House of Commons

Committee of Public Accounts

Tackling Child Obesity—First Steps

Eighth Report of Session 2006–07

Report, together with formal minutes, oral and written evidence

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The Committee of Public Accounts

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The current staff of the Committee is Mark Etherton (Clerk), Philip Jones (Committee Assistant), Emma Sawyer (Committee Assistant), Anna Browning (Secretary), and Luke Robinson (Media Officer).

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Summary

Obesity is a serious health condition. It is defined as carrying too much body fat for your height and sex. A person is considered obese if they have a body mass index or BMI (weight in kilograms divided by the square of their height in metres) of 30 or greater.

Obesity is a causal factor in a number of chronic diseases and conditions including high blood pressure, heart disease, type 2 diabetes and, overall, it reduces life expectancy by an average of nine years. There has been a steady rise in the number of children aged 2-10 who are obese—from 9.9% in 1995 to 13.4% in 2004. Such children are more likely to be obese adults.

The rise in obesity prevalence adds a significant financial burden to the NHS. It is estimated that obesity already costs around £1 billion a year and the UK economy a further £2.3 to £2.6 billion in indirect costs. If current trends continue, by 2010 the annual cost to the economy could rise by another £1 billion a year.

In 2004 a Public Service Agreement target (PSA) was established, shared between the three Departments of Health, Education and Skills and Culture, Media and Sport:

"to halt, by 2010, the year-on-year increase in obesity among children under 11 in the context of a broader strategy to tackle obesity in the population as a whole."

Other than a proposed social marketing campaign, there are no ring-fenced funds nor are there any specific programmes to tackle child obesity. Instead the approach being taken by the Departments is to influence existing and forthcoming programmes that have a bearing on the diet and lifestyle of children:—of these there are four main programmes—School Meals, the School Sport Strategy, the Healthy Schools Programme and the Children's Play initiative.

In addition to these programmes, the Departments are seeking to influence the food industry to reduce the levels of fat and sugar in foods targeted at children and to encourage a more responsible approach to the marketing of these types of foods.

The delivery chain to tackle child obesity is complex and the Departments have found it difficult to communicate across the network of organisations involved. Important messages on diet and lifestyle have yet to get through to parents and children as clearly or as effectively as required.

To date, there has been little comprehensive, published research on the effectiveness of prevention and treatment strategies for child obesity and, consequently, the Departments have so far done little to intervene directly with individual children who are obese or at risk of becoming so or their parents. The National Institute of Health and Clinical Excellence has put out for consultation comprehensive guidance on prevention and treatment which they plan to publish in December 2006 and the Department of Health has issued a Care Pathway and a Weight Loss Guide to General Practitioners.

Performance against the PSA is to be measured by the annual Health Survey for England. The latest data from that survey is from 2004, and with no interim measures, the three

Departments cannot determine what progress has been made against the target to date. But, with little concrete action yet taken, much will need to be achieved in the remaining three and a half years if the target is to be met.

On the basis of a Report by the Comptroller and Auditor General,[1] we took evidence from the three Departments on three main issues: progress against the PSA target, the involvement of parents and influencing organisations.

1 C&AG's Report, *Tackling Obesity: First Steps*, HC (2005-06) 801

Conclusions and Recommendations

1. **The 2004 Health Survey for England showed an overall rise in obesity amongst children aged 2-10 from 9.9 % in 1995 to 13.4% in 2004.** Despite the introduction of a specific PSA target in July 2004 aimed at tackling the growing problem of child obesity, the Departments have been slow to react and have still not published key sections of the Delivery Plan. The Departments need to increase the pace of their response and improve their leadership by, for example, appointing a senior, high profile champion, to lead and galvanise activity.

2. **The three Departments have set up a complex delivery chain for tackling child obesity involving 26 different bodies or groups of bodies.** Our predecessors' report on obesity identified confusion over roles and responsibilities both between different departments and others charged with tackling the problem.[2] This confusion still exists. The Departments need to clarify responsibilities throughout the delivery chain and introduce measures to judge the performance and contribution of the respective parties, perhaps similar to those under development for Local Area Agreements.

3. **Parents have not been engaged; the only initiative planned by the Departments that will directly target parents and children is a social marketing campaign which will not be launched until 2007.** The campaign should be started as soon as possible. It should present some simple but high profile messages and advice to parents, children and teachers, outlining the risks of obesity and show simple ways in which children can make a difference to their lifestyles: for example, the message that consuming one less chocolate biscuit per day can help lead a child out of obesity (the Departments' own example).

4. **Despite embarking on a national programme to measure children in all primary schools in England the Department of Health is still not clear about whether parents should be informed if their child is overweight or obese.** The Departments decided originally that to protect children from stigmatisation and bullying, parents should not be informed. Reflecting the Committee's concerns, however, the Department is now considering how and when parents could be informed. The Department should move quickly to disclose the information in ways that will help parents to address the dietary and exercise needs of their children.

5. **There is a delay of up to two years between the Health Survey for England and publication of results, so Departments do not currently know what progress is being made towards halting the rise in child obesity.** The Departments should use the annual data from weighing and measuring in schools as an interim measure of overall performance, determining where most and least progress is being made and using this data to identify factors which contribute to performance.

6. **The Departments' strategy of working alongside the food industry to influence its approach to the marketing of foods and drinks that are high in fat, salt and sugar**

2 Committee of Public Accounts, Ninth Report of Session 2001-02, *Department of Health: Tackling Obesity in England*, HC 421; C&AG's Report, *Tackling Obesity in England*, HC (2000-01) 220

has not been successful in changing the way the majority of unhealthy foods are marketed. The Departments should encourage the growth in the market for healthy food and drink for children. For example, they could introduce an accreditation scheme with readily identifiable badging and publicity material which highlights those companies who are doing most to tackle this issue.

7. **Advertising for food high in fat, salt and sugar accounts for 80-90% of all food advertising on television.** In November 2006 the Office of Communications (Ofcom) announced new restrictions on the advertising of unhealthy foods. These include a ban on advertisements for unhealthy foods "in and around all programmes of particular appeal to children". Ofcom should make arrangements with the Departments concerned to monitor and assess the impact of the new restrictions and tighten the restrictions if those now planned are found to be ineffective.

8. **In 2003-2004, 72 new playing fields were created against 52 lost and during the same period 131 swimming pools were opened against the 27 that were closed.** Departments have made progress in encouraging children to lead more active lifestyles, but there is scope for better targeting at children's preferences and at localities and social groupings with fewer opportunities. The Departments for Education and Skills and for Culture, Media and Sport should encourage local authorities, schools and other providers to develop more public facilities such as lidos, and identify and prioritise those competitive and other sports and physical activities that children are most likely to take up.

1 Progress against the PSA target

1. Obesity is a serious health condition. It is defined as carrying too much body fat for your height and sex. A person is considered obese if they have a body mass index or BMI (weight in kilograms divided by the square of their height in metres) of 30 or greater.

2. In the Spending Review of 2004, the Departments of Health, Education and Skills and Culture, Media and Sport agreed a joint Public Service Agreement target to:

> halt, by 2010, the year-on-year increase in obesity among children under 11 in the context of a broader strategy to tackle obesity in the population as a whole.

3. The most recent data available (published in April 2006) on the prevalence of child obesity are from the 2004 Health Survey for England, which showed that there had been an overall rise in obesity amongst children aged 2-10 from 9.9% in 1995 to 13.4% in 2004. Because this data is two years old the three Departments are unable to assess what progress they have made since the target was established.[3]

4. The Committee's report on Obesity in 2001 identified the need for more effective joined up working and a clarification of responsibilities.[4] Since the PSA target was established in 2004 the three Departments have been planning to tackle the problem through a complex set of delivery arrangements (Figure 1) but it is not clear whether such complexity is either necessary or the best way of getting children to lead more healthy lifestyles.[5] With responsibility not yet clearly assigned between different organisations at each level of delivery the three Departments recognise that more clarity is needed to meet the target.[6]

5. The Departments acknowledge that much more could have been done more quickly.[7] It took them over a year to hold their first joint Programme Board meeting, key parts of the Delivery Plan were still not published at the time of the Committee's hearing in May 2006 and a planned obesity social marketing campaign to raise awareness among children and parents will not be launched until 2007.[8] This campaign will have a reduced effect compared with what might have been achieved had it been up and running in the first two years of the target. Similar types of campaign have been run recently without such delays, such as that to raise awareness of the dangers of excessive salt intake and the Five-A-Day message to encourage increased consumption of fruit and vegetables by children.[9] The Departments' example of how, through reducing calorie intake by consuming just one less

3 Q 10

4 Committee of Public Accounts, Ninth Report of Session 2001-02, *Department of Health: Tackling Obesity in England*, HC 421; C&AG's Report, *Tackling Obesity in England*, HC (2000-01) 220

5 Qq 7, 21, 38

6 Q 7

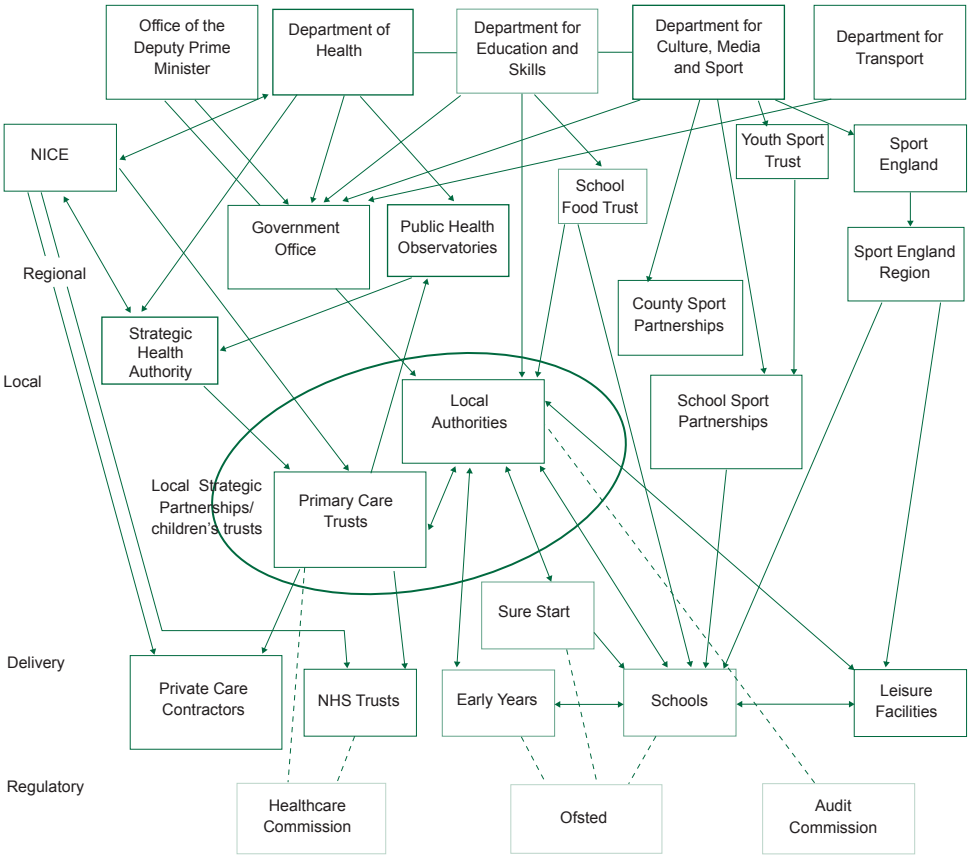
7 Qq 69, 115

8 Qq 12, 13, 48, 74

9 Q 85

chocolate biscuit a day (typically 80 calories) children can lead themselves out of obesity, offers the potential for a simple and clear message to be targeted at parents and children.[10]

Figure 1: The delivery chain for tackling child obesity



6. As a joint target, shared between three Departments, strong leadership is needed to galvanise effort and get the message across to children and their parents that obesity is a serious health issue.[11] The Senior Responsible Owners for the PSA target in each Department have many other responsibilities and competing demands on their time, while the Programme Manager (based in the Department of Health) does not have the necessary seniority or authority to lead and co-ordinate the many programmes and organisations involved.[12]

7. Action to tackle other public health issues, such as smoking or heavy drinking, has been characterised by direct action by Departments, be it the banning of smoking in certain places or taxing harmful products such as cigarettes.[13] Foods, especially snacks such as

10 Q 42

11 Qq 114, 115

12 Qq 115, 116

13 Q 117

crisps, chocolate and fizzy drinks are particularly price sensitive because of the fact that most children have limited funds.[14] The Departments have not, however, explored options to raise the price of foods and drinks that are high in fat, salt and sugar because they believe there is insufficient evidence to show that this would have a beneficial effect on levels of child obesity.[15]

8. In March 2006 the National Institute for Health and Clinical Excellence published draft guidance, for consultation, on the prevention and treatment of obesity which they plan to publish in December 2006.[16] In addition the Department of Health published, in April 2006, a care pathway and a weight loss guide which was sent to general practitioners and other healthcare professionals.[17]

14 Q 120

15 Qq 117, 118, 120-121; C&AG's Report: *Tackling Obesity: First Steps*, HC (2005-06) 801, para 1.9, page 27

16 National Institute of Clinical Excellence, *Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children*, Draft for Consultation; March 2006

17 National Health Service, *Your weight, your health. How to take control of your weight*. April 2006; National Health Service, *Care pathway for the management of overweight and obesity*, April 2006

2 Involving parents

9. The Departments have been reluctant to involve parents in their efforts to tackle child obesity despite evidence which shows that parents have most influence over their children's lifestyle.[18] The delay in getting the obesity social marketing campaign up and running has meant simple and clear messages on diet and lifestyle have not yet reached parents. Information gathered through the weighing and measuring of children in schools is not currently being passed on to parents unless specifically requested.

10. Successfully managing and losing weight is based on the simple principle of maintaining a healthy balance between the levels of energy taken in (calories consumed) to the levels of energy expended (exercise undertaken).[19] There is a wide range of factors from conception to age 11 that can contribute to obesity in children. These factors include family income, the conditions of the neighbourhoods where people live, the quality of schools and the lifestyle of parents.[20]

11. The strongest risk factor for child obesity is parental Body Mass Index score. For example, 47% of obese children under 11 come from families where both parents are obese or overweight and 25% come from families where one parent is obese or overweight (Figure 2).[21] Data also shows that obesity is more common amongst poorer communities and some ethnic groups.

12. The Committee's 2001 investigation into tackling obesity found that there was a considerable disparity in the opportunities for sport being offered by schools.[22] The Departments for Education and Skills and for Culture, Media and Sport nonetheless still do not measure differences in sport take up across different social groups and different neighbourhoods.[23]

18 Ev 19

19 Q 21

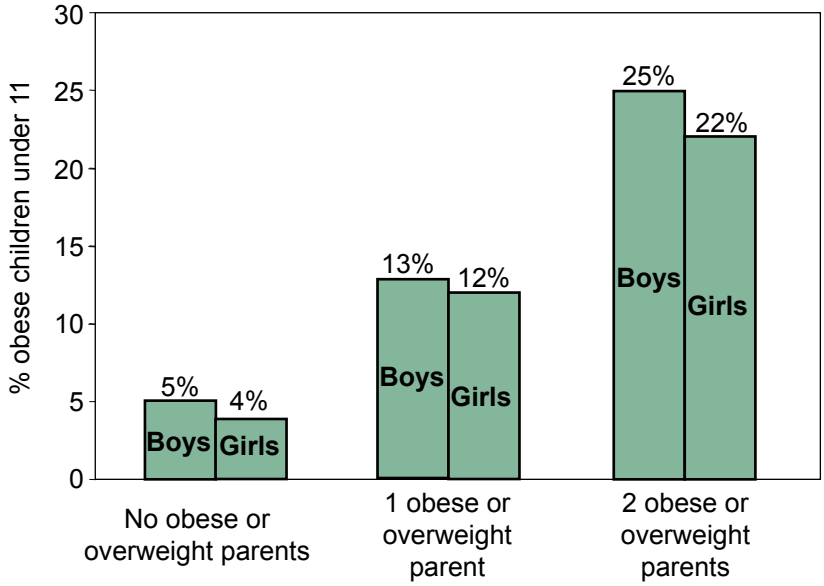
20 C&AG's Report, *Tackling Obesity: First Steps*, HC (2005-06) 801, para 1.6, page 26

21 *ibid*

22 Committee of Public Accounts, Ninth Report of Session 2001-02, *Department of Health: Tackling Obesity in England*, HC 421, para 47

23 Qq 129, 130

Figure 2—Obesity prevalence among children 2–10 years, by parental BMI status



13. Since the summer of 2006, all school children in Reception and Year 6 are now weighed and measured.[24] It is still not clear, either from the hearing or the Departments' guidance, how local bodies, such as primary care trusts or schools, should use the data from this exercise to target resources and shape local strategies and programmes to where they are needed most.[25]

14. Although measuring every child will identify children whose health is at risk, the Departments had initially decided not to tell parents or children the results unless they asked for them, because of concerns raised by the Children's Commissioner and child health officials about potential stigmatisation and bullying in schools.[26] In light of concerns raised by the Committee that failing to tell parents that their child is dangerously overweight could lead to the risk of serious illness and possibly early death, the Departments are now considering how and when information on their child's weight can be offered to parents.[27]

15. In response to the Committee's concern for more information on the cost of weighing and measuring, the Department of Health estimated, in June 2006, that the total cost for all primary care trusts in England would be approximately £1.3 million in 2006-07.[28] This figure is based on the fact that three quarters of primary care trusts are already routinely recording height and weight at infant school entry.[29] The cost may be higher than this because of the risk, identified in the Comptroller and Auditor General's Report, of

24 Q 98

25 Qq 110, 111, 141

26 Qq 23, 104-111

27 Qq 111, 143, 145; Ev 20

28 Qq 104, 155, 156

29 Ev 20

incompatibility between existing measurement methods and the methods set out in the Department's guidance published in January 2006.[30]

16. Following the hearing, the Departments now acknowledge the importance of involving parents, making them aware of the risks and causes of obesity and getting their support for programmes aimed at tackling the problem.[31]

30 C&AG's Report, *Tackling Obesity: First Steps*, HC (2005-06) 801, Box 4, point 4, page 18

31 Qq 2, 112, Ev 20

3 Influencing organisations

17. Apart from the planned obesity social marketing campaign there is no additional funding or any specific set of initiatives aimed directly at child obesity. Instead, the Departments are seeking to tackle the issue through influence over the activities of a wide range of organisations from the public, private and voluntary sectors whose work bears on the diet and lifestyle of children. These include NHS primary care trusts, local authorities, schools, children's charities, and sports providers. The four main programmes which will have an impact on child obesity are School Meals, the School Sport Strategy, the Healthy Schools Programme and the Children's Play Initiative (the latter being funded by the Big Lottery Fund).[32]

18. Tackling child obesity at a local level involves many different agencies and bodies, all with different funding streams and performance monitoring arrangements. Local Strategic Partnerships and emerging Local Area Agreements are bringing together different funding streams to tackle issues such as child obesity and have the potential to provide a basis by which agencies can pool resources around agreed priorities.[33] Children's trusts have been established to bring together the wider activities of local authorities and primary care trusts. They are still at an early stage so it remains to be seen how effectively they can bring focus to the work of local agencies to tackle the specific problem of child obesity.[34]

19. The Department for Education and Skills has established new nutritional standards for all school meals (including the food sold through vending machines in schools).[35] Food-based standards for lunches were introduced in September 2006 and nutrient-based standards will be mandatory in all primary and secondary schools by September 2009. In March 2005, the Department made £220 million available to schools and local authorities over a three year period from 2005-06 as transitional money to enable them to meet these new standards. In September 2006 the Department announced that a further £240 million would be made available over the three years from 2008-09. Further investment in school kitchen and dining areas is to come from established capital funding for schools which will rise from the £5.5 billion available in 2006-07 to £8.0 billion by 2010-11.[36] The Department has only limited arrangements in place to assess how well the transitional money is being used by schools and local authorities or how effectively existing capital budgets will be used to improve school food provision.[37]

20. In 2004 there was an overall increase of 11% in the level of sports and activities undertaken by children in England.[38] In 2003-04 72 new playing fields were created against 52 lost and during the same period 131 swimming pools were opened against the 27 that

32 C&AG's Report, *Tackling Obesity: First* Steps, HC (2005-06) 801, Fig. 2, page 13

33 *ibid*, para 35c, page 21, paras 22-25, pages 15-16

34 *ibid*

35 Q 14; Ev 18

36 Ev 18; The Department for Education and Skills guidance on capital programmes states that priority should be given to improving school food provision through better kitchens and dining areas.

37 C&AG's Report, *Smarter food procurement in the public sector: Case Studies*, HC (2005-06) 963-II, fig. 4, page 6

38 Q 122

were closed (including the closure of a number of lidos which provide popular public facilities for families).[39]

21. As part of the Healthy Schools Programme and the School Sport Strategy, there is a target to increase the percentage of school children in England who spend at least two hours each week on physical education and school sport.[40] This was set at 25% in 2002, rising to 75% in 2006 and 85% by 2008. In 2004-05 the Department for Education and Skills reported that 69% of pupils were spending at least two hours or more on sport.[41]

22. In September 2003 the Food Standards Agency published a comprehensive review of research examining the way foods are promoted to children and the possible link between promotional activity and children's eating patterns. The review concluded that advertising to children does have an effect on their preferences, purchase behaviour and consumption.[42]

23. Despite working alongside the food industry for a number of years, the Departments have yet to demonstrate much concrete action to change the way foods that are high in fat, salt and sugar are marketed.[43] Such foods are still marketed at times when children are watching television and some leading retailers have chosen to opt out of the voluntary food labelling scheme promoted by the Food Standards Agency.[44] The Government stated in its White Paper, C*hoosing Health*, that if the industry had not acted appropriately by 2007, it would look to introduce legislation to control the marketing of unhealthy foods.[45] The Departments also recognise that healthiness is becoming a point of competitive advantage within the food industry but have yet to take steps to fully exploit the opportunities that this presents.[46]

24. During May and June 2006 the Office of Communications (Ofcom) ran a consultation on options for new restrictions on the television advertising of food and drink products to children. In a note requested by the Committee following the hearing, Ofcom outlined their attitude and policy towards the advertising of food and drink to children.[47] In particular Ofcom provided details about their consultation on three options for further restrictions on the advertising of food and drink to children. These were:

- timing restrictions on specific food and drink products;
- timing restrictions on all food and drink products; and
- volume based restrictions on all food and drink products.

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39 Q 32

40 C&AG's Report, *Tackling Obesity: First Steps*, HC (2005-06) 801, fig. 1, page 10

41 Department for Education and Skills, *The Results of the 2004/05 School Sport Survey 2005*, para 35, page 8

42 Committee of Public Accounts, Forty-fifth Report of Session 2002-03, *Protecting public health and consumer interests in relation to food: the Food Standards Agency*, HC 708, para 32, page 16

43 Qq 19, 20

44 Qq 19, 153

45 Qq 20, 52

46 Q 20

47 Ev 24-29

25. Ofcom did not, however, include in the consultation an option for a total ban on the advertising of food and drink high in fat, salt and sugar before 9pm. The decision not to include this option was criticised by a number of bodies, including the Food Standards Agency, the National Consumer Council, Which? and the National Heart Forum.[48]

26. In November 2006 Ofcom announced new restrictions on the television advertising of food and drink products to children. The restrictions include a total ban on advertisements for foods and drinks that are high in fat, salt and sugar "in and around programmes of particular appeal to children". The new restrictions will take effect by the end of January 2007. In addition Ofcom have also launched a further consultation to seek views on extending the restrictions to protect all children under the age of sixteen as opposed to just under-9s, which will close by the end of December 2006.[49]

48 Qq 49-55, 145-146; Office of Communications, *Television Advertising of Food and Drink to Children: Options for new restrictions. Update to Consultation Document of March 28, 2006*, 8 June 2006

49 Office of Communications, *Television Advertising of Food and Drink Products to Children, Statement and Further Consultation*, November 2006

Formal minutes

MONDAY 11 DECEMBER 2006

Members present:

In the absence of the Chairman, Mr Alan Williams was called to the Chair.

Mr Richard Bacon	Mr Sadiq Khan
Mr Philip Dunne	Mr Austin Mitchell
Helen Goodman	Mr Don Touhig

Oral evidence
Sir John Bourn KCB, Comptroller and Auditor General, was in attendance and gave oral evidence.

Ms Paula Diggle, Treasury Officer of Accounts, was in attendance.

The Comptroller and Auditor General's Report on Update on PFI debt refinancing and the PFI equity market (HC 1040, Session 2005-06) was considered.

Mr John Kingman, Managing Director, Finance & Industry Directorate, and Mr Richard Abadie, Head, PFI Policy Team, HM Treasury, gave oral evidence (HC 158-i).

The witnesses withdrew.

Draft Reports
A draft Report (Tackling child obesity—First steps), proposed by the Chairman, brought up and read.

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

Paragraphs 1 to 26 read and agreed to.

Conclusions and recommendations read and agreed to.

Summary read and agreed to.

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

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

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

[Adjourned until Wednesday 12 December at 3.30 pm.]

List of witnesses

Wednesday 10 May 2006

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Oral evidence

Taken before the Committee of Public Accounts on Wednesday 10 May 2006

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon
Greg Clark
Mr Ian Davidson
Helen Goodman
Sarah McCarthy-Fry
Mr Austin Mitchelll
Mr Alan Williams

Mr Tim Burr, Deputy Comptroller and Auditor General, National Audit Office, was in attendance and gave oral evidence.

Mr Marius Gallaher, Alternate Treasury Officer of Accounts, HM Treasury, gave evidence.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

TACKLING CHILD OBESITY—FIRST STEPS (HC 801)

Witnesses: **Dame Sue Street DCB,** Permanent Secretary, Department of Culture, Media and Sport, **Mr David Bell,** Permanent Secretary, Department for Education and Skills, **Mr Hugh Taylor CB,** Acting Permanent Secretary and **Dr Fiona Adshead,** Deputy Chief Medical Officer, Department of Health, gave evidence.

Q1 Chairman: Good afternoon. Welcome to the Committee of Public Accounts today where our Report is the Comptroller and Auditor General's Report on *Tackling Child Obesity—first steps.* We welcome Hugh Taylor, his first appearance in front of us, you are very welcome. Mr Taylor is the Acting Permanent Secretary at the Department of Health.
Mr Taylor: That is right.

Q2 Chairman: We also welcome David Bell, who is the Accounting Officer at the Department for Education and Skills, and Dame Sue Street, who is the Accounting Officer and Permanent Secretary at the Department for Culture, Media and Sport. I think it is your last appearance?
Dame Sue Street: It may well be, Sir.

Q3 Chairman: That will be a relief to you. We also welcome Dr Fiona Adshead, also making her first appearance, who is the Deputy Chief Medical Officer at the Department of Health. Dr Adshead is present as an expert witness, and we are all very grateful to you for coming this afternoon. Mr Taylor, who is in charge of this whole programme, is it you?
Mr Taylor: I think the Department of Health is taking the lead. I have taken responsibility, in a sense, *primus inter pares* with my colleagues in leading the programme forward.

Q4 Chairman: This will, no doubt, take the course of the Committee of Public Accounts hearings and we will be asking you lots of difficult questions about targets and why we are not meeting them. But I have got some sympathy with you, Mr Taylor, and indeed all your colleagues in that I do think there are limitations on what the Government can achieve to stop children getting fat. It is really down to parents so I have some sympathy for you. You may want to agree with that, Mr Taylor, or not, that primarily it is the responsibility of parents.
Mr Taylor: I think parents are absolutely critical to this but I do not think that means the Government and other agencies working in the field of health and the other agencies which we represent should ignore this problem.

Q5 Chairman: I am not suggesting you should. I am just trying to give you an excuse.
Mr Taylor: Not an excuse.

Q6 Chairman: I do not often do it.
Mr Taylor: It is certainly a complex issue.

Q7 Chairman: It is certainly very complex. That brings me straight on to my next question. Would you like to look at the figure, please, on page 30. I am not sure people can figure it out but it is absurdly complex, is it not? How are you getting all these people to work together?
Mr Taylor: The first thing is to recognise that there are a lot of organisations rightly involved in this, so it is complex. I think there is scope for clarification at all levels, and I think we have been able to make some progress on that. We are working closely at national level and we can talk a bit more about that if that would be helpful. We think there is scope for clarifying lines of responsibility at regional level and that was one of the things which was helpfully brought out in the NAO Report and we think we can make progress there. As the Report itself indicates, there are mechanisms at local level, the work of PCTs through children's trusts, the local strategic partnerships, local area agreements, all of which I

think can be brought to bear on what is a genuinely difficult problem, and which can bring together some of the components of this complex delivery chain. It is complex—the illustration on page seven does demonstrate that—but I do not think that should deflect us.

Q8 Chairman: You have a target, have you not? You do not really know whether you are on track to meet this target, do you?
Mr Taylor: I do not think we can say that confidently at this stage, no. I think we can say we have made some good progress on some of the programmes which have been set in hand.

Q9 Chairman: I am going to stop you there. Children are getting fatter, are they not?
Mr Taylor: They are.

Q10 Chairman: You do not know whether you will meet your own target which you set yourselves?
Mr Taylor: We do not know whether we are going to hit it. Our ambition is to hit it. I have to say that I do not think any country has cracked this problem yet.

Q11 Chairman: Let us not talk about other countries, we are not responsible for other countries, we are responsible for our country. Can I ask you about the Health Survey for England that was published in April 2006. That shows that the problem is getting worse, is it not, although that was based on a survey which is now two years old. The amount of information available to us is very limited, is it not, but it did show the problem is getting worse.
Mr Taylor: It did confirm a trend towards increasing obesity amongst children in the relevant age group. We do need better data, which is one of the things that we have put in hand, but I think it is true to say, yes, at the moment the trend is still in the wrong direction. That is why we are committed to trying to halt the trend.

Q12 Chairman: You started this programme in 2004, did you not? We are two years into this programme, are we not? Why are we still waiting for the Obesity Awareness Campaign, when will that appear?
Mr Taylor: We said in *Choosing Health* that we would kick off the campaign in 2007, and we will now commit to doing that in early 2007. We have recently, in the last few weeks, launched a campaign called "Small—
Dr Adshead:—Change, Big Difference".
Mr Taylor: The core programme on a social marketing campaign on obesity is still being developed in the Department and is targeted to be launched at the beginning of next year.

Q13 Chairman: We started this process in 2004. We agreed that public awareness, particularly what parents can do, is absolutely vital. Why are you waiting until 2007 for an awareness campaign?
Mr Taylor: I think, first of all, it is a question of bringing key partners together to make that work and then it is a question of pulling together the funding so that it makes an impact. We have set ourselves a timetable for doing that and we will do our best to adhere to that.

Q14 Chairman: Mr Bell, may I turn to schools now. You have got £220 million extra funding for school meals which sounds a lot but, in fact, it is £10,000 per school over a three year period, is it not? Is that going to make much difference? Are you going to use the money effectively?
Mr Bell: The money goes directly to schools and the money that local authorities are using is to help to improve the standard of school meals. That can be done in a number of ways. For example, it is helping to ensure that schools have the money to buy ingredients that are going to allow healthier school meals to be sold and it is also allowing them to have greater use of fruit and vegetables in school meals. It is also helping schools to meet the new nutritional standards which are going to be established very soon. This is a long-term programme. I think the money that was put in on school meals was intended as transitional funding to take us from where our funding is and what it is doing in school meals to where it might be in the future by doing those things that I have described, by helping schools to think more generally.

Q15 Chairman: Why did we have to wait for Jamie Oliver before we had this money?
Mr Bell: I think it is fair to say that health awareness, including school meals and what is eaten in school, was not just brought to the public attention or brought to the education systems' attention by Jamie Oliver, although undoubtedly he had a galvanising effect. There is absolutely no argument about that, of course he did. Take, for example, the Healthy Schools Initiative, which does include looking at the content of school meals and the other things that children eat, that has been running for a number of years. 40% of schools in the country are now designated as healthy schools; 75% of schools in the country are engaged in the healthy schools programme. I absolutely accept the point that Jamie Oliver galvanised everyone to think about the contribution school meals make to healthy eating.

Q16 Chairman: We will try and do our fair share of galvanising as best we can. You have got this target, have you not, for two hours sport per child per week?
Mr Bell: Correct.

Q17 Chairman: Is that enough? Is it going to be effective? I know you are bound by the National Curriculum but I just wonder if it is sufficient.
Mr Bell: It is important, of course it is, to ensure that we get children doing at least two hours PE in the curriculum or other high quality sport. We are on target to ensure that 75% of schools have reached that by the end of this year and 85% of schools by 2008. But I do not think you can see school sport, PE

in the curriculum, on its own because it is related to other activities like healthy schools, like the school meals programme that you have identified. I think there is no doubt that getting children to take part in regular vigorous exercise is part of that suite of programmes which will help children to live more healthily.

Q18 Chairman: Dame Sue, you are the Permanent Secretary for Sport, as it were, are you pressing your colleagues in the Department for Education to put more emphasis on sport?
Dame Sue Street: This is a joint PSA so we work absolutely together with them. I think the good news is that we are on target for the universal offer. You may think it is not ambitious enough but we are doing what we said. What will enable us to do from the autumn is to focus some additional help on the overweight children at risk of becoming obese. I think collectively we have begun to feel across all our programmes that if we are trying to halt the trend we need to look at those overweight children most at risk. From the autumn we will begin, through the school sports strategy, to put particular support, evidence, facilities and monitoring through the Youth Sport Trust focused on that.

Q19 Chairman: Dame Sue, have you had any success in influencing the advertising industry to take a more responsible attitude? Powerful adverts to my children make them want to consume more and more fizzy drinks, chocolates, sweets and other bits of rubbish which I am utterly weak and hopeless in stopping them eating.
Dame Sue Street: I think earlier on, Chairman, you said that all of us who have been parents know how difficult it is to change children's behaviour so it is difficult for parents, well-wishers and the Government. What the Government made clear and said in the *Choosing Health* White Paper was that if it has not seen real change in the nature and balance of food promotion by 2007 we will look at existing powers or legislation to make sure it happens. That is a very clear assertion. In the meantime, we are finding the industry quite ready to step forward.

Q20 Chairman: I must stop you there on "step forward" because I am advised there has been no success in making them restrict the amount of advertising for unhealthy fattening foods. Is that a fair criticism?
Dame Sue Street: We have not yet sought to make them. The British Retail Consortium and the Food and Drink Federation are developing guidelines on good practice. Some firms, for example Cadburys, do not advertise to children under eight. I think the market will help here as we are advised by retailers that health is becoming a point of competitive advantage. It is hoped that the market will drive some improvement but if it does not we are all very clear, and Government has set out, that 2007 will see a move by Government.

Q21 Mr Mitchell: Everybody goes on, and the Report goes on and we have, about this being a complex subject, very difficult, but surely it is not in this kind of mess with complex structures like that, and so many organisations responsible because we do not know the causes of overweight young kids, surely it is a fairly simple thing, they are eating too much and exercising too little. Is that not right, Dr Adshead?
Dr Adshead: The basic issue is absolutely, as you say, what each individual child, encouraged and supported by their parent, chooses to do around the amount of activity that they undertake and the nature of the food that they eat. It is absolutely, as you say, a balance between the calories they take in and the calories they expend on activity. However, I think if we draw from our own personal experience we know that the reasons why we do or do not take activity and the reasons why we do or do not eat as healthily as we might know that we should are very complex. I think the delivery chain diagram outlines the influences of why a child does have to have—

Q22 Mr Mitchell: We can get into all kinds of complexities and all kinds of blame. As the Chairman said, it is partly the fault of the parents; others say it is the fault of the food industry advertising; some say it is the fault of television generating things. If the basic issue is that the kids are eating too much and exercising too little why can each child not be assessed? I do not know if we have school nurses any longer. Why can each child not be assessed and given a prescription, "Stop stuffing yourself and get some exercise"? An individual prescription can then inform the parents so we can tell them what to do.
Dr Adshead: It is very important, as you suggest, that parents know what to do if they are concerned about their child being overweight or obese, which is precisely why on 4 May we distributed a guide to the public on your health, your weight, actually outlining to them what they should do and what the issues are. For example, seeking help from their general practitioner, explaining to them that often people think you suddenly become obese, of course you do not, what it often means for children is if they have just the wrong balance of calories, just 30 to 60 calories a day can build up over a period of a few years to mean that your child can become overweight. We think it is really important that we communicate clearly to parents the advice they can take and at the same time we are communicating to our primary care teams, which will include school nurses, what they should do and how they can advise children and parents best if they, as practitioners, have concerns about their weight as well.

Q23 Mr Mitchell: There is no point pussy-footing around with it, what is the problem with examining each child and giving a prescription of what to do?
Dr Adshead: One of the big concerns that we have come across is that the Children's Commissioner, Professor Aynsley-Green, has raised with us very considerable concerns about us actually measuring

and screening which means that you systematically measure each child in school and feed back the results to them. In *Choosing Health* and the *Choosing Health* delivery plan, when we signalled our intention that we were going to measure children in schools, in the Department of Health we had a lot of concerns from child health officials who really wanted to caution us against systematically feeding information back to children. The reason they did that is at the moment, as the Report reflects, we are not fully sure that we can guarantee effective treatment. We can give children who are—

Q24 Mr Mitchell: Give them facts about fatness and tell the parents, "Your child is a fat slob and you have got to do something about it".
Dr Adshead: I think we also want to give children as sensitive advice as we can because, in fact, the Children's Commissioner undertook some research with children on how they felt about being weighed, just about being weighed and measured.

Q25 Mr Mitchell: What did they say?
Dr Adshead: Whilst they took, as you might expect, a very pragmatic, in fact a positive approach about it, in fact some of the kids, particularly the younger ones, expressed concerns about being measured. What they said was that they were concerned that they might be bullied and particularly if children already have a reason why they might be bullied—because they also surveyed disabled children—they were concerned. At the heart of what we are trying to do here, as I think you appreciate, we are trying to put children's best interests at the centre of our work. Many schools are doing this very pragmatically. I can give you an example, in Birmingham schools they have a brilliant idea where they are integrating measuring children in numeracy lessons. Alongside the same time as they learn about their weight and height they will record what colour their eyes are, all those sorts of things.

Q26 Mr Mitchell: This is only preliminary stuff, they are not in a position to do that for all kids and will not be for a long time.
Dr Adshead: At the moment what we need to do is measure children at a school level, as our guidance says, we need to gather evidence on what is acceptable as soon as we can, and there is some research going on at the moment by one of our leading researchers to look at the acceptability of feeding back information to children and their parents by school nurses.

Q27 Mr Mitchell: Broadly speaking, is this a middle class/working class differential in the sense that working class kids are more obese?
Dr Adshead: It is certainly true, as the Report points out, that you are more likely to be overweight or obese if you come from a working class background but it is such a scale of problem that it is not that children in the higher socio-economic groups are not affected, they are. It is more likely that you will be obese if you come from a working class background.

Q28 Mr Mitchell: What is the difference between different ethnic communities?
Dr Adshead: There we are beginning to see an emerging trend. For example, girls from black and Afro-Caribbean communities are more likely to be obese than some of their counterparts. Some of the patterns are reflecting what we also see in adult communities, for example with Asian children as well. Part of the reason for our Health Survey for England and taking different samples—and the reason why, in fact, the 2004 survey data took so long to come out was because it was very complex because we looked at ethnic minority groups in detail—is because, as you were suggesting, we have to get to the bottom of which children we most need to, as Sue was describing, really help and provide that intensive support. Once we have got the research and trial data we can prove what we can most effectively do to support them.

Q29 Mr Mitchell: Can I ask Mr Taylor, we are not getting to grips with the issue because with this complex subject we are pussy-footing around to a degree. Is this because we are afraid of taking on the food industry head on?
Mr Taylor: No, I do not think it is. I think we need to be confident about knowing what works. There are a range of options on the table there. Working with the food industry and as Sue was saying, in relation to advertising and taking measures, if necessary, to reduce the impact of advertising on children is something which the Government is doing.

Q30 Mr Mitchell: The food industry is peddling the product in the first place. It is the adverts for crisps and McDonalds and whatever it might be that are distracting the kids from a plain, straight forward diet.
Mr Taylor: I do not know that there is conclusive evidence which points to that as an overriding factor in trends in obesity. There are other factors at work as well, such as the fact that children exercise less, spend more time in front of TV/computer screens, and so on. As I think the NAO Report helpfully brings out, there is a range of factors giving rise to increasing trends in obesity and I think we would be going down the wrong route if we focused just on one part.

Q31 Mr Mitchell: Your approach is to work with the food industry rather than take it on?
Mr Taylor: If we can work with the food industry that is the right thing but if we have to take them on in the areas that Government has stated already, as Sue has said, then, yes, we will take action.

Q32 Mr Mitchell: Dame Sue Street, we have had this discussion before in another context. I cannot see how we can expect kids to get the kind of exercise which would be necessary when we are selling off playing fields, when local authorities are closing swimming baths because they are so expensive. Bromley Council was saying to one of my grandchildren at the swimming baths there it costs

£5—lost to the council—every time one of the kids goes to the swimming bath and, therefore, there was a big temptation to close it down. As long as there is that situation, and we have not got the playing field provision or even the swimming baths, the schools in Grimsby have, broadly speaking, closed their swimming pools to save money and as long as that situation prevails they will never get the exercise they want.

Dame Sue Street: I think the tide has turned now. I know there has been a lot of concern about facilities as discussed at a previous hearing, we now have very much tighter regulations before any playing field can be lost. In 2003–04, for example, 52 were lost but 72 were created so we are just about in credit but, of course, we need to do more. There are about 50,000 grass pitches now. There are 4,400 swimming facilities in England and last year 131 pools were opened and 27 were closed.

Q33 Mr Mitchell: I am glad to hear that.

Dame Sue Street: We are moving in the right direction. We need to do more. The aim is—and I think we will get there—people will not be further than 20 minutes' travel time from a high quality facility within the next two or three years. It is a big push and the tide is turning.

Q34 Chairman: You are supporting the Lido Awareness Campaign, which was launched today, are you, to stop the disastrous decline in lidos all over the country? You are aware of the campaign, are you?

Dame Sue Street: I am aware of it. I think one needs to look overall at what facilities are available in any local region.

Q35 Sarah McCarthy-Fry: I am quite interested in the method you are using to define obesity. Correct me if I am wrong but children above the 95th percentile are defined as obese and above the 85th percentile as overweight. Does that mean that you have not got a specific weight but you are saying you will look at the average of all children? Is that really fair?

Dr Adshead: When children grow up, as some of us may have experienced, they are benchmarked against growth charts. You can see the children's age and sex, where they are. In order to tell whether a child is over or underweight you need to look at how they compare with their peers, the average. The idea of having a normal curve in the population perspective is so you can tell where your own child fits with its peers. That is why we use this mathematical device, if you like, to say that if you are on average above the 85th percentile it means that 85% of children will weigh less than you if you are above that level and you are overweight and obviously the same is true for 95%. In other words, the majority of children will weigh less than your child if your child is over that level. That may seem like a technocratical device but clearly if we are trying to look at an individual child we need to compare him or her against his peers and it is a well tried and tested method. Obviously we are aware of new advances coming out. The World Health Organisation has just published some growth charts. We are working with national experts to check those out to make sure that we are using absolutely the best data. I think there is also an important issue for us in terms of tracking targets where we need to try to use continuity of data over time. Data cut-offs that you mention have been available to us nationally through the Health Survey for England, which we heard about earlier, since 1995. They are a very useful way of at least managing at a national level how children's weight is tracking over time.

Q36 Sarah McCarthy-Fry: If the problem is getting worse and more children are getting obese, does that not mean what you are tracking is missing the target? Whereas 10 years ago if you were doing it you would be treated as obese, now you are not.

Dr Adshead: I can see entirely the point you are making. In fact, what we do is we freeze frame, we fix at one point in time how those 95th and 85th percentiles are taken. In fact, they are taken against what we term a reference population that was in fact arrived at in 1990. Obviously, as you describe, children are getting more obese but it is not, in a sense, a moving target in terms of the baseline.

Q37 Sarah McCarthy-Fry: Let me move on because that was just to get it clear in my head. It has taken NICE—National Institute of Clinical Excellence—since the PSA was agreed in 2004, we are only now consulting on the effectiveness and cost-effectiveness of the interventions. Is that because we have never tried to look at it before?

Mr Taylor: I think it is true to say, and I think the NAO Report brings this out well, that there is not well-documented evidence, not just in this country but elsewhere, about the best means of tackling obesity. That is in itself an important step forward. The guidelines are in draft because NICE consults stakeholders on draft recommendations to see if they could be improved before they are finalised. I think it is true to say that this has not been widely acknowledged across the health community even necessarily as a problem which needs to be tackled in this way.

Q38 Sarah McCarthy-Fry: Given the complexity of the spaghetti, and I must say my mind absolutely boggled when I looked at figure 7 and thought how on earth does anybody ever make sense of it, and given that we have problems in communication which has come out of the Report, when you get the NICE recommendations of best practice to go forward how are you going to get that information out to the people? Are you satisfied they are going to be able to turn their policies around quickly enough to be able to use them?

Mr Taylor: I think the first thing to say is the illustration in figure 7 is a very good and graphic way of demonstrating complexity. If we were drawing it, I think we would have a slightly

simplified version of it. NICE guidelines are a well-established way of communicating ways of establishing clinical effectiveness across the health system. We have been working hard to try and establish more effective lines of communication in relation to obesity and we have recently just done something which we committed to do some time ago which is produce a first communication on obesity to go down the delivery chain which brings together all the recent developments which have been taking place: updates on various programmes that are described in the NAO document and bring people up-to-date with what is going on in some of the schemes that are already working to tackle childhood obesity where evidence is being built up and refers to the NICE guidelines. We are establishing a better communication chain which reaches down through that complex network of organisations. I think through changes that we are making at each tier in the system at regional and local level it will be possible to direct communication better. Recently, I should say, we have been reviewing this ourselves as colleagues and we know there is more to do there. We are not saying we have got all that cracked, there is definitely more awareness raising to be done. Turning out one bulletin is not going to be the answer, that has to be followed up consistently with further communications. We have to build on the fact that for the first time we have raised this as a priority issue with the NHS. There are other competing priorities in the NHS. We have got to keep working away at this over a period of time.

Q39 Sarah McCarthy-Fry: Would you say the focus on the evidence is more establishing why there is a problem rather than tackling how they are going to tackle it? I only ask this because my own PCT has just recently published an atlas of health inequalities and it has thrown up some incredible statistics which do not make any sense. I have got one ward where 27% of children are obese. I have got another ward which demographically in areas of deprivation is identical and only has 14%. The most affluent ward has 20%. My PCT is going to have to spend a lot of time analysing those figures to find out why before they are going to be able to find out how to tackle it.
Mr Taylor: That is, if I may say so, an extremely good illustration of the complexity issue but also that does not mean to say we should duck it. What we have got are some examples, admittedly limited, of programmes which are going forward—they are referred to in the document—MEND and other programmes, which are beginning to suggest means of effectively tackling obesity programmes, targeted programmes, particularly children who are overweight and obese. I think as the PCT community, but not just the PCT, local authorities and other organisations, get to know more about what works then they will get better insights into how to deal with some of those local complexities. We do not have a magic wand to wave over it.

Q40 Sarah McCarthy-Fry: This is probably going on in pockets all around the country. I think what came out of the Report is it is different in different parts of the country. How are you going to make sure that people talk to each other?
Mr Taylor: First of all, it is important to recognise difference. For example, one of the important pieces of the delivery chain is PCTs working with local partners through the local strategic partnership and local area agreement process.

Q41 Sarah McCarthy-Fry: But they are only being piloted, there is not a local agreement everywhere, is there?
Mr Taylor: There is not everywhere but it is interesting that in the local area agreements that do exist obesity commitments are there in the majority. Seven local authorities, I think, by recollection have got stretch targets on obesity. The evidence is beginning to build up and we need to interrogate that a bit more ourselves to find out what people are doing there. It is important to recognise that both within local authority areas and across the country differential action is going to need to be taken. In some parts of the country malnutrition is still perceived to be an issue in a way that obesity is not and that is one of the issues that people have with this. We are asking PCTs, and their local partners, to take this seriously as an issue and begin to work together on programmes that we hope the evidence will become increasingly clear can make an impact on.

Q42 Sarah McCarthy-Fry: Given the length of time it has taken to get to this stage, given that we are still very much at a learning stage, we do not know what works, we have not even identified what the problem is, do you think that PSA target in 2010 is achievable?
Mr Taylor: Yes. Just to illustrate this, it sounds absurd—let me just get my facts on this right, Fiona will have it at her fingertips—
Dame Sue Street: It is the chocolate biscuit test.
Mr Taylor: Yes, it is the chocolate biscuit test. If you look at what it would take to shift children out of the obesity category, we are talking about children on the cusp reducing their calorie intake by 30 to 60 calories a day. A chocolate digestive biscuit is 80 calories a day; a packet of crisps is 120 calories a day. In a sense that gives you a measure that this ought to be a problem that is tackle-able. The fact that there are huge societal effects which are resistant to it is evident. I do not think we should give up and say "This is not something which can be done" we think it is a challenge we have to face up to as a society. None of us around this table are going to give up on the target notwithstanding the difficulty of achieving it and the fact that if we are being honest no developed country so far has demonstrated the capacity to shift the trend.

Q43 Helen Goodman: Mr Bell, I have been to have school meals in three of the secondary schools in my constituency and they have improved quite

significantly, they tell me, and having had them I can see this. One of the best things they have done is take the catering in-house instead of employing Scolarest but, as the Chairman pointed out, at the beginning you are only allowing £10,000 per school for transitional costs. Do you think you can equip a school kitchen which has to feed 600 children on £10,000?

Mr Bell: It is not a case of just using the transitional funding, of course schools will spend more money on school meals depending on the size of school. The transitional funding was intended to enable them to make some of the changes that I described earlier. I think what we would also be suggesting, and this is happening we know, is schools are looking at the totality of what they spend and they have got the catering in-house or via larger scale contracts to change the diet for the children. It is not about £10,000 doing everything, it is about using the money that is going to each individual school as part of a process of looking at the totality of what is offered in school meals.

Q44 Helen Goodman: I was not suggesting that the £10,000 was to deal with everything, was to deal with the nutritional content of the meal, obviously that is not the case but it is the transitional funding to enable them to bring the catering in-house instead of having it out. Do you think £10,000 is enough to equip a kitchen to feed 500 or 1,000 pupils?

Mr Bell: I do not know the particular circumstances because, of course, secondary schools—if one takes secondary schools where this usually happens—if they take the catering back in-house they will already have, in most cases, kitchen facilities on-site which have been used by the contractor. It is not simply a case of saying you go from everything being done by a contractor and it all disappears to having to set it up for yourself.[1]

Q45 Helen Goodman: I have to tell you that in my constituency the contractor took the cutlery, the trays, the glasses, all they left were some tables. I would be very pleased if officials in DfES could revisit that one. Dame Sue Street, could I ask you to look at chart 2 which shows the major initiatives for primary schools on page 13. Are you aware of the research that Roger Mackett at the University College London did into children's calorific expenditure?

Dame Sue Street: I would need to be advised on that.

Q46 Helen Goodman: What he found in 2004 was that children expended more calories on free play in their own time and walking to school than they did in sport. Given that is the case, why are you spending three times as much money on sport as you are on play?

Dame Sue Street: I think that it has to be a combination. I noticed a reference to an article in the *British Medical Journal* in 2001 which said opportunities for spontaneous play may be the only requirement that young children need to increase their physical activity. It has to be part of the overall strategy. The Big Lottery Fund is making available £155 million as you know, and a further £90 million for parks. In my own world, the Royal Parks Agency with Sport England are now putting significant investment into things like The Hub in Regent's Park. That is very London-centric but all parks I think are beginning to wake up to this. David Bell may wish to add something on this. I think all of us consider that the early years and getting children to play is important, partly because children enjoy it, you are getting away from the feeling that you have to do it or it is competitive which does not appeal to everyone. I completely agree that it is a mixed economy and that is what we are working towards.

Q47 Helen Goodman: Given that this piece of research shows there are lots of aspects of children's lives, I wonder if Mr Taylor could tell the Committee who is on the overall project planning board? Who is represented in Whitehall? Which department?

Mr Taylor: These three departments form the core of this. ODPM, Defra and DfT are on the Committee as well.

Dr Adshead: And the Treasury.

Mr Taylor: And the Treasury, yes.

Q48 Helen Goodman: *Choosing Health* was published before Christmas 2004, why did the board not meet until September 2005?

Mr Taylor: There were meetings between the Departments before that. The programme board was established following the appointment of a programme manager. There were meetings between the Department moving this agenda forward but the proper programme structure for delivering PSA did not really get into gear then. I think that was a consequence of getting the thing up and running in a proper fashion. We want to keep the Government's arrangements under review.

Q49 Helen Goodman: Fine. Dame Sue, you pointed out, quite correctly, that in 2004 the Government made a commitment to take further action if we have not seen a change in practice on broadcasting and promotion of food to children by early 2007. That is only eight months away now. What monitoring have you done up to now and what have you found so far?

Dame Sue Street: We are waiting, quite patiently, for the end of the Ofcom consultation if we are talking about broadcast media where their research showed that television advertising has a modest effect on children's food choices They went out to consultation; you may have seen quite a big document on options for regulated broadcast; and the closing date is 6 June.

Q50 Helen Goodman: Yes, why is it so late? That is 18 months after the White Paper. That does seem quite slow. What can DCMS do to chivvy Ofcom along?

[1] Ev 18

Dame Sue Street: The Secretary of State asked Ofcom to take on this. It is not necessarily something they would have to do within their statutory obligations. I think we not only chivvy, but the Secretary of State did request them to do this.

Q51 Helen Goodman: Why was this consultation a task given to Ofcom, not a task held in Government, given that it is about balancing conflicting interests between different stakeholders?
Dame Sue Street: This is about regulating the broadcasters and Parliament has set up Ofcom to regulate the broadcast media. That seems to be the proper place because you obviously do not want to use the media in any inappropriate way.

Q52 Helen Goodman: From the point of view of DCMS this is essentially an issue about the broadcast media?
Dame Sue Street: I was just referring to what we have done for the broadcast media. For the non-broadcast media, as I said, we are looking for very active voluntary self-regulation for the industry, but if we do not see it, then the Government will act next year and the Deputy Chief Medical Officer who chairs the Food and Drink Promotion Forum which looks at what more could be done, will act if we need to next year. I have to say, partly driven by the market, many of those in the industry are acting very responsibly, but not all.

Q53 Helen Goodman: I wonder if I can draw your attention to some of the things in the Ofcom document. Ofcom have ruled out, they have not even put on the table as an option, banning adverts up to the nine o'clock watershed because—and here I am quoting—"Ofcom considers that on the basis of the current analysis the impact on broadcasters would be disproportionate". The options they have put forward, they have helpfully provided some assessment of what the impact would be. The overarching impact on broadcaster revenues will be—on one of the options for example—to reduce them by approximately £31 million per year. The benefits would be in the range of £63 million to £103 million. Everything is around a cost of about £30 million to the broadcasters and the benefit between £60 million and £300 million in terms of the public good. Do you think that is a reasonable balance between the interests of the different stakeholders? Why should it be that £30 million million is all we can expect from the broadcasters when we, in terms of the public purse, are spending £1 billion a year on the NHS and by 2010 £3.6 billion? How can it be that only £30 million is an appropriate cost to the broadcasters?
Dame Sue Street: The Government has not offered a view on Ofcom's options. Ofcom has set out their options. I think they have another catch-all, "and anything else people would like to suggest". The options they set out are based on their own research and the view that food promotion has a modest effect on children's food choices and a view that what they wanted should be proportionate to the damage that might be caused. I think really we have to wait to see what comes back.

Q54 Helen Goodman: The Government does not have a view on whether Ofcom have conducted this consultation properly or not?
Dame Sue Street: We do. The Government does consider that they are conducting it in a proper way based on the evidence. For the record, it has not ruled out other options affecting their decision.

Q55 Helen Goodman: From the point of view of the Department of Health, these burdens are going to come on to your budget, the £1 billion on NHS, £3.6 by 2010. Are you happy with this attitude and this approach with the broadcast media? Do you think all the £30 million would be disproportionate?
Mr Taylor: I take the same view as Dame Sue on this. I think we have asked Ofcom to do a job and they are doing it. We must await the outcome of their consultation and then the Government, as Dame Sue has already indicated, will take a view next year on whether all this moves us far enough forward. I just cannot go further than that at the moment.

Q56 Mr Bacon: Mr Taylor, you said earlier that none of us is going to give up. You are the Acting Permanent Secretary, are you not?
Mr Taylor: Yes.

Q57 Mr Bacon: You have been involved in running the Prison Service, is that right?
Mr Taylor: No.

Q58 Mr Bacon: I was reading your CV earlier. You were at the Cabinet Office and then the Prison Service, and did various other things. You are not permanently Permanent Secretary, are you?
Mr Taylor: Sorry?

Q59 Mr Bacon: You have taken over from Sir Nigel Crisp, have you not?
Mr Taylor: Yes.

Q60 Mr Bacon: But only temporarily?
Mr Taylor: Yes.

Q61 Mr Bacon: For how long?
Mr Taylor: That remains to be seen.

Q62 Mr Bacon: Is there not yet a view in terms of the Department of Health when Sir Nigel Crisp's permanent successor will be appointed? When did he go?
Mr Taylor: He went about six weeks ago, I think.

Q63 Mr Bacon: This is a very important post.
Mr Taylor: Yes.

Q64 Mr Bacon: Presumably action is ongoing inside the Department of Health?
Mr Taylor: Ultimately it is a matter for the Prime Minister to cite who succeeds Sir Nigel.

Q65 Mr Bacon: He has been quite busy, has he not?
Mr Taylor: He has. What we have done is to split Sir Nigel's previous post into two positions. I have taken on the role of Permanent Secretary and Sir Ian Carruthers has taken on Sir Nigel's full responsibilities in relation to the NHS as Chief Executive of the NHS. We are job-sharing in relation to Sir Nigel Crisp's previous responsibilities. I think the Government announced last Friday that an advertisement would go out shortly for the position of Chief Executive of the NHS.

Q66 Mr Bacon: So there has not even been an advert yet?
Mr Taylor: No.

Q67 Mr Bacon: You are not expecting to stay in the Department of Health?
Mr Taylor: I am. I have been in the Department of Health since 1998 and, as far as I know, I shall continue there.

Q68 Mr Bacon: Dame Sue, you are leaving when?
Dame Sue Street: At the end of September.

Q69 Mr Bacon: So "none of us is going to give up" is not quite strictly true, is it?
Dame Sue Street: It is completely true in respect of the Departmental will. Secretaries of State change occasionally, permanent officials occasionally change, but the Public Service Agreements for goodwill go on forever. I think this is the first tripartite Public Service Agreement ever involving three departments and maybe we can be criticised for taking a while to get the show on the road but it is on the road and it has the commitment not just of the people you see before you but all of those who would hold office in our place.

Q70 Mr Bacon: I am not sure whether it is the first tripartite Public Service Agreement or not, it is not the first time three Permanent Secretaries have been before us and it is not the first time three Permanent Secretaries have been before us to discuss this subject because this Committee looked at this five years ago.
Dame Sue Street: Absolutely.

Q71 Mr Bacon: I was just looking through the transcript and I came across this sentence, and I am going to read it out. This is from the Chairman, as far as I can make it out. "I am very impressed . . ." he said ". . . that we have three Permanent Secretaries here. In the past there would have been some huge issue of peace or war at stake to get three permanent secretaries in front of a House of Commons Committee. We did a bit of research in the office today and we found that there were 261,000 registered cancer sufferers and the NHS spent a £1.5 billion on them. There were eight million adults who were obese and you only spent half a billion on them. Do we really take this subject seriously?" Here we are five years later, the Public Service Agreement you referred to was agreed, how long after this Report in 2001?
Mr Taylor: It was agreed in 2004.

Q72 Mr Bacon: Three years after that. Now two years down the road from that, and you said earlier, Dame Sue, and I wrote it down, "We are all very clear that 2007 will see action by Government". There is no real urgency about this, is there?
Dame Sue Street: I think 2007 was referring particularly to the food promotion balance between self-regulation and Government taking action. An enormous amount has been done in the other spheres and I think we spoke about the progress towards far more sport in schools and towards healthier diets. Although there is this spaghetti-like diagram that the Committee has drawn attention to, what we have now in terms of organisation and governance should be pretty clear from the point of view of the child or the parent. Namely, that at local level it is primary care trusts and directors of children's trusts; at regional level, as the Report says, the Director of Public Health has a pivotal role; and at national government level we have a ministerial committee and a programme board chaired by Dr Fiona Adshead. It has been driven but has taken a while to set that up.

Q73 Mr Bacon: There has been a lot of public management speak of various kinds. I listened to Dr Adshead earlier and there was a lot of public sector management jargon in what Dr Adshead said. The Comprehensive Spending Review identified something should be done which led to the Public Service Agreement which was three years after that report—I thought it was two years ago—and you have still only got, as Mr Taylor referred to earlier, a joint draft delivery plan. It is a draft one because Mr Taylor still thinks it could be improved. I put it to you again, there is no sense of urgency, is there?
Dame Sue Street: There is. If you went through what we have been doing in the meantime that contributes to this, there is a huge amount.

Q74 Mr Bacon: Why has the Obesity Awareness Campaign not started? How difficult can it be? Mr Taylor said earlier that it was all about getting the agencies together—how many times have we heard that in the context—and that it was about pulling the funding together. The need for funding was identified in the Comprehensive Spending Review in 2004.
Mr Taylor: I will ask Dr Adshead to come in on this. First of all, in terms of raising awareness about obesity, a number of steps have been taken. For example, for the first time in 2004 we put as a specific priority to the NHS the need to formulate plans to tackle obesity and contribute towards this target of halting the trend in the increase in obesity. We have committed ourselves and recently produced the NICE guidelines on effective treatment. We have published a care pathway on tackling obesity. We have produced communication. I think there has

been a lot of awareness raising going on. The Government made a specific commitment to a social marketing campaign in this area in the *Choosing Health* White Paper which it said it would do in 2007, and that remains our intention. What we are trying to do there—and I will ask Dr Adshead to say more about this—is really to look at how to make that kind of campaign effective. We do not think that is an entirely straightforward issue.

Q75 Mr Bacon: Where do you think most people get their information from about the world in general? It is a variety of sources, is it not? Where is the single biggest source?
Mr Taylor: In their home, home influences obviously, and school.

Q76 Mr Bacon: Which is the biggest single source, do you think?
Mr Taylor: I have no idea.

Q77 Mr Bacon: Where do people get their news from mostly?
Mr Taylor: The media.

Q78 Mr Bacon: Yes, which one?
Mr Taylor: Broadcasting.

Q79 Mr Bacon: Which one?
Mr Taylor: Television.

Q80 Mr Bacon: Yes. Most people get most news from television. Dame Sue was talking about broadcast advertising and the influence of that and research that could be done on that and so on. Of course advertising does play a significant part, I am sure you will all agree on that, although how much could be open to interpretation and argument. It is broadcast media that has had a huge impact, particularly television. What discussions have been had with programme makers about making programmes of the kind that we see about people jazzing up their gardens or whatever it is? Surely getting it on television is going to have more influence than local area agreements and all the other public sector management guff that you have been talking about, is it not? Get it on television. Show some really fat people on television, that is what you need to do.
Dame Sue Street: I do not know whether you have watched these programmes but there has been ITV's *Britain on the Move* and BBC's *Fat Nation*. There are an awful lot of fat brat camp type programmes of greater or lesser taste—no pun intended—but those two have really been tremendously well presented.

Q81 Mr Bacon: Are there plans for more work of that kind involving the Government?
Dame Sue Street: Government does not tell the BBC what to show.

Q82 Mr Bacon: Of course not. I am not suggesting that.
Dame Sue Street: It is extremely useful to help any public awareness, of course it is.

Q83 Mr Bacon: Can I ask you about PFI because there have been stories repeatedly that the Government on the one hand, education authorities, health PCTs and so on are trying to encourage children in schools not to eat chocolate. PFI companies operating contracts in schools have got vending machines and if the contract says the company can have in it what it likes there is not a lot you can do. What work has been done to try and sort that problem out?
Mr Bell: Can I come in on that one. The Education and Inspections Bill which is currently in Parliament will extend the nutritional guidelines for all food sold on school premises. The School Food Trust will be publishing guidance about that in due course. I think there is a recognition that if you are trying to change behaviour in school meals and what is offered to children, it does not seem sensible, therefore, not to include the vending machines that are on school sites.

Q84 Mr Bacon: Will the legislation—I am not deeply familiar with it—override or allow authorities to override existing contracts retrospectively?
Mr Bell: I am not sure about the retrospective element but it will certainly make it a requirement that nutritional standards are set and it will apply both to school meals and other foods sold on school premises.[2]

Q85 Mr Bacon: This is a question for Mr Taylor, possibly Dr Adshead. How do you characterise the changes? When we looked at this five years ago there was a comment that GPs were not taking it seriously enough. When I met with consultants in the Norfolk and Norwich Hospital recently they said the overriding thing which would have more impact than anything else on their workload, costs and everything else would be the lifestyle choice—diet, exercise and so on. That was top of their list. What used to be called late onset diabetes is now being seen in children and teenagers and that was not the case even 10 years ago. How do you characterise the change among GPs and consultants or has there been one?
Dr Adshead: *Choosing Health*, at the heart of it in terms of its focus on the NHS was to really try to make sure the NHS not only focused on excellent care but also improved people's health. One of the central tenets in that was that every contact a health professional has with a patient ought to be used, where appropriate, as an opportunity to improve their health by giving effective lifestyle advice. I know from talking to a range of clinical colleagues that awareness of lifestyle issues is certainly going up in the profession. That is why we published very recently, as you heard earlier, our *Clinical Care Pathway* because we wanted to clarify for general practitioners exactly what sort of advice they should

[2] Ev 18–19

be giving, when they should refer patients to more specialist services, because one of the things that your earlier Report highlighted was that whilst GPs might have concerns about this they do not always know what best to do and what support is there for patients. The guidance makes it clear that there are information leaflets they can give to patients and we are responsive to developing support for patients directly, which is the reason behind our health trainers' programme and why next year when we develop Health Direct, which will be our interactive service working through digital TV but also through call centres and a website, patients will be able to get better advice on their health. However, it is important to recognise that the Food Standards Agency already does a lot to highlight what a good balanced diet is for consumers, which is why it has had such a strong emphasis just recently on the levels of salt in food and why we have worked with the industry on very important messages such as five-a-day where we have very much taken the attitude that we want to work with them—

Chairman: All right; thank you, doctor. That is a long enough answer.

Q86 Greg Clark: We have heard that this is the first tripartite PSA route, so is this a success, Mr Taylor?

Mr Taylor: I think it is building into a success in the way we have been working but we have recognised that we have still got progress to make.

Q87 Greg Clark: There seems to be a strange clash of perceptions here because it has been very positive, what we have heard today, but when the NAO Report came out, the headlines in the newspapers were, and I will quote a few, "Children grow fatter as the experts dither", "Child obesity targets at risk, says Report", "Shambles on obesity". Mr Burr, is it your perception that this is a success?

Mr Burr: Well, certainly it is an area in which there is considerable scope to achieve the targets that have been set.

Chairman: That is NAO-speak.

Q88 Greg Clark: It is NAO-speak for "it has got a long way to go", is it?

Mr Taylor: But the NAO Report does not—

Q89 Greg Clark: Can we hear from Mr Burr? Is that correct: it has a long way to go?

Mr Burr: Yes, absolutely.

Q90 Greg Clark: That is my view and I think it is worth reflecting that but, if this is the first tripartite one, in terms of its lessons for others I think it is a bit worrying. Just to be specific about it, ultimately you should be able to measure your success presumably under a PSA target, and the target is to be met by 2010. When will you know whether you have met the target, Mr Taylor?

Mr Taylor: In 2010 we will know.

Q91 Greg Clark: Will you? How will you know?

Mr Taylor: Because we will at that stage have evidence based on—

Q92 Greg Clark: From where?

Mr Taylor: From the survey data that Dr Adshead has already referred to.

Q93 Greg Clark: When does that come out?

Mr Taylor: It will come out at the end of 2010 for 2009.

Q94 Greg Clark: The history so far is that it has come out two years after it has been gathered.

Mr Taylor: In the most recent case that is true. It does not always take that long.

Q95 Greg Clark: But so far it has come out two years afterwards. Why is the data not going to be available in year before—

Mr Taylor: My understanding is that the data for 2005 will be available within a shorter timescale than the two years.

Q96 Greg Clark: How long?

Mr Taylor: We will be measuring as we go along.

Q97 Greg Clark: How long will it be before the 2005 data is available?

Dr Adshead: It has normally been by December of the subsequent year, and obviously the field work, as you are probably aware, takes quite a lot of time, so if the survey is undertaken within a calendar year that is going to take several months because it is a very big survey and is obviously not just focusing on obesity.

Q98 Greg Clark: That is my concern. There is a lag of at least a year before you can know whether you have met the targets. Presumably when you get to 2010 you will have to have a new strategy but you will not know whether the existing one has succeeded or not. Just in terms of measurement, there is a programme going on, I think, at the moment which requires all PCTs to measure every child in the country in reception and year 6, but you are not going to use that information to evaluate your progress against targets, are you, Mr Taylor?

Mr Taylor: We will be using the data that we get from that source to evaluate progress against the target, particularly the progress of primary care trust—

Q99 Greg Clark: But I thought the measure was against the health survey.

Mr Taylor: Yes, that is because, as we have already explained, we needed a base line, which goes back to 1995. That is collected in one form.

Q100 Greg Clark: If you are having a base line the subsequent data gathering statistics will have to be against the same sample. You cannot have a base

line of one set of statistics and a target with another one, so are you going to repeat this every year, this requirement that PCTs weigh every child in the school?
Mr Taylor: Yes.

Q101 Greg Clark: That is going to be happening every year?
Dr Adshead: I think you need to make a distinction—

Q102 Greg Clark: Just on that point, Mr Taylor, are we going to weigh these children every year?
Dr Adshead: We are, but I think that there is a distinction between the national public service agreement target which is measured through the Health Survey for England and the work we do through strategic health authorities where they performance manage our primary care trusts, so the data that we are collecting through schools is going to be very helpful and much more timely to help us to tell—

Q103 Greg Clark: I am sure it is going to be helpful, but, Mr Taylor, that is exactly my point. These are two completely different data sets.
Mr Taylor: They are.
Dr Adshead: They are.

Q104 Greg Clark: We all know that our PCTs are under a great deal of pressure. They are being required to weigh every child in year 6 and reception and yet this is completely separate from the measurement against which your target is evaluated. I wonder whether, given the constraints on the resources of PCTs, this is a helpful exercise because it is the case, is it not, that although every child is being weighed these children, or their parents, will not get to know whether they are at risk of obesity? Is that correct, Mr Taylor?
Dr Adshead: Parents can ask to have their children's height and weight if they want to.

Q105 Greg Clark: If they want to?
Dr Adshead: If they want to.

Q106 Greg Clark: You are weighing every child in the country at a certain age in reception and you have got this very valuable information but it will not be helpful for the objective of tackling child obesity, which is the purpose of this Report. It is not helpful to say, "Your child shows signs of becoming obese. We think you should do something about it. This is what you could do".
Dr Adshead: As I explained earlier to one of your colleagues, it is because we are concerned that that might stigmatise children.

Q107 Greg Clark: But this is what I find extraordinary, Chairman, that here we have an issue that apparently is a national crisis, that apparently is a public health crisis and no doubt a particular problem for the individuals; it is so important that we are putting a lot of money into it, but because the Children's Commissioner thinks that it might stigmatise individual children to be told, presumably in confidence, what their weight is we have the situation that we tiptoe around having expensive schemes to deal indirectly with the issue, but actually we do not do what Mr Mitchell said earlier, which is humanely to approach the children who have a problem and help them to do something about it. This is political correctness, is it not?
Mr Taylor: I think this is an area where we have got to go a step at a time. It was quite a big exercise in itself to establish the principle and then the practice of weighing and measuring at these levels.

Q108 Greg Clark: Can I stop you there? It is difficult to establish the principle and the practice of measuring individual children?
Mr Taylor: Because there were concerns, which are reasonably well documented, amongst professionals about stigmatisation and other issues. That is where we are. We have got to keep moving forward, so I am perfectly prepared to say that between us we would want to keep precisely the point you have been getting at under review.

Q109 Greg Clark: But this is very serious. Here we have a programme that, as Mr Bacon has commented on, already seems pretty tardy as a response to a national crisis, and we have apparently some marvellous unprecedented tripartite agreement, and a long way into it you are thinking about keeping under review the desirability of telling overweight children that they have a problem and you might be able to help. This is a waste of public money, is it not?
Mr Taylor: We certainly do not think that. The data which will be collected by primary care trusts will certainly be helpful to them in focusing attention within their areas, talking to local partners about areas where there are clearly priorities, but it will also help us to evaluate progress at local level against targets.

Q110 Greg Clark: What you are saying, Mr Taylor, is that it will be very helpful to officials, it will be very helpful to the various elements of the bureaucracy but it will not be helpful at all to the individual children and their parents who have a problem and who we know might need some expert advice as to what to do about it. It is helping the system but not the children.
Mr Taylor: To the contrary: the aim is to enable those professionals who can help children and their parents to do so in a way that makes that happen effectively, and at the moment the evidence that we have, and it is limited, suggests that working with groups of individuals is more effective than one-on-one prescriptive type treatment of the kind—

Q111 Chairman: Sorry; I cannot bear this any more. That must be complete nonsense. This is ridiculous. This hearing has already lasted an hour and 10 minutes. You have got 20 more minutes. You have got to do better than this—three Permanent

Secretaries. You are talking drivel. Are you actually saying, the Permanent Secretary at the Department of Health, that some vague target setting, which apparently will not even affect your target anyway, and working with partners is more important than going back to the parents of a child and saying, "Your child is dangerously obese. Here is how we can help you do something about it"? Are you seriously telling this Committee that?
Mr Taylor: No.
Chairman: Right; well, you had better try and do better.

Q112 Greg Clark: I think the Chairman's words stand for themselves. It is ludicrous to leave children without the advice they clearly need when you have the capacity to do that, precisely at a time when you are imposing on PCTs, already cash-strapped, an obligation to gather statistics purely for your administrative convenience. It really is a disgraceful use of resources, and to cut out parents from it entirely I think is a great shame. This Report and this PSA agreement I think are a case study of how to make complex a simple issue. Perhaps this is a question for Mr Burr. I am concerned that in the methodology, which is not sufficiently critical of this, I might say, of all of the interviews that were conducted, and we understand that 150 representatives were interviewed, they included directors of public health, government officers, invited staff from PCTs, local authorities, relevant stakeholders in the north west, the West Midlands and the south west. Not a single parent was interviewed as part of this and, given that by my calculations children spend maybe 12% of their time in schools and 88% of their time with their parents, I would have thought parents' views as to how they would like to be helped to tackle obesity might have been central both to the work of this joint system and to the Report.
Mr Taylor: It is a reasonable challenge and I take it in that spirit. What I think it is important to stress is that the data we are collecting is not for officials or anything like that. It is in order to enable people who are committed to doing something about this problem formulate programmes to work with schools, children, parents and so on, in an effective way and then to measure progress against those actions. It certainly is not the intention to do it for bureaucratic or other reasons.

Q113 Mr Davidson: Can I just clarify whether or not there is, as it were, a single champion that is responsible for driving this forward? I am not quite sure who should answer that.
Mr Taylor: I think The Department of Health should take the lead across Whitehall. Fiona Adshead is the senior responsible officer for the PSA; she is its champion in the Department of Health and across Whitehall, and then at each level there should clearly be people in the regions who want directors of public health to champion the target.

Q114 Mr Davidson: I must confess that has not been the impression I have had in listening to the dialogue that have had so far. Would it be unfair for me to have the view that this initiative is insufficiently driven?
Mr Taylor: I think it would be unfair to say that it is insufficiently driven. I think we have established a clear programme across Whitehall for driving it forward. The three Permanent Secretaries, including my predecessor, have met to review progress on this and push it forward. There have been issues, including issues about data collection, which have not been straightforward to resolve and which have required intervention at permanent secretary level, so I think it would not be fair to say that this has not been driven.

Q115 Mr Davidson: I just have the impression though that all of the three Permanent Secretaries must be exceedingly busy with a whole variety of things, of which this is only a small part, and, with all respect to you, Dr Adshead, I cannot see that you would necessarily be in a position, given that while senior you are relatively junior as compared to Permanent Secretaries, to be able to drive this through the departments. The impression I have had from all my colleagues is that there is a feeling of drift and lack of progress and momentum, in particular on the point that came up about dealing with professionals. Would it be fair to get the impression that there is a lack of momentum to overcome the extent to which so many professionals have managed to get their fingers into the pies and, as it were, pull it in the wrong direction and it has just ended up in things stalling?
Mr Taylor: I do not think it would be fair to put it like that but it would also be right to say that we have reviewed where we are on the programme across Whitehall and we do recognise and believe, which was brought out in the NAO Report and through our own stocktaking progress, that we should put some momentum behind it, which is why we are committing ourselves to looking at, for example, as Dame Sue Street was saying, how we can get some of these big programmes which we have launched more specifically focused on childhood obesity than they have been up to now. We do need to keep trying, yes, and we accept the need to have more momentum.

Q116 Mr Davidson: In other areas we have had tsars appointed. Do we need to have a named person, a fat controller, as it were, appointed in a way that then focuses attention on this? I get the impression that it has just dissipated. Would that help?
Mr Taylor: I do not know that it would help. It is certainly something we can look at. The reason for having such a person would not be that there is not a commitment to pursue this in the Department of Health, at ministerial level and in the trusts. There are few issues of greater importance for the future of our country, as the committee has already made clear, so it is not that there is not a focus or concern about it in the department. There is an issue about getting it higher up the—

Q117 Mr Davidson: I understand that. Can I come back to the question of action being taken, and I think of the smoking ban in Scotland. Clear, direct action is being taken. It has raised the profile of smoking and smoking-related disease enormously. There is not an equivalent being done here though, is there?
Mr Taylor: One of the issues, if you look at tackling obesity versus dealing with smoking as an issue, for example, is that we have not had the same evidence base to show what makes the biggest difference in stopping people, in this case, becoming more obese or how to tackle it, and it is really helpfully brought out in the NAO Report why we need to do more on what works.

Q118 Mr Davidson: I understand that point entirely but you do not think that the merits of doing something in order to raise the profile of it would have consequential effects? You mentioned digestives. A ban on chocolate digestives in all places of learning would certainly have the scribblers from the press writing away quite a bit and it would raise the profile quite considerably. You do not seem to be doing any of that.
Mr Taylor: In comparison with the well-documented and well-evidenced business of stopping smoking in public places, that kind of example we do not have at the moment and we are open to suggestions.

Q119 Mr Davidson: Dr Adshead, did you want to get in there?
Dr Adshead: I think that is absolutely right but if you look at the approach that we are taking on obesity it covers the same kind of process. We are looking at how we can give clear messages—

Q120 Mr Davidson: I understand that. It is not quick enough, in a sense, is the issue. I am sorry; we have only got a limited amount of time. Maybe I can come back to the question of price. My understanding would be that with things like crisps and chocolates and so on there would be a high degree of price sensitivity. Is it your view and have you advocated, for example, that a doubling of the price of chocolate biscuits would have an impact and, similarly, a doubling of the price of crisps, would concentrate minds quite considerably as to why that was being done? Have you considered whether anything like that would be helpful?
Mr Taylor: I do not think at the moment we have the evidence to suggest that specific action of that kind would by itself make that much of an impact. What we know is—

Q121 Mr Davidson: Okay; can I just be clear? Given that the high price of cigarettes and the high price of alcohol have been introduced largely as a means of choking off demand, if you accept, as I think you do, that chocolate biscuits are generally a bad thing in terms of obesity, though within reason and so-and-so they can be included as part of a balanced diet, as the Government would say, and crisps similarly, surely it would stand to reason that jacking up the price would reduce consumption, which would have the effect of being beneficial in obesity terms?
Mr Taylor: What we have tried to focus on there so far, through the activities of the Food Standards Agency, is campaigns aimed at bringing to people's attention foods which are bad for you for different reasons.

Q122 Mr Davidson: But generally people know that foods like that are bad and they know that smoking is bad for you, but it does not actually stop people from doing it. It is only when other actions are taken that it is restricted. Can I come on to the question of schools and sport? Dame Sue, have you got indicators of activity that would be able to demonstrate that there was an increase in the number of youngsters participating in sports and activities?
Dame Sue Street: Yes. There was an 11% increase in—

Q123 Mr Davidson: I just wanted to know if that was there. Can I ask for clarification about whether or not there is a differentiation in class terms?
Dame Sue Street: Do you mean in social class terms?

Q124 Mr Davidson: Yes.
Dame Sue Street: I think, as Dr Adshead said, we do have some evidence that the lower socio-economic groups are more at risk of obesity.

Q125 Mr Davidson: I know that. I was talking about sporting activities and you indicated that there were indicators. Is there any evidence from those indicators that what is presumably an increase in the take-up of sporting activity has any social class differentiation?
Dame Sue Street: I am not aware of that in that form.

Q126 Mr Davidson: Do you measure that?
Dame Sue Street: We measure—

Q127 Mr Davidson: Yes or no?
Dame Sue Street: We are aware that there are particular participation problems with certain under-represented groups but not by social class. So, for example,—

Q128 Mr Davidson: So you do not actually measure participation by social class?
Dame Sue Street: I do not think so.

Q129 Mr Davidson: Even though we have already heard that lower social classes are more prone to suffering from obesity and that physical activity is deemed to be one of the ways of tackling it, you do not actually measure whether or not your efforts are having any impact upon the social classes that are most at risk from obesity?
Dame Sue Street: We come at it in a different way, but I think that—

Q130 Mr Davidson: I know you do. Is that a yes or a no?
Dame Sue Street: That is a no.

Q131 Mr Davidson: Right; thank you. Can I express my concern at that? Can I take up with Dr Adshead on the question of tackling obesity whether there is any differentiation by social class in your approach?
Dr Adshead: Yes. We have *Choosing Health* quite a comprehensive package about how we are going to tackle inequalities in health, and obesity is one of them. Our programmes include targeting health trainers to spearhead areas which are the fifth most deprived group of local authorities in the country. We plan to pilot Life Check in the most deprived areas. We have Healthy Schools and again many of the initiatives there have been piloted together with breakfast clubs in the most deprived areas, so yes, we do.

Q132 Mr Davidson: Okay. Can I just clarify that? If that is being done by yourselves why is it, do you think, that the Department of Culture, Media and Sport does not seem to have picked up any of that if this is meant to be an integrated campaign? If the overall thrust is that it does differentiate between social classes why has that message not reached the DCMS?
Dame Sue Street: It has reached it.

Q133 Mr Davidson: Sorry, I was not asking you, although I heard your reply earlier on and you said no, it did not, you see, so—
Dame Sue Street: I was trying to explain that we look at participation. So where we have seen problems, for example, with girls, then we focus on girls. From September we will focus on the overweight children at risk of becoming obese. We look at who is being active, which is not unreasonable, although it may not be what you want.

Q134 Mr Davidson: Let me just clarify that point. You focus on girls, but again, unless I am very much mistaken, there is a differentiation amongst girls by social class, which you do not recognise.
Dame Sue Street: There is a differentiation in relation to girls from ethnic minority groups where—

Q135 Mr Davidson: I did not mention ethnic minority girls. I mentioned social class.
Dame Sue Street: But that is where they are not participating.

Q136 Mr Davidson: No; I mentioned social class, particularly relating to working class and lower class people, who do have less take-up of sporting activities and you do not positively discriminate in favour of them at all?
Dame Sue Street: We are heading for a universal offer in a very methodical way and then focusing on those groups which are not participating.

Mr Davidson: Right, fine. I give up, Chairman. Thank you.
Mr Williams: Mr Taylor, it has been a very disappointing hearing so far. You referred to going step by step but the impression is that you are going step by step in circles with divers' boots on. The answer you gave to Greg in relation to the weighing of children was frankly incredible and incomprehensible. The idea that you meet all the costs of weighing them and then do not make use of the information is too ludicrous even to articulate. I am amazed you dare tell us that. Did the Children's Commissioner seriously say that they should not be told?
Greg Clark: No, that was the evidence from Dr Adshead.

Q137 Mr Williams: Who said that?
Mr Taylor: When the—

Q138 Mr Williams: No; did someone say it?
Mr Taylor: Yes.

Q139 Mr Williams: Who?
Mr Taylor: It was Dr Adshead.
Dr Adshead: It was me.

Q140 Mr Williams: You said they should not be?
Dr Adshead: Yes. It was not just the Children's Commissioner. It was a range of children's doctors who raised the concern and that was why the Children's Commissioner—

Q141 Mr Williams: I do not care who it was. We are spending all this money getting the information and we are treating them as statistics by just collecting statistics and no-one is making use of them at the individual level in relation to the families.
Mr Taylor: With respect, we did not say that people were not making use of it. We want primary care trusts and other people working locally to make use of the information.

Q142 Mr Williams: So what are you telling them about it?
Mr Taylor: First of all, we want them to find out where the evidence points in terms of communities, schools,—

Q143 Mr Williams: Yes, but that is communities and schools. I am talking about people, the parent who does not want his or her child to die at the age of 14 from a heart attack.
Mr Taylor: I understand your frustration about this. All I can say at the moment is that the agreement which we have reached in order to collect this information is that it will not at the moment be used for referral in individual cases.

Q144 Mr Williams: To whom did you have to make that concession in order to get an agreement? This is public money you are spending. We want maximum

value out of that public money. Who objected? Who blocked taking the information to the families who need it?

Mr Taylor: I think a range of concerns was expressed. I think probably a number of the bodies who were consulted about this have difficulties, but it is also true to say that health practitioners, the kinds of people that Fiona was referring to, have had reservations about using this data as a basis for referral, but I will take the Committee's concern away—

Q145 Mr Williams: I think we need a detailed note on this[3], a really comprehensive note on the background to this decision, which at first sight to us seems to be an astonishing waste of public money and also irresponsible and negligent in terms of what it could mean for individuals' health. Individuals could end up with ill health, even some of them dying, just because of political correctness. Helen Goodman made some fascinating points about advertising and the role of Ofcom. Some years ago I was in the United States where there was a conference on obesity and at that stage they were very worried about youngsters of 13, 14, 15 being at risk of heart attack, but they came out with an astonishing statistic I had never heard before. They said that children as young as two were developing brand preference. This comes particularly from promotional toys, promotional gifts, given with particular products, so they do not know what it is about other than that they want the product because it is the way to get at the gift. To think that children as young as two are being trapped in this way by what their parents are quite innocently letting them watch on television is quite unacceptable. Ofcom does not seem to be doing much as far as we can gather. As Helen said and as *Which?* said, its duty is to protect citizens and consumers; that is one of the reasons it is there, and yet *Which?* has accused it of putting the economic interests of broadcasters ahead of public health. Do you talk with Ofcom? Have you had any contact with them? They are not in your vast chart of all the people you deal with. It seems the people you should also deal with are the retailers and manufacturers of food and also people like Ofcom with their influence over the mass media, because the mass media is where a lot of the children are picking up their eating habits. What contact have you had with Ofcom?

Dame Sue Street: The primary contact was when the Secretary of State, initiating this on behalf of the department, asked Ofcom to research the effect of broadcast food promotion and consult on options for reducing any malign effects. They did their research and concluded that television advertising has a modest effect on children's food choices, and they are now consulting on options for reducing the damage. The stick at the end of all of this is Government's declared intention; if regulation is not sufficient in 2007, we will act further in relation to both non-broadcast and broadcast. In the meantime, as I say, we see some signs in non-broadcasting forums of better, but not enough, self-regulation.

Q146 Mr Williams: You see, again, if *Which?*'s report is correct, and the focus has been purely on restricting advertising to children nine and under, that alone needs explaining because, as was pointed out, much of the obesity is in that age group and up to 15. Also, *Which?* makes the point that none of the advertising restrictions for children up to nine includes advertising during the programmes that most of the children of that age would watch. Does that not seem to be an absurdity? Is it not something you should talk to them about? Have you discussed it with them?

Dame Sue Street: We are standing back until the consultation is complete because Government will have to see the evidence and arguments that comes back, and *Which?* and others are making some very powerful arguments, but Ofcom will then present it to the Secretary of State who has the final decision.

Mr Williams: We need something more urgent than that. Chairman, I wonder if we can ask the National Audit Office, in conjunction with this Report, to go to Ofcom and get from them a report on their attitude and their policy towards advertising in relation to children, particularly in relation to food, obviously, in age groups right up to 15. We want a very detailed report from them and we may want to call them here to see what they can do to get a move on because it is clear that the departments are not getting a move on[4].

Q147 Mr Mitchell: Mr Bell, you have had a fairly light time in this grilling but I was surprised by your answers to Helen Goodman because you gave me the impression that the big sums of money that were talked of when Jamie Oliver's programme first came out, and which certainly I made a lot of in the election, were in fact a con: it is not enough to deal with the problem. I was faced then—and I was glad to receive—with letters from the public saying, "Marvellous. We are doing something about food at last", but now I am getting letters from schools in Grimsby, where it was the Labour council that abolished school dinners and brought in some ludicrous thing called "sandwiches-plus" or something, who said (not all of them) when that came in, "We took out our kitchens, ripped it all out and fired our dinner ladies. What do we do now?". What is my answer to those schools because it is an enormous expense? What do they do now and where is the money going to come from?

Mr Bell: The first thing to say is that under local management it is for schools themselves to decide what arrangements they make for school meals.

[3] Ev 19–20

[4] Ev 24–29

Q148 Mr Mitchell: It is not quite because when I opposed the "sandwich-plus" scheme I found that the Department for Education and Skills had wiped the nutritional standards so there was no nutritional base from which I could attack that.
Mr Bell: There are now nutritional standards but how schools go about procuring school meals is entirely their choice, and for that reason it was never going to be possible to meet the needs of 24,000 separate schools because 24,000 separate schools across the country had made different arrangements. As I suggested in response to Ms Goodman, some of them have running contracts, some of them are doing it themselves. The transitional funding was intended to allow them to make a number of steps to meet the new nutritional standards and make other arrangements, but I do not think anyone said other than that it was transitional funding to help schools do that. Just to repeat the point which I made to Ms Goodman if I might—

Q149 Mr Mitchell: Jamie Oliver is fairly disillusioned now and I think an expectation was created that something was being done and that is obviously not true.
Mr Bell: It is true that something was done. That extra money went into schools and many schools across the country have started to change their arrangements, and certainly some inspection evidence is beginning to emerge about the quality of school food, the range of choice, the healthy eating dimension. To be clear, it was never said other than that this would be transitional funding to help schools meet these new nutritional standards.

Q150 Mr Mitchell: What do I say to the Grimsby schools that say, "Where is the money coming from to achieve this?"?
Mr Bell: Each school in the country got a sum of money and each local authority in the country got a sum of money to help them through that transitional phase, to look at school meals and to make certain changes, and many schools did—new, more expensive ingredients, more healthy ingredients, different ranges of school menus, and that has happened across the country.

Q151 Mr Mitchell: Mr Taylor, you said you were co-operating with the food industry, which I would have thought was a bit like co-operating with the drug dealers in the war against drugs. Can I ask what concrete help the food industry has provided in this campaign? Is it providing money, is it providing backing or is it just saying, "Go easy on us. We will try and put on a salad course at McDonalds"?
Mr Taylor: First of all, I think there has been specific co-operation in areas of food labelling, for example, and they are actively taking part in conversations in the forum which Dr Adshead is—

Q152 Mr Mitchell: All of them, or some sections, not others?
Dr Adshead: Some of the representative bodies, the Food and Drink Federation, the British Retail consortium, so it is the overarching bodies rather than individual companies.

Q153 Helen Goodman: Could I please ask you whether you are aware of the fact that Tesco which, as you know, is the corporation which receives more money than any other in the entire country, is refusing to take part in the FSA labelling scheme?
Dr Adshead: We are aware of that, but what they have done is produce nutritional labelling on the front of the packs, and what we are doing with the Food and Drink Federation, which represents, as you are aware, some of the major retailers as well as the manufacturers, is working with them on getting concrete data on what the changes in purchasing patterns are compared to Sainsbury, Asda and Waitrose who are aligning themselves much more with what the Food Standards Agency has recommended as the best standards. I think we need to look at what happens in real terms. We know from recent data and financial reporting that in fact—

Q154 Helen Goodman: In other words the regulation is optional. They can take part in the FSA scheme if they feel like it and if they do not feel like it they do not have to, and you will not require them to take part in it; you will simply go back in three years' time and do a bit of research to see how it has panned out.
Dr Adshead: Legislative action on that would need to be taken at a European level. When we had the Presidency of the EU we championed some work on food labelling and were working actively with the EU platform on obesity and Robert Madelin's programme in order to make sure that the leadership role we are taking in this country on labelling, where we are in fact ahead of what many other European countries are doing on labelling, is influencing the current Green Paper proposals on obesity in the EU itself.

Q155 Greg Clark: Mr Taylor, how much are PCTs spending on measuring the weight of every child in the country in reception year 6?
Mr Taylor: I have not got that information but I can let you have it.[5]

Q156 Greg Clark: Thank you very much. Will you write to the Committee with it?
Mr Taylor: I will provide you with that and with a note on the reasons which led the expert advisory group to advise us as they did in relation to the way that the data is used.

Q157 Greg Clark: On the cost of it, can you also advise whether this is being funded centrally or whether they have to divert it from other activities?
Mr Taylor: I will let you have a note on that.[6]

Q158 Mr Davidson: I want to pick up on the point you were making earlier on, doctor. I wonder if you could give us report to add to the Committee's Report about

[5] Ev 20
[6] Ev 20

the extent to which the money and effort that is being put into this is being targeted at those in the greatest need or at the greatest risk of suffering from obesity, and the extent to which the programmes that you are running do actually recognise the class differentiation of the problem. I think that would be very helpful. Rather than trying to drag it out bit by bit, as it were, if we could have that as a supplementary report that would be helpful[7].

Dr Adshead: Yes, we can do that.

Chairman: Ladies and gentlemen, that concludes our hearing. This is clearly a national crisis. We are told that obesity can reduce life expectancy by up to nine years and that if present trends continue by 2010 the annual cost to the economy could be an extra £3.5 billion a year. I am sure I speak for my colleagues in saying that we have not been entirely satisfied with the evidence that you have given, especially as this is the second inquiry that we have had. I am not sure in our Report that we will go so far as to recommend a crisps tax but we will certainly reflect on this situation where every child is going to be measured, quite rightly, in year 6, but apparently, because of political correctness, it is not considered possible to go back and talk individually to parents. If we did nothing else I suspect this one change of policy would make a dramatic difference and I very much hope that that will be in our Report. Thank you very much for appearing before us.

[7] Ev 21–23

Supplementary memorandum submitted by the Department for Education and Skills

Questions 44 (Helen Goodman) and 150 (Mr Austin Mitchell): The additional £220 million additional sum for transitional school meal costs

On 8 August 2005 the Department wrote to Directors of Children's Services detailing the conditions and 2005–06 allocation for each local authority of the share of the £220 million transitional funding. The letter explained that we expected local authorities to take a lead role in addressing school food issues. This message was reinforced on 12 September in a joint letter from Peter Housden (then Director-General for Schools) and Fiona Adshead (Deputy Chief Medical Officer, Department of Health) to Chief Executives in local authorities. This lead role was given to local authorities because of the many and varied starting points for schools across the country.

As these letters made clear, the purpose of the transitional funding is to place school food on a sustainable footing at a level of quality which at least meets the new nutritional standards. The new standards were published on 19 May.

The letters encourage schools and local authorities to invest in their school meals service rather than become dependent upon the transitional money for funding ingredients. Apart from free school meals, school meals are a paid for service. The Government's expectation therefore has always been that any increase in costs of school meals would be met by paying customers. Our £220 million grant over three years is a contribution to costs that might be met in the transition to a higher standard of provision.

The grant is intended to cover transitional costs only. Capital investment in kitchens or dining areas will come through already established capital funding streams. Capital funding for schools this year is £5.5 billion and it will rise to £8.0 billion by 2010–11. Much of this funding is allocated to local authorities and to schools for their local needs and priorities, which should reflect Government priorities. The Department's guidance on capital programmes makes clear the priority we give to improving school food provision, through better kitchens and dining areas.

One particular point raised concerned the removal of equipment by a contractor. Clearly I am unable to comment on that precise circumstance but I can shed some light in this area. In examining the market for provision of school meals, Departmental officials learned of numerous contract variants, one of which entails upfront investment in equipment by contractors, with the cost spread over subsequent years as part of the contract price. Contracts will vary, but it may be that this style of contract, if broken early, could see the removal of equipment in the way described in the hearing.

Question 84 (Mr Richard Bacon): The effect of the proposed legislation on school vending machines

The Department is absolutely clear that no school contracts, including PFI contracts, should adversely affect the health of pupils. To that end, we have ensured that recently signed school PFI contracts, which include catering provision, fully support our aims of improving the quality of school catering and will deliver our nutritional and food targets.

Where earlier PFI contracts which include catering services (including vending) are not delivering a satisfactory service, we urge authorities and contractors to work together to bring about improvements. Contract variation as a result of changes to the law is a matter for local negotiation. If goodwill is lacking and variation proves difficult, such matters will be caught by the five-yearly benchmarking review of the delivery of services (including catering) which should now be a feature of all PFI contracts.

To help with contract variation we also published, on 19 May, additional procurement guidance for use by local authorities and schools aimed at assisting managers who wish to make variations to existing contracts. In addition to this, the Treasury has recently announced the formation of a cross-Government PFI Taskforce to improve the delivery and operation of PFI contracts.

Supplementary memorandum submitted by the Department of Health

Question 145 (Mr Alan Williams): Routine return of information to parents

EXPERT ADVISORY GROUP

1. The Expert Advisory Group was set up to gather the diverse and strongly held views, and to benefit from the expertise, of the many stakeholders in this controversial area. The Expert Group carefully deliberated as to whether or not information should routinely be fed back to parents on whether their children were obese or overweight.

2. Their clear and unanimous advice was that we should not routinely feed back information to parents. Their main concerns were:

(a) It is unethical to screen children (ie take children who do not know that they have a health problem and tell them that they do) and inform their parents, when services to treat overweight and obesity are not uniformly available;

(b) feeding back information to parents could lead to children being bullied or stigmatized, although sensitive handling could significantly mitigate this;

(c) BMI is the best available measure of children being overweight or obese. In a clinical situation, identifying whether or not a child is obese would normally take into account a broader range of factors. In this circumstance, because there is uncertainty about the effectiveness of individual treatments, the Expert Group advocated a cautious approach to screening on the basis of BMI alone.

3. The group includes representatives from DH, DfES, community paediatrics, academia and epidemiology, the National Screening Committee, nursing, public health, PCTs, the Children's Commissioner and the Healthy Schools Programme. The Group also took input from others, for example, head teachers focus groups and a Children's Commissioner consultation with children.

Why weigh and measure children? How will it benefit children and their parents?

— It will identify local areas where child obesity is a particular issue—particularly schools with high rates of obese and overweight children;

— It will be fed back to schools, PCTs, children's centres, Local Authorities and Government Offices so they understand the extent to which obesity is a problem for local children and can work together to target action to tackle it;

— It will enable PCTs and local partners to be held to account for changes in local obesity. They will have to demonstrate what they have done to tackle the problem;

— Existing national group interventions that improve diet and increase physical activity will, wherever possible, be accelerated: earlier this week the Government announced tough new nutritional standards for meals in schools. Where possible, the national programme will be intensified in obesity/overweight hotspots: for example the School Sport strategy will have overweight and obese children as a target group and can be flexed to meet local need;

— We will increasingly use the new local childhood obesity data to monitor the impact of national programmes such as sport, food and social marketing.

What information will parents get?

5. Schools are aware that parents can ask their PCT for their child's height and weight following measuring. We will take action to let parents know that they can do this. In addition, using the Healthy Schools network and other channels the Government intends to signpost parents who are concerned about their child's weight to relevant self-help information such as *Your Health, Your Weight* and to encourage them to seek advice from their GP's surgery. This communication will publicise to parents the fact that surgeries have been recently provided with Weight Loss Guides and tools to strengthen the help they can offer.

Why not routinely feedback to parents on whether their children are found to be overweight or obese?

6. DH has recently provided tools for GPs on how to manage obesity (the Obesity Care Pathway for Children, 4 May), but it is clear that not all PCTs will have all the elements of the Care Pathway in place yet. NICE guidance is still under consultation and will be finally disseminated to the NHS in November 2006. The Obesity Care Pathway and draft NICE guidance give rise to training implications for staff in many PCTs. Current trials of community programmes to treat childhood obesity are already offering useful insights, but they are not available nationally and results are not yet published. Specialist paediatric referral services are only available in some areas. NHS capacity for treating the problem of childhood obesity therefore remains limited.

7. Evidence suggests that obese and overweight children tend to have lower self-esteem and confidence than their peers. Every unsuccessful attempt by a child to change their lifestyle can further reduce their confidence and self-esteem. Government is concerned to avoid setting children up for failure. There are costs and risks to children of premature or ineffective individual interventions in this area. Before moving to a policy where parents are routinely told that their children are overweight or obese, Government wished to be confident that it can offer effective help and advice. Government therefore judged on the advice of the Expert Advisory Group on weighing and measuring, that writing to parents this year was premature.

Future Changes to Policy

8. The Government recognises the strong case for providing information to parents on the results of the weighing and measuring exercise, notwithstanding the Expert Advisory Group's reservations, and it understands the concerns raised by the Public Accounts Committee on this issue. Parental support and involvement is vital in halting the rise in childhood obesity. In the light of feedback from the Public Accounts Committee, the Government is therefore happy to consider further how and when additional information can be offered to parents.

Question 155 (Greg Clark): Costs to PCTs of weighing and measuring

1. We do not collect information centrally on what PCTs are spending on weighing and measuring. We have however estimated the cost to PCTs of measuring the height and weight of every child in England in reception year and year 6.

2. The two age groups include a pupil population of approximately 1.1 million. Survey evidence indicates that approximately three quarters of PCTs in England routinely record height and weight at infant school entry (around 5 years).

3. Our estimate therefore assumes that there will be an additional need to measure the height and weight of pupils in 25% of the pupil population in reception year and 100% of pupils in year 6, totalling approximately 700,000 pupils.

4. PCT staff, possibly with the assistance of school nurses, will be responsible for measuring the height and weight of school children, and this involves PCTs in a range of administrative, measurement and data handling tasks. These include communicating with schools and parents, training measurement staff, purchasing measurement equipment, measuring individual pupils in schools, recording the measurements, entering data onto databases and providing feedback to schools and parents. DH will provide a central database and a local spreadsheet application.

5. On the basis of informed assumptions about the time involved in these tasks and the likely numbers, we therefore estimate that the cost of the measurement programme for all PCTs in England is approximately £1.3 million in 2006–07.

Question 157 (Greg Clark): Funding of weighing and measuring

1. Total PCT allocations are £64 billion in 2006–07 and £70 billion in 2007–08. These allocations separately identify funding of £211 million in 2006–07 and £131 million in 2007–08, £342 million in total, in support of the Choosing Health White Paper. This funding includes £21 million in 2006–07 and £34 million in 2007–08 for action on diet, activity and obesity. Funding decisions within this allocation are made at local level.

Source: AWP(06-07)PCT01 PCT revenue resources limits 2006–07 and 2007–08 .doc AWP(06-07)PCT01 Annex D.xls

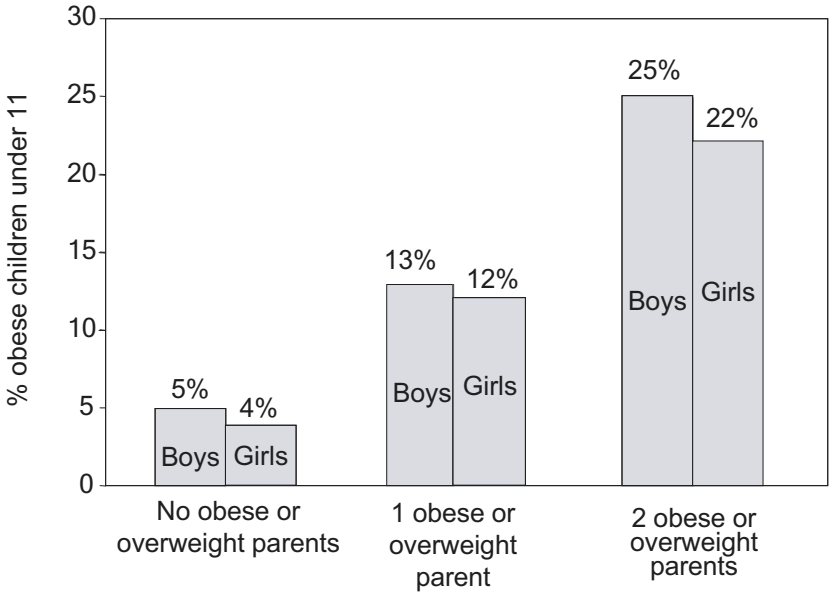
Question 158 (Mr Ian Davidson): Extent to which programmes are targeted by socioeconomic difference

RISK FACTORS FOR CHILDHOOD OBESITY

Parental BMI status:

1. The strongest risk factor for childhood obesity is parental BMI status. In households where both parents were classed as obese or overweight, 22–25% of children were obese. This compares to just 4–5% of children in households where neither parent was obese or overweight (see figure 1 below). Levels of childhood obesity were also 8–9 percentage points higher in households where one parent was overweight or obese (12–13%). This finding highlights the importance of family behaviours and the influence they have on child obesity.

Figure 1—Obesity prevalence among children 2–10 years, by parental BMI status

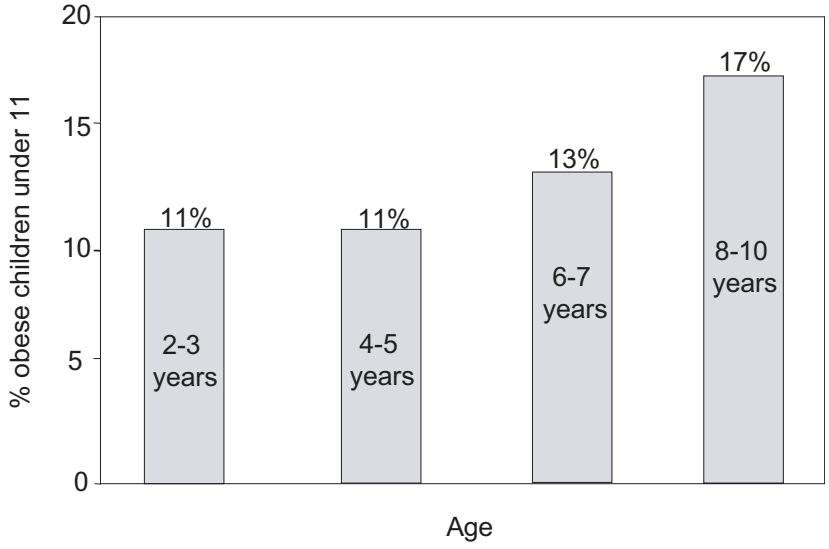


Source: Forecasting Obesity to 2010, Joint Health Surveys Unit (2003)

Overweight as risk factor:

2. Older children are more likely to be obese than younger children (see figure 2). Being overweight is clearly a strong risk factor for becoming obese—as children get older they tend to cross over into the obese category.

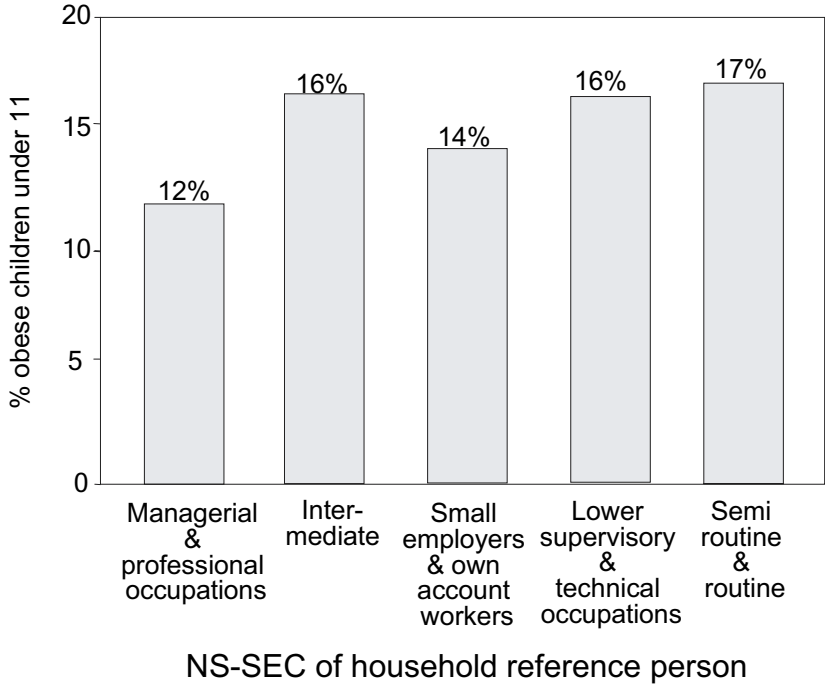
Figure 2- Obesity prevalence among children 2–10 years, by age



Source: Health Survey for England

Socioeconomic differences:

Figure 3—Obesity prevalence among children 2–10 years, by NS-SEC of household reference person



Source: Health Survey for England

3. As figure 3 (see above) shows, there is some social class gradient in childhood obesity. The lowest social class has more obesity than the highest (levels of childhood obesity were lowest among managerial or professional households (12.4%) and highest among semi-routine and routine households (17.1%). But the second highest social class has very nearly as much obesity as the lowest. Among adults there is a social class gradient among women but not among men.

4. Moreover, among children it appears from local studies that the social pattern which emerged in the early stages of the obesity epidemic has since narrowed. A detailed study of the Wirral during the rise of the epidemic showed geographical and social diffusion from the most deprived areas and families into the community more generally. The authors of the study conclude that children's obesity reflects obesogenic environments in families and communities. The greater prevalence of childhood obesity in families with two obese or overweight parents corroborates this view.

How the Programmes are Targeted:

5. The obesity epidemic is a growing problem in *all* socioeconomic groups. It is appropriate therefore that the Government's Obesity Delivery Plan includes universal programmes for *all* children.

6. In addition, the Government is currently reviewing relevant programmes to target them, where possible on the children of overweight and obese parents. Ante-natal and early years programmes such as support for breastfeeding and weaning and Children's Centres, offer opportunities to target help towards obese parents because of one-on-one contact between parents and professionals.

7. From September 2006, the current PCT weighing and measuring exercise will provide data on the prevalence of overweight and obesity by school and neighbourhood. It is the intention that all the programmes will be monitored, and where possible, targeted against data on local rates of obesity and overweight. This should be the single most effective basis on which to ensure that resources are targeted towards those at highest risk.

8. As described above, obesity is increasing in all social groups. However, since children in lower socio-economic groups are slightly more at risk, it is helpful that many of the programmes target these groups.

Healthy Start	Healthy Start, the new scheme to replace the existing Welfare Food Scheme, is a nutritional safety net targeted at low-income families. Pregnant women and young children in families in receipt of certain qualifying means-tested benefits will receive Healthy Start vouchers that can be exchanged for liquid milk, fresh fruit and vegetables, and infant formula. The scheme will therefore provide assistance to some of the lowest income households across Great Britain.
Children's Centres	The focus on the whole community in the 30% (phase 1) more disadvantaged areas, and on vulnerable families in the remaining 70% (phase 2) more advantaged areas may ensure that families everywhere with obese children, or who are in socioeconomic categories more prone to obesity, are likely to be targeted.
Breastfeeding	The Government is committed to supporting and promoting breastfeeding, particularly among women from disadvantaged backgrounds. PCTs are responsible at a local level for providing breastfeeding services and support. At a national level, the Department of Health provides information and advice to parents and health professionals about the practical and health benefits of breastfeeding. Increasing breastfeeding initiation rates by 2% points per year, set in the Priorities and Planning Framework 2003–06, has been carried forward and is now a proxy to the Department's PSA target to reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth.
Play	The Big Lottery Fund took socioeconomic data into account when it made the allocations to each Local Authority as part of its play programme. The formula used was a function of both child population of each area and the Index of Multiple Deprivation for that area. (To note that Big's play programme is not a Government programme.)
Healthy Schools	Funding for Healthy Schools programmes is targeted towards those schools where there is 20%+ free school meals entitlement.
School Food	Some pupils are eligible for free school meals, but not all take them up. The School Food Trust has a target to increase meal uptake. Free School Meal uptake is not explicitly targeted.
School Fruit & Vegetable Scheme	Specifically set up to be a universal scheme where every 4–6 year old in school gets one piece of fruit or vegetable at school every day. We are looking at how we can improve the value of the scheme by strengthening links with learning, wider school policies and Healthy Schools to deliver a better long term change in children's eating behaviour.
Reformulation, portion sizes & signposting	DH and the Food Standards Agency are working with industry across the full range of food and drink products that they market to all consumers. Nevertheless, in determining which signpost labelling scheme would be most effective the Food Standards Agency conducted consumer research particularly focused on lower socio-economic groups. The FSA Board specifically took into account which model would best help these groups choose healthier foods.
School Sport Strategy	School sport partnerships were rolled out initially in areas of high social deprivation before the programme was widened to more affluent areas. Children from deprived backgrounds are one of the priority groups for all school sport partnerships. Survey data on School Sport is regularly analysed according to data on eligibility for Free Schools Meals to see how well deprived areas are being reached and to inform action.
Travelling to School	This is a universal programme with no targeting by socioeconomic status.

9. The current exercise to collect local weight and measurement information will strengthen the targeting of the Obesity Programme, allowing it to more effectively target those most at risk.

Briefing from Ofcom (Office of Communications) on television advertising of food and drink products to children

Introduction

In recent years there has been growing social and public policy concern about the increase in childhood obesity. That increase has been driven by a complex web of inter-related factors in which changes in lifestyle, changes in diet and changes in marketing and promotion all play their part.

Against that background, Ofcom was asked in 2004 to research the impact of television advertising of food and drink to children in this mix; and to consider proposals on strengthening its rules on television advertising of food and soft drinks to children. The report published by Ofcom in July 2004, building on extensive previous research, showed that television food advertising has a modest direct effect and a larger but unquantifiable indirect effect on children's preferences, consumption and behaviour. Our conclusion was that the *status quo* was an undesirable option and that there is a case for strengthening the rules on advertising to children as part of a multi-faceted approach to the problem.

In the meantime, the market has already produced a significant shift in the balance of television food promotion to children: the overall volume of food, drink and restaurant advertising to children dropped by around 13% in 2005; and a number of food and soft drink manufacturers have voluntarily decided to withdraw from television advertising in children's airtime.

The television advertising industry's self-regulatory body BCAP (Broadcast Committee of Advertising Practice), has also proposed a range of restrictions on advertising techniques and treatments in television food advertising to children. Ofcom welcomes these proposals which form an integral part of the policy options we are consulting on.

That leaves the important issue of whether, and if so what, further scheduling or volume restrictions there should be on food advertising to children. Ofcom has concluded that some form of scheduling or volume restriction is justified and proportionate. But, as is the case with many social policy issues, there is no easy one size fits all, or one size suits all, policy prescription. This difficulty is reflected in the absence to date of any proposals from industry, beyond BCAP's treatment changes, which can command broad support across broadcasters, advertisers, retailers, and food manufacturers and there is even less evidence that any approach to regulation could achieve support from both industry stakeholders and consumer health groups.

Ofcom is currently consulting until 30 June on a range of options including three core proposals for different types of scheduling or volume restriction, designed to produce the best balance between an effective shift in television food advertising to impact on children's preferences and behaviours with an unduly adverse effect on the funding for range and quality in children's programmes or on the legitimate activities of food manufacturers and retailers. Our statutory duties are set out in detail below however, briefly put Ofcom is obliged in law to protect the public by maintaining television standards. But the Communications Act 2003 also sets out detailed statutory obligations regarding public service broadcasting and the availability of high quality programming; including original programming for children. Television funding comes from three sources: the license fee, advertising, and in the pay-TV market, subscriptions. In considering new television advertising restrictions, Ofcom is compelled by Parliament to examine the impact of such restrictions on investment in the programmes we and out children see on our screens. Each option has its own advantages and disadvantages. Ofcom expresses no preference for any one alternative and invites comments on all three packages.

Indeed, Ofcom has actively invited proposals for a fourth option, which could be a permutation of the package of measures in the three core proposals or could be a completely new proposal. We would welcome any such option capable of commanding broad support and of making a positive and substantive contribution to changing children's preferences, behaviour and consumption of food and drink.

Changes in television food advertising have a part, but a modest part, to play in the overall mix that produces the solution that society as a whole wishes to see: a change in children's behaviour, parental responsibility, schools policy, opportunities for exercise, food promotion, and many other factors that will enable our children to live healthy lives today and tomorrow.

Background

Ofcom is the independent regulator of television, radio, telecommunications and wireless communications services in the UK. Part of our role is to set standards for television advertising. All television broadcasters must comply with these standards in relation to any advertising they transmit. In late 2004 we transferred the responsibility for the Television Advertising Standards Code to the Advertising Standards Agency (ASA), including the functions of complaints handling policy development. Under this co-regulatory scheme Ofcome still retains final responsibility for all television advertising standards as the backstop regulator under the terms of the Communications Act 2003.

Ofcom also has duties towards:

— furthering the interests of citizens and consumers;

— promoting competition;

— the protection of under-18s;

— maintaining a sufficient plurality of television services;

— securing the availability throughout the UK of a wide range of television services which (taken as a whole) are both of high quality and calculated to appeal to a variety of tastes and interests;

— preventing undue discrimination between advertisers; and

— regulating in a proportionate, transparent and least intrusive manner.

In November 2004, following the earlier request from the Secretary of State for Culture, Media and Sport, the Department of Health in its *Choosing Health* White Paper, asked Ofcom to consult on proposals to tighten the rules on broadcast advertising, sponsorship and promotion of food and drink products. Those proposals would be informed in part by work by the Food Standards Agency (FSA) which had not been concluded at that time.

The subsequently delivered to Ofcom its nutrient profiling model which might potentially be used it differentiate between different types of products so that restrictions on food and drink advertising to children could be appropriately targeted.

Ofcom has since sought the view of consumer organisations, broadcasters, its co-regulatory partner BCAP, advertisers and others. Ofcom has also assessed recent academic research and has conducted its own impact analysis.

Research and Analysis

As an independent regulator Ofcom must be satisfied that there is sufficient link between television advertising of food and drink to children and children's food preferences and through this, children's consumption, to consider whether restrictions are justified. If restrictions are justified, Ofcom must also consider what form these should take and whether they should apply to all food and drink advertising or should attempt to specifically HFSS food and drink advertising to children.

Accordingly, in 2004 we undertook a research project drawing together information from previous academic research, national food surveys and lifestyle research, re-analysis of information available in food industry and broadcasting databases, as well as new, bespoke and quantitative projects.

The study concluded that television advertising has a "modest direct effect" on children's food preferences, consumption and behaviour. Indirect effects are likely to be larger, but there was insufficient evidence to determine the relative size of the effect of TV advertising on children's food choice, by comparison with other relative factors such as exercise, trends in family eating habits inside and outside the home, parents' demographics, school policy, public understanding of nutrition, food labelling and other forms of food promotion. The survey also examined parents' attitudes to television advertising and regulation, and found that parents accept responsibility for their children's diets, but believe that increased regulation of food advertising would help them to encourage their children to eat more healthily.

Ofcom has since undertaken further research work:

— updating our original analysis on the size, spend and impact of the market for television advertising of food;

— updating our original analysis of the television viewing patterns of children;

— analysing the content of food and drink advertising to children on television; and

— updating the review of academic research into the effects of television advertising on children.

The new and updated studies confirm the original findings. There is now a growing body of evidence of the links between television advertising exposure and children's food preferences. It is also clear that whilst television advertising of food to children is declining each year, it remains significant; television advertising is still the key medium for communicating messages about food and drink products to the widest audiences.

Rationale for Regulation

We acknowledge that self-regulation by the food industry and by broadcasters could play a part in reducing the influence of food advertising, and that measures have already been taken by some food manufacturers to withdraw from targeting advertising to younger children. We do not however believe that self-regulation alone will be a sufficient response to the issue given the difficulties of gaining consensus and commitment on a permanent basis across a wide spectrum of stakeholders, where robust action may be needed to achieve the desired effect.

In the light of all the above, of our statutory duties, of the research evidence, and noting the widely held belief that there is a societal belief to reducing the amount of HFSS advertising that children are exposed to, we consider there is a case for strengthening the rules on food advertising to children.

We aim to develop measures that balance the health and social benefits against broadcast advertising's modest role and the costs to broadcasters if food advertising is restricted. We must take into account the fact that Ofcom must have regard to best regulatory practice, only to intervene where necessary, and to do so in a proportionate and targeted way. We also not the evidence that, in media literacy terms, the most vulnerable children are those under the age of eight, and that by the age of 11–12, children have developed a critical understanding of advertising.

It should also be noted that any advertising restrictions imposed on broadcasting would be only one of a number of measures. There are a range of government initiatives on childhood health and obesity and the Department of Health is concerned to ensure that action is taken in respect of non-broadcast advertising, as well as broadcast, through its Food & Drink Advertising and Promotion Forum.

Policy Proposals

Against the background of our duties and the evidence summarised above, Ofcom has in its consultation examined a number of potential ways of meeting it regulatory objectives, starting with those at either end of the spectrum of regulation.

Voluntary Self-regulation

In pre-consultation with stakeholders, it was claimed by some that there have already been significant changes in the nature and balance of food advertising on television, and that a number of food manufacturers have taken voluntary action to reduce the impact of food advertising on young children and to improve the nutritional information on food labels. It was also claimed that existing standards on food advertising provide a sufficient degree of protection when allied with voluntary self-regulation by industry (although some limited tightening up could be considered).

There was a view therefore that there is neither need nor justification for restricting the amount of food advertising on television in order to reduce further its impact upon children.

There has undoubtedly been some change in the nature of balance of advertising on television since the government's call for action. Expenditure on advertising of Core Category products has declined as a share of total advertising expenditure in recent years, and Core Category advertisements as a proportion of all advertising impacts in children's airtime have also dropped. As regards self-regulating, Ofcom has made clear that it will always seek the least intrusive regulatory mechanisms to achieve its policy objections.

However, while Core Category's share of total advertising has dipped, the amount spent on Core Category advertisements has in fact risen in 2004 and 2005. Even if expenditure were to go into decline, it could take a long time to achieve an appropriate reduction in HFSS impacts on young children. As for the argument that existing advertising standards provide sufficient protection, Ofcom note that these do not currently prevent the use of a variety of advertising techniques designed to make advertising attractive to young children.

It might seem, looking at the wide variety of voluntary actions taken by manufacturers, that voluntary self-regulation would meet the criteria for targeted and consistent action. However, while the possibility of greater regulation may have encouraged manufacturers and advertisers to exercise self-restraint in the short-term, there is no guarantee that they would continue to do so if the threat of new regulation was lifted.

In summary, Ofcom is not persuaded that voluntary self-regulation would meet is regulatory objectives.

Pre-9pm Exclusion of HFSS Advertising

We have also considered the option of excluding all HFSS advertising before the 9pm watershed. Excluding all HFSS advertising before 9pm would remove 82% of the recorded HFSS impacts on all children (aged 4-15 years). Clearly, this measure would achieve a key regulatory objective of significantly reducing the impact of HFSS advertising on younger children. It would also contribute to enhancing protection for older children by reducing their exposure to HFSS advertising.

The FSA has provided Ofcom with an assessment of the benefits which they believe would result from restricting HFSS advertisements to children. This analysis has been included in Ofcom's Impact Assessment. In including this, Ofcom recognises that there are inherent difficulties in quantifying the health benefits of measures to restrict food and drink advertising on television. Our assessment of the likely impact of all the various policy options we have evaluated is predicated on this basis.

In relation to this option of restricting HFSS advertising up to 9pm, the FSA estimates that the social/health benefits of such exclusion of HFSS advertising could be in the ranges of £53 million–£204 million or £245 million–£990 million per year depending on the value of life estimate that is employed. More details are given in the impact assessment.

However, in Ofcom's view, this option would not meet Ofcom's regulatory objectives which Ofcom must, statutorily, take into account. Rather than being targeted at younger children, it would prevent adults from viewing advertisements for most HFSS food and drink products aimed at them, and could make television an unattractive medium for food and drink advertisers. In qualitative research described in Section 3 of the consultation, the majority of parents who expressed a view indicated that they do not favour a ban on HFSS advertising extending to 9pm. Importantly, Ofcom considers that on the basis of the current analysis, the impact on broadcasters would be an excessive burden.

We estimate that excluding HFSS advertising up to 9pm could result in a net cost to broadcasters somewhere around £141 million per year in lost advertising, rising to around £175 million if Core Category advertising was excluded.

Accordingly, we have concluded on the current evidence that the exclusion of HFSS advertising before 9pm would not meet Ofcom's regulatory objectives, that it would be disproportionate based on the existing evidence and have invited comments on our view.

Proposed Policy Packages

Having reached the view in this consultation that voluntary self-regulation and a pre-9pm exclusion would not meet Ofcom's regulatory objectives, there are a number of other options which could in our view meet those objective. However this is a complex issue and it has become clear that no agreed common position is emerging between industry, consumer, medical and governmental interests, and it appears not to be possible to reconcile differing views amongst industry interests (broadcasters, platform operators, advertisers, food manufacturers, retailers). In these circumstances, we have developed three packages for consultation to meet the regulatory objectives.

But, acknowledging the complexity of the issues, we also inviting stakeholders to submit a fourth package of proposals which may be a permutation of the measures already in the three packages, or may be a completely new proposal. If a new proposal is received which appears to command broad support, which seems a sensible response to the issue and which meets Ofcom's regulatory objective, it may be necessary to conduct a short additional final consultation on this proposal to allow other interested parties an opportunity to comment.

All the proposed three packages share two common elements:

— No advertising of or sponsorship by HFSS products in programmes aimed at pre-school children (less that 5 years old).

Research indicates that this is the most vulnerable group of children, not able to distinguish properly between programmes and advertisements and with no purchasing power. We do not consider it appropriate to allow HFSS advertising targeted at this group.

— A range of rules aimed at the content of all food and drink advertising, designed to reduce its impact on children generally, and to avoid targeting certain techniques at some age groups altogether.

The content rules have been drawn up by BCAP, the broadcasting and advertising industry self-regulatory body responsible for the advertising standards codes. We believed it was appropriate to invite BCAP to submit proposals in the light of our co-regulatory arrangement. We will be working with BCAP to finalise and approve changes to the rules following consideration of responses to this consultation on both the substance of the BCAP rules and also on their wording.

On their own, we consider that the content rules are insufficient to achieve the regulatory objectives but that they should form part of a blended approach together with rules aimed at excluding or reducing the amount of HFSS advertising at certain times of day. Briefly the provisions of the BCAP content riles for all food and drink are that:

— advertisements must avoid anything likely to encourage poor nutritional habits or an unhealthy lifestyle in children;

— advertisements must not advise or ask children to buy, or ask their parents to buy, the products. There must be no appearance of encouraging children to pester others to buy the products on their behalf;

— promotional offers (including collectables and giveaways) in food and drink advertisements must not be targeted at children aged under 10;

— advertisements must not encourage children to eat or drink the product only to obtain a promotional offer;

— celebrities and licensed characters must not be used in food and drink advertisements targeted directly at children under 10;

— nutrition claims must be supported by sound scientific evidence, and must not give a misleading impression of the health benefits of the product as a no nutritional or health claims may be targeted at pre-school children; and

— advertisements must not condone or encourage excessive consumption of any food or drink.

As stated, each of the three proposed packages, set out in Ofcom's consultation of 28 March 2006, contains the specific elements mentioned above.

Package 1: Timing Restrictions on Specific Food and Drink Products

— no HFSS product advertising to be shown in programmes specifically made for children;

— no HFSS product advertising to be shown in programmes of particular appeal to children up to nine years old;

— no sponsorship by HFSS products of programmes affected by the above restrictions;

— BCAP's rules will be applied to food and drink advertising and sponsorship.

The likely effects of implementing this package are as follows:

— the exposure of children (aged four to 15) to HFSS food and drink advertising will fall, we estimate, by 39% and the exposure of children (aged four to nine) will fall, we estimate, by 50%;

— terrestrial broadcasters' revenues will fall, we estimate, by just less than half a percent (0.4%) of their total revenues;

— children's channels revenues will fall more substantially—we would estimate by roughly 2%–10% of total revenues (depending on the channel);

— the overarching net impact on broadcaster revenues will be, we estimate, to reduce them by approximately £18 million per year; and

— there would be health benefits for children. Based on FSA data these could be valued at amounts ranging around £49 million or £235 million (depending on the value of life measure used).

In summary, broadcasters as a whole would be likely to lose less than 1% of total revenues, which while significant, would appear to be sustainable. The impact on children's channels would be greater, as they derive between 2%–10% of revenue from advertising HFSS food products. Any measure excluding HFSS advertising from children's programming could therefore have a potentially damaging economic effect on these channels. In the worst cases (especially with smaller channels), the loss of food and drink advertising could threaten the viability of the channel. Some may contemplate moving their established base to other European countries to avoid the restrictions, whilst still broadcasting to the UK.

In acknowledgement of these difficulties, if this package were adopted, we invite comments on whether there should be a phase-in period for children's channels.

Package 2: Timing Restrictions on all Food and Drink Advertising

— No food or drink advertising to be shown in programmes specifically made for children;

— no food or drink advertising to be shown in programmes of particular appeal to children up to nine years old;

— no sponsorship by food or drink products of programmes affected by the above restrictions;

— the above restrictions do not apply to healthy eating campaigns supported or endorsed by the government; and

— BCAP's rules will be applied to food and drink advertising and sponsorship.

The likely effects of implementing this package are as follows:

— the exposure of children (aged four to 15) to food and drink advertising will fall, we estimate, by 37% and the exposure of children (aged four to nine) will fall, we estimate, by 47%;

— terrestrial broadcasters' revenues will fall, we estimate by just under half a percent (0.4%) of their total revenues;

— children's channels revenues will fall more substantially—we would estimate between 3%–11% of total revenues (depending on the channel);

— the overarching impact on broadcaster revenues will be, we estimate, to reduce them by approximately £21 million per year; and

— there would be health benefits for children. Ofcom has not estimate these, directly but estimates based on FSA data (see paragraph 1.25) would suggest they would be of a similar order of magnitude (albeit slightly lower) to benefits for Package 1, ie ranging around £49 million or £235 million per year (depending on the value of life measure used).

In summary, broadcasters would be likely to lose slightly more advertising revenue than under Package 1, but still less than 1% of their total advertising revenues. Once again, the impact on children's channels could be significant (though no materially different from the impacted assessed for Package 1).

In acknowledgement of these difficulties, if this package were adopted, we invite comments on whether there should be a phase-in period for children's channels.

PACKAGE 3: VOLUME BASED RESTRICTIONS ON ALL FOOD AND DRINK PRODUCTS

- No food or drink advertising at all to be shown in programmes made for pre-school children; and
- a limit to the amount of food and drink advertising when children are most likely to be watching. This could be:
  - a limit of 30 seconds per hour between 6am and 9am and between 3pm and 6pm on week days, as well as 6am to 1pm at the weekend;
  - a limit of 60 seconds per hour during family viewing times—between 6pm and 8pm on week days and between 1pm and 8pm at the weekend; and
  - a limit of 30 seconds per hour throughout the day for children's channels—except pre-school channels, which would carry no food or drink advertising at all.
- For context, cable and satellite broadcasters are allowed to show an average of nine minutes of advertising per hour; terrestrial broadcasters can show an average of seven minutes per hour, rising to eight minutes at peak times (7am to 9am and 6pm to 11pm). These proposals would therefore restrict the advertising of food and drink to a small minority (between 7% and 12%) of all available advertising airtime.
- BCAP's rules will be applied to food and drink advertising and sponsorship.

The likely effects of implementing this package are as follows:

- the exposure of all individuals to food and drink advertising will fall, we estimate by around a third. We estimate that this would equate to a reduction of about 37% in children's (aged four to 15) exposure to food and drink advertising and a reduction of about 44% in the exposure of children aged four to nine;
- terrestrial broadcasters' revenues will fall, we estimate by 1.2% of total revenues;
- children's channels revenues will still fall but less substantially than for other packages—we would estimate by roughly 1%–6% of total revenues;
- the overarching impact on broadcaster revenues will be, we estimate, to reduce them by approximately £43 million per year;
- there would be health benefits for children. Ofcom has not estimated these, but the FSA suggests they could be valued at amounts ranging around £46 million or £221 million (depending on which value of life measure is used).

In summary, the proposed volume limits have been set to reduce significantly the exposure of younger children to HFSS advertising when they are most likely to be watching. The greatest numbers of children (up to two million) are tuned in to television between 6pm and 8pm.

We consider that these three packages represent a fair and balanced approach to meeting the regulatory objectives. We are expressing no preference for any one alternative and invite comments on all these packages and on whether there are changes that could be made to improve them. We also invite from stakeholders a fourth, as yet undefined, package which achieves broad support and which they believe would meet the objectives.

This fourth option could draw from—or combine—some or all of the measures in the three packages. Alternatively, it could be a completely new proposal. However, Ofcom will only consider proposals which both command broad support across broadcasters, advertisers, retailers and manufacturers and which also demonstrate a realistic prospect of contributing positively and significant to the social policy aim of altering children's preferences towards—and actual consumption of—HFSS products.

The consultation will close on 30 June 2006. Ofcom will issue a final statement later in the year, which will enable any content standards to be incorporated in to he BCAP code and implemented with immediate effect. The content rules would be immediately applicable to any campaign conceived after the statement date, but we would expect a grave period for existing campaigns and for new campaigns which are already being developed. At this stage, six months seems a reasonable grace period, although it will be necessary to monitor developments, including the expected timescale for the government's own change monitoring programme in 2007. Scheduling rules or volume restrictions would come in to force on 1 January 2007 with immediate effect.

This consultation is concerned solely with television advertising, but with the expectation that development and publication of riles for the non-broadcast sector by CAP will follow as soon as is practicable after Ofcom's final statement. Ofcom will, on a similar timescale to the CAP work, investigate whether action may need to be taken in relation to radio advertising and if so, what.

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