

Choosing a Better Diet:

a food and health action plan



Working in partnership across government with people, their communities, local government, voluntary agencies and business

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FOREWORD

The *Choosing Health* White Paper delivery plan outlines the key steps that will be taken over the next three years to deliver the commitments to improve public health set out in *Choosing Health: Making healthier choices easier*. This food and health action plan brings together, in one place, action to meet all the commitments relating to food and nutrition in the White Paper, as well as further activity across government to encourage healthier eating. It provides further detail on the action that needs to be taken at national, regional and local levels to improve people's health through improved diet and nutrition.

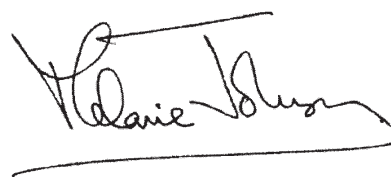
The action plan aims to improve diet and nutrition in England and, as part of encouraging a healthy lifestyle, to contribute to a reduction in cardiovascular disease, cancers and in particular obesity, which is a major risk factor for diabetes, heart disease and some cancers. In parallel with this plan, a cross-government plan on physical activity, the other key lifestyle factor, has also been drawn up to tackle obesity.

We have consulted widely in developing this action plan through the *Choosing Health?* consultation and through *Choosing a Better Diet: A Consultation on Priorities for a Food and Health Action Plan*. The action set out in the *Choosing Health* White Paper, and developed further here, responds to what we heard in the consultation. We heard that people wanted to be able to make healthier choices but that they wanted some

support from the Government to be able to do this. Concerns about advertising food to children were a frequent theme and people asked for more information, including simple and clear nutritional messages about food so that they can make healthier choices more easily.

Good nutrition is vital to good health. Whilst we are fortunate that many people in England eat well, a large number do not, and inequalities exist in the nutritional quality of our diets. Poor nutrition is a recognised cause of ill health and premature death in England – an estimated one-third of cancers can be attributed to poor diet and nutrition. While there is high awareness of healthy eating, most people consume less than the recommended amounts of fruit and vegetables but more than the recommended amounts of fat, salt and sugar. Overconsumption of energy relative to our needs is a major factor in increasing levels of obesity.

The action set out here is the start, and not the end, of the process and we will need your help to ensure that everyone has more opportunities for healthier eating.



Melanie Johnson
Minister for Public Health

CHAPTER 1: INTRODUCTION

NUTRITION AND HEALTH IN ENGLAND

Good nutrition is vital to good health. While many people in England eat well, a large number do not, particularly among the more disadvantaged and vulnerable in society. In particular, a significant proportion of the population consumes less than the recommended amount of fruit and vegetables and fibre but more than the recommended amount of fat, saturated fat, salt and sugar. Such poor nutrition is a major cause of ill health and premature death in England. Cancer and cardiovascular disease, including heart disease and stroke, are the major causes of death in England, accounting together for almost 60% of premature deaths. About one-third of cancers can be attributed to poor diet and nutrition.¹

Increasing the consumption of fruit and vegetables can significantly reduce the risk of many chronic diseases.² It is estimated that eating at least 5 varied portions of fruit and vegetables a day can reduce the risk of deaths from chronic diseases such as heart disease, stroke, and cancer by up to 20%.³ Research has shown that each increase of one portion of fruit or vegetables a day lower the risk of coronary heart disease by 4% and the risk of stroke by 6%.⁴ Evidence also suggests that an increase in fruit and vegetable intake can help lower blood pressure.

Unhealthy diets, along with physical inactivity, have contributed to the growth of obesity in England. 22% of men and 23% of women in England are now obese – a threefold increase since the 1980s – while 65% of men and 56% of women – 24 million adults – are either overweight or obese.⁵ Obesity is a growing problem among children and young people too. Around 16% of 2 to 15 year olds are obese.⁶ Obesity brings ill health, including hypertension, heart disease and type II diabetes. Obesity is responsible for an estimated 9,000 premature deaths per year in England (6% of all deaths, compared to 10% for smoking).⁷ It is estimated that the treatment of ill health from poor diet costs the National Health Service at least £4 billion each year.⁸

There are many inequalities in nutrition and health that need to be addressed. For example, consumption of fruit and vegetables varies markedly between socio-economic groups. 27% of men and 33% of women in the managerial and professional groups consume the recommended five portions per day compared to 16% of men and 17% of women in routine and semi-routine occupations.⁹ Mothers from disadvantaged groups are least likely to breastfeed.¹⁰ Obesity is more prevalent among the lowest socioeconomic groups, and this difference is more marked for women. 29% of women

and 22% of men in semi-routine and routine occupations are obese, compared to 19% of women and 21% of men in managerial and professional occupations.¹¹

WHY WE HAVE A FOOD AND HEALTH ACTION PLAN

This action plan is a statement of the Government's plans to encourage and coordinate the action of a range of organisations to improve nutrition and health in England and to reduce health inequalities. It sets out a framework for action at a national level, complementing other regional or local planning arrangements aimed at the needs of specific communities. It also complements the action that is taken at the individual level, for example between a doctor and patient.

The programme of action which this plan addresses was announced in November 2004 in *Choosing Health*, the White Paper on public health. This action plan, therefore, is a summary of how we will deliver the nutrition commitments in the White Paper and other government actions on nutrition. The delivery plan for the White Paper, *Delivering Choosing Health*, provides the framework for delivery and elements of this are described below.

The commitment to a food and health action plan was made first in the Government's Strategy for Sustainable Farming and Food.¹² While the action plan is an integral part of the White Paper delivery programme it also remains part of the farming and food strategy. As much as possible, the action to deliver our nutrition commitments will also contribute to the goals of this strategy, as discussed below.

The World Health Organization (WHO), at the fifty-seventh World Health Assembly in May 2004, adopted a global strategy on diet, physical activity and health for the prevention of non-communicable diseases.¹³ Building on this, the WHO European Region has produced the first Action Plan for Food and Nutrition Policy and urged member states to have nutrition plans and strategies in place, with the target that 'By the year

2015, people across society should have adopted healthier patterns of living.'¹⁴

Following much consultation with stakeholders, we have developed the programme of work on nutrition presented in this action plan as part of the development of the White Paper. This consultation process is summarised in the Appendix.

WHAT THE FOOD AND HEALTH ACTION PLAN COVERS

This action plan is about diet and nutrition – about the food that people eat, which influences the risk of developing chronic diseases such as cardiovascular disease and some cancers. The plan therefore prioritises action on diet and nutrition to reduce the intake of fat, saturated fat, salt and sugar and increase the consumption of fruit and vegetables in England.

A key priority of the White Paper is tackling obesity, particularly among children, and a number of White Paper commitments aim to contribute to that, including those presented in this action plan. The White Paper also includes commitments to improve obesity services and to increase physical activity, which are presented in *Choosing Activity: a physical activity action plan*,¹⁵ a counterpart to this action plan.

Whilst the need to tackle obesity is a key priority of the White Paper, it is recognised that there are also groups of people in the population who are underweight and/or at risk of having a low intake of certain nutrients, for example calcium and iron. For these groups targeted action within their local settings will be required. However, the overall aim of the action plan is to improve diet through better information and choice and access to healthier food, which will also be of benefit to the groups of people most at risk.

The food and health action plan provides action to improve diet and nutrition across all sectors of the population. However, specific attention is also needed to tackle the difficulties experienced by those on low income in accessing a healthy diet. Food poverty can be defined as the inability to afford, or to have access to, food to make up a healthy diet. Those experiencing food poverty may have limited money for food after paying for other household expenses; live in areas where food choice is restricted by local availability and lack of transport to large supermarkets; or be lacking in the knowledge, skills or cooking equipment necessary to prepare healthy meals. Reducing inequalities is one of the Government's targets and the action plan aims to address food poverty through supporting community initiatives, such as 5 A DAY, which target disadvantaged communities; and also through reform of the Welfare Food Scheme, which will improve access to fruit and vegetables as well as providing support to those most in need.

The action plan is not about wider aspects of food and health. Issues relating to the safety of food – food-borne illness or genetic modification of crops, for example – are the responsibility of the Food Standards Agency and the programme of work set out in its Strategic Plan.¹⁶ Improving diet, for example, reducing the frequency and amount of sugar consumption, can have a major impact on the prevention of dental caries, a common preventable disease in England. This will be addressed in the Oral Health Action Plan to be published later in the year.

Alcoholic drinks, while not classed as a nutrient, can for many people make a significant contribution to total energy intake. Alcohol is the subject of the Alcohol Harm Reduction Strategy for England,¹⁷ which sets out the Government's strategy for tackling the harms and costs of alcohol misuse. As part of our work on obesity, however,

we will consider how best to increase public awareness of the energy content of alcoholic drinks.

This action plan builds on the strategy presented within the *Choosing Health* White Paper and its delivery plan. It sets out the aims and objectives of the plan and its links to the *Strategy for Sustainable Farming and Food* (SSFF).

This action plan presents the actions that the Government will take across a wide range of areas:

- **healthy eating in a consumer society** and how information can be improved, and to how industry can help to enable healthier choices;
- encouraging healthy eating behaviours in **children and young people**;
- promoting opportunities for **healthy eating in the communities** where we live;
- ensuring that the **NHS promotes healthy eating** in all aspects of its work; and
- promoting opportunities for **healthy eating in the workplace** and ensuring that the public sector leads by example.

The action plan also sets out how we will ensure that this strategy is implemented and how we will monitor and evaluate its effects, as well as the research and development that will need to be continued as our plan of action is taken forward.

AIMS AND OBJECTIVES

The aim of the action plan is to improve health in England by reducing the prevalence of diet-related disease, and to reduce obesity in England by improving the nutritional balance of the average diet.

This aim will contribute, in particular, to the Government's following health improvement PSA targets¹⁸ to:

- Substantially reduce mortality rates by 2010 from heart disease and stroke and related

disease by at least 40% in people under 75, with at least a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole.

- Substantially reduce mortality rates by 2010 from cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole.
- Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth.
- Halt the year-on-year rise in obesity among children under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole. (Joint target with the Department for Education and Skills (DfES) and the Department for Culture, Media and Sport (DCMS).)

The action plan aims to promote a healthy, balanced diet, based on the recommendations of the Committee on Medical Aspects of Food and Nutrition Policy (COMA), Scientific Advisory Committee on Nutrition (SACN) and the World Health Organization. The association between a healthy, balanced diet and health and well-being is well recognised, and surveys have consistently shown an increasing awareness in the population of the need to consume such a diet, particularly with respect to salt, sugar, fat and fruit and vegetables. Despite this, most people's diet remains low in fruit and vegetables and complex carbohydrates (particularly dietary fibre), but higher in fat, saturated fat, salt and sugar. Dietary objectives for the plan therefore address these issues and are presented in the table overleaf.

Our work to improve the nutritional balance of the average diet in England will be directed by the following objectives to:

1. increase the average consumption of a variety of fruit and vegetables to at least five portions per day (currently 2.8 portions per day);¹⁹
2. increase the average intake of dietary fibre to 18 grams per day (currently 13.8 grams per day);
3. reduce the average intake of salt to 6 grams per day by 2010 (currently 9.5 grams per day);
4. reduce the average intake of saturated fat to 11% of food energy (currently 13.3%);
5. maintain the current trend in the average total intake of fat at 35% of food energy (currently 35.3%); and
6. reduce the average intake of added sugar to 11% of food energy (currently 12.7%).

Inevitably, the recommended average intakes set out in our objectives do not fully reflect the differences – and inequalities – in the diets of particular groups, such as low-income families, minority ethnic groups and older people. Action to address such inequalities will also happen at the regional and local levels through various initiatives such as Healthy Start, Sure Start and 5 A DAY. Frontline support will be aimed at addressing the problems of specific communities and individuals. As much as possible, though, we will address inequalities through our national action, as set out below.

The food and health action plan is aimed at all people and organisations with an interest in improving food and nutrition in England – including local communities, voluntary organisations, businesses, local authorities, primary care trusts (PCTs), regional government and all policy-makers. If no such coordinated action is taken, the necessary dietary change will be hard to achieve.

SUSTAINABLE FARMING AND FOOD

This action plan remains closely tied to the SSFF, where the commitment to such a plan is made in answer to the call of Sir Don Curry's Policy Commission on Farming and Food for a 'strategy on all aspects of encouraging healthy eating'.²⁰

This action plan will contribute to the SSFF's overarching aim 'for Government, the industry and other stakeholders, working in partnership, to provide a competitive and efficient farming and food sector, which protects and enhances our countryside and wider environment, and contributes to the health and prosperity of all our communities.' It will also contribute to some of the SSFF's objectives to:

- increase the economic viability/sustainability of the farming and food industry;
- increase education, information, support and opportunities for people employed in these sectors;
- reduce the negative environmental impact caused by agriculture and the wider food chain and enhance the positive aspects;
- improve the stewardship of the countryside;
- improve public health through better diet;
- develop a more strategic and prioritised approach to research;
- shift the focus from production to outcome-based farming; and
- reduce the likelihood and impact of animal diseases.

This means that we will consider the implications of the actions in this plan for their impact on both the food industry and – through what we require of the food chain – the wider environment. We will manage this primarily through cost-benefit analysis during policy development, in particular through the Government's Regulatory Impact Assessment process.

There are many links between the food and health action plan and the SSFF. These include:

- work under the Public Sector Food Procurement Initiative to encourage catering contractors to improve the nutritional balance of food available in catering units;
- identification of nutrition as one of the priorities in the Food Industry Sustainability Strategy currently being prepared;
- inclusion of diet and health within the scope of the Research Priorities Group set up to advise on research needs to underpin delivery of the SSFF;
- work under the Organic Action Plan to explore the role that organic food can play in contributing to improved nutrition;
- work carried out by the Food Chain Centre to raise competitiveness in the horticulture sector, which will improve its ability to stimulate and compete for growing demand for fruit and vegetables; and
- changes to the Common Agricultural Policy which decouple subsidy from production and reduce price distortions between commodities so that farmers become more focused on producing to meet market needs.

SSFF priorities such as farmers' markets, school farm links and local food networks can also support the promotion of healthy eating messages and provide links between producer and consumer.

CHAPTER 2: HEALTHY EATING IN A CONSUMER SOCIETY

Education campaigns

Context

The White Paper noted²¹ that the problem of health education, generally, is not so much a lack of information but that health messages can be inconsistent or uncoordinated or out of step with the way people live their lives. Evidence suggests this is so in the case of nutrition. Surveys of consumer awareness, such as the Food Standards Agency (FSA) *Consumer Attitudes Survey 2003*,²² show that most respondents know what constitutes a healthy diet (though some groups, such as the over-65s or lower income groups, know less than others). However, they often lack awareness of what such general information means in practice.

Physical inactivity, along with unhealthy diets, has contributed to the rapid increases in obesity in both adults and children, with 22% of men and 23% of women in England now obese – a threefold increase since the 1980s. If we expand the category to include those who are overweight, then 65% of men and 56% of women – 24 million adults – are either overweight or obese. Clearly many people are struggling to get the balance right between the energy we consume in our diets and the energy we expend through daily activity. Moreover, levels of obesity are not distributed equally across the population – there is a marked social gradient, particularly among women.

Evidence from other countries shows that increasing consumer awareness can influence consumption. In the USA, evaluation of the National Cancer Institute's '5 A DAY for Better Health' campaign²³ found that the strongest predictors of dietary change were:

- knowledge of the recommendation to eat five or more servings of a variety of fruit and vegetables per day;
- taste preferences; and
- self-efficacy, in particular, confidence in preparing and consuming fruit and vegetables in different situations.

The action

A core principle of the White Paper is informed choice: helping people make their own decisions about choices that affect health. To that end, the Government is introducing a new strategy for promoting health by influencing people's attitudes to the choices they make.²⁴ As an early focus of this strategy, there will be a cross-government campaign to raise awareness of the health risks of obesity and the steps that people can take through diet and physical activity to prevent it.²⁵ Healthy eating messages, such as 5 A DAY, increasing dietary fibre, and reducing fat, sugar and salt will be a necessary part of any campaign to improve diet.

We will take the following steps to promote healthy eating messages through the obesity education campaign, and build on our existing campaigns, especially the 5 A DAY programme to promote fruit and vegetable consumption (see Chapter 4):

1. DH will work with creative media, the FSA, the food industry, consumer groups, health professionals and others to agree a clear and simple set of healthy eating messages, building on existing campaigns such as 5 A DAY, which will continue to be developed separately.
2. The Government will promote these healthy eating messages, especially to those who will benefit most, through the new cross-Government obesity education campaign; and will ensure that these messages are promoted consistently across the public sector and beyond, for example in schools and the workplace, through health professionals, and through well-being support programmes for people with severe mental illness.
3. Recognising that the food industry's advertising spend is many times that which the Government spends on healthy eating campaigns²⁶ the Government will explore with the food industry how it might contribute to promoting positive health information and education.²⁷

DH will lead Government in the development of the obesity education campaign and will work with others in promoting healthy eating messages. Other government departments and agencies involved include the FSA, DCMS, the Department for Environment, Food and Rural Affairs (Defra), DfES and the Department for Transport (DfT). Key stakeholders outside central government include the food industry, consumers and their representatives, health professionals and the media.

5 A DAY campaign

Building on existing work, we will develop further this campaign with a focus on those groups of consumers with the lowest fruit and vegetable intake, such as families in the lower socio-economic groups, children and young people (see also section on food labelling). We will also look to simplify the 5 A DAY message by clarifying what a portion means for adults and children.

Health Direct

We will establish Health Direct, by mid-2007, as a telephone, Internet and digital television service to provide the public with cost-effective, easily accessible and confidential personal advice, relevant quality-assured lifestyle improvement information and practical support to encourage people to take responsibility for their own health.

Education campaigns

What	Who	When
Discuss with the food industry how it might contribute to funding national campaigns and other national initiatives to promote positive health information and education	DH with other government departments (OGDs) and agencies	Mid-2005
Develop obesity campaign and trial	DH	September 2005
Pilot obesity campaign regionally and evaluate	DH with creative media	2006
Launch obesity campaign nationally	DH	March 2007
Impact of obesity campaign monitored and evaluated	DH	After launch
Promote and integrate messages with National Institute for Clinical Excellence (NICE) guidance	DH	2007
Continue 5 A DAY targeted campaign	DH	Ongoing

The service will act as a virtual health trainer, offering the public (especially children and young people, health professionals and employers) a series of electronic gateways through which they can educate themselves about the options for improving their own, their clients' or their employees' lifestyle(s) or condition(s), and make initial steps to change behaviour.

The service will link up to approved motivational lifestyle improvement programmes, and national or local health improvement services, such as obesity care pathway services.

Social Marketing Strategy

DH has also appointed the National Consumer Council (NCC)²⁸ as an independent body to help develop a social marketing strategy that promotes health by influencing people's attitudes to the choices they make, and extends across all aspects of health improvement.

The NCC will: consider health psychology and social research to determine how best to influence lifestyle and change behaviour; support the development of a broader public health marketing intelligence base including the establishment of a National Centre for Media and Health; investigate innovative ways of communicating to assist behaviour change; examine examples of social marketing best practice at local, national, and international levels; build on previous marketing communications activities on smoking, salt, 5 A DAY, mental well-being and sexual health; and extend the strategy to include information on obesity, healthy eating and physical activity in different groups.

Close cooperation with all government departments and its agencies responsible for health improvement and protection, children, food, sport, physical exercise, the environment, transport, employment and community development and regeneration, with the voluntary sector, and with local government will ensure that the strategy is effectively integrated and implemented.

Personal Health Guides

A DH-accredited online practical health assessment, the Personal Health Guide, will also be offered as a core educational module to the public, employers, health professionals and other community support mentors seeking to improve health and quality of life and to raise productivity.

The guides will be tools to assist people in planning for health, and will be unique to every individual and controlled by them. They will promote the opportunity for people to assess their own health, set out their goals and determine what action they want to take. Adults and children will have support from the NHS in developing their guides, including support from health trainers, as well as help in putting their plans into practice. The guides may come in a number of formats to suit the individual such as in an electronic format, or as a diary or personal health organiser.

For children, personal health guides will be able to build on child health records and children's health guides. As they grow up a child will take responsibility for developing their own health goals, and there will be opportunities to review the plans at key transition points.

Simplified food labelling

Context

Food labelling is a key source of information that can inform consumer choice. Currently, nutritional labelling is required by law only for those products that make nutritional claims, such as 'low fat' or 'reduced sugar'. In practice, however, there is a high level of voluntary nutritional labelling among UK industry. The Food and Drink Federation has made 'more informative labelling' one of the commitments in its Food and Health Manifesto.²⁹

All the same, consumers are calling for simpler and clearer labelling, more in keeping with their lifestyles, and which recognises inequalities in literacy and numeracy levels (these were prominent themes in responses to the *Choosing Health?*³⁰ and *Choosing a Better Diet?*³¹ consultations). The IGDs' *Consumer Watch* report of June 2003³² found that

Simplified food labelling

What	Who	When
Publish the results of consumer research on signpost labelling	FSA	July 2005
Publish the nutrient profile model for children's foods in the light of public consultation initiated in November 2004	FSA	September 2005
Consult stakeholders on package of guidance based on the nutrient profile model on high-medium-low descriptors salt, fat and sugar levels in children's food, signposting and nutrition and health claims	FSA	July 2005
Publish guidance on signposting salt, fat and sugar levels in children's food, signposting and nutrition and health claims	FSA	October 2005
Adoption by industry of nutritional signposting	Industry	From March 2006
Gain EU agreement to amend EU nutritional labelling legislation	UK ministers briefed by FSA, in consultation with DH and OGDs.	April 2006
Monitor and evaluate impact of signposting guidance	FSA	October 2006
Publish guidance on 5 A DAY logo on composite foods and foods targeted at children	DH	September 2005
Monitor and evaluate impact of 5 A DAY logo guidance	DH	Ongoing
Implement and communicate 5 A DAY messages (see also education campaigns)	DH and stakeholders including industry	Ongoing

34% of consumers identified clearer food labelling as the main way that the food industry could help them make healthier food choices.

Improvements to nutrition labelling must be made through the European Commission, which makes the legislation. However, there is much support in Europe for change.

Many respondents to the *Choosing Health?* and *Choosing a Better Diet* consultations called for the introduction of some kind of common 'signposting' labelling system (of which 'traffic lights' is one example) to help consumers see how much a food contributes to a healthy diet. Similarly, after taking much evidence from a range of stakeholders, the House of Commons Health Committee inquiry into obesity recommended

the introduction of 'traffic lighting' or 'signposting'.³³ More recently, FSA research has suggested that people would like simple labelling signposts to help them make informed and healthier food choices.³⁴ Some companies have already begun to use signposting systems. The FSA is currently carrying out research to find out which of a number of alternative signposting formats works best. The FSA is currently consulting on nutritional criteria which could be used to underpin such a scheme or to identify foods that can be promoted to children. These build on the approach used to promote nutritional criteria for the use of the 5 A DAY logo on composite foods that contain added fat, sugar and/or salt in addition to fruit and vegetables.

The action

The Government will take the following steps to simplify and clarify food labelling:

1. We will press for progress, before and during the UK presidency of the EU in 2005, to simplify nutritional labelling and make it mandatory on packaged foods.³⁵
2. We will work with the food industry to develop the signposting approach further on the completion of FSA consumer research. Our goal is, by early 2006, for there to be a clear, straightforward coding system that is in common use, and that busy people can understand at a glance, to find out which foods can make a positive contribution to a healthy diet, and which are recommended to be eaten only in moderation or sparingly.³⁶ By mid-2005 we aim to have introduced a system that could be used as a standard basis for signposting foods. This will build on the nutritional criteria for the 5 A DAY logo. The criteria will also be used, among other things, to identify which foods can be promoted to children. The criteria for use of the 5 A DAY logo will be extended to processed foods and to foods targeted at children.³⁷

The FSA will lead Government in the development of improvements to food labelling. Other government departments and agencies involved include the Devolved Administrations, DH, Defra and the Small Business Service. Key stakeholders outside central government include the food industry (including small businesses), local authorities trading standards, consumers and their representatives, health professionals and the media.

Advertising and promotion of food to children

Context

In a FSA-funded study, Professor Hastings of Strathclyde University conducted the UK's first systematic review of the research literature on food advertising and promotion to children.³⁸

The review found that children's food promotion is dominated by television advertising, and that most

of the research has focused on this area. However, it found that this research may 'understate the effect that food promotion has on children' and 'the cumulative effect of television advertising combined with other forms of promotion and marketing is likely to be significantly greater' than television alone.

The review concluded that 'food promotion can have and is having an effect on children, particularly in the areas of food preferences, purchase behaviour and consumption', and that 'these effects are significant, independent of other influences and operate at both a brand and category level'.

In addition to the Hastings Review, an Office of Communications (Ofcom) report³⁹ concluded that television has 'modest direct effects on children's food choices. While indirect effects are likely to be larger, there is insufficient evidence to determine the relative size of the effect of TV advertising on children's food choices by comparison with other relevant factors.' Ofcom concluded that a total ban on television advertising of food and drinks to children would be neither proportionate nor, in isolation, effective. However, Ofcom also concluded that there is a need for some specific and targeted tightening of the rules on television advertising, in the context of other changes. Ofcom's recent tightening of rules governing alcohol advertising is a good example of regulation evolving and modernising to keep up with changes in society.

Many respondents to the *Choosing Health?* and *Choosing a Better Diet* consultations thought that Government should intervene, where necessary, to protect children and help them make healthier choices. Many people felt it was wrong for children to be bombarded by sophisticated marketing that confuses their ability to make healthy choices. On television, the Government will work with broadcasting and advertising sectors on ways to help drive down levels of childhood obesity, and in particular, will look to Ofcom to consult on proposals to tighten the rules on broadcast

advertising, sponsorship and the promotion of food and drink to children.

The action

The White Paper is based on the principle of informed choice, recognising that people generally want to make their own choices. However, the White Paper also considers that children need a protected environment as they learn about making lifestyle decisions that impact on their health – a responsibility that government shares with parents.

To have maximum effect, action needs to be comprehensive and taken in relation to all forms of food advertising and promotion including:

- broadcast;
- non-broadcast;
- sponsorship and brand-sharing;⁴⁰
- point-of-sale advertising, including vending in schools; and
- labels, wrappers and packaging.

The Government will take the following steps to restrict further the advertising and promotion to children of those foods and drinks that are high in fat, sugar and/or salt:⁴¹

1. We will look to Ofcom to consult on proposals to tighten the rules on broadcast advertising, sponsorship and promotion of food and drink, and to secure effective implementation by broadcasters in order to ensure that children are properly protected from encouragement to eat too many foods high in fat, salt and/or sugar.
2. The proposals should also include options for broadcasters and advertisers to participate in healthy living promotions.⁴²
3. We will work with industry, advertisers, consumer groups and other stakeholders to encourage new measures to strengthen existing voluntary codes in non-broadcast areas and will establish a new Food and Drink Advertising Promotion Forum to review, supplement, and strengthen and bring together existing provisions.⁴³

4. The Government will monitor the success of these measures and assess their impact in relation to the balance of food and drink advertising and promotion to children, and children's food preferences.

5. The Government will look to the broadcasting and advertising sectors, including Ofcom, to consider how they could have a positive impact on children's food choices.⁴⁴

The FSA is undertaking work on the nutrient profiling of children's foods that will help identify which foods might be considered for specific restrictions.

DH will lead Government in the work to further restrict advertising and promotion of foods to children based on the work of the FSA. Other government departments involved include DCMS, the Department for Trade and Industry (DTI), DfES and Defra. Key stakeholders outside central government are Ofcom, the Advertising Standards Authority (ASA), the food and advertising industries, Local Authority Coordinators of Regulatory Services (LACORS)/Trading Standards, the Office for Standards in Education (Ofsted), and schools. The involvement of key stakeholders will be coordinated through the new Food and Drink Advertising and Promotion Forum.

Working with the food industry

Context

The food industry has a major impact on what people eat. Nine out of ten consumers do most of their shopping at a supermarket and half of the country's food is now sold from just 1,000 large stores.⁴⁵ Consumers are eating increasing amounts of food prepared and processed by the food industry. The 'convenience retailing' sector, which sells a larger proportion of prepared and semi-prepared foods, is growing by 9.7% year-on-year and is forecast to continue to grow rapidly as major retailers open more of these stores.⁴⁶ Eating out is increasingly popular too. 25% of respondents to the FSA *Consumer Attitudes Survey 2003* said they regularly used some form of fast food or takeaway outlet.

Advertising and food promotion to children

What	Who	When
Publish nutritional criteria, which will be used as basis for advertising and food promotion to children	FSA	June 2005
Success criteria for monitoring and evaluating effectiveness of voluntary industry action established	DH/FSA	Summer 2005
First meeting of Food and Drink Advertising and Promotion Forum	DH/FSA	Early 2005
Consult on tighter broadcast rules	Ofcom	Mid-2005
Identify how to strengthen voluntary non-broadcast codes	DH/new forum/FSA	Mid-2005
Consult on and propose how industry can have a positive impact on children's food choices	Industry/Ofcom with DH and FSA	
Consult on draft codes for non-broadcast media	New forum/partners	August–October 2005
Industry Code of Conduct agreed and adopted		Early 2006
Assess change to nature and balance of food advertising and promotion and children's food preferences	DH/FSA/DCMS	Early 2007
Take decision on whether or not to introduce legislation	DH with OGDs (including DCMS and FSA)	Mid-2007

Prepared and processed foods can be comparatively high in salt, fat, sugar and calories, especially as portion sizes have been growing. 75% of salt in the national diet comes from processed foods, mainly from cereals, cereal products, meat and meat products.⁴⁷ The main contributors to total and saturated fat intakes are meat and meat products, cereal and cereal products, and milk and milk products. The main source of non-milk extrinsic sugars (NMES) is from beverages, including soft drinks and alcoholic drinks, with a majority from carbonated drinks.

The food industry has a corporate social responsibility to promote healthier eating. The Government acknowledges that industry recognises its corporate social responsibility and has shown it wants to play its part, working with the Government to help tackle obesity; there are already numerous examples that demonstrate responsibility in this area. For example, many individual food retailers have made clear

commitments to increase the availability of healthier choices for customers.

The Government has already been working with the food industry to reduce salt in processed foods, working to targets and a timeline based on an FSA modelling framework of how reductions in salt in food would reduce salt intakes to the recommended level of six grams per day. DH and the FSA have been leading the programme. To date, commitments to salt reduction have been received from 65 organisations, with detailed plans from 44 of those. A large number of companies and organisations in the food industry have introduced salt reduction programmes, in some cases going beyond the reductions identified in the FSA salt model and with plans to achieve them in advance of the 2010 target date. Future work will include the identification of interim and long-term targets in key product categories, for example, pizzas and ready meals, with the support of cross-industry working groups. Consumers are already benefiting from this work and from the

action taken by an increasing number of retailers and manufacturers who now label products with their salt content.

We will build on this work to achieve reductions in the fat and sugar content of people's diets.

The action

The Government will take the following steps to increase access to healthier foods:

1. We will continue to work with the food industry to reduce levels of salt in prepared and processed food, based on the FSA modelling framework. The FSA will work with the food industry to identify interim and long-term targets for salt reduction in key product categories that make the greatest contribution to salt intakes.⁴⁸

2. The Government will work with the food industry to reduce levels of added sugars and fat, using new long-term and interim targets for reducing levels in different categories of food, with regular monitoring.⁴⁹
3. The Government will develop and publish guidance on portion sizes to reduce energy, fat, sugar and salt intake.⁵⁰

DH and the FSA will jointly lead Government in the work with industry to increase access to healthier foods, taking separate responsibility for different actions. Other government departments and agencies involved include Defra, DTI and the Small Business Service. Key stakeholders outside central government are the food industry, consumers and their representatives and health experts.

Working with the food industry

What	Who	When
Agree scoping plan on reducing fat and sugar levels in processed foods	DH/FSA	By May 2005
Work with industry to identify interim and long-term targets for salt reduction in key product categories and consider interim targets for overall reduction	FSA/DH	By September 2005
Set interim target for salt reduction	FSA/DH	By 2007
Consult on Regulatory Impact Assessment on 'action on reducing fat and sugar intakes in England'	FSA	By March 2006
Work with industry to identify interim and long-term targets for sugar and fat	FSA/DH	By December 2005
Publish final targets for sugar and fat	FSA/DH	June 2006
Publish a toolkit for health professionals on salt and hypertension	DH-funded	May 2005
Facilitate industry action to reduce sugar, fat and salt levels through jointly sponsored scientific scoping studies and research	Defra	March 2006
Monitor and facilitate industry action on salt towards interim and final salt target (6 grams per day) by 2010	FSA/DH	Ongoing
Survey current range of portion sizes	FSA/DH	March 2006
Publish guidance on portion sizes for stakeholder consultation	FSA/DH	Autumn 2006

CHAPTER 3: CHILDREN AND YOUNG PEOPLE

The actions outlined in this section support the commitments made in the *Choosing Health* White Paper and contribute to the overarching strategies in:

- The National Service Framework for Children, Young People and Maternity Services (DH September 2004); and
- Every Child Matters: Change for Children programme (DfES/DH December 2004).

Early years: Giving babies and infants a healthy start

Context

Good nutrition is essential, before and during pregnancy, for both the mother and unborn child. Nutrition in the early years of life is a major determinant of infant mortality, growth and development and influences adult health.

Sir Donald Acheson's 1998 inquiry into health inequalities⁵¹ found that a child's long-term health was related to the nutrition and physique of its mother. Low birth-weight was closely associated with death in infancy and with increased risk of coronary heart disease, diabetes and hypertension in later life. Infants whose mothers were obese had a greater risk of developing coronary heart disease in later life. Accordingly, the inquiry emphasised the importance of policies aimed at reducing health inequalities and recommended

'improving the health and nutrition of women of childbearing age and their children, with priority given to the elimination of food poverty and the reduction of obesity'.

The PSA target to reduce health inequalities by 10% by 2010 has breastfeeding as a proxy indicator for infant mortality. There is a target in the Priorities and Planning Framework for 2003–06 for the NHS to increase breastfeeding initiation rates by 2 percentage points per year, focusing particularly on women from disadvantaged groups. Breastfeeding has a major contribution to make to improving public health and reducing inequalities.

Breastfeeding provides clear short and long-term health benefits for both the infant and the mother. Breastfed babies are five times less likely to be admitted to hospital with infections such as gastroenteritis in their first year, and are less likely to become obese in later childhood. Mothers who breastfeed have a reduced risk of developing premenopausal breast cancer and are more likely to regain their pre-pregnancy weight. Those mothers least likely to breastfeed are the young, the poorly educated and those from disadvantaged groups.

The National Service Framework (NSF) for Children, Young People and Maternity recommends as a minimum standard the *Good*

Practice and Innovation in Breastfeeding guide.

This guide sets out minimum standards for practice to increase support for breastfeeding. The National Breastfeeding Awareness week is an annual public health campaign that aims to raise awareness of the health benefits of breastfeeding, particularly among young women, their partners, family and friends.

Evidence has found many interventions have a positive effect on increasing breastfeeding rates among low-income groups – including peer support programmes, ante- and postnatal support groups and the targeted education of health professionals.⁵² Mothers and children are supported by health professionals and others in a number of early years settings, including nurseries, playgroups, mother and toddler groups and the home. Sure Start children's centres and Sure Start local programmes provide support to young disadvantaged families, including help with infant feeding, weaning and healthy and economical eating. The NHS, through health visitors and midwives in particular, also provides maternity services, including support for breastfeeding. The good practice guide is a resource for health professionals and provides practical insights from successful innovative projects to increase support for breastfeeding.

For decades, the Welfare Food Scheme provided low-income families with vouchers that they could exchange for milk for their children under five years of age. A COMA review of the scheme in 2002 concluded that it made a valuable contribution to the diet and nutrition of children but recommended that the vouchers should also be usable for fruit and vegetables. In response, the Government is introducing the Healthy Start Scheme to replace the Welfare Food Scheme. Under the scheme, eligible pregnant women (including all under-18s), mothers and young children in low-income families will have greater access to, and encouragement from health professionals and others to eat a healthy diet.

The action

We will take the following steps to improve nutrition in the early years of a child's life:

1. DH will introduce the new Healthy Start voucher scheme, which will help improve diets in pregnancy and early years, particularly by encouraging fruit and vegetable consumption. Healthy Start will include a communications campaign aimed at families, to encourage their use of the scheme and to give them advice about diet and health. It will also include a communications and training programme for health professionals, to support them in targeting women and families in the most vulnerable groups.⁵³
2. Government will continue to recommend and promote breastfeeding as the best nutrition for infants in the first six months of life, in particular through National Breastfeeding Awareness Week.
3. Through Healthy Start, infant formula milk will no longer be available from healthcare premises, which will reduce its promotion in the NHS. The Government will continue to press the European Union to amend the Directive on Infant Formula and Follow-on Formula. We will also review the UK Infant Formula and Follow-on Formula Regulations with a view to restricting further the advertising of infant formula.⁵⁴
4. Sure Start children's centres will be developed in every community by 2010, offering integrated services to families, including information and guidance on breastfeeding and nutrition.⁵⁵

DH will lead the introduction of Healthy Start and with the FSA work to revise the EU infant formula legislation. Other key stakeholders include Sure Start and the NHS, NGOs, food retailers, the dairy industry, fruit and vegetable producers and infant formula manufacturers.

Nutrition in schools**Context**

All recent studies show that obesity is increasingly prevalent among children. The Health Survey for

Healthy Start

What	Who	When
Consultation ends on draft regulations for first phase of Healthy Start rollout, to Devon and Cornwall	DH	April 2005
Engage experts in planning Healthy Start evaluation programme	DH	April 2005
Evaluation plans for phase one established	DH	June 2005
Phase one of rollout of Healthy Start scheme begins	DH	July 2005
Evaluation of phase one completed and new regulations drafted for national rollout	DH	March 2006
National rollout of Healthy Start Scheme	DH	Mid-2006
Communication programme to promote breastfeeding	DH	Ongoing
Communication and training to improve infant nutrition for health professionals	DH	Mid-2005

Other

What	Who	When
Establish a Sure Start children's centre in every community	Sure Start, with input from DH	2010
Provide support for health professionals	DH	2005
Press for amendments to EU Directive on Infant Formula and Follow-on Formula	FSA with input from DH	2005
Receive EU draft regulation		Mid-2006
Review the UK Infant Formula and Follow-on Formula Regulations (1995)	DH	2005

England (HSE) 2002 found that 16.6% of males and 16.7% of females aged 2–15 were obese compared to 10.4% of males and 11.7% of females in 1995. A further 13.6% of males and 14.3% of females were estimated to be overweight compared to 13.4% of males and 13.6% of females in 1995.

Most children in the UK eat too much fat, particularly saturated fat, added sugars and salt. Average salt intakes are up to 50% higher than recommended and only around 15% of all children meet the recommendations for added sugars, around 8% meet the recommendations for

saturated fat and around 42% meet the recommendations for total fat. Children on average eat only around 2 of the recommended 5 portions of fruit and vegetables a week⁵⁶ and children from the lowest social group tend to eat 50% less fruit and vegetables than those from the highest social group.

Schools offer a place where the Government and others can support most children and young people in making informed choices about their diets, now and in later life, and provide them with access to healthier foods. Evidence suggests that action in schools can affect key health outcomes.

A Health Development Agency review,⁵⁷ for example, showed the effectiveness of school-based interventions to reduce obesity and overweightness in schoolchildren, particularly girls. These interventions included nutritional education, physical activity promotion, reduction in sedentary behaviour, behavioural therapy, teacher training, curricular material and the modification of school meals and tuck shops.

The *Choosing Health* White Paper set out a commitment that half of all schools will be 'healthy schools' by 2006, with the rest working towards healthy school status by 2009 – targeting schools with more than 20% of the school population receiving free school meals and Pupil Referral Units as a priority to support a reduction in health inequalities. The possibility of extending the Healthy Schools Programme to include nursery education will also be explored. The definition of a healthy school is being revised so that from April 2005, nutrition and physical activity will be incorporated as essential elements of the healthy schools programme.

Food in Schools Programme

The Government's Food in Schools (FiS) Programme helps schools become healthy schools by promoting good practice through the school day, in healthier breakfast clubs, tuck shops, vending machines, lunch boxes and cookery clubs, as well as water provision, growing clubs and the dining room environment. This is being done through a new interactive resource centre, available online at www.foodinschools.org (from April 2005), which will inspire, guide and assist schools in implementing their own healthy eating activities across these areas. The FiS Programme also supports teaching and learning in the National Curriculum, providing teaching resources, training and support. Expert food technology teachers train and support their primary school colleagues to assist practical food education in the classroom.

School meals

DfES sets statutory nutritional standards for school lunches, which give minimum requirements for the four main food groups (starchy foods; fruit and vegetables; milk and dairy foods; and meat, fish and alternative sources of protein). Guidance is provided to caterers on implementing the standards. All the same, a recent DfES/FSA survey⁵⁸ found that secondary pupils make poor food choices at school, eating meals with too much fat, salt and sugar, and little or no fruit or vegetables, even though, usually, healthy food is on offer. Food eaten in primary schools is thought to be healthier, because choices are restricted, although anecdotal evidence suggests that primary school meals still contain too much fat, salt and sugar. DfES and the FSA are currently conducting an evaluation of the food on offer in primary schools and the choices made, which will report in December 2005.

Local education authorities (LEAs) or, where the budget for school meals is delegated to them, individual schools are responsible, through their head teachers and governing bodies, for providing school meals that meet the statutory nutritional standards prescribed by DfES. However, there is no clear accountability for those standards and some schools do not believe that school meals should be a priority.

The Government is committed to improving school meals. Nutritional standards for primary and secondary schools are being revised, including strong consideration of nutrient-based standards. New improved standards will be in place by September 2006 and standards, subject to legislation, will be extended to cover all school food. Additional support will be provided for heads and governors in sourcing a healthy school meals service, and a school catering qualification will be available from mid-2005. From September 2005, Ofsted inspectors will be looking at healthy eating in schools, and will take account of any school meals provided in doing so. In addition, an independent School Food Trust is to be set up to

give independent support and advice for schools to improve school food; tougher standards will be set for processed food; and parents will be empowered to help drive change.

Food in the National Curriculum

There are many opportunities throughout the National Curriculum to teach healthy eating principles. Children learn about different types of food, in the context of a balanced diet, nutrition, safety and hygiene. Food technology is studied by all primary pupils and introduces practical food preparation and cooking skills, using equipment, tools and simple food hygiene. It is offered at Key Stage 3 by around 90% of schools. Science, Design and Technology teaches about food, nutrition and healthy eating and cooking. Personal, Social and Health Education (PSHE) teaches about the benefits of good nutrition and a healthy lifestyle. The DfES Growing Schools programme encourages schools to use the 'outdoor classroom' with an emphasis on fruit and vegetable growing and farming, and on the countryside as a resource across the curriculum.

Extended Schools

Extended Schools are ideally placed to offer accessible, year-round activities that promote healthy eating, physical activity and well-being to pupils, parents and the wider community. There is an expectation that over time all schools will deliver a core set of services. These core services include sport and outdoor activities (as an element of study support), swift easy referral to specialised support services for pupils (for example health and social care), parenting support and wraparound childcare, which might include breakfast clubs. We are already seeing some extended schools deliver a range of innovative programmes, including 'cooking nutritious meals on a budget', breakfast clubs and holiday activities delivered by local sports professionals.

School nurses

The role of the school nurse will be expanded and developed to help build public health expertise

within schools and provide individual children, young people and families with access to individual support and advice to prevent obesity and promote healthier eating. Every PCT will have at least one full-time, year-round, qualified school nurse working with each cluster or group of primary schools and the related secondary school. School nurses will use individual health guides to discuss nutrition and physical activity with children and young people and identify ways to increase access to physical activity. School nurses will support the obesity PSA target through their involvement in Extended School Schemes leading programmes that include identifying healthy foods, raising understanding of the 5 A DAY message, and cooking. They also use PSHE sessions to influence thinking around healthy lifestyle.

Free food to school children

School Fruit and Vegetable Scheme (SFVS)

The Government also provides free food to schoolchildren. The DH-led SFVS, which forms part of the 5 A DAY programme, provides 4 to 6 year olds in participating LEA-maintained infant, primary and special schools in England with a free piece of fruit or vegetable each school day. The SFVS is reaching close to two million children in over 16,000 schools. The SFVS also promotes the benefits of fruit and vegetables and healthy eating to the children, within the context of the whole-school approach. A National Opinion Poll (NOP) survey⁵⁹ has shown the benefits of the scheme for the whole family:

- Over a quarter of parents reported that their children and families ate more fruit at home as a result of the scheme.
- Nearly half of all parents questioned thought the scheme had made them more aware of the importance of fruit for a healthy diet.
- The scheme had the most positive impact on parents from lower socio-economic groups – they learned more than the other parents about the importance of eating fruit and vegetables

and reported the highest increases in their consumption at home.

School milk

Under the EU school milk subsidy scheme, nursery and primary schools may claim the payment of an EU subsidy, topped up by a national subsidy, for the provision of school milk, including semi-skimmed. Where milk is provided, it must be given free to those children who – or whose families – are in receipt of certain welfare benefits.

Free school meals

Lastly, children whose parents are in receipt of qualifying benefits are entitled to receive free school meals. As of January 2004, 17.3% of children in maintained nursery and primary schools and 14.3% of secondary schools in England were eligible to receive a free school meal. The Secretary of State for Education and Skills strongly recommends that the value of a free school meal should be set to enable children to have a standard two-course lunch and a drink each school day.

DH has commissioned research to review the literature and practice on schemes that offer incentives for positive choices for young people. If this research demonstrates that there is potential for incentive schemes to encourage healthy eating by young people, we will consider pilots in this area.

The action

We will take the following steps to support children in schools:

Healthy Schools Programme

1. The definition of a 'healthy school' is being redefined so that nutrition and physical activity are incorporated as essential elements of the Healthy Schools Programme.

School nurses

2. We will provide additional funding to expand the school nursing workforce and to develop

and promote a new role that includes preventing obesity and supporting schools in encouraging healthy eating.

3. We will provide a qualified school nurse to work with each cluster or group of primary schools and its related secondary school, taking account of health needs and school populations. School nurses and their teams will be part of the wider health improvement workforce described.

School food

4. We will help schools become 'healthy schools' by promoting best practice through the Food in Schools programme, to support implementation of the whole-school approach to healthy eating and drinking. We will roll out guidance and resources for schools.⁶⁰
5. We will revise primary and secondary school meal standards and strongly consider including nutrient-based standards.⁶¹
6. We will extend standards to all foods provided in schools, including vending machines and tuck shops.⁶²
7. We will set specifications for processed foods.
8. We will introduce guidance for head teachers and governors on food procurement.⁶³
9. We will introduce training for catering staff.⁶⁴
10. Ofsted will inspect school food, including school meals.⁶⁵
11. Following evaluation, we will consider a possible extension of the SFVS to LEA-maintained standalone nurseries.⁶⁶
12. We will set up a new independent School Food Trust to provide independent advice and support to parents and schools.
13. We will introduce a Framework for Governors to inform them of their responsibilities in relation to food issues in schools and to provide information about options.

DH, DfES and the FSA are jointly working on improving school food. DfES leads on schools policy generally, including nutrition within the curriculum and work on school meals. DH and DfES jointly lead on the Food in Schools Programme. DH leads on the School Fruit and Vegetable Scheme.

Progress, however, can only be delivered through wide-ranging partnerships involving schools, parents and children, governors, local health and education authorities, and caterers and other sectors of the food industry. The National Healthy Schools Programme and the School Food Trust will be key in fostering these partnerships.

Healthy Schools Programme

What	Who	When
Launch new definition of what makes a 'healthy school'	DH/DfES	April 2005

Food in Schools Programme

What	Who	When
Launch Food in Schools package of guidance and resources for schools	DH	March 2005
Train Healthy Schools Coordinators and others in the use of the Food in Schools package	National Healthy Schools Team/DH/DfES	April–May 2005
Launch Food in Schools website	DfES/DH	April 2005

School Fruit and Vegetable Scheme

What	Who	When
Launch new materials to help schools integrate scheme into whole-school approach and link to 5 A DAY	DH	Achieved December 2004
Publish evaluation of the SFVS	DH/Big Lottery Fund	June 2005
Consider extending the SFVs to LEA-maintained nurseries		After June 2005

School meals

What	Who	When
Expert panel reviews secondary school meal standards where we will be strongly considering nutrient-based standards	DfES (DH/FSA)	February–November 2005
Make available training qualification for school caterers	DfES/FSA	April 2005
Produce guidance on food procurement	DfES (DH/FSA/Defra)	July 2005
Consult on nutritional specifications for foods used in schools	FSA	July 2005
Complete consultation on revised secondary school meal standards	DfES	Late 2005
Complete evaluation of primary school meal standards (secondary schools meals evaluated in 2004)	DfES	December 2005
Panel reviews primary school meal standards where we will be strongly considering nutrient-based standards	DfES (DH/FSA)	December 2005–June 2006
Complete consultation on revised primary school meal standards	DfES	May 2006
Bring into force new statutory requirements for primary and secondary school meal standards	DfES	September 2006
Subject to legislation, extend revised school meal standards to cover food across school day by August 2007	DfES	As soon as parliamentary process allows

Other

What	Who	When
Ofsted to start inspecting school food	Ofsted	September 2005
School Food Trust to be operational	DfES	September 2005
Launch framework for Governors	FSA	May 2005
Make parent's toolkits available	DfES	September 2005
Roll out of school nurses in the 20% of PCTs with the worst health and deprivation indicators		2006–2007

CHAPTER 4: HEALTHY EATING IN THE COMMUNITY

Local communities must be engaged in improving nutrition and health. Isolated action will have only a limited impact and a partnership approach is required. Primary Care Trusts and local authorities, working through Local Strategic Partnerships, have a key role to play in supporting healthy eating in communities. They will need to ensure that they are working closely on strategies to encourage, and promote access to, healthy eating, through their Community Strategies and Local Delivery Plans. Specific action in each area will depend on local priorities, and might include initiatives such as boosting sales of fruit and vegetables through local retailers, food growing schemes, cooking skills development, food co-operatives and community lunches, but will be supported by national and regional action, in particular, the national 5 A DAY programme.

Neighbourhood Renewal initiatives and programmes such as the New Deal for Communities and Neighbourhood Management initiatives have an emphasis on partnership working and community involvement. These offer good opportunities to implement diet improvement programmes developed by, and involving, local people. The Government has also produced *Creating Healthier Communities: A resource pack for local partnerships* as part of the implementation of the *Choosing Health White*

Paper. This provides practical guidance on working in partnership, targeting action and using tools such as Local Area Agreements, and Overview and Scrutiny arrangements, including specific guidance on healthy eating initiatives within communities.

Encouraging fruit and vegetable consumption – 5 A DAY

Fruit and vegetables are a key part of a balanced diet, providing many necessary vitamins and minerals as well as fibre. Eating at least five portions per day of a variety of fruit and vegetables could reduce premature death from chronic diseases, such as heart disease, stroke and some cancers, by up to 20%. It has been estimated that increasing fruit and vegetable consumption is the second most important cancer-prevention strategy after reducing smoking.

The average consumption in England, however, is only 2.8 portions per day, compared to the widely recommended minimum level of at least five portions per day.⁶⁷ This average consumption conceals wide inequalities in consumption of fruit and vegetables. The lowest consumption is among children and young people, men, and people in lower socioeconomic groups. For example, adults in routine and semi-routine occupations consume approximately 30% less fruit and vegetables

than those in management and professional occupations.⁶⁸

The Government's 5 A DAY programme includes work with the food industry to increase access to, and availability of, fruit and vegetables, and education and promotion campaigns to increase consumer demand. 5 A DAY particularly aims to encourage access for, and consumption by, disadvantaged groups. The 5 A DAY community initiatives, which focus on disadvantaged communities, use a range of approaches tailored to their particular local needs (including food co-operatives, 'grow your own' allotments, delivery schemes and subsidised transport to shops and cookery classes).

The 5 A DAY programme has proved successful. The evaluation of five DH-funded pilots, for example, showed that over a year the 5 A DAY community initiatives increased average consumption of fruit and vegetables by one portion per day among those people with the lowest intakes. A survey of the 5 A DAY School Fruit and Vegetable Scheme⁶⁹ found that over a quarter of children and their families reported that they were eating more fruit at home after joining the scheme, rising to nearly a third for lower socioeconomic groups.

The FSA Consumer Attitudes Survey shows an increase in awareness of the 5 A DAY message, from 52% in 2002 to 59% in 2003. A recent 5 A DAY brand tracking survey⁷⁰ found that 37% of respondents claim to have eaten more fruit and vegetables over the past 12 months, with that number rising to 40% in the lowest socioeconomic groups, compared to 32% in the highest. Fruit consumption in particular appears to have risen, and a recent survey found an increase in consumption of fresh fruit of 5.8% from 2001/02 to 2002/03.⁷¹

The action

The Government, working in partnership with the food industry and other stakeholders, including charities such as Cancer Research UK and the

British Heart Foundation, will continue to encourage consumers to eat more fruit and vegetables through the 5 A DAY programme (and the School Fruit and Vegetable Scheme covered below). Work to promote fruit and vegetable consumption will continue and build on the research into what works by targeting groups with the lowest intakes, particularly those in disadvantaged groups and areas:

1. From 2006, DH has allocated £17 million over 2 years directly to PCTs to establish more 5 A DAY community initiatives so as to encourage fruit and vegetable consumption in deprived communities, building on the experience of the pilots and the 66 lottery-funded initiatives.⁷²
2. DH will launch new 5 A DAY primary care resources – a video and booklet – during 2005 to help GPs and other healthcare professionals support people in increasing fruit and vegetable consumption.⁷³
3. DH will simplify the 5 A DAY message by clarifying what a portion means for adults and children (for example, in terms of 'handfuls').⁷⁴
4. Government will extend the use of the 5 A DAY logo to processed foods and foods for children, within controlled limits for salt, fat and added sugars.⁷⁵

DH will continue to lead the 5 A DAY programme, working in particular through its regional and local 5 A DAY Coordinators, overseen by the Government Offices for the Regions (GOs). Other government departments and agencies involved include Defra, DfES and the FSA. Key stakeholders outside central government include the food industry, the horticultural producer organisations, health professionals (especially GPs and others in primary care) and the NHS, especially in the PCTs.

The 5 A DAY community initiatives will focus on increasing fruit and vegetable consumption in deprived communities. Children and young people are among those with the lowest intake of fruit

and vegetables, and the School Fruit and Vegetable Scheme will improve their eating habits by introducing regular consumption of fruit and vegetables at an early age, while taste preferences are still being formed. The School Fruit and Vegetable Scheme is currently providing a fresh piece of fruit or vegetable every school day to close to two million children in over 16,000 LEA maintained schools across England.

The 5 A DAY communications programme will focus on those groups of consumers with the lowest fruit and vegetable intake, for example families in the lower socioeconomic groups and children and young people.

Defra will step up activity under the Public Sector Food Procurement Initiative (PSFPI) to promote 5 A DAY through catering units operating in the public sector.

Developing supplier networks

Defra will continue to engage the GOs, Regional Development Agencies, and bodies such as English Farming and Food Partnerships and the National Farmers' Union (NFU) in developing supplier networks to assist producers in competing to supply produce to the public sector, including fruit and vegetables for the 5 A DAY programmes and the

School Fruit and Vegetable Scheme. These initiatives are supported by local authorities and non-government organisers such as Sustain and the Soil Association, and receive input from other community-based organisations such as universities and colleges. Defra has calculated that every £10 spent locally generates £25 for the local economy. This can help improve the standard of living in poorer communities, allowing people to afford more nutritious food that is better for their health.

Food Vision

The 'Food Vision' project, launched in September 2002, was created by the FSA, the Local Government Association and LACORS to promote the production of, and access to, safe, sustainable and nutritious food to improve local community health and well-being.

'Food Vision' promotes good practice regarding the many ways in which local authorities can act to help promote access to safe and nutritious food and improve community health and well-being. The project concentrates on activities directed towards helping people achieve healthy balanced diets.⁷⁶

Building on the learning gained from the 'Food Vision' project will enable local communities to develop local strategic food visions.

Encouraging fruit and vegetable consumption (see also Education campaigns and Simplified food labelling)

What	Who	When
Agree with stakeholders a measure of portion size	DH	2005
Launch new 5 A DAY primary care resources for healthcare professionals	DH	Mid-2005
Extend use of 5 A DAY logo to composite fruit and vegetable products and foods targeted at children	DH	September 2005
Publish evaluation of the 66 5 A DAY community initiatives and update PCT guidance	DH/Big Lottery Fund	December 2005
Introduce further 5 A DAY community initiatives	DH	From April 2006
Explore with horticultural producer organisations scope for fruit and vegetable producers to use EU assistance to help improve market orientation and competition	Defra	Ongoing

Accessibility

Making it easier for people, particularly for those without the use of a car, to access affordable and healthy food is also crucial in promoting healthy eating. DfT and DH have issued guidance on accessibility planning which sets out the main objectives for improving access to key services, including food shopping, and encourages those involved with delivering health improvements to work with local transport authorities on producing accessibility strategies for their area.

Communities for Health

The Communities for Health programme is a new approach to unlocking the energy that lies within communities. To be piloted from Spring 2005, the programme will promote action across a range of local organisations on locally chosen priorities for health. The pilot areas have identified activity to improve diet and increase physical activity as local priorities for action.

Local authorities will take a lead in the Communities for Health programme, building on the activity they are leading in many areas to tackle poor health and health inequalities.

Obesity care pathway and services

What	Who	When
Identify methodology for measuring children's height and weight	DH/DfES	April 2005
Initial development/training of workforce on obesity management	DH	April 2005
Issue guidance to PCTs on care pathway	DH	June 2005
Issue guidance on 'diets'	DH	July 2005
Conduct SHA overview of PCT planning for obesity services, such as identifying local obesity teams and specialist obesity services	DH	July 2005
Make access to obesity services available in all PCTs	DH	June 2006
Outcome of GP contract (QOF)	DH	End 2006
NICE guidance published	NICE	June 2007

CHAPTER 5: A NHS THAT PROMOTES HEALTHY EATING

Obesity care pathway and services

Context

A health and social care system in which advice and support for physical activity played an integral part would help people lead healthier lives. Doctors, nurses, pharmacists, dieticians, nutritionists, other health professionals and social care workers encouraging their patients and clients to lead active lives has the potential to bring about significant benefits. The NHS and the wider public sector also have an important role to play as major employers.

The action

A comprehensive 'care pathway' for obesity will provide a model for prevention and treatment in the NHS and will ensure that:

- there is coordinated activity on obesity prevention and management in each PCT for both adults and children, with a range of appropriately trained staff – to include health trainers, school nurses, health visitors, community nurses, well-being support programmes in spearhead PCTs, practice nurses, dieticians and exercise specialists. Services may also be drawn from the voluntary and independent sectors;
- there are clear referral mechanisms to specialist obesity services which will be staffed by

multidisciplinary teams with specialist knowledge and training in obesity management; and

- in addition to specialist services there will also be trained staff who can work in different settings such as schools, leisure services and the community, working alongside obesity prevention and management experts within the overall whole-system approach to obesity within a PCT.

The number of people who are overweight and obese means that each PCT area will need a specialist obesity service with access to a dietician and relevant advice on behavioural change. PCTs do not need to commission all these elements from NHS providers, but should develop innovative clinical models that will help support evaluation of different approaches to delivery of obesity services at local level, for example quality assured, commercial diet providers and leisure centres. PCTs will receive additional funding of £55 million for action on diet, physical activity and obesity for the two years 2006/07 and 2007/08. This will enable them to strengthen primary care capacity to prevent weight gain and tackle obesity, and to develop services to respond to patient needs across the whole care pathway.

Funding to PCTs has been allocated for enhancing workforce capacity in the form of NHS-accredited Health Trainers and school nurses. NHS-accredited Health Trainers will have the skills and techniques to support individuals in changing their behaviour, reaching out to those who need help most and tailoring their work to an individual's circumstances. They will provide advice and practical support on what people can do, such as taking up more exercise and healthy eating, as well as explaining how to access other help locally.

Local partnerships with the voluntary and community sectors, local authorities, the leisure industry and other alternative service providers will be able to enhance capacity and the new primary care contracting arrangements will support this. The independent sector may have a key role in providing effective behaviour change programmes in ways that are more acceptable to some groups of patients than traditional NHS care.⁷⁷

Another opportunity is to test approaches to tackle obesity through the Healthy Communities Collaborative.⁷⁸

We are developing a patient activity questionnaire, which will be available by the end of 2005, to help NHS staff and others to understand their patients' level of physical activity and assess needs for interventions such as exercise referral.⁷⁹ We already have a simple questionnaire to assess fruit and vegetable consumption.

CHAPTER 6:

NUTRITION IN THE WORKPLACE

Promoting healthy eating in the workplace

Context

The workplace provides a significant opportunity to promote healthy lifestyles, as over half of the UK population are currently in employment and it is estimated that people may spend up to 60% of their waking hours in their place of work.⁸⁰

The workplace is also an important setting for addressing inequalities, including issues of access, health status and gender differences.

As well as providing opportunities for healthy eating through the food that many workplaces provide in staff canteens, employers can also play a significant role in influencing wider staff health and well-being. There is a strong business case for employers to help keep their staff healthy.

However, workplaces are generally under-utilised as a setting for promoting health and well-being.

The action

Employers, government and trades unions all have a role to play in establishing environments that support healthy choices across a range of behaviours, including better diet, smoke-free environments, smoking cessation and encouragement of activity. Relatively low-cost, simple solutions have the potential to make big differences.

The evidence base of what works in this setting does need to be further developed, and to this end we will establish national workplace pilots to test out interventions across a range of health behaviours to support active living and also to promote healthy eating. Each pilot will focus on a specific type of workplace, such as a NHS organisation, a local council and small and medium-sized businesses.

There will also be action within government to lead by example and, in conjunction with business partners, the establishment of a Healthy Workplace Award to recognise the positive work companies are already doing to improve the health and well-being of their employees.

Under the *Choosing Health* White Paper commitment to build health into the workplace,⁸¹ Investors in People (IiP) UK have agreed that they will develop a new healthy business assessment, in conjunction with DH, identifying the advantages for business and employees of investing in staff health, and of building on mechanisms already available to businesses from IiP. This work will be incorporated into the IiP Standard when it is next reviewed in 2007.

Public sector procurement: leading by example

Context

Public sector catering represents around 7% of the UK catering sector with roughly 61,500 outlets.⁸² Many of the millions of meals it provides every year are for people in its workforce and in its charge, including some of the more vulnerable in society. The NHS alone employs 1.3 million people and provides over 300 million meals a year in 1,200 hospitals.⁸³ Altogether the public sector in England (including the NHS, central government, local authorities, the education system, prisons and the armed forces) spends over £1.8 billion annually on food and catering services.

- In the NHS, some £500 million annually is spent on catering and £300 million on food. This is split equally between NHS Trusts and the NHS Purchasing and Supply Agency (PASA). PASA spends about £120 million to £150 million a year on fresh food.
- The Ministry of Defence (MOD) spends some £95 million annually on prime cost of food.
- HM Prison Service's annual budgets for food and catering total £48 million devolved to Prison Governors.
- School meal providers are estimated by the Local Authority Caterers Association to spend over £360 million on food and £45 million on equipment and cleaning annually.

The public sector, including the NHS, has a Corporate Social Responsibility to offer healthy nutritious food in its institutions and to lead by example in improving the diets of its staff and patients. Its organisations are already working together under PSFPI, which is seeking to embed sustainability in procurement, with healthier food as a goal. Providing a range of healthy food options has not always been a priority for public procurers, for various reasons. Factors have included local autonomy in purchasing decisions, the absence of any standard nutritional

requirements for procured foods and tight financial controls. In some cases, the responsibility for food provision has been contracted out to the private sector, with agreements based on a financial, customer service and food safety basis rather than on nutrition.

There are many examples of good progress at the local level – for example in individual prisons, schools, local authorities and NHS trusts – of which there are some case studies on the PSFPI website.⁸⁴ The site also contains guidance and tools on healthy eating for buyers and specifiers and links to other useful sources of information – including information provided by the Expert Panel on Armed Forces Feeding in their recently published *Recruits' Guide to Nutrition and Commanders' Guide*.

In determining value for money, public bodies must look beyond initial price to consider the wider benefits to the organisation and the taxpayer as a whole. Providing more nutritious food to improve patient recovery times can achieve savings far in excess of those achievable from trying to cut the cost of food and catering services. Tastier food is also likely to result in less waste from leftovers and thus reduce disposal costs.

The action

Building on the work of Defra's sustainable food procurement initiative and work on improving school meals, we will take the following steps:

1. Building on best practice, DH will set up a new working group and work with stakeholders to develop and implement nutritional standards for all foods procured by the NHS, the Armed Forces and HM Prisons.⁸⁵
2. The Government will promote the procurement standard, in particular through a new 'Healthy Eating' award.⁸⁶

DH will lead government in the development and promotion of the standards, drawing on the progress already made with school meals, and will

involve other stakeholders through the new working group.

Those stakeholders will include:

- the FSA, to assess current standards and develop new ones, as appropriate, linking with the FSA objective to review nutritional standards in foods served in institutions;
- Defra, to make the link to the PSFPI and the Food Procurement Implementation Group (FPIG);
- NHS Estates, in conjunction with the National Patient Safety Agency;
- the NHS Purchasing and Supply Agency (PASA);
- Ministry of Defence (MoD), drawing on the work of the Expert Panel on Armed Forces Feeding;
- HM Prison Service; and
- public sector suppliers' representatives within the food industry.

Work to improve nutritional standards in school meals is well advanced and specific to children's needs, and so is being handled separately.

Public sector procurement

What	Who	When
Map current work and identify key personnel involved in relevant institutions	DH	April 2005
Convene new working group including NHS, MoD and the Home Office and define terms of reference	DH	June 2005
Establish a programme to develop new nutritional standards where appropriate/required	FSA with DH	September 2005
Implement through government departments' food procurement action plans, including pilots	DH with the FPIG	From November 2005
Pilot and evaluate, where required	DH with FSA and relevant providers	November 2005 onwards
Subject to evaluation, roll out of implementation	DH with FSA and relevant providers	Spring 2006 onwards
Evaluate impact of standard	DH with FSA and relevant providers	September 2006
Consider new 'Healthy Eating' award	FSA/DH	2007

CHAPTER 7: MAKING IT HAPPEN – NATIONALLY, REGIONALLY, LOCALLY

DELIVERY THROUGH THE CHOOSING HEALTH DELIVERY PLAN

The *Choosing Health* White Paper delivery plan sets out the key steps that need to be taken over the next three years and a national framework to deliver the White Paper commitments. Tackling obesity is one of the key *Choosing Health* priorities. We will deliver this action plan using the White Paper's delivery plan arrangements.

The national engine for health improvement is to be found in the ambition of people themselves to live healthier lives. Action to deliver the White Paper is therefore underpinned by three key principles:

- informed choice for all;
- personalisation of support to make healthy choices; and
- working in partnership to make health everyone's business.

This action plan recognises that in order to help people make healthier choices, support and services need to be provided at a local level. It recognises the vital importance of co-delivery between local government and the NHS in partnership with local communities, business and the voluntary and community sectors.

This plan sets out the national action – such as regulation and national campaigns – that will create the right environment for action at a local level. This chapter sets out the supporting delivery mechanisms that have been put in place to aid regional and local delivery.

GOVERNANCE

Delivery across government will be overseen by the Cabinet Committee MISC 27, chaired by the Secretary of State for Health, supported by a Health Improvement Board of senior government officials. Other boards and steering groups involving partners outside government and other stakeholders will be convened to help lead change and to report on progress, including the Obesity PSA Programme Board, which will oversee delivery of the work in this action plan. Their role will be to monitor progress and manage risks, resources and interdependencies for their workstreams.

These will ensure that action across government is properly monitored, that risks to delivery are identified and minimised, and that interdependencies between programmes are managed effectively. During 2005, DH will work with other government departments to develop agreements setting out how they will work together to deliver key *Choosing Health* priorities. ODPM and DH will work together to ensure that

government policy reduces health inequalities, and that improving the overall health and well-being of the population does not inadvertently widen health inequalities.

We committed in *Choosing Health* to setting up a national partnership for obesity to promote practical action on the prevention and management of obesity and as a source of information on obesity (for both diet and physical activity) and evidence of effectiveness.⁸⁷

DH will also continue to report on this action plan to the Sustainable Farming and Food Implementation Group, the Food Procurement Implementation Group and the Consumer Health Needs workstream subgroup, to help integrate the public health and sustainable farming and food agendas.

REGIONAL AND LOCAL DELIVERY

This action plan is intended, with the White Paper, to outline the framework of actions that will be taken to support, and help set the direction for, regional and local delivery. It is not intended to direct the action happening in local communities but rather to complement regional and local initiatives by delivering those actions that can only be driven nationally, by national organisations.

The NHS is responsible for taking forward the health improvement agenda but it can only do this effectively through partnerships with key stakeholders. It is essential that PCTs work in partnership with local authorities to co-deliver the *Choosing Health* priorities.

Regional delivery

At a regional level, the Government Offices (GOs), Regional Assemblies and Regional Development Agencies also play an important part in helping to shape the wider economic determinants that can impact on obesity, including transport, the environment and regeneration.

GOs bring together the activities of 10 Whitehall departments and include, for example, ODPM's interests in sustainable communities and deprived neighbourhoods, and DfES' interests in children

and learners. This makes GOs ideally placed to achieve the connections necessary between these activities to improve health and well-being.

Regional Directors of Public Health and their Public Health Groups (PHGs) are based within GOs and will support local delivery of health improvement by coordinating regional task forces and other action to support the delivery of health improvement PSAs, involving other key stakeholders within the GO, brokering support for local action, and commissioning their Public Health Observatories to track and report performance.

The regional role in delivery is key for the successful implementation of many of the actions in the plan. Many of the actions outlined will be delivered most effectively with support from a dedicated regional food and health role (in Government Offices) which will provide the link between national policy and regional, sub-regional and local interventions.

Regional food and health action plans will be developed to identify and gain commitment to the essential contribution of regional agencies such as Regional Development Agencies, Regional Assemblies and other stakeholders in improving diet and nutrition.

Regional food and health action plans will coordinate with, and contribute to the delivery of, the Strategy for Sustainable Farming and Food (SSFF). We will ensure that the regional delivery plans of the SSFF all include commitments on nutrition. This will serve to help coordinate the work of national, regional and local government, the voluntary sector, business and others.

Local delivery

Local Strategic Partnerships (LSPs) bring together LAs, other public services, and private, voluntary and community sector organisations to work with residents to improve local areas and services. In some areas they are already setting challenging and inspiring goals for improving health and well-being.

Delivery planning for *Choosing Health* is an integral part of PCTs' Local Delivery Plans (LDPs), which should be developed in close consultation with LA partners and other key stakeholders in LSPs. Within their LDPs, PCTs will agree local targets to reduce childhood obesity that are designed to meet local needs and that will be agreed with the local education authority and other local partners.

A planning and performance toolkit⁸⁸ has been circulated to PCTs to support them in planning locally for *Choosing Health*.

Performance levels within LDPs will be agreed between PCTs and strategic health authorities (SHAs), and PCTs will be held accountable for delivery. SHAs will have an important role in ensuring that the spearhead PCTs are making faster progress than the average of all PCTs in order to reduce inequalities in line with the national targets.

Children's trusts are being established by LAs working with colleagues in the health sector and other local stakeholders. They will determine the services needed to drive improvements in children's health and well-being in line with the Children's Outcome Framework.⁸⁹ It is essential that PCTs and the emerging children's trusts work together to co-deliver local action on obesity.

RESOURCES AND CAPACITY

The NHS will invest its mainstream budgets to secure improvements in public health, well-being and health inequalities. Over the next three years, more than £1 billion of additional funding will be invested to support and deliver the *Choosing Health* White Paper. Around half of this has been allocated directly to PCTs to deliver on specific areas, some of which are outlined below.

In addition to the investment flowing from DH, there will be investment right across government to support activities that will contribute directly and indirectly to health improvement.

Choosing Health White Paper funding has been targeted on the most deprived areas, including the

spearhead PCTs. All areas will receive a significant increase in funding to implement the White Paper commitments. In allocating the funding, we have given a head start to the PCTs in spearhead areas to recognise that they have more difficult challenges to address. But all PCTs will be expected to make progress in tackling inequalities and providing services for the hardest-to-reach groups.

Further funding will be held centrally to pilot new interventions and to find out what works, for national campaigns such as those mentioned above, and for other national projects.

£55 million has been allocated for the two years 2006/07 and 2007/08 directly to PCTs for action on diet, physical activity and obesity. This will enable PCTs to take more action on reducing obesity, including promoting healthy lifestyles. This includes improving diet by extending the 5 A DAY programme across more PCTs and supporting development of an obesity care pathway, as well as physical activity interventions as described in the physical activity action plan.

A further £50 million has been allocated to PCTs in this period for capacity expansion – strengthening the local health improvement workforce plans to meet local needs. It will be vital that these include sufficient local skilled capacity to deliver on tackling obesity for example, dieticians and diet assistants. Evidence shows that delivery of services needs effective coordination and planning. For example, the success of the community 5 A DAY pilots was due to dedicated funding per PCT with a coordinator overseeing the work. A similar approach for developing obesity services would require such coordination, with appropriately trained staff in diet, physical activity and behaviour modification.

Programmes are being put in place to boost the numbers of public health specialists and public health practitioners to help shape, drive and deliver the services that people need to help improve their health. The NHS workforce will have a better understanding of, and better skills, in health

improvement to make the best opportunity of people's encounters with the NHS to promote healthy lifestyles. In the primary care setting, practitioners with a special interest will provide a focus for health improvement. New and extended roles for pharmacists will provide a flexible source of help and advice. Expansion in the numbers of school nurses will provide a fresh focus to influence the role of diet and physical activity in the health of schoolchildren.

Regional food and health managers will work with Public Health Networks and Health in the Regions to increase the quantity and relevance of initial and Continuous Professional Development training available to support the implementation of this plan.

CHAPTER 8:

MONITORING AND EVALUATION

The overall success of this action plan will be evaluated in terms of the aim and objectives set out above. Overall, therefore, we will track the impact of this action plan by measuring the prevalence of breastfeeding and the average consumption, across socio-economic and demographic groups, of:

- fruit and vegetables;
- dietary fibre;
- salt;
- total and saturated fat; and
- added sugar (NMES).

We will track these measures through existing surveys:

- The DH/FSA National Diet and Nutrition Survey (NDNS) programme provides comprehensive information on dietary habits for the population of Great Britain, including socio-economic, demographic and lifestyle characteristics. There is also a National Infant Feeding Survey. The NDNS is currently under review with the key objectives of reducing under-reporting, maintaining response rates, and developing a new structure and methodology. As part of the review the Scientific Advisory Committee on Nutrition and various stakeholders have been

consulted and have commissioned further work to characterise misreporting in the survey.

A rolling programme of surveys of a UK representative sample aged 1½ years and above is being proposed which includes:

- The DH Health Survey for England, which provides annual information about various aspects of people's health, and monitors selected health targets, such as the prevalence of obesity, salt intakes and fruit and vegetable consumption.
- The Defra Expenditure and Food Survey, which provides a continuous survey of UK households giving information about food purchases and expenditure, food consumption (including that consumed outside the home) and nutrient intakes.
- In addition, the FSA has commissioned a low-income Diet and Nutrition Survey to increase the evidence base on people's diet and their income. The results of the survey are expected in mid 2006.

Each action will have its own particular success measures around what it is specifically trying to achieve. In addition, each action will be periodically assessed (quantitatively and/or qualitatively) for its contribution to improving

the nutritional balance of the average diet and, through that, to improving health.

Public Health Observatories already play a major role in collating, analysing and reporting on health data, nationally and locally. Amongst other initiatives, PHOs and partners have for example taken forward three major indicator initiatives:

- Regional Public Health Indicators;
- Local Basket of Indicators; and
- Health Poverty Index.

(i) Regional public health indicators

The reports of these aim to present data on the health of the public in England in a useful and accessible way, comparing key indicators (such as heart disease mortality or the prevalence of obesity) geographically between regions or local authorities. All the information is taken from routinely available data sets, such as the Health Survey for England and the Compendium of Clinical and Health Indicators published by DH. The first two data reports were written largely for professional readers; the most recent – lifestyles and health – is aimed at a wider audience, including partners in local government and the voluntary sector.

Also published alongside these reports are regional – and intermittently local – indicators across key domains of public health, including the wider determinants of health. Indicators relevant to food and nutrition include prevalence of adult and child obesity and prevalence of consumption of at least 5 portions of fruit and vegetables a day.

(ii) Local Basket of Indicators (LBOI)

The LBOI was released on the London Health Observatory website (www.lho.org) on 30 October 2003. It comprises around 70 indicators.

The purpose of the LBOI is to support local action and priority-setting to tackle health inequalities. It is aimed not just at the NHS, but also at wider local organisations, for example LAs, Local Strategic Partnerships, and partner organisations

such as the voluntary, community and private sectors.

The LBOI, which was developed through cross-sectoral and cross-government consultation, includes indicators relating to areas such as employment, poverty, homelessness, education, crime, lifestyle and health measures (including preventive interventions).

The LBOI is based on existing data collections – there are no requirements on the service to collect additional data, indicators are not mandatory and targets have not been imposed by DH. Its value is in drawing together existing measures of inequalities in a single package. For example, the percentage of children with active dental decay.

(iii) Health Poverty Index (HPI)

The HPI is primarily a visualisation tool for identifying local health and health inequalities issues, using indicators on health and wider determinants of health. The indicators included in the HPI cover the following domains: health status, health behaviours, unmet health care need, environment, and individual and community resources. It allows local health communities to identify issues that can be built into their planning to improve health and to tackle health inequalities.

The HPI's function is to provide summary key information on differences in health and health outcomes between various groupings of society, and allowing differences to be monitored over time. This should stimulate action on health inequalities. The HPI website uses 'spider' charts, bar charts and data tables to present the information on a web-based tool.

The HPI is intended to help identify local problems and challenges, catalysing and empowering local action on health inequalities. It should also invigorate data collection on health and health inequalities, and complement related initiatives on health inequalities such as the LBOI.

Evidence and evaluation

The Government is committed to building the evidence base for the effectiveness and cost-effectiveness of public health interventions, including those related to diet and nutrition. As a first step, the Health Development Agency (HDA) has already published *Evidence Briefings* on obesity⁹⁰ and breastfeeding,⁹¹ and the National Institute for Health and Clinical Excellence (NICE) will be publishing definitive guidance on the prevention, identification, management and treatment of obesity early in 2007.

The Scientific Advisory Committee on Nutrition (SACN) advises UK Health Departments and the Food Standards Agency. SACN's review of scientific evidence and advice will inform the Government's work to improve diet and nutrition of the population. SACN advises on scientific aspects of nutrition and health with specific reference to:

- nutrient content of individual foods and advice on diet as a whole, including the definition of a balanced diet, and of the nutritional status of people;
- monitoring and surveillance of the above;
- nutritional issues which affect wider public health policy issues, including conditions where nutritional status is one of a number of risk factors (for example, cardiovascular disease, cancer, osteoporosis and/or obesity);
- nutrition of vulnerable groups (for example, infants and the elderly) and health inequalities issues; and
- research requirements for the above.

All nutrition programmes will be fully evaluated. Evaluation of the SFVS and 5 A DAY Community Initiatives is currently underway to assess the impact on overall diet and particularly on consumption of fruit and vegetables. Evaluation of the Healthy Start scheme, to be launched later this year, is being planned.

In the *Choosing Health* White Paper, the Government has committed to commission further studies to support the development of new approaches where there are gaps within the evidence base.⁹² This will be achieved through:

- reviewing the existing R&D strategy for public health to provide a strategy focused on supporting delivery of the White Paper through improved, timely evidence;⁹³
- establishing a new public health research initiative within the framework of the United Kingdom Clinical Research Collaboration (UKCRC);⁹⁴
- providing new funding for the public health research initiative, building to £10 million by 2007/08;⁹⁵
- launching a public health research consortium, bringing together national policymakers and researchers from a wide range of disciplines, to focus effort on strengthening the evidence for effective health interventions to support White Paper delivery;⁹⁶
- launching a national prevention research initiative;⁹⁷ and
- providing additional resources to support NICE in its new work on health improvement.⁹⁸

In addition, the Government will establish a new Innovations Fund, of £30 million in 2006/07 and £40 million per annum from 2007/08, in order to pilot and evaluate health improvement activities and support the rapid roll-out of effective interventions, such as those around diet and nutrition.⁹⁹

The White Paper also signalled the commitment to develop a comprehensive public health information and intelligence strategy that will be overseen by a National Health Information and Intelligence Task Force.¹⁰⁰ The strategy will play a key part in monitoring the delivery of the Health of the Population and related PSA targets and the *Choosing Health* White Paper commitments from national and local level.

Ultimately, the aim is to develop a real-time public health information system, with evidence of cost-effective interventions, and so lead to action to improve health and to tackle health inequalities at national, regional and local levels, across the NHS, with partner agencies, and in local communities.

Research and development

The national prevention research initiative, working in collaboration with research funders in the fields of obesity, cancer, coronary heart disease and diabetes, will provide dedicated funding for research aimed at the primary prevention of these diseases. Building on existing work between DH and partners, emphasis will be on studies on the development, evaluation and implementation of interventions to influence behaviour.

APPENDIX

OUTCOME OF THE CHOOSING A BETTER DIET CONSULTATION

The key areas where the *Choosing a Better Diet* consultation asked for views were:

- a proposed framework of goals;
- priorities for action; and
- roles and responsibilities.

Responses

We received over 200 responses to the consultation.

In general, the responses we received were positive and, wherever possible, have been incorporated into this document. The overall tone of responses was that the action plan needed to fit into a wider public health agenda and also have a positive impact on sustainability and environmental policies.

The main areas identified for action to emerge from the *Choosing a Better Diet* responses were:

- improving information and education on food issues, including better food labelling and food promotion to children;
- improving diet for children and young people, especially in schools;
- improving the range of healthier foods, for example producing food with less fat, sugar and salt content;

- helping communities to help themselves, for example through improved access to healthy foods; and
- increasing support from the NHS.

Conclusion

As a result of the consultation we have been able to confirm that many of the key priorities for action we had identified are shared by the wider health community, interested voluntary bodies, industry and the wider public.

A fuller analysis of the consultations will be available in due course.

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