Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Plant a Phobl Ifanc
The Children and Young People Committee

Dydd Iau, 4 Rhagfyr 2013
Thursday, 4 December 2013

Cynnwys
Contents

Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir trawsgrifiad o'r cyfieithu ar y pryd.

These proceedings are reported in the language in which they were spoken in the committee.

In addition, a transcription of the simultaneous interpretation is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Jocelyn Davies	Plaid Cymru (yn dirprwyo ar ran Simon Thomas) The Party of Wales (substituting for Simon Thomas)
Keith Davies	Llafur Labour
Suzy Davies	Ceidwadwyr Cymreig Welsh Conservatives
Rebecca Evans	Llafur Labour
Ann Jones	Llafur (Cadeirydd y Pwyllgor) Labour (Chair of the Committee)
Bethan Jenkins	Plaid Cymru The Party of Wales
David Rees	Llafur Labour
Aled Roberts	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Andrea Basu	Arweinydd Tîm Deietegwyr Datblygu Cymunedol—Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr Community Development Dietitian Team Lead—Betsi Cadwaladr University Local Health Board
Dr Julie Bishop	Ymgynghorydd Iechyd Cyhoeddus Consultant in Public Health
Dr Angela Tinkler	Ymgynghorydd Iechyd Cyhoeddus Consultant in Public Health
Lisa Williams	Hwylusydd Hyfforddiant Maetheg Cymru Gyfan—Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro All Wales Nutrition Training Facilitator—Cardiff and Vale University Local Health Board

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

Sarah Bartlett	Dirprwy Glerc Deputy Clerk
Victoria Paris	Y Gwasanaeth Ymchwil Research Service
Marc Wyn Jones	Clerc Clerk

Dechreuodd y cyfarfod am 10:02.
The meeting began at 10:02.

Cyflwyniadau, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **Ann Jones:** Good morning, everyone, and welcome to the Children and Young People Committee. I ask that you please switch off your mobile phones as they affect the translation and broadcasting equipment. We operate bilingually, so should you need to use the translation facility from Welsh into English, it is on channel 1, and channel 0 is for the floor language, should you need amplification of sound. We do not expect the fire alarm to operate, so if it does, we will wait to take our instructions from the ushers. However, if we can get out through this main building, the assembly point is by the Pierhead building. If not, as I say, we will take our instructions from the ushers.

[2] We have had apologies for absence this morning from Lynne Neagle and Angela Burns. Also, Simon Thomas is sitting on another committee, therefore Jocelyn Davies will be substituting for him. However, Jocelyn is also in another committee meeting; so I think that it might be a matter of timings. I am sure that Jocelyn will join us at some point.

[3] Given that we are starting a new inquiry, do Members need to declare any interests that they have not already declared? I see that there are none. Thank you very much.

10:03

Ymchwiliad i Ordewdra Ymysg Plant—Sesiwn Dystiolaeth 1
Inquiry into Childhood Obesity—Evidence Session 1

[4] **Ann Jones:** Our first evidence session on childhood obesity is with Public Health Wales. We are delighted to have with us Dr Angela Tinkler and Dr Julie Bishop, who are both consultants in public health. Thank you very much for coming along today. We have had a paper; so, thank you for that. We have quite a substantial number of questions, as is always the case, and time is tight, given that there are some events happening at lunch time. So, we may have to move on quite quickly. It would be helpful if we could move straight to questions. Would you like to take the first set of questions, David?

[5] **David Rees:** Good morning. We have had quite a lot of evidence on the obesity pathway, which indicates that there is some concern over the take-up of the different levels of the pathway. I suppose that my first question is basically about the extent of the implementation, particularly at the higher levels. It seems that level 1 is quite widely implemented, but the question is whether we go for levels 2, 3 and 4—although I know that level 4 is not available to children. What is the extent of that take-up and implementation of the pathway up to levels 2 and 3?

[6] **Dr Tinkler:** I think the extent of the take-up is variable across all levels of the pathway in Wales. We are not alone in Wales in the challenges that we have in implementing the pathway. Some of our other partners have those challenges as well. There is an annual return that is submitted by each health board to the Welsh Government on progress across all levels, but with a particular focus on levels 1, 2 and 3 of the pathway. I think that it is fair to say that there has been a lot of good work undertaken locally and collaboratively, but I think that there still remains a challenge, certainly across levels 2 and 3 in particular. The structures are not necessarily in place for people who require that intervention at level 3.

[7] **David Rees:** Is it the structures of the multidisciplinary teams that are not there, or is there anything that we should be asking the Welsh Government to do to ensure that those structures are put into place?

[8] **Dr Tinkler:** We have just recently held a national public health workshop to look specifically at level 3 of the pathway, and we will be reporting and making some recommendations on that basis. I think that there is still some work to be undertaken, particularly around level 3.

[9] **David Rees:** Therefore, you are undertaking some evaluation of the pathway at the moment.

[10] **Dr Tinkler:** We are undertaking an assessment and looking at progress, and there has been a specific focus just recently on level 3.

[11] **David Rees:** Do you have any idea when that will be coming out?

[12] **Dr Tinkler:** I know that the notes from the workshop that was held last week are just being circulated for approval at the moment.

[13] **David Rees:** I was going to ask a question about the direction, but obviously the direction may vary as a consequence of the output from that. It would be very interesting if you could give us information as soon as possible on that aspect.

[14] **Dr Tinkler:** Yes.

[15] **David Rees:** Are the programmes of the right scale, in your view, to actually tackle the issues? You have said there is variation across the UK, but are we hitting the right levels and the right targets at this point in time? Is our focus correct?

[16] **Dr Tinkler:** I think that the obesity pathway is a very well-structured pathway. There is a strong evidence base in terms of which interventions work. If we start to think about treating obesity as we treated smoking all those decades ago, and then if we look at the progress that we have made on smoking, we will see that there are real opportunities to tackle this, but I think that it needs a cross-organisational, cross-population approach, and that everybody has to take some responsibility as well.

[17] **David Rees:** You said cross-population there, and I think it needs to be cross-departmental as well; that is as an issue. We often hear about the joined-up thinking in departments, but are we seeing evidence of joined-up thinking across departments, or is that lacking in the Welsh Government?

[18] **Dr Tinkler:** I think that there is some evidence of cross-departmental thinking. If you look at the number of programmes and strategies, you will see that, collectively, they would have an impact on the prevalence of obesity. So, these include some of the physical activity strategies and some of the nutrition and diet strategies that are in place. I do think that there are some cross-cutting themes that are emerging quite strongly.

[19] **David Rees:** I just have one final question, Chair, if that is okay. This question is on the involvement of health professionals in relation to the development and evaluation of the programmes, and perhaps the enthusiasm of health professionals in taking this forward. We have heard a lot of evidence—anecdotal, perhaps—and we can all see that the rate of child obesity in Wales is very high, therefore it is an issue that we have to tackle. What is the view of the health professionals who are involved in this? I am not talking about public health—I am talking about perhaps the GPs and that side of things.

[20] **Dr Tinkler:** I think that health professionals have been and are involved in some of the existing schemes, and some of the existing schemes that we have are multiprofessional. One of the issues that we have encountered, certainly in some of the work that we have done

locally—my main patch is north Wales—in terms of the many multi-agency workshops that we have done with health professionals and other professionals, is that professionals need to have the confidence and skills to be able to raise the issue in the first place; this issue constantly emerges for us, as I am sure it does elsewhere. There is a need to build on the concept and notion of making every contact count, so that when an individual or a family is there for a slightly different reason, you can use it as an opportunity to perhaps raise some other issues. Although professionals have got the desire to do so, they sometimes feel that they do not necessarily have the right skills to raise that type of issue. There is willingness, an enthusiasm and a commitment, and a recognition that something needs to be done. However, I think that there are some other issues that make it complex.

[21] **Ann Jones:** We will now move on to child measurement programmes. Keith, do you want to take the first questions?

[22] **Keith Davies:** Yes, thank you, Chair.

[23] Bore da. Good morning.

[24] **Dr Bishop:** Bore da. **Dr Bishop:** Good morning.

[25] **Keith Davies:** Byddaf yn gofyn fy nghwestiynau yn Gymraeg. Rydych yn cael data oddi wrth y rhaglen mesur plant. Sut ydych chi'n gallu defnyddio'r data i fesur effaith gweithgareddau atal ar lefel poblogaeth?

Keith Davies: I will be asking my questions in Welsh. You have data from the child measurement programme. How can you use that data to measure the impact of prevention activities at a population level?

[26] **Dr Bishop:** Well, obviously, we are relatively new in terms of our child measurement programme—we have only produced the first report this year. Looking at experience from other parts of the UK, we would expect to build on what we have started, and to be able to achieve a greater uptake, although, actually, it has been extremely good across most local authority areas for the first attempt. Obviously, the better coverage that we have, the more useful data we have. Therefore, what we know at the moment, from the first survey, is that we have a good understanding of the scale of the problem across the whole of Wales. We understand which communities in Wales experience greater levels of childhood obesity than others, and, within communities, we can also see, across deprivation levels, which groups of the population are likely to experience greater levels of obesity. Therefore, for example, we are very clear that the more deprived communities experience greater levels, and we know that there are certain local authority areas that experience greater levels. Perhaps what is quite unusual about this data, compared with a lot of the health data that we look at—we are very used to seeing the highest levels of health problems in the south Wales Valleys; that is a recurrent theme—is that areas such as Pembrokeshire and Powys, which are rural communities, have slightly more problems in terms of obesity than is traditionally the case in relation to other health conditions. Therefore, the data have already shown us something that we might not have anticipated was there.

[27] However, I think that, for us, one of the critical things that we will use the data for is to monitor the effectiveness of the measures that we put in place. So, the data on four to five-year-olds give us tremendous opportunities for preventative interventions; they give us a really clear focus to say that our goal is to reduce the number of children who enter school who are already overweight or obese, so that we know what our starting point is. We also know what the good international evidence says about the kinds of things that are likely to help. Therefore, if we can really tackle that consistently, as Angela says, bringing together all aspects of society, and drawing on all the programmes that we already have in communities, such as Flying Start, then we should really be able to make a difference to that, and

understand the difference that we are making.

[28] **Keith Davies:** I ddilyn hynny, pam fod pethau mor wahanol yng Nghymru, a pham fod pethau'n waeth yng Nghymru nag yn unrhyw ardal arall yn Lloegr?

Keith Davies: To follow up on that, why are things so different in Wales, and why are things worse in Wales than in any other area in England?

[29] **Dr Bishop:** That is quite a difficult question to answer. I think that, probably, it has something to do with the fact that when you start to measure something, it draws attention to it, and it stimulates action. The measurement programme for children in England started, I think, in 2005 or 2006, so it has been doing this for quite a lot longer. Now, we have benefitted from that in many respects, because we have been able to learn from the experience of those in England, and so our early programme was much more successful than theirs. However, they have clearly had a head start in terms of focusing on this. So, we think that that is probably the main reason for the difference—it is not that there are fundamental differences between what is going on in Wales and what is going on in England, it is just that it has been tackling the issue slightly longer than we have.

[30] **Keith Davies:** Iawn. Fodd bynnag, rydych hefyd yn dweud fod rhaglenni yn defnyddio meini prawf gwahanol yng Nghymru. Beth allwn ni ei wneud i sicrhau eu bod yn defnyddio yr un meini prawf?

Keith Davies: Okay. However, you also say that programmes use different criteria in Wales. What can we do to ensure that they use the same criteria?

[31] **Dr Bishop:** The criteria that are used in the measurement programmes in England and Wales are the same. Therefore, the way in which we are measuring obesity is the same. There are some other studies that are done on children at different ages, as well as on adults, that use different criteria, so we have to be careful. However, the English and the Welsh data are comparable at this stage, so that is not the issue.

[32] **Keith Davies:** Iawn. Fodd bynnag, rydych hefyd yn dweud eich bod eisiau symud ymlaen, a'n bod yn mesur plant naw mlwydd oed, neu beth bynnag, yn hytrach na dim ond plant pedair neu bump oed. A yw hynny'n mynd i ddigwydd?

Keith Davies: Okay. However, you also say that you want to move on, and that we measure nine-year-old children, or whatever, and not just four and five-year-old children. Is that going to happen?

[33] **Dr Bishop:** We very much hope so. We are in discussions with the Welsh Government at the moment about how we might resource that, in terms of its implementation. We know how valuable the data have been for four and five-year-olds. So, if we can have data for slightly older children then we can really understand how we are making a difference. We would see that as one of our biggest priorities.

10:15

[34] **David Rees:** Obviously, the child measurement programme is looking at levels of obesity, looking at the weight and height of a child and working out their BMI. Is there any plan to follow that information up with a targeted investigation as to the dietary options that these children are having, so that we can have an idea of what might be causing the obesity?

[35] **Dr Bishop:** That is a good question. It has often been said that measuring what people eat is one of the hardest things to do accurately. It is notoriously difficult to do dietary surveys and they are also very expensive. There are a number of national diet and nutrition surveys that are already undertaken, so we have some information, but they do not provide the lower level and really local data that you would ideally want. It is a very valid question, but it

would be quite a challenge to do well. We would probably have to think of other ways to get an idea of what children are eating. You can look at it from one point of view and say that the fact that they are overweight suggests that they are either eating too much or not being active enough. So, we do have some idea of what the problem is. It would probably be better for us to focus our efforts on improving levels of activity and improving diet in general, rather than spending a lot of money investigating it in enormous detail, but it is a very valid question.

[36] **Ann Jones:** We are going to move on to Change4Life. Rebecca is next.

[37] **Rebecca Evans:** You say in your evidence—and thank you for it—that there is little good evidence of the effectiveness of specific programmes, and you are referring to Change4Life in that. How is the programme being evaluated and monitored in Wales, if it is?

[38] **Dr Tinkler:** I am happy to answer that question as best I can. As Members may be aware, Change4Life is something that originated in England and has been running in England for some time now. It has more recently been adopted in Wales. We are aware that, in England, there has been some formal evaluation, but there has not been any evaluation of the Wales implementation. From a public health perspective, because it is a social marketing tool, it is something that we would see as complementing other interventions and programmes. In principle, the use of social marketing techniques has been proven to work. Due to the fact that it has an orientation towards a family approach to lifestyle behaviour change, it is something that we would promote. However, in terms of Change4Life as a product itself, it is not currently evaluated in Wales.

[39] **Rebecca Evans:** What did they find when they evaluated the programme in England? You mentioned that other social marketing campaigns have been successful in public health; can you give us some examples of those?

[40] **Dr Bishop:** Social marketing has been recognised for some time as one of the tools that would be part of a multifaceted approach. One of the things we often say in public health is that there is no one solution. So, there will always be an element of trying to influence population norms and raise population awareness to bring about change. In the UK, we have seen success with some programmes. Some of the obvious ones are things like putting children to sleep on their backs rather than on their fronts to prevent cot death. We saw a very dramatic and quick change as a result of that, which is an example of a social marketing programme. Internationally, they have been used successfully; young people and smoking is one good example. There is quite a lot of evidence to suggest that they are something that we should do. However, on their own, they are part of creating the climate for change; they will not bring about the change.

[41] **Rebecca Evans:** Did the England evaluation tell us anything about this specific programme?

[42] **Dr Bishop:** We are not directly involved, so we do not have all the information about what has happened in England. What you will find, which is typical with most social marketing programmes, is that they measure the awareness and uptake of the programme. The programme evaluation suggests that Change4Life has been quite successful in that sense, in terms of meeting its targets. Evaluation of the difference it makes is much more difficult to do. There has been one study published that we are aware of, which did not seem to show that there was a big difference between the people who had engaged with the programme and the people who had not. That would not be enough information to say that it was not worth doing; obviously, it raises questions and those need to be addressed, but we need a lot more research before we fully understand that.

[43] **Rebecca Evans:** In the evidence that we have received from other people, we have

heard criticisms that the administration from the Welsh Government has been inconsistent and disappointing with regard to Change4Life. Is that a criticism that you would recognise? Is that fair?

[44] **Dr Tinkler:** I am not sure that we are in a position to answer that. Neither Julie nor I have been directly involved in the programme implementation whatsoever. So, I am not sure. We can seek an answer for you, possibly, outside of the meeting, but I do not think that either of us—

[45] **Rebecca Evans:** That is okay; we can raise that directly with the Minister.

[46] I have one last question on Change4Life. The Department for Environment, Food and Rural Affairs' family food survey found clear evidence that the affordability of a nutritious diet has worsened between 2007 and 2011. Do you feel that austerity and poverty have been taken into account in the Change4Life programme? Do you feel that the resources are appropriate, given the situation that many families find themselves in?

[47] **Dr Bishop:** As Angela says, I do not know the materials well enough, personally, to know whether that is the case, so I could not comment; however, from a public health point of view, we would say, clearly, that financial issues are one of the biggest influences on what people eat and how healthy their diet is. So, we would expect that the recent decline in living standards of some people, because of the wider financial circumstances, will have made it very difficult for some families to maintain a healthy diet. So, it is important that these programmes take account of that.

[48] **Dr Tinkler:** That was a very good question. Thank you.

[49] **David Rees:** My question follows on in one sense, because it also highlighted that maternal obesity is an issue. What involvement do you have in working with expectant mothers in the Change4Life programme and other programmes such as that?

[50] **Dr Tinkler:** I am happy to talk about some local work that we did recently, and we are sharing that work with colleagues. In north Wales, we have developed a maternal obesity pathway in collaboration with the health board, local authority and midwives. From a public health perspective, we would like to see that built upon and that that is something systematic that is delivered across all health boards, because, as you have rightly pointed out, in some of the evidence that we have submitted, if we are taking this approach where we want prevention and early intervention and if you want to tackle intergenerational obesity, this is one of the key things that you would need to seriously look at.

[51] **Ann Jones:** Aled is next on Appetite for Life.

[52] **Aled Roberts:** Bore da. Byddaf yn gofyn fy nghwestiwn yn Gymraeg hefyd. Mae'r cynllun Blas am Oes wedi bod yn weithredol rŵan ers rhyw bum mlynedd. Rydych chi wedi sôn nifer o weithiau y bore yma ei bod yn bwysig ein bod yn gwerthuso. A ydych chi'n ymwybodol o unrhyw werthusiad sydd wedi ei wneud o'r cynllun hyd yn hyn?

Aled Roberts: Good morning. I will also ask my question in Welsh. The Appetite for Life scheme has been active for about five years now. You have mentioned a few times this morning that it is important that we evaluate. Are you aware of any evaluation of the scheme that has been done as yet?

[53] **Dr Bishop:** There was some evaluation of the early stages. As you say, it has been running for quite some time. There was initial evaluation that sought to see how the different elements of the programme were being implemented and the kinds of impact that they might

have, including, if I remember correctly, an attempt to do some kind of economic evaluation, which is one of the things that is increasingly important. However, I do not think that it has happened more recently, in terms of the current level of implementation. I think that, probably, as with all of these kinds of programmes and policies, it is about maintaining the momentum and the emphasis, when, inevitably, new things come along, and it is often difficult. Essentially, the Appetite for Life scheme is a sound evidence-based approach. So, what we have to do is make sure that the elements of the programme are all consistently being implemented at the level that we would require. Part of that is looking at the particular nutritional standards of school meals. There is some monitoring of that, in the sense that a nutritional assessment is done that enables local authorities to see where their school meals pitch, in terms of the standards. However, beyond that, I am not aware of anything.

[54] **Aled Roberts:** Mae'r arfer yn wahanol iawn o sir i sir. Mae rhai siroedd nad ydynt yn rhoi dewis i blant o dan y cynllun Blas am Oes, yn yr ysgolion cynradd. Os ydych chi'n edrych ar yr ystadegau, mae niferoedd y plant yn yr ysgolion cynradd hynny yn anghyson iawn o sir i sir. Mae rhai siroedd lle mae'r cyfartaledd yn eithaf uchel ac mae eraill lle mae gostyngiad sylweddol wedi bod ers i'r cynllun hwn gael ei gyflwyno. Pa fath o drafodaethau sy'n cymryd lle ar lefel genedlaethol ynglŷn â deall beth yw arfer da ac, os oes problemau ynglŷn â'r ffordd mae'r cynllun yn cael ei ddehongli mewn rhai siroedd, i sicrhau bod y problemau hynny yn cael eu datrys?

Aled Roberts: The practice is very different from county to county. Some counties do not give children a choice under the Appetite for Life scheme, in the primary schools. If you look at the statistics, the numbers of children in those primary schools are very inconsistent from county to county. There are some counties where the average is quite high and there are others where there has been a significant decrease since the introduction of this scheme. What kind of discussions are taking place on a national level regarding understanding what constitutes good practice and, if there are problems about how the scheme is interpreted in some counties, to ensure that those problems are resolved?

[55] **Dr Bishop:** Again, it is not something that I have detailed personal knowledge of. We can certainly go away and give you further evidence in writing afterwards. You are right, though, that there are always differences in the level of implementation, and one of the things that we see consistently across all sorts of issues that we work on is that there are places that do things very well and places that do not seem to achieve the same levels of success. One of the things that we recognise that we need to be much better at is spreading that good practice across Wales, and that is certainly something that Public Health Wales has had a greater focus on in the last year, in terms of increasing the role that we can play in helping to identify best practice in the first place and also to spread it across Wales.

[56] **Aled Roberts:** Heb sôn am fanylion y cynllun, a gaf i ofyn am eich barn broffesiynol ynglŷn â rhaglen sydd yn dweud bod angen cyflwyno yn union ur un pryd i blentyn pedair blwydd oed o fewn ysgol, efo'r un *nutritional levels* yr oeddech chi'n sôn amdanynt, ag i blentyn 11 mlwydd oed? Mae nifer o Aelodau Cynulliad wedi bod yn gofyn cwestiynau ynglŷn ag a ddylai maint pryd ar gyfer plentyn pedair blwydd oed fod yr un fath â phryd ar gyfer plentyn 11 mlwydd oed. Eto, mae'r cynllun yn mynnu mai'r un math o bryd sy'n cael ei ddarparu. Yn eich barn broffesiynol chi, a yw hynny'n ddilys?

Aled Roberts: Without going into the details of the scheme, may I ask your professional opinion regarding a programme that states that exactly the same meal should be given to a four-year-old child in a school, containing the same nutritional levels that you mentioned, as to an 11-year-old child? A number of Assembly Members have been asking questions about whether the size of a portion for a four-year-old child should be the same as that for an 11-year-old child. Yet again, the scheme insists that the same kind of meal is provided. In your professional view, is that valid?

[57] **Dr Bishop:** I think that, again, I do not have enough detail about the requirements of the scheme to necessarily know exactly what is required, and I suspect that, with all of these things, there is a balance to be struck to make it relatively easy to do. You could have a very specific breakdown for every age group, and children are different sizes, so they will have slightly different nutritional requirements, or you could take a wider population approach and talk about averages. I think that that is probably the approach that has been taken here and there is some validity to that. The requirements of a four-year-old and an 11-year-old are clearly different. They are not different in a proportional sense, but they are different in a quantitative sense, so the response that I would give is that we would expect the proportions, nutritionally, to be very similar in terms of the balance between the different nutrients, for example, but, clearly, children who are 11 are going to need a higher calorie level than children who are four.

[58] **Aled Roberts:** It is surprising that you are not aware of any analysis that has been undertaken of the scheme because if, for example, there was a drop-off and children were getting to the age of 11 and, basically, feeling that they were not having a sufficient amount of food and, because of that, ending up eating a sandwich, crisps and a chocolate bar, then, although the scheme in principle might be wise, it would seem to be defeating its objectives.

[59] **Dr Bishop:** I agree entirely. I think that because Angela and I do not know about it does not mean that it has not happened, and we have colleagues who work quite closely with this programme, so I will be very happy to come back to you with that.

[60] **Dr Tinkler:** Yes, we would like to come back to you on that.

[61] **Ann Jones:** Bethan, do you have a point to raise?

[62] **Bethan Jenkins:** Touching upon what Aled said and what Rebecca said earlier about deprivation, I know that in some schools, for example, teachers can identify the fact that somebody is very hungry. I have heard of instances where children will steal from other people's lunchboxes because they have not had food before coming to school. Is there any analysis of the nutritional needs of certain individuals from certain backgrounds if that type of activity is happening on a wider scale, so that they may need, as Aled was hinting at, more nutritional support than others within the school context, because they are not getting that outside of the school environment, or is that something that cannot be monitored or evaluated?

[63] **Dr Bishop:** That is quite difficult, I think, because the child has the same basic nutritional needs. What you are highlighting is that some children may not be getting enough food at home before they come to school, compared with others. Obviously, that is not about their nutritional needs, as such; it is about their access to food. There are schemes, for example, the breakfast scheme in schools, that have been shown to be quite effective at addressing, particularly for some of the most disadvantaged children, that potential for coming to school without any food. So, there are some measures that are already available to schools whereby they can start to tackle that, but I think that you are right that there is always more that we could know about the needs of particular groups in the population.

10:30

[64] We are aware of the fact that, as you say, schools will identify children who have particular needs, and I guess it is about how we can work with schools through the various programmes that are available for them to be able to look at how those can be met at a local level. Things such as our healthy schools schemes, for example, are about schools looking at their particular needs and the needs of the children in those schools, and thinking about what they might be able to do in order to address the issue. We would probably encourage schools

to use those kinds of vehicles to bring in other agencies and other types of support and other programmes that might actually help to address it, but it is a very complicated issue.

[65] **Dr Tinkler:** I would just add that, from a more family-orientated approach, through the funding of Nutrition Skills for Life, there has certainly been a lot of development recently of cook-and-eat programmes, which are particularly focused on working with Communities First clusters, taking that broader perspective about encouraging skills for life, within a family context, about not just how to prepare food, but how to purchase and prepare a balanced meal. I think it goes back to that point that there is not one quick fix for this, but there are a number of schemes that complement each other.

[66] **Aled Roberts:** Rydych wedi cynnal adolygiad o'r gwahanol raglenni sy'n cael eu cyflwyno yng Nghymru. Rydym wedi derbyn tystiolaeth gan Ffederasiwn Cenedlaethol Sefydliadau'r Merched, sy'n cwyno bod awgrym bod menter y Bws Coginio yn mynd i gael ei dileu. Rwy'n meddwl bod eich tystiolaeth yn dweud eich bod yn dadansoddi'r adolygiad ar hyn o bryd, a bod Iechyd Cyhoeddus Cymru'n mynd i ddweud yn union beth sy'n mynd i ddigwydd, ond pa fath o amserlen yr ydym yn ei rhagweld am benderfyniadau?

Aled Roberts: You have carried out a review of the various programmes being introduced in Wales. We have received evidence from the National Federation of Women's Institutes, which complains that there is a suggestion that the Cooking Bus initiative is going to be abolished. I think that your evidence states that you are analysing that review at present, and that Public Health Wales is going to say exactly what will happen in the future, but what kind of timetable are we looking at for decisions on that?

[67] **Dr Bishop:** You are right; we undertook a national health improvement review, which was published earlier this year. It made some recommendations about a whole range of programmes specifically, and also about the kind of approaches that we wanted to take to try to address some of the challenges that we have in population health. The Cooking Bus was one of the programmes that were looked at. It was identified by the review as one of the programmes where we could perhaps address the goals of the initiative in a better way. One of the things I think it is worth remembering with all of these programmes is that all of the ones that we looked at have some value. It is not about us looking at the Cooking Bus or any of the other initiatives in isolation; it is about us looking at the resources available to us and the population health needs that we have to meet and asking how we can best use the money to greatest effect. So, that is the stage that we are at at the moment. The implementation process is just getting under way now and we are looking across a range of programmes, so we would expect that, within the next 12 months, we would have a response in each of the life course areas—for children, for adults and for older people—in terms of what we feel represents the most effective programme, given the resources that we have, to meet those needs. So, that is the sort of timescale in which those decisions are likely to be made.

[68] **Ann Jones:** We will move on to 'Creating an Active Wales', which Keith has questions on, and I think that Bethan may also have a couple of points on it.

[69] **Keith Davies:** Diolch, Gadeirydd. Gofynnaf yn Gymraeg eto.

Keith Davies: Thank you, Chair. I will ask in Welsh again.

[70] Yn y dystiolaeth yr ydym wedi ei chael am 'Creu Cymru Egnïol', mae'n gweud taw dim ond 44% o blant saith i 11 oed a 35% o blant 11 i 16 sy'n gwneud ymarfer corff am awr yr wythnos. Mae'r Llywodraeth yn edrych ar ymarfer corff yn ein hysgolion ac yn gweud y dylai pob ysgol gynnig dwy

The evidence that we have received on 'Creating an Active Wales' says that only 44% of children aged seven to 11 and 35% of 11 to 16-year-olds do physical activity for an hour a week. The Government is looking at physical education in our schools and it says that every school should offer two hours of

awr o ymarfer corff i blant bob wythnos. Beth y gallwn ni ei wneud am hyn?

physical activity a week. What can we do about this?

[71] **Dr Tinkler:** I think that 'Creating an Active Wales', from a public health perspective, is a very sound strategy. We know from local feedback that partners have embraced that and have worked locally to try to deliver it. One of the challenges has been that there has not been formal guidance that specifically holds to account outcome measures that can then be tracked back. So, while I think that there has been some local progress, there is probably more work to be done in terms of outcome measures and enabling local authorities in particular, which lead on it, to deliver through a results-based accountability framework.

[72] In respect of physical activity for young people in different age groups, we have very clear guidance, which came from the chief medical officers across the UK. It is always going to be a challenge. Unfortunately, we live in an environment where, particularly for teenagers, the pull of the Xbox is always there. As a parent myself, I know what that challenge is. However, that is not to say that we should not be focusing a lot on reducing sedentary behaviour among the whole of the population, but particularly among our young people, because, again, we know that, with regard to the impact on lifelong conditions in the future, prevention, early intervention and establishing healthy patterns of behaviour early on will, hopefully, be maintained into adulthood. So, there is still a lot of work to be done, but, as I said, as a parent, I fully relate to the challenges in terms of young people and physical activity.

[73] **Keith Davies:** A oes digon o gyllid ar gael er mwyn sicrhau bod y cyfleoedd yno i blant? Efallai mai'r broblem yw nad oes cyfleoedd iddynt.

Keith Davies: Is there sufficient funding available to ensure that there are opportunities there for children? One issue might be that there are no opportunities for them.

[74] **Dr Bishop:** You can be physically active at no cost whatsoever. So, it is not always about resources. It is certainly about access to safe environments and opportunities to be physically active, but it is quite important that we look at using the resources that are all around us. In Wales, we have a wonderful outdoor environment and most children have reasonably good access to green space. A lot of the solutions that have been shown to be effective internationally are the things that are about being active in our day-to-day lives: so, walking to school rather than going by car, walking to work, and so on. Those are the kind of things that we can implement without major resources, and we should probably be looking at those as a priority.

[75] **Dr Tinkler:** I would just add that the Active Travel (Wales) Act 2013 adds to that suite of additional existing programmes and strategies. I know, again, from my work locally, that certainly our partners in the local authority are very keen to lead on this and to put the structures in place. Going back to the earlier conversation about social marketing, that might be a tool that we would want to use to promote the fact that it does not have to cost money, you do not need to be a member of a gym and you do not need to be kitted out in a certain outfit to be able to get out and enjoy the environment.

[76] **Keith Davies:** Iawn. Mae gennym y Deddf Teithio Llesol (Cymru) 2013 a bydd llwybrau gennym, ac yn y blaen, ond sut y byddwn yn sicrhau eu bod yn cael eu defnyddio?

Keith Davies: Okay. We have the Active Travel (Wales) Act 2013 and we will have routes, and so on, but how do we ensure that they are used?

[77] **Dr Bishop:** I think that that was the point that Angela was making about social marketing, to some extent. We know that, particularly for active travel, active commuting,

and things such as that, you need the environment, so you need the routes to be created, the cycle paths and the safe walking routes, but you also need people who are motivated to use them. We know that that is where things such as social marketing programmes can be very useful. So, it is about both of those things, really.

[78] **Bethan Jenkins:** I do a lot of work on eating disorders and, at the moment, I am working with Cardiff University on a desktop review of the self-esteem and confidence lessons that many organisations do in schools and community groups to try to find out whether we can look at how that would not only stop people from developing an eating disorder but encourage young girls especially to take part in sport instead of focusing their attention on food, as well as dealing with the other potential confidence issues that they face in schools. I have gone in and done many workshops. I was wondering whether you have looked at anything like this, because, while physical activity is free and anybody can do it, if there are social boundaries or peer pressure not to do so because of a certain group—we have all been there—or how we feel about ourselves, then those barriers may stop teenagers and they might not get back into sport when they are older. So, I was wondering whether you had taken an interest in that particular area.

[79] **Dr Tinkler:** It is not something that we have had a specific focus on. With the child measurement programme that we referenced earlier, obviously the key focus was on childhood obesity and being overweight. However, part of that programme, because it was looking at weight per se, was used to identify that we have a very small cohort of children that were classed as underweight. There might be a number of reasons for that; it is quite complex, and it might be to do with medical conditions, or it might just be their growth pattern. Obviously for us, because our biggest challenge is childhood obesity, that has—

[80] **Bethan Jenkins:** I am not saying to focus on the anorexia and bulimia side of things. I am talking about the psychological barriers generally, especially, perhaps, if you are a bit overweight, that can stop you from putting on gym gear, and such that you do not feel comfortable at all about prancing around a sports hall—that type of thing. I have hang-ups from my youth. [*Laughter.*]

[81] **Dr Tinkler:** That is a really valid point, and, when you do look at some of the multi-disciplinary interventions that we would want to implement, based on evidence in relation in particular to level 2 and level 3, psychological support is one of the critical components along that pathway. So, I completely agree with you, but quite often it is almost seen as a luxury add-on to an intervention, whereas it is actually quite fundamental, because, if you do not get an individual—whatever their lifestyle behaviour is, even smoking, for example, exercise, physical activity, reducing their alcohol consumption—in the right place to be able to make that behavioural change, then you are not likely to get them to make that change. So, it is a very valid point.

[82] **Bethan Jenkins:** Okay.

[83] **Ann Jones:** David is next, and then Aled. We need to make some progress.

[84] **David Rees:** I just have a very quick question. We are talking about childhood obesity and the activity levels of our children, but clearly linked to that are the activity levels of the parents, in the sense of encouraging them to take part in family activities. How much are we talking about that work so that we can encourage more parents so that children will follow their lead?

[85] **Dr Tinkler:** We would not disagree at all. We all recognise, either as parents or professionals, that, if you look at the whole population and at the issue of being overweight

and obesity, that it has become normalised, and we are starting to talk quite a lot now about that. We have done workshops with health professionals where we have presented body images to them, just as a test, and asked, 'How would you class that body image if that person presented in your surgery or in your clinic? Would you be able to visually identify?' Most of them classed people who were overweight, or even starting to become obese, as being a normal healthy weight. It is because it has become normalised within our society. Over 50% of our adult population is either overweight or obese. That means that more people are overweight or obese than not. Again, for us the challenge is similar to that of decades ago when a high proportion of the population smoked and it was accepted and normalised. Then the evidence came out, and, although it took a long time from the publication of the evidence to get the action we needed, we did get it and we have seen a change. So, for me, and certainly from a Public Health Wales perspective, we are trying to take that approach that we have to de-normalise it as we have de-normalised smoking.

[86] **Dr Bishop:** Equally, picking up on your point, it is also about normalising some of the behaviours that help. So, becoming a more active society in our everyday lives is one of the norms that we need to establish. You are quite right that very often we focus a lot on children and it is important that we do, but we sometimes forget that children live in communities, they live in families and they pick up their behaviours from those environments, and, unless we work on those as well, we are not going to be successful.

[87] **Aled Roberts:** Your written evidence on your child measurement programme suggests that you are looking to include a second cohort. You mention that you are involved in discussions with the Welsh Government now. If you look at children who are aged eight or nine, they are becoming very much more conscious of their own bodies. What is the position in other countries as far as those older children are concerned? Is there an age-sensitivity regarding a message that is being given out on being overweight or obesity? If there are tendencies as far as eating disorders are concerned, could there be a danger that those tendencies are exacerbated?

10:45

[88] **Dr Bishop:** I do not think so. There is not a lot of evidence or, really, any robust evidence that links the two things. So, where we are talking about an approach to a healthy weight and tackling genuine overweight or obesity, there is not a lot of evidence that that can lead to more complex eating disorders. Those tend to have their origins in a slightly different place and are often a manifestation of psychological and emotional wellbeing problems. There is not a lot of evidence to support that, but there is concern, and I think that the perception is as much of an issue as the reality. I therefore think that it is true to say that there are concerns that parents sometimes express about the focus on weight for those reasons. So, it is quite important that we address that at all age groups, but I also think that it goes alongside what Angela was just saying, namely that we know that parents—and professionals—find it really difficult to identify whether their child is overweight. So, there is quite a lot of work to do to have the conversation at a society level about what normal looks like, what we are aiming for, how we have a healthy attitude and approach to body image, and size, to separate out a healthy weight for life from this notion of an idealised image that I am sure we are all familiar with.

[89] **Ann Jones:** We will move on to the MEND programme. Suzy, you have some questions.

[90] **Suzy Davies:** We will talk about MEND a little bit here, which is where the preventative messages, we have heard, have either missed their targets or have not been heard in the first place. The evidence that we have had from other witnesses in written testimony is that MEND reaches only a very small number of children and their families, and for a variety

of reasons that I shall come back to in a minute. It strikes me that the children who are involved in this programme are basically school-age kids of five to 13. If you were looking at a more population-based public health message, how would you plan to articulate it? These children are basically in school, and schools are already overwhelmed with work—we have already heard in your evidence to Keith that they can barely get the hours of activity into the curriculum, let alone anything else—so how, in a population-based level, would you reach these children and families, because MEND strikes me as quite medicalised and very specific to the individual?

[91] **Dr Bishop:** We started off by talking about the obesity pathway, and MEND is an intervention for children who already have a problem. So, if you like, it is a treatment intervention. You are quite right; the health improvement review found that, if people engage with the programme and complete it, it is likely to be successful, but it does not reach the number of children that we need it to. That is one of the reasons that we are looking at it again and at what the solutions would be. However, I think that there are two slightly different issues. We would say that all the international evidence shows that schools that have really joined-up programmes that have elements of physical activity and good nutritional standards, and which create an environment in which these issues are taken seriously, will bring about a change in children's weight on a population level. That is why we are saying that the focus on prevention in the yearly years settings and in school settings, and having those programmes in place, is incredibly important.

[92] Equally, because there will always be children who are overweight and who need support, we need evidence-based programmes that support them. I do not think that that is something that we would expect schools to be responsible for. Clearly, they are part of the process by which we identify children who need help, and I think that that would most definitely be improved, but we as an organisation will probably be saying to our partners—local authorities and the health boards—we know what the programme looks like, so we know, as Angela has already said, that it will include elements of psychological inputs, it will have physical activity, it will have bits about nutrition, and it will involve the whole family, ideally. We know that those are the things that are important, but each local area might have a different way of putting that together, to deliver those kinds of programmes that meet families' needs more effectively than MEND does at the moment. That might be where it is delivered, or it might be the range of people who are involved in delivering it. So, as part of our health improvement review implementation, that is one of the conversations that we will be having, really, namely what ideas local communities and local partnerships have for how we can deliver this type of intervention in a different way.

[93] **Suzy Davies:** May I come back to this partnership delivery idea? I can understand why it is done that way, but because of the financial pressures on the particular types of partner that you have mentioned here today, do you think that it would be fair to say that, actually, this kind of work is not their priority when it is competing with other priorities? Also, might there be an element of each individual partner saying that, actually, this is somebody else's work? That might be one of the reasons that it is not prioritised, rather than because there is not much money sloshing around.

[94] **Dr Tinkler:** In answer to part, but probably not all, of your question, once again, I can only talk about my experience locally. Among the partners that I have worked with across the health board and local authorities—and not forgetting the third sector and the voluntary sector, which have a very critical role to play and a wealth of experience and skills to contribute—there is willingness, but, unfortunately, because of the climate we are in, it will continue to be a challenge. From a public health perspective—Julie and I have been in public health for a very long time—there are always competing challenges for public health priorities, whether we are in austerity or not. We quite often have to fight our corner. Inevitably, with primary prevention, you are not going to realise the results and impact for

some years down the line and there is not always an immediate outcome. For some organisations, where things are target driven, that is a more complicated picture. However, I would say, from my experience locally, that I have always experienced a willingness to collaborate and tackle some of these public health priorities. In Wales in particular, there is a real strength in wanting to tackle public health priorities.

[95] **Suzy Davies:** That is encouraging. I have a final question. We have had some written evidence from other witnesses and, because enough money does not come to them and it is not in an identifiable package, they use that as a reason why their participation in these schemes is not what it might be. My worry is that, even if it were identified as being for a specific purpose, it would disappear into general budgets anyway. So, even if more money came for it, where would the guarantee be that it would head towards the programmes for which it was intended originally? I know what the Chair would say, but I wonder what you would say.

[96] **Dr Tinkler:** That is a very valid point and we experience that. I agree with you. We always find it helpful in public health when funding is made available that it is ring-fenced. Nutrition Skills for Life is one example; it remains ring-fenced until next year, and I have started to ask questions locally about what happens after that. So, that is a really valid point and we would welcome more ring-fenced money.

[97] **Ann Jones:** I have a smile on my face now; I quite like that answer. We will move on to future developments.

[98] **Bethan Jenkins:** A particular bugbear of mine is the predominance of situations where we have more and more people being sedentary, lots of fast food takeaways opening up, planning systems allowing that to happen and houses being built on green spaces. Is there more that local authorities and the Welsh Government could do, as Wrexham County Borough Council has done by prohibiting takeaways from opening within 400m of schools? Could this type of activity be carried out so that we have a wider view that is not just on focused plans, but that there is a strategic view of how we take forward this agenda in society, as opposed to it being one person's responsibility or that of an individual?

[99] **Dr Bishop:** We would agree with that. A problem like child or adult obesity is a product of a whole range of things that are not within the gift of any one agency. So, it needs us all to take responsibility for it at that strategic level. One of the responsibilities that Public Health Wales has is that it provides support to local authorities and others in undertaking health impact assessments. That is one of the tools that can be used to support a health-in-all-policies approach. That is, for us to start to look at all of the plans, all of the structural developments that we undertake and think about the potential health impacts and the extent to which it contributes to the problem.

[100] **Bethan Jenkins:** Have you made an analysis of how effective they are when taken forward by local authorities? It seems to me that they cannot be that effective at the moment with the predominance of developments that would be classed, as I said earlier, as being unhealthy.

[101] **Dr Bishop:** It is growing, and we are seeing some notable successes. For example, we have been doing a lot of work with a number of major housing schemes across Wales to look at how the design of those housing schemes can create environments that are health-enhancing. That is something that we have been doing in a number of different areas in Wales. We have also worked with a lot of local authorities on their local development plans. It is in its early stages. I am not suggesting for one second that we have all of the answers or that this is as embedded as we would like it to be, because it is not. We understand that we have tools that could help. You are right in saying that a greater emphasis on those kinds of

approaches is probably what is needed in order to make those kinds of differences.

[102] **Bethan Jenkins:** Would putting the health impact assessments within the public health Bill help, in terms of making that a statutory provision? You have indicated that you do work with a lot of areas, but if it is up to their discretion or if they think that it is a tick-box exercise, they may not carry that forward.

[103] **Dr Bishop:** We think that that would be beneficial. We have to be careful in thinking through what to apply it to, because it could become an industry in itself and that would be unhelpful. What makes the difference is the action that you take to mitigate the negative impacts and enhance the positive impacts. The process of doing a health impact assessment in itself achieves nothing. We have to guard against ending up with a system that has lots of people doing tick-box assessment exercises. The bit that makes the difference—how we could do this better to make that impact or reduce that impact—does not tend to happen. There is tremendous potential, through a public health Bill or other ways, to adopt a health-in-all-policies approach. However, we have to focus on the requirement to take action to mitigate negative effects on health rather than just doing a HIA.

[104] **Bethan Jenkins:** Could we have examples of the impact assessments that you are working on, if you are able to share them, with some of the housing developments or some of the councils that you are working with? It would be interesting to see how other councils could use it as best practice, if they are not already aware of it. Certainly, I would like to know for the ones in my area.

[105] **Dr Tinkler:** In Flintshire, I know that public health has been supportive locally. I am sure that it would be willing to share what it has conducted so far. I do not think that it has completed it, but it is well into it. I am sure that I can take that back and have it shared.

[106] **David Rees:** Bethan started on the wider aspects of tackling obesity and thinking outside the box. Do you have any examples, or are you aware of any examples, of other countries or regions that are doing those things as part of their statutory laws? We have a planning Bill coming up and a public health Bill possibly coming up. Are there areas that are already doing this that we can look at?

[107] **Dr Bishop:** There are elements being done in other countries. For example, there has been quite a lot of success in France, where it has been community based in small towns, led by the mayor, which is a slightly different environment to here. However, they have made some really effective differences to childhood obesity. We could adopt some of those elements in a UK context. In terms of the health-in-all-policies approach, there has been quite a lot of success in Australia in adopting those kinds of measures at a Government level, in terms of policy scrutiny. There are good examples from other countries that we can learn from. None of them are exactly transferable to Wales, but we can learn from the components of those.

[108] **Ann Jones:** We are bang on time. Thank you for your evidence this morning. There are a couple of notes for you to send; the clerks will work with you on those. We will send you a copy of the transcript to check for accuracy, so that we have not put words into your mouth. That would be very helpful. Thank you both very much for coming this morning.

10:59

Ymchwiliad i Ordewdra Ymysg Plant—Sesiwn Dystiolaeth 2
Inquiry into Childhood Obesity—Evidence Session 2

[109] **Ann Jones:** This is our evidence session with the local health boards. We are

delighted to have with us Andrea Basu, community development dietician team lead from Betsi Cadwaladr University Local Health Board—crikey, that is a long title—and Lisa Williams, all-Wales nutrition training facilitator from Cardiff and Vale University Local Health Board; again, an equally long title. I am sure that we will have a very good evidence session.

11:00

[110] Welcome, both of you. Thank you very much for your written evidence. We have sets of questions and we are tight up against time. If we go past 12 p.m. we will be competing with 'O Come, All Ye Faithful' or 'Hark the Herald' or whatever, so we need to try and finish for the Assembly's carol concert as the band will play and we will get drowned out. So, we will go straight into questions. David, do you want to take the first set on the all-Wales obesity pathway?

[111] **David Rees:** Good morning. The all-Wales obesity pathway is attempting to tackle obesity and has four different levels within it. We have had concerns in the evidence that we have received that it is not being adhered to totally across Wales. As health boards, what are you seeing on the ground? What can the Welsh Government do to give leadership in that sense?

[112] **Ms Williams:** We are both representing dietetics services, so a lot of our answers will reflect that. A lot of the work around focusing on childhood obesity, for us, occurs at level 1, with the Nutrition Skills for Life programme, which was formerly the increased dietetic capacity grant scheme, funded through the Welsh Government. A lot of our preventative work is focusing on early years settings and a settings approach. It is about supporting and training staff to be able to promote healthy food and drink options in early years settings. It is about supporting Appetite for Life, but also focusing on training community-based workers so that they are confident and competent to cascade nutritional messages to the families in the communities that they work with.

[113] **Ms Basu:** Through the Nutrition Skills for Life programme, which is operational across all health boards—I am speaking for north Wales—we are starting to see the benefits of some of those interventions and training in some settings, particularly in some of the early years settings like nurseries and childcare settings, which is very pleasing for us. We have seen a significant shift, in my 13 to 14 years' experience, from all playgroups providing squash and biscuits at snack time, to now providing milk, water and fruit. The change is quite dramatic. So, I think that we are making a difference on a settings level. As Lisa says, we are doing a significant amount of work through that scheme at level 1.

[114] Equally, as dieticians, we recognise that, looking at the obesity pathway alongside those settings-based and population-based approaches, we need to have interventions that support families that have children that are already overweight and obese. That pertains to levels 2 and 3 of the obesity pathway. I am certainly aware that, at level 3, we have a little bit of a deficit. There are some dietetics services in health boards that have a very small and very limited service offering one-to-one interventions with families. However, we know from National Institute for Health and Care Excellence guidance that was issued this year that that needs to be multidisciplinary. Not many of the children at that level are accessing psychological support. We feel that that is a gap and it is an area that, as dieticians, we are keen to support, so that families get that multidisciplinary input from health psychology, exercise specialists, dieticians and, of course, paediatricians and paediatric nurses. That team approach at that level is quite critical.

[115] **Rebecca Evans:** How are you ensuring that families, particularly new mums and dads, are getting consistent messages? Talking informally to people in that situation, I have

heard that they are concerned, because they see one thing on television, they read another in magazines, and then, depending on which healthcare worker they get, they might get a different message from one visit to the next. It can be really confusing. How can we get consistent messages?

[116] **Ms Williams:** We hear that a lot. People are saying that the messages seem to change very often, and this sort of thing. This is where the role that we have in terms of our preventative work and training others is key, to make sure that they are getting consistent messages and that those messages are consistent for all activities—through things like the Change4Life social marketing campaign and through the training that we are delivering—so that the information is evidence based, consistent, accurate and non-biased. Then, the people who we train are able to cascade that out to the communities that they are working, with professional support.

[117] **Aled Roberts:** Rwyf am gyfeirio at y pwynt a wnaethoch ynglŷn â'r bwlch yn lefel 3 a bod diffyg darpariaeth o ran timau amlbroffesiynol. Beth sy'n digwydd yn eich byrddau iechyd chi er mwyn ymateb i'r diffyg hwnnw?

Aled Roberts: I just want to pick up on the point that you made about the gap in level 3 and that there is a lack of provision in terms of multiprofessional teams. What is happening in your health boards in response to that deficiency?

[118] **Ann Jones:** I think that I put Andrea off earlier, so would you like to start with this one and add the point that you wanted to make?

[119] **Ms Basu:** I will answer your question first, so that I do not forget the answer. Certainly within Betsi Cadwaladr, this is an issue that our paediatric dieticians have recently discussed, to ensure that, as a health board, we are being consistent in what we can offer across the patch within the limits of what we can offer, but recognising that we are not at present able to meet those recommended national standards. I think that it is then a case of cascading up through our networks within the health board—through the clinical programme groups and senior management—what the best practice should be, so that we can give the best possible service to our families. I think that it is something that we are quite keen to build upon. At the present time, it is a very limited service and it is the children who are very much at the high end of the spectrum in respect of obesity—those who have perhaps tried other interventions that have not worked those who have co-morbidities at a young age, such as problems with blood pressure or cholesterol, or other co-morbidities that are related to obesity—who need that specialist dietetic input.

[120] **Aled Roberts:** Just to hold you to that, we carried out a neonatal review, and Betsi Cadwaladr University Health Board in particular—which I have an interest in—has not met national guidance for years. Are you saying that there is a plan in place so that they move up to that national guidance?

[121] **Ms Basu:** I can only speak in terms of the work that I am aware of that paediatric dieticians have done in trying to pull together a coherent approach as to how we provide services for the children who are referred to us for overweight and obesity issues, how we can manage that within the confines of the resources that we have and how we can cascade up what the deficits are to our senior management. I could not comment beyond that at this stage.

[122] I will go back to the point that you raised about the consistency of messages. It is an area that we, as dieticians, are particularly skilled in. Our art is being able to translate the science of nutrition into understandable information for the public. I have worked very closely with our midwives in north Wales over the last 12 to 18 months, because we recognise that there is a very strong link between maternal obesity and child obesity. We have a significant number of women entering pregnancy with a high BMI or some women who gain

excessive weight during pregnancy. We know that those are indicators that we need to try and tackle so that we can try to stem that increase in child obesity. My work has been very much training and supporting community midwives to give a consistent message from the outset. Through the work of things like Nutrition Skills for Life, linking with Flying Start and other organisations, we hope to reach health visitors and other community-based staff that are not professionals but do have a supportive role and work very closely with families. There is much to be done in promoting that consistency, but it is essential.

[123] **Rebecca Evans:** Thank you.

[124] **Ann Jones:** You are on rationing, David. We have been round the table somewhat. Sorry.

[125] **David Rees:** We have done most of it. You said that you hoped to reach various groups. I suppose that my concern relates to the guarantees that we have that you have the professional involvement at those levels, so that you do reach those groups, not hope to reach them.

[126] **Ms Basu:** It might have been my phrasing, but I can certainly say that, in the north, and particularly in relation to the work with community midwives, we have support from our women's CPG. I have developed some accredited short programmes for our community midwives, and we have permission to reach all of our community midwives with that training—I have reached 50% already—so we are already making inroads. In the work that we are doing more broadly through Nutrition Skills for Life to build the professions of the future, Lisa and I have been working closely to look at preregistration training for health professionals; we are reaching them before they come into practice so that they have those core nutrition skills before they commence their professional careers. We are working quite closely with Bangor and Cardiff universities to develop that for the future as well as through professional development mechanisms to reach our professionals now. I think that it was a slip of the tongue.

[127] **David Rees:** I have two further questions, so I will be quick. How are you involved in the evaluation of these programmes? It is important that we assess whether they are effective and achieving the targets and goals that we want. I will come back to the second question after that.

[128] **Ms Williams:** I can talk about the Nutrition Skills for Life programme, because that is part of my remit. In the initial phases, it was evaluated by Glyndŵr University, so we have benefited from some evaluation tools and questionnaires that we used with staff that we were training, but also questionnaires that people that we have trained would use with community members to try to evaluate the impact of the programme. That has shown very positive outcomes. There was an evaluation report in the first two years and then in the second phase of the programme—the second two years. Since then, we have moved on with support from the Welsh Government to develop an evaluation framework using the results-based accountability methodology. Through that, we develop a report card that summarises all that information about how well we are doing, how much we are doing and, crucially, who is benefiting from that and the results of that in communities.

[129] **Ms Basu:** I think that health boards are very committed to contributing to evidence and research. Linking back to the work that I have been doing in the last 12 months with our community midwives, we have evaluated training and we are confident that those that have been through the training have an increased level of confidence around tackling and talking about the sensitive issue of weight in pregnancy, which we know from the body of literature is something that midwives perhaps do not feel so confident about, or have not done historically. We have some evidence that was starting to make some headway in that area, and

we are increasing their knowledge around nutrition also, which can only go on to improve the messages that they cascade to women. We have also submitted some work for publication to reflect that change in knowledge that we are very proud of and which we hope will have a cascade effect.

[130] **David Rees:** Are you aware whether there is a shift across health boards?

[131] **Ms Basu:** This is a new area of work and it is extending.

[132] **Ms Williams:** Nutrition Skills for Life is consistent across all health boards.

[133] **David Rees:** What about yours?

[134] **Ms Basu:** The area around maternal health has emerged because we are much more attuned now to understanding the term 'obesity'. At the outset, we are very keen on working with the early years. It is well established, and we know from the child measurement programme that we have an issue with obesity in four and five-year-olds and, therefore, that the early years are critical. It is about taking that right to the beginning with preconception and pregnancy. This is early developmental work that we are now beginning to share. In south Wales, they are looking at other programmes, such as Foodwise for Life in pregnancy. We are looking at different approaches and at what works, trying to build knowledge of nutrition in the workforce.

[135] **Keith Davies:** Rwy'n credu eich bod wedi esbonio sut yr ydych yn defnyddio'r rhaglen mesur plant i edrych ar y gweithgareddau atal sydd ar gael, oherwydd rydych yn gweithio gyda phobl ac mae gennych y ffigurau. Fod bynnag, pam mae'r ffigurau am blant o bedwar i bump oed yng Nghymru lawer yn waeth na'r rheini ar gyfer unrhyw ardal yn Lloegr. Beth yw'r rheswm dros hynny?

Keith Davies: I think that you have explained how you used the child measurement programme to look at prevention actions that are available, because you work with people and you have the figures. However, why are the figures for children aged four and five in Wales much worse than those for any area in England? What are the reasons for that?

[136] **Ms Basu:** We have to be a little bit cautious in that this is Wales's first year of reporting—it is in a transitional phase and it is the first report that we have had on child measurement across Wales. England has been doing it for years, so there is an argument that they might perhaps have a bit of a head start. I think that they started back in 2006, so it is likely that they will have put some interventions in place because they have had the data a little bit earlier. There is perhaps an argument there.

[137] **Ms Williams:** We have seen that social gradient where we know that levels of obesity, in particular, are higher in areas of social deprivation. We know that, in Wales, there are areas of deprivation and some of the results from the child measurement programme show that obesity levels are high in some of those areas. That is where we could perhaps use the data from the child measurement programme to focus our programmes and projects, and hopefully aim to embed some of the work that we are doing through Nutrition Skills for Life with some of those key players, partners and third sector organisations that are working with those communities to embed some of the work around early years and schools within their work.

[138] **Keith Davies:** O'ch ateb chi, rydych yn dweud bod pethau'n gallu gweithio mas yn dda, felly a ydych chi'n credu y dylem gael mesur i blant naw a 10 oed hefyd?

Keith Davies: From your response, you say that things can work out well. Therefore, do you think that we should also have a measure for nine to 10-year-olds?

[139] **Ms Basu:** I think that we should have another cohort in addition to the reception age. That is quite important because it will help to track any interventions relevant to the school-age period. Obviously, at reception, we have an understanding of what happens before school entry. It is about what year group would be most appropriate. England has gone with year 6 and has been doing that in addition to reception for some time, so there is an option to look at that and compare directly with England. I believe that the European picture would be more on year 4, and while there are arguments for looking at that, my professional view is that we need two cohorts. That would add much value to the data and help us to track the interventions and the pattern of what is happening over time.

11:15

[140] **Ms Williams:** Perhaps it is about directing the services according to some of those outcomes as well. However, as Andrea said, it is about being able to track the current cohort as well, to see whether we are making a difference or what the issues might be.

[141] **Ann Jones:** Shall we move on to Change4Life, Rebecca?

[142] **Rebecca Evans:** Yes. You have referred to Change4Life already, but what is your assessment of it on the ground and within your health board areas? Do you see it making a difference? We have heard that there has not been a formal evaluation of it in Wales, so it would be very useful to have your assessment of it.

[143] **Ms Williams:** We build Change4Life messages into all of our work within Nutrition Skills for Life, so all of the staff who we train are aware of how to sign up to the campaign and how they can access resources, so that they can cascade them and use them with the communities that they work with. We have also used some of the brand assets to make sure that some of our learning and teaching resources are also consistent and are seen to be promoting, through the use of that brand, the Change4Life campaign. So, as Andrea mentioned, Foodwise for Life, which is our community weight management programme for adults, is designed in the same way, using the brand assets from Change4Life to market and promote it.

[144] **Ms Basu:** I would echo that. Change4Life is absolutely a critical component. It is a key socio-marketing approach, so it is very much part of a range of interventions. It is having an impact in terms of people on the ground at community level recognising the messages, which are very acceptable. People engage with the messages and find them very non-judgmental. It is a credit to the people who devised the socio-marketing approach programme; a lot of consultation was done to ensure that the messages were acceptable. As dieticians, as Lisa said, we embed them in a lot of our programmes.

[145] The sister brand of Change4Life, Start4Life, focuses very much on the early years. It produces a lot of literature that, for example, our health visitors and people who work with early years use to promote breastfeeding and appropriate weaning practices. Professionally, it would be very valuable to see—in England, for example, there is a range of materials that are not yet available in Wales, which focus on pregnancy and pre-conception messages. It would be fantastic to see those available bilingually in Wales to support women who are planning a pregnancy, women of child-bearing age, and those working with those women at a community level.

[146] **Rebecca Evans:** Lisa, in your evidence, you referred to the DEFRA family food survey, which found evidence that the affordability of a nutritious diet has worsened between 2007 and 2011. Do you feel that the Change4Life materials are appropriate? Do they reflect the challenging financial situations in which many families find themselves?

[147] **Ms Williams:** Absolutely. It is important that those messages are, for example, about practical cooking skills—being able to confidently prepare healthy, economical, simple meals for the family. We know that cooking skills are an issue; we know that that is a gap and we want to be able to encourage people. So, there is a raft of materials, including practical things that people can use. It complements what we deliver through Nutrition Skills for Life, because a lot of our work is about training up, for example, Communities First staff, or Flying Start family health workers to deliver these messages to the people who they see daily. It complements, quite well, what we are doing, which definitely focuses on being able to make affordable nourishing meals.

[148] **Keith Davies:** I ddilyn hynny, yr wythnos hon rwyf wedi bod unwaith, ac fe fyddaf yn mynd eto ar ddiwedd yr wythnos, i un o'r *food banks* hyn. A yw'r bwyd mae pobl yn ei gael o *food banks* yn mynd i helpu, ac a yw'r bwyd yn ddigon da o'i gymharu â'r bwyd y mae pobl yn ei brynu?

Keith Davies: Following on from that, this week I have been once, and I will be going again at the end of the week, to one of these food banks. Is the food that people get from food banks going to help with this, and is the food good enough compared to the food that people buy?

[149] **Ms Basu:** Certainly, my knowledge with respect to food banks is that the use of them is increasing and that that is causing us some concern, in terms of the nature and reasons for that. However, it is important that we understand that food banks are very much used at a crisis point for families that are experiencing a specific crisis. This scheme is currently set up to provide food, but not necessarily to provide food on a longer-term basis. So, the food that they provide is limited. It cannot be fresh; it has to be packaged so that it has a longer shelf life. Therefore, it is not always of a perfect nutritional balance, and that is why I think that it is more for use at the crisis point.

[150] **Ms Williams:** Absolutely, and we have worked with food banks locally. From my experience, it is about recommending to people, when they are looking at their shopping lists, the options that might be lower in salt or sugar. I think that they do provide things that are aimed specifically at age groups. There might be a family with young children, so some of the foods that they need will need to be appropriate for that age range. It is also important that we support people who are using the food banks on a more long-term basis, so that they are able to access other community food initiatives, such as the food co-operatives—the fruit and vegetable co-operatives. There are now around 350 across Wales that sell bags of fruit and vegetables very affordably at around £3 or £3.50. So, it is a matter of linking people into other initiatives that they may be able to use more on a long-term basis. We are also able to link in Healthy Start, because eligible families that are on benefits can get a voucher for £3.10 a week, which can be used in the food co-operatives. They can redeem those vouchers there. It is a matter of making sure that that infrastructure is there, within communities, so that we are joining up all of these initiatives and helping to support people who are at crisis point.

[151] **Ms Basu:** Also, linked with that, as part of the suite of work that we do with Nutrition Skills for Life, we develop some very good programmes, which we are beginning to work with Communities First and Flying Start to take forward. These are practical cooking programmes for families that just need that additional support in preparing healthy meals. In north Wales we have Dechrau Coginio—Come and Cook—and we also have Get Cooking in the south part of Wales. The early feedback from those is very positive in terms of the parental input and engagement that we are getting.

[152] **Ann Jones:** Suzy has a point on this, and then I will come back to Rebecca, because I know that she has not finished her question.

[153] **Suzy Davies:** I will take a very short answer on this question. The school curriculum

is up for review fairly shortly. Certainly, my personal experience of cookery on the secondary school curriculum meant opening a jar of tomato sauce and putting it on a ready-made pizza base. Are you going to be putting any kind of consultation response into the curriculum review on that particular point?

[154] **Ms Williams:** On an all-Wales basis we have a really strong network of public health dieticians in Wales, and we do respond regularly to consultations. I think that that consultation is one on which we would want to have an input.

[155] **Suzy Davies:** Those lessons need to be valuable, because, of course, they bleed out as people get older.

[156] **Ms Williams:** We have quite a bit to contribute in terms of what we are doing with schools. Not, perhaps, in all health board areas, but through Nutrition Skills for Life, some areas have prioritised work with schools and have looked at developing learning and teaching resources that can be used by staff across relevant areas of the curriculum that support or promote those key nutrition messages to young people. We use things like Moodles so that they can access those resources around the eatwell plate to make sure that children have a healthy diet. It is a matter of supporting Appetite for Life, really, but Appetite for Life is around food provision in schools, which needs to be supported by a whole-school approach, including food and health on the curriculum.

[157] **Suzy Davies:** So, it is skills development. Thank you.

[158] **Ann Jones:** We come back to you, Rebecca.

[159] **Rebecca Evans:** In respect of the Archbishop of York's recent research on poverty, I suppose that many people found it surprising that he identified rural food poverty as a particular issue. The reasoning behind that was that some people cannot afford the transport to go to buy fresh food regularly and so on. Some people could not even afford to get to a food bank. Is this something that you recognise, particularly perhaps from the north Wales experience, given that you cover large rural areas?

[160] **Mr Basu:** Yes, there are elements of that in terms of accessibility to healthy foods. What is available can vary significantly between rural communities. Where we have seen the set up of things like a community fruit and vegetable co-operative, that has been supported, whether it is in a central community venue—a school, a GP setting or whatever. I think that that has dramatically helped to improve access. I am thinking of the work that we have done with Age UK and our partners in north Wales with assisted shopping schemes and assisting older people to shop on the internet for food, if accessibility is an issue. We try to utilise those sorts of opportunities, notwithstanding obviously that we need to ensure that social opportunities are there also, because when you use the internet, you do lose that social interface. So, I think that it is something that we are aware of, and it absolutely is an issue, but I am not quite sure what else I can add at this stage.

[161] **Ms Williams:** It is an important issue that we need to be aware of it, really, and perhaps try to target interventions where there are recognised needs in those communities. I think that the work that we can do through the Communities First teams, or other partner organisations based within those communities, can perhaps help.

[162] **Ann Jones:** We have talked about Appetite for Life, and we are going to come on to that because, Aled, you have got some questions around that.

[163] **Aled Roberts:** Rydych chi wedi sôn am raglen Blas am Oes; beth yw eich profiad

Aled Roberts: You mentioned the Appetite for Life programme; what is your experience

chi o ran y cysondeb ar draws eich byrddau iechyd chi o ran y ffordd y mae'r gwahanol gynghorau yn ymwneud â'r rhaglen?

in terms of the consistency across your health boards in terms of the way that different councils relate to the programme?

[164] **Ms Williams:** Within Cardiff and the Vale, I think that we have always prioritised work with the Appetite for Life co-ordinators within the local authorities, and that has been a big part of our Nutrition Skills for Life programme. So, we have had quite good close partnership working there, and now, with the school meals Measure, we know that nutrition standards have to be met—that is now compulsory. Around Appetite for Life, the things that we think are key, which have been mentioned, are around the whole-school approach, so that where schools are taking that approach, through the healthy schools co-ordinator and healthy schools teams, they have nutrition embedded within the curriculum, they have school nutrition action groups, and that they have a commitment from the senior leadership team and school governors to make sure that food is part of the curriculum and a big part of the school. That is where we can see some successes, really. We are aware that, through Appetite for Life and school meals regulations, nutrition—or food and drink provision—will be part of the school inspection process. I think that there is an opportunity for dieticians to be involved, because school inspectors may not have nutrition training. If nutrition training and support, or dieticians, can be involved in that process, it would be a really positive move.

[165] **Ms Basu:** In my experience, particularly in the north east, which is my patch, if you like, we have historically had very good partnership working between schools in the healthy schools network, school caterers, dietetic school nurses, et cetera—particularly in the early days of Appetite for Life. There have been some additional benefits, particularly supporting the whole-school approach, through our food ambassadors programme and peer education approaches, so that we are cascading messages through young people themselves, and they are having an input, which has been quite successful. Also, this links with the work that we have been doing very successfully in Wrexham local authority in respect of planning the exclusion zone for fast-food takeaways within close proximity to schools. We are very proud of that in Wrexham, and that is a direct result of the leadership that we have from local authorities, the third sector in particular, and partner organisations, including the health board. That work is very well respected, particularly by the secondary school communities and by headteachers, who value that approach also. So, I think that we have had some real successes in terms of a more holistic approach to Appetite for Life, notwithstanding the monitoring of school food provision and the appropriate process to ensure that menus are meeting the requirements of children.

[166] **Aled Roberts:** A gaf i ofyn hyn: beth yw eich barn broffesiynol ynglŷn ag anghysondeb ynglŷn â'r ffordd y mae'r rhaglen yn cael ei hystyried o sir i sir? Mewn rhai siroedd nid oes dewis i blant mewn ysgolion cynradd o ran y pryd maent yn ei gael amser cinio, tra bod cynghorau eraill yn rhoi'r dewis hwnnw. A ydych chi'n gwneud unrhyw fath o astudiaeth o'r ffigyrau ynglŷn â'r plant sydd, oherwydd hynny, yn penderfynu nad ydynt eisiau prydau ysgol? A yw'r canran o'r rheini sy'n cael prydau ysgol yn gostwng oherwydd hynny, ac a yw'r plant hynny yn mynd ymlaen i fwyta prydau nad ydynt mor llesol iddynt—brechdanau, creision a bar siocled—ac felly a yw'r rhaglen yn gwneud y gwrthwyneb i'w amcanion yn y lle cyntaf?

Aled Roberts: May I ask you this: what is your professional view on the inconsistency in the way that the programme is considered from county to county? In some counties there is no choice for primary school children in relation to the meal that they have at lunch times, while other counties provide a choice. Have you undertaken any study of the figures in relation to the children who then decide that they do not want school dinners? Does the percentage in terms of those receiving school meals reduce because of that, and do those children go on to eat meals that are not so beneficial to them—sandwiches, crisps and perhaps a chocolate bar—and therefore is the programme doing the opposite to what its objectives were in the first place?

11:30

[167] **Ms Basu:** In complete honesty, I cannot comment on the last six to 12 months, but I have been involved with Appetite for Life locally from its inception. Over that time, certainly within the areas that I have been supporting, there has been a steady increase in the uptake of school meals. I am not aware that any of our menus have been so restrictive—

[168] **Aled Roberts:** Yn y gogledd-ddwyrain—rwy'n dod o ardal Wrecsam—mae'r dewis ar gael, ond mae yna siroedd yn y de lle nid oes dewis rŵan a lle mae'r ffigurau, o achos hynny, wedi gostwng. Rwy'n synnu bod dadansoddiad gwahanol yn cael ei wneud o sir i sir os yw'r sir yn gweld y canlyniad i rai o'i pholisïau.

Aled Roberts: In the north-east—I come from the Wrexham area—the choice is available, but there are counties in the south where there is no choice now and where the figures, as a result of that, have come down. I am surprised that a different analysis is being made from county to county if the county sees the result of some of its policies.

[169] **Ms Basu:** I know from my catering colleagues that they meet up on an all-Wales level to share information, but I cannot comment so much on what is happening in the south. I do not know whether Lisa can.

[170] **Ms Williams:** I think that if there is an issue, there needs to be that constant evaluation now and, through the school meals Measure, we know that there are regulations and that the meals have to meet strict nutrition guidelines. If there are issues around choice and uptake possibly reducing, we may need to look at that, but I am not aware of the actual levels locally. We can find out.

[171] **Aled Roberts:** May I ask one final question? We have had a couple of instances recently where individual Assembly Members have raised concern that the nutritional content of the meal is determined so that a child who is four years of age is getting the same meal as a child who is 11 years of age and claiming, in effect, that the 11-year-old child is still hungry. Is it acceptable that there is that sort of strict application of rules, in your professional opinion, or should there be a bit more flexibility with regard to the interpretation?

[172] **Ms Williams:** The nutritional requirements are going to differ as will the requirements based on the levels of activity of the children: some can be very active and burn off a lot of calories. I think that there are differences and there are choices in terms of the fruit options and the bread options that are available during that lunch-time period. There are also things like the school breakfast schemes that are available in the mornings, so that children do not have to go right through from the night before to lunch time, and those who may have missed breakfast are able to have something in school. However, there are differences, and it is definitely my professional opinion that there needs to be some flexibility there to meet those needs.

[173] **Ms Basu:** Where we have been fortunate, in terms of being able to provide dietetic input in support and training for our catering colleagues, we can look at the portion sizes that are being served up based on the child that is in front of you. A four-year-old versus an 11-year-old will have very different energy and nutritional requirements, and while the menu may be the same, as it is a primary school, the portion of a certain food group that you might serve will be different. So, again, guidance for caterers on that in terms of the actual serving size is probably quite key in that aspect, and is appropriate to—

[174] **Aled Roberts:** Is there much work done on diagnosing what is happening on the ground rather than what is in a strategy document?

[175] **Ms Basu:** There has been an awful lot of work done on ensuring that menus meet nutritional standards and that food-based standards are met, particularly in preparation for the new legislation, and that is something that I am aware that schools and governors et cetera have been working very hard to achieve. As with all things, perhaps when areas arise that need a little fine-tuning, or when problems crop up, for example, around portion sizes, that heightens the tension and perhaps that is an area of work that needs to be explored in a little more detail. We have national guidelines from the UK, Caroline Walker Trust guidelines, which help to guide as to what portion sizes should look like for children of different ages. So, perhaps there is scope there to develop that a little further.

[176] **Aled Roberts:** Given that it is the lunch time meal, are assumptions made with regard to what that child is receiving nutritionally at home over which the state has no control? So, a child who is hungry on reaching school, and perhaps has not had breakfast, can have very different nutritional needs to a child who has had a full—

[177] **Ms Williams:** I think that that is why it is an important imperative that the food that is provided in the lunch time period is of high nutritional quality, and it is essential that it meets those nutrition regulations. It is providing quite a considerable amount of that child's energy and nutritional intake during the day.

[178] **Ms Basu:** It has to be acceptable to children as well, because we can provide them with this nutritionally balanced meal, but they have to want to eat it. To be fair, that is where a lot of work has been undertaken with Appetite for Life, consulting with young people and children about the meals that are on the menu. So, it is about getting that balance between meeting nutritional standards and what children would like to eat and we can encourage them to eat.

[179] **Ms Williams:** That work still needs to be a priority going forward in terms of evaluating the school meal Measure, its impact and whether we are involving children in those future developments and those decisions that are being made in schools.

[180] **Ann Jones:** Thank you very much. Moving on, Keith and Bethan have some points on 'Creating an Active Wales'.

[181] **Keith Davies:** Fe wnaf i ofyn fy nghwestiwn yn Gymraeg eto. Mae'r cynllun gweithredu 'Creu Cymru Egnïol' yn rhoi ffigurau am faint o weithgaredd mae plant yn ei wneud yn ystod yr wythnos, ac mae'n dweud mai dim ond 44% o'r plant sydd rhwng saith ac 11 oed a 35% o'r plant sydd rhwng 11 a 16 sy'n gwneud rhywbeth egnïol am awr yr wythnos. Mae'r Llywodraeth yn dweud, cyn belled ag y mae ymarfer corff yng nghwricwlwm yr ysgol yn cael ei weithredu, mae'n gobeithio y byddai plant yn cael dwy awr o ymarfer corff. Nid yw hynny'n digwydd chwaith. Mae eich dau fwrdd—Betsi Cadwaladr a Chaerdydd a'r Fro—yn dweud bod eisiau camau gweithredu lleol neu genedlaethol er mwyn gwella'r sefyllfa. Beth yw'r camau yr ydych chi'n credu dylai ddigwydd?

Keith Davies: I will ask my question in Welsh again. The 'Creating an Active Wales' action plan gives figures for how much activity children undertake during the week, and it says that only 44% of children aged between seven and 11 and 35% of children aged between 11 and 16 do a physical activity for an hour a week. The Government says, as long as physical education in the school curriculum is implemented, it hopes that children will have two hours of physical education. That is not happening either. Your two health boards—Betsi Cadwaladr and Cardiff and Vale—say that local or national action needs to be undertaken to improve the situation. What steps do you think should be taken?

[182] **Ms Basu:** As dieticians, we are probably not the most appropriate professionals to

answer questions around physical activity. That said, we invest very much in the link between physical activity and nutrition in terms of preventing people from being overweight or obese, and particularly children. The thing that I would add here is that clearly there is pressure on the school day. As dieticians, we have been very concerned over the years about the shortening of the school lunch hour, and we feel that that has ramifications in terms of the type of food that can be put on and the number of children that you can get through. So, that, coupled with the pressure of injecting further physical activity time into the school day, is difficult. That said, many schools engage in extra-curricular activities to support children and the breadth of what is on offer now is quite extensive. So, we need to consider beyond the traditional hour of PE those extra-curricular activities that are available.

[183] All of the additional work and activities around the periphery on active travel to and from school and outside of school need to be factored in to ensure that our children are being as active as possible. Of course, we also need to try to reduce sedentary behaviour. So, on the one hand it is about actively increasing physical movement, but on the other reducing sedentary behaviour, that is, the time spent being sat down, and the link between that and obesity. Interestingly, we know that there is also a link between insufficient sleep and obesity. We are looking at things such as television viewing late into the evening, et cetera.

[184] **Ms Williams:** In terms of some of the work that we have been involved in as a provider of the obesity management programme for children, MEND, we work in partnership with people such as the 5x60 officers who can also deliver or are providers of the programme. Their role within schools is often very sport focused and not every child is going to be very sporty. So, perhaps the focus should be around just doing more physical activity, running around and walking back and forth to school, and those very practical things that people can do.

[185] **Ann Jones:** Bethan, do you have a point on this?

[186] **Bethan Jenkins:** Going back to the beginning, you mentioned about the third element in terms of psychological support earlier. I took that to mean that that would be the intervention for people who are already obese, and that type of psychological support. However, is there any support that you would work with as dieticians and psychologists on a more general basis, especially in relation to young girls not getting involved in physical activity because of the fact that they may be concerned about their confidence and self-esteem in that respect? How would that fit in with your role as nutritionists, at both ends of the scale, really, with people perhaps overeating or, as Aled mentioned earlier, perhaps with healthy eating pushing people to the other extreme and them taking the messages very literally and then developing an eating disorder as a result? I just wondered whether you could answer. If you cannot, do not worry.

[187] **Ms Williams:** We were talking about the level 3 input in terms of the multidisciplinary team and ensuring that input for people to be able to make the lifestyle behaviour change that we would perhaps be involved in recommending, because they may have quite complex underlying issues that need to be tackled first. That is where we know the input of our colleagues in the multidisciplinary team would be essential. I do not know if there is anything else.

[188] **Ms Basu:** Just to add to that, as dieticians, through the nutrition training that we provide, and any direct work that we do with young people and children, we are always very conscious of not bringing ‘weight’ into the equation; we focus very much on eating well and being active and on how that helps to improve your wellbeing. We look at the factors that affect the body besides weight. So, we are not drawing any negative attention to it. I think that that has been an underlying ethos in the work that we do, but we are highly attuned to recognising issues, because it is obviously a massive spectrum for eating disorders. We see a

range of binge-eating disorders for children who are perhaps slightly overweight but have complex eating issues. We would try to ensure that they are picked up if they are identified and are referred through to the appropriate mechanism. So, we are very aware of it. However, in terms of the general work that we do, we are very cautious about how we approach the discussion about weight.

[189] **Ann Jones:** You have mentioned MEND, and Suzy has a couple of questions on that programme.

[190] **Suzy Davies:** I think that it was you, Lisa, who mentioned something earlier about embedding messages about good nutrition, certainly at level 1 and just generally in society as best we can, but, obviously, there are some children that those messages will miss, or they do not chime with them, and they may end up needing the next level of intervention, which is MEND. I think that we have established through other people's written evidence that that programme reaches only a very small number of people, and of course, it is delivered in partnership. Can you explain to us a little bit about how the partnership may work in your area? I cannot call it a 'balance of power', exactly, between the different partners, but who tends to lead on it and, therefore, has a more directional approach over the other partners?

[191] **Ms Williams:** MEND is the current childhood weight management intervention at level 2 of the pathway. It won the contract to deliver on that service specification. We are a provider in that programme and, where it works, it works really well, and we know of many children and families who have really benefited from it. In the partnerships, dietetics has been a provider, we have an assistant on the programme, and then there is a physical activity lead as well. Crucially, however, it needs a programme manager, and I think that some of the issues have perhaps been around where the programme manager sits and about the specific funding for that person, because, very often, they are doing it as part of their current job. They do not have any dedicated, specific funding for that role like some of the other programmes might have, such as the national exercise and referral scheme for adults and other programmes that we are aware of.

[192] So, there have been issues and difficulties, and I think that those issues would be there whatever the programme was that was providing that service specification. I think that it is something for which, in going forward, there needs to be that very clear remit as to whose role it is. That programme manager role is key for co-ordinating the programme's recruitment and making sure that the staff are all in place. It runs for two hours, twice a week; it is an intensive programme with a very clear evidence base that it works; and, it runs for 10 weeks. There is a lot to organise in terms of its delivery. However, as I say, when it runs, it runs really well, and we have seen some very positive outcomes.

[193] **Suzy Davies:** Right. So, you say that it is a very specific programme that runs for 10 weeks, because I picked up the impression that it was very focused on the individual child and their family. So, this now sounds a little bit like a programme that is done to children rather than designed around them. Is that an unfair observation?

11:45

[194] **Ms Williams:** It is an evidence-based programme, and it is a family-focused, community-based group intervention. So, families and children will come together; children will attend part of it and the adults attend another part separately. This is done in order to send those key messages that perhaps are not appropriate for children that need to be tackled with parents only. The children will go off and do physical activity for the hour that forms the second part of the session. It is a very participatory, children-focused programme.

[195] **Suzy Davies:** I would like to refer you to the evidence that you have given us about

MEND in particular. You said that greater flexibility on what could be run, as opposed to delivering MEND or doing nothing would allow other areas to contribute to this agenda. Are you saying that it is an all or nothing situation in your part of Wales?

[196] **Ms Williams:** Is that within the Betsi Cadwaladr response?

[197] **Suzy Davies:** Yes.

[198] **Ms Basu:** I will answer that. I agree with everything that Lisa has said. The challenges are that any targeted intervention, whether adult or child focused, on weight management has inherent issues in relation to recruitment and retention. That is embedded in the literature. So, we know that there is always an issue when you look at a targeted intervention. This is for a range of reasons, notwithstanding recruitment, parents recognising that their child is overweight or obese and so on. It is multi-factorial. In north Wales, in Wrexham, we had a programme that was managed by leisure, and we had some very good outcomes from the programme. One of the challenges that has unfortunately led to it not continuing at this time is partly the way in which the money is allocated. It is very much given, at the moment, on a retrospective basis, so you have to ensure that you have your families recruited and you have to retain a certain number to gain the funding. Obviously, if you do not manage to recruit and retain a number of people in the programme, then you have invested a lot of staff time and effort, but you perhaps will not get the funding to support that element. So, that is a risk, particularly for some of our services that are economically a little bit vulnerable at the present time. We have to acknowledge that.

[199] I would also go back to the point that Lisa made about it not necessarily having a dedicated workforce, as we have for the exercise on referral and all of the other programmes. That has possibly been one of the biggest challenges with regard to making it happen. I do not think that it is inherent to what the programme offers, as that is sound. It is evidence-based and it is participatory, as Lisa has said. Some of those challenges need to be unpicked.

[200] **Suzy Davies:** I shall finish with this question on funding, then. You said that the programmes are funded retrospectively, effectively, just to simplify it; do you think that that might be because there is pressure on all public services to show that whatever they do now produces results and good outcomes and that programmes should not be front-loaded with money so that they then spend it and achieve very little? I do not know whether you heard my question to the previous witnesses, but there might be a concern that, if money was given upfront for a particular programme, it might just disappear into general spending rather than being used for the work that it was intended for. Is that something that you recognise as an idea?

[201] **Ms Basu:** Yes. What I would say is that we absolutely need a service at level 2, without question. If it is a national programme, it reduces the effort and duplication for each local area to come up with a programme that meets the same evidence-based guidance. So, I firmly believe that we have an evidence-based programme and there needs to be acknowledgment of the challenges. With respect to funding, there has to be some protection of that funding for the purpose for which it is dedicated in order to ensure that it is used for that purpose. I am all for ensuring that we provide the results and the evidence, but there needs to be acknowledgment that, with the best will in the world, we have attrition rate issues with this type of programme.

[202] That does not take away from the benefit for some families. Over time, where MEND has been active in other parts of the UK for longer, through word of mouth, people hear about the families that have benefited and think that it sounds like a good programme to which they could take their child. It needs momentum and time to build to improve and enhance its acceptability at a community level. However, we need to have the funding there to support

staff and to ensure that services feel that they can deliver and not feel that they will not be paid for the time that has been inputted. It needs to follow in due course, because it is the nature of the problem that we are facing with engagement in weight-management programmes.

[203] **Ms Williams:** I think that it is that long-term funding commitment as well, because we know that we would now be planning programmes for after March next year, but at the moment we only know that MEND is available to families until the end of March. We do not know what is happening after that, so it is quite difficult to plan programmes.

[204] **Aled Roberts:** We have stacks of evidence—as you can see—but the only evidence that I can see that is comparative, showing the picture on an all-Wales level, are the figures for adult obesity given by the BMA. I wonder whether you have information available by health board, compiled nationally, on the numbers on these programmes. It is not just a case of the resource, but rather of what is being done with the resource. Past experience suggests that the variation between different health board areas can be quite marked in Wales.

[205] **Ms Basu:** With respect to the current programme, MEND, information on programmes run within each health board area would be available. That would be accessible through the appropriate channels. At the moment, it is Public Health Wales that oversees that programme. The only point that I would make is to draw your attention the fact that it is not a population-based programme, so the numbers are not huge. It is a targeted intervention for families that have specific needs. Sometimes, looking at the reach factor for a programme such as this does not give you the whole picture. That is why we need the population-based-settings approaches, but we also need the targeted approaches. I think that it is useful to see the spread and to ensure that it is available in all areas across Wales, and that we have an equitable service. However, I think that caution is needed when looking at sheer numbers; for this type of programme, it is probably not always a useful indicator.

[206] **Aled Roberts:** It is useful if we see that a certain amount of money is being given to health boards and that very different things are provided. You made the point about Betsi Cadwaladr not meeting NICE guidance.

[207] **Ms Basu:** I think that that could be across Wales, to be fair.

[208] **Aled Roberts:** I am not being critical, but it is interesting for us to see what decisions are being taken at a local level.

[209] **Ms Williams:** I think that through the annual reports to Welsh Government on the levels of the all Wales obesity pathway, that information is being fed back. As Andrea said, on things like MEND, the evaluation and the numbers that are required in terms of how that money is being spent should be part of that service specification, so that it is clear that that needs to be incorporated and fed back. As Andrea has mentioned, with MEND, a considerable amount of data have been collected over the last two and a half years while it has been running.

[210] **Ann Jones:** Shall we move on to future developments? Bethan, you have some questions.

[211] **Bethan Jenkins:** You referred to the 400m planning development issue in Wrexham. Looking at the broader scheme of things, and how we can change what society does in general, either through the planning process, as with Wrexham's strategy, or how Public Health Wales is developing health impact assessments with certain housing developments, how could we target this issue on a wider strategic level, as opposed to targeted interventions, that could help society as a whole?

[212] **Ms Williams:** I think that the health impact assessment is really important and it is incorporating that, particularly with planning departments, if there are issues that may impact upon people's health in terms of childhood obesity. There is a place for that in terms of health for all. I am not sure that it is something that we have a great deal of experience of implementing.

[213] **Ms Basu:** From my experience, I would say that it is a very useful methodology, if it is used in the appropriate way and to best effect, that the results are then heard and observed, and that it is not just done as an exercise. It has its place, particularly where there could be an impact in a particular community of perhaps affecting a green space or allowing the building of a new food outlet. I do think that those are times when we could try to encourage and support our planning colleagues in local authorities to use that methodology and involve the relevant parties. I think that the critical element with health impact assessments is ensuring that you have all the right people involved, so that you have to have full engagement from the various people who would be affected by the impact of what is being proposed.

[214] **Bethan Jenkins:** We heard earlier that there is a higher proportion of people who are in poverty or from lower-income families who have issues with nutrition. As dieticians, have you worked with other partners in looking at certain developments, like fast food outlets or large-scale multinational ones that are cropping up in out-of-town developments, to see where they are being developed and the areas where they are in relation to other strategies that the council or the Government may be putting in place? It may undermine what is already happening locally if you place a large proportion of these outlets in a given area. I cannot see a clear connection between how you can help people get out of a situation where they are overeating or eating the wrong things, and developing these outlets in areas of high deprivation. That is the most unhelpful thing ever to put in those areas.

[215] **Ms Williams:** It is a challenge. As Andrea mentioned, if there are positive examples of planning departments having managed to prevent new fast food outlets from opening within a 400m radius of schools, we could use those as an example of good practice for other areas to do some other things in other communities.

[216] **Ms Basu:** It is also about how we withstand challenges to that.

[217] **Bethan Jenkins:** It is worrying that you do not seem to know. You would have thought that dieticians would be consulted on these types of things, or would they look to consult with other dieticians in other places when they are making these decisions within planning departments?

[218] **Ms Basu:** The example in Wrexham is good. We have a partnership group, healthy eating and being more active, which is chaired by a colleague in the third sector and involves representation from the health board and various departments in the local authority. That example is a beacon that other areas are now looking at to build on in their areas. On a positive front, we are engaged. There are other examples that we could bring if we had a bit longer to consult with colleagues across Wales. There are other examples, but that is a key one, because it has been publicised quite heavily.

[219] **Ann Jones:** Everybody is quiet because we are getting to that time. I can see people gathering outside. I thank you both for that evidence; some very good points came out of that. We will send you a transcript to check for accuracy. Were there a few things that you were going to provide? No, it was not you that was going to provide further evidence.

[220] **Bethan Jenkins:** It was the previous witnesses.

[221] **Ann Jones:** Okay, I just had a five-minute senior moment there. Thank you for coming today. You are more than welcome to join the carol service, which is about to start upstairs.

11:58

Papurau i'w Nodi
Papers to Note

[222] **Ann Jones:** There is a paper on additional information from Estyn on our inquiry into educational outcomes for children from low-income households, and there is also a letter from the Minister for Health and Social Services on the budget.

11:58

Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o'r Cyfarfod ar gyfer y Canlynol
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Meeting for the Following Business

[223] **Ann Jones:** I move that

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order No. 17.42.

[224] I see that the committee is in agreement.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 11:58.
The public part of the meeting ended at 11:58.