eat well
 - using innovative ways to encourage lifestyle change amongst staff, eg intranet messages on health, and signposting local activity/weight management opportunities
 - using staff training as an opportunity to ensure that leaders are aware of the importance of encouraging proactive approaches to staff health
 - enabling equitable staff access to a range of weight management and activity options, by commissioning weight management services which have proven effectiveness.
 4. Occupational health departments have a responsibility to diagnose overweight and obesity in new employees, and wherever employees make health contacts (eg winter influenza vaccination) to communicate the health benefits of weight loss, and signpost obese employees either to 'in-house' or community-based services. Occupational health services could contribute to the monitoring of those engaged in weight management programmes by providing weighing facilities and information on healthy eating and activity opportunities within and outside the workplace.

Local and national leadership on obesity

1. There should be a lead physician, ideally in due course a bariatric physician, within each hospital trust to lead on obesity. This person should interact with commissioning groups, be a source of patient information and act as a link between the hospital and the community. S/he will be part of a national network, working together for the benefit of patients with obesity problems, coordinating local resources in a hub-and-spoke manner and ensuring the delivery of the patient charter. S/he will work with others in the local delivery of prevention and nutrition advice and advise on physical activity, and coordinate with those involved with children's services.
2. The obesity lead physician will need at least one session per week to undertake these duties.
3. The RCP should develop an independent multidisciplinary intercollegiate group to lead on obesity advocacy. The Royal College of Surgeons and the Royal College of General Practitioners have agreed to this, but the group should also develop to include other royal colleges (eg the Royal College of Obstetricians and Gynaecologists, the Royal College of Paediatrics and Child Health, the Royal College of Anaesthetists), as well as the Royal College of Nursing and public health representatives. This group should meet two to three times a year with a programme of activity addressing the needs of the public and patients with obesity.
4. This group should be called the Royal College of Physicians' Advisory Group on Weight and Health.
5. This group should monitor progress of the development of obesity services up and down the country.
6. This group should develop a patient charter for obesity services.

7. This group should also have a role in accrediting hospitals' health and nutrition policy.
8. Obesity services should be formally reviewed within two years.
9. The RCP recognises that this report does not deal with the details of prevention, nutrition, diet, physical activity or pharmacotherapy – all important and indeed essential aspects of this problem. It is therefore recommended that the RCP address these aspects in the near future in further reports.
10. There should be one person who should lead a cross-departmental government group and coordinate action across all relevant government departments. This post requires effective and dynamic leadership.
11. Prevention also needs to be led and coordinated by government – both national and local, spanning a range of departments. There should be a single figure leading this to add visible leadership and momentum, and to take responsibility for integrating prevention and treatment activity.

Education and training of healthcare professionals

1. All healthcare professionals should know and understand the 'Ten essential facts about obesity'.

THE 10 ESSENTIAL FACTS ABOUT OBESITY

1. *In the UK 1 in 4 adults are obese (2012).*
2. *In the UK 1 in 5 children aged 10 to 11 are obese (2011).*
3. *Obesity is strongly heritable (60% of weight variance is attributed to heredity) yet currently known gene mutations and polymorphisms account for <5% of weight variability.*
4. *Diagnosis by BMI requires measuring height and weight accurately; risk stratification in overweight and modest obesity requires measuring waist circumference and possibly the use of a clinical staging system (Edmonton Obesity Staging System (EOSS)).*
5. *Prevention and long-term weight loss maintenance require sustained changes in diet and physical activity habits.*
6. *Obesity is a major risk factor in diabetes (5 x), cancer (3 x the risk of colon cancer), and heart disease (2.5 x).*
7. *Obesity is a major cause of health inequality and impaired quality of life and costs the NHS £5.0 billion per year (2012).*
8. *Modest weight loss (~10 kg) helps to improve diabetes, improves quality of life and reduces morbidity.*
9. *An energy deficit of only 100 calories per day predicts a 0.5 kg weight loss in a month.*
10. *Cost-effective treatments in appropriate patients include weight loss programmes (commercial: eg WeightWatchers; GP delivered: eg Counterweight); pharmacotherapy (eg orlistat); and bariatric surgery.*

2. Knowledge, understanding and training in nutrition, physical activity, exercise and the public health aspects of obesity should be an essential part of undergraduate and postgraduate curricula. This knowledge should be examined.

3. Every discipline in medicine should include training in the role of nutrition, physical activity and obesity in their core curricula which should be examined because complications of obesity cross all specialty and professional boundaries.

Obesity as a subspecialty

1. There is a need to establish a subspecialty of obesity medicine for physicians. The terms 'bariatric medicine' and 'bariatric physician' are proposed.
2. The subspecialty should be within the umbrella of diabetes and endocrinology, although this does not preclude physicians with other primary specialties from developing subspecialty recognition in bariatric medicine.
3. A core curriculum and relevant experience for accreditation in this specialty is needed.
4. Physicians specialised in bariatric medicine will provide local leadership in the planning, provision and delivery of obesity treatments, within secondary care and in collaboration and partnership with primary care.

French National Nutrition and Health Program 2011-2015, Manger Bouge, Programme National Nutrition Santé (2012)

The nutritional public health objectives set by the French High Council for Public Health (HCSP):

- 1 – Reduce obesity and overweight among the population
 - Stabilise the prevalence of obesity and reduce overweight in adults
 - Reduce the prevalence of obesity and overweight among children and adolescents
- 2 – Increase physical activity and decrease sedentary behaviour in all age groups
 - Increase physical activity among adults
 - Increase physical activity and combat sedentary behaviour among children and adolescents
- 3 – Improve eating habits and nutritional intake, especially among high-risk population groups
 - Increase fruit and vegetable consumption
 - Reduce salt intake
 - Increase calcium intake among high-risk groups
 - Fight against iron deficiency in women living in poverty
 - Improve the folate status of women of childbearing age
 - Promote breastfeeding
- 4 – Reduce the prevalence of nutrition-related health conditions
 - Undernutrition, eating disorders

STRATEGIC FOCUS OF THE PROGRAM

FOCUS AREA 1 – Reduce nutrition-related health inequalities between social classes through specific actions within general preventive measures

The measures included in this focus area are aimed at achieving the objectives set by French High Council for Public Health (HCSP) in April 2010 with regards to nutrition and to cardiovascular and metabolic diseases. These are outlined below, where SO stands for “specific objective”.

NUTRITIONAL OBJECTIVES

General objective 3 – Improve eating habits and nutritional intake, especially among high-risk population groups

- **General sub-objective 3-1: increase fruit and vegetable consumption**

SO 3-1-1: within 5 years, increase the fruit and vegetable consumption of the general adult population, so that:

- at least 70% of adults eat at least 3.5 servings of fruit and vegetables per day;
- at least 50% of adults eat at least 5 servings of fruit and vegetables per day.

SO 3-1-2: within 5 years, increase the fruit and vegetable consumption of adults living in poverty, so that:

- the number of adults declaring that they eat fruit and vegetables at least 3 times a day is doubled;
- the number of adults declaring that they eat fruit and vegetables at least 5 times a day is increased fivefold.

SO 3-1-3: within 5 years, increase the fruit and vegetable consumption of children and adolescents aged 3 to 17, so that:

- at least 50% eat at least 3.5 servings of fruit and vegetables per day;
- at least 25% eat at least 5 servings of fruit and vegetables per day.

- **General sub-objective 3-2: reduce salt intake**

SO 3-2-1: within 5 years, reduce the average salt intake of the population to:

- 8 g/day for adult men;
- 6.5 g/day for adult women and children.

- **General sub-objective 3-3: improve the macronutrient ratios in non-alcoholic energy intake**

SO 3-3-1: within 5 years, reduce the average contribution of total fats to the non-alcoholic energy intake of adults and children to 36.5%

SO 3-3-2: within 5 years, reduce the average ratio of saturated fatty acids in total fat intake to:

- 36% for adults; - 37% for children.

SO 3-3-3: in both adults and children, increase the ratio of complex carbohydrate and fibre intake and reduce the ratio of simple carbohydrates from sugary foods in the total energy intake

SO 3-3-3-1: within 5 years, increase the proportion of people with complex carbohydrate intakes \geq 27.5% of the total non-alcoholic energy intake:

- by 20% for adults; by 35% for children

SO 3-3-3-2: within 5 years, increase the proportion of people with a simple carbohydrate intake from sugary foods $<$ 12.5% of the total non-alcoholic energy intake:

- by 7% for adults; by 20% for children.

SO 3-3-3-3: double the proportion of adults with a fibre intake $>$ 25 g/day

SO 3-3-3-4: within 5 years, reduce by at least 25% the proportion of children drinking more than half a glass of sugar-sweetened beverages per day

- **General sub-objective 3-4: increase calcium intake in high-risk groups**

SO 3-4-1: reduce by at least 10% the proportion of young women, adolescents and elderly people with a calcium intake from food that is below the EAR (Estimated Average Requirement)

- **General sub-objective 3-5: fight against iron deficiency in women living in poverty**

SO 3-5-1: within 5 years, reduce by a third the incidence of iron deficiency anaemia among women of childbearing age (15 to 49 years old) who are living in poverty

- General sub-objective 3-6: improve the folate status of women of childbearing age

SO 3-6-1: within 5 years, reduce by at least 30% the proportion of women of childbearing age (15 to 49 years old) at risk of folate deficiency (plasma folate levels $<$ 3 ng/mL)

SO 3-6-2: within 5 years, reduce by at least 20% the proportion of women with folate levels below the EAR

SO 3-6-3: within 5 years, increase by at least 50% the number of units of folic acid tablets (0.4 mg) prescribed for a planned pregnancy

- **General sub-objective 3-7: promote breastfeeding**

SO 3-7-1: within 5 years, increase by at least 15% the percentage of children breastfed from birth

SO 3-7-2: within 5 years, increase by at least 25% the proportion of children that are breastfed exclusively from birth

SO 3-7-3: within 5 years, extend the median duration of breastfeeding by 2 weeks

SO 3-7-4: within 5 years, postpone the median age for introducing foods other than milk (whether mother's milk or formula) by one month

General objective 1 – Reduce obesity and overweight among the population

- **General sub-objective 1-1: stabilise the prevalence of obesity and reduce overweight among adults**

SO 1-1-1: within 5 years, stabilise the prevalence of obesity among adults

SO 1-1-2: within 5 years, reduce by at least 10% the prevalence of overweight among adults SO 1-1-3: within 5 years, stabilise the prevalence of obesity among women living in poverty SO 1-1-4: within 5 years, reduce by at least 15% the prevalence of morbid obesity

- **General sub-objective 1-2: reduce the prevalence of obesity and overweight among children and adolescents**

SO 1-2-1: within 5 years, reduce by an average of 15% the overall prevalence of overweight and obesity among children and adolescents aged 3 to 17

SO 1.2.2: within 5 years, reduce by an average of 15% the prevalence of overweight and obesity among Focus area 1

OBJECTIVES RELATING TO CARDIOVASCULAR AND METABOLIC DISEASES

General objective 2 – Reduce hypercholesterolemia and arterial hypertension

SO 2-1: within 5 years, reduce by 5% average cholesterolemia (LDL-cholesterol) among the adult population

SO 2-2: within 5 years, increase the proportion of hypercholesterolemia sufferers who are treated and stabilised

SO 2-3: within 5 years, increase the proportion of patients with high blood pressure who are treated and stabilised

Since the PNNS was introduced in 2001, numerous preventive actions have been developed to avoid the appearance of risk factors or health conditions caused by an inadequate diet. By drawing on the principles of health promotion, these actions aim to create a synergy between:

- initiatives aimed at giving individuals the means to make informed choices with regards to food and physical activity, through the design, dissemination and implementation of campaigns, tools and programs that inform and educate people about nutrition (based on the PNNS definition of nutrition);
- initiatives aimed at making the environment more conducive to exercising the right choices when it comes to food and physical activity.

FOCUS AREA 1 Reduce nutrition-related health inequalities between social classes through specific actions within general preventive measures

Measure 1. Take specific actions to reduce nutrition-related health inequalities between social classes

ACTIONS

1. First: identify the inequalities and mobilise the stakeholders by:

(1.1) Completing the available data and analyses regarding health inequalities between social classes, by finalising the collective assessment of the specific issue of nutrition-related health inequalities between social classes, entrusted to the French Institute of Health and Medical Research (INSERM) and initiated in 2010.

2. Develop specific education and information actions by:

(2.1) Raising awareness of the nutritional health issue among social workers (employees of the family benefit and old-age pension funds), by providing them with relevant documents (information sheets, brochures) to broach the subject when speaking with benefit recipients;

(2.2) Designing and disseminating nutrition messages and tools in a format that is suitable for the various audiences affected by nutrition-related health inequalities between social classes (TV, free newspapers).

3. Specifically encourage the accessibility of foods of good nutritional quality with the aim of reducing health inequalities between social classes, by:

(3.1) Continuing the analyses aimed at improving the way consumers are informed about healthy eating, in order to make their choices easier;

(3.2) Continuing to analyse the impact of variations in food prices, taking into account the impact on individual health (in terms of nutritional quality), the environment, society, the economy;

(3.3) Evaluating how public funds and food consumption (fruit, vegetables, fish, dairy products, etc.) are impacted by various welfare organisations providing food vouchers to households experiencing financial hardship.

4. Train local community stakeholders in nutrition by:

(4.1) Having the French Association of Nutritionist-Dieticians (AFDN) provide a training module to the organisations responsible for training social workers;

(4.2) Encouraging staff members of local authorities to go through training in conjunction with the National Centre of Territorial Civil Service (CNFPT).

5. Increase the amount of human, material and financial resources available by:

(5.1) Making suitable PNNS logo-bearing tools available to the teams working among the target populations; (5.2) Encouraging access to resource persons as part of civic service.

Measure 2. Extend the nutritional prevention strategy to the food industry

ACTIONS

6. Make good quality food accessible to all (Focus Area 1 of the PNA)

I.1 Improve the eating habits of people experiencing financial hardship

I11 Increase quantities and encourage a more balanced diet

I.1.1.1 by mobilising more donations and unsold food items for food aid

i.1.1.2 by reorganising food aid

i.1.1.3 by supporting food aid distribution with social actions

i.1.1.4 by ensuring fair distribution of food aid across the entire country throughout the year

i.1.1.5 by removing the obstacles that prevent associations from properly distributing food

I.1.2 Encourage initiatives that link measures stopping food waste and measures helping the destitute

I.2 Adopt good eating habits in schools and extracurricular facilities

I.2.1 Make the distribution of fruit widespread in schools, in addition to the fruit served at the canteen

I.2.2 Make school canteen meals balanced and enjoyable for young people

i.1.2.2.1 by compelling school canteens to follow the rules of good nutrition

i.1.2.2.2 by developing the “plaisir et cantine” (enjoyment and canteen) campaign in secondary schools

i.1.2.2.3 by encouraging students to learn good eating habits and facilitate their discovery of unprocessed food products at social prices

i.1.2.2.4 by developing nutritional education in universities

i.1.2.2.5 by providing guidance and special training courses to managers of school catering services

I.3 Ensure better eating in health and medico-social establishments

I.3.1 Improve patient comfort

i.3.1.1 by improving the well-being of weakened elderly people through a range of approved foods that are adapted to their needs and combine nutrition and enjoyment

i.3.1.2 by encouraging health and medico-social establishments to make practical improvements to their menus and the conditions in which meals are taken

i.3.1.3 by evaluating the “baskets of fresh fruit and vegetables in hospitals” programme

I.3.2 Provide families with guidance and advice to help maintain the convivial aspect of meal times when a child has a disease requiring him or her to be monitored and to follow a specific diet outside of the healthcare establishment

I.4 Improve the diet of elderly people

I.4.1 Adapt the diet of elderly people to take into account new requirements

i.4.1.1 by improving compliance with the rules of good nutrition in nursing homes and care facilities

I.4.2 Help the elderly to remain independent for as long time as possible

i.4.2.1 by improving meal delivery services to their homes

i.4.2.2 by enabling elderly people in remote areas to receive “farmers’ market baskets”

i.4.2.3 by increasing available information regarding nutrition for people over 55

I.5 Improve the food supply in prisons and detention centres and encourage reintegration through food

I.5.1 Encourage the cooks of the various establishments to share their practices with one another to improve the catering service

I.5.2 Use food as a means to support professional reintegration by developing training courses in food-related professions

I.5.3 Provide youths under judicial protection with guidance and training in trades relating to the fields of agriculture and the environment, the agri-food industry, food and forest industries, and rural services, in accordance with the framework agreement established in May 2009 between the French Ministry of Justice’s Department for the Judicial Protection of Minors (DPJJ) and its Department of Prison Administration (DAP), and the Teaching and Research Department (DGER) of the Ministry of Agriculture, Food, Fisheries, Rural Affairs and Town and Country Planning

7. Improve the food supply (Focus Area II of the PNA)

II.1 Encourage the widespread implementation of voluntary initiatives and public/private partnerships that enable innovations to improve the quality of ingredients

II.1.1 Set up a food observatory to improve the monitoring of food quality

II.1.2 Incite professionals from the industry in question to formulate suggestions for improving the quality of their products via collective quality standards agreements

II.1.3 In order to facilitate these changes, encourage innovation in the fields of agricultural production, fishing and food, in particular where SMEs (small and medium enterprises) are concerned

II.1.4 Improve access to basic products

II.1.5 Improve or maintain the organoleptic aspect of the food supply

II.1.6 Reduce salt intake via the food supply

II.1.7 Evaluate opportunities for developing and enhancing the agricultural production methods that can improve the nutritional quality of food products

II.1.8 Create a strategic committee of players in the food processing industry

II.2 Develop fruit and vegetable varieties with high environmental, nutritional and organoleptic value

II.2.1 Modify the selection criteria for new varieties so that they include environmental, nutritional and organoleptic value

II.2.2 Improve information about varieties available commercially

II.3 Bring producers and consumers closer together

II.3.1 Develop short/local distribution channels for agricultural produce and fish and seafood

II.3.2 Make it easier for consumers in public institutional catering facilities to have access to food products from those channels

II.4 Improve the safety of the foods that are made available to consumers

II.4.1 Impose food hygiene training for all professionals in the catering industry

II.4.2 Help small businesses and on-farm food processors to incorporate food safety into the management of their business

COMPLEMENTARY ACTIONS

Actions that are complementary to those of the PNA outlined above are proposed to achieve the 3rd nutritional objective of the HCSP detailed above: "Improve eating habits and nutritional intake, especially among high-risk population groups."

8. Develop and promote voluntary charters of commitment to nutritional progress for a food supply that adheres to the PNNS objectives, by:

(8.1) Developing the standard frame of reference for the individual voluntary charters of commitment to nutritional progress; promoting the charters among relevant players among the business community, the media, professional intermediaries, the general public; and developing a framework that allows signatories to advertise their commitment;

(8.2) Helping SMEs (small and medium enterprises) to create charters.

9. Develop a system of reference to more health-conscious cooking that is in keeping with the PNA and aimed at healthcare professionals, social workers and young people.

Measure 3. Implement the actions mentioned in the Health Education Program 2011-2015 that have an impact on public health and complement this program

ACTION

10. As part of the Health Education Program 2011-2015, improve nutritional education in schools by:

(10.1) Developing nutrition-related education based on the school curriculums in particular, especially in CE2 and 5ème (year 4 and year 8);

(10.2) Promoting and disseminating reference tools for nutritional education in primary schools, including tools for analysing food advertising, sensory education tools, and tools for cooking workshops;

(10.3) Developing parents' awareness, based on the newly updated resource kit;

(10.4) Distributing a circular about food intake at school (primary school, junior high school and senior high school).

Measure 4. Develop actions aimed at educating and informing about nutrition

ACTIONS

11. Develop updated communication tools regarding the nutritional recommendations in the PNNS, as well as tools that are adapted to specific audiences; inform people about the relationships between nutrition and disease by:

(11.1) Updating the nutritional recommendations; increasing communication about them so that they are adopted and applied (including lesser known recommendations such as starchy foods), using an approach that takes into account the specific characteristics of the different target groups; developing information about portion sizes; informing people about alcohol consumption; promoting iodised and fluoridated salt to limit salt intake;

(11.2) Increasing information about sedentary behaviour (particularly screen time); including awareness-raising information about the links between sleep and weight gain in the published PNNS and PO documents aimed at professionals and the general public;

(11.3) Informing health professionals about the links between nutrition and disease, whilst providing nutritional recommendations to support the treatment of chronic organ disease; raising awareness among professionals about food allergies;

(11.4) Taking into account the main conclusions of studies performed on the subject of body image, with a view to developing concrete measures for a better representation of body diversity;

(11.5) Developing government-approved information about the proper use of food supplements;

(11.6) Communicating about the reports on weight loss produced by ANSES, the French national agency responsible for food, environmental and occupational health safety, and AFSSAPS, the French health products safety agency.

Placing restrictions on home shopping services that promote products and devices that have an effect on nutritional status (see Obesity Plan).

12. Increase public health messages and lessen the effects of advertising pressure by:

(12.1) Continuing to explore ways to reduce the advertising pressure exerted on children to encourage the consumption of fatty/sugary/salty foods;

(12.2) Improving the health messages that are included in advertising that emanates from food industry;

(12.3) Raising awareness among producers of television shows regarding the relationship between nutrition and health

Measure 5. Promote breastfeeding

ACTION

13. Implement some measures from the breastfeeding action plan to:

(13.1) Communicate with mothers, inform them and raise their awareness regarding feeding methods for newborns, whilst including an objective view of breastfeeding (including the benefits and the necessary conditions) to allow mothers to make an informed decision;

(13.2) Ensure that maternity wards really do provide women with personalised and objective information for making their decision. Establishments that meet these conditions must state so in the certification process.
