Why prioritise strategies for nutrition and food poverty?

C

This section shows how local nutrition and food poverty strategies can help to achieve local targets and how they are central to the government's health agenda. It also shows how such strategies give benefit to and receive support from some of the government's other programmes. It will be of help to:

- public health professionals
- strategic planners in local government
- Local Strategic Partnerships
- health promotion specialists, and
- National Service Framework coordinators and leads.

Your PCT plans and local government plans need them!

Developing a local nutrition and food poverty strategy will help tackle national priorities and targets as well as local priorities related to local populations and local circumstances. They can also help deliver other requirements of Public Service Agreements and health scrutiny. In particular:

Planning a health equity audit

A local nutrition and food poverty strategy can be an excellent basis for a health equity audit. These are now required by the Department of Health's Priorities and Planning Framework.

Further guidance

Health Equity Audit Made Simple: A Briefing for Primary Care Trusts and Local Strategic Partnerships. Working Document. *Produced by the Association of Public Health Observatories and the Health Development Agency.*

Working in local partnerships

Health and local authorities are now required to work in partnership and local authorities have to improve the well-being and reduce the health inequalities of their populations. A local nutrition and food poverty strategy can be an excellent basis for integrated planning across health and local government to achieve integrated local actions to tackle health inequalities through health plans, community strategies, education plans, transport plans and local neighbourhood renewal strategies. The strategy should have sign-off by the director of public health and the leader of the council and be endorsed via the Local Strategic Partnership.

Local transport plans

Directors of public health within each primary care trust will be asked to play a leading role in improving access to food at a local level through accessibility planning.

Value for Money and Best Value targets

Such integrated services will help the Department of Health to achieve its PSA (Public Service Agreement) Value for Money target of a 2% improvement per year with an improvement of 1% in local cost efficiency and service effectiveness. They will also help local authorities to achieve their Best Value targets. (Best Value is the way local government measures, manages and improves its performance. Best Value can apply to a service, a department or a whole council, but is most effective when applied holistically and used to drive improvement.)

Health scrutiny

A nutrition and food poverty strategy could provide a good basis for a report to a local authority health scrutiny committee.

Further guidance

Making Health Scrutiny Work: The Toolkit.
Produced by the Democratic Health Network (T: 0207 554 2802 or www.dhn.org.uk). Price £15.

The government's health agenda related to food poverty

There are several government health policies, targets, standards and programmes that together make up its health agenda and these are listed in Table 10. The priorities are set out in the Department of Health's Public Service Agreement (PSA) and supported by the policy and planning framework (PPF). The most important priorities related to food poverty are health inequalities and the priority health areas. A Food and Health Action Plan is also being developed.

Tackling health inequalities

Reducing health inequalities is a national priority for both the NHS and local government. They share the same Public Service Agreement (PSA) target of reducing inequalities in health outcomes by 10% by 2010, as measured by infant mortality and life expectancy at birth.

Tackling health inequalities was the subject of a cross-cutting review, and an all-government action plan on tackling health inequalities was published in 2003.[1] Reducing health inequalities is a priority area in the Department of Health's Priorities and Planning Framework (PPF) 2003-2006, which reflects the Department's current PSA.

The objectives for reducing health inequalities in the PPF state that the NHS should narrow the health gap by:

- ensuring that the distribution of health benefit from service expansion and development consistently favours individuals and communities that have been traditionally under-served
- ensuring that service planning is informed by an equity audit and supported by an annual public health report by the director of public health
- tackling the wider determinants of health – agreeing a single set of local priorities with local authorities and other partners, contributing to regeneration and neighbourhood renewal programmes, and ensuring that the NHS makes a full contribution to support the Sure Start programme
- building capacity for public health improvement and protection in primary care trusts.

The priority health areas

The Department of Health's PPF also sets out the key health and social care priority areas. Most of these involve significant health inequalities which are related to unhealthy diets. These priority areas are:

- cancer
- coronary heart disease
- older people, and
- improving life chances for children.

Within each of these priority areas there are objectives and targets for 2003-06 which action on food poverty can help to achieve. Underlying these priority areas are the *NHS Cancer Plan* and the National Service Frameworks for coronary heart disease, diabetes and older people, and the National Service Frameworks for children and for long-term conditions. In particular Milestone 2 of the National Service Framework for coronary heart disease requires that " ... all NHS bodies with local authorities will have agreed to and be contributing to the delivery of the local programme of effective policies on promoting healthy eating and reducing overweight and obesity."

The Food and Health Action Plan

The Department of Health is currently leading the development of a Food and Health Action Plan, which will address healthy eating at every stage of life. It will build on current work by government, and will include partnerships with industry and consumers to support and influence:

- the production, manufacture and preparation of healthier food
- the ease with which consumers are able to buy or obtain the range of foods needed for a healthy diet, and
- the provision of information to consumers about healthy eating and nutrition and the acquisition of the skills and behaviours necessary for good nutrition.

Delivery of the Action Plan will require action by all sections of the food chain, at national, regional and local levels, particularly through strengthened links between health organisations and food growers and producers. The Plan will be available in 2004.

Table 10 The health agenda

Underlying government health policies	Saving Lives: Our Healthier Nation Health Act 1999 The NHS Plan Shifting the Balance of Power Tackling Health Inequalities
Government health targets and standards	Priorities and Planning Framework (including PSA targets) Health inequality targets NHS frameworks, goals and milestones: – NHS Cancer Plan – National Service Framework for Coronary Heart Disease – National Service Framework for Older People – National Service Framework for Diabetes – National Service Frameworks on children and on long-term conditions Population dietary recommendations Nutritional standards for schools meals

Continued on next page

Government health programmes	5 A DAY programme (including the National School Fruit Scheme)
	Nutrition Action Plan
	Healthy Eating for Looked After Children
	Healthy Start (formerly the Welfare Foods Scheme)
	National Healthy School Standard
	Food in Schools programme
	Better Hospital Food Programme

See Tool C1 *The health agenda related to food poverty.* This describes the policies and programmes listed above and outlines the National Service Framework standards which are relevant to food poverty, and the relevant objectives and targets of the Priorities and Planning Framework.
See Tool C4 *Population dietary recommendations for England.* This describes the progress made towards the population dietary recommendations and the impact on health of achieving them.

The government's environment, social and education agendas related to food poverty

The important role of socioeconomic and environmental circumstances (the wider determinants of health) in health inequalities has been acknowledged in the Department of Health's Priorities and Planning Framework (PPF). Action is supported by the policies, Public Service Agreements (PSAs) and programmes of several other government departments. (These are listed in Table 11 and described in Tool C2.) Actions are also supported by the PSA health inequalities target for local government.

Local authorities can develop Local Public Service Agreements (LPSAs) in agreement with the Office of the Deputy Prime Minister (ODPM). These LPSAs reflect local as well as national priorities. Each local authority has about 12 LPSAs and at least one of these has to relate to health and social services. If these are 'stretched targets', (i.e. targets above that which would normally be expected), and the target is achieved, the authority will receive a grant award of up to 2½% of its total budget. Authorities in areas with low life expectancy are encouraged to adopt health inequalities targets.

See also *Food and Health Action Plan* on page 73.

Table 11 The agenda for the wider determinants of health

Underlying government policies related to food poverty	Securing Our Future Health: Taking a Long-term View
	Securing Good Health for the Whole Population
	A Better Quality of Life: A Strategy for Sustainable Development for the UK
	Our Towns and Cities: The Future
	Our Countryside: The Future
	Best Value Framework: Local Government Act 1999
	Local Government Act 2000
	Health and Social Care Act: Health scrutiny provisions
	A New Commitment to Neighbourhood Renewal
	The Children (Leaving Care) Act 2001
	Opportunities for All: Tackling Poverty and Social Exclusion
	The Strategy for Sustainable Farming and Food
	Making the Connections: Final Report on Transport and Social Exclusion

Government Public Service Agreement (PSA) targets related to food poverty	Department for Education and Skills PSA Department for Environment, Food and Rural Affairs PSA Department for Work and Pensions PSA Home Office PSA Office of the Deputy Prime Minister PSA Local Government PSA
Government environment, social and education programmes related to food poverty	The Children's Fund Neighbourhood Wardens New Deal for Communities The Phoenix Fund Skills and Knowledge Programme Skills for Life Small Retailers in Deprived Areas Initiative Sure Start Vital Village Scheme

See Tool C2 *The agenda for the wider determinants of health*, which describes in detail the policies, targets and programmes listed above, including the relevant targets and standards of Public Service Agreements.
See Tool C3 *Young@heart policy recommendations*, which gives the National Heart Forum's recommendations for a comprehensive national strategy to improve nutrition among children and young people.

The Common Agricultural Policy and food poverty

The Common Agricultural Policy (CAP) is an immense programme of subsidies to agricultural production, accounting for 45% of the total EU budget. These subsidies have maintained prices at a higher level than necessary. These higher prices have a greater impact on poorer people as they spend a greater proportion of their total income on food than the better off. The CAP has also led to vast surpluses of food, although there is now a Surplus Food Scheme which redistributes easily stored foods to the less well off. However, the Scheme does not cover fruit and vegetables and billions of kilos are destroyed each year.

Reform of the CAP away from subsidies for production is a vital aspect of reducing food poverty in the UK. The Curry Report[2] suggested that "the general principle must be that the public money should be used to pay for public goods that the public wants and needs." The government is seeking reform of the CAP along these lines to:

- promote a sustainable, competitive and safe food supply chain which meets consumers' requirements
- deliver more customer-focused, competitive and sustainable food and farming, and secure CAP reforms that reduce production-linked support, enabling enhanced EU funding for environmental conservation and rural development.

The economic benefits of improving diets

Treating diet-related ill health costs the NHS an estimated £2 billion each year.[3] However, this grossly underestimates the total cost to the economy from production losses both from people suffering from diet-related illnesses and their informal carers. For example, the direct costs of coronary heart disease are only 25% of the total costs,[3] and the direct costs of obesity are only 18% of total costs.[4]

Although most of the costs of poor diet are related to diseases of overnutrition, there are significant costs due to undernutrition around hospital admissions. In one study, the average length of hospital stay for undernourished patients admitted to general medical wards was 15 days, compared with 10 days for other patients, and the hospital charges were double. It is estimated that around 10% of patients admitted to hospital care are undernourished. Improving nutritional status could lead to shortening their hospital stay by an average of five days, which would save the NHS £226 million a year (1992 figure).[5]

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3 Liu JLY et al. 2002. The economic burden of coronary heart disease in the UK. *Heart*; 88: 597-603.

4 National Audit Office. 2001. *Tackling Obesity in England.* Appendix 5. London: The Stationery Office.

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Tools

The health agenda related to food poverty

Government HEALTH policies	52.295 mmPolicies that promote action on food poverty
Saving Lives: Our Healthier Nation. 1999. White paper.	Introduced new national targets including those for coronary heart disease and stroke, mental health and cancer. Also introduced the concept of local health inequality targets. Called for new directions and new, more effective partnerships formed at local community level between the NHS, local authorities and other agencies. Health Improvement Programmes (HimPs) would reflect these new partnerships and be renamed Health Improvement and Modernisation Plans (HIMPs).
Health Act 1999	The Health Act 1999 made provision for primary care trusts (PCTs). It created a new duty of cooperation within NHS bodies and between NHS bodies and local authorities in England and Wales. It provided for local strategies to be developed for improving health and health care. It also gave new operational flexibilities, including pooled budgets, to allow NHS bodies and local authorities to enter into joint arrangements for the purchase or provision of health and health-related services.
The NHS Plan. 2000. White paper.	This white paper has 10 priorities. Priority 9 is "The NHS will help keep people healthy and work to reduce inequalities." The white paper recognises that good health also depends on social, environmental and economic factors and requires the NHS to work with other public services to intervene not just after but also before ill health occurs. Introduced the concept of national targets for health inequalities. Introduces the concept of intermediate care, to bridge between hospital and home, by helping people recover and resume independent living more quickly. Rapid response and integrated health care teams will respectively ensure that people get active support to avoid unnecessary hospital admissions and to remain independent at home. Calls for new partnerships between health and local services to address the wider determinants of health. Requires the NHS to play a full part in the government's national strategy for neighbourhood renewal and to help develop Local Strategic Partnerships (LSPs). Suggests that Health Action Zones could be integrated into Local Strategic Partnerships.
Shifting the Balance of Power. Securing Delivery. 2001. **Shifting the Balance of Power. Next Steps.** 2002.	In England, primary care trusts (PCTs) (300) have become the lead NHS organisation in assessing need, planning and securing all health services and improving health. They are to form new partnerships with local communities and lead the NHS contribution to joint work with local government and other partners (via LSPs). PCTs took over HIMP development from 2002, and will benefit from aligning with local authorities' community strategies. They will also be responsible for mainstreaming Health Action Zone programmes. Strategic health authorities (28) will lead the strategic development of the local health service and performance manage PCTs. Since April 2003, nine regional directors of public health and their teams have been co-located in each of the government offices for the regions. Their work includes developing an integrated approach to tackling the wider determinants of health at regional level, and providing an overview of the health contribution to LSPs in their region.
Tackling Health Inequalities. Summary of the Cross-cutting Review. 2002.	This joint publication from the Treasury and the Department of Health identifies the most significant interventions to deliver the government's inequalities targets. This was followed by *Tackling Health Inequalities: A Programme for Action*. Interventions on improving the diets of adults and children are identified as being likely to make a major impact on both the life expectancy and infant mortality inequality targets.

Tackling Health Inequalities: A Programme for Action. 2003.	This cross-government programme is arranged across four themes: – Supporting families, mothers and children – Engaging communities and individuals – Preventing illness and providing effective treatment and care – Addressing the underlying determinants of health. The nutrition actions are the 5 A DAY programme and increasing breastfeeding.
Choosing Health? A Consultation on Improving People's Health. 2004	In 2004 the Department of Health launched a public health consultation, Choosing Health?, which seeks views on the role different sectors in society should have in helping people to be healthier. The document asks what changes might be desirable from individuals, organisations and government, at national and local level, on a range of topics including access to fruit and vegetables, advertising and encouraging walking and cycling. The results of the consultation are expected to be published in a Public Health White Paper in 2004.
Securing Good Health for the Whole Population. 2004.	This review from Derek Wanless focused on prevention and the wider determinants of health in England and on the cost-effectiveness of action that can be taken to improve the health of the whole population and to reduce health inequalities. It considers consistency of current policy with the public health aspects of the 'fully engaged' scenario outlined in the 2002 Wanless report. It states that people need to be supported more actively to make better decisions about their own health and welfare because there are widespread systematic failures that influence the decisions individuals currently make. The report outlines a series of recommendations towards achieving this goal.

Government health targets and standards	Where action on food poverty can help achieve policy objectives
Improvement, Expansion and Reform: The Next 3 Years' Priorities and Planning Framework, 2003-2006 and **Department of Health Public Service Agreement** www.hm-treasury.gov.uk/performance/ www.dh.gov.uk www.hm-treasury.gov.uk/performance/health.cfm	The priorities in the Priorities and Planning Framework (PPF) for 2003-06 are based on the Department of Health's Public Service Agreement (PSA) and include reducing health inequalities. The aim of the underlying PSA is to transform the health and social care system so that it produces faster, fairer services that deliver better health and tackle health inequalities. The objectives of the PSA relevant to policies on nutrition are: *Objective 2: Improve health and social care outcomes for everyone.* • Reduce substantially the mortality rates from the major killer diseases by 2010: from heart disease by at least 40% in people under 75; and from cancer by at least 20% in people under 75. • Improve the quality of life and independence of older people. • Improve life chances for children. • By 2010 reduce inequalities in health outcomes by 10%, as measured by infant mortality and life expectancy at birth. Within these priority areas, the key targets of the PPF related to nutrition are: *Coronary heart disease* • In primary care, update practice-based registers so that patients with coronary heart disease and diabetes continue to receive appropriate advice and treatment in line with National Service Framework standards. • By March 2006 ensure that practice-based resisters and systematic treatment regimes, including appropriate advice on diet, physical activity and smoking, also cover the majority of patients at high risk of coronary heart disease, particularly those with hypertension, diabetes or a BMI greater than 30. *Older people* • To improve the quality of life and independence of older people so that they can live at home wherever possible, by increasing, by March 2006, the number of those supported intensively to live at home to 30% of the total being supported by social services at home or in residential care.

	Improve life chances for children (shared with local government) • Improve the educational attainment of children and young people in care (target under review). • Improve the level of education, training and employment outcomes for care leavers aged 19, so that levels for this group are at least 75% of those achieved by all young people in the same area by March 2004, and maintain this level up to 2006. *Reducing health inequalities* • Deliver an increase of 2 percentage points per year in the breastfeeding initiation rate, focusing especially on women from disadvantaged groups. • Achieve agreed local teenage conception reduction targets while reducing the gap in rates between the worst fifth of wards and the average by at least a quarter, in line with national targets. • Contribute to a national reduction in death rates from coronary heart disease of at least 25% in people under 75 by 2005 compared with 1995-97, targeting the 20% of areas with the highest rates of coronary heart disease. • Contribute to a national reduction in cancer death rates of at least 12% in people under 75 by 2005, compared with 1995-97, targeting the 20% of areas with the highest rates of cancer.
Health inequality targets. 2002. **NHS Plan. A Plan for Investment. A Plan for Reform.** www.nhs.uk/nhsplan **Tackling Health Inequalities. A Programme for Action.** Department of Health, 2003.[1]	The health inequality targets were developed as part of the *NHS Plan*. They are: • Starting with local authorities, by 2010 to reduce the gap by at least 10% between the 20% of areas with the lowest life expectancy at birth and the population as a whole. • Starting with children under 1 year, by 2010 to reduce the gap in mortality between manual groups and the population as a whole by at least 10%. These have been combined into the PSA target of: By 2010 to reduce inequalities in health outcome by 10% as measured by infant mortality and life expectancy at birth.
NHS Cancer Plan. 2000	Recognises that, after smoking, diet is the next biggest contributor to cancer deaths.
National Service Framework for Coronary Heart Disease. 2000.	Sets national standards for the care and prevention of coronary heart disease. Reducing health inequalities is a guiding principle. This National Service Framework (NSF) acknowledges the influence of the wider determinants of health and the importance of policies on agriculture and food. Standards 1, 3, 4, 11 and 12 are relevant to action on food poverty. *Standard 1*: Reducing the prevalence of coronary heart disease risk factors in the population and reducing inequalities in risk of developing heart disease. Public agencies are encouraged to estimate and report publicly on the likely impact that their major decisions will have on the cardiac health of the local population, including inequalities (health impact assessments). Directors of public health are expected to produce an 'equity profile' for their population which will inform the HIMP. A community development approach is sought, with health visitors a vital resource. All NHS bodies, working closely with local authorities, are required to have an effective local policy and programmes on promoting healthy eating and reducing overweight and obesity. Public agencies are encouraged to promote healthy workplaces including making a variety of healthy foods available to staff. *Standards 3 and 4*: Identifying and treating all people with established cardiovascular disease (CVD) and those at high risk of developing CVD, including giving information on modifiable risk factors. This specifically includes diet and weight. *Standard 11*: Heart failure and palliative care for people with coronary heart disease. Includes treatments to relieve symptoms and reduce the risk of death, including practical nutritional and dietary advice.

	Standard 12: Cardiac rehabilitation. Including assessment of individuals' risks and needs and developing individualised plans to meet those needs. This includes the benefits of a healthy lifestyle and practical advice about how it can be achieved, including food and its preparation.
National Service Framework for Older People. 2001.	A 10-year programme of action with eight standards, four of which are directly relevant to tackling food poverty. *Standard 3:* Intermediate care, re-iterating the NHS Plan. "To provide integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living." *Standard 4:* General hospital care. To ensure that older people receive the maximum benefit from having been in hospital. This includes maintaining and improving their health status while in hospital. *Standard 7:* Mental health. "To promote good mental health in older people and to treat and support those older people with dementia and depression." *Standard 8:* The promotion of health and active life in older age. "The health and well-being of older people is promoted through a coordinated programme of action led by the NHS with support for councils." Key interventions include programmes for improved diet and nutrition. Specifically mentions the importance of reducing the risk of hip fracture and osteoporosis, reducing constipation and improving well-being and self-esteem.
National Service Framework for Diabetes. 2001.	Three standards are relevant to food poverty: *Standard 1:* Strategies to prevent type 2 diabetes in the general population and reduce inequalities in the risk of developing type 2 diabetes. Key interventions include local strategies for the prevention and reduction of the prevalence of overweight and obesity, and reducing risk by eating a balanced diet, losing weight and increasing physical activity. Implications for service planning include continuing education for health professionals about the interventions which are effective in these areas. *Standard 3:* Empowering people with diabetes. Includes help to adopt and maintain a healthy lifestyle, including the tools to support behaviour, for example affordable healthier food options both at home and in the workplace. *Standard 4:* Clinical care of adults with diabetes. Emphasises that weight loss and increased physical activity are the first intervention for people with newly diagnosed type 2 diabetes.
Future National Service Frameworks	The National Service Framework for long-term conditions will concentrate on stroke and other neurological conditions. A National Service Framework for children is also being planned and will include the issues of diet and nutrition and obesity.
Population dietary recommendations [2-4]	*Total fat:* To reduce the average contribution of total fat to dietary energy to about 35%. *Saturated fat:* To reduce the average contribution of saturated fatty acids to dietary energy to no more than about 10%. *Oily fish:* To double the intake of omega-3 fats (mainly from fish) to 1.5g a week. *Fruit and vegetables:* To increase the consumption of fruit and vegetables by at least 50%, to at least 5 portions a day. *Salt:* To reduce consumption of salt to 6g a day. *Dietary fibre:* To increase the intake of dietary fibre from breads and other cereals, potatoes, fruit and vegetables to 18g a day. *Meat:* To avoid an increase in the average consumption of red and processed meat from 90g a day. **See Tool C4 *Population dietary recommendations for England*, for a summary of current levels and trends in relation to dietary recommendations.**

Nutritional standards for school meals www.dfes.gov.uk/schoollunches	These minimum standards came into effect in 2001. Local education authorities or schools may set higher standards.

Government HEALTH programmes	How the programmes can directly address food poverty
5 A DAY programme www.dh.gov.uk	The 5 A DAY programme is a key feature of the prevention strategies to reduce early deaths from cancer and coronary heart diseases and reduce health inequalities. It has five strands: • The National School Fruit Scheme. By 2004 every child aged 4-6 in England will be entitled to a free piece of fruit each school day. • 5 A DAY community initiatives. Five pilots in disadvantaged areas have been evaluated and the New Opportunities Fund has made £10 million available to support 66 new initiatives, led by primary care trusts. • A communications programme which will aim to increase consumption and awareness of the health benefits of fruit and vegetables. A 5 A DAY logo has been produced. • Work with the food industry to improve access to fruit and vegetables. • Evaluation and monitoring. Two validated questionnaires have been produced to aid the assessment of fruit and vegetable consumption at a local level and to assess the impact of the National School Fruit Scheme on children's diets. The Health Survey for England aids the monitoring of population trends in BMI, physical activity and fruit and vegetable consumption. See also *The community setting* on page 125, *The school setting* on page 128, and page 133.
Nutrition Action Plan www.food.gov.uk/multimedia/pdfs/NutritionStrategicFramework.pdf	The Food Standards Agency (FSA) agreed a *Nutrition Strategic Framework* in 2001, and produced an Action Plan to implement the framework in 2002. The aims are: • to review and strengthen the evidence base underpinning future FSA activity. The joint FSA / Department of Health Scientific Advisory Committee on Nutrition has been set up to assist this. • to explore new avenues to inform the general population and promote uptake of a healthy balanced diet • to identify means by which barriers to changing dietary behaviour can be addressed • to strengthen the evaluation and monitoring of the effectiveness of FSA action. For more information see the FSA website www.food.gov.uk
Healthy Eating for Looked After Children	The Food Standards Agency has carried out a series of seminars to encourage the practical use of *Eating Well for Looked After Children and Young People* – nutritional guidelines developed by The Caroline Walker Trust (part funded by the FSA).[5] Action plans developed at the seminars will be followed up at 3, 6 and 12 months.
Healthy Start. Proposals for Reform of the Welfare Foods Scheme. 2002 www.dh.gov.uk	The government's proposals for the reform of the Welfare Foods Scheme. The aim is to improve nutrition for pregnant women, mothers and young children. There will be a wider choice of foods available including fruit and vegetables, cereal-based foods, other foods suitable for weaning, liquid milk and infant formula.
National Healthy School Programme www.wiredforhealth.gov.uk	Launched in 1998 as a key part of the government's drive to improve standards of health and education and tackle health inequalities, this programme aims to make children, teachers, parents and communities more aware of the opportunities that exist in school for improving health. Healthy eating is the most popular of the modules that can be chosen in order to achieve the National Healthy School Standard. However, it is possible to be accredited as a healthy school without taking any action on improving diet and nutrition. For more information see www.wiredforhealth.gov.uk

Food in Schools programme	This programme is jointly led by the Department of Health and the Department for Education and Skills (DfES). It is currently developing a whole range of nutrition-related activities and projects in schools to complement and add value to the other initiatives. The output of Food in Schools will also help schools work towards the healthy eating target of the National Healthy School Standard. The Food in Schools programme falls under the umbrella of the Food and Health Action Plan. In the DfES strand of the Food in Schools programme, schools are encouraged to look at all aspects of food during the school day through an 'audit' and to develop whole-school food policies. Schools are also encouraged to set up local food partnerships, where secondary school teachers who have received training around food issues train and support their primary colleagues. The Department of Health strand is made up of eight projects including healthier breakfast clubs, tuck shops, vending machines and cookery clubs. These will build on good practice and consult key stakeholders on issues such as healthier product choice, marketing and barriers to success. Pilots will run in approximately 500 schools across England. The results will be available from early 2005 to assist schools in providing a wider range of healthier foods for pupils. For further information see www.dh.gov.uk and www.teachernet.gov.uk/educationoverview/briefing/currentstr
Better Hospital Food Programme www.patientexperience.nhsestates.gov.uk/bhf	This programme seeks to improve the ways in which meals are prepared and served through a programme developed by patients, a panel of leading chefs, and NHS staff including caterers, nurses and dietitians.

See also: *Securing Our Future Health: Taking a Long-term View*, and *Securing Good Health for the Whole Population*, on page 83.

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The agenda for the wider determinants of health

Government ENVIRONMENT, SOCIAL and EDUCATION policies	Policies that promote action on food poverty
Securing Our Future Health: Taking a Long-term View.[1] 2002. www.hm-treasury.gov.uk	The 'Wanless Review' *Securing Our Future Health: Taking A Long-term View* assessed for the first time the long-term resource requirements for the NHS. It concluded that, in order to meet people's expectations and to deliver the highest quality over the next 20 years, health care needs more resources, matched by reform. The review looks at three different scenarios, including a 'fully engaged' scenario in which the public are actively involved in maintaining their health, life expectancy increases, health status improves dramatically, use of resources is more efficient and the health service is responsive. The fully engaged scenario is the least expensive scenario which modelled and delivered better health outcomes. Implementing this scenario is forecast to save the NHS around £30 billion more than other scenarios by 2022/23.
Securing Good Health for the Whole Population.[2] 2004. www.hm-treasury.gov.uk	*Securing Good Health for the Whole Population* is an update review of *Securing Our Future Health* (see above) which sets out the challenges to implementing the fully engaged scenario. The review makes recommendations on how to best invest in public health measures to help achieve the fully engaged scenario. (See also page 78.)
A Better Quality of Life. A Strategy for Sustainable Development for the UK.[3] 1999.	Reflecting Agenda 21, this is a strategy to meet the needs of the present generation without compromising the ability of future generations to meet their own needs. This includes building a sustainable economy by producing affordable and good-quality food in accordance with high environmental and animal welfare standards. The strategy states that, at local level, sustainable development and health strategies must reinforce each other.
Our Towns and Cities. The Future. Delivering an Urban Renaissance.[4] 2000. Urban white paper	Acknowledges that urban areas need to be designed and developed so that there is access to local shops. Announced the review of Planning and Policy Guidance 1 (PPG1) General Policy and Principles, which explains how to plan for sustainable development.
Our Countryside. The Future. A Fair Deal for Rural England.[5] 2000. Rural white paper.	Acknowledges that one-third of all villages have no shop and that the decline in public transport has further reduced access. Introduced the Rural Services Standards but this did not include access to shops or food.
Best Value Framework: Local Government Act 1999 www.hmso.gov.uk/acts/acts1999/19990027.htm#1	This Act came into effect in 2000. A Best Value authority must make arrangements to secure continuous improvement in the way in which its functions are exercised, having regard to a combination of economy, efficiency and effectiveness.
Local Government Act 2000	This act creates a new discretionary power for principal local authorities in England and Wales to do anything they consider likely to promote or improve the economic, social or environmental well-being of their area. It introduces the duty to prepare a community strategy or plan to promote well-being and sustainable development. This act also reinforces the provisions in the Health Act 1999, reinforced in the *NHS Plan*, which provided health authorities and local authorities with a power to work with each other where there is a clear cross-over between the services being commissioned and provided by the local authority and the NHS. The well-being provision extends the ability of local authorities to work in partnership with other bodies, in addition to the NHS.

Health and Social Care Act 2001: Health scrutiny provisions	Amends the Local Government Act 2000 to give local authorities with social services responsibilities the role of reviewing and scrutinising health service matters and making reports and recommendations to NHS bodies. Also requires the NHS to work with the health scrutiny committees.
A New Commitment to Neighbourhood Renewal: National Strategy Action Plan.[6] 2001.	Led by the Office of the Deputy Prime Minister, this is an action plan to renew poor neighbourhoods, based on joint working and enabling communities to be actively involved. It introduced Local Strategic Partnerships as equal partnerships including representatives from public, private, voluntary and community sector organisations. Local Strategic Partnerships are expected to set local targets to reflect national targets and ideally incorporate them into Local Public Service Agreements and Best Value Performance Plans. The Neighbourhood Renewal Strategy targets 88 areas identified by the government as being the most deprived in England. LSPs in these areas have to develop a neighbourhood renewal strategy and this can attract Neighbourhood Renewal Funding. Local programmes cover the following areas: jobs and local economy, crime, skills, health, housing and physical environment, partnership working and community development.
The Children (Leaving Care) Act 2001	Increases the support that care leavers receive from their local authority. Up to 75% leave care with no educational qualifications, up to 50% are unemployed and up to 20% experience some form of homelessness within two years of leaving care.
Opportunities for All: Tackling Poverty and Social Exclusion. Fourth Annual Report. 2002 www.dwp.gov.uk/publications/dwp/2002/oppal-fourth/index.asp	First published in 1999, Opportunities for All is the government's evidence-based strategy for tackling poverty and social exclusion. It included, for example, proposals for the national minimum wage and working families' tax credit. It established a series of indicators of progress in tackling the causes and symptoms of poverty. There is an annual report which includes the indicators of progress.
The Strategy for Sustainable Farming and Food: Facing the Future. Department for Environment, Food and Rural Affairs, 2003 www.defra.gov.uk/farm/sustain/newstrategy/strategy.pdf	Acknowledges that the food we eat is a major factor in our health. States that the government will strengthen the links between public health and food producers at all levels. Announced the development of the Food and Health Action Plan. Supports the European Commission's proposals for reform of the Common Agricultural Policy away from production subsidies.
Making the Connections: Final Report on Transport and Social Exclusion. Social Exclusion Unit, 2003. (Chapter 12 Access to healthy, affordable food.) www.socialexclusionunit.gov.uk/publications/reports/pdfs/SEU-Transport_Main.pdf	Introduces a new framework of accessibility planning to be built into the next round of local transport plans. Each local authority should consider looking at the provision of food shops across their area and evaluating whether public transport and walking routes in deprived areas and for disadvantaged groups allow adequate access. The summary states that the new directors of public health within each primary care trust will be asked to play a leading role in improving access to food and nutrition at a local level.

Government PSA targets related to food poverty	Where action on food poverty can help achieve policy objectives and/or policy action can help reduce food poverty
Department for Education and Skills Public Service Agreement	The PSA targets include: • To improve the basic skills (literacy and numeracy) of 1.5 million adults between the launch of Skills for Life in 2001 and 2007, with a milestone of 750,000 by 2004. • By 2007, 90% of pupils to reach level 4 in English and Maths by age 12.

Department for Environment, Food and Rural Affairs Public Service Agreement	The PSA targets include: • To promote a sustainable, competitive and safe food supply chain which meets consumers' requirements. • To deliver more customer-focused, competitive and sustainable food and farming, and secure CAP reforms that reduce production-linked support, enabling enhanced EU funding for environmental conservation and rural development.
Department for Work and Pensions Public Service Agreement	The PSA targets include: • To ensure the best start for all children and end child poverty in 20 years. • To combat poverty and promote security and independence in retirement for today's and tomorrow's pensioners. • To improve rights and opportunities for disabled people in a fair and inclusive society.
Home Office Public Service Agreement	The PSA targets include: • To reduce crime and the fear of crime, including robbery in the street. • To support strong and active communities in which people of all races and backgrounds are valued and participate on equal terms. Target of increasing voluntary and community sector activity, including increasing community participation by 5% by 2006.
Office of the Deputy Prime Minister Public Service Agreement	The PSA targets include: • To work with the full range of government departments and policies to raise the levels of social inclusion, neighbourhood renewal and regional prosperity. • To deliver effective programmes to help raise the quality of life for all in urban areas and other communities.
Local Government Public Service Agreement	The PSA targets include: • To reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth. • To reduce crime and the fear of crime. • To improve life chances for children, including by: – improving the level of education, training and employment outcomes for care leavers aged 19 (target under review) – narrowing the gap between the proportions of children in care and their peers who are cautioned or convicted and – reducing the under-18 conception rate by 50% by 2010. • To increase employment rates of disadvantaged areas and groups. • To increase the employment rates of people with disabilities.

The government's ENVIRONMENT, SOCIAL and EDUCATION programmes	**How the programmes can address food poverty**
The Children's Fund www.cypu.gov.uk/corporate/childrensfund/index.cfm	The Children's Fund is targeted at 5-13 year olds. Its aim is to prevent children from falling into drug abuse, truancy, exclusion, unemployment and crime by listening to their needs and supporting them in breaking the cycle of poverty and disadvantage.
Neighbourhood Wardens Neighbourhood Renewal Unit www.neighbourhood.gov.uk/nswardens.asp	Wardens work to make the streets safer, cleaner places to be and help to build a greater sense of community and better quality of life for residents. There will be 85 schemes by 2004, with £18.5 million of funding.

New Deal for Communities www.neighbourhood.gov.uk/ndcomms.asp	New Deal for Communities (NDC) is a key programme in the government's strategy to tackle multiple deprivation in the most deprived neighbourhoods in the country, giving some of the poorest communities the resources to tackle their problems in an intensive and coordinated way.
The Phoenix Fund. Department of Trade and Industry www.sbs.gov.uk/default.php?page=/phoenix/default.php	Approximately £2 billion has been committed to 39 partnerships. This fund is administered by the Small Business Service. It is designed to encourage entrepreneurship in deprived areas. There is a further £50 million available from 2003. The fund is now making retail one of the priority sectors in their strategy to encourage small and medium-sized business development in disadvantaged areas.
The Skills and Knowledge Programme. Neighbourhood Renewal Unit www.neighbourhood.gov.uk/sandk.asp?pageid=36	This programme aims to promote better sharing of knowledge about what works and to ensure that everyone involved in neighbourhood renewal has the skills to make a real difference. It includes: • renewal.net, which provides a guide to what works • The Learning Curve, which is a strategy that sets out a range of actions at national, regional, local and neighbourhood level which will guide the work of the Neighbourhood Renewal Unit • neighbourhood renewal advisors • regeneration networks to enable people to gain support and share good practice • a community learning chest of £10 million to fund residents' learning opportunities for neighbourhood renewal.
Skills for Life www.dfes.gov.uk/readwriteplus/	Skills for Life is the government's strategy to increase adult basic literacy and numeracy skills. It includes the Get On campaign which is aimed at encouraging employers to improve the basic skills of their workforce. It also includes family literacy and numeracy programmes and Early Start, a course for parents of young children.
Small Retailers in Deprived Areas Initiative. Home Office www.crimereduction.gov.uk/srda1.htm	Crime problems faced by small retailers were highlighted in the Social Exclusion Unit's report on providing access to decent shopping facilities in deprived areas.[7] £15 million has been set aside under the Capital Modernisation Fund to help tackle these problems from 2001 to 2004. The aim of the project is to improve the security of small retailers in the 10% of most deprived areas in England and Wales by providing a range of interventions to individual shops or groups of shops (such as better locks and toughened glass), or by making improvements to their immediate environment (such as better lighting).
Sure Start. Department for Work and Pensions www.surestart.gov.uk/	Enables young children from the most deprived areas of England to start school healthy and ready to learn. Local Sure Start programmes are led by partnerships including health bodies, social services, and voluntary sector and community groups. By 2004, Sure Start aims to reach 400,000 children living in deprived areas of England.
Vital Village Scheme Department for Environment, Food and Rural Affairs www.countryside.gov.uk/vitalvillages/whatis/default.asp	The rural white paper sets out how the government intends to support vital village services – for example through expanding services offered through post offices, and helping some village shops, pubs and garages, so that over time people in rural communities will have easy local access to a much wider range of services. A new Community Service Fund, worth £15 million over 3 years, is supporting local development and helping to re-establish vital services.

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Young@heart policy recommendations

The following are the key recommendations relating to nutrition proposed by the National Heart Forum's young@heart initiative. The young@heart initiative also made recommendations for comprehensive strategies for increasing physical activity and tackling smoking among children and young people.[1]

A national strategy for improving nutrition among children and young people

The recommendations proposed here aim to improve nutrition during the critical developmental periods in early life and to encourage eating habits, preferences and understanding about food and health which children can carry into adult life.

POLICY ACTION

LA = Local action

A Improve nutrition in women before and during pregnancy.

Supporting actions

A1 The Treasury to undertake a review to reformulate how it calculates minimum income standards and benefit levels, in order to ensure that families can afford the essential requisites to give their children a healthy start in life. In particular, it is important to maintain income levels that are adequate to safeguard people's ability to afford a healthy diet before and during pregnancy.

A2 End the age discrimination in benefit levels for single parents. Teenage mothers have at least the same nutritional needs as all mothers.

LA A3 Include nutrition advice and support within the remit of ante-natal and mother and baby clinics. Expanding the Sure Start programme to provide national coverage could help deliver this support.

LA A4 Use community outreach workers to contact and support pregnant women who do not attend ante-natal clinics, especially the socially excluded, women from black and minority ethnic groups, and those for whom English is not their first language. This service could be funded by local authorities or primary care trusts and supported as part of a nationally available Sure Start programme.

B Improve infant and pre-school nutrition.

Supporting actions

B1 Review the Welfare Foods Scheme within the context of setting minimum income levels for families.

LA B2 Make information on breastfeeding, appropriate bottle-feeding and weaning available in every maternity ward, in English and minority languages.

B3 Hospitals should review the policy of routinely giving free samples of formula milk to women leaving maternity wards.

B4 Better enforcement of the ban on providing free samples of artificial milk to mothers of young babies.

LA B5 Develop peer support programmes for new parents which encourage breastfeeding. These should be informed by the findings of the Department of Health's Infant Feeding Initiative.

B6 Require nursery schools, through the Early Years Development and Childcare Partnerships (EYDCP), to provide meals which conform to nutrient-based standards (such as the nutritional guidelines proposed by The Caroline Walker Trust[2]). Nurseries should be provided with menu-planning tools such as the *CHOMP Menu Planner* computer programme,[3] to help them meet these standards.

B7 Review and strengthen the provisions within the Sure Start programme that offer nutrition and food skills for parents, particularly on breastfeeding and weaning.

LA B8 Ensure, through the Sure Start programme and the EYDCPs, that children in pre-school education are given the opportunity to try, and to taste repeatedly, a wide range of nutritious foods, and to be involved in preparing food.

C **Improve the quality and uptake of food in schools through a combination of investment in school infrastructure, extending entitlement to free school meals, strengthening the National Healthy School Standard and health-promoting school policies.**

Supporting actions – Investment

LA C1 Invest in school dining facilities to make them attractive and pleasant to use, and address problems of queuing and over-crowding.

C2 Provide extra investment for schools, or establish a dedicated health and well-being grant scheme, to establish and maintain state-provided breakfast clubs where there is an identified need. Current provision relies largely on local sponsorship from providers such as supermarkets and fast food chains.

C3 Provide extra resources to schools to reduce their reliance on the promotional activities of the commercial sector to buy essential books and equipment. Such activities can undermine the ethos of the health-promoting school by encouraging children and young people to consume large quantities of a single food item which is commonly high in fat, salt and/or sugar.

Supporting actions – School policies

C4 Introduce statutory provision under the Education Act for all schools to develop and implement health-promoting policies on smoking prevention, food in schools, and a physically active school day. Schools should be required to provide information about all health policies including food policies in information prepared for parents, such as prospectuses or annual reports.

LA C5 Schools should routinely involve children and young people in planning improvements to school food services. This could be done through School Nutrition Action Groups or other school food committee structures.

Supporting actions – Quality and uptake of school meals

C6 Introduce minimum national standards for school meal providers for both the quality of and expenditure on school meals. The expenditure on each meal should be not less than £1.30 for primary schools and £1.50 for secondary schools (at 2001 prices). The standards should be a statutory requirement for free school meals.

C7 Extend entitlement for free school meals to all primary school children whose families receive tax credits.

C8 Raise parents' awareness of their entitlement to claim free school meals for their children through national and local initiatives.

LA C9 Introduce pricing policies for cafeteria-style school meals which offer discounted prices for the healthier options. Schools could make this a requirement in catering contracts.

LA C10 Introduce cashless payment systems – using smart cards – for all school meals, to reduce stigma around free meals and increase overall efficiency of the service.

D **Strengthen children's practical understanding about food and nutrition.**

Supporting actions

D1 Lessons in life skills and parenting – which should emphasise nutrition and include breastfeeding, cooking and practical food skills – should be introduced as statutory elements of the Personal, Social and Health Education (PSHE) and Citizenship curricula at all key stages. Children should also be taught to become critical consumers with a good understanding of food advertising, promotion and labelling.

D2 Establish an independent accreditation system for providers of educational materials from all sources (but particularly those featuring food or branded food products), to help teachers assess the quality, reliability and impartiality of their content. The criteria could be based on the National Consumer Council guidelines.[4]

E **Influence the food culture to support a more balanced diet by addressing manufacturing processes and the retailing, marketing and promotion of food as they influence children and young people.**

Supporting actions

E1 There should be a national inquiry to look at the impact of advertising and commercial promotions on family and child health. This should focus in particular on the food and tobacco industries and be the basis for developing appropriate interventions such as advertising regulations.

E2 Introduce measures, which may include legislation and differential taxation, to control excessive and unfair advertising and promotion of foods that are high in fat, salt and/or sugar to children.

E3 Review the remits of the Advertising Standards Authority and the Independent Television Commission to consider the overall effect of advertising, particularly to children, rather than on a case-by-case basis.

E4 The National Healthy School Standard should develop its own code of practice to help schools determine the implications of promotional activities of food manufacturers and retailers for the ethos of the health-promoting school. This should include issues such as catering provision and the balance of goods available from commercial vending machines.

E5 The government should work with food manufacturers to improve the quality of processed and pre-prepared foods – in particular to reduce the levels of salt, sugar, fat and saturated fats.

E6 Develop agreements between national and local government and the food industry to support the production, promotion, sale and accessibility of those foods that would constitute a balanced diet. This should include a dedicated programme to promote the consumption of fruit and vegetables, supported by government, and should look at introducing pricing policies which aim to offer discounted prices on more nutritious foods, especially fruit and vegetables (where margins are often highest).

E7 Review health claims made on food aimed at children, and implied health claims on foods which are fortified with vitamins and minerals but which are high in sugar, salt and/or fats.

E8 The government should seek amendments to the 1990 European nutrition labelling directive to allow individual countries to adopt a food and nutrition labelling system relevant to their food and nutrition policies.

E9 Continue work started by the Food Standards Agency and some retailers such as the Co-op, to review food and nutrition labelling. The goal should be to provide comprehensive, comprehensible and compulsory nutrition labelling, based on a high/medium/low banding scheme, which enables consumers to readily gauge levels of energy, fat, saturated fat, sugar, salt, and dietary fibre in food products.

E10 The Food Standards Agency should undertake a public information campaign to improve understanding of the *Balance of Good Health* dietary recommendations[5] and how nutritional labelling relates to this model.

Research and development agenda

R1 Undertake baseline assessments of health, including dental health, as well as the state of educational development in 5 year olds entering primary schools. This information should be gathered by school nurses and used to monitor child health indicators nationally over time.

R2 The minimum nutritional standards for school lunches should be subject to an independent, developmental review, to see whether the food-based standards ensure that COMA nutrient intake recommendations are met. This might be undertaken jointly by the Food Standards Agency and the Health Development Agency.

R3 Undertake research into the effects of a range of motivators – including advertising and promotions, price, availability and packaging – on children's eating behaviour (especially on their intake of fat, sugar and salt), and on their understanding of nutrition and health.

R4 Monitor and evaluate the impact of the National School Fruit Scheme on both health and consumption indicators.

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Population dietary recommendations for England

The chart below gives the population dietary recommendations for England, the progress towards achieving them, any associated inequalities and the effect on health of achieving the recommendations. The recommendations are from the Department of Health's Committee on Medical Aspects of Food Policy, and its successor, the Scientific Advisory Committee on Nutrition, an independent committee advising both the Food Standards Agency and the Department of Health.[1-4] There are no government dietary targets for England although there are for Wales, Scotland and Northern Ireland.

See also *Inequalities in what people eat*, in Section B.

Dietary recommendations for England: current levels and trends and potential impact on health

	Dietary recommendations	Current levels and trends	Associated inequalities	Effect on health of achieving the recommendations
Total fat	To reduce the average contribution of total fat to dietary energy to about 35%.	Currently 36% for men and 35% for women.[5] Slowly reducing.	No socioeconomic or geographical inequalities.	A reduction of 3% in total fat and 5% in saturated fats could lead to a reduction in average plasma cholesterol of around 5%, which will reduce risk from coronary heart disease by 10%-15%.[3]
Saturated fat	To reduce the average contribution of saturated fatty acids to dietary energy to no more than about 10%.	Currently 13%.[5] There was a 5% reduction between 1975 and 2000.	Varies with ethnic group. No socioeconomic or geographical inequalities.	
Oily fish	To double the intake of long chain omega-3 fats (mainly from oily fish) to 1.5g a week.	Currently 0.7g a week.[7] Oily fish consumption doubled between 1980 and 2000, but there has been only a slight increase in overall fish consumption.[6]	Socioeconomic inequalities.	Could reduce sudden death associated with coronary heart disease by 50% in men and 30% in women.[8, 9]
Fruit and vegetables	To increase the consumption of fruit and vegetables by at least 50%, to 5 portions or more a day.	Current average consumption is fewer than 3 portions a day. Overall trend slowly increasing. The amount of fresh fruit and fruit juice consumed has increased, offset by a decrease in vegetables.[6]	Geographical, socioeconomic and ethnic inequalities.	Could produce a reduction of up to 20% in overall deaths from chronic disease, including coronary heart disease, stroke and cancer.[10]
Salt 9g salt = 3.5g sodium = 2 teaspoonfuls 6g salt = 2.4g sodium	*Adults* To reduce consumption of salt to 6g a day. *Children* 0-6 months: Less than 1g a day 7-12 months: 1g a day 1-3 years: 2g a day 4-6 years: 3g a day 7-10 years: 5g a day 11-14 years: 6g a day	Current daily intake of salt is 10.9g for men and 7.9g for women.[11] There has been a good reduction in the amount of salt added at the table, but possibly an increase in salt intake from pre-prepared foods.	No geographical differences. Minor socioeconomic differences.	Reducing salt intake by 3g a day reduces systolic blood pressure on average by 3.5mmHg. A 2mmHg reduction in blood pressure reduces stroke by 16% and coronary heart disease by 6%.[12]

Dietary fibre	To increase the intake of dietary fibre from breads, other cereals, potatoes, fruit and vegetables to 18g a day.	Current average intake of fibre is 15.2g a day for men and 12.6g a day for women.[5] Intake has been falling slowly over the past 20 years.[6]	Socioeconomic and geographical inequalities.	Research not specific enough to quantify.
Overweight and obesity	To maintain a healthy body weight (BMI between 20-25), and to prevent weight gain with age, through regular physical activity and eating appropriate amounts of food conforming to dietary recommendations.[2,3]	Obesity has been rising dramatically over the 1980s and 90s. For example, the number of obese men has tripled.[13]	Geographical, ethnic and socioeconomic differences.	No recommendations. However, 30,000 deaths were attributed to obesity in 1998 in England.[14]
Red and processed meat	Adults who eat more than 90g of red and processed meat a day – especially those who eat more than 140g a day – should consider reducing the amount they eat.	90g a day.[2]	Socioeconomic and ethnic inequalities.	Recommendation not specific enough to quantify.

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