NATIONAL HEART FORUM

Towards a generation free from coronary heart disease

Policy action for children's and young people's health and well-being

Young@heart

A healthy start for a new generation

This document sets out:

- proposals for **a national plan for children's and young people's health and well-being**, with a particular focus on coronary heart disease prevention (see pages 12-27),

  and

- recommendations to develop **comprehensive national strategies** for improving nutrition, increasing physical activity, and tackling smoking among children and young people (see pages 28-37).

The proposals and recommendations are based on a comprehensive scientific and policy review by the National Heart Forum.

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NATIONAL HEART FORUM

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young@heart
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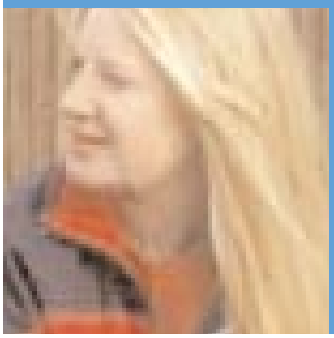


Introduction

Towards a generation free from coronary heart disease

Every child born in the UK today should be able to live to at least the age of 65 free from avoidable coronary heart disease. This is the goal of a new approach to coronary heart disease prevention from the National Heart Forum to tackle the causes of the disease from its beginnings in early life. Young@heart places children's and young people's health and well-being at the centre of a comprehensive agenda for policy action to prevent avoidable coronary heart disease by giving the new generation a healthy start in life.

We all share responsibilities towards children. As parents and as a community we have a duty to protect and to nurture them. As a signatory to the United Nations Convention on the Rights of the Child, the government has a responsibility to ensure that all children have the best possible start in life. Protecting children from avoidable disease is fundamental to fulfilling these responsibilities.

Current evidence about the major lifestyle risk factors for coronary heart disease – inadequate nutrition, physical inactivity and smoking – especially among children, is a serious cause for concern. Unless we take action now on current trends and inequalities in diet, physical activity, obesity and smoking, and make children's and young people's health a national priority, we will fail to prevent an epidemic of coronary heart disease, as well as stroke, cancer and diabetes, in 40-50 years' time.

This document sets out:

- proposals for **a national plan for children's and young people's health and well-being**, with a particular focus on coronary heart disease prevention (see pages 12-27), and
- recommendations to develop **comprehensive national strategies** for improving nutrition, increasing physical activity, and tackling smoking among children and young people (see pages 28-37).

The proposals and recommendations are based on a comprehensive scientific and policy review by the National Heart Forum.

A central recommendation is that the government should relocate the **Children and Young People's Unit** into the Cabinet office and give it a coordinating responsibility, working across government, to address the wider determinants of health. The Unit should collaborate with the national administrations for Wales, Scotland and Northern Ireland to deliver national plans for children's and young people's health and well-being.

The link between children's health and coronary heart disease risk

Heart attacks and illness from coronary heart disease seem remote from children's lives, but the key risk factors for developing coronary heart disease – raised blood cholesterol, high blood pressure, diabetes and smoking – all develop over the life course, and most originate during childhood.

Some people have a genetic disposition towards some of these risk factors, but for most people the risk of coronary heart disease is largely determined throughout life by diet, physical inactivity (especially as it relates to weight control), and smoking. Studies have shown that the early signs of coronary heart disease are already apparent in some children and adolescents. Atherosclerosis (fatty deposits in the walls of the arteries) has been found in a small minority of children as young as 2 years old. By the age of 20, it may be present in as many as one in three young people.[1] The risk of developing diabetes and coronary heart disease is significantly increased in individuals who are overweight or obese. Children who put on excessive weight, due to a combination of a high caloric intake and low energy expenditure, are likely to be at increased risk, especially if they remain overweight as adults.

Foetal development and babies' consequent birthweight make up another very important piece of the risk factor 'jigsaw'. Studies suggest that low birthweight (particularly when followed by rapid weight gain in infancy) is associated with a number of coronary heart disease risk factors.[2] Birthweights show a clear socioeconomic gradient: the average birthweight of babies from low-income families is lower than that of babies born into better off families. Closing this gap demands measures that ensure adequate infant feeding and nutrition in pregnancy, and also appropriate nutrition during adolescence to support the healthy physical development of future mothers.

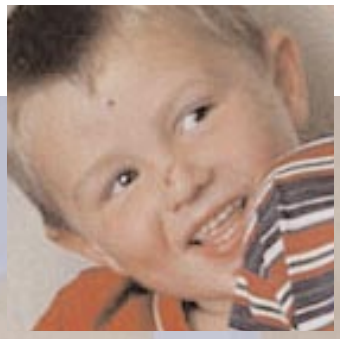
The burden of coronary heart disease

Around 86,000 people in the UK suffer a heart attack before the age of 65 every year – 66,000 men and 20,000 women.[3] More people die prematurely (under the age of 65) from coronary heart disease than from any other single cause of death in the UK, and many more live with the disabling effects of heart attacks and heart failure instead of enjoying a full and active adulthood.

The wider social and economic costs of coronary heart disease are enormous. Death and illness in mid-life can deny families of parents and providers, and place a huge burden of care on families and the health services. It is estimated that the annual costs to the UK economy due to coronary heart disease (across all ages) include about £8.5 billion through days lost due to death, illness and informal care of people with the disease. In addition to this, the estimated costs to the health care system are £1.6 billion, bringing the total cost of coronary heart disease to over £10 billion per year.[3]

Coronary heart disease trends

Data from international studies, including the World Health Organization's MONICA Project,[4,5] suggest that where coronary heart disease mortality rates are falling, this is explained by a combination of improvements in life-saving treatments and downward trends in cholesterol levels, blood pressure and smoking. In an era of better treatments and an ageing population it is likely that there will be more people living with coronary heart disease in their later years unless and until we succeed in preventing the disease from early life.



Children's and young people's health and well-being

Children's health and well-being are affected by a broad spectrum of social, economic, cultural and environmental influences. The Young@heART initiative places a special focus on those influences that impact directly and indirectly on children's dietary patterns, physical activity levels, and smoking behaviours.

Food poverty and 'modern malnutrition'

Many families on low incomes do not have enough money to buy food, and struggle to afford even a poor and monotonous diet. At all ages, people in poorer households have lower nutritional intakes than people in richer households and this gap has widened over the last 20 years. Pregnant women on a low income have very poor diets and this has important health implications for their babies who are more likely to be of low birthweight and less likely to be breastfed.[6]

The status of children's diets and the impact of poor nutrition on their health are causes for serious concern. The government's National Diet and Nutrition Survey[7] exposes a pattern of 'modern malnutrition' among many British children, especially those in low-income families. Chips, cakes, biscuits and salty snacks are dominating children's diets at the expense of fruit and vegetables, and many children are deficient in the nutrients they need for healthy growth and development.

The food that families and children are eating today is determined through a complex balance of social and cultural customs, choice, price, availability and accessibility. As long as foods which are high in fat, sugar and salt are more heavily advertised and more accessible than other more nutritious options, there will continue to be an unhealthy bias in children's diets.

Less active, less often

Studies show that children in the UK are becoming increasingly sedentary in their habits. Free time, traditionally spent on active play, is more often spent watching TV and playing computer games. Car journeys to school have doubled in the last 20 years with almost 30% of children going to school by car, compared with less than 50% walking and just 1% cycling.[8] The total time devoted to PE lessons in schools has declined in recent years, and the time allocated to PE in secondary schools in England and Wales is now lower than anywhere else in the European Union.[9] Low levels of physical activity together with energy-dense diets (high in soft drinks and snacks) are leading to rising rates of obesity among British children. Data from the National Study of Health and Growth shows that among 4-11 year olds, 9% of boys and 13.5% of girls are overweight and 1.7% of boys and 2.6% of girls are now obese.[10]

Young smokers

Government figures show that one in ten 11-15 year olds in England regularly smokes at least one cigarette a week (12% of girls and 9% of boys).[11]

These figures reveal a slight increase in overall prevalence but, because of the fluctuation in teenage smoking behaviour since the early 1980s, it is not possible to say whether this is a new upward trend in smoking. Nicotine is highly addictive. Although half of young smokers from higher socioeconomic groups stop smoking by their 30s, three-quarters of those from low-income groups are at the beginning of a long-term, life-threatening habit. Significantly, young people who have not started smoking before they are 20 are unlikely to start.

Starting to smoke is a process that involves many factors and influences including a child's social environment, family circumstances and emotional well-being. Studies show that attitudes towards smoking start to develop while children are still very young and may be reinforced throughout childhood and adolescence.

The case for policy action

There is no one simple solution to reducing children's and young people's risk of coronary heart disease in adult life. But we do have the knowledge to take the necessary policy action, at national and at local level, to begin to tackle the many social, economic and environmental determinants for the major lifestyle risk factors – at home, at school, in the community and through the health services.

The National Heart Forum believes that the status of children's and young people's health and lifestyles, the inequalities affecting children living in poverty, and the impact of poor health on children's educational and work prospects, together create a clear mandate for 'joined up' government action. Moreover, the consequence of inaction – a future epidemic of coronary heart disease – makes action an urgent priority.

Children and young people under 16 make up one-fifth of the population,[12] yet public health initiatives aimed at children have lacked both the priority and the resources given to adult interventions. This is inequitable and can be counter-productive. Investing in child-centred strategies has the potential to yield both immediate and long-term benefits – by protecting young hearts from the damaging effects of poor nutrition on early growth and development, and by fostering and sustaining positive health behaviours throughout life.

young@heart proposes a common health-promoting agenda for departments across government and for agencies, partnerships and organisations working at both national and local level across the public and commercial sectors. It recognises the important non-health benefits – such as improving educational standards and preventing crime – that could accrue from a shared investment in children's health and well-being. Taken as a whole, the scope of young@heart is intentionally ambitious. But it recognises the need for UK-wide policy coordination and continued policy development and implementation by the administrations in England, Northern Ireland, Scotland and Wales. Where

appropriate, the policy actions proposed in this document seek to build on current initiatives and good practice and to set out an effective health protection and health promotion remit for evolving structures such as the National Service Frameworks for coronary heart disease and for children's services.

In some instances, the National Heart Forum has used the precautionary principle, that is, recommendations are made even where the cause and effect relationships are not fully established scientifically, in order to protect long-term health. The recommendations reflect the principles and values agreed at a summit meeting of invited experts in public health, health economics, children's welfare and education and social policy held in 2001 – the need to involve children and young people in decisions that affect them, and the need to take account of inequalities in children's health, and the socioeconomic, ethnic and gender divides that lie behind these inequalities.

Priorities for action

By bringing together what we know about the causes of coronary heart disease and about the influence of the lifestyle risk factors across the life course, it is possible to identify priority actions for improving long-term health among the young. These are presented as ten key young@heart recommendations (shown on page 10). The criteria for identifying these priority actions are:

- actions which could have an immediate impact on health by preventing irreversible damage to young hearts – particularly those relating to maternal and infant nutrition;
- actions which could have an impact on long-term health behaviours – such as children's diets and smoking;
- actions which could contribute to reducing inequalities – such as measures to prevent and relieve food poverty among the poorest families; and measures which target the more inactive groups of young people, for example, girls and young women;
- actions which build on current policy directions and initiatives, such as child poverty measures and the Sure Start programme.

Background to young@heart

The young@heart national plan for children's and young people's health and well-being is the result of an extensive process of scientific and policy review which has brought together contributions from a wide range of experts in public health, health economics, children's welfare and education and from policy-formers in both national and local government. A full report of specially commissioned research reviews, a UK-wide policy audit, and the findings of a policy summit meeting held in June 2001, will be published by the National Heart Forum in 2002.

The initiative has been generously sponsored by the British Heart Foundation, the Nuffield Trust and the Health Development Agency. The National Heart Forum is grateful to its member organisations, individual members, and many other contributors, for the invaluable support they have given to young@heart.

Summary

The aim of the National Heart Forum's young@heart initiative is that every child born in the UK today should be able to live to at least the age of 65 free from avoidable coronary heart disease.

The scope of young@heart

young@heart puts forward:

- proposals for a **national plan for children's and young people's health and well-being**, with a particular focus on coronary heart disease prevention, and
- recommendations to develop **comprehensive national strategies** for improving nutrition, increasing physical activity, and tackling smoking among children and young people.

A national plan must address all the different direct and indirect influences on children's and young people's health. It must engage the many opportunities for policy action across all sectors, and seek to build health capacity for families, children and young people, in the home, at school and in the community.

The young@heart proposals for a national plan are grouped into six key areas for policy action (pages 12-27):

- End child and family poverty
- Make every school a healthy school
- Build healthy communities
- Strengthen and expand public health roles
- Secure corporate responsibility for health, and
- Give a voice to children and young people.

The national plan draws on the recommendations made to develop comprehensive national strategies focused on children and young people to improve nutrition, increase physical activity and tackle smoking (pages 28-37).

There are recommendations for action at local, national and international levels. Opportunities for local action are highlighted with this symbol. L

Young@heart also makes recommendations for future research and development. These recommendations reflect the need:

- to reinforce the case for action through modelling the impact of recommendations on NHS expenditure and workforce productivity in the future
- to develop methods and tools for delivering, monitoring and/or evaluating recommendations and for sharing best practice, and
- to conduct research into the current status of children's and young people's health and behaviours where unknown, to provide a baseline.

Taking forward the proposals

To take forward the young@heart proposals it is suggested that the government should relocate the Children and Young People's Unit into the Cabinet office and give it a coordinating responsibility, working across government, to address the wider determinants of health. The Unit should collaborate with the national administrations for Wales, Scotland and Northern Ireland to deliver national plans for children's and young people's health and well-being.

Young@heart key recommendations

Comprehensive national strategies

- There should be comprehensive national strategies to:
  – improve nutrition among children and young people, with an emphasis on healthy eating for pregnant women, and breastfeeding and healthy weaning for their babies (see pages 28-31);
  – increase physical activity among children and young people, with an emphasis on young girls, all adolescents, and children of South Asian descent (see pages 32-33);
  – tackle smoking among young people, with an emphasis on girls, young women and pregnant women, and 4-8 year olds in primary school, and interventions throughout adolescence (see pages 34-37).

A national plan for children's and young people's health and well-being

There should be a national plan for children's and young people's health and well-being which addresses six key areas:

End child and family poverty

- The Treasury should 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. (See recommendation 1 on page 13.)

Make every school a healthy school

- The government should introduce a statutory requirement for all schools to develop and implement health-promoting school policies under the Education Acts. (See recommendation 2 on page 15.)
- The requirements of the National Healthy School Standard should be strengthened and new resources provided to enable and encourage all schools to meet an enhanced national Standard. Meeting the new Standard should be included within the statutory inspection remit of Her Majesty's Inspectorates for Schools. (See recommendation 3 on page 15.)
- National targets should be set and monitored to raise the quality and uptake of school meals, with particular emphasis on free school meals. (See recommendation 6 on page 17.)

Build healthy communities

- There should be government investment and local action to expand the Sure Start programme to provide national coverage for all children under 4 and their families, and strengthen the child health components. These should include nutrition and food skills for parents, particularly on breastfeeding and weaning. (See recommendation 7 on page 19.)
- There should be government investment and local action to ensure national provision of support and mentoring services for teenagers which incorporate a health and well-being element. The Connexions service in England should be expanded and should act as a model for other national services. (See recommendation 8 on page 19.)

Strengthen and expand public health roles

- Public health training, standards, and recruitment and retention initiatives should be developed to support everyone working with children, young people and families to fulfil a core responsibility for promoting and protecting health. (See recommendation 13 on page 23.)

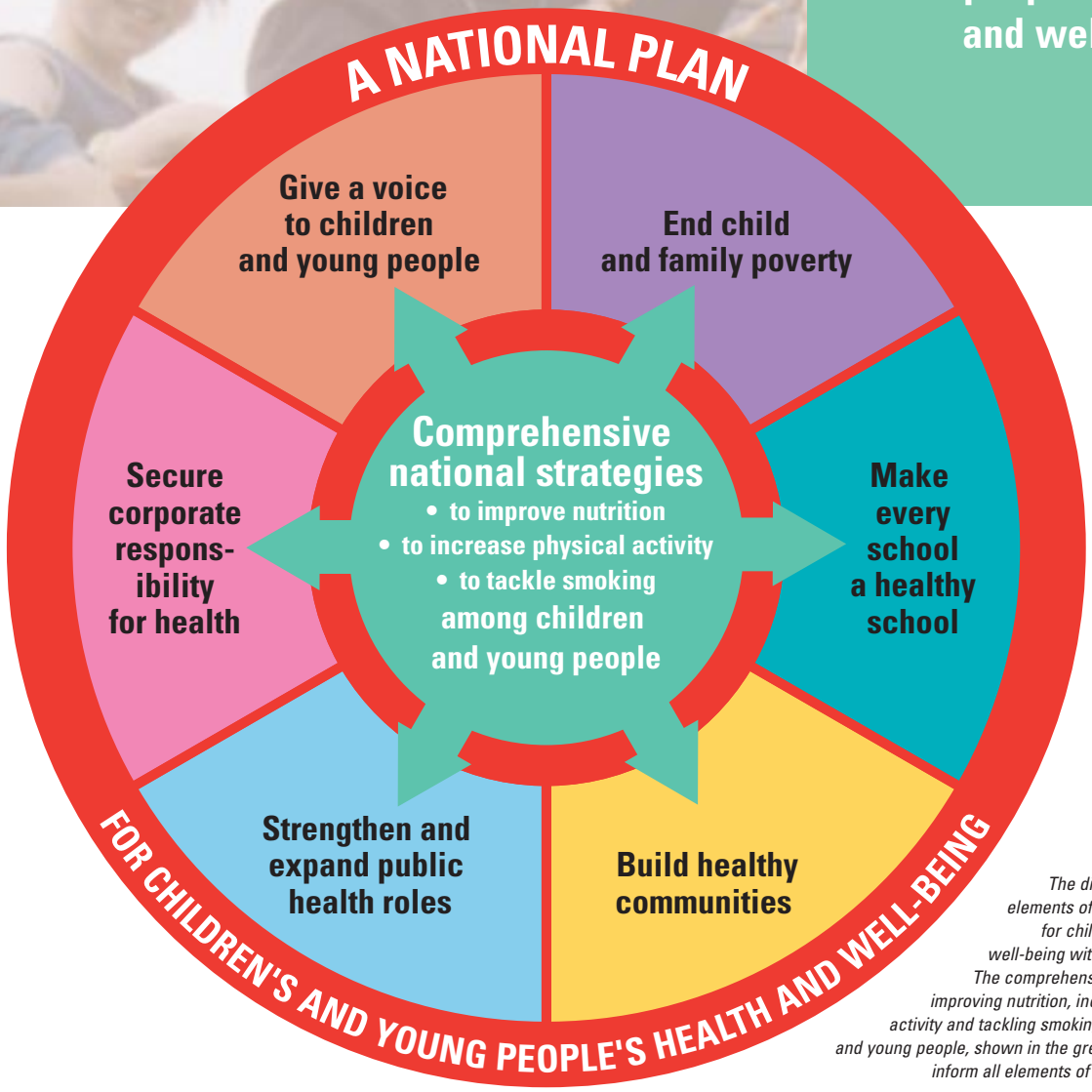
Secure corporate responsibility for health

- 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. (See recommendation 14 on page 25.)

Give a voice to children and young people

- All of these policy actions should be developed and implemented with a commitment to involving children and young people and taking account of their views, so that national and local policy-making is effective, appropriate and responsive to their needs. (See recommendation 20 on page 27.)

Policy action for children's and young people's health and well-being



The diagram shows the elements of the national plan for children's health and well-being within the red circle. The comprehensive strategies for improving nutrition, increasing physical activity and tackling smoking among children and young people, shown in the green circle, should inform all elements of the national plan.

The aim of young@heart is that every child born in the UK today should be able to live to at least the age of 65 free from avoidable coronary heart disease. An overview of the policy action which is needed in order to achieve this goal is shown above.

Taking forward a national plan for children's and young people's health and well-being

Many organisations are involved in building and sustaining children and young people's health, including government departments, health services, local authorities, schools, and commercial organisations. It is recommended that the government should give the Children and Young People's Unit a coordinating responsibility, working across government, to address the wider determinants of health (see page 9).

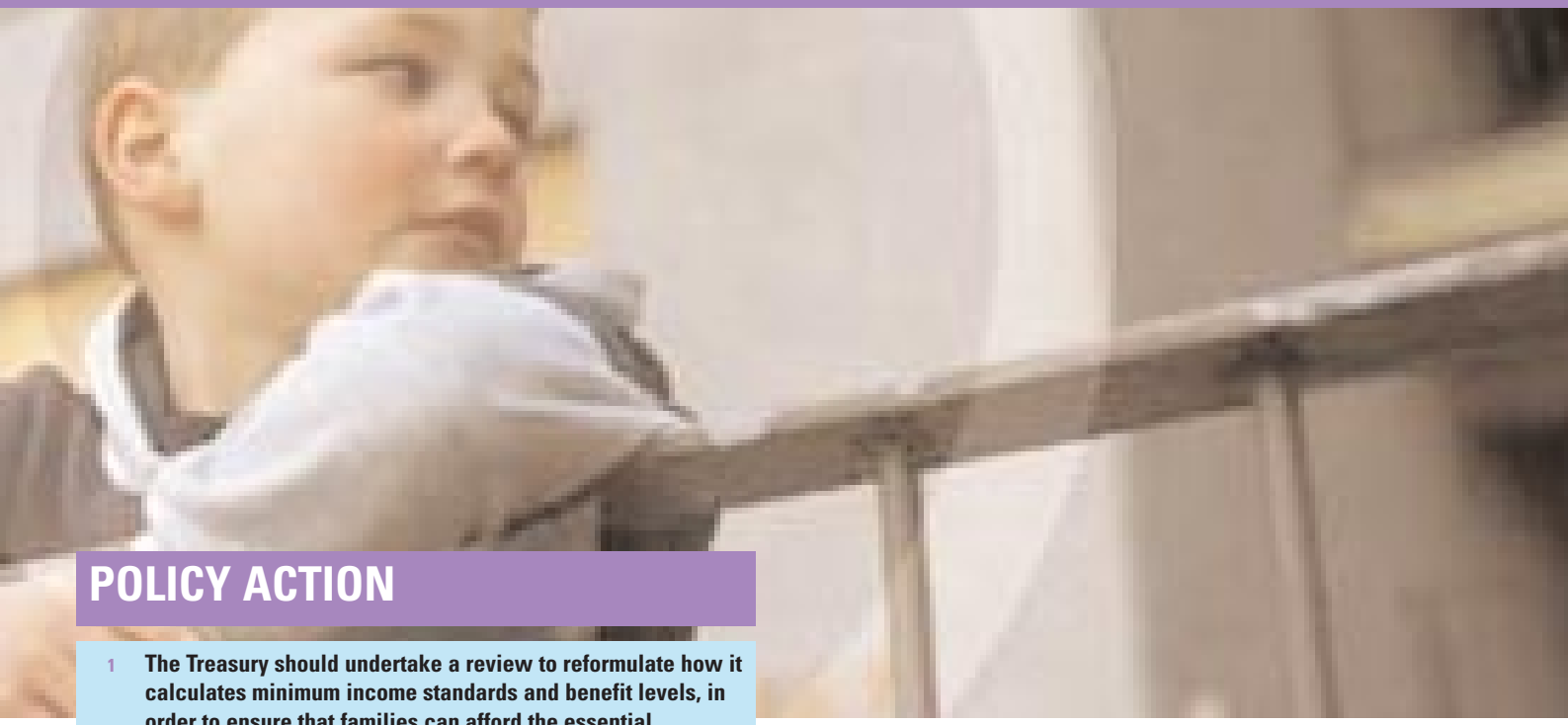
End child and family poverty

One in three children in the UK grows up in relative poverty; this proportion is higher than in any other EU member state.[13] The relationship between socioeconomic background, child poverty and long-term ill health is complex. Women from low socioeconomic groups tend to have babies of low birthweight, as a result of their own low birthweight, their short stature and their poor nutritional status during pregnancy.[14] Low birthweight is an independent predictor of coronary heart disease. Poor educational attainment is another independent predictor of coronary heart disease. Boys whose fathers are from a low socioeconomic group are unlikely to reach the highest educational level.[15]

A family's lack of access to or ability to afford good quality food (food poverty) is another crucial factor in the relationship between childhood deprivation and long-term ill health. Under or malnourished children tend to be shorter than their better-off peers and the mechanisms which retard growth appear to increase prevalence of adult hypertension and diabetes. Childhood undernutrition is also detrimental to cognitive development, behaviour, concentration and school performance.[16]

The government is committed to ending child poverty over the next 20 years. To achieve this, it must continue with long-term policies to prevent child poverty, while supporting short-term initiatives to relieve it. In particular, policies are needed to establish minimum income standards and benefit levels that will support parental choice and ensure that all families can afford the minimum requisites of health and well-being. These should link to the development of the health poverty index referred to in the *NHS Plan*.[17] Benefit policies are needed that will relieve the effects of poverty.

The recommendations which follow reflect the need for income distribution policies which directly tackle family and child poverty, and for investment in targeted services to alleviate the effects of living in poverty.



POLICY ACTION

1 **The Treasury should 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. This will require the development of a new method of 'health impact assessment' which takes account of health and well-being, and which can be used for reviewing and setting state benefit and minimum wage levels on an annual basis.

Supporting actions

1.1 Ensure that health is included within new EU indicators of poverty which are being developed.

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

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

1.4 Increase maternity and paternity benefits and paid parental leave to allow parents the option to remain at home, with sufficient income to keep themselves and their children healthy.

1.5 Make the benefits system supportive of mothers who wish to combine parenting and part-time work.

1.6 Provide more equitable, high quality, low cost childcare services to support parents and children most in need. One way to do this is to expand the number of Early Years Development and Childcare Partnerships to all neighbourhoods, with sustained investment.

L 1.7 Help parents access attractive training and development opportunities. An important way to do this is to open community cafés with cyber and childcare facilities to tackle the 'digital divide' in opportunities.

L 1.8 Promote integrated community transport plans that support regeneration and social inclusion in both urban and rural areas. Plans should encourage walking and cycling for daily travel and enable easy access to local shops and services.

Research and development agenda

R1 Develop a new method of health impact assessment for reviewing and setting state benefit and minimum wage levels, on an annual basis.

R2 Undertake research to analyse the costs and benefits of government investment for child health and well-being in the short, medium and long term. This analysis should include: long-term savings on NHS costs for treating chronic disease; national productivity benefits both in terms of fewer days lost to ill health and in terms of better educational standards and employment prospects. It should also include shorter term benefits such as raising educational standards and improving the environment.

R3 Establish an annual national audit for the determinants of child health and health inequalities. The data for the audit could be fed into the UK Children and Young People's Unit (see page 4) by Local Strategic Partnerships, using established indicators.

L = local action

Make every school a healthy school

Schools have an extremely important role to play in fostering the health of children and young people at a formative point in their physical, social, mental and attitudinal development.

A healthy school ethos and environment builds pupils' health, self-esteem and well-being. This in turn can contribute to improved educational attainment. Schools should have coherent policies to promote a balanced diet and to curb smoking, a strong commitment to a physically active day, safety policies to reduce bullying and personal attacks, and mentoring services available to all.

Many children depend on the school meal as their only substantial meal of the day. The provision of school meals – both free and paid for meals – is very variable across the UK in terms of both quality and uptake. Proper investment in a valued school meals service that is subject to the same inspection rigour as education standards will drive up standards of food provision and uptake in schools.

Many schools have achieved or are working towards the National Healthy School Standard – part of the government's Healthy Schools Programme. Many other schools have established health-promoting policies and practices outside the structure of the programme. To build on the success of what is already in place, it is recommended that the Standard should be strengthened and resourced and actively promoted so that all schools across the UK are provided with the opportunity to become a nationally recognised healthy school. To ensure that health issues are given priority in schools, it is recommended that the Standard should, in due course, be included within the statutory inspection remit of Her Majesty's Inspectorates for Schools.

The recommendations that follow focus on building and sustaining a whole school approach towards health promotion, linking school policies and culture, the physical environment and the curriculum. The young@heart research and policy evidence suggests that priority should be given to actions which can:

- increase the opportunity for active play and PE in schools and raise participation levels among children and young people – especially girls and all adolescents;
- improve the quality and uptake of school meals, and particularly free school meals; and
- strengthen anti-smoking education especially targeting 4-8 year olds and teenagers.

POLICY ACTION

2 **The government should introduce a statutory requirement for all schools to develop and implement health-promoting school policies under the Education Acts.**

Supporting action

L 2.1 Schools should be required to provide information about all health policies in information prepared for parents, such as prospectuses or annual reports.

3 **The requirements of the National Healthy School Standard should be strengthened and new resources provided to enable and encourage all schools to meet an enhanced national Standard. Meeting the new Standard should be included within the statutory inspection remit of Her Majesty's Inspectorates for Schools.**

Supporting actions to strengthen the National Healthy School Standard

L 3.1 Introduce and enforce no-smoking policies for all teachers, support staff and pupils on school premises and excursions.

3.2 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.

L 3.3 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.

L 3.4 Schools should have a stronger policy focus on promoting walking and cycling among pupils and staff, and a commitment to establishing Safe Routes to School.

L 3.5 Schools should develop a participatory approach to physical education, involving children and young people. Such an approach should emphasise the health-related benefits of physical education and recognise self-esteem as a key outcome. Facilities and activities should reflect the needs and preferences of particular groups. For example, young women prefer single-sex activities, in particular dance and aerobics, and wearing loose clothing, and value privacy when changing.

Policy action continued overleaf...

L = local action

Supporting actions to provide adequate facilities and resources for schools

(Funding for these actions could be delivered via a dedicated, national health and well-being grant scheme.)

3.6 Provide resources for schools to carry out structural improvements to create a more health-promoting environment. This might include upgrading dining areas and changing facilities, providing playing fields, or creating sheltered play areas.

3.7 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.

3.8 Fund appropriate staff cover during lunch and break times during the school day to allow adequate opportunity for supervised sport and active play.

3.9 Cover the costs of and offer financial incentives for teachers, parents and support staff to run after-school activity sessions in schools and youth clubs. After-school activities can bring additional benefits for young people's health and well-being by offering an alternative to risky behaviours including smoking and alcohol consumption.

3.10 Establish and maintain state-provided breakfast clubs where there is an identified need. Some current provision relies on local sponsorship from providers such as supermarkets and fast food chains.

3.11 Ensure that primary schools can afford to offer teachers in-service training in physical activity, or to bring in external specialists to provide an adequate level of physical activity expertise.

4 **Develop and build on existing school-based smoking prevention interventions. These should start in all primary schools and continue into secondary schools and be delivered as part of a statutory provision for school health-based policies under the Education Acts. Interventions should aim to reinforce anti-smoking attitudes and to equip children to understand and resist the influence of the tobacco industry.**

Supporting actions

4.1 Promote to schools existing web-based health promotion resources that support smoking prevention interventions, such as Wired for Health.[18]

4.2 Introduce targeted interventions for older adolescents in all secondary schools that focus on stopping smoking while reinforcing the prevention message.

5 **Ensure that the school curriculum and teaching practices support the ethos of a healthy school.**

Supporting action

5.1 Lessons in life skills and parenting – which should emphasise nutrition and the value of breastfeeding, and include 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.

6 **National targets should be set and monitored to raise the quality and uptake of school meals, with particular emphasis on free school meals.**

Supporting actions

6.1 Introduce minimum national standards for school meal providers for both the quality 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.

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

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

L 6.4 Raise parents' awareness of their entitlement to claim free school meals for their children through national and local initiatives.

L 6.5 Introduce cashless payment systems – using smart cards – for all school meals, to reduce stigma around free meals and increase overall efficiency of the service.

Research and development agenda

R1 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.

R2 An assessment of the value of school meals to both child and adult health, and as a cost-saving measure against health service expenditure, should be undertaken. This could be conducted through a collaboration of the Treasury, Cabinet office, the Department for Education and Skills, and the Department of Health.

L = local action

Build healthy communities

Heart health can be influenced by a number of factors within the community. Access to a healthy diet and opportunities to be physically active are determined by both our physical environment and the organisation of local services.

There is a very strong correlation between deprivation and risk of coronary heart disease. Over the last 30 years, growing inequalities in income have been closely mirrored by a widening social class gulf in coronary heart disease with the poorest members of society now suffering a greater than two-fold risk of premature mortality than those who are better off.[19] Strategies to tackle social exclusion and to regenerate communities can have an important impact on reducing health inequalities and reducing the avoidable health risks among the most vulnerable groups in society.

Social exclusion is strongly linked to a lack of self-esteem and poor mental health among young people. The Connexions service and peer-mentoring schemes can play an important role in helping young people deal with social exclusion and with stress. This may reduce risk-taking behaviour such as smoking.

The recommendations which follow reflect the particular needs of families with babies and young children, especially those living on a low income, and of adolescents. Priority should be given to community level actions which will help tackle food poverty, support active transport plans, raise community participation in sport and recreation, and offer support to young people during adolescence. All local planning and decision-making across all sectors and involving all partners, including children and young people, should aim to build healthy communities.

POLICY ACTION

7 There should be government investment and local action to expand the Sure Start programme to provide national coverage for all children under 4 and their families, and strengthen the child health components. These should include nutrition and food skills for parents, particularly on breastfeeding and weaning.

Supporting actions

7.1 Provide public health training for Sure Start workers.

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

L 7.3 Sure Start local programmes, in partnership with the Early Years Development and Childcare Partnership (EYDCP), should ensure 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.

L 7.4 Sure Start local programmes, in partnership with the EYDCP, should require nursery schools to provide meals which conform to nutrient-based standards (such as the nutritional guidelines proposed by the Caroline Walker Trust.[20]) Nurseries should be provided with menu-planning tools such as the *CHOMP Menu Planner* computer programme,[21] to help them meet these standards.

L 7.5 Sure Start local programmes should work with the EYDCP to help young children (particularly girls) in nursery education to practise running, jumping, landing, rolling, throwing, catching and bouncing balls. Guidelines on building these skills should be given emphasis in the foundation stage curriculum.

L 7.6 The Sure Start programme should work with parents in the community to promote smoke-free homes as a support to adult smoking cessation and to discourage children from starting to smoke.

8 There should be government investment and local action to ensure national provision of support and mentoring services for teenagers which incorporate a health and well-being element. The Connexions service in England should be expanded and should act as a model for other national services.

Supporting action

8.1 Ensure that training for Connexions workers is focused and inter-disciplinary, covering areas such as smoking cessation, mental health and behaviour change.

Policy action continued overleaf...

L = local action

9 **Local Strategic Partnerships in England and Wales, and their equivalents in Scotland and Northern Ireland, should have strong, independent public health input, include plans for children's health and well-being, and reflect the views of children and young people in their development and working practices.**

Supporting actions

L 9.1 Ensure that the public health sector is represented as a key partner in the Local Strategic Partnership (LSP) and its equivalents, and that the local Health Improvement and Modernisation Plan (HIMP) is central to the LSP's activities.

L 9.2 Align HIMPs and Community Strategies at local and regional level.

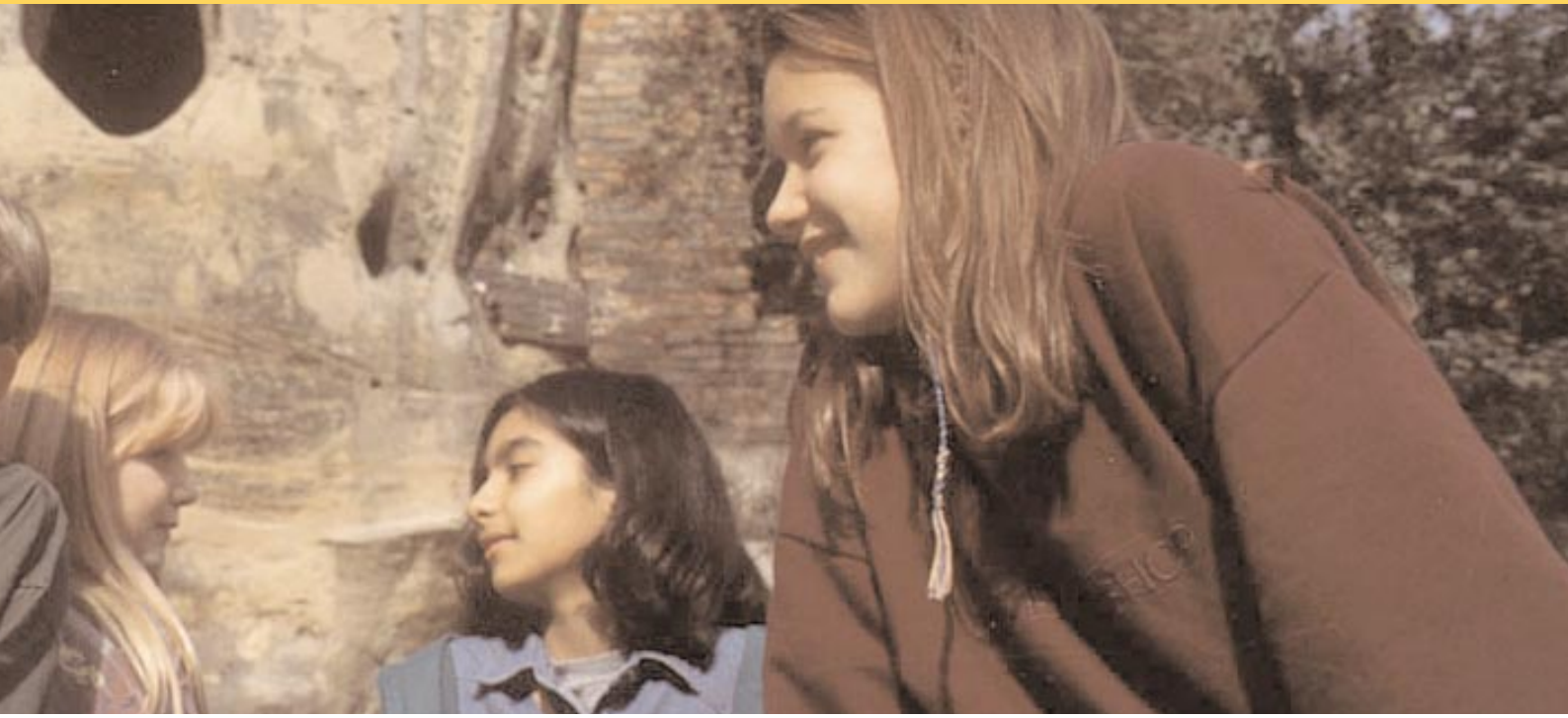
L 9.3 Draw up local food strategies to increase access to shops and affordable, nutritious foods. This initiative could be led by LSPs and involve local authorities, primary care trusts (and their equivalents in Scotland and Northern Ireland), and the voluntary and private sectors.

L 9.4 Include action targeted towards children and young people within coronary heart disease prevention plans, as part of the National Service Framework for coronary heart disease.[22]

L 9.5 Develop mechanisms which ensure that children and young people are involved in guiding the activities of LSPs – for example, through focus groups or citizens' juries.

9.6 Provide nationally coordinated guidance to LSP partners on their obligations, responsibilities and opportunities to develop the health and well-being of the community. This might be produced by a collaboration of the Department of Transport, Local Government and the Regions, the Department of Health, the Improvement and Development Agency and the Health Development Agency.

L 9.7 Directors of public health should continue to report annually on the health and well-being of the whole population they serve. These reports should include child health and well-being targets and indicators which LSPs should be required to act upon. The reports should be made available to all professionals and others working with families, children and young people.



10 **Develop community forums, with joint funding from health and local authorities, to develop and support local health promotion programmes.**

Supporting action

L 10.1 Such a forum could incorporate the proposed primary care trusts' public/patient forum.

11 **Increase children's and young people's participation in and access to sport and recreation in the community.**

Supporting actions

L 11.1 Ensure that leisure services encourage and support children and young people to try a range of activities and set prices and opening hours so that the services are accessible and affordable, particularly during school holidays. Ensure that leisure services staff are trained to work with and support young people.

L 11.2 Include responsibility for sports and other exercise facilities within the remit of Local Strategic Partnerships or Neighbourhood Management Programmes where they exist. One of these responsibilities should be to undertake local reviews of how resources for sport and leisure provision are used and organised, with a view to targeting resources where they are most needed.

L 11.3 Introduce sports development officers and physical activity coordinators in every local authority and health promotion unit, respectively. Their training and development programmes should cover the health benefits of physical activity.

L 11.4 Leisure centres and after-school clubs should offer taster activity sessions or skills appraisal sessions to guide children and young people on which sports or activities might interest them and suit them best.

12 **Make walking and cycling a healthy means of daily travel for more children and young people.**

Supporting actions

12.1 Extend the Safe Routes to School initiative to encourage more children to travel to school, parks and shops safely on foot or by bicycle. The Travel Plan scheme of the Department of Transport, Local Government and the Regions should be extended so that all local authorities have in post a school travel plan coordinator to help schools to develop school travel plans.

12.2 Create a target of establishing, by 2006, 1,000 Home Zones with safe, low speed limits and a legal right of way for pedestrians.

12.3 The Department of Transport, Local Government and the Regions should develop a grant scheme that will support infrastructural improvement in and around schools (such as secure bike sheds, cycle lanes, and traffic-calming).

L 12.4 Implement a quiet roads initiative in rural areas, giving priority to cyclists and pedestrians.

L 12.5 Incorporate walking and cycling initiatives and adequate street lighting as a priority in regeneration and Neighbourhood Renewal Plans.

Research and development agenda

R1 Develop methodologies and guidance for conducting health impact assessments – particularly child health impact assessments – at local level.

R2 Develop and disseminate models for applications to the Neighbourhood Renewal Fund that seek to address the determinants of coronary heart disease.

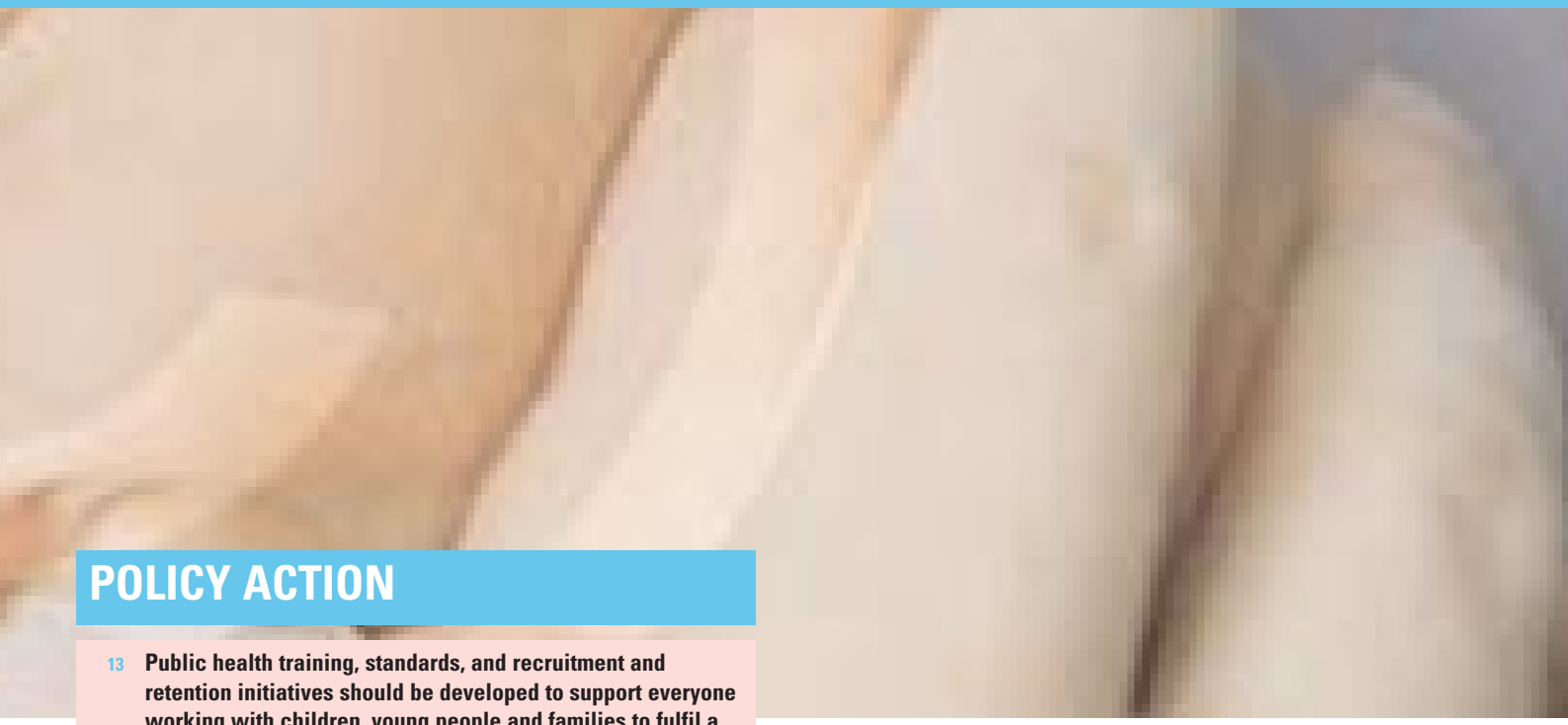
L = local action

Strengthen and expand public health roles

A wide range of people working with families, children and young people have capacity to build health, yet many are an under-used or unrecognised resource. Improving children's health and well-being should be a core responsibility shared by all professionals who work with children, young people and families.

Policies are needed to strengthen public health training, to improve recruitment and retention among key professional groups, and to give a sharper health advocacy focus to existing roles and responsibilities. All professionals working in primary care could be more effective advocates for local sports facilities, safe routes for walking and cycling to school, and for providing a wide variety of health information.

Many of the training and guidance recommendations made here support the development of initiatives and programmes recommended elsewhere in this document to support mothers, infants and under-4s, and young people, such as Sure Start and the Connexions service.



POLICY ACTION

13 **Public health training, standards, and recruitment and retention initiatives should be developed to support everyone working with children, young people and families to fulfil a core responsibility for promoting and protecting health.**

Supporting actions

Health professionals

13.1 Develop national standards for public health competencies and incorporate these into core training for all health professionals.

13.2 Include training in health impact assessment in core training for health professionals.

13.3 Ensure that health visitors and midwives receive training in offering smoking cessation support and advice.

13.4 Increase the number of community dietitians from current national levels as a key resource for developing and implementing healthy eating policies in local education authorities and schools.

13.5 Address the poor career structure for school nurses to strengthen recruitment and retention in the profession.

L 13.6 Involve school nurses in referring young people to services in the community (for example the Connexions service).

Schools

13.7 Provide guidance and training for school governors, senior managers, head teachers and non-teaching staff in health improvement, food and nutrition (including awareness of multicultural issues), and participatory learning methods.

13.8 Make child physical and emotional development and Personal, Social and Health Education (PSHE) mandatory subjects in the core teacher training syllabus, and include PSHE training in in-service training.

L 13.9 Involve school nurses in reviewing and implementing school policies on food, physical activity practices, and the PSHE curriculum.

Sure Start workers

13.10 Include public health training within training for all Sure Start workers.

Connexions service

L 13.11 Include public health training for youth workers within an expanded (national) Connexions service which includes a health and well-being element (see recommendation 8 on page 19). Ensure that training is focused and inter-disciplinary, covering areas such as smoking cessation, mental health and behaviour change.

General

13.12 Ensure that training towards accredited work qualifications in early education, childcare and play covers child health, nutrition and physical activity.

13.13 Include public health representatives on the evaluation board of the Neighbourhood Renewal Fund, and involve health professionals in assessing applications.

13.14 Include training in health-enhancing physical activity within training and development for sports development officers.

13.15 Provide access to multiprofessional, web-based materials – via the National Electronic Library for Public Health, the University of the NHS, and sites such as Wired for Health – to support the public health role of a range of professional groups.

Research and development agenda

R1 Develop and provide tools to enable caterers, school staff, and school governors to assess their school meals and to monitor compliance with the minimum nutritional standards.

L = local action

Secure corporate responsibility for health

Children and young people are growing up in an increasingly sophisticated commercial environment. They have access to a greater choice of foods than previous generations and are exposed to far more advertisements and promotions, via a growing range of media, in the home, at school and in the wider environment.

The commercial sector influences children's diets by determining what is in the food children eat, and the purchasing patterns of families through price, promotion and availability, and by influencing the food choices children and young people make through advertising and promotional activities. These influences may have a greater impact on families living on a low income. Poorer parents will often be obliged to buy foods which are inexpensive and filling and which will not be wasted, at the expense of more nutritious alternatives such as fruit and vegetables, which children may refuse to eat.

Tobacco advertising and promotions have an important influence on children's smoking behaviour. Advertising creates and sustains the impression that smoking is a socially acceptable norm, and surveys show that children tend to smoke the brands that are most heavily promoted.[23, 24] A study of secondary school children found that 38% of smokers and 56% of non-smokers thought that tobacco advertising had quite a lot or a lot of effect on influencing young people to start smoking.[25]

A particular concern is the imbalanced nutritional message conveyed by the overall bias in food advertising during children's TV programming. The *National Food Guide: The Balance of Good Health*[26] recommends that fatty and sugary foods should comprise no more than 7% of the total diet. However, in surveys of TV advertising,[27-29] confectionery, cakes and biscuits account for up to three-quarters of foods advertised during children's viewing hours. Conversely, fruit and vegetables, which should comprise at least a third of the total diet, featured in no advertisements during the same periods. This imbalance serves to undermine the efforts of parents, schools and health professionals to encourage healthier eating patterns.

The recommendations on the next page propose joint working between the commercial sector and government towards good practice and appropriate regulation, to achieve four key goals:

- to protect children and parents from excessive or unfair advertising and promotions aimed at children of foods that are high in fat, salt and/or sugar;
- to reduce the amounts of hidden salt, fat and sugar in pre-prepared and processed foods;
- to support public health initiatives that encourage mothers to breastfeed their babies; and
- to protect children from the influence of the tobacco industry.

POLICY ACTION

14 **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.**

Supporting actions

14.1 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.

14.2 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.

15 **Measures should be introduced to limit and control promotions in schools by commercial companies.**

Supporting actions

15.1 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.

15.2 Provide extra resources to schools to reduce their reliance on the promotional activities of the commercial sector to buy essential books and equipment.

15.3 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.[30]

16 **The government should work with the commercial sector to improve the nutritional quality of processed and catered foods and the availability of fruit and vegetables.**

Supporting actions

16.1 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.

16.2 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).

17 **The government should work with food manufacturers and food retailers to improve food labelling and public information about food and healthy eating.**

Supporting actions

17.1 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.

17.2 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.

17.3 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.

18 **The government and the health services should ensure that commercial activities do not undermine public health initiatives.**

Supporting actions

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

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

18.3 Ban tobacco companies from any involvement in anti-smoking programmes or initiatives.

19 **Ban the promotion of tobacco products.**

Supporting actions

19.1 Introduce a ban on tobacco advertising and sponsorship – including indirect advertising – without delay.

19.2 Support the US campaign to encourage film and music video-makers to reduce the frequency of images of tobacco use in their productions.

19.3 Ban the distribution of free cigarettes in bars and nightclubs.

Research and development agenda

R1 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.

Give a voice to children and young people

To be effective, appropriate and responsive to children's and young people's needs, policy-making to improve health and well-being has to be informed by children's and young people's views.

Engaging children and young people in decisions which influence their daily lives can also contribute to a sense of ownership and citizenship, and help build self-esteem.

It is apparent from the increasing number of initiatives and projects now involving them, that children and young people actively enjoy being involved in decision-making processes at school and in their community. It is highly likely that their involvement improves health-promoting outcomes at both a community and individual level.

Young people's views can be heard through well-established mechanisms such as focus groups, citizens' juries, arrangements established through the national Healthy Schools Programme, or School Nutrition Action Groups. Consultation with children and young people offers a variety of opportunities: to 'road test' proposals for their viability and credibility, to identify gaps in knowledge, and to identify creative and practical solutions to problems.

Legislative change – both nationally in the form of the Children's Act 1989, and internationally in the form of the UN Convention on the Rights of the Child (1990) – place a duty on government to ensure that its actions are conducted in the best interests of children and young people. Article 12 of the UN Convention accords children a specific right to free expression of opinion in matters affecting the child.

POLICY ACTION

20 **All of the policy actions proposed in this document should be developed and implemented with a commitment to involving children and young people and taking account of their views, so that national and local policy-making is effective, appropriate and responsive to their needs.**

Supporting actions

L 20.1 Local Strategic Partnerships should engage with children and young people – through focus groups, citizens' juries or via the Internet – to take account of their views in decisions about local services and town planning which impact on health and well-being.

L 20.2 All schools should establish and encourage participation in pupil forums – such as school councils, School Nutrition Action Groups, school Intranet, and junior governors – as part of the National Healthy School Standard.

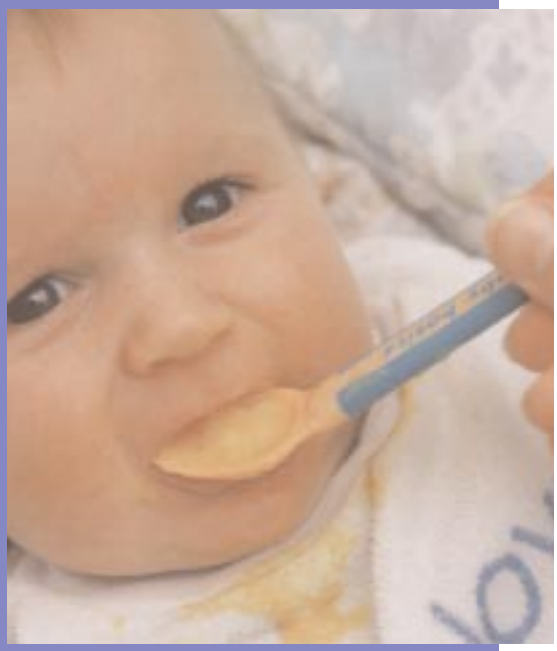
L 20.3 Young people should be involved in community forums as a way to encourage their engagement in local health promotion programmes. Such a forum could incorporate the proposed primary care trusts' public/patient forum.

Research and development agenda

R1 The Health Development Agency and the Improvement and Development Agency should research and draw up guidance for commercial organisations on socially responsible health promotion. The guidance should reflect children's and young people's views and include an audit mechanism.

L = local action

A comprehensive strategy for improving nutrition among children and young people



A child's diet has an important influence on his or her growth and development and on the risk of chronic disease – including coronary heart disease – in later life. Foetal under-nutrition, as a result of the mother's inadequate diet, may lead to small size and altered body proportions at birth, and increase susceptibility to later coronary heart disease.[2] Poor nutrition in girls, particularly in adolescence, increases their likelihood of having low birthweight babies and so the risk is carried from one generation to the next. Breastfeeding up to four to six months, as well as conferring benefits in early life, may protect against high blood pressure and coronary heart disease in adulthood. Better nutrition in both mothers and children can improve long-term health.

A healthy, balanced diet (derived from the Committee on Medical Aspects of Food Policy [COMA] guidelines)[31] should provide at least five portions of fruit and vegetables a day. Total fat should contribute not more than 35% of total dietary energy, saturated fat not more than 11%, and NME sugars (sugar and added sugars) not more than 11%. Salt intake should not exceed 1.7g for 4-6 year olds, 2.9g for 7-10 year olds and 4.0g for 11-18 year olds.

The status of British children's diets and the impact of poor nutrition on their health is a cause for serious concern. Data from the *National Diet and Nutrition Survey*[7] showed that British children are eating less than half the recommended amounts of fruit and vegetables to protect their health. The survey showed that 92% of children have intakes of saturated fat which exceed the recommended level, and 83% have intakes of NME sugars which are higher than the recommended level. More than half of children have intakes of salt which are higher than the maximum recommended amounts. Iron intake among teenagers was below recommended levels. (Low iron intake is associated with poor cognitive function.) One in four teenage girls is receiving less than the minimum recommended levels of calcium at the critical age for bone mass development. Both iron deficiency and calcium deficiency have important health

consequences for both this generation of young people and the next. Many young people depend for a significant proportion of their total intake of energy on three foods – chips, cakes and biscuits – at the expense of more nutritious options.

The majority of foods and drinks advertised during children's and young people's television programmes constitute these sugar, fat and salt-dense products. Most children and many young people do not purchase the food they consume, implying that advertising to this group is for the purpose of garnering 'pester power'.

There is a widely supported theory that there is a 'critical age' in the development of preferences. It is not known exactly what that critical age is, but evidence suggests that the post-weaning years are crucial and the years between ages 2 and 7 are important both for developing preferences and establishing life-long habits.[32] Children's awareness of the social and cultural factors around food develops from an age as young as 2 and 3 years.

It is estimated that 30% of children do not go home to a cooked meal. School meals are for many children the only substantial meal of the day.[33] The potential for school meals to build health in children cannot be underestimated. Improving the nutritional quality of school meals will support joined-up government policy to improve children's health and education, tackle the burden of chronic disease, and reduce inequalities.

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

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 other mothers.

L 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 (see recommendation 7 on page 19).

L 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.

L 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.

L 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 [20]). Nurseries should be provided with menu-planning tools such as the *CHOMP Menu planner* computer programme,[21] 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.

L 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.

Policy action continued overleaf...

L = local action

> Comprehensive national strategies

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

L 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 Acts 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.

L 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.

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

L 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.

L 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.[30]

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[26] 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.

L = local action

A comprehensive strategy for increasing physical activity among children and young people

Low levels of physical activity, together with a poor diet, are leading to rising rates of overweight and obesity in the UK, increasing the risk of diseases including coronary heart disease and adult-onset diabetes. It is estimated that if everyone did more physical activity (moving up one exercise level) this could reduce deaths from coronary heart disease among men and women by around 14%.[34]

A physically active lifestyle when young is associated with lower body fat and increased fitness in early adulthood. There is also some evidence that active children are less likely to become regular smokers. Other important benefits include weight control, improved self-esteem and greater emotional well-being. Physical activity needs to be sustained into adulthood to confer protection against coronary heart disease. Interventions and strategies aimed at the whole population to encourage physical activity are needed across the lifespan to tackle the age-related decline in activity levels.

Studies of physical activity patterns suggest that priority groups for action are young girls, all adolescents, and children from minority ethnic groups, in particular Pakistani, Bangladeshi and Indian children.[35-37] After-school and weekend activities should be given special emphasis as a way of tackling the most sedentary periods for most children of all ages.

The policy map on physical activity is varied across the UK. Many building blocks for strategies are already in place in Scotland, Wales and Northern Ireland. The goal must be to build on these foundations and create comprehensive, integrated strategies that bring together policy-making across all government areas and all sectors.

The recommendations proposed on the next page aim to get more children and young people, more active, more often. Policies should address the barriers to participation in sport and active play and the obstacles to walking and cycling to school and in the community. Children and young people must be involved in the development and implementation of new opportunities for physical activity so that they reflect enthusiasms and preferences and engage a high level of participation.

POLICY ACTION

A Increase children's and young people's participation in and access to sport and recreation in the community.

Supporting actions

L A1 Include responsibility for sports and other exercise facilities within the remit of Local Strategic Partnerships or Neighbourhood Management Programmes where they exist. One of these responsibilities should be to undertake local reviews of how resources for sport and leisure provision are used and organised, with a view to targeting resources where they are most needed.

L A2 Introduce sports development officers and physical activity coordinators in every local authority and health promotion unit, respectively. Their training and development programmes should cover the health benefits of physical activity.

L A3 Leisure centres and after-school clubs should offer taster activity sessions or skills appraisal sessions to guide children and young people on which sports or activities might interest them and suit them best.

B Strengthen physical education, sport and active play in schools through a combination of investment, school policies and teaching practices.

Supporting actions – Investment

B1 Provide resources for schools to carry out structural improvements to create a more activity-friendly environment. This might include upgrading changing facilities (often poor or absent in primary schools and of particular concern to young women), providing playing fields, or creating sheltered play areas.

B2 Fund appropriate staff cover during lunch and break times during the school day to allow adequate opportunity for supervised sport and active play.

B3 Cover the costs of and offer financial incentives for teachers, parents and support staff to run after-school activity sessions in schools and youth clubs.

B4 Ensure that primary schools can afford to offer teachers in-service training in physical activity, or to bring in external specialists to provide an adequate level of physical activity expertise.

Supporting actions – Policies and practices

L B5 Help young children (particularly girls) in nursery education to practise running, jumping, landing, rolling, throwing, catching and bouncing balls. This could be included within the Sure Start and Early Years Development and Childcare Partnership programmes and guidelines on building these skills should be given emphasis in the foundation stage curriculum.

L B6 Schools should develop a participatory approach to physical education, involving children and young people. Such an approach should emphasise the health-related benefits of physical education and recognise self-esteem as a key outcome. Facilities and activities should reflect the needs and preferences of particular groups. For example, young women prefer single-sex activities, in particular dance and aerobics, and value privacy when changing, and wearing loose clothing.

L B7 Establish and promote links between schools and community sports and leisure facilities. This could be a responsibility of school governors.

C Make walking and cycling a healthy means of daily travel for more children and young people.

Supporting actions

L C1 Schools should have a stronger policy focus on promoting walking and cycling among pupils and staff, and a commitment to establishing Safe Routes to School. This should become part of the National Healthy School Standard. Schools should include Safe Routes information in welcome packs to parents of new pupils. The Travel Plan scheme of the Department of Transport, Local Government and the Regions should be extended so that all local authorities have in post a school travel plan coordinator to help schools to develop school travel plans.

C2 Provide extra investment in schools to build secure cycle storage.

C3 Create a target of establishing, by 2006, 1,000 Home Zones with safe, low speed limits and a legal right of way for pedestrians.

L C4 Implement a quiet roads initiative in rural areas, giving priority to cyclists and pedestrians.

L C5 Improve street lighting to reduce the dangers and perceived dangers to pedestrians and cyclists.

L C6 Incorporate walking and cycling initiatives as a priority in regeneration and Neighbourhood Renewal Plans.

Research and development agenda

R1 Undertake a regular national survey of children's activity levels to monitor achievement of the government's pledge of 'one hour a day minimum'.

R2 Monitor the quality of provision of sport, physical education and active play in schools and the community, including after-school clubs and weekend clubs and activities.

R3 Develop a standardised questionnaire for use in physical activity surveys nationwide.

L = local action

A comprehensive strategy for tackling smoking among young people

Around 9% of boys and 12% of girls aged 11-15 in England smoke regularly and around 450 children in the UK start smoking every day.[11] The evidence suggests that people who do not start smoking before the age of 20 are unlikely to take up the habit. The earlier children take up smoking and persist in the habit as adults, the greater the risk of dying prematurely. A broad-ranging strategy is needed that will address all of the contributing factors and motivations that can lead to under-age smoking. Measures are also needed to protect unborn babies and children from the additional health risk from mothers smoking while pregnant and from exposure to passive smoking in the home.

A key focus for an effective strategy must be to counter the influence of tobacco marketing. Unlike most manufacturers, tobacco companies sell a product that kills its consumers. Whatever their sales policies, tobacco companies have a commercial imperative to recruit new smokers to consume their product. The evidence that children smoke the most heavily advertised cigarette brands means that controls on all tobacco advertising and promotions must be central to an effective strategy to reduce smoking in the young.

Anti-smoking interventions and tobacco control measures need to address all age groups – reinforcing rather than redirecting current efforts. To tackle smoking effectively in young people, additional energy and resources need to be directed towards: girls and young women; stopping smoking during pregnancy; and young children (aged 4 to 8 years).

There is increasing evidence of the link between low self-esteem, low control, health-related behaviours and disease. These patterns of behaviour are established early in life and mechanisms need to be implemented for breaking this self-repeating cycle of disadvantage. Initiatives and programmes to support and mentor young people and build self-esteem should be recognised as important ways to help reduce smoking and will reinforce dedicated smoking prevention interventions.

There is evidence that young people who achieve higher educational attainment are less likely to start smoking. Policies for better educational standards will bring many additional benefits in terms of health and well-being.

The goals of a comprehensive strategy must be:

- To discourage young people from smoking. This will need a combination of national sustained anti-smoking campaigns with targeted school- and community-based prevention interventions. The promotion of non-smoking must be complemented by measures to control tobacco promotion and to ensure that price and availability are an effective disincentive to smoking.
- To help young smokers to stop smoking.
- To create smoke-free environments around children and young people.

POLICY ACTION

A **Establish a strong national commitment to anti-smoking campaigns and initiatives with a special emphasis in schools.**

Supporting actions

A1 Investment in national anti-smoking multimedia campaigns must be maintained year on year. A sum equivalent to the proportion of tobacco tax collected from under-age smokers should be invested in the promotion of health for children and young people. This should be over and above statutory provision for the purpose.

A2 Programmes should address all ages and social groups and should reflect the differing values, behaviours and motivations of different cultural sub-groups. Initiatives targeting children and young people should link with and complement adult-focused initiatives. Priority should be given to initiatives that target girls and young women, among whom smoking rates are rising.

L A3 Develop and build on existing school-based smoking prevention interventions. These should begin in all primary schools and continue into secondary schools and be delivered as part of a statutory provision for school health-based policies under the Education Act.

A4 Interventions should be a core element of the Personal, Social and Health Education (PSHE) curriculum and should aim to reinforce anti-smoking attitudes and to equip children to understand and resist the influence of the tobacco industry.

A5 Promote to schools existing web-based health promotion resources that support smoking prevention interventions, such as Wired for Health.[18]

A6 Ban tobacco companies from any involvement in anti-smoking programmes or initiatives. There is no evidence that attempts by the tobacco industry to position cigarettes as a product for 'adults only' contributes to preventing youth smoking. It may even have a negative effect by reinforcing the desirability of cigarettes to young people due to their associations with adult lifestyle and rebellion.

L A7 Community forums could offer training for young people to act as peer educators in schools and in the community on issues relating to health and well-being such as smoking.

B **Protect unborn babies and young children from the harmful effects of parental smoking.**

Supporting actions

B1 Extend the reach of the Sure Start programme (see recommendation 7 on page 19) so that smoking cessation advice and support are available to more pregnant women and mothers of young children.

B2 Ensure that health visitors and midwives receive training in offering smoking cessation support and advice.

Policy action continued overleaf...

L = local action

> Comprehensive national strategies

C Ensure that price and availability are effective disincentives to youth smoking.

Supporting actions

C1 Maintain taxation policies that keep price increases of cigarettes ahead of inflation.

C2 Sustain anti-smuggling measures at national and international levels.

C3 Operate a system of licensing shopkeepers for the sale of tobacco products. The licence should be revoked if the shopkeeper is prosecuted for selling tobacco to under 16s. The threat of a loss of tobacco income will be a greater deterrent to breaking the law than the present system of small fines (an average of £250 under the Children and Young Persons Protection from Tobacco Act 1991) and inadequate (non-statutory) enforcement by local authorities.

C4 Undertake a review to check whether the National Association of Cigarette Machine Operators' voluntary code of practice on the siting of cigarette vending machines is being observed, or whether more binding rules are required.

D Ban the promotion of tobacco products.

Supporting actions

D1 Introduce a ban on tobacco advertising and sponsorship – including indirect advertising – without delay.

D2 Support effective national implementation of EU measures on the manufacture and packaging of tobacco products: to strengthen health warnings, ban misleading labels such as 'mild' and 'light', limit tar yields and declare cigarette ingredients.

D3 All UK nations should contribute towards achieving effective international tobacco controls – in particular to reduce smuggling and tobacco advertising and promotion – by strengthening and supporting the WHO Framework Convention on Tobacco Control.

D4 Support the US campaign to encourage film and music video-makers to reduce the frequency of images of tobacco use in their productions.

D5 Ban the distribution of free cigarettes in bars and nightclubs.

E Help young smokers to stop smoking.

Supporting actions

E1 Make nicotine replacement therapy (NRT) readily available to young people under the age of 16, subject to the findings of the current Cancer Research UK randomised control trial into the effectiveness of NRT in helping under 16s to quit.

L E2 Introduce targeted interventions for older adolescents in all secondary schools, that focus on stopping smoking while reinforcing the prevention message.

F Create smoke-free environments.

Supporting actions

F1 Introduce and enforce no-smoking policies for all teachers, support staff and pupils on school premises and excursions. This should be part of the National Healthy School Standard and should be included within the statutory inspection remit of Her Majesty's Inspectorates for Schools.

F2 Introduce the delayed Approved Code of Practice on passive smoking at work (backed by the Health and Safety Commission) to encourage smoke-free environments where everyone, but especially young people and parents, work and socialise.

L F3 Work with parents in the community, through Sure Start, Health Action Zones and schools, to promote smoke-free homes as a support to adult cessation and to discourage children from starting to smoke. Initiatives could encourage a goal similar to the US Environmental Protection Agency campaign for smokers to smoke outside if they live with small children.

G Recognise the supportive effect of education and welfare policies and initiatives.

Supporting actions

L G1 Out-of-school activities can offer young people an alternative to risky behaviours including smoking and alcohol consumption. Providing schools with resources to staff and run after-school clubs (see recommendation 3.9 on page 16) brings additional benefits for young people's health and well-being.

L G2 Expand the Connexions service to provide national coverage and incorporate a health and well-being element. Ensure that training for Connexions workers is focused and inter-disciplinary, covering areas such as smoking cessation, mental health and behaviour change (see recommendation 8 on page 19).

Research and development agenda

R1 Undertake studies to determine the safety and effectiveness of nicotine replacement therapy (NRT) during pregnancy.

R2 Undertake evaluations of cessation programmes aimed at teenagers, including those trialling NRT.

R3 Learning from experiences in the US, conduct research trials to inform a comprehensive anti-smoking programme that includes targeting young people.

R4 Monitor the effectiveness of legislation and guidance controlling the marketing of tobacco to young people, especially through new technologies such as the Internet and text messages.

R5 Conduct research into the use of menthol cigarettes and whether these are more palatable to young people, and whether they encourage smokers to inhale more deeply.

L = local action

Glossary

Community strategies
Local authorities are required to produce a community strategy for promoting and improving the economic, social and environmental well-being of their communities. Community strategies will reflect local priorities for action arising from the specific needs of the different communities served. Local authorities are expected to ensure the commitment of other organisations (public, voluntary and private) by establishing a community planning partnership, and are expected to engage with the community at an early stage.

Connexions service
Individually tailored support for young people aged 13-19. Running in 16 areas from April 2001. To address priority needs of young people. To provide information, advice and guidance on personal development, learning opportunities and careers.

Early Years Development and Childcare Partnership
Strategic plans developed and implemented by local partnerships to provide good quality, affordable childcare for 3 year olds in disadvantaged areas for every lone parent entering employment and to provide universal education for all 3 year olds. Plans should also include provision of training of young people and sector workers in early years education, childcare and playwork. Currently 150 partnerships are now in operation in England.

Health Action Zones
Established in areas of deprivation and poor health to tackle health inequalities and modernise services through local innovation. They aim to develop and implement a health strategy that cuts inequalities, and delivers within their areas measurable improvements in public health and health outcomes, and in quality of treatment and care. Two strategic objectives are: to identify and address the public health needs of the local area, in particular trail-blazing new ways of tackling health inequalities; and modernising services by increasing their effectiveness, efficiency and responsiveness.

Health Improvement and Modernisation Programmes (HIMP)
The main strategic plan for the NHS and its local partners, requiring an integrated approach to planning for health improvement and healthcare locally. Succeeds the Health Improvement Programme (HImP) with the inclusion of the government's modernisation agenda. Includes tackling health inequalities, responding to local management review outputs, delivery of key NHS Plan priorities and tackling the wider determinants of health.

Home Zones
The aim is to improve quality of life in residential streets by making them places for people, and not just traffic. Home Zones are designed to meet the needs of the local community and can provide areas for children to play and encourage environmental improvements.

Infant Feeding Initiative
Department of Health-funded local projects to encourage breastfeeding. Midwives, health visitors, GPs and other health professionals actively provide mothers with information about breastfeeding. The strategy is targeted at low-income households in an attempt to reduce health inequalities.

Local Strategic Partnerships

To join up action locally. To bring together local authorities and other public services as well as residents and the private, voluntary and community sector organisations. They will identify which neighbourhoods should be prioritised, find the root cause of neighbourhood decline, develop ideas on how organisations and individuals can improve links, and implement agreed actions. This partnership is likely to be the same as the community planning partnership described under *Community strategies* on page 38.

National Healthy School Standard/Healthy Schools Programme

Launched in 1999 as part of the Healthy Schools Programme, the National Healthy School Standard has been designed to complement and enhance Personal, Social and Health Education (PSHE) in schools. The National Healthy School Standard offers support for local programme coordinators and provides an accreditation process for education and health partnerships. The overall aim of this work is to help schools become healthier and assist in the long-term objectives of *Saving Lives: Our healthier nation*,[38] while also addressing health inequalities in line with the Acheson report on *Inequalities in health*.[39]

Neighbourhood Management Programmes/Neighbourhood Renewal Plans/Fund

The aim of the Neighbourhood Renewal Strategy is to 'arrest' the decline of deprived neighbourhoods, to reverse it and to prevent it from recurring. It draws on the work of the 18 Policy Action Teams (PATs) set up by the Social Exclusion Unit to help develop policies to address the needs of deprived neighbourhoods. The strategy focuses on four imperatives: reviving the local economy; reviving and empowering the community; improving key public services, particularly schools, the health services and the police; and leadership and joint working. The Fund to help implement this strategy is worth £800 million over four years.

Neighbourhood management was the subject of one of the PAT reports and is being piloted as a government scheme worth £45 million over three years. The idea is to have a single person, team or organisation as the point of contact for local people, employed either by a Neighbourhood Management partnership or by one of the partners in the Local Strategic Partnership.

Safe Routes to School

A Sustrans initiative supported by the Environmental Action Fund and other charitable trusts. It provides guidance to local authorities, schools and parents on establishing safe routes to school.

Sure Start

A cross-government strategy for children under 4 and their families in areas of disadvantage. Sure Start promotes the health and well-being of pre-school children so that they are primed for a positive start to their school career. It will provide better access to childcare, health, early education and family support. The Department for Education and Skills and the Countryside Agency have been working together to ensure that Sure Start is effective in rural areas. Sure Start will cover a third of all children living in poverty by 2004. Funding will increase to around £500 million.

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About the National Heart Forum

The National Heart Forum (NHF) is an alliance of over 40 national organisations concerned with the prevention of coronary heart disease. Members represent the health services, professional bodies, consumer groups and voluntary organisations.

The mission of the National Heart Forum is to work with and through its members to prevent disability and death from coronary heart disease in the UK. In order to achieve this, the NHF operates nationwide and internationally. It has four main objectives:

1 To provide a forum for members for the exchange of information, ideas and initiatives on coronary heart disease prevention

2 To identify and address areas of consensus and controversy, and gaps in research and policy

3 To develop policy based on evidence and on the views of member organisations

4 To stimulate and promote effective action.

The National Heart Forum embraces professional, scientific and policy opinion in current issues in coronary heart disease prevention. It coordinates action to reduce heart disease through information, education, research, policy development and advocacy.

Other publications by the National Heart Forum

At least five a day: Strategies to increase vegetable and fruit consumption
Coronary heart disease: Are women special?
Coronary heart disease: Estimating the impact of changes in risk factors
Let's get moving: A physical activity handbook for developing local programmes
Looking to the future: Making coronary heart disease an epidemic of the past
Physical activity: An agenda for action
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NATIONAL HEART FORUM

Member organisations

Age Concern England
ASH
ASH Scotland
British Association for Cardiac Rehabilitation
British Association for Nursing in Cardiac Care
British Cardiac Society
British Dietetic Association
British Heart Foundation
British Medical Association
British Nutrition Foundation
CASH (Consensus Action on Salt and Hypertension)
Chartered Institute of Environmental Health
Child Poverty Action Group
Community Practitioners' and Health Visitors' Association
Consumers' Association
CORDA
Coronary Prevention Group
DATA (Design and Technology Associates)
Diabetes UK
Faculty of Public Health Medicine
Family Heart Association
Health Development Agency
Health Promotion Agency for Northern Ireland
King's Fund
National Association of Governors and Managers
National Heart Research Fund
NHS Confederation
Northern Ireland Chest, Heart and Stroke Association
Nuffield Trust
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Royal College of Nursing
Royal College of Paediatrics and Child Health
Royal College of Physicians of Edinburgh
Royal College of Physicians of London
Royal College of Surgeons of England
Royal Institute of Public Health
Royal Pharmaceutical Society of Great Britain
SHARP (Scottish Heart and Arterial disease Risk Prevention)
Society of Cardiothoracic Surgeons of Great Britain and Ireland
Society of Health Education and Health Promotion Specialists
Society of Occupational Medicine
Sport England
Trades Union Congress
UK Public Health Association

Observers

Department of Health
Department of Health, Social Services and Public Safety Northern Ireland
Medical Research Council
The National Assembly for Wales
National Consumer Council
Scottish Consumer Council
The Scottish Executive
Stroke Association

In addition a number of distinguished experts in the field have individual membership.

Every child born in the UK today should be able to live to at least the age of 65 free from avoidable coronary heart disease. This is the goal of YoungHeART – a new approach to coronary heart disease prevention from the National Heart Forum to tackle the causes of the disease from its beginnings in early life.

This document sets out:

- proposals for a national plan for children's and young people's health and well-being, with a particular focus on coronary heart disease prevention, and
- recommendations to develop comprehensive national strategies for improving nutrition, increasing physical activity, and tackling smoking among children and young people.

Taking action now – on diet, physical activity, obesity and smoking – and making children's and young people's health a national priority will help to give young people a healthy start in life, and ensure that the next generation is free from avoidable coronary heart disease.

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