



Association of Directors of Public Health (UK)

## Association of Directors of Public Health – Response to Health Committee Inquiry into the impact of diet and physical activity on health

The Association of Directors of Public Health (ADPH) is the representative body for Directors of Public Health (DsPH) in the UK. It seeks to improve and protect the health of the population through DPH development, sharing good practice, and policy and information sharing programmes. [www.adph.org.uk](http://www.adph.org.uk)

Directors of Public Health (DsPH) are the frontline leaders of public health working across health improvement, health protection, and health care service planning and commissioning.

ADPH has a strong track record of collaboration with other stakeholders in public health, including those working within the NHS, local authorities, government and other sectors.

### ADPH response

#### 1. Evidence of the impact of diet and physical activity on health

- 1.1 The Chief Medical Officers of England, Scotland, Wales and Northern Ireland have said that *“for most people, the easiest and most acceptable forms of physical activity are those that can be incorporated into everyday life. Examples include walking or cycling instead of travelling by car, bus or train”*<sup>(i)</sup>.
- 1.2 This is supported by the Government’s Foresight obesity report, which stated that *“the top five policy responses assessed as having the greatest average impact on levels of obesity [include] increasing walkability / cyclability of the built environment”*<sup>(ii)</sup>.
- 1.3 ADPH, Sustrans and the UK Health Forum have led a policy call *Take action on active travel*, a UK-wide group of over 100 transport and public health bodies that in 2010 recommended, *“invest at a realistic level: commit 10% of transport budgets to walking and cycling immediately, and in future ensure that transport funds are allocated proportionate to the new, ambitious target levels”*<sup>(iii)</sup>. In 2013 the core national members of this group assessed progress in England towards the original recommendations and reaffirmed their commitment to the call<sup>(iv)</sup>.
- 1.4 The British Medical Association has also called for *“ambitious growth targets for walking and cycling at national and regional levels, with increased funding and resources proportional to target levels”*<sup>(v)</sup>.
- 1.5 The National Institute for Health and Care Excellence (NICE) calls for a list of practical interventions in favour of walking and cycling, including road space reallocation, traffic calming, road user charging and network improvements<sup>(vi)</sup> as well as a range of motivational and information approaches<sup>(vii)</sup>. NICE says that *“walking and cycling should become the norm for short journeys”*<sup>(viii)</sup>.
- 1.6 The All Party Commission on Physical Activity called in 2014 for *“reallocation of transport investment, providing long-term continuity of dedicated funding for walking and cycling as regular daily transport”*, and for *“developments and infrastructure to be ‘health checked’ so that walking and cycling [...] are prioritised”*<sup>(ix)</sup>.
- 1.7 The Cabinet Office has calculated that people could replace 78% of their local car trips under five miles with walking, cycling or public transport<sup>(x)</sup>.

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**1.8** ADPH therefore supports recommendations made by a wide range of public health bodies, and other organisations and groups, including the All Party Commission on Physical Activity, that:

- physical activity should be identified as a national priority for action, and should be visible in all relevant ministerial programmes, including transport and planning
- investment priorities need to change: physical activity should be a priority objective in the investment plans of all relevant departments, including transport
- a significant, dedicated investment programme should be created for cycling and walking, to build on the successful Local Sustainable Transport Fund, and with a still clearer focus on shifting local transport choices from motorised to active travel
- existing and planned developments and infrastructure should be ‘health-checked’ to ensure they encourage and facilitate a shift from sedentary to active travel
- policy should be developed based on robust evidence of effectiveness and take account of the range of approaches that are effective

**1.9** For national evidence on diet and nutrition we would refer the Committee to sources such as NICE Public Health guidance and other national Public Health organisations across the UK.

**1.10** Locally there are many examples of effective community based projects supporting healthy eating – particularly working with families, children and young people. Resources directed at: building the evidence base for effective diet and nutritional interventions, supporting the development of such interventions, and the sharing of good practice, would enable greater impact across the whole of the population.

**1.11** Those on low incomes suffer from poor diets, as evidenced by lower fruit and vegetable intakes, and a higher prevalence of dental caries among children, exacerbating health inequalities.<sup>xi</sup> Income and social deprivation have an important impact on the likelihood of becoming obese. Women and children in lower socio-economic groups are more likely to be obese than those who are wealthier. The cost of a healthy diet and the inability of many low income groups to afford healthy foods must be considered in any reform of welfare instruments, as should the introduction of universal healthy free school meals.

**1.12** In a recent ADPH survey on action to improve the public’s health, protect children & young people and reduce health inequalities, Directors of Public Health included the following measures in their top priorities:

- **reducing income inequality through taxation and economic development measures**
- **promoting the living wage**
- **meeting the targets set by the Child Poverty Act 2010**

**2. Recent trends in body mass index, physical activity levels, diet and conditions linked to obesity and physical inactivity, including the availability and quality of data in this area. What are the current and future costs to our wider economy and to the NHS of obesity and physical inactivity?**

**2.1** The Chief Executive of the NHS has recently warned of the impact of obesity on the health service unless Britain gets serious about tackling the problem. Reducing obesity and sustaining a healthier weight amongst the adult and child population is therefore a

priority area for public health and for the NHS. In this case, prevention is far better than cure, so efforts need to be concentrated 'upstream', before the problem develops. The NHS, local government and third sector have a crucial role to play in addressing this problem.

- 2.2 Spending on the growing obesity epidemic by local government is expected in 2014 to reach over £127 million, a 21 per cent increase on the previous year's figures. Councils are committed to spend £19 million this year delivering the National Child Measurement programme and a further £108 million (£72.5 million adults and £35.7 million children) tackling obesity in adults and children. Moreover, councils are the biggest public sector investors in leisure services spending some £905 million per year (excluding capital spend) on leisure centres, swimming pools and other facilities that promote healthy lifestyles. They also spend £797 million on open spaces where the majority of this country's nine million grass roots enthusiasts play sport. Reductions in local government budgets necessitate a radical shift in the way physical activity provision is delivered. Although local government already commits significant resource at a local level there needs to be a continued focus on moving the inactive into activity and tackling the growing tide of obesity with urgency. This must be supported by greater understanding of what works to support this behaviour change and a move towards scaling up investment for targeted inactivity and dietary interventions.
- 2.3 For understandable reasons a considerable amount of energy to date has focused on the impact of obesity and physical inactivity on the NHS, however there is an urgent need to explore the pressures these place on social care. There is an important link between obesity and social care. Obesity is a contributory factor to the development of long term conditions such as diabetes and cardiovascular disease. In addition, severe obesity can result in physical and social challenges which impact on social care. Increasing obesity prevalence along with the growing needs of an ageing population, the rise in non-communicable diseases associated with obesity, and rising public expectations for service intervention and treatment present significant challenges and cost implications to both the health and social care systems.
- 2.4 Analysis by the Local Government Association shows that the financial black hole facing local government is widening by £2.1 billion a year, and will reach £14.4 billion by 2020. Local services are already facing the deepest cuts in the public sector, with a 40 per cent real terms reduction in councils' grant from central government across the life of this Parliament. With statutory services like adult social care, children's services and waste taking an ever bigger proportion of council funding, the money available for other local services, including physical activity will potentially shrink by 46 per cent by 2020.

### **3. The effectiveness of recent policy action to improve physical activity levels and diet, and the evidence base supporting different interventions, including: National public health initiatives; local public health initiatives, including the role of Local Authorities, Health and Wellbeing Boards, schools and the Child Measurement Programme; the impact of broader factors on physical activity and diet, including transport, sport and recreation, town planning, and food labelling, marketing, availability, pricing and formulation.**

- 3.1 Local Authorities have been engaged in supporting public health measures for many years, and with the recent transfer of public health functions to local government in England – and with leadership from Directors of Public Health and Health & Wellbeing Boards – local authorities now have greater responsibilities and opportunities, supported by increased knowledge and skills from their public health teams.

- 3.2 Amongst a range of other ‘public health gains’, this offers a very important opportunity to integrate physical activity as a key component of public health policy (see section 1 above for evidence and recommendations for policy development) and to support preventative measures to tackle obesity.
- 3.3 Many councils are already engaged in innovative schemes which are helping families with children stay healthy, such as ‘green gyms’, school and community based projects which use targeted education and advice on how to cook and eat healthily on a budget; and NHS/local authority partnerships to encourage physical activity for those whose health is most likely to benefit, such as ‘exercise on prescription’, promoting exercise in the workplace, offering separate swimming sessions for men and women and ‘50+ clubs’ for older people at leisure centres. Across all of this work, much more could be done with the right resources.
- 3.4 One specific example is a web-based tool developed by Devon County Council which aims to connect people who may not have been active for some while, with activities that suit their needs and preferences: [www.getactivedevon.co.uk](http://www.getactivedevon.co.uk), and we would be happy to collate and share with the Committee other examples of good population based work to monitor and improve dietary intakes and activity levels (such as the “Let’s Get Going!” project in Berkshire, and Slough’s School Food Survey and Mission Healthy Eating project).
- 3.5 A number of local authorities have drawn up supplementary planning documents (SPDs) to restrict the development of new fast food premises near schools. However, it is recognised that due to consultation and other procedures, these can take a long time to prepare and agree.
- 3.6 **In a recent ADPH survey on action to improve the public’s health, protect children & young people and reduce health inequalities, 81% of Directors of Public Health who took part highly prioritised the need to amend licensing legislation to empower Local Authorities to control the total availability of junk food, alcohol, and gambling outlets.**
- 3.7 In relation to planning and development regulations, ADPH would also recommend that consideration of applications should include the use of Health Impact Assessments to ensure that the health and wellbeing of development proposals is properly considered alongside environmental impacts, in line with the refreshed NPPF guidance, 2014 which states: *“Local planning authorities should ensure that health and wellbeing, and health infrastructure are considered in local and neighbourhood plans and in planning decision making. Public health organisations, health service organisations, commissioners and providers, and local communities should use this guidance to help them work effectively with local planning authorities in order to promote healthy communities and support appropriate health infrastructure.”*
- 3.8 [Community Led Local Development Guidance](#) is an example of a useful tool for supporting sustainable and inclusive growth to support social inclusion, health and wellbeing. Linked to the EU Structural and Investment Funds, this can support local authorities, local communities and Local Enterprise Partnerships to work together to address the specific needs of their localities.
4. **The role of schools, parents, Local Authorities and government in encouraging active play, travel and sport for children and young people, including: how do we encourage and enable greater physical activity in older adults and the disabled?**
- 4.1 Please see sections above covering Local Authorities and government action. In relation to schools, we would highlight the PHE [briefing The Link between pupil health and wellbeing and attainment](#), and ADPH recently recommended to Ofsted that their

Inspection Framework should address the evidence-based approaches highlighted in this paper to:

- improve the health and wellbeing of children and young people
- improve their potential for educational attainment
- and so help to reduce health and other inequalities.

**4.2** We also recommended that the Ofsted inspection framework supports a whole-school approach to improving health and wellbeing of children and young people:

- robust evidence (as referenced in the PHE briefing) shows that interventions taking a 'whole school approach' have a positive impact in relation to outcomes including: body mass index, physical activity, physical fitness, fruit and vegetable intake, tobacco use, and being bullied.
- healthy school meals, universally applied to all pupils, have been shown to improve academic attainment, particularly for pupils with lower prior attainment.

We further recommended that the inspection framework supports:

- the introduction across all primary and secondary schools of statutory and comprehensive personal, social and health education (PSHE) programmes supported by specialist teaching, which foster social and emotional health and wellbeing; and tackle issues around sex and relationships, child sexual exploitation, social inclusion, bullying, drug and alcohol use and mental health.
- implementation of the recommendations in the School Food Plan, including food and nutrition training for teachers.

**4.3** **In our recent ADPH survey on action to improve the public's health, protect children & young people and reduce health inequalities, Directors of Public Health who took part prioritised the introduction across all primary and secondary schools of statutory and comprehensive personal, social and health education (PSHE) programmes supported by specialist teaching.**

**5. The role of NHS organisations and Public Health England in improving levels of physical activity and diet, including: what services are currently provided and commissioned to encourage healthy eating and physical activity, and do these services meet current needs both in terms of availability, access and quality and is there sufficient evidence for what works best at local level?**

**5.1** ADPH has worked closely with PHE to develop both the structures (national and local) and effective working relationships that are vital to the success of the public health system in England.

**5.2** Effective working relationships locally between Directors of Public Health/their teams in local government, PHE Centres, NHSE/LATs and CCGs are critical to making the system work effectively. The vision is for all elements to work together and within one public health system – however there is still more work to be done to fully realise this vision, and ADPH and Directors of Public Health are working with colleagues on this.

**5.3** Public health data and information (across all relevant population levels); surveillance and monitoring; and real-time data flows must all be maintained and be easily and rapidly accessible to Directors of Public Health and their public health staff working in local authorities and across the local systems. ADPH members have appreciated continuing efforts to resolve issues that have emerged in relation to access to patient data and non-patient identifiable data for local authority based public health intelligence teams, and have highlighted the importance of sufficient PHE resources being made available to ensure an appropriate technical solution is in place to

efficiently deliver such data to all public health intelligence teams based in local authorities across England.

- 5.4 Reducing obesity and sustaining a healthier weight amongst the adult and child population is a priority area for public health and for the NHS – in both cases the focus should be on prevention and evidence based ‘upstream’ interventions.

**6. National and local accountability for improving physical activity levels and diet. What policy changes, including national or local regulation, taxation or financial incentives have been shown to be effective in other countries?**

- 6.1 Tackling diet and physical inactivity requires action to address the wider economic, social and environmental determinants of disease, and by doing so there are potential co-benefits for health inequalities and other factors.

- 6.2 The UK needs a comprehensive approach to food and nutrition that will promote a healthy food environment and help combat the growing problem of diet-related ill-health including overweight and obesity.

- 6.3 ADPH is concerned that public-private partnerships with companies (particularly those who produce unhealthy foods) can undermine efforts to regulate in the interest of protecting public health e.g. harmful marketing and other business practices. We would like to see government establish alternative funding streams to remove food industry from sponsorship of physical activity and sport, especially programmes in schools and targeted at children.

- 6.4 **In a recent ADPH survey on action to improve the public’s health, protect children & young people and reduce health inequalities, Directors of Public Health included the following measures in their top 10 priorities - ADPH is therefore calling on government to:**

- **Introduce standards for salt, saturated fat and sugar reduction in the food supply**
- **Implement a sugar sweet beverage duty at 20p per litre and to consider the wider application of taxes on unhealthy foods**
- **Ban the marketing of foods and beverages high in fat, sugar and salt before 9pm on broadcast media**

- 6.5 There should be continued and increased investment in national research institutions such as National Institute for Health Research, Medical Research Council and Economic and Social Research Council. This could help to ensure evidence in support of high impact upstream policy, including the development of epidemiological, modelling and simulation tools used to determine which actions will be most effective and cost-effective.

- 6.6 As highlighted in the sections above, local authorities need strengthened planning powers to tackle the clustering of junk food outlets on high streets. This would allow local planning authorities to place any type of premises which is posing a local challenge or priority to the area into this ‘umbrella’ use-class.

**7. Are we losing the fight and simply encouraging a 'normalisation' of obesity and is this distracting from prevention and early intervention?**

- 7.1 The British Medical Association (BMA) has called for £1bn extra for public health and we support their view that an increase in funding for public health has the potential to relieve pressures on other health and care services in the future. Indeed the case for spending more on preventative services has been well made for some time and overwhelmingly accepted.

- 7.2** Attached below is the Executive Summary of the ADPH Business Case for increased investment in local public health (2012) - which illustrates that increased funding for public health and preventative measures could be spent efficiently and effectively by Local Authorities and would deliver outcomes that improved health whilst reducing premature mortality and health inequalities.

**Association of Directors of Public Health  
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# The Association of Directors of Public Health

## The Case for Additional Investment in Public Health

### Executive summary

The paper *'The Case for Additional Investment in Public Health'* sets out the evidence that there is a health need that warrants additional investment, and that this can be invested in cost-effective, evidence based interventions to deliver improved population health and reduced demand on health care services whilst facilitating more efficient healthcare service delivery.

- An additional £1.2 billion pounds investment in public health programmes in 13/14, increasing to £1.5 billion pounds in 15/16, would ensure delivery of the government's aspiration to improve health through its existing commitments to roll out the NHS Health Checks programme, reduce smoking prevalence, implement NICE recommendations in relation to alcohol brief interventions, meet cost pressures particularly in relation to GUM provision, build capacity in relation to school nursing and to tackle obesity.
- As well as delivering improved health outcomes for individuals a major beneficiary will be the NHS, with more cost efficient care delivery and a reduced burden of ill health.
- It would also allow local communities to embrace the public health agenda unfettered by inequity resulting from historical under-investment by the NHS in preventative services, whilst not reducing the allocation for those who have invested more in effective public health programmes.
- This amount whilst being significant for public health would have a marginal effect on the overall comprehensive health service budget (a 1% shift in the comprehensive health service budget to Public Health equates to £1 billion). It would also represent a reasonable proportion of the QIPP savings that we understand are to be re-invested in front-line services including public health programmes.
- Much of the investment would be used to develop and increase provision within programmes that are well established such as NHS Health Checks, tobacco control and GUM provision and therefore money can be committed immediately.
- There are however a number of areas of investment (school nursing, primary care, public health, leadership and community empowerment) where there will be a constraint on commitment of resources because of shortage of staff. In these areas capacity can be developed over a three year period in a similar way to that being undertaken currently with health visiting.
- In the case of alcohol misuse there is an increased level of investment in year 1 but as an increasing number of people are screened and receive a brief intervention there is a reduction in spend in future years.

Below are examples of programmes which would benefit from the investment and their health impact and value for money.

## Programme areas

Programme Area	Additional Investment	Health Impact	Financial Benefit
NHS Health Checks	£165 million	<ul style="list-style-type: none"> <li>414 lives saved</li> <li>1,018 strokes and heart attacks prevented</li> <li>2,545 diabetes cases prevented</li> <li>12,727 diabetes and CKD (Chronic Kidney Disease) identified</li> </ul>	£1.8 billion per annum
Tobacco	£110 million	<ul style="list-style-type: none"> <li>7250 fewer deaths per annum</li> <li>Reduced admissions for CVD (Chronic Vascular Disease), COPD (Chronic Obstructive Pulmonary Disease) etc</li> </ul>	£600 million net revenue gain pa £69 billion over 50 years (Net Present Value)
Alcohol misuse	£292 million reducing to £75 million	<ul style="list-style-type: none"> <li>4.9 million people identified for brief intervention</li> <li>Reduced alcohol-related admissions</li> <li>Additional 19,600 – 93,100 quality adjusted life years</li> </ul>	£980 million – £4.6 billion
Sexual health	£186 million	<ul style="list-style-type: none"> <li>Reduction in HIV diagnosed late</li> <li>Increased cases of HIV identified</li> <li>Reduction in HIV transmission</li> <li>669,000 screened for chlamydia</li> <li>40,152 cases of Chlamydia identified and treated</li> <li>Reduced cases of Pelvic Inflammatory Disease (PID), ectopic pregnancy, infertility and associated treatment costs</li> </ul>	Every £1 pound invested in contraceptive and sexual health services saves the NHS £11 pounds.
Children's health	£382 million	<p>Improved health through:</p> <ul style="list-style-type: none"> <li>Implementation of Marmot recommendations</li> <li>a full time school nurse for each secondary school and cluster of primary schools</li> </ul>	

Other areas that will become the responsibility of the local authority that are likely to require some additional investment include:

- Obesity - The total annual cost to the NHS of overweight and obesity was estimated in 2001 at £2 billion, and the total impact on employment may be as much as £10 billion. By 2050 the NHS cost could rise to £9.7 billion, with the wider cost to society being £49.9 billion (at today's prices). It is difficult to assess what it would cost to put in place effective interventions across the country to achieve this but the costs are likely to be significant.
- Accidental injury prevention.
- Mental health promotion - by way of example, economic modelling shows a long term return on investment of 14:1 for school-based interventions to reduce bullying (these interventions are delivered/ facilitated through healthy schools programmes).
- Workplace health promotion programmes have been modelled to show a rate of return of 9:1 for the business, contributing to economic productivity. (There would be additional savings over and above this in health and care services).
- Social determinants – investment of PH funds in debt advice. Debt advice services show a rate of return on investment of 3:1 realisable over 2-5 years.
- Community safety, violence prevention and response.
- Fuel poverty / seasonal mortality.
- Wider determinants e.g. poverty, housing and overcrowding, homelessness, transport, health promoting environments and sustainable communities (e.g. green space, crime and road safety and noise levels), truancy and worklessness.

**Association of Directors of Public Health  
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- <sup>i</sup> **Department of Health, 2011** Start active, stay active: A report on physical activity for health from the four home countries' Chief Medical Officers
- <sup>ii</sup> **Government Office for Science, 2007** Foresight Tackling Obesities: Future Choices
- <sup>iii</sup> **Association of Directors of Public Health, 2010** Take action on active travel
- <sup>iv</sup> **Sustrans, 2013** Is England taking action on active travel?
- <sup>v</sup> **British Medical Association, 2012** Healthy transport = Healthy lives
- <sup>vi</sup> **National Institute for Health and Care Excellence, 2008** Promoting and creating built or natural environments that encourage and support physical activity
- <sup>vii</sup> **National Institute for Health and Care Excellence, 2012** Walking and cycling: local measures to promote walking and cycling as forms of travel or recreation
- <sup>viii</sup> **National Institute for Health and Care Excellence, 2012**  
<http://www.nice.org.uk/newsroom/pressreleases/NoTimeForPhysicalActivityTheAnswersOnYourdoorstepSaysNICE.jsp>
- <sup>ix</sup> **All Party Commission on Physical Activity, 2014** Tackling Physical Inactivity – A Coordinated Approach
- <sup>x</sup> **Cabinet Office, 2009** An analysis of urban transport
- <sup>xi</sup> **Reference Food Poverty and Health**, Faculty of Public Health 2013  
[http://www.fph.org.uk/uploads/bs\\_food\\_poverty.pdf](http://www.fph.org.uk/uploads/bs_food_poverty.pdf)