Scottish Government Consultation – 'A Healthier Future'
Action and Ambitions on Diet, Activity and Healthy Weight

Response from Chest Heart & Stroke Scotland.

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

The Scottish Government's proposal to use legislation in order to restrict price promotions is very welcome, however a more proportionate response to tackling the obesogenic crisis would be to extend this to all types of price promotion to reduce retailers' options for encouraging upselling. These should include temporary price reductions and 'extra-free' where the size of the product is temporarily increased. YouGov's recent survey on behalf of Cancer Research UK shows there is significant public support (62%) for such measures.

Alcohol Focus Scotland have rightly included in their response to this consultation the important learning available to the Scottish Government from the response by retailers to the ban on multi-buy discount promotions in 2011 where they subsequently identified alternative methods of promotion. Any such loop-holes need to be identified and tackled when drafting new legislation in relation to food products. Non-monetary promotions should also be addressed, including the positioning of products within stores near tills to maximise sales.

In order to tackle health inequalities, new restrictions on price promotions should be balanced by making healthier food options more affordable for people on low incomes. We support Voluntary Health Scotland's call for transferring savings and promotions on high in fat, salt and sugar to healthy food items such as fruit and vegetables and alternative foods (highlighted in their formal consultation response).

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

Steps to restrict non-broadcast advertising are welcome but should be more ambitious and extend to restricting the sponsorship of events by retailers and manufacturers of products high in fat, salt and sugar such as McDonalds (London Olympics 2012) and Irn Bru (Glasgow Commonwealth Games 2014). Such sponsorship by tobacco companies has now become unthinkable – given the public health crisis facing Scotland, the same in the future should apply to the food and drink sector. Major events – particularly international sporting events - are an opportunity to communicate messages about healthy living to a wide audience across Scotland; at present the opposite is true.

Question 5
Do you think current labelling arrangements could be strengthened?

We welcome the commitment to explore strengthening the current food labelling arrangements. These should take account of the potentially complex and confusing messages sometimes given by

nutrition labelling, making comparison between products difficult. Scottish Government should take account of health literacy issues when considering how best to communicate about products' nutritional values.

We also support Alcohol Focus Scotland's call for labelling of alcohol so that people are more informed about the calorific value of drinks as well as the alcohol content.

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

Obesity is clearly linked to health inequalities, deprivation, reduced life expectancy, and the resulting increased prevalence of stroke and long-term conditions such as heart and lung disease.
The mortality rate for cerebrovascular disease in the most deprived areas was 39.5% higher than in the least deprived areas in 2016 [Scottish Stroke Statistics, ISD]. Similarly, rates of obesity in areas of deprivation are significantly higher, as the consultation acknowledges.

The Scottish Government's commitment to prioritise work with families in poverty and on low incomes is welcome. Within the range of existing health and wellbeing interventions which people experience there will be a number of opportunities to support healthy weight in these key populations, both directly and indirectly. The Link Workers programme to embed social practitioners in some GP practices in areas of socio-economic deprivation aim to mitigate the social and economic impact of inequalities on health. Within regional Health Board services, Cardiac and Pulmonary Rehabilitation programmes should include weight management, diet and physical activity as core components; however the availability of key allied health professionals such as dieticians can be variable. Access to comprehensive Rehab programmes is critical to people's recovery, wellbeing, self-management, and the secondary prevention of further illness. Ongoing intervention by health professionals in the rehabilitation process is vital in supporting behavioural change.

Our experience is that there is insufficient resourcing of Dietetic services and professionals. Dieticians though will be key to the delivery of a national strategy, and should play an important role in leading the development of effective programmes. We endorse the British Dietetic Association's proposal for a long-term and comprehensive weight management service within health and social care whereby dieticians train and support the wider workforce, communities and volunteers to deliver programmes. Point 2.13 of the consultation refers to developing training and resources for front-line staff, but with no reference to the role of dieticians in this.

In the latest Scottish Social Attitudes Survey a majority (86%) of respondents believed that more free weight management courses should be made available. We would welcome opportunities for greater partnership between the health and social care sector and the third sector within such a service – organisations such as Chest Heart & Stroke Scotland are ideally placed to target high risk populations across communities.

There can be barriers to people attending weight management services, with a low rate of completion (Read. S, Logue J, *Variations in weight management services in Scotland: a national survey of weight management provision*: see https://academic.oup.com/jpubhealth/article/38/3/e325/2239833). These include accessibility issues caused by availability of transport, or suitability of times at which programmes are available. There are similar issues with the delivery of rehabilitation programmes provided to people with long-term health conditions such as COPD, which support people to improve their health and self-manage their conditions. The same learning can be taken from how to reduce barriers to attendance and completion – ideally programmes should be structured around individuals

rather than system-focused [PARCS – Person-centred activities for people with Respiratory, Cardiac and Stroke conditions – www.chss.org.].

Third sector organisations like Chest Heart & Stroke Scotland are key providers of community based support for people living with long-term conditions; we have 160 volunteer-led groups affiliated to us. Support groups such as these have typically removed some of the barriers to participation by catering for the additional support needs for their members, for example with transport assistance, or peer support. People want services to be as local and accessible as possible. By meeting with a group of people with similar health experiences, people feel comfortable in their surroundings, and there are important psychosocial benefits particularly for people who are at greater risk of isolation due to their health.

The strategy should also tackle issues around food affordability, enabling low income families to more easily source and use healthy food options. There is disappointingly little in the draft strategy about the importance of community food initiatives and how these could be further supported in order to expand their reach and impact.

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

The referral route should link across to people with diagnosis of other long-term conditions such as stroke and heart disease who are likely to be at greater risk of obesity and diabetes. Weight management will be a critical part of their effective rehabilitation and the secondary prevention of, for example, further stroke or heart attack.

Physical activity should be a critical part of weight management services, but it will be crucial for the necessary infrastructure to be in place to ensure that non-statutory interventions are accessible. Health professionals need to be able to readily refer and signpost people to opportunities in their local communities through 'social prescribing'. With the demise of the national Active Scotland database the Government needs to ensure that an effective alternative which is fit for purpose is in place.

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

Whilst we recognise the important of systemic change, this should be reinforced through messaging to the wider population about healthy eating and weight loss. We endorse the BDA's call for there to be a national awareness campaign to highlight the positive steps that people could take to improve health, including the impact which obesity has on physical health and mental wellbeing, and the need to address exercise alongside diet. In order to successfully influence behaviours direct messages about health benefits are not necessarily effective; instead healthy eating, physical activity and other behavioural changes need to be 'sold' through highlighting the benefits to overall quality of life and wellbeing.

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

Obesity is best tackled by a combination of both diet and exercise, and Chest Heart & Stroke Scotland welcomes the whole system approach to encouraging physical activity through influencing the wider environment and behavioural change such as active travel and influencing the planning system. However given that inactivity is more prevalent than smoking, and the proven harm to

physical and mental wellbeing caused by sedentary behaviour (with some research concluding that inactivity has a far higher mortality rate than obesity, see *Ekelund, U et al. Activity and all-cause mortality across levels of overall and abdominal adiposity in European men and women: the European Prospective Investigation into Cancer and Nutrition Study (EPIC). American Journal of Clinical Nutrition; 14 Jan 2015*), we are disappointed that the strategy has little to say on physical activity. An opportunity has been missed whereby the complex issues which contribute to poor health continue to be treated in silos rather than bringing them together into an effective whole, particularly when work is underway simultaneously by the Scottish Government to review the Active Scotland Delivery Plan.

Around one in ten of Scotland's population is living with lung disease, heart disease, or has had a stroke. Whilst the mortality rates from cardiac disease and stroke continue to decline, the numbers of people living with the long-term effects are increasing, due to our ageing population and the improvements being made to medical treatment. The benefits of physical activity to this population aid secondary prevention, support physical and mental recovery, health and wellbeing, and improve cognitive function. Physical activity helps enable people to better self-manage their conditions, and can reduce hospital admissions and GP visits, proving to be cost-effective. The benefits of physical activity can be gained from all forms of movement, whether walking, house-work, gardening, as well as high intensity activity in sports such as cycling, football or running.

However for people living with long-term conditions such as lung or heart disease, or having had a stroke, the challenges they face in being physically active are significant. Self-reported levels of physical activity in the Scottish Household Survey (2016) among people with a condition causing long-term major reduced daily capacity were less likely to be physically active (39% compared to 87% with no condition). Indeed, health has the biggest impact on participation, greater than age or demographic. People may be living with physical disabilities which limit their day to day activities, or coping with fatigue and fluctuating conditions, and often there will be an impact on their mental health too leading to low confidence and self-esteem. Some disabilities can be hidden, particularly after stroke where communication and cognitive difficulties are common, affecting around one-third of stroke survivors.

NHS Health Boards should provide Rehabilitation programmes for people with heart and lung disease, or after a stroke (as recommended by clinical guidelines). These incorporate exercise, advice and information to help people be better able to self-manage their conditions, including dietary changes. However the rates of referral to these programmes can be low, levels of take up limited, and completion rates low. Those who complete the programmes have told us they sometimes then feel 'abandoned' by the system afterwards, and the evidence suggests that the benefits can be lost within 6-12 months without maintaining physical activity. Ideally, in order to continue being physically active, there needs to be a pathway from NHS treatment and rehabilitation through to exercise maintenance in the community.

There are a number of initiatives which could contribute to tackling obesity:

PARCS project – Person-centred activities for people with Respiratory, Cardiac and Stroke conditions:
This project was funded by Scottish Government and delivered by a partnership of third sector organisations including Chest Heart & Stroke Scotland. The project scoped the provision of exercise based activities across regional health boards, evaluated the success factors and motivations for participants, identified key barriers, and developed a proposed national framework for community-based physical exercise. The national Service Framework was designed to be promoted to NHS Boards, Local Authorities, and Health and Social Care Partnerships, but on completion of the project, the findings were not subsequently taken forward by the Scottish Government.

The key recommendations within the Framework included:

- Integration of exercise maintenance in to a referral 'pathway' which extends from NHS Rehabilitation programmes through primary care and into communities;
- Community-based physical activity services which are focused on people, rather than health conditions;
- The importance of collaboration and partnership working across NHS, third sector, local authorities and other agencies;
- The better use of telehealth and other innovative approaches;
- Development of a specialist exercise instructor training course for multi-condition groups (expanding the current courses available for single health conditions eg stroke, and cardiac);
- Development of a national dataset to standardise the approaches taken to data collection, evaluation and audit; and
- A standardised single point of referral within regions.

NHS:
The NHS has a key part to play in tackling inactivity, and the National Physical Activity Pathway was developed by NHS Health Scotland in 2014 as a resource for healthcare professionals providing guidance on how to approach the idea of increased physical activity in patients. The Pathway includes a validated screening tool for inactivity (Scot-PASQ) and has been designed to support health professionals in offering simple advice and signposting patients to appropriate support or activities. However we are not aware of significant ongoing investment in ensuring the Pathway is adopted at scale to ensure it has the necessary impact; nor is there ongoing evaluation of its impact. http://www.healthscotland.scot/publications/physical-activity-pathway

Employers:
NHS Health Scotland developed in 2015 draft standards for organisations to meet in order to be exemplar employers in promoting physical activity and reducing sedentary behaviour within the workplace. A number of outcomes within the national physical activity implementation plan A More Active Scotland focus on the importance of exemplar employers, and yet despite development of the draft standards these have not been taken forward. Exemplar Employer Physical Activity Award

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

As described above, the commitment to create standards for exemplar employers who promote physical activity has been made before (A More Active Scotland, 2014) yet has not come to fruition. We welcome the further commitment to encourage employers to take action in promoting health living, but this needs to be reinforced by clear delivery plans.

The renewed commitment to community food initiatives is welcome but this is a key area of tackling inequalities and should therefore be a more substantial component of the strategy.

Consideration should also be given to the Scottish Food Coalition's proposal for a rights-based approach to the governance which underpins the food system, ensuring that food is accessible, adequate, and available.

Question 12
How can we build a whole nation movement?

The Strategy rightly highlights the need for strong action and leadership across all sectors. The Government should foster and support partnership work across sectors, and co-production of

solutions which includes people affected by obesity. The Third sector has a key part to play, with our experience of tackling barriers to engagement and participation, and our existing access to high risk populations.

Within Government there is a need to identify the role of the wide range of national policies which can impact on obesity; the consultation touches on many of these, such as employment, planning, and education. The current development of national Public Health priorities should play a key part in meeting the aspiration to develop a 'whole nation' movement to tackle obesity by working across traditional policy areas. The Public Health national priorities should help continue the shift away from a medical-centric model of care towards putting people at the centre of all decision making and identifying personal outcomes. Whilst systemic interventions at a population level to influence behaviour change are crucial, obesity remains a health condition for which supported self-management remains a key factor.

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