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HEALTH



A Healthier Future –

Action and ambitions on Diet,
Activity and Healthy Weight

Analysis of Consultation Responses



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A Healthier Future –

Action and ambitions on diet, activity and healthy weight: Analysis of consultation responses

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Executive summary

Introduction

1. Between 26 October 2017 and 31 January 2018, the Scottish Government undertook a public consultation to gather views on its proposals for improving diet and promoting healthy weight, as outlined in *A Healthier Future – Action and Ambitions on Diet, Activity and Healthy Weight*.¹ The consultation paper contained three main sections: (i) transforming the food environment (Questions 1-6); (ii) encouraging and supporting the adoption of healthier and more active lives (Questions 7-10); and (iii) effective leadership and exemplary practice (Questions 11-13).

The respondents

2. The consultation received 362 responses comprising approximately equal numbers of responses from individuals (179) and organisations (183). Three-quarters (74%) of the organisational responses came from public health, public sector and third sector organisations.² One-fifth (20%) came from private sector and business organisations. The remaining 6% included private sector weight management organisations and regulatory bodies. In addition, four organisations (the Scottish Youth Parliament, Young Scot, Food Standards Scotland and the Scottish Public Health Network) carried out separate engagement exercises. These sessions were carried out with specific groups of interest, e.g. young people, and as part of the wider consultation to the strategy.

Overview of findings

3. In general, respondents of all types acknowledged that overweight and obesity were significant and serious public health problems. They welcomed the intention of the Scottish Government to address this issue, thought that ‘everyone should be involved’ in this agenda, and endorsed the combined focus on diet, activity and healthy weight. Two distinct perspectives emerged from: (i) public health, third sector and private weight management organisations; and (ii) food and drink industry, advertising and media organisations. The views of individual respondents were mostly aligned to the former.

4. Public health, third sector and private weight management organisations expressed support for the consultation proposals, but also repeatedly raised a range of caveats and concerns. These related mainly to the strategy: (i) needing to have a greater focus on (the root causes of) inequalities in health, (ii) not widening health inequalities, and (iii) being comprehensive, bolder, and more ‘joined-up’ across all the relevant policy areas (e.g. education, transport, economy, health, food, etc.).

5. Industry respondents generally opposed the proposals set out in Questions 1-6 and expressed concern about their potential for negative impact on industry and consumer choice. In particular they (i) opposed restrictions on price promotions of products high in fat, sugar and salt, (ii) opposed any extension of the current (UK-wide) restrictions on broadcast and non-broadcast advertising, (iii) saw significant practical complications and competitive disadvantages for industry if arrangements diverged from those in the rest of the UK, and

¹ See <http://www.gov.scot/Publications/2017/10/1050>.

² This group of respondents will be referred to hereafter as ‘public health and third sector’ organisations.

(iv) thought the proposals would have negative impacts on food producers, retailers and consumers. This group wanted improved consumer education, rather than legislative action.

Headline findings for each question group

Restricting price promotions of foods high in fat, sugar and salt (Questions 1-2)

6. Public health and third sector respondents generally (i) supported restricting price promotions, (ii) identified other types of promotion to restrict, and (iii) highlighted other mechanisms (both price and non-price related) to encourage healthier diets. Their main concern was the impact on people on low incomes. They suggested various ways to promote healthier food and drink and make them more affordable. In terms of the products to be targeted, respondents suggested using: (i) the nutrient profiling model (discussed in the consultation paper); (ii) the traffic light labelling system; and / or (iii) the Eatwell guide.

7. By contrast, private sector and business respondents generally (i) were opposed to price promotion restrictions, (ii) highlighted the important purposes of promotions, and (iii) raised concerns or identified negative consequences. These included: (i) a loss of business for supermarkets and small retailers, (ii) disadvantaging small food producers, (iii) placing a further burden on products or businesses already targeted for government intervention (e.g. through the Soft Drinks Industry Levy), (iv) increasing food waste, and (v) increasing prices and reducing consumer choice. They emphasised that, if promotional restrictions were introduced, there must be clear, specific and evidence-based definitions of targeted foods. This group also highlighted difficulties in using the nutrient profiling model.

Advertising (Question 3)

8. Respondents who agreed with proposals for introducing (or strengthening) restrictions on advertising generally thought that such actions would help to reduce the purchase and consumption of products high in fat, sugar and salt. This group included public health and third sector organisations, private sector weight management organisations and most individual respondents. These respondents also thought that advertising was mainly used to promote such products, and that the messages within advertising aim to normalise their consumption. Many called for a complete ban on advertising of products high in fat, sugar and salt.

9. Respondents who did not favour new or extended restrictions were mainly from industry. They argued that (i) the proposals are likely to have only a modest influence on children's food preferences, (ii) the impact of current non-broadcast regulations should be assessed before any additional restrictions are imposed, and (iii) proposals are likely to have substantial, and far-reaching negative impacts for the food and drink industry, broadcasters, the advertising industry, public transport operators, and members of the public.

Development of a separate strategy for the out of home sector (Question 4)

10. Respondents were asked their views about a proposal to work with stakeholders to develop a sector specific strategy for out of home (OOH) food and drink providers. In general, respondents thought that such a strategy would be appropriate and they discussed what the strategy might cover in broad terms (for example in relation to product information, planning and licensing, public sector procurement and portion control).

11. Respondents from all sectors saw the potential for an enhanced role for local authority environmental health services which was seen as a key partner in relation to this

agenda. While individuals and public health / third sector respondents were generally in favour of calorie content information being available on (all) menus, representatives of the OOH catering sector said there was 'business opposition' to this due to the additional costs, and asked for the evidence of the impact this would have on food choices. There were also differences of opinion between the two groups in relation to (reducing) portion size.

Food labelling (Question 5)

12. Industry respondents were generally content with current labelling arrangements. However, manufacturers did not wish to see labelling arrangements diverge from other parts of the UK. They argued that market-specific packaging would be costly and wasteful, make supply chains (needlessly) more complex and result in competitive disadvantages. Individuals and public health / third sector respondents were generally positive about the current (voluntary) arrangements, but they also offered a range of suggestions for how the current system could be built on and improved – including being made mandatory, covering a wider range of products and sectors, and being standardised.

Support for reformulation and innovation (Question 6)

13. The consultation set out a commitment by the Scottish Government to invest £200k over three years to assist SMEs (small and medium-sized enterprises) to reformulate and innovate. Respondents from all groups said this sum was insufficient. Retailers, manufacturers and OOH outlets all made a positive case that much had already been achieved in relation to reformulation. Some respondents thought that specific businesses were reaching the limits of what could be achieved.

14. There was widespread agreement on the importance of advice, guidance and expertise being available to all SMEs. In general, respondents focused on the need for (i) written guidance and online materials, (ii) nutritional expertise including access to advice in the workplace, and (iii) opportunities for networking and sharing. They also talked about the need for 'additional funding' or 'grant funding' for SMEs. This could take the form of 'tax reductions' for rent and rates, 'tax subsidies' for producing healthier foods, and / or 'advertising subsidies' for promoting reformulated products.

Healthy weight from birth to adulthood (Question 7)

15. Respondents provided wide-ranging comments on what was required to give families and children the support they need to develop a healthy and positive relationship with food. Some – primarily public health and third sector organisations and private sector weight management organisations – discussed high-level issues in relation to policy and strategy development; others expressed views about service delivery; and others made detailed suggestions about the development and targeting of specific kinds of interventions, including better education on nutrition and cooking skills within the school curriculum.

16. The main themes in comments related to (i) addressing inequalities, (ii) tackling the obesogenic environment, (iii) framing the strategy to focus on 'healthy weight' (which was seen as positive), rather than 'tackling obesity' (which was seen as negative), (iv) ensuring joined up policy in this area, (v) workforce development, and (vi) funding.

17. Some respondents noted that focussing on individual level interventions risked widening inequalities. A range of measures were also seen to be 'missing' from the strategy

or given insufficient attention, such as alcohol, mental health, pre-conception and pregnancy, food security, and environmental sustainability.

Supported weight management services and other interventions (Questions 8-9)

18. The consultation paper described the Scottish Government's plan to invest £42m over five years to establish supported weight management interventions for people with – or at risk of developing – type 2 diabetes. Private sector organisations offered very few comments on this. Other respondents were unclear why interventions were to be targeted at one specific condition, rather than being made available to anyone who needs support.

19. Respondents were generally familiar with and supportive of GP referrals to weight management services. There was also support for these services to be available through self-referral and from referrals by a range of other professionals.

20. Respondents thought all programmes and services needed to take a broad and holistic view of support, and therefore should (i) cover both diet and physical activity; (ii) address self-management and behaviour change; (iii) provide psychological support if required; and (iv) include education about healthy eating, meal planning, and cookery skills. Third sector involvement and community-led programmes were thought to be vital.

Physical activity (Question 10)

21. Responses to this question came mainly from individuals and public health / third sector organisations. There was general support for proposals to develop opportunities for active travel, and to build on the Daily Mile initiative in schools. There was widespread acceptance that efforts to encourage physical activity should be part of any healthy weight strategy, but there was also acknowledgement of the barriers (e.g. stigma) facing obese people wishing to participate.

Building a 'whole nation' movement (Questions 11-12)

22. There was broad support for the idea that 'everyone should be involved' in the effort to reduce obesity. There was agreement this would require (i) good collaboration between the private, public and voluntary sectors, and (ii) clear accountability arrangements. There was also discussion about the importance of leadership across all sectors and at all levels, and the point was repeatedly made about the importance of the public sector 'leading by example' (e.g. by providing nutritious food in hospitals, schools, care homes, prisons, etc.).

23. Respondents believed that (i) employers should ensure that employees are able to have a good work-life balance, including proper breaks during the working day, flexible working arrangements, and opportunities to improve physical activity levels, (ii) health and environmental sustainability should be prioritised, and (iii) there should be increased investment in community food initiatives, including community gardens.

Monitoring change (Question 13)

24. Respondents were asked for their views on monitoring and evaluation. Generally they asked for a better national surveillance system for monitoring weight, particularly with a focus on improving data collection at a local level. There were three perspectives on the main outcomes to be monitored. All respondents thought that weight and weight-related measures should be monitored. However, one group thought the focus should be **only** on weight, while a second larger group thought that the focus of monitoring should be on health

and wellbeing more generally. A third group (mainly those from the food and drink industry) called for impacts on retail sales, nutritional content, and consumption to also be measured (as well as health, wellbeing and weight-related outcomes).

1. Introduction and background

1.1 In late 2017, the Scottish Government undertook a public consultation, *A Healthier Future – Action and Ambitions on Diet, Activity and Healthy Weight*, to gather views on its proposals for improving diet and weight in Scotland. The consultation ran from 26 October 2017 to 31 January 2018. This report presents findings from an analysis of the responses.

Policy context

1.2 In Scotland, as in many developed countries, poor diet combined with sedentary lifestyles have resulted in a high prevalence of people who are overweight or obese. The 2016 Scottish Health Survey estimates that two-thirds (65%) of adults in Scotland are now overweight, with almost one-third (29%) being obese.³ Moreover, levels of obesity are linked to the circumstances in which people live, and specifically, to the level of resources (financial, power, knowledge and social) that people have. Obesity levels in Scotland are higher for adults and children living in areas of deprivation compared with those living in less deprived circumstances.⁴

1.3 The health, social and economic consequences of these levels of overweight and obesity are severe and include increased risks of developing a range of diseases (including type 2 diabetes, some cancers, cardiovascular disease and depression) as well as wider indirect economic costs arising from sickness absence and premature mortality.⁵

1.4 These challenges are long standing. In 2010, Scotland's first obesity strategy, *Preventing Overweight and Obesity: A Route Map Towards Healthy Weight*, was published jointly by Scottish Government and COSLA.⁶ Since then, a range of other relevant policy documents and initiatives have been developed on food and health, active living, health and work, health inequalities, and on reforming the public health function.⁷ A national indicator for the percentage (%) of healthy weight children in Scotland was also introduced. The most recent measurement of this (in 2016) puts the figure at 70% (down from 72% in 2015).⁸

1.5 At the same time, there is an emerging body of evidence in relation to the effectiveness of specific weight loss interventions from both the UK and further afield. This evidence covers the effectiveness of (i) responses to childhood obesity and obesity in the wider adult population, (ii) interventions specifically aimed at those with type 2 diabetes, and

³ J McLean *et al* (2017) *The Scottish Health Survey, volume 1, main report*. Scottish Government, October 2017. See <http://www.gov.scot/Resource/0052/00525472.pdf>.

⁴ E Tod *et al* (2017) Obesity in Scotland: a persistent inequality. *International Journal for Equity in Health*, 16: 135. See <https://doi.org/10.1186/s12939-017-0599-6>.

⁵ A Castle (2015) Obesity in Scotland. *SPICe Briefing*, 15/01. 7 Jan 2015. See http://www.parliament.scot/ResearchBriefingsAndFactsheets/S4/SB_15-01_Obesity_in_Scotland.pdf

⁶ Scottish Government (2010) *Preventing Overweight and Obesity in Scotland: A Route Map Towards Healthy Weight*. See <http://www.gov.scot/Publications/2010/02/17140721/0>

⁷ See <http://www.gov.scot/Topics/Health/Healthy-Living>.

⁸ Scotland Performs – see <http://www.gov.scot/About/Performance/scotPerforms/indicator/healthyweight>.

(iii) ways of improving the obesogenic environment.^{9,10,11,12,13,14} Evidence about public attitudes to obesity is also available from the recent (2017) Scottish Social Attitudes Survey. This survey found that actions to address the obesogenic environment, including actions that will make energy-dense food relatively more expensive and less widely promoted, are likely to be supported by the majority of people in Scotland.¹⁵

The consultation

1.6 The consultation paper set out proposals for (i) transforming the food environment (through, for example, a mix of voluntary and statutory measures on the promotion, advertising and labelling of specific types of food and drink); (ii) encouraging and supporting the adoption of healthier and more active lives (through, for example, initiatives aimed at young children, supported weight management for people at risk of type 2 diabetes, and increased investment in active travel); and (iii) more effective leadership and exemplary practice within both the public sector and the food and drink industry.

1.7 The consultation contained 14 questions – eight open, and six closed questions with space to provide further comments. The questions covered:

- The introduction of measures in relation to promotion, advertising and labelling and the extent to which these should vary across food and drink type and / or by sector (Questions 1-5)
- The specific support required by Scottish food and drink SMEs (small and medium-sized enterprises) (Question 6)
- Actions required to support healthier, more active lives (Questions 7-10)
- The adoption of measures on a broad, population basis (Questions 11-12)
- Additional requirements for monitoring progress (Question 13)
- Any other comments about issues raised in the consultation (Question 14).

1.8 Annex 1 contains a complete list of the consultation questions.

⁹ An 'obesogenic environment' is one which promotes weight gain and is not conducive to weight loss – within the home, the workplace, or wider society.

¹⁰ Gortmaker SL *et al* (2015) Three interventions that reduce childhood obesity are projected to save more than they cost to implement. *Health Affairs*, 34(11): 1304-1311. See <http://choicesproject.org/publications/cost-effective-nutrition-interventions-health-affairs-summary/>.

¹¹ SFL Kirk *et al* (2012) Effective weight management practice: a review of the lifestyle intervention evidence. *International Journal of Obesity*, 36: 178-185. See <https://www.nature.com/articles/ijo201180>.

¹² C Ma *et al* (2017) Effects of weight loss interventions for adults who are obese on mortality, cardiovascular disease and cancer: systematic review and meta-analysis. *BMJ*, 359. See <https://doi.org/10.1136/bmj.j4849>.

¹³ MEJ Lean *et al* (2018) Primary care-led weight management for remission of type 2 diabetes (DiRECT): an open label, cluster-randomised trial. *The Lancet*, 391(10120): 541-551. See [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(17\)33102-1/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)33102-1/fulltext).

¹⁴ J Ananthapavan *et al* (2014) Economics of obesity – learning from the past to contribute to a better future. *International Journal of Environmental Research and Public Health*, 11(4): 4007-4025, Apr. See doi:10.3390/ijerph110404007. Also A Looijmans *et al* (2017) Changing the obesogenic environment to improve cardiometabolic health in residential patients with a severe mental illness: cluster randomised control trial. *British Journal of Psychiatry*, 211(5): 296-303, Nov. See doi: 10.1192/bjp.bp.117.199315.

¹⁵ NHS Health Scotland (2017) *Public attitudes to reducing overweight and obesity in Scotland*. See <http://www.healthscotland.scot/media/1705/public-attitudes-to-reducing-obesity-in-scotland.pdf>

Aim of this report

1.9 This report presents a robust analysis of the material submitted in response to the consultation. It also incorporates findings from four engagement events carried out among specific stakeholder groups. The structure of the report follows the structure of the consultation paper, and considers the response to each consultation question in turn.

Chapter 2 provides a description of the consultation respondents and participants in the engagement exercises. **Chapters 3-12** summarise the main issues raised by respondents in relation to the consultation questions. Finally, **Annexes 1-7** provide further detail about the consultation questions, the responses, the respondents, and the views expressed.

Approach to the analysis

Quantitative analysis

1.10 Frequency analysis was undertaken in relation to all the closed (tick-box) questions in the consultation questionnaire. Five of the consultation's six closed questions were of the form 'Do you think further or different action is required on X?' and offered respondents the choice between 'yes', 'no' and 'don't know'. The sixth tick-box question asked respondents to indicate the extent to which they agreed with a proposal and offered five options ranging from 'strongly agree' to 'strongly disagree'. The analysis of closed questions is presented in Annex 2, but is not otherwise discussed throughout the report, due to the limitations discussed below.

1.11 Some respondents made comments in relation to a question without ticking a response at the relevant closed question. If the respondent's reply to the closed question could be inferred from their written comments (for example, if their comments began with the words 'yes' or 'no', or if their comments clearly indicated that they agreed or disagreed with a certain proposal), then the analysts replaced the missing data for the tick-box question with the implied response – i.e the response was imputed.

1.12 There was not always a straightforward relationship between respondents' choice of answer to the closed questions and their comments in the accompanying qualitative comments. Upon further examination of the qualitative comments, it was clear that, in many cases, respondents (especially those in public sector and third sector organisations) ticked 'yes' to closed questions **not** because they wanted further or different action, but because they wanted to (i) explain why the proposals in the consultation paper should be implemented, or because (ii) they simply wanted the opportunity to give their perspective on the issue. Moreover, those who ticked 'no' often went on to say they wanted further or different action (or to maintain the status quo).

Qualitative analysis

1.13 Comments made in response to each question were analysed qualitatively. The aim was to identify the main themes and the full range of views expressed in relation to each question or group of questions, together with areas of agreement and disagreement in the views of different types of respondent.

1.14 As will be seen in the next chapter, the consultation elicited responses from a wide variety of individual and organisational respondents. Many of the individuals who responded had specific interests in the topic either because (i) they were professionally qualified in

some way (some were currently working in the field) or because (ii) they had personal experience in relation to the topic (some had direct experience of weight management programmes, others were overweight or obese themselves, or had caring responsibilities for people who were affected by obesity). The analysis, therefore (i) incorporates both professionally informed, and lay perspectives, (ii) recognises that parts of the questionnaire are less relevant for some (groups of) respondents, and (iii) ensures that the views from different perspectives and groups are represented in a fair and balanced way.

1.15 Many respondents submitted lengthy responses which discussed and debated the current evidence in this area and included lists of reports and published research papers. It was not within the scope of this analysis to comment on the factual accuracy of responses or assess the quality of any evidence cited.

Comment on the generalisability of the consultation findings

1.16 As with all consultations, the views submitted in this consultation are not necessarily representative of the views of the wider public. Anyone can submit their views to a consultation, and individuals (and organisations) who have a keen interest in a topic – and the capacity to respond – are more likely to participate in a consultation than those who do not. This self-selection means that the views of consultation participants cannot be generalised to the wider population. For this reason, the main focus in analysing consultation responses is not to identify how many people held particular views, but rather to understand the range of views expressed and the reasons for these views.

2. About the respondents and responses

2.1 This chapter provides information about the respondents to the consultation and the responses submitted.

Number of responses received

2.2 The consultation received 363 responses. This included one duplicate response submitted via the online hub and e-mail. After this duplicate response was removed, the analysis was based on 362 responses.¹⁶

About the respondents

2.3 Responses were submitted by 179 individuals and 183 organisations or groups. (See Table 2.1.) These figures do not include individuals who took part in a variety of engagement exercises organised by third parties (described below in paragraphs 2.7 and 2.8).

Table 2.1: Types of respondent

Respondent type	n	%
Individuals	179	49%
Organisations	183	51%
Total	362	100%

2.4 Many of the individual respondents to this consultation were public health professionals or academics with specialist knowledge of this subject.

2.5 A complete list of organisational respondents is provided at Annex 3 of this report. For the purposes of the analysis, organisational respondents were grouped into three categories as follows:

- Public health and third sector organisations and groups¹⁷ (n=136)
- Private sector and business organisations and groups (n=37)
- Other organisational respondents (n=10).

2.6 The first category included third sector organisations; public health professional and representative groups; NHS organisations; local authorities and partnership bodies; organisations concerned with sport, fitness and play; and academic / research organisations. The second category included food and drink industry and business representative bodies; food and drink manufacturers; retailers; and advertising and media organisations. The third category comprised organisational respondents who did not fit into either of the first two categories. This group included five private sector weight management organisations. (See Table 2.2.)

¹⁶ Published responses to the consultation are available at: https://consult.gov.scot/health-and-social-care/a-healthier-future/consultation/published_select_respondent.

¹⁷ This category includes local authorities, partnership bodies and other public sector organisations.

Table 2.2: Organisation / group types

	n	% of total
Public health and third sector organisations and groups		
Third sector organisations	42	23%
Public health professional and representative groups	26	14%
Public sector health organisations	21	11%
Local authorities, local partnerships and other public sector bodies	19	10%
Organisations concerned with fitness, sport, recreation and play	15	8%
Academic, educational or research organisations	9	5%
Other professional bodies and representative groups	4	2%
Private sector and business organisations and groups		
Food and drink industry and business representative bodies	17	9%
Food and drink manufacturers	9	5%
Retailers	5	3%
Advertising, media or broadcast organisations	4	2%
Out of home providers (e.g. restaurant, fast food outlet, coffee shop)	2	1%
Other organisational respondents		
Private sector weight management organisations	5	3%
Regulatory bodies	2	1%
Other organisations	3	2%
Total	183	100%

Engagement exercises

2.7 In addition to the responses received directly by the Scottish Government (described in the paragraphs above), four organisations carried out engagement exercises among specific stakeholder groups on behalf of the Scottish Government. The organisers, the nature of the engagement, and the participating groups are described in Box 2.1 below. Altogether, 632 people were reported to have participated in these exercises.

2.8 Summary findings from these exercises were submitted in separate reports and are incorporated into the qualitative analysis in this report, but are referred to only where they contributed distinctive, or new information / views. Copies of the reports from the engagement exercises are available from the Scottish Government.¹⁸

¹⁸ https://consult.gov.scot/health-and-social-care/a-healthier-future/consultation/published_select_respondent.

Box 2.1: Engagement exercises among stakeholder groups

Scottish Youth Parliament – held a focus group on 18 January 2018 with young people exploring their views and opinions in relation to diet and obesity. Topics of discussion included healthy eating, advertising, food promotions and ideas of how to improve diet and influence healthy eating choices. In addition, local consultations focusing on similar issues were carried out by Members of the Scottish Youth Parliament (MSYPs). Altogether, 11 young people took part in the focus group and 34 additional responses were gathered by MSYPs.

Young Scot – hosted a focus group on 22 November 2017 with young people exploring their views and opinions around the topic of diet and obesity. In conjunction with this event, Young Scot also conducted a *Diet, Activity and Healthy Weight Survey* between 22 October 2017 and 21 January 2018. The survey included 19 questions which sought information about young people's perceptions and experiences of a healthy lifestyle (including diet and physical activity), food promotions and 'unhealthy' food. Altogether, 15 young people took part in the focus group and the survey was completed by 308 young people in Scotland aged 11-25.

Food Standards Scotland – conducted a workshop on 7 December 2017 for local authority environmental health officers. The workshop programme included two introductory presentations and three themed workshops focused on: (i) the out of home food environment; (ii) the planning system and the food environment; and (iii) leadership and transforming the food environment. Altogether 55 representatives from 21 local authorities attended.

Scottish Public Health Network (ScotPHN) – conducted a series of workshops attended by representatives from public health organisations – primarily from the public and third sectors. Four events were held in total, in Glasgow (6 December), Edinburgh (8 December), Inverness (10 January) and a 'virtual event' (11 January) which included mainly participants from rural NHS Boards. The workshops included introductory presentations, followed by two facilitated discussions. These focused on carrying out a SWOT analysis of certain aspects of the proposals set out in the consultation paper; and a discussion of how the proposals could be implemented at a local level. Altogether, 224 individuals attended these events.

Responses to individual questions

2.9 Not all respondents answered all the questions in the consultation questionnaire. In particular, private sector and business organisations mainly focused their comments on Questions 1 to 6, and did not respond (or did not respond in the same detail) to the remaining questions. At the same time, not all of the comments made at each question were necessarily directly relevant to the question being posed – some related to other consultation questions, or to other issues not covered by any of the questions in the consultation document.

2.10 Details of the number of respondents who made comments at each question are shown in Annex 4. However, given the point above, the figures shown in Annex 4 should be considered as indicative only and should not be seen as 'response rates' for the questions.

2.11 Responses to Question 14 (any other comments) generally reiterated points made earlier in the responses. Comments made at Question 14 have therefore been integrated throughout this report, and no separate analysis of this material is presented.

3. Restricting price promotions (Qs 1-2)

3.1 The consultation paper discussed proposals to restrict the in-store promotion of food and drink high in fat, sugar and salt. Views were sought about (i) the type of price promotions that should be covered, and (ii) the types of food and drink which should be subject to promotional restrictions. These two issues were addressed by the first two consultation questions.

Types of price promotion restrictions

3.2 The consultation paper suggested that restrictions should apply to multi-buy, X for Y, and temporary price promotions. Respondents were asked if there were any other types of price promotion that should be included within these proposals.

Question 1: Are there any other types of price promotion that should be considered in addition to those listed above? Please explain your answer.

3.3 Altogether, 275 respondents (146 organisations and 129 individuals) provided comments at Question 1. There were clear distinctions in the views expressed by public health and third sector respondents on the one hand, and private sector and business respondents on the other.

3.4 In their comments, public health and third sector respondents generally (i) supported the proposal to restrict price promotions, (ii) identified other types of price promotions which should be restricted, and (iii) highlighted other mechanisms (both price-related and non-price-related) which could be used to encourage healthier diets.

3.5 By contrast, private sector and business respondents generally (i) expressed opposition to price promotion restrictions, (ii) highlighted the important purposes of promotions, and (iii) raised concerns or identified negative consequences which could result from restrictions on promotions.

3.6 Individual respondents and private sector weight management organisations (included in the 'other organisational respondents' category) were more likely to express views similar to those of public health and third sector respondents. However, a relatively small number of individuals expressed opposition to the proposals set out in the consultation paper.

3.7 While some respondents referred extensively to research in this area, other were less familiar with the evidence base and wanted to see more information about what works to change consumer behaviour towards a healthier diet.

3.8 All of these views are discussed in more detail below.

Views in favour of price promotion restrictions

3.9 Respondents who supported price promotion restrictions on products high in fat, sugar and salt often highlighted the high levels of obesity in Scotland. These respondents noted that in-store promotions were heavily weighted in favour of such foods, and that consumers are more likely to purchase such foods on promotion – and to purchase more

than they otherwise would have had the foods not been on promotion. This group of respondents also pointed out that healthier alternatives were less likely to be available on promotion.

Additional price promotions which should be restricted

3.10 Respondents who supported restrictions on price promotions suggested a wide range of other types of promotions which they thought should be included within the scope of such restrictions. These suggestions were offered by public health and third sector organisational respondents as well as by individual respondents. Those suggested most often were:

- Meal deals which incorporate confectionary, sugared drinks or which encourage 'upsizing' – some respondents also referred to 'bunching promotions' (i.e. 'hot drink and cake')
- 'Extra free' promotions where the size of a product is temporarily increased, while the price remains the same
- Attaching or including free 'gifts' targeted at children within packages of cereals or other products; or gifts which can be claimed only after purchasing a certain number of a particular item
- The offer of a free bar of chocolate or a bag of crisps when buying certain newspapers.

3.11 Less commonly, respondents (usually individuals) suggested there should be restrictions on (i) the promotion of 'festive chocolate' (for example, large chocolate Easter eggs and Christmas selection packs) which are cheaper per 100g than a standard chocolate bar by the same manufacturer, and (ii) the use of free samples and tasting promotions. Individual respondents were also more likely than organisational respondents to make general suggestions about the use of promotions, rather than identifying a specific type of promotion as a candidate for possible restriction. Two examples were to: 'limit the percentage reduction [in price] of discretionary foods'¹⁹ and 'restrict how much foods high in fat, sugar and salt can be reduced by even as they go out of date'.

3.12 It was noted that multi-buy promotions are a common type of promotion used in Scotland, and it was suggested that a practical first step could be to restrict all multi-buy promotions for foods high in fat, sugar and salt. However, more often, public health and third sector respondents called for a universal ban on **all** price promotions. This group cited evidence which indicated that restrictions on just one (or a few) types of promotion were unlikely to be effective, as supermarkets would simply use other types of promotions instead.

Concerns – equalities issues

3.13 The main concern of respondents who supported actions to restrict price promotions was that such actions could have the potential to adversely affect the poorest people in Scotland. In particular, it was noted that people on low incomes are reliant on price promotions to feed their families. This group of respondents thought there was a risk that

¹⁹ Food Standards Scotland define these as confectionery, sweet biscuits, crisps, savoury snacks, cakes, pastries, puddings and sugar containing soft drinks.

people / families living in poverty could be disadvantaged further by not being able to stretch their existing food budget to cover the cost of more expensive healthier food.

3.14 Thus, it was common for this group of respondents to advocate the use of promotions to **encourage** the purchase of healthier alternatives, such as fruit and vegetables, and they frequently called for a two-pronged approach which would involve banning all promotions of unhealthy foods, while making greater use of promotions to encourage the purchase of foods low in fat, sugar and salt. The point was repeatedly made that healthy options should always be more affordable than unhealthy ones. This group also wanted to see a greater emphasis on the use of universal price-related mechanisms (described in paragraph 3.16 below) to achieve this purpose.

Other mechanisms for encouraging healthier choices

3.15 Public health and third sector organisations and a wide range of individual respondents offered suggestions about other types of mechanisms – both price-related and non-price related – to encourage healthier food and drink choices among consumers.

3.16 Specifically, there were repeated calls to increase the price of unhealthy foods through universal mechanisms such as a tax or levy on foods high in fat, sugar and salt, while using subsidies (or tax exemptions) to reduce the cost of foods low in fat, sugar and salt. Less often, there were suggestions to establish a ‘minimum pricing scheme’ for foods and drinks that contain added sugar (e.g. a minimum price per quantity or proportion of sugar added).

3.17 Respondents in favour of price promotion restrictions pointed out that supermarkets make use of a variety of other tactics for promoting products which do not necessarily involve price – for example, the position and amount of space occupied by products within the shop. These respondents wanted to see action taken to restrict the positioning of foods high in fat, sugar or salt within supermarkets and shops – for example, avoiding the end of aisles, window displays, top shelves, immediately inside the entrance, and / or at the check-out.

Views opposed to restrictions on price promotions

3.18 Opposition to price promotion restrictions was mainly voiced by organisations in the food and drink manufacturing and retail sectors, the out of home sector,²⁰ and their representative bodies. A small number of individual respondents also expressed opposition to the proposals, arguing that if people want to purchase products high in fat, sugar and salt, they should be able to do so, and will do so regardless of the price. Some individual respondents described the proposals to restrict price promotions as an example of a ‘nanny state’ policy.

Food and drink industry initiatives to promote a healthier diet

3.19 Respondents from the food and drink industry (manufacturers, retailers, out of home providers and representative bodies) highlighted the wide range of actions they had already undertaken on a voluntary basis in relation to in-store marketing and promotions. Examples

²⁰ The out of home sector includes restaurants, takeaways, bakeries, sandwich outlets and other establishments which sell food and drink for consumption outside the home.

included: removing foods high in fat, salt and sugar from check-out areas; making a commitment to end multi-buy deals; taking steps to reduce portion sizes and / or to reformulate their products to reduce the sugar content.

3.20 These respondents frequently stated that they supported the Scottish Government's ambition to promote healthier food and drink choices, but they saw price promotions as having important benefits (for businesses and consumers), and they were concerned that restrictions on price promotions would have a wide range of negative impacts. These respondents repeatedly emphasised that any measures to restrict promotions should be based on evidence, and they called for the Scottish Government to engage positively and collaboratively with the food and drink industry on this issue.

The purposes of price promotions

3.21 Respondents from the food and drink industry and other private sector respondents commented that promotions serve a number of purposes. In particular, they provide a way for retailers to (i) differentiate themselves from their competitors, (ii) respond to changing customer demand, and (iii) tailor their products to their customer base. They are, in effect, used to 'encourage changes in consumer behaviour' (e.g. to switch brands or stores, or to try new products). Thus, they were seen to be important for encouraging competition among retailers and for giving consumers greater value and choice.

3.22 This group of respondents emphasised that the use of price promotions is based on complex commercial negotiations and agreements between retailers and manufacturers (which vary for different categories of food). This, it was argued, makes it an unsuitable area for Government intervention.

Potential negative impacts of restricting promotions

3.23 Respondents from the food and drink sector and other business respondents identified a range of specific negative impacts – for consumers and for businesses – which could result from restricting promotions, including:

- **Loss of business for supermarkets and small retailers:** It was noted that the ability to compete on price is fundamental to businesses across all sectors. Respondents thought that restrictions on promotions would reduce the ability of supermarkets to compete against each other, lead to a loss of footfall in high street shops, and put further pressure on retail businesses which are already struggling in a highly competitive environment. Promotions were seen to be particularly important for small convenience stores which have 'a low-margin high volume business model' (and many of which have little control over the products that they put on promotion, or how long a promotion may run). The point was made that the majority of people in Scotland do not use a convenience store for their weekly shop. Instead, consumers in Scotland use convenience stores to top up their weekly shop, for a one-off meal solution, and for emergency purchases. As a result, the product mix and business focus in convenience stores and supermarkets are quite different, and promotional restrictions could have a greater adverse impact on these kinds of smaller retailers.
- **Disadvantaging small food producers in competition with larger businesses:** Food manufacturers pointed out that, although they are not in control of when and how retailers promote their products, they are expected to cover the cost of

promotional activities. Food manufacturers stated that a substantial proportion of their sales (ranging from 48% to 80%) were driven by products on promotion; therefore, a restriction on promotions would have a significant impact on their profitability. Moreover, this impact was likely to be felt disproportionately among Scottish food producers who rely on promotional activity to help them compete against bigger brands (for whom Scottish sales represent a much smaller proportion of their turnover). It was suggested that the overall effect of promotional restrictions would be to 'hamstring' a sector of the Scottish economy which drives growth and employment. Some warned that some smaller producers simply would not survive.

- **Placing a further burden on (certain) products / businesses already being targeted by government intervention:** Respondents from the soft drinks manufacturing sector pointed out that they had taken significant steps to reduce the sugar content in soft drinks in advance of the Soft Drinks Industry Levy (which came into force in April 2018). This group argued that the outcomes from the Soft Drinks Industry Levy should be assessed first before any further restrictions would put on the sale of their products.
- **Increased food waste:** Food manufacturers, retailers and out of home providers all pointed to the importance of using price promotions to encourage the purchase of items approaching the end of their shelf-life. These respondents saw the potential for restrictions on promotions to result in a significant increase in food waste.
- **Price increases and reduction in choice for consumers:** Retail respondents pointed out that many of their customers rely on price promotions to be able to afford certain products. They argued that restrictions would effectively lead to price increases, thus squeezing household budgets, and penalising people on low incomes. Promotional restrictions would also result in consumers having less choice as they would prevent retailers from competing on price.

Other issues raised by food and drink industry respondents

3.24 Respondents across the food and drink industry typically raised several additional points:

- There was a recurring view that there would be 'complex practical difficulties' for manufacturers and retailers in having different promotional rules in Scotland compared to the rest of the UK. As noted above, there were particular concerns that Scottish food producers would be seriously disadvantaged by restrictions in Scotland which did not apply to producers selling products elsewhere in the UK.
- There were concerns that the impacts of any promotional restrictions might be felt quite differently by different kinds of retailers. On the one hand, some respondents called for consistency (or a 'level playing field') across sectors, and some thought that: (i) within the retail sector, larger companies should not be disproportionately affected compared to small retailers; and (ii) there should be a consistency of approach across the retail and out of home sectors (including all online shopping platforms). However, there was also a contrasting view from a business representative body that the Scottish Government should carefully consider ('conduct a detailed impact assessment of') the differing impacts that promotional restrictions would have on different kinds of retailers (i.e. supermarkets vs convenience stores vs small bakeries and cafés).

- There were also differences of opinion about whether any measures taken in this area should be voluntary or mandatory. Among the relatively small number of respondents who raised this issue, food manufacturers tended to request a voluntary approach, while retailers emphasised the need for ‘a level playing field’ and therefore advocated a mandatory approach.

3.25 Respondents opposed to price promotions restrictions generally suggested that the Scottish Government should focus greater efforts on educating consumers to make more informed choices about the food they eat.

Defining food and drinks for promotional restrictions

3.26 The consultation paper noted the importance of clearly defining the types of food that would be targeted for promotional restrictions. Three options were discussed (i) the existing nutrient profiling model (which was developed by the Food Standards Agency, and which is used by Ofcom as the basis for determining which food and drinks will be subject to restrictions on broadcast and non-broadcast advertising targeted at children); (ii) the level of a specific nutrient in food (for example, sugar, or saturated fat); and (iii) foods which contribute the most calories to a diet. Respondents were asked to give their views on this issue.

Question 2: How do we most efficiently and effectively define the types of food and drink that we will target with these measures? Please explain your answer.

3.27 Altogether, 275 respondents (131 organisations and 144 individuals) provided comments. It should be noted that those who offered suggestions in relation to this question were generally those in favour of promotional restrictions (i.e. public health and third sector organisations, private sector weight management organisations, and a relatively large number of individual respondents). These respondents suggested three main methods for defining the types of food and drink that should be targeted for promotional restrictions: (i) the nutrient profiling model (discussed in the consultation paper); (ii) the use of the traffic light labelling system; and (iii) the use of the Eatwell guide. Each of these suggestions is discussed further below.

3.28 Respondents from the food and drink industry and business groups generally reiterated their objections to promotional restrictions. In particular, they highlighted difficulties or disadvantages in relation to the use of the nutrient profiling method. This group of respondents emphasised that, if promotional restrictions were introduced, it would be crucial that the definitions are clear, specific and evidence-based. There were concerns that if the definitions were too complex: (i) smaller businesses would find it difficult to navigate the rules; and (ii) larger businesses might be able to exploit loopholes to avoid the restrictions. These respondents repeatedly highlighted the challenges of the task, and it was noted that the UK Treasury had taken 18 months to define ‘soft drinks’ for the purposes of the soft drinks levy.

Nutrient profiling

3.29 Nutrient profiling was the method discussed most often by respondents as a potential way of defining types of food and drink which should be subject to promotional restrictions.

This model uses a scoring system that balances the contribution made by beneficial nutrients with components of food / drink that should be eaten less often. The model applies to all food and non-alcoholic drinks. Respondents pointed out that nutrient profiling models (NPMs) had been used successfully to identify foods and beverages to be regulated in the marketing of food to children (as discussed in the consultation paper) and they identified the following advantages of using this type of method:

- It is evidence-based, well known and currently being used across the food industry – thus it would provide a consistent message and avoid the need to spend significant time and resources in developing a new model.
- It does not define specific food products as ‘unhealthy’ per se, but rather considers the overall impact products will have on health, reflecting the importance of a balanced diet.

3.30 However, some respondents also thought that: (i) the language used in relation to the profiling model needed to be more accessible / understandable to the general public (it was thought this was currently not the case); and (ii) there was a need for flexibility to prevent restrictions on some products that do not meet the NPM thresholds – it was suggested that discussions with the Food Standards Scotland may highlight examples of these products.

Concerns or perceived disadvantages of the NPM

3.31 By contrast, food and drink manufacturers (and some retailers and out of home providers) expressed a range of concerns about the existing NPM. These respondents commonly said they were not in favour of using the current NPM for the following reasons:

- It was designed for the specific purpose of restricting broadcast and non-broadcast advertising in relation to children, and may not be valid for use in relation to in-store promotional restrictions (which are seen by all ages). It was suggested that its use in other contexts should be tested and evaluated.
- The model is presently under review by Public Health England, and (respondents thought) was likely to change. It was suggested the Scottish Government should delay any decision on this matter until the review is completed.
- The NPM was seen to be complex and difficult to use as it requires information about the levels of ingredients and nutrients, which may not be readily available.
- The model was seen to produce ‘unintended consequences’, and has led to restrictions on advertising of certain ‘nutrient-rich’ foods (examples included milk, lamb and cheese) – which cannot be reformulated as some (so-called) ‘nutrient-poor’ products have been.

3.32 There was also a specific concern raised by respondents from the soft drinks industry. These respondents noted that significant efforts had been made over the past two years to reformulate their products in line with threshold set out under the Soft Drinks Industry Levy (5g of total sugars per 100ml). Nevertheless, it was likely that these products would still be classified as ‘high sugar’ according to the current NPM. These respondents were opposed to promotional restrictions, but argued that if they were introduced, the threshold of 5g total sugar per 100ml should be used to define ‘high-sugar’ drinks under any future NPM.

3.33 Some respondents pointed out that there are different NPMs available, and that these vary in their classification of foods. They suggested that the Scottish Government should consider each of these, and select the model which can be best implemented in relation to restrictions on promotions. Occasionally, respondents highlighted other classification systems (similar to NPMs), including: (i) the NOVA classification which identifies ultra-processed food, and drink products²¹; and a classification system used in Australia, which distinguishes between 'core' and 'non-core' foods.

Traffic light labelling system

3.34 The second main suggestion made by respondents was that the front of pack (FOP) traffic light labelling system should be used for defining foods and drinks subject to promotional restrictions. These suggestions generally came from public sector, public health, third sector and individual respondents.

3.35 There were differences of opinion in relation to how this should operate. Some thought that if any one label (for fat, sugar or salt) was red, the product should not be promoted. Others thought that promotional restrictions should apply only when a product has two or more red labels.

3.36 Those in favour of this type of approach thought that traffic light labelling was easy for consumers to understand, and that it would provide a clear and consistent way of comparing food and drinks. However, it was noted that there is no equivalent of the traffic light scheme for children's foods. The point was also made that this system does not promote healthy foods, only attempts to warn against unhealthy foods. Chapter 6 contains further discussion of respondents' views on the traffic light labelling system.

Eatwell guide

3.37 The third (less frequent) suggestion was that the Eatwell Guide (2016) (previously the 'Eatwell plate' (2006)) could provide the basis for identifying foods which should be subject to promotional restrictions.²² Those offering this suggestion were mainly academic, public sector or third sector organisations, and a small number of individual respondents. This model was reported to be widely used in NHS and educational contexts and therefore was familiar to many members of the public.

3.38 A few respondents specifically stated that the group of high fat, high salt and high sugar foods previously shown in the (2006) 'Eatwell plate' could be used as the basis for defining foods for promotional restrictions.²³ Others referred to the revised (2016) guide and suggested that the foods not listed (referred to as 'discretionary foods') should be consumed seldom and in small amounts and therefore would be suitable for restrictions.

²¹ CA Monterio *et al* (2018) The UN decade of nutrition, the NOVA food classification and the trouble with ultra-processing. *Public Health Nutrition*, 21(1):5-17. See doi: 10.1017/S1368980017000234.

²² <http://www.foodstandards.gov.scot/consumers/healthy-eating/eatwell>

²³ These foods included oils and spreads, chocolate, cakes, crisps, sweets, table sauces, carbonated drinks and diluting squashes. The development of the Eatwell Guide was led by Public Health England (PHE) in association with the Welsh Government, Food Standards Scotland and the Food Standards Agency in Northern Ireland. Information about the changes made in the 2016 version, and the reason for those changes is provided here:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/528201/Eatwell_guide_whats_changed_and_why.pdf

3.39 Respondents who suggested use of the Eatwell Guide thought there was scope to build on the guide, including it on food packaging and introducing colour-coding of shopping aisles within supermarkets linked to the guide.

Views of individual respondents

3.40 Individual respondents were more likely than organisational respondents to offer general comments about the types of food and drink that should be subject to promotional restriction (e.g. ‘foods high in saturated fats, sugar and salt’; ‘processed food’; ‘ready meals’; ‘convenience foods’; ‘anything that is not naturally occurring / with lots of chemicals / with artificial sweeteners’). Individual respondents also often named specific types of food and drink which they thought should be targeted for promotional restrictions (e.g. crisps, chocolate, sweets, etc.).

Foods which should NOT be targeted for restrictions

3.41 A relatively small number of respondents identified foods which they thought should **not** be included in any promotional restrictions. Examples included foods with a relatively high fat content (e.g. whole milk, cheese, avocados, nuts) as well as some with a high sugar (fructose and starchy carbohydrate) content (e.g. fruit, potatoes, rice). There was a view that these kinds of single-ingredient foods – or ‘real foods’ as some respondents described them – should be exempted from restrictions on promotions.

3.42 There was debate about whether or not infant formula and follow-on formula should be included in the scope of any promotional restrictions. On the one hand, there was a view that such products should **not** be included as they are already subject to a high level of regulation. However, other respondents (mainly public health organisations) called for the Scottish Government to (i) fully implement the WHO international code on the marketing of breastmilk substitutes – which would help to define the categories of formula / follow-on formula that should be covered²⁴; and (ii) focus specifically on the added sugar in formula milk and weaning foods.

3.43 Finally, one industry representative body thought that savoury snacks should not be included in the scope of promotional restrictions as (i) their contribution to dietary intakes of calories, salt and fat is ‘relatively low’ and (ii) ‘they are consumed in small amounts’.

Other points

3.44 There was little comment regarding the proposal (see paragraph 3.26 above) to focus on a specific nutrient. Those who did comment on this issue were opposed, as they thought this would result in ‘demonisation’ of specific nutrients and would not help consumers understand how to eat a balanced diet.

3.45 A range of food and drink manufacturers called for the Scottish Government to take the time to fully assess the impact of a range of diet-related initiatives currently being taken forward by the UK government and Public Health England. These include the ‘sugar reduction programme’ for industry, the Soft Drinks Industry Levy, and recent changes to the

²⁴ World Health Organisation (1981). *International Code of Marketing of Breast-milk Substitutes*. See http://www.who.int/nutrition/publications/code_english.pdf

CAP code in relation to non-broadcast advertising (discussed in further detail in the next chapter).

4. Advertising (Q3)

4.1 The consultation paper discussed options for introducing (or strengthening) restrictions on advertising in the wider environment – both in relation to broadcast and non-broadcast advertising. Specifically, there were proposals to (i) extend current restrictions on advertising targeted at children to all programmes broadcast before the 9pm watershed; (ii) review the implementation and impact of the Committee of Advertising Practice (CAP) code on non-broadcast advertising of products high in fat, salt and sugar; (iii) explore the scope for extending the current CAP restrictions at, or near, streets or locations commonly used by large numbers of children; and (iv) explore opportunities to restrict advertising on buses and trains and in transport hubs.

4.2 Respondents were asked whether they agreed with the actions proposed in relation to non-broadcast advertising.

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? Please explain your answer.

4.3 A total of 265 respondents (139 organisations and 126 individuals) provided comments at Question 3. Although the question asked for views specifically in relation to actions on non-broadcast advertising, respondents generally also commented on the proposal to restrict advertising to all programmes before the 9pm watershed. Box 4.1 below briefly summarises the current UK restrictions on broadcast and non-broadcast advertising.

Box 4.1: Current restrictions on broadcast and non-broadcast advertising

Broadcast advertising: The Broadcast Committee on Advertising Practice (BCAP) Code prohibits advertising of foods high in fat, sugar and salt on children’s channels, in children’s programming and in other programmes that are of particular appeal to children. There are also restrictions on the use of licensed characters and celebrities, and promotions in ads appearing outside restricted parts of the schedule, but which are nevertheless likely to appeal to pre- and primary school children.

Non-broadcast advertising: In July 2017, the Committee on Advertising Practice (CAP) introduced a comprehensive ban on the advertising of food and drink high in fat, sugar and salt in all children’s non-broadcast media – i.e. media attracting an audience where 25% or more of the audience were aged 15 or younger. This covers print, cinema, online – including online TV-like content, such as video-sharing platforms and social media. The rules also apply to social influencers, in-game advertising and ‘advergames’ subject to the 25% child audience test.²⁵

Views in favour of new or extended advertising restrictions

4.4 Respondents who agreed with the proposals set out in the consultation paper generally thought that actions to change the food environment – and to restrict advertising, in particular – would help to reduce the purchase and consumption of foods high in fat,

²⁵ An advergame is a video game which in some way contains an advertisement for a product, service, or company. Some advergames are created by a company with the sole purpose of promoting the company itself or one of its products, and the game may be distributed freely as a marketing tool.

sugar and salt. This group included public health and third sector organisations, private sector weight management organisations and most individual respondents. These respondents argued that ‘advertising sells goods’; if it did not, companies would not do it. They also thought that advertising was mainly used to promote foods high in fat, sugar and salt; and that the messages within advertising aim to normalise the consumption of such foods. Respondents in this group pointed to the effectiveness of restrictions on tobacco and alcohol advertising, and suggested similar restrictions should be introduced for ‘junk food’. Many called for a complete ban on all advertising of foods high in fat, sugar and salt.

4.5 In relation to advertising likely to appeal to children, these respondents pointed out that children are more susceptible to advertising than adults. Furthermore, even where advertising is not overtly aimed at children, it can have a strong influence on their behaviour and ‘pester power’, thus putting pressure on parents to buy unhealthy foods for their children.

Broadcast advertising

4.6 Among the respondents who expressed general support for advertising restrictions, there was also support for the specific proposal to restrict advertising of foods high in fat, sugar and salt before the 9pm watershed. At the same time, there were some in this group who felt this proposal did not go far enough. As noted above, there were calls to ban **all** broadcast advertising of such foods.

4.7 The point was also made that while it may be desirable for control over broadcast advertising to be devolved to Scotland in the long term, it will take time for this to happen. In the meantime, the focus should be on pressing the UK government to strengthen current restrictions, or to implement a ban on advertising unhealthy food before the 9pm watershed.

Non-broadcast advertising

4.8 There was widespread support among public health and third sector organisations and individual respondents for restrictions on advertising on routes to schools, and within schools, sport centres and all public buildings. These respondents also supported restrictions of advertising on public transport, bus shelters (particularly bus shelters near community venues), and family visitor attractions; and it was suggested there should be restrictions on the use of mobile billboards to promote sugary drinks.

4.9 Some respondents thought that a targeted approach to restricting non-broadcast advertising was likely to be difficult to implement, and thus unlikely to be effective. Instead, they called for a universal ban on all non-broadcast advertising of foods high in fat, sugar and salt.

4.10 Some respondents who supported restrictions on non-broadcast advertising highlighted other forms of advertising – or contexts for advertising – which they thought should be included within the scope of any actions taken. The two issues raised most often were in relation to:

- Online advertising and advertising through social media: Respondents noted that food marketing on social media, the use of branded food websites, and ‘advergames’ are increasing as the food industry seeks more sophisticated and innovative ways to reach young people. They also pointed out that children’s viewing habits have

changed: they tend to watch less live television and more live streamed, on demand programmes. YouTube videos and vloggers were also reported to be influential among young people. Respondents thought that controlling online advertising would be more challenging than restricting advertising on TV.

- Sponsorship: It was suggested that fast food chains and soft drink companies should not be permitted to sponsor sporting events and sports equipment and that the promotion of sugary energy drinks in sports venues should be restricted.

4.11 A few respondents also wanted 'misleading advertising' to be tackled. Specifically, they thought products should not be able to be advertised as 'healthy' unless these claims can be substantiated against certain standards. Reference was made to formula milk ('sold under the misconception that it is better for the child' than breastmilk) and to foods that claim to be 'low fat', but which are very high in sugar or artificial sweeteners.²⁶

4.12 At the same time, respondents were in favour of the idea of using the same sophisticated marketing methods employed by major food and drink manufacturers to promote (through media and social media) good nutrition and healthy eating. There were suggestions that such a campaign should (i) focus on wellness and eating well, not 'bad' vs 'good' foods; (ii) involve registered nutritionists and dieticians in developing the key messages; (iii) target children, parents and grandparents; (iv) involve suitable role models for both children and adults (various celebrities from sport, TV and music were suggested); (v) be 'snappy, memorable and not preachy'; and (vi) have the aim of going 'viral'.

4.13 Finally, some respondents who supported restrictions on advertising also expressed some caveats as follows (i) any actions taken must be enforceable, (ii) people should not simply be told what **not** to do, they should also be offered affordable alternatives, and (iii) efforts will still need to be taken to motivate people to change their buying and eating habits.

Views opposed to new or extended advertising restrictions

4.14 Respondents who did not favour new or extended restrictions on advertising were mainly organisations from the food and drink industry and business sectors. These respondents highlighted the wide range of actions already taken by them to support government efforts to address overweight and obesity (i.e. product reformulation, and voluntarily agreeing not to market certain products to children long before the current CAP regulations came into force). These respondents repeatedly stated that they supported the current BCAP and CAP codes, and that they supported the objectives of the Scottish Government. However, they did not think that proposals to extend advertising restrictions at this point in time were appropriate for achieving these objectives.

4.15 There were three main themes in the comments made by these respondents (i) that the proposals are likely to have only a modest influence on children's food preferences, (ii) that the impact of the current regulations should be assessed first before any additional restrictions are introduced, and (iii) that the proposals are likely to have substantial and far-

²⁶ Note that current regulations exist under the Committee on Advertising Practice (CAP) code with regard to misleading advertisements, while EU Health Claims legislation regulates claims which can be made on food packaging.

reaching negative impacts – and not only for the food and drink industry. The main issues raised in relation to each of these themes are summarised below.

4.16 A small number of respondents said they disagreed with the Scottish Government’s proposals in relation to advertising restrictions because they believed the proposals did not go far enough.

Proposals will have only a modest influence on children’s food preferences

4.17 Respondents opposed to further advertising restrictions pointed out that there are multiple and complex factors that contribute to obesity, and they argued that advertising plays only a small role in the choices people make. This group cited research which showed that media restrictions were ranked relatively low (12th out of 16) in terms of possible cost-effective interventions for tackling obesity.²⁷

4.18 They also referred to research indicating that (i) young people aged 12-16 are easily able to identify and understand the persuasive intent of marketing communications, and (ii) children are increasingly accessing social media and viewing television programmes via devices (phones, tablets, computers), rather than through a television.

4.19 These respondents concluded that actions to further regulate either broadcast or non-broadcast advertising were unlikely to have the desired effect. They called for any further interventions in this area to be evidence-based and proportionate, while at the same time minimising any undesirable costs and impacts on the business sector.

The impact of the current regulations should be assessed first

4.20 Respondents pointed out that the CAP’s non-broadcast regulations were only introduced in July 2017 and they noted that, even before these new regulations had come into force, Ofcom had described the UK’s broadcast advertising rules as ‘amongst the strictest in the world’.

4.21 These respondents thought the new regulations needed time to ‘bed in’, and that their impact should be evaluated before any steps are taken to further restrict broadcast or non-broadcast advertising. Some respondents went further, stating that it would be ‘premature’, ‘unwarranted’ and ‘disproportionate’ to take further action in this area without clear evidence that the current system was ineffective.

The proposals will have significant negative impacts

4.22 Respondents opposing further restrictions on advertising identified a wide range of potential negative impacts from the proposals, not only for businesses within the food and drink sector, but also for broadcasters, for the advertising industry, for public transport services, and for the general public.

Businesses in the food and drink sector

4.23 Respondents were concerned about the potential impacts of the proposals on small food and drink businesses (including small, independent eating and drinking out

²⁷ R Dobbs *et al* (2014) *Overcoming obesity: An initial economic analysis*. McKinsey Global Institute. See <https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/how-the-world-could-better-fight-obesity>.

establishments), many of whom rely on advertising on public transport and in other contexts to reach their potential customers. The proposals were also seen to be indiscriminate, in that they would have an impact on businesses irrespective of whether they mainly sold foods high in fat, sugar and salt, or a wider range of healthier options.

4.24 Respondents considered that the proposed restrictions (in particular, the 9pm watershed) would represent a significant intrusion on the ability of companies to reach a legitimate audience for their products.

Broadcasters

4.25 Respondents cited evidence from Ofcom (reported in 2007) which forecast that £211 million would be lost to broadcasters from a 9pm watershed ban on advertising foods high in fat, sugar and salt. The Ofcom report stated that the public health benefits of such a ban were too uncertain and the impacts on broadcaster revenues too great to warrant such restrictions.

4.26 A range of respondents also noted that restrictions on advertising would have an impact on programme investment, thus reducing programme choice for Scottish audiences. They again cited Ofcom which reported that between 2008 and 2014, the ban on advertising of foods high in fat, sugar and salt relating to children's programmes had contributed to a 74% reduction in spend by commercial public service broadcasters on UK-created children's programmes. Some respondents raised concerns specifically about the impact on STV: they noted that if broadcasting / media regulation were devolved, the proposed restrictions on advertising would apply only to STV since other commercial broadcast service available to viewers in Scotland, but distributed across the UK, have no ability to differentiate their commercial inventory by region. This would have the effect of putting STV at a competitive disadvantage in relation to other broadcasters.

Advertising industry

4.27 Respondents cited evidence which highlighted the positive contribution that advertising has on the Scottish economy – with every £1 spent on advertising leading to £5 returned in GDP (Gross Domestic Product).²⁸ They also noted that advertising supports large numbers of jobs in creative industries.

Public transport revenue

4.28 Respondents noted that food and drink advertising on public transport services and in transport hubs helps to subsidise the cost of public transport. Restricting advertising in these locations would mean a shortfall in funding for these services.

Members of the public

4.29 Respondents thought that impacts on members of the public would be seen in terms of less choice in television programming and a loss of media plurality (seen to be fundamental to culture and democracy); and potentially higher public transport costs.

²⁸ GDP is a monetary measure of the market value of all final goods and services produced in a period (quarterly or yearly) of time.

Other issues raised by those opposed to new or extended advertising restrictions

4.30 The following additional points were also made by respondents who were opposed to, or concerned about, proposals to introduce further restrictions on advertising:

- There was a commonly expressed view that a UK-wide approach should be taken in relation to advertising regulation. Respondents were concerned about the practical difficulties and increased complexity for businesses if there were different rules in Scotland.
- All significant changes to the BCAP code must be put out to public consultation and agreed by Ofcom.
- If further restrictions were put on television advertising, there is likely to be a move towards greater advertising on social media, which is where increasing numbers of children aged 5-15 are watching television programmes or films. Advertising restrictions on social media would be harder to enforce.
- These respondents advocated improved education to enable consumers to make better, more informed choices about the foods they eat.

5. Out of home sector (Q4)

5.1 The consultation paper discussed a proposal to work with Food Standards Scotland, NHS Health Scotland and other stakeholders to develop a sector specific strategy for out of home providers. Out of home (OOH) providers include establishments such as restaurants, takeaways, sandwich shops, bakeries, coffee shops, school tuck shops, and community cafés where food and drink is purchased and consumed away from the home. Respondents were asked if any further or different action was required.

Question 4: Do you think any further or different action is required for the out of home sector? Please explain your answer.

5.2 A total of 278 respondents (133 organisations and 145 individuals) provided comments. These indicated that, in general, respondents thought that developing a strategy for the OOH sector was appropriate.

General views about a strategy for the out of home sector

Content of the strategy

5.3 It was recognised that the draft strategy for the OOH sector was not yet developed, and therefore comments were not made in response to specific proposals. Respondents discussed the issues it would be important to include, and gave their views on the best approach(es) for this sector. There was widespread recognition that any such strategy would be likely to involve substantial changes and would be challenging to introduce. Respondents therefore emphasised the importance of piloting and evaluating any new approach(es) and adjusting the strategy in line with the developing evidence.

5.4 In their comments respondents emphasised the importance of the strategy including actions relating to (i) creating a 'level playing field', (ii) increasing the availability of healthier options, (iii) developing better product information, (iv) portion sizes and reducing portion size, (v) the need for public sector procurement to set a good example, (vi) improving the availability of healthy options in food outlets near schools, and (vii) the role of the planning and licensing system. Each of these themes is discussed in more detail below.

Creating a 'level playing field'

5.5 A range of respondents, particularly those in the manufacturing and retail sectors, but also respondents in the third sector as well as professional bodies, emphasised the importance of creating 'a level playing field' so that OOH outlets would be held to the same standards and requirements as those in place or proposed for supermarkets and other retailers. This would involve requiring the OOH sector, as a minimum, to provide nutritional information and calorie labelling on their menus. However, the point was also made by some of these respondents that many OOH outlets have already made progress in relation to the provision of this kind of information, and that the focus of any strategy should therefore be on requiring those OOH outlets who had not already been proactive to do so. Thus the 'level playing field' was thought to be important both between the OOH and the retail sector as well as within the OOH sector itself.

5.6 Respondents from the food and drink industry, and from public health and third sector bodies emphasised the diversity of the OOH sector. For retail sector respondents, this meant that a ‘one size fits all’ approach was not appropriate. In contrast, public health and third sector respondents asked for a ‘comprehensive strategy’ which would cover all OOH outlets in ‘a consistent way’.

5.7 Views about whether or not a standardised approach was desirable were often linked to comments about whether any changes which were introduced should be mandatory or voluntary. In general, respondents from public health and third sector organisations argued for a standardised approach and mandatory changes. By contrast, private sector and business organisations, as well as individual respondents were more divided in their views; some of these respondents suggested either that (i) any new regulations should be made mandatory and enforced only for larger businesses (i.e. SMEs and other more informal providers should not be bound by (new) regulations), or that (ii) there should be ‘no disproportionate burden’ for small businesses and SMEs.

Availability of healthier options

5.8 In general, respondents from all sectors wished to see more healthy options available in the OOH sector. There was a particular concern at the lack of healthy options in deprived areas where (it was thought) there were large numbers of outlets selling only food and snacks of poor nutritional quality. However, recent evidence from the Scottish Social Attitudes survey was also cited to the effect that those living in the most deprived areas were slightly less supportive of restrictions on the numbers of fast food outlets in their areas.

5.9 At the same time, some respondents also focused on improvements which had been made more recently. These respondents (from the third sector and from the food industry) described the efforts made both by hospitals and by larger food chains and outlets to develop healthier options. The OOH sector in particular described their work in support of Public Health England’s Childhood Obesity Strategy (including work towards sugar reduction targets) and their participation in the Out of Home Nutrition Code of Practice, a voluntary code of conduct for the OOH sector, introduced in response to a request from the UK Government.

Product information

5.10 It was common for respondents from all sectors and groups to highlight the importance of having more product information available within the OOH sector, especially in relation to calories and portion information and there were some suggestions that calorie labelling should be mandatory. However, representatives of the OOH catering sector said there was ‘business opposition’ to calorie content being (mandatorily) shown on menus and asked for evidence of the impact that this would have. The reasons for this opposition stemmed from the additional costs incurred in calculating calories (and they queried whether this could be done with any accuracy), training kitchen staff and maintaining the data, (especially if menus change frequently). In addition, it was not clear how this could work in a self-service context.

5.11 There were also suggestions about having traffic light labelling added to menus. Less often there were requests that product information should cover Recommended Daily Intake (RDI), nutrient / macro nutrient profiles, and ingredients more generally. It was suggested

that the strategy should support the development of online apps to provide this kind of point of sale information. Local authority participants in the engagement event organised by Food Standards Scotland (FSS) referred to MenuCal as a useful tool.²⁹

5.12 A representative body for the OOH hospitality sector emphasised the work which it had undertaken to provide guidance on nutrition and food preparation for hospitality professionals. Specific mention was made of the 'Nutrition Guide for Catering Managers and Chefs' which has been developed to 'help facilitate best practice on nutrition and provide hospitality professionals with expert advice on how to develop, prepare and promote healthier meals'.

Portion size

5.13 Respondents (including one academic respondent who cited evidence) said that portion size had increased markedly over the last 10-20 years. This was seen to be an important issue to address in any strategy for the OOH sector, particularly as two recent evidence reviews have highlighted that larger portion size leads to higher consumption. This meant that – in theory at least – reducing portion size would reduce consumption.

5.14 Portion size was often discussed in the context of 'upselling' and other promotions, as well as in relation to – specifically – the takeaway sector. Respondents described a strong culture of 'getting your money's worth' in the OOH sector but repeatedly emphasised that portion sizes were simply too large. The main suggestions for addressing this included: (i) using smaller plate sizes; and (ii) offering smaller portions or half portions (particularly but not only to children and older people).

5.15 Local authority environmental health participants in the FSS engagement event highlighted potential difficulties in implementing and regulating smaller portion sizes. They thought this was more of an issue for SMEs than big companies. However, they also thought that if there was mandatory calorie labelling, this would be likely to result in smaller portion sizes. There were also some suggestions that businesses could benefit from having regulated portion sizes as this would eliminate competition between businesses to maximise the amount of food served.

5.16 Respondents from the food industry (including the OOH sector) raised specific points in relation to (reducing) portion sizes. Specifically, they noted:

- Reducing portion sizes is unlikely to reduce prices to any substantial degree (given that most of the costs are accounted for by labour and other overheads). Thus consumers may be dissatisfied, and they may also then purchase additional snacks as a consequence. This might mean that reduced portion sizes do not have a positive impact on reducing obesity.
- The parts of the OOH sector which do business across the UK have been working with Public Health England to meet targets for reductions in portion sizes and calories; working towards potentially different targets in Scotland would be problematic.

²⁹ <https://menucal.fss.scot/Account/LogOn?ReturnUrl=%2f>

- Many OOH outlets have already reduced their portion sizes and / or taken action to influence or control portions provided at self-service buffets.

Public sector leadership

5.17 Respondents from all sectors repeatedly commented that the public sector should be taking a lead in this area by providing good quality food and drink in public sector eating establishments (i.e. in schools, hospitals, local authority leisure centres, and public sector workplaces). Respondents were critical about current provision and insisted that more needed to be done within the public sector to exemplify high nutritional standards. Respondents also discussed the value of award and recognition schemes, and particularly the Healthy Living Award scheme. (The issues of public sector leadership and the use of award schemes in OOH food establishments are both discussed in more detail in Chapter 11.)

Children and schools

5.18 Respondents from all sectors often commented on issues relating to children, and especially to children's eating choices during school time. There was concern expressed about the availability – and large numbers – of outlets around schools which sold 'junk food'. Respondents called for these outlets to be controlled (or even eliminated).

The role of the planning and licensing system

5.19 Respondents from all sectors thought that the planning and licensing system could be used to great effect in developing the OOH strategy. They discussed this especially in terms of food outlets in the vicinity of schools; however, it was also mentioned more generally as a way of minimising the overprovision of outlets that were perceived to be offering only unhealthy foods. Respondents suggested that health impact assessments and specific licensing conditions (for example, in relation to opening times, or the amount of staff training given) could be used to good effect in this area.

5.20 Respondents from all sectors saw the potential for an enhanced role for local authority environmental health officers, who were seen as key partners in relation to this agenda. They suggested there was scope for these professionals to offer education, advice and support to the OOH sector in relation to the use of healthier ingredients, healthier menus and improved cooking practices as part of their official programme of visits to OOH establishments.

6. Food labelling (Q5)

6.1 The consultation paper explained how labelling works alongside other aspects of the food environment (information, advice, reformulation, etc.) to make it easier for people to make more informed – and healthier – choices. It also described the UK-wide voluntary Front of Pack (FoP) colour coded nutrition labelling scheme (introduced in 2013) which is used on about two-thirds of all pre-packed food and drink products in the UK. Finally, the paper set out the Scottish Government’s intention to explore how current labelling arrangements could be strengthened.

6.2 The consultation asked whether respondents thought current labelling arrangements could be strengthened.

Question 5: Do you think current labelling arrangements could be strengthened? Please explain your answer.

6.3 A total of 286 respondents (137 organisations and 149 individuals) provided comments. As no responses were received from those in the advertising industry, the private sector response for this question comes from respondents in the food and drink industry only.

Views of those in the food and drink industry

6.4 Respondents from the food and drink industry were generally content with current labelling arrangements and did not think these needed to be changed or strengthened. These respondents thought current arrangements were working well and were ‘popular and effective’ with consumers. They highlighted the industry’s compliance with current EU and UK-wide labelling regulations and the participation of many (though not all) businesses in voluntary mechanisms such as front of pack labelling. These respondents thought that additions or changes to current arrangements would be confusing for consumers, and they asked for there to be a full review of the efficacy of the current approach before any new responsibilities were imposed.

6.5 The main issue raised by respondents in this group, especially by manufacturers, was that they would **not** wish to see labelling arrangements in Scotland diverge from those in other parts of the UK. These respondents argued that this kind of divergence would be costly and wasteful and would make supply chains (needlessly) more complex. It would also bring competitive disadvantages due to the need for market-specific packaging which would be costly (as it would require smaller runs of packaging to be produced at higher unit cost and the productivity of production sites would be negatively impacted if lines had to be reset).

6.6 Other respondents from the food and drink industry commented on the difficulties which would be faced – particularly by smaller OOH operators and SMEs – if compulsory calorie labelling of menus (or any other measure requiring more detailed nutritional information on menus) was introduced. These smaller operators did not have access to nutritional expertise and would find it difficult to provide accurate information, especially given the frequency with which menus were changed.

6.7 It was not common for respondents from the food and drink industry to make suggestions for improvement. However, those who did offer suggestions generally echoed the points made by individuals and those in public health / third sector organisations. These suggestions were in the context of small improvements to a labelling system which they believed was generally performing well and should not be changed.

Views of individuals and those in public health / third sector organisations

6.8 Individual and public health / third sector organisational respondents were fairly positive about the current FoP traffic light labelling arrangements, but they also offered a range of suggestions for how the current system could be built on and improved, particularly in relation to its (i) voluntary status, (ii) coverage, (iii) standardisation, (iv) information coverage, and (v) textual and graphical presentation.

6.9 These respondents also expressed a range of views about how the traffic light system is used. Moreover some respondents, particularly those in public health organisations and partnerships, also focused on the broader context, and particularly on questions relating to health inequalities.

6.10 Each of these points is expanded on below.

Voluntary status of FoP labelling

6.11 As set out in the consultation paper, the FoP labelling system is a UK-wide voluntary system. There was a widespread view among these respondents that FoP labelling should be made mandatory / compulsory. Occasionally respondents discussed this change as being brought about through a series of (small) incremental changes, but more often they simply expressed a view that 'a mandatory system would be preferable'.

Coverage of FoP labelling

6.12 Respondents were aware that currently, FoP labelling was limited to pre-packed food and drink. They thought that the system should be extended to other types of foods (i.e. ready meals, all processed foods, freshly baked items, and products purchased online), and to the out of home sector (i.e. restaurants, takeaways, delicatessens, work canteens, etc.).

6.13 It was also suggested that alcoholic products and beverages should be covered by (FoP) labelling. This was thought to be important because of the calories and sugar content in alcoholic products.

Standardisation and simplification of FoP labelling

6.14 Both individuals and public health / third sector organisational respondents commented that there were many versions of the 'traffic light system' in place. They thought this was confusing and that it would be preferable to have one standardised version which was adopted by everyone.

6.15 Requests for 'standardisation' often went hand-in-hand with requests to reduce 'the complexity', 'the inconsistency' or the 'ambiguity' of the current system. While it was recognised that some subtle distinctions would be lost in making this change, respondents

overall felt that simplicity and comprehensibility of the system were crucial if the labelling was to be useful to – and more used by – consumers.

Labelling information

6.16 There was a very strong focus in the comments on the importance of providing information which related to (i) a realistic portion size and (ii) the actual pack being purchased (rather than some arbitrary reference amount). For example, in relation to the first point, one respondent noted that ‘the calories look OK until you realise the portion size is unrealistically small’.

6.17 Other items which respondents wished to feature – or to feature more prominently – in the FoP labelling scheme included: protein, ‘nutritional density’, vitamins and nutrients. It was suggested that in an ideal system a single number, or composite score should be produced for each product (the analogy of a unit of alcohol was offered).

6.18 There was a particular focus on how information about sugar and ‘hidden sugar’ should be presented. It was thought there was much room for improvement in this area. Suggestions included: (i) using teaspoons as well as grams; (ii) distinguishing naturally occurring from refined sugars / other sugars; and (iii) distinguishing sugars which are added (‘extrinsic’) from those which are naturally part of the raw product (‘intrinsic’).

(Textual and visual) presentation of labelling information

6.19 There was a strong focus in respondents’ comments on making sure that labelling information was clearly presented. Respondents said the information should not be ‘hidden’ or ‘concealed’ by making it very small print and / or placing it somewhere on the package where it was unlikely to be seen. It was also suggested that consideration should be given to the effectiveness of labelling for people with poor health literacy. This meant that the presentation would have to be clear, to incorporate images (including perhaps emojis), that it would have to be in a large font, and be written in plain English.

6.20 Participants in the Scottish Youth Parliament’s engagement exercise echoed these views. They thought that traffic light labelling was confusing and a few said that they had been completely unaware of these labels. This group thought the traffic light labelling should be better communicated and that it should be mandatory. They also wanted these labels to include another column which would indicate how much exercise would be required to work off the calories contained in the product (‘if a pizza box says it is 100 Kcal, it means nothing – but if it said how long it would take to burn off this type of food, this would make an impact’).

Using the traffic light system

6.21 While respondents were reasonably positive overall about the traffic light system, some individuals raised questions about its use. For example, they asked:

- How should two ‘amber’ ratings be combined?
- Did it make sense to award a ‘green’ to an item which had no nutritional value?
- What balance of ‘red’, ‘amber’ and ‘green’ would be required for a ‘healthy’ basket of food?

Broader context of health inequalities

6.22 There was a concern, particularly expressed by public health organisations and partnership groups, that focusing on labelling undermined the main message of the consultation paper. While (mandatory) labelling is regulated by government (EU, UK) and voluntary codes of practice are administered or adopted on an industry-wide or business-specific basis, the impacts of labelling (and the response to the information contained in the labelling) depends on the individual. These respondents highlighted that it was therefore possible (and some cited evidence that it was likely) that improving labelling could increase inequalities (since it was likely that those in the least deprived groups would respond to a greater degree to the 'messages' contained in the labelling than those in the most deprived groups).

6.23 These respondents thought it was important to place a greater emphasis on addressing wider influences (education, support, training, tackling the obesogenic environment using upstream interventions, etc.) which had more impact on people's food choices.

Other points

6.24 Other relevant issues raised by respondents were that labelling should be improved for specific groups (vegans, diabetics and children were specifically mentioned), and that new technologies should be exploited (including online calorie calculators and apps).

7. Support for reformulation and innovation (Q6)

7.1 The consultation paper described the current situation across the UK to change consumer preferences and to encourage businesses to reformulate their products in favour of healthier food options.³⁰ It then went on to explain that while large food and drink manufacturers might have the resources to invest in reformulation and innovation, it would be more difficult for small and medium enterprises (SMEs) – which make up 98% of Scottish food businesses – to follow suit.

7.2 The paper set out the Scottish Government’s commitment to investing £200k over the next three years to assist SMEs with this task, and went on to ask (at Question 6) about the specific support which would be required for Scottish food and drink SMEs.

Question 6: What specific support do Scottish food and drink SMEs need most to reformulate and innovate to make their products healthier?

7.3 A total of 241 respondents (109 organisations and 132 individuals) provided comments at this question. Advertising and media organisations did not comment, so the response from private sector and business organisations was, in effect, a response from the food and drink industry.

7.4 Respondents made a series of general points at this question, especially about the (lack of) affordability of healthier foods, the importance of changing the eating habits and preferences of consumers, and the inclusion of alcoholic products in the discussion around (obesity and) reformulation. Both individual and organisational respondents thought it was important to understand and incentivise consumer demand for healthier food, so that there is a market for (reformulated) products. This would involve educating the public in relation to healthier choices.

7.5 As regards specific support to SMEs, respondents focused their comments on (i) the availability of and access to guidance and expertise, (ii) staff training, (iii) the importance of incentives including financial incentives, and (iv) issues relating to reformulation. These points are discussed in turn below.

7.6 In relation to the Scottish Government’s proposal to invest £200k in Scottish food and drink SMEs over the next three years, respondents from all groups considered this to be much too small a sum (‘a drop in the ocean’), given that – as set out in the consultation paper – 98% of all Scottish food and drink businesses are SMEs. However, respondents did not make any specific suggestions about alternative sums.

Availability of and access to advice, guidance and expertise

7.7 There was widespread agreement about the importance of advice, guidance and expertise being available and accessible to all SMEs. Individuals and organisational

³⁰ Reformulation involves changing the composition of a product, for example, to reduce the amount of sugar, fat or salt it contains.

respondents from all sectors focused on the importance of being able to access (i) written guidance and online materials, (ii) nutritional expertise including access to practical expertise and advice in the workplace, and (iii) opportunities for networking and sharing.

7.8 Respondents identified a wide range of topics for which advice and guidance was required including: the evidence on healthy eating / healthy foods / nutrition; the nutritional requirements of different groups and the veracity or otherwise of claims about the nutritional value of specific products; consumer demand; diversification options if some product lines are to be reduced or withdrawn; labelling; recipe development; choice of ingredients; cooking methods; and portion sizes.

7.9 Respondents from the food and drink industry, and particularly those involved in the OOH sector, discussed the importance of being able to access help and input from nutritionists in the workplace. Respondents talked specifically about accessing advice from a 'registered nutritionist', 'Food Law Officer', 'food technology specialist', or someone who was 'suitably qualified'. Moreover, environmental health officers participating in the FSS engagement event saw a potential role for themselves in working with OOH establishments and manufacturers to advise on nutrition, signposting to information, and organising local training seminars.

7.10 Organisational respondents from larger food and drink manufacturing businesses suggested that the types of – highly productive – partnerships which they were able to have with research institutes and universities should be extended to SMEs. More generally, those in the research and academic sector thought it was vital that SMEs were aware of ongoing work in developing novel sugar substitutes and low salt alternatives.

Staff training

7.11 Respondents from the OOH sector, as well as public health and partnership bodies suggested that opportunities for (low cost) staff training and development should be made widely available to SMEs. These respondents said that staff would need to acquire new knowledge and skills in a wide variety of areas including diet and nutrition, cooking methods (frying techniques and temperatures were mentioned in particular) and (the nutritional quality and composition of) ingredients.

Incentives including financial incentives and funding support

7.12 Paragraph 7.6 above has already discussed the (perceived inadequacy of) the Scottish Government's proposal to invest £200k in SMEs over the next three years. More generally, respondents from all sectors and groups talked about the need for 'additional funding' or 'grant funding' for SMEs. For example:

- Some partnership bodies suggested the use of 'tax exemptions', including rent and rate reductions. These suggestions were especially mentioned in the context of SMEs who were producing locally sourced food.
- Among public sector and third sector organisations and individual respondents, there was discussion of the use of 'tax subsidies' and / or 'advertising subsidies' to support the production and / or marketing of 'healthy food' (as established by testing against an established Nutrient Profiling Model).

- Some individual respondents also talked about using the soft drinks levy as a subsidy to SMEs, which (they thought) would also increase the transparency of the use of the soft drinks levy. They also suggested introducing a levy on larger businesses which could be distributed to SMEs.

7.13 As far as the specific purposes for additional financial support were concerned, respondents from all sectors suggested that the support should be used to undertake reformulation. In addition, a range of respondents (both individuals and organisational respondents from different sectors) suggested that financial support could be used for other purposes including to: incentivise (more) SMEs to introduce traffic light labelling; test new products; set up 'taste panels'; allow SMEs to audit their current practice and to produce an improvement plan; and to improve their understanding of consumer preferences in order to market / advertise new products effectively. As regards this latter point, it was suggested that it would be worthwhile to provide greater support for the promotion of healthy Scottish produce through supermarkets, SMEs and food outlets.

7.14 In addition to financial incentives, it was suggested that the introduction of a 'logo', 'charter mark', 'local award' or 'national award' for 'healthy, locally produced products' might be useful in promoting innovation and reformulation.

Reformulation

7.15 Retailers, manufacturers and OOH outlets all made a positive case that much had already been achieved in relation to reformulation; indeed some retailers thought that they were reaching the limits of what could be achieved through reformulation. Respondents from the academic and research sector echoed this point and agreed that there were technical barriers (relating to taste, food safety, and product integrity) in relation to ever-increasing reformulation efforts. More generally, respondents from both the food and drink industry as well as from the public health and research communities, emphasised (i) the varying scope for reformulation that exists across different product categories, and (ii) the complexity of the task and the need for multidisciplinary teams (including all parts of the supply chain) to work on reformulation.

7.16 Respondents from across the food industry indicated that their efforts were often linked to the ongoing Public Health England reformulation programme. Respondents from all groups asked that those already engaged in reformulation (especially the larger manufacturing businesses) should be required to share their experience and expertise with SMEs.

7.17 A broad range of respondents, but third sector and public health respondents in particular, emphasised the importance of taking a wider view of reformulation and seeing it in a more 'holistic' context; removing or reducing specific ingredients was only one aspect – it was thought to be equally important to increase the use of nutrients and other 'healthy' ingredients.

7.18 Respondents disagreed in their responses about the role of artificial sweeteners in the reformulation process. While some manufacturers urged the government to give its explicit backing and support to artificial sweeteners (and argued that the general public needed to be reassured about the safety of these), other respondents, particularly those

from the public health sector, were against any reformulation process which removed natural ingredients (including sugar) and replaced these with artificial substitutes. These latter respondents thought that the overall goal of the reformulation should be to reduce the overall sweetness of the product (not replace one form of sweetness with another), and they also objected to the introduction of 'an artificial element into the diet' which could affect the taste of a product.

7.19 Finally, and less commonly, respondents discussed whether a mandatory approach to reformulation was required. While a mandatory approach was supported by a range of public health and third sector organisations, and by respondents involved in large food and drink businesses (who wished to ensure 'a level playing field'), it was not supported by those retailers or OOH sector respondents who commented.

8. Healthy weight from birth to adulthood (Q7)

8.1 The consultation paper discussed proposals to give families and children the support they need to develop a healthy and positive relationship with food. Respondents were asked if they thought that any further or different action was required.

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

8.2 Altogether, 294 respondents (144 organisations and 150 individuals) commented at Question 7. These comments were wide-ranging, with some respondents discussing high-level issues in relation to policy and strategy development; others expressing views about service delivery; and still others making detailed suggestions about the development and targeting of specific kinds of interventions. This chapter focuses on respondents' comments relating to high-level, policy / strategy issues. A summary of views in relation to service delivery and targeted interventions is provided at Annex 5.

8.3 Comments on policy and strategy development primarily came from public health and third sector organisations (e.g. local authorities and partnership bodies, NHS organisations, public health professional groups) and private sector weight management organisations. The main themes in respondents' comments related to (i) addressing inequalities, (ii) addressing the obesogenic environment, (iii) the focus and framing of the strategy, (iv) ensuring joined up policy in this area, (v) workforce development, and (vi) funding. Each of these themes is discussed below.

8.4 Private sector / business respondents were less likely to provide comments in response to this question. Those who did often raised entirely different issues to those above. These comments are summarised briefly at the end of this chapter.

Need to address inequalities

8.5 Respondents repeatedly highlighted the link between deprivation and obesity. They emphasised that any strategic plan in this area must demonstrate an understanding of the influence of poverty on diet, and clearly articulate the implications of this. In particular, respondents were concerned that actions targeted at individual behaviour change have the potential to **widen** health inequalities, rather than reduce them.

8.6 Those affected would include not only people living on very low incomes, but a range of other vulnerable groups (e.g. people with mental health problems, people with learning disabilities, children in care, older people, people with physical disabilities, and people from black and minority ethnic communities). It was suggested that initiatives would need to be tailored to each of these groups.

8.7 Some respondents also discussed issues of food poverty (and food insecurity). On the one hand, there was a view that steps must be taken to reduce the need for people to use foodbanks. At the same time, others thought that the consultation paper should have included actions to improve the standard of food donated to food banks, much of which (it was noted) is processed, poor quality food high in fat, sugar and salt.

8.8 Respondents also called for strategy in this area to be framed in terms of human rights (and child rights in particular) – as they thought that having the strategy framed in this way would help to reduce inequalities, while also giving a legal and moral impetus to public health initiatives aimed at addressing poor diets.

Focus on changing the obesogenic environment

8.9 Related to the issue of addressing inequalities, there was a widespread view that any strategy to improve diet and tackle overweight should focus much more clearly on ‘upstream’ interventions to address the wider determinants of health. This would include, for example, the use of taxes to increase the cost of ‘unhealthy’ food and the use of subsidies to decrease the cost of (for example) fruit and vegetables. There was a view that the consultation paper should also have referred to recommendations from World Health Organisation (WHO) Commission on Ending Childhood Obesity (ECHO) (2016) and the ECHO Implementation Report (2017) in particular.

8.10 While the dominant view was that (reducing) obesity should be seen as a societal issue, with action taken at business and government levels, a small number of respondents highlighted issues relating to personal choice and responsibility. These respondents suggested that the focus of any strategy should be on communicating to the public about the health risks of obesity and on encouraging healthy choices.

Focus and framing of the strategy

8.11 There was virtually unanimous agreement that obesity was a serious problem in Scotland, which needed to be addressed. However, respondents repeatedly commented that any strategy that was developed should not focus solely on reducing obesity; rather the strategy should be more ‘holistic’, and directed towards improving health and wellbeing more generally. This meant that the strategy should include actions not just on weight, diet and nutrition, but on physical activity too.

8.12 Moreover, respondents often highlighted the importance of framing any actions to address diet, activity and weight in positive terms (i.e. achieving a healthy weight), rather than in negative terms (i.e. tackling obesity). These respondents emphasised the need to reduce weight-related stigma (‘fat shaming’) and to change the current culture where individuals were often ‘blamed’ for their obesity. They thought that reducing stigma would encourage people to engage positively with initiatives, and would also help to prevent dangerous negative responses (i.e. eating disorders). Such comments were often linked to views about the need to acknowledge the emotional relationships that people have with food, and the importance of providing psychological support within weight management programmes.

8.13 Related to these issues, participants in the ScotPHN engagement exercises thought the issue of weight-related stigma – and its effects on children and young people, in particular – should be considered more prominently in a strategy to promote a healthy diet. This group thought that ‘more needs to be done in relation to social media and the pressure on teenagers’ regarding inappropriate body images. The engagement exercises carried out by the Scottish Youth Parliament and Young Scot also highlighted this as an important issue for young people. It was noted that ‘a lot of people get unhealthy in their attempt to achieve a certain image’.

Need for joined up policy

8.14 Respondents called for more joined up policy on the issue of diet and weight. They noted that any policy to tackle overweight must link closely to policies on housing, transport, active travel, greenspace, education, child poverty, mental health, and other related health policies and implementation plans. They also highlighted the importance of linking to economic policy (in terms of taxes, subsidies, economic growth, etc.) and employment policies (in terms of flexible working and improving work / life balance). In addition, respondents wanted to see a clear connection to Scotland's Good Food Nation policy.

8.15 Given the recurring views that the issue of 'healthy diet' is a cross-policy concern, some respondents also cautioned against framing obesity as an 'NHS issue'. There were views that the second half of the consultation paper, in particular, was too NHS focused.

Workforce development

8.16 Respondents identified a wide range of community-based professionals who should have a role in supporting work in this area (e.g. midwives, health visitors, nursery staff, general practitioners and other primary care staff, teachers, social workers, care workers, etc.). They pointed to a need to skill up these staff and give them the confidence to be able to sensitively and effectively engage people in conversations about their weight and behaviour change.

8.17 Some respondents noted the specialist expertise available from dietitians and nutritionists, but noted that these posts were not well resourced and the availability of such staff was variable across Scotland. Other respondents referred to the considerable expertise and experience available from third sector partners.

Funding

8.18 While respondents acknowledged and welcomed the commitment to additional funding for weight management programmes (see Chapter 9 for a discussion of this), they also highlighted a wide range of other areas where additional funding was required – including funding for dietitians, home economics teachers and community-based food initiatives. (See Annex 5 for details.) Respondents saw any strategy to address diet as a long-term strategy, and thus argued that long-term funding would be required.

Views of private sector and business respondents

8.19 As noted in paragraph 8.4 above, private sector respondents in the food and drink industry were less likely than others to offer views in relation to this question. This group of respondents expressed their support for the proposals to provide a greater focus on food, nutrition and physical exercise within the school curriculum, and they generally highlighted the importance of educating consumers to make more informed choices about the foods they eat. Some also highlighted their work in supporting community initiatives (i.e. through sponsorship of local sports teams, through involvement in the 'Eat Better, Feel Better' campaign, and through disbursements to communities of funds raised through the plastic bag levy).

9. Supported weight management services & other interventions (Qs 8-9)

9.1 The consultation paper set out current estimates of the prevalence and incidence of type 2 diabetes in Scotland, and described the impacts of this condition on peoples' lives, on the health service, and on the economy. It went on to describe the Scottish Government's plan to invest £42m over five years to establish supported weight management interventions for people with, or at risk of developing type 2 diabetes. The consultation paper also covered proposals to support the delivery and development of (wider) healthy living interventions as treatments through the NHS and third sector.

9.2 Respondents were asked for their views on the implementation arrangements for the weight management service (at Question 8) and for their views on support for healthy living interventions – including the quality and referral arrangements for weight management programmes – (at Question 9). There was substantial overlap in the comments at these questions, and they have therefore have been considered together.

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?

Question 9: Do you think any further or different action on healthy living interventions is required? Please explain your answer.

9.3 Altogether 260 respondents (108 organisations and 152 individuals) provided comments at Question 8, and 238 respondents (115 organisations and 123 individuals) provided comments at Question 9. Very few comments were offered by private sector and business organisations in relation to these questions. By contrast, almost all public sector health organisations, local authorities and partnership bodies, public health professional groups and weight management organisations, and around half of third sector organisations, research organisations, sports bodies, and other professional bodies provided comments.

9.4 The comments covered a wide range of issues, both general and specific. Detailed responses, including evidence about efficacy and effectiveness, were offered in relation to specific weight management programmes. Most often these comments came from public health or NHS organisations, or commercial weight management organisations. However, a small number of well-informed individuals also provided detailed evidence and commentary.

9.5 The main themes raised in these comments are discussed below under the headings of (i) coverage and targeting, (ii) referral routes, (iii) the nature and content of weight management programmes, and (iv) the broader context.

Coverage and targeting

9.6 Respondents from all sectors and groups welcomed the funding commitment from the Scottish Government for supported weight management programmes. There was a widespread view that substantial investment was needed in this area, and that there was wide variation in the availability (and potentially the quality) of the programmes currently

available across Scotland. There was a general assumption that this funding would be (initially) directed into the NHS. However, respondents also emphasised that (some of) the funding would subsequently be directed onwards into other organisations and sectors, in particular through the use of ‘social prescribing’ and through referrals to commercial weight management programmes.³¹

9.7 The following issues relating to coverage and targeting were raised by all groups who responded to this question:

- It was not clear why these programmes were to be targeted only at those with – or at risk of developing – type 2 diabetes; the issues of obesity and overweight extend beyond these subgroups. These programmes should be available to anyone – and everyone – who needed support.
- Offering these programmes only to people who were already diagnosed, or who were identified as being at risk, meant the investment would be focused on treatment (of the individual) and not on prevention (at a population health level). This was thought to run counter to the government’s commitment to a preventative approach. Respondents therefore thought that this investment would have to go hand-in-hand with investment in more ‘upstream’ interventions.

9.8 In addition, respondents from the NHS and from public health organisations asked how those ‘at risk of developing type 2 diabetes’ would be identified as the UK National Screening Committee does not currently recommend population screening for type 2 diabetes.³²

9.9 The recruitment to and uptake of programmes was also discussed by a wide range of respondents, particularly in relation to groups where uptake was historically low (e.g. men, people with long-term conditions, black and minority ethnic groups, parents with young children, adolescents, and more deprived socio-economic groups). In addition, there were suggestions that certain groups should be specifically targeted (e.g. people with long-term conditions, adolescents, pre-conceptual women, pregnant women, and cancer survivors). The importance of providing accessible, age-specific, socially and culturally appropriate services which were free at the point of delivery (e.g. if referral to an exercise class was part of the programme this would have to be funded), was emphasised by a wide range of individual and organisational respondents, especially in the context of not increasing health inequalities.

Referral routes

9.10 Respondents discussed referral mechanisms. Both individual and organisational respondents were most familiar with referral by GPs. However, there appeared to be differing opinions about whether the current GP referral system was working well. Consultation respondents were supportive of current GP referral arrangements and pointed to the trust between patients and their GPs, and to evidence which suggests that patients are willing to act upon advice given to them by their GPs. However, attendees at the ScotPHN engagement events suggested that the current GP referral system was too

³¹ Social prescribing is a means by which primary care services are able to refer people to a range of local, non-clinical services, often provided the voluntary or community sector.

³² <https://legacyscreening.phe.org.uk/diabetes>

complex and it was thought there may be some scope to improve this through the new GP contract.

9.11 Thus, while there was general support for a GP referral system, there was also widespread support for a broader range of possibilities in relation to referral to a supported weight management programme. Specifically, respondents thought such services should be available by self-referral, as well as through referral by a range of other professionals including:

- Health care professionals within a primary care setting (pharmacists, community nurses, specialist diabetes nurses, mental health nurses, allied health professionals, etc.)
- Health care professionals within a secondary care setting (who might see someone for weight-related co-morbidities)
- Employers
- Other professionals (social workers, advocates, leisure centres, third sector, etc.).

9.12 This suggestion of a wider range of possibilities for referral pathways was often accompanied by a request for (i) more investment in the training of both health care professionals and non-health care professionals so that they are better equipped to provide advice and guidance on healthy weight; and (ii) more 'joined up' working across agencies in the public, private and voluntary sectors to ensure that available resources were deployed to best effect.

9.13 The NICE Guideline on population and community-level interventions for the prevention of type 2 diabetes (which covers, *inter alia*, referral pathways) was mentioned as a positive approach, mainly by NHS and partnership bodies.³³ More broadly, respondents from all sectors emphasised the importance of developing referral pathways that are simple and 'streamlined' so that any barriers to access would be reduced.

9.14 There was specific comment from two organisations offering weight management programmes that existing referral processes in some areas are not currently working as they should; these organisations had capacity to provide a service to many more people than were currently being referred.

Nature and content of weight management programmes

9.15 There was a substantial amount of comment on what a weight management programme should include, much of it – particularly from those directly involved in delivering programmes – discussing the (emerging) research evidence. The importance of programmes being evidence based, and proven to be effective, was emphasised by all groups. Respondents across a variety of organisational groups described the success of programmes currently up and running in Scotland.

9.16 There was a general view that programmes needed to take a broad and holistic view of the support required, and therefore should (i) cover both diet and physical activity; (ii) address self-management and behaviour change; (iii) provide psychological support if

³³ NICE Public Health Guideline (PH35), May 2011 - <https://www.nice.org.uk/guidance/ph35>. A decision on the timetable for updating this guideline is imminent.

required; and (iv) include education about healthy eating and meal planning, and the development of cookery skills.

9.17 There was widespread support for the involvement in weight management of organisations and resources beyond the health sector. Community-led programmes of all kinds, and the involvement of the third sector in general, were thought to be vital. Respondents talked about building on existing arrangements for ‘social prescribing’ and highlighted the benefits of walking groups, exercise classes, etc., for those across the entire spectrum of overweight and obesity – both in relation to weight loss and weight maintenance.

The broader context

9.18 Some respondents – particularly individuals with personal experience of weight management services – focused on the importance of the broader context. They thought weight management programmes: should avoid ‘simplistic messages about eating less and exercising more’; should address psychological wellbeing and mental health issues; and should not stigmatise or ‘blame’ the obese person. Related to this, a range of individuals and organisations (particularly from the public and third sectors) thought programmes should focus on wellbeing more generally, with weight loss being seen as a secondary outcome.

9.19 Both individual and organisational respondents (especially from the public health, public sector and third sectors) called for more investment – and longer term investment – in programmes that go wider than weight management to tackle issues of healthy living, community cohesion and social isolation. These respondents described local programmes and community-based initiatives which they were involved in, or knew about, and which they thought should be sustained and / or rolled out on a wider basis. Respondents frequently said that there was evidence that these initiatives were effective, and some cited published evidence to that effect. Many of the specific examples mentioned focused on (i) physical activity, (ii) community food initiatives (including cooking classes), and (iii) family based programmes.

Other points

9.20 Other relevant issues raised by respondents were that:

- The duration of a weight management programme was important. Evidence was cited that many current weight management programmes are not long enough, and respondents advocated programmes that last at least one year.
- There needs to be a strong focus on maintaining weight loss (weight-regain prevention) as well as on weight loss itself. This points towards programmes of a longer duration.
- Offering someone access to a programme at the point at which they are diagnosed with type 2 diabetes might provide the best opportunity to encourage engagement / participation.
- Local and national campaigns to alert people to the dangers of obesity could be beneficial. In addition, technology, apps and social media could be used to deliver online messages and advice.

10. Physical activity (Q10)

10.1 The consultation paper described the wide range of activities and initiatives currently funded by the Scottish Government to support improvements in physical activity among the people of Scotland. These include commitments to: (i) have Scotland become the first ‘Daily Mile’ nation – an intervention targeted at children, young people and staff in nurseries, schools, colleges, universities and workplaces; (ii) put active travel at the heart of transport planning; and (iii) to appoint an Active Nation Commissioner. The consultation paper also discussed proposals to: (iv) link increased investments in active travel with efforts to support weight management; (v) make improvements to the planning system to ensure that it supports active travel and healthy choices; and (vi) consider ways of creating ‘active places’ to make it easier for people to be more active.

10.2 Respondents were asked for their views on how the Scottish Government’s work to encourage physical activity can contribute most effectively to tackling obesity.

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

10.3 A total of 281 respondents (124 organisations and 157 individuals) provided comments at Question 10. Responses to this question came mainly from individuals and from public health and the third sector organisations. Few respondents from the food and drink industry or business organisations replied to Question 10. Those who did highlighted their work in communities and among disadvantaged groups to encourage and promote physical activity and sponsor local sports teams.

10.4 Among those who addressed this question, there was general support for proposals to develop and / or expand opportunities for active travel, and to build on the success of the Daily Mile initiative in schools. Respondents made a wide range of specific suggestions about how to create an environment – and communities – that would encourage and normalise physical activity.

10.5 A few respondents made more general comments. These focused mainly on policy and strategy development in this area. Views were also expressed about the appropriateness – or not – of linking physical activity to efforts to tackle obesity. These general comments are discussed first below, followed by respondents’ specific suggestions, and observations about equalities issues.

General points regarding policy / strategy development

10.6 There was widespread acceptance among respondents that efforts to encourage physical activity should be part of any strategy to tackle obesity. However, respondents emphasised that the challenges of getting people to become more active should not be underestimated, and they pointed out that all the available evidence indicates that simply signposting people to exercise classes and other physical activity opportunities will not be enough to motivate people to become more active. Evidence was cited to suggest that focussing on outcomes **other** than physical health (e.g. fun, friendship, family time) will result in better engagement in physical activity.

10.7 At the same time, respondents also thought there was a need to develop motivational tools and techniques for engaging people who are uninterested in sport and exercise **and** for overcoming the multiple barriers that people who are obese, in particular, may face (including weight-related stigma, insecurity, and anxiety). (See Annex 6 for detailed suggestions about motivational tools and techniques.)

10.8 While most respondents accepted the premise in the consultation paper that encouraging physical activity was important in any attempt to tackle obesity, there were also some who questioned this. Specifically, it was noted that increasing physical activity on its own is not enough to result in weight loss. Rather, any national strategy to improve rates of physical activity will only reduce levels of obesity if it is coupled with: (i) action to tackle the obesogenic food environment, and (ii) clear advice / guidance in relation to a healthy diet.

10.9 While all respondents agreed that increasing levels of physical activity has a wide range of benefits for health and well-being, this latter sub-group of respondents thought that attempts to increase physical activity should not be a 'distraction' from the need to reduce calorie intake. There was also a view (expressed less often) that strategic efforts to improve levels of physical activity should be entirely separate from a strategy to tackle obesity, simply because the benefits of physical activity extend far beyond weight loss – and because weight loss cannot be achieved through physical activity alone.

10.10 However, the opposite view was also expressed: that the consultation paper did not give **enough** prominence to encouraging physical activity – that this part of the consultation paper seemed like an 'add-on', which did not reflect the Scottish Government's commitment to encouraging physical activity.

10.11 Respondents making such comments highlighted the importance of developing policies in this area that were coherent and consistent (i.e. across all government departments).

Specific suggestions

10.12 There was general agreement among respondents that policy in this area should aim to 'normalise' physical activity: 'Being physically active should be the norm and not seen as something that people have to add to an already busy life'. Thus, there was widespread support for active travel initiatives – and cycling and walking, in particular. Respondents also discussed workplace initiatives; advocated improved access to community, sport and leisure facilities; and suggested a range of steps which could be taken to encourage physical activity among children and young people specifically, and among families more generally. Annex 6 provides details of specific suggestions in relation to each of these points.

Equalities issues

10.13 Respondents often cited evidence of the social patterning of diet and physical activity. These respondents thought policy in this area should aim to tackle social disadvantage and interventions should be tailored to ensure they are effective across the social gradient. Respondents identified specific groups likely to require such tailored interventions, including (i) people who are struggling with weight, low motivation and chronic health conditions (who will need more intensive psychological support to help them become more active); (ii)

adolescent girls (who are far less likely than their male peers to be physically active); and (iii) people with musculoskeletal conditions.

10.14 Respondents made suggestions about how to improve engagement in physical activity among people in Scotland's most disadvantaged communities (including protecting sports fields and playgrounds from development, and reducing financial barriers to accessing community leisure facilities. Respondents emphasised that access to opportunities to become more physically active should be available to all, and not dependent on income or where people live.

11. Making obesity a priority for everyone (Qs 11-12)

11.1 The consultation paper described a range of actions for making obesity a priority for everyone and for building a 'whole nation movement'. The actions covered (i) creating a network of local government and health leaders to enhance and share their improvement work on weight and diet; (ii) developing plans to further support the health and wellbeing of Scottish Government staff and encouraging others to commit to action; (iii) ensuring that health and environmental sustainability are key considerations in the public procurement of food; (iv) expanding the Healthy Living Award to publically funded catering locations which do not currently offer customers a mark of health; (v) exploring opportunities to extend Healthcare Retail Standard criteria beyond the NHS; and (vi) renewing the commitment to community food initiatives.

11.2 The paper asked respondents about these proposals.

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

Question 12: How can we build a whole nation movement?

11.3 Altogether, 283 respondents (134 organisations and 149 individuals) provided comments in response to Question 11 and 263 respondents (119 organisations and 144 individuals) provided comments in response to Question 12. For organisational respondents, whether or not a comment was provided varied by organisational type. In particular, a smaller proportion of private sector and business organisations commented, as compared to public health and third sector organisations.

11.4 There was broad support for the idea that 'everyone should be involved' in the effort to reduce obesity, and there was agreement that tackling obesity would require effective collaboration between the private, public and voluntary sectors. The only caveat was that there was a possibility that by making obesity 'everyone's problem', it could become 'no-one's problem'. Thus it would be important to be very clear about what exactly the strategy / approach involved, and who had lead responsibility in relation to the delivery of individual elements.

11.5 Reducing obesity and promoting healthy eating and active living was described as a long-term agenda involving major cultural change. It would require sustained investment, political will, 'joined up' thinking (and specifically more joined up thinking than was currently the case), and leadership at all levels over a substantial period of time. However, as discussed elsewhere in this report (Chapter 8), respondents repeatedly commented that it was important that any strategy that was developed should not be simply an obesity strategy.

11.6 In their comments respondents focused on (i) leadership and exemplary practice, (ii) the workplace environment, (iii) environmental sustainability, (iv) community food initiatives, and (v) learning from elsewhere. Each of these areas is discussed below.

Leadership and exemplary practice

11.7 There was discussion about the importance of leadership across all sectors and at all levels and the point was repeatedly made about the importance of 'leading by example'. Respondents characterised this leadership in different ways as (i) national, local, and community levels or (ii) political, organisational and grassroots. Partnership bodies, and third sector organisations focused more on the importance of leadership at 'grassroots' or community level, while those in professional or representative bodies were more concerned with (national) strategic leadership – at least in the first instance.

11.8 Respondents from all groups thought it was vital that hospitals, schools, care homes, prisons and other public sector locations provided nutritious food. Individuals who commented on current provision in hospitals criticised the vending machines selling unhealthy foods and the 'substandard frozen meals'. The provision of food in schools (including school meals) was also criticised. However, it should also be noted that respondents wished that more pupils actually took advantage of the availability of school meals, rather than going outside the school for their food at lunchtime.

11.9 As far as the Healthy Living Award was concerned, respondents who commented were supportive of the idea to expand this to other publically funded catering locations. However, they also thought the impact of the award should be evaluated and that the criteria for the award should be strengthened / made more stretching.

11.10 Only a few respondents discussed the broader adoption of the Healthcare Retail Standard beyond the NHS to other retail settings operating in publicly funded locations. While individual, academic, public health and public sector respondents supported this extension (subject only to an evaluation of its impact to-date), respondents from the food and drink industry argued that this would not be appropriate. The rationale for not supporting wider introduction related to the intense support required to introduce it, the (perceived) lack of capacity for that support, the severity of the restrictions, and the potential impacts on businesses which are (they argued) already providing consumers with healthier items and more information to support healthy choices.

11.11 Finally, there was a predominant view that it was difficult for staff within the NHS to 'lead by example' (including raising the topic of weight management with patients) if they themselves were overweight or obese. However, there were also occasional comments to the effect that overweight or obese individuals found it 'easier to relate' to nurses and other healthcare professionals who themselves had problems with their weight.

The workplace environment

11.12 Respondents commented on the importance of the workplace environment, especially in relation to offering support to employees to develop healthier lifestyles. The general view was that employers should ensure that employees are able to have a good work-life balance, including proper breaks during the working day, flexible working arrangements, and opportunities in relation to improved physical activity. (Issues relating to workplace initiatives to encourage physical activity in are discussed in detail in Annex 6.) A range of organisational respondents across diverse sectors also described their own approaches to supporting their employees' health.

11.13 It was noted that the NHS has committed to support healthy eating, physical activity and weight management for all NHS staff through the Health Promoting Health Service (HPHS) initiative. Respondents queried why the HPHS was not mentioned in the consultation document

Environmental sustainability

11.14 Health and environmental sustainability were mentioned by respondents particularly in relation to (i) public sector procurement where it was thought commitments to sustainability made in other policy initiatives (e.g. Good Food Nation) should be implemented; (ii) the adoption of sustainable diets (vegan diet, vegetarian diets and plant-based diets were particularly mentioned); and (iii) increasing awareness among both consumers and producers of the importance of adopting sustainable practices within the food industry.

Community food initiatives

11.15 There was widespread support for increased investment in community food initiatives including community gardens. These were thought to be very important in educating people about food and in providing a context for people to work and undertake practical tasks together, thus supporting social interaction and wellbeing. Many specific examples of successful community food initiatives which involved food growing, nutritional education, and the development of cooking skills were offered. The point was made that such initiatives were often operating in communities where food budgets were very constrained.

Learning from elsewhere

11.16 The approaches adopted to address Scotland's unhealthy relationship with alcohol and in relation to tobacco control were frequently mentioned as models for developing an approach on obesity.

11.17 Respondents also pointed to successful initiatives from further afield where there had been a sustained and integrated effort to tackle obesity. Annex 7 provides specific examples in relation to the Oklahoma Weight Loss Initiative, the French VIF initiative, and the Amsterdam Healthy Weight Programme, among others. Respondents who provided these examples gave substantial accounts of what had been done and what had been achieved.

Other points

11.18 Other relevant points were that:

- There were many areas in which respondents were keen to see increased (financial) support. These included: (national) public campaigns, documentaries and broadcasts; marketing campaigns for healthy food; promotion of healthy eating and active living; training of more public health practitioners, dietitians, applied psychologists / health psychologists, community workers; the development of new roles in obesity leadership; and more investment in public infrastructure, especially transport and active travel infrastructure.
- Respondents, especially individuals and those from partnership bodies and third sector organisations focused on the importance of the approach being accessible to

everyone, especially those in difficult financial circumstances; they sometimes framed these comments as taking a 'rights based approach'. These respondents focused on the importance of ensuring that healthy food was available at a reasonable price, and also that opportunities to get involved with physical activity and exercise were freely available to all. It was suggested that more consideration needed to be given to the infrastructure which was required to promote, encourage and facilitate wide participation.

- It was vital that health inequalities were not increased as an unintended consequence of the efforts to tackle obesity; this would mean ensuring there was a strong focus on actions to deal with the obesogenic environment and the social determinants of health.

12. Monitoring change (Q13)

12.1 The consultation paper set out the commitment to ensuring that the development of Scotland's approach to improving health is based on robust evidence. The paper confirmed that a monitoring and evaluation programme to measure the impact of the new proposals would be put in place, and that a biennial international conference to measure progress and share good practice would be hosted.

12.2 Respondents were asked for their views on whether further steps should be taken to monitor change.

Question 13: What further steps, if any, should be taken to monitor change?

12.3 A total of 207 respondents (110 organisations and 97 individuals) provided comments in response to Question 13. For organisational respondents, whether or not a comment was provided varied by organisational type. In particular, a smaller proportion of private sector and business organisations offered comments, as compared to public health and third sector organisations.

12.4 Respondents who commented affirmed the importance of robust monitoring and evaluation procedures to measure progress. They highlighted that this was a complex area and that it was important to develop a consistent approach with well-specified definitions and measures, where outcomes are used to drive further improvement.

12.5 However, respondents differed in their views in relation to the breadth of the data collection which should be undertaken, and – by implication – which outcomes were the most important to monitor. In addition, respondents discussed the strengths and weaknesses of existing measurement approaches (including surveys and routine administrative data) and their possible application to the current proposals. They identified sources of existing data as well as other monitoring and evaluation programmes and approaches that had already been developed, and which might provide a starting point. These aspects are discussed further below. A final section summarises a range of other relevant points made by respondents.

12.6 Note that respondents also used this question as a further opportunity to restate their views on which interventions were most likely to be effective, and which interventions they would wish to see implemented. This included comments about the targeting of any initiatives and in particular the importance of targeting (geographic) areas of high deprivation and the importance of focusing on 'upstream interventions'. These comments have been discussed in full in relation to earlier questions and are not repeated here.

Data to be collected

12.7 Respondents offered a range of views on what data should be collected in relation to monitoring and evaluation. There were three main perspectives as follows:

- The main focus should be on monitoring weight, and other related measurements such as BMI and waist circumference.

- The main focus should be beyond weight, and should focus on issues relating to health and wellbeing more generally – or ‘quality of life’. This would involve measuring indicators relating to diet, fitness, activity (including uptake of exercise classes), mental health, and so on, as well as measuring impacts on health inequalities. This perspective was particularly common among respondents from public health and third sector organisations.
- Other respondents (including those in the food and drink industry, but also individuals and respondents from a range of other organisations) thought it was important to monitor impacts on health and wellbeing (including weight) but also on retail sales, nutritional content, and consumption. This group argued that since the Scottish Government’s proposals (on promotions, advertising and labelling) were aimed at changing consumption patterns and nutritional content, then any monitoring and evaluation programme should include measurement of these elements. They also argued that these types of measures might give an earlier indication about whether the proposals were having an effect (compared to impacts on weight and / or health and wellbeing which would take longer). These respondents suggested that information should be collected on sales, the provision of product information in food outlets, the nutritional content of foods and nutritional standards generally, and food consumption.

12.8 In all cases, respondents recognised that changing the diet, exercise and eating habits of the Scottish population was a long-term project which might take a generation or more to achieve. Therefore, there needed to be a long-term perspective in any monitoring and evaluation activities.

12.9 The topic of ‘surveillance’ was discussed extensively at the ScotPHN engagement events. Additional key points from these events were that:

- Monitoring and evaluation activities would be useful in addressing the current lack of consistency in interventions (by highlighting which approaches were most effective), and would also improve the arrangements for follow-up of outcomes (which were currently inadequate).
- Economic evaluation should also be undertaken to understand the return on investment in prevention, as well as assessing the cost benefits of treatment.
- Long-term population surveillance would be required, and it was not clear how this could be sustained with only short-term funding. Given the pressures on NHS Boards and local authorities, work in this area may not be prioritised. It was suggested that funding for interventions should be allocated on condition that monitoring / evaluation is undertaken.

Strengths and weaknesses of data collection approaches

12.10 Respondents from a wide range of organisations, but particularly those concerned with public health, asked for a better national surveillance system for monitoring weight. This would include measuring children’s weight at the end of primary school (as had been done previously), but would also involve (i) using GP visits and other health service contacts (e.g. in ante-natal clinics) to measure and record people’s weight, and (ii) encouraging self-

monitoring of weight. It was suggested that ‘body fatness’ rather than ‘overweight’ or BMI was the most relevant measure.

12.11 While respondents were supportive of using the Scottish Health Survey (SHeS) to collect data on weight on an annual basis, it was thought that the sample size would have to be increased considerably if SHeS was to be useful as a monitoring tool at local level. Public sector respondents suggested that disaggregation by local authority, NHS board, integrated joint board, health and social care partnership, community planning partnership, and even individual GP practice would be useful. It was also thought that the way physical activity data are collected within the SHeS should be reviewed.

Learning from other monitoring and evaluation activity

12.12 Some respondents, especially those with experience of the NHS, emphasised the importance of using routinely available administrative data, including GP-held patient data and data on diabetes from the Scottish Care Information – Diabetes Collaboration (SCI-DC) initiative in relation to monitoring and evaluation. Third sector respondents also described a range of measurement tools which they had developed or were using (e.g. the Cycling Potential Tool, the Hands Up Scotland Survey) and suggested that investment in these tools would be worthwhile.

12.13 Participants in the ScotPHN engagement events suggested that a range of other existing population level data may also be used to support monitoring and evaluation efforts. These included (in addition to SHeS) UK Treasury data, and data collected through Healthy Working Lives and the Healthy Living Award schemes. Reference was also made to Kantar (consumer panel) data which (it was suggested) could be used to monitor the impact of promotions. In addition, it was thought there was an opportunity to use and extend current cohort studies (for example, the ‘Growing Up in Scotland’).

12.14 More broadly, respondents referred to a range of examples where comprehensive monitoring and evaluation programmes or approaches had already been developed, and which could contribute to developing a programme in this area. In particular:

- Monitoring and Evaluating Scotland’s Alcohol Strategy (MESAS) – developed by NHS Health Scotland – was thought to provide a good example of a comprehensive approach to monitoring and evaluation of a complex series of interventions. Respondents suggested that a similar approach might be adopted in the current context.
- The National Observatory for Obesity (NOO) set up by Public Health England (PHE) was thought to provide an example of good practice in relation to monitoring obesity. The approach was thought to be comprehensive and to include key performance indicators across a wide range of topic areas.
- The Scottish Food Enforcement Liaison Committee Diet and Nutrition Working Group (SFELC) are currently working on monitoring the activities of local authorities in relation to diet and nutrition. These could be built into any comprehensive approach which was developed.
- It was thought that revisiting the Healthy Weight Outcomes Framework would be worthwhile.

Other issues

12.15 The relevance of improvement methods and ‘small tests of change’, and of a regular international conference to discuss progress – as set out in proposals in the consultation paper – were not widely discussed. However, on the occasions where they were discussed, they did not attract support. Respondents did not think that tests of change were particularly relevant in such a complex field where change – if it happened – would take place over a long timeframe. The conference was not viewed as providing ‘value for money’.

12.16 A wide range of respondents emphasised the importance of focusing on children and schools in relation to this agenda. School meals, health and wellbeing in schools, and nutritional quality near schools were all mentioned repeatedly, as was the importance of measuring children’s weight as they left primary school. It was suggested that a ‘nutritional scoring risk rating scheme’ to evaluate nutritional quality near schools should be developed.

Annex 1: Consultation questions

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

Yes No Don't know

Please explain your answer.

Question 2: How do we most efficiently and effectively define the types of food and drink that we will target with these measures?

Please explain your answer.

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?

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly disagree

Please explain your answer.

Question 4: Do you think any further or different action is required for the out of home sector?

Yes No Don't know

Please explain your answer.

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

Yes No Don't know

Please explain your answer.

Question 6: What specific support do Scottish food and drink SMEs need most to reformulate and innovate to make their products healthier?

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

Yes No Don't know

Please explain your answer.

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?

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

Yes No Don't know

Please explain your answer.

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

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

Question 12: How can we build a whole nation movement?

Question 13: What further steps, if any, should be taken to monitor change?

Question 14: Do you have any other comments about any of the issues raised in this consultation?

Annex 2: Frequency analysis of closed questions

Question 1

Table A1.1: Question 1 – Are there any other types of price promotion that should be considered in addition to those listed above?

Respondent type	Yes		No		Don't know		Total	
	n	%	n	%	n	%	n	%
Public health and third sector	69	84%	6	7%	7	9%	82	100%
Private sector and business	2	18%	6	55%	3	27%	11	100%
Other organisational respondents	6	86%	1	14%	–	0%	7	100%
All organisations	77	77%	13	13%	10	10%	100	100%
Individual respondents	95	56%	38	22%	36	21%	169	100%
Total (organisations and individuals)	172	64%	51	19%	46	17%	269	100%

Percentages may not total 100% due to rounding.

Question 3

Table A1.2: 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?

Respondent type	Agree or strongly agree		Neutral		Disagree or strongly disagree		Total	
	n	%	n	%	n	%	n	%
Public health and third sector	102	94%	4	4%	2	2%	108	100%
Private sector and business	1	4%	5	21%	18	75%	24	100%
Other organisational respondents	5	71%	–	0%	2	29%	7	100%
All organisations	108	78%	9	7%	22	16%	139	100%
Individual respondents	139	81%	21	12%	12	7%	172	100%
Total (organisations and individuals)	247	80%	30	10%	34	11%	311	100%

Percentages may not total 100% due to rounding.

Question 4

Table A1.3: Question 4 - Do you think any further or different action is required for the out of home sector?

Respondent type	Yes		No		Don't know		Total	
	n	%	n	%	n	%	n	%
Public health and third sector	84	82%	5	5%	14	14%	103	100%
Private sector and business	9	56%	5	31%	2	13%	16	100%
Other organisational respondents	6	86%	1	14%	–	0%	7	100%
All organisations	99	79%	11	9%	16	13%	126	100%
Individual respondents	114	68%	34	20%	20	12%	168	100%
Total (organisations and individuals)	213	72%	45	15%	36	12%	294	100%

Percentages may not total 100% due to rounding.

Question 5

Table A1.4: Question 5 – Do you think current labelling arrangements could be strengthened?

Respondent type	Yes		No		Don't know		Total	
	n	%	n	%	n	%	n	%
Public health and third sector	92	89%	1	1%	10	10%	103	100%
Private sector and business	2	13%	12	75%	2	12%	16	100%
Other organisational respondents	6	100%	–	0%	–	0%	6	100%
All organisations	100	80%	13	10%	12	10%	125	100%
Individual respondents	127	74%	20	12%	25	15%	172	100%
Total (organisations and individuals)	227	76%	33	11%	37	12%	297	100%

One respondent answered 'Yes' and 'Don't know'. This response is not included in the table above. Percentages may not total 100% due to rounding.

Question 7

Table A1.5: Q7 – Do you think any further or different action is required to support a healthy weight from birth to adulthood?

Respondent type	Yes		No		Don't know		Total	
	n	%	n	%	n	%	n	%
Public health and third sector	112	97%	1	1%	2	2%	115	100%
Private sector and business	4	40%	3	30%	3	30%	10	100%
Other organisational respondents	6	76%	–	0%	1	14%	7	100%
All organisations	122	92%	4	3%	6	5%	132	100%
Individual respondents	129	76%	22	13%	19	11%	170	100%
Total (organisations and individuals)	251	83%	26	9%	25	8%	302	100%

Percentages may not total 100% due to rounding.

Question 9

Table A1.6: Question 9 – Do you think any further or different action on healthy living interventions is required?

Respondent type	Yes		No		Don't know		Total	
	n	%	n	%	n	%	n	%
Public health and third sector	99	92%	3	3%	6	6%	108	100%
Private sector and business	4	50%	1	13%	3	38%	8	100%
Other organisational respondents	4	80%	–	0%	1	20%	5	100%
Total organisations	107	88%	4	3%	10	8%	121	100%
Individual respondents	112	70%	19	12%	29	18%	160	100%
Total (organisations and individuals)	219	78%	23	8%	39	14%	281	100%

Percentages may not total 100% due to rounding.

Annex 3: List of organisational respondents

A total of 183 organisations took part in the consultation. These are listed below.

Third sector (42)

Alcohol Focus Scotland
Arthritis Research UK incorporating Arthritis Care
ASH Scotland
The Braveheart Association
Breast Cancer Now
The Breastfeeding Network
Broomhouse Health Strategy Group
Cancer Research UK
Central Scotland Green Network Trust
Chest Heart & Stroke Scotland
Children in Scotland
Community Health Exchange (CHEX)
Compassion in World Farming
Cyrenians Good Food
Diabetes Scotland
Down's Syndrome Scotland
Edinburgh Community Food
Federation of City Farms and Community Gardens
Fife Voluntary Action
Food Foundation
The Food Life
Food Monsters CIC
Go Vegan Scotland
HENRY
Inspiring Scotland
Lanarkshire Community Food and Health Partnership
Living Streets Scotland
Medact
Men's Health Forum
North Glasgow Community Food Initiative
Nourish Scotland
Obesity Action Scotland
Obesity Health Alliance
Outside the Box
Pilton Community Health Project
The Ross County Foundation
The Scottish Cancer Prevention Network
Scottish Independent Advocacy Alliance
Sustain: the alliance for better food and farming
Triple P International
UK Health Forum
Voluntary Health Scotland

Public health professional and representative groups (26)

Association of Directors of Public Health
British Dental Association Scotland
British Dietetic Association Scotland Board
British Medical Association (BMA) Scotland
The British Psychological Society

Consultants in Dental Public Health / Chief Administrative Dental Officers
Faculty of Public Health Public Mental Health Special Interest Group in conjunction with the Scottish Public
Mental Health Special Interest Group
Healthy Weight Leads Network
International Health Economics Association's (iHEA) Economics of Obesity Special Interest Group
NHS Public Health Nutrition Group
Obesity Group of the British Dietetic Association (formerly domUK)
Royal College of General Practitioners (RCGP)
Royal College of Midwives
Royal College of Nursing Scotland
Royal College of Paediatricians and Child Health Scotland
Royal College of Physicians and Surgeons of Glasgow
Royal College of Physicians of Edinburgh
Royal College of Psychiatrists in Scotland
Royal College of Surgeons of Edinburgh
The Royal Environmental Health Institute of Scotland
Scottish Diabetes Group (SDG) - Prevention Short Life Working Group
Scottish Directors of Public Health (SDsPH) Group
Scottish Health Promotion Managers
Scottish Infant Feeding Advisor's Network
Scottish Public Health Registrar Group
UK Society for Behavioural Medicine (UKSBM)

Public sector health organisations (21)

European Public Health Association (EUPHA), Food and Nutrition Section
NHS Ayrshire & Arran
NHS Borders
NHS Education for Scotland
NHS Fife Nutrition and Dietetic Department
NHS Fife, responding on behalf of Fife Health and Wellbeing Alliance
NHS Forth Valley
NHS Grampian, Dietetic Service
NHS Grampian, Public Health Directorate
NHS Grampian, Tier 4 Obesity (Bariatric Surgery) Service
NHS Greater Glasgow and Clyde
NHS Greater Glasgow and Clyde, Director of Public Health
NHS Health Scotland
NHS Highland
NHS Lanarkshire, North Lanarkshire HSCP, and South Lanarkshire HSCP
NHS Lothian, Directorate of Public Health and Health Policy
NHS Lothian, Health Promotion Service
NHS Orkney, Public Health Department
The State Hospital Board for Scotland
NHS Tayside (including input from partner organisations)
NHS Western Isles

Local authorities, local partnerships and other public sector bodies (19)

Aberdeen City Health and Social Care Partnership and Aberdeen City Council, Integration Joint Board
COSLA
Dumfries and Galloway Community Planning Partnership
Dumfries and Galloway Community Planning Partnership Board
Dundee Health and Social Care Partnership
Dundee Healthy Weight Partnership on behalf of Dundee Community Planning Partnership
East Ayrshire Health and Social Care Partnership
East Dunbartonshire Health & Social Care Partnership

East Renfrewshire Health and Social Care Partnership
Fife Community Food Project, Community Learning and Development, Fife Council
Glasgow City Council
Glasgow City Health and Social Care Partnership
Glasgow Food Policy Partnership
Midlothian Health & Social Care Partnership (and CPP representation)
Renfrewshire Council
Scottish Borders Council
South East of Scotland Transport Partnership
West Dunbartonshire Health and Social Care Partnership
West of Scotland Food Liaison Group

Food and drink industry and business representative bodies (17)

Association of Licensed Multiple Retailers
Automatic Vending Association
British Hospitality Association
The British Sandwich & Food to Go Association; The Pizza Pasta & Italian Food Association; and The Café Life Association
British Soft Drinks Association
British Specialist Nutrition Association (BSNA) Ltd.
The British Takeaway Campaign
Dairy UK
Diamond Spider
Food and Drink Federation Scotland
FSB (Federation of Small Businesses Scotland)
Natural Hydration Council
School and Nursery Milk Alliance
Scottish Grocers' Federation
Scottish Retail Consortium
Scottish Wholesale Association
Snack, Nut and Crisp Manufacturers Association (SNACMA) Ltd.

Organisations concerned with fitness, sport, recreation and play (15)

Cycling Scotland
Cycling UK
The Daily Mile Foundation
Edinburgh Leisure
Glasgow Life
Mearns Fitness Ltd
Paths for All
Play Scotland
Ramblers Scotland
Scottish Out of School Care Network (SOSCN)
Sporta
sportscotland
St Ninians Stay and Play family support group
Sustrans Scotland
VOCAL Scotland

Academic, educational or research organisations (9)

Centre for Excellence for Looked after Children in Scotland (CELCIS)
College of Contemporary Health
Education Scotland
Glasgow Centre for Population Health
Scottish Environment Food and Agriculture Research Institutes (SEFARI)

University of Aberdeen, Rowett Institute
University of Glasgow, MRC / CSO Social and Public Health Sciences Unit
University of St Andrews, School of Medicine, Weight Communication Research Team
University of Stirling, Global Food Security Group

Food and drinks manufacturers (9)

A.G. Barr plc
Coca-Cola Great Britain & Coca-Cola European Partners
Haribo UK
Lucozade Ribena Suntory Ltd
Mackie's at Taypack Ltd
Mars Chocolate UK and Wrigley UK
Muller UK & Ireland Group LLP
Nestle UK Ltd
PepsiCo UK

Private sector weight management organisations (5)

Cambridge Weight Plan
Scottish Slimmers
Slimming World
Weight Watchers UK Ltd
Zingy Life

Advertising, media or broadcast organisation (4)

The Advertising Association
Advertising Standards Authority
ISBA (Incorporated Society of British Advertisers)
STV Group plc

Retailers (5)

Asda Stores Ltd.
Marks and Spencer plc
Sainsbury's Supermarkets Ltd
Scottish Midland Cooperative Society Ltd
WH Smith

Other professional bodies and representative groups (4)

ASSISTFM
Heads of Planning Scotland (HOPS)
Royal Town Planning Institute (RTPI) Scotland
The Royal Society of Edinburgh

Out of home providers (e.g. restaurant, fast food outlet, coffee shop) (2)

Casual Dining Group
Whitbread plc

Regulatory bodies (2)

Food Standards Scotland
Scottish Food Enforcement Liaison Committee Diet & Nutrition Working Group (SFELC)

Other (3)

Jamie Oliver Group
Scotland Excel
Which? UK

Annex 4: Response to individual questions

Question		Number of responses	% of total responses (base=362)
Section 1: Transforming the food environment			
Q1	Are there any other types of price promotion that should be considered in addition to those listed above? [Yes / No / Don't know]	269	74%
	Please explain your answer.	275	76%
Q2	How do we most efficiently and effectively define the types of food and drink that we will target with these measures? Please explain your answer.	275	76%
Q3	To what extent do you agree with the actions we propose on non-broadcast advertising of products high in fat, salt and sugar? [Strongly agree / Agree / Neutral / Disagree / Strongly disagree]	311	86%
	Please explain your answer.	265	73%
Q4	Do you think any further or different action is required for the out of home sector? [Yes / No / Don't know]	294	81%
	Please explain your answer.	278	77%
Q5	Do you think current labelling arrangements could be strengthened? [Yes / No / Don't know]	297	82%
	Please explain your answer.	286	79%
Q6	What specific support do Scottish food and drink SMEs need most to reformulate and innovate to make their products healthier? Please explain your answer.	241	67%
Section 2: Living healthier and more active lives			
Q7	Do you think any further or different action is required to support a healthy weight from birth to adulthood? [Yes / No / Don't know]	302	83%
	Please explain your answer.	294	81%
Q8	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?	260	72%
Q9	Do you think any further or different action on healthy living interventions is required? [Yes / No / Don't know]	281	78%
	Please explain your answer.	238	66%
Q10	How can our work to encourage physical activity contribute most effectively to tackling obesity?	281	78%
Section 3: Leadership and exemplary practice			
Q11	What do you think about the action we propose for making obesity a priority for everyone?	283	78%
Q12	How can we build a whole nation movement?	263	73%
Q13	What further steps, if any, should be taken to monitor change?	207	57%
Q14	Do you have any other comments about any of the issues raised in this consultation?	228	63%

Annex 5: Action to support healthy weight from birth to adulthood

Question 7 asked respondents for their views about what further or different action is required to support a healthy weight from birth to adulthood. Responses to this question covered a very wide range of issues. Chapter 8 discusses respondents' comments in relation to high-level policy and strategy development. This annex covers the more detailed suggestions respondents made in relation to service development and targeted interventions.

These comments generally focused on children, young people and families. There was little comment on actions needed to support healthy weight in adulthood – except to say that the strategy should include a focus on the nutritional needs of older people. However, there was a great deal of discussion about the importance of community based initiatives (see below), many of which work with adults.

Early years

Respondents highlighted the importance of the first 1000 days of a child's life (from conception to age 2) for laying the foundation for the child's future eating habits. Respondents cited evidence demonstrating the links between mother's weight and the child's future development of obesity, and there was much comment about the need for more and better pre-natal / ante-natal support and education for women, and interventions aimed at helping women to achieve a healthy weight before they get pregnant and throughout their pregnancy. (However, the challenges of this were also noted, since many pregnancies are not planned.)

There was also considerable discussion about the importance and health benefits of breastfeeding. Respondents repeatedly noted that the UK has among the lowest rates of breastfeeding in the world, and they thought any strategy to address diet must address this issue in a much more focused way. Respondents wanted to see more breastfeeding support available to new mothers, and they also wanted to see joined up policies (in relation to maternity leave and flexible working).

At the same time, some respondents also thought there should also be support for women who do not breastfeed (who are more likely to be women living on low incomes and in areas of deprivation) and those who cannot breastfeed.

There were also calls for greater support for weaning and for steps to be taken to ensure that nurseries are providing nutritious meals to pre-school children.

Finally, some respondents commented on existing national initiatives targeted at mothers and infants. In particular, they welcomed the reform of the devolved Healthy Start Scheme, and wanted efforts to be made to maximise uptake of the scheme (it was noted that existing processes and administration of the scheme make it difficult and cumbersome for some families to engage). Some also called for links to be made to the Maternal and Infant Nutrition (MIN) strategy and framework, suggesting that work to address healthy diet should also include more focussed work to monitor, review and develop the work of the MIN framework.

Primary school years

In relation to the primary school years, it was common for respondents to call for an increase in the availability of free school meals. Respondents noted that there is a great deal of variability in the quality of school meals across Scotland, and they wanted to see improved regulation of school meals. Some thought that free school meals should also be made available during school holidays and the summer recess period, particularly in the most deprived communities of Scotland.

Other respondents (often individual respondents) focused more on making free milk and / or fruit and vegetables available in all schools, or on banning certain types of foods from schools (soft drinks, sweets, snacks), including in packed lunches and other items brought from home.

Respondents also advocated: (i) the reintroduction of health checks and the Child Healthy Weight Scheme; (ii) ensuring that the Curriculum for Excellence focuses more on food and nutrition; and (iii) encouraging more 'family style eating' at schools (both primary and secondary).

Secondary school years / adolescence

The two main issues raised in relation to the adolescent years were (i) the importance of providing practical skills to young people (i.e. in relation to cooking, developing a menu and budgeting) and (ii) the importance of restricting the accessibility of 'junk food' outlets (burger vans, tuck shops, fast food outlets) around schools.

In relation to the first point, there were frequent calls to address the chronic shortage of home economics teachers in Scottish secondary schools. Respondents also advocated making home economics compulsory for all children (some specified up to age 15). It was suggested that 'no child of either sex should leave school without being able to cook a decent meal'.

It was also suggested all schools (both primary and secondary) should have space to grow food. Some respondents noted that new secondary schools, in particular, are being built with no green space around the school. Finally, there were calls for school kitchens to be opened up as a community resource for cookery classes.

Among the young people who took part in the Scottish Youth Parliament engagement exercise, there was general agreement that schools had an important role to play in providing 'effective home economics classes'. This group did not necessarily think that home economics should be compulsory, but they did feel that schools could provide more practical education in relation to shopping for food, budgeting and making healthy meals. They also suggested that Personal and Social Education (PSE) classes could be used to promote healthy eating.

Some of the young people participating in this engagement exercise also expressed the view that schools are not able to explore making other types of food because 'it is cheaper and the ingredients for scones / fairy cakes last longer'. It was also noted that participation in home economics classes (at least in some areas) can be expensive for the families of young people, as 'pupils have to provide the vegetables if they want to make a meal and

they have to pay £10 a term'. This effectively limits access to these courses among young people from disadvantaged families.

It was common for consultation respondents to argue that greater efforts should focus on restricting young people's access to out of school food. However, young people participating in the Scottish Youth Parliament engagement exercise had quite a different perspective on this. This group highlighted that 'going to the shop at break time and lunchtime is cheaper than eating school meals'. Some also commented on the portion sizes of school meals (not large enough), the presentation of school food ('a salad bowl covered in cling film'), and the lack of choice ('no fruit available in the school canteen'). This group believed that there was a 'gap in the market for healthy fast food' among food outlets near schools.

Community initiatives

Some respondents commented that there was a great deal of excellent work going on in communities, led by grassroots organisations. Respondents particularly mentioned 'family initiatives' including cookery classes, community gardens, local food networks, family activity days, etc.

This group of respondents expressed disappointment that there was little recognition in the consultation paper of the work being undertaken by the community and voluntary sector in this area. The point was made that community organisations are often better placed than public sector agencies to engage with and provide tailored support to people in deprived communities – with evidence of successful initiatives cited. These respondents called for partnerships to be established with third sector / community partners, and they highlighted the need for more secure and longer-term funding streams to support these organisations.

The importance of physical activity

There was much discussion about the importance of promoting / encouraging physical activity. Respondents called for infrastructure developments and planning decisions to prioritise outdoor activity and outdoor play; active travel (including the development of footpaths and cycle networks); 'social prescribing' of gym memberships; and initiatives to encourage children to walk to school. Chapter 10 and Annex 5 discuss respondents' views on the subject of physical activity in more depth.

Annex 6: Encouraging physical activity

This annex contains respondents' detailed suggestions in relation to Question 10, which asked how physical activity can contribute to tackling obesity.

Motivational tools and techniques to encourage physical activity

Suggestions were made about the development of motivational tools and techniques to encourage physical activity. These included:

- Using social media or text reminders / apps to provide motivational messages (e.g. different ways to burn up 100 calories)
- The use of incentives (participants in the Scottish Youth Parliament engagement event talked about 'Sweat Coin', an app that gives people a 'digital currency' whenever they work out; these Sweat Coins can be redeemed against the purchase of fitness clothing, access to gym classes, or other services or products)
- Providing pedometers or activity trackers on prescription, along with guidance on personalised goal setting
- (In some cases) providing intensive psychological support.

Active travel

Respondents agreed with the consultation paper that further investment in active travel should be prioritised at both national and local levels and they supported the commitment of 10% of the national transportation budget for active travel initiatives. Respondents frequently recounted the multiple benefits of walking and cycling and increased use of public transportation – not only for physical and mental health, but also for air quality, traffic congestion and the environment. They also highlighted the fact that walking and cycling can 'double-up' as transportation, and so can be more easily integrated into busy lifestyles – unlike an exercise class or a visit to the gym.

Respondents pointed to the existing barriers to active travel, including traffic levels and lack of infrastructure. They called for active travel to be 'safe, affordable and convenient', and they suggested that this could be achieved through:

- Bicycle borrowing facilities
- Increased availability of bicycle racks
- Use of workplace incentives such as cycle-to-work schemes
- Shower facilities in workplaces
- Cycle lanes separated from (or respected by) motorised traffic (thus, cycle lanes need to be enforced)
- Safe walking paths (well lit, with a good pavement surface, kept clear of ice and snow in winter)
- Development of park and ride facilities (with walking options).

They also thought that special consideration needed to be given to people living in rural areas – where, at present, the only practical form of travel is by car.

Respondents argued that public transportation costs in Scotland are expensive and are not the same across the country. They called for public transportation costs to be reduced on the one hand and, on the other, for measures to be introduced (e.g. increased purchase price, tax, parking restrictions) to discourage access to and use of private cars – except for people with disabilities.

Workplace initiatives

Respondents thought that workplaces could play a much greater role in encouraging physical activity among people in Scotland through, for example:

- Encouraging ‘walking meetings’ (i.e. walking and talking, rather than meeting around a table)
- Providing standing desks
- Developing healthy food and activity policies
- Encouraging employees to take short (10-minute) breaks twice a day to have a walk around the block
- Holding lunchtime exercise clubs (yoga, Zumba, etc.) or promoting lunchtime walks
- Promoting a Daily Mile
- Promoting and incentivising active travel.

It was suggested that the Healthy Working Lives Award scheme could be expanded to cover such initiatives.

Initiatives targeted at children and families

Respondents emphasised the importance of keeping children physically active. Some noted that there was much good work going on in nursery and primary schools (through Active Schools and the Daily Mile), but they expressed concerns that this good work was being undone in secondary school, university / college and the workplace. It was also noted that some schools are not meeting minimum requirements in relation to physical education, and there were calls for the Scottish Government to ensure that these requirements are met.

Some of the suggestions made by respondents included:

- Creating car parking / bus drop-off exclusion zones around schools to encourage children to walk a reasonable distance to school
- Ensuring that the Curriculum for Excellence puts greater emphasis on health and wellbeing, including diet and exercise
- Ensuring that children and young people have safe places to play in their neighbourhoods (this needs to be addressed in the planning process for new residential developments; some respondents also pointed to recent cases where children’s playgrounds and sports fields had been sold for property development)
- Providing more opportunities for families to become active together (i.e. developing family oriented after-school clubs, offering mother and child Zumba classes through local authority leisure centres, etc.).

Respondents to the Young Scot survey highlighted some of the barriers for young people in becoming more active. These included pressures associated with school, college or university work; a physical health condition; and lack of motivation / confidence.

Improving the availability and accessibility of local assets

Some respondents highlighted the importance of having easy access to green spaces (parks, community gardens, nature trails, etc.) and the benefits of walking and gardening. They emphasised the need to improve the availability and standard of such spaces, and there were suggestions that local parks could be closed to all traffic at regular, scheduled times to allow people to use the park roads for exercise.

Other respondents discussed ways of improving access to local leisure and recreation facilities – and ways of removing financial barriers in particular. It was suggested that consideration should be given to the affordability of local authority leisure centres and that these centres should be available to everyone, regardless of income or physical / mental disability. Respondents also called for action to allow better access to school sport and leisure facilities by members of the community during evenings, weekends, and school holidays.

Making use of planning regulations and building standards to support physical activity

Respondents thought that there was scope for planning regulations and building standards to better support active neighbourhoods. It was suggested that all new buildings and developments, particularly those in the public sector, should be required to consider how both the internal and external space can be used to enable people to more active. Some respondents referred to the Place Standard tool³⁴ and suggested that this could be used to help set minimum standards in this area.

³⁴ See <https://placestandard.scot/>

Annex 7: Learning from elsewhere about obesity management

In their responses to Questions 11 and 12, respondents referred to successful initiatives from further afield where there had been a sustained and integrated effort to tackle obesity. These initiatives included:

- The ‘Oklahoma Weight Loss Initiative’ took a societal approach to promoting health and wellbeing and challenged the citizens of Oklahoma to lose 1 million pounds in weight. They achieved this within five years.
- The French VIF initiative (previously EPODE – “together let’s prevent childhood obesity”) started in 10 towns in 2004 and has since been taken up by more than 250 local authorities. This initiative is aimed at children aged 5-12 who are overweight or at risk of weight gain.³⁵ While overweight and obesity have levelled across France, both are increasing in lower socio-economic communities. However, overweight and obesity are decreasing in all VIF communities.
- The Amsterdam Healthy Weight Programme is aimed at all children under the age of 19 and their parents, care-givers and teachers, but with a particular focus on children who are already obese and those from high risk social groups.³⁶ Between 2012 (just before the programme began) and 2014, the prevalence of overweight and obesity has levelled off, with a 10% decrease in prevalence in children of all age groups and 18% decrease among very low social economic groups.
- In Finland, the WHO’s Health in All Policies approach has been adopted and had led to a fall in levels of childhood obesity in 5-year-olds. Reference was made specifically to a strategy developed in the city of Seinäjoki.

In addition, the Portuguese government has recently launched an Integrated Strategy for the Promotion of Healthy Eating (EIPAS) in 2017 – an approach which incorporates health into policies across all sectors. This national policy is closely aligned with recommendations contained in the WHO European Food and Nutrition Action Plan 2015–2020 and the European Union Action Plan on Childhood Obesity 2014–2020. Given the early stage that this initiative is at, results from monitoring are not available at the time of writing.

³⁵ A whole range of local actors are mobilised – schools, nurseries, doctors, nutritionists, local press and businesses, after-school and sport clubs, politicians, and civil society – to support and advise families about their child’s weight status, diet, and activity. Local initiatives can also develop resources or run campaigns and activities with participating actors.

³⁶ This Programme seeks to address the structural causes of obesity: individual lifestyle factors and values and psychological aspects underlying them, the social and physical environment, and living and working conditions that make it difficult for people to ensure their children eat healthily, sleep enough and exercise adequately. It requires all Council departments to contribute through their policies, plans and day-to-day working.



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