

TOWARDS A FOOD AND HEALTH ACTION PLAN

DISCUSSION PAPER FOR 23 FEBRUARY STAKEHOLDER EVENT

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Health Improvement and Prevention
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1. PURPOSE OF THIS DISCUSSION PAPER

The food we eat, and the way it is produced and manufactured, has a significant impact on our health. Cancer and cardiovascular diseases, including heart disease and stroke, are the major causes of death in England, accounting for almost 60% of all premature deaths between them. Poor nutrition contributes to about a quarter of deaths from cancer. Poor nutrition, along with physical inactivity, and other lifestyle factors, also contributes to the growth of obesity in England. Obesity brings its own health problems, including hypertension, heart disease and diabetes. In total it is thought that treating ill-health caused by poor diet costs the NHS at least £2bn each year.¹

The Department of Health is leading Government, the food industry and other stakeholders in the development of a Food and Health Action Plan (FAHAP) to address healthy eating at every stage of life. Building on existing work, the FAHAP will support and influence:

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

FAHAP will sit within a broader public health context set out in ANNEX A. In scope, it will focus on nutrition but will contribute to wider policy agendas, for example on health inequalities and farming and food. It will not cover food safety, which is covered by the work of the Food Standard Agency. FAHAP will sit alongside related strategies on physical activity, a key life style factor in obesity, and alcohol consumption.

In Summer 2003, Government consulted widely on a “Food and Health Problem Analysis”, identifying dietary trends and their impact on health (see www.doh.gov.uk/fahap for a summary of the responses). We are now focussing on actions to tackle those problems. On 23 February 2004, a wide range of stakeholders will come together at an event to consider such action. Following this event, we will enter into a consultation on a first draft FAHAP.

This discussion paper, prepared by the Department of Health in consultation with other Government Departments and Agencies, is intended to provide background material to support the thinking at the 23 February event.

¹ Source: British Heart Foundation 1998 Coronary heart disease statistics: economic supplement www.heartstats.org

2. AIM OBJECTIVES AND NUTRITIONAL PRIORITIES FOR FAHAP

2.1. Top level aim and objectives for FAHAP

The aim of FAHAP will be to improve public health of the population in England through better nutrition.

Contributing to that broad aim are four objectives:

1. increase access to the wider range of food choices contributing to a healthy diet;
2. improve the availability and awareness of nutritional and dietary information;
3. increase fruit and vegetable consumption to at least “5 A DAY”; and
4. reduce the levels of salt, fat and added sugar and increase fibre in the diet.

2.2. General nutritional priorities – setting a direction for objectives 3 and 4

A broad direction for Objectives 3 (fruit and vegetables) and 4 (salt, fat, added sugar and fibre), above, will be set by five general nutritional priorities for the population. The five nutritional priorities, in the table below, cover the recommendations of the Committee on Medical Aspects of Food and Nutrition Policy (COMA) (for adults and children aged 5 and over) and the Scientific Advisory Committee on Nutrition.

General population priority	Key health impacts	% Contribution by main food sources (see Annex B)
<p>1. Increase average consumption of a variety of fruit and vegetables to at least 5 portions per day</p> <p>TREND: Increased from 2.6 portions in 1986/87 to 2.8 portions in 2000/01</p>	<p>Increasing fruit and vegetable consumption:</p> <ul style="list-style-type: none"> • reduces risk of deaths from cardiovascular disease stroke and some cancers by up to 20% • reduces risk of excessive weight gain • increases vitamin C intake, helping iron absorption and alleviating iron deficiency 	<ul style="list-style-type: none"> • Vegetables 40% • Fruit 36% • Fruit juice 18% • Beans and pulses 7%. <p>Composite foods provide around 3% of total intakes</p>
<p>2. Reduce average intake of salt intakes to 6 grams per day</p> <p>TREND: Increased from 9g/day in 1986/87 to 10g/day in 2000/01(11g for men and 8g for women)</p>	<p>Reducing salt intake:</p> <ul style="list-style-type: none"> • estimated to result in a reduced incidence of hypertension by 17%, CHD by 6% and stroke by 15% 	<ul style="list-style-type: none"> • Cereals and cereal products 35% • Meat and meat products 26% • Vegetables, excluding potatoes 7% • Potatoes and savoury snacks 4% • Fish and fish dishes 4% • Miscellaneous - soups, sauces and condiments 9%

<p>3. Reduce average intake of added sugar (NMES - non-milk extrinsic sugar) to 10% of total energy</p> <p>TREND: Current average intakes 13%, unchanged since 1986/7**</p>	<p>Reducing added sugar intake:</p> <ul style="list-style-type: none"> • reduces risk of dental caries • reduces risk of excessive weight gain • elevate blood glucose and insulin concentrations 	<ul style="list-style-type: none"> • Drinks 37% (of which carbonated soft drinks 12%, beer and lager 9%) • Sugar, preserves and confectionery 32% • Cereal and cereal products 19% <p>Consumption of added sugars particularly high among young adults.</p>
<p>4. Reduce average intake of fat to 35% and saturated fat to 11% of food energy intake</p> <p>TREND: Decreased for total fat from 40% in 1986/87 to 35% in 2000/01</p> <p>TREND: Decreased for saturated fat from 16% in 1986/87 to 13% in 2000/01</p>	<p>Reducing fat intake:</p> <ul style="list-style-type: none"> • reduces risk of excessive weight gain • reduces blood levels of cholesterol and so reduces risk of heart disease • reduces risk of some cancers 	<p>Total fat:</p> <ul style="list-style-type: none"> • Meat and meat products 23% • Cereal and cereal products • Milk and milk products 14% • Fat spreads 12% • Potatoes and savoury snacks 10% <p>Saturated fat:</p> <ul style="list-style-type: none"> • Milk and milk products 24% • Meat and meat products 22%
<p>5. Increase average intake of dietary fibre (NSP - non-starch polysaccharides) to 18 grams per day</p> <p>TREND Increased from 12g/day in 1986/87 to 14g in 2000/1</p>	<p>Increasing fibre intake:</p> <ul style="list-style-type: none"> • reduces risk of bowel disease including cancers • has bulking effect on diet so reducing energy density of the diet • aids management of blood cholesterol 	<ul style="list-style-type: none"> • Cereals and cereal products 42% • Vegetables, excluding potatoes 20% • Potatoes and savoury snacks 16% • Fruit & nuts 10%

* Data from National Diet and Nutrition Surveys (NDNS) for adults aged 19-64 year olds

** definition for assessment changed between the two surveys – therefore some caution is required when assessing trends in intakes between 1986/7 and 2000/1

2.3. Energy intakes

The National Diet and Nutrition Survey (NDNS) for 19-64 year olds (2000/1) found that mean daily energy intakes were 2313 kcals for men and 1632 kcals for women - a decrease of 78 kcals for men 43 kcals for women (around 3%) since 1986/7.

Despite these figures, energy intakes may have increased since the 1980s. The NDNS estimated that energy intakes were underestimated by around 25%. Individuals who are overweight or obese are more likely to misreport their food intake and so, based on trends in obesity, the extent of misreporting is likely to have increased between 1986/7 and 2001.

This conclusion is in line with research that suggests that portion sizes and the consumption of snacks and sugared drinks are increasing. Meals and snacks eaten outside of the home

are also increasing and there is evidence that these may be higher in fat – the National Food Survey shows that almost 40% of calories from foods and drink outside the home is from fat, compared with less than 37% from foods and drinks eaten in.

2.4. Additional analysis

The Food Standards Agency is undertaking a secondary analysis of data from the National Diet and Nutrition Survey, looking at the dietary characteristics of high salt, fat and sugar consumers, which will be used to support continuing discussion with industry and other stakeholders.

2.5. Nutritional priorities along the life course

The general nutritional priorities, set out above, are for the population of England as a whole. Action in FAHAP will also be directed towards the following nutritional priorities along the life course.

Life course priority	Nutrition and health issues	Issues/main food sources (where appropriate)
Expectant mothers <i>Data from NDNS for adults aged 19-64 year olds</i>		
<p>Folic acid</p> <p>Recommended intake is 200 micrograms per day, plus 400 micrograms supplement from before conception until the 12th week of pregnancy.</p>	<p>Folic acid prevents neural tube defects in babies at birth</p>	<p>Women of lower socio-economic status and those with unplanned pregnancies least likely to have adequate dietary intakes or use pre-conceptual supplements.</p> <p>Main dietary sources for women:</p> <ul style="list-style-type: none"> • Cereal and cereal products 33% • Vegetables (excluding potatoes) 17% • Potatoes and savoury snacks 12% • Fruit and nuts 4%
<p>Vitamin D</p> <p>Recommended intake during pregnancy is 10 micrograms per day</p>	<p>Building adequate vitamin D stores in pregnant mothers helps infants avoid deficiency and rickets</p>	<p>Asian women who rarely go out or wear concealing clothes are vulnerable. Low awareness about supplements.</p> <p>Main <i>dietary</i> sources for all women:</p> <ul style="list-style-type: none"> • Fish and fish dishes 30% (of which oily fish 29%) • Cereal and cereal products 22% • Meat and meat products 18% • Fat spreads 15% • Egg and egg dishes 9%

<p>Iron</p> <p>Recommended intake for females age 19-50 is 14.8mg per day.</p>	<p>Iron prevents iron deficiency anaemia</p>	<p>Vulnerable groups include women in social classes IV and V and some ethnic minority groups e.g. women of South Asian descent.</p> <p>Iron from non vegetarian sources (haem iron) better absorbed than from vegetarian sources (non haem iron)</p> <p>Main sources of <i>total</i> iron for all women:</p> <ul style="list-style-type: none"> • Cereal and cereal products 45% (47% of non-haem iron) • Meat and meat products 15% (80% of haem-iron) • Vegetables (excluding potatoes) 11%
<p>Infants Data from Infant Feeding Survey 2000</p>		
<p>Exclusive breastfeeding for six months</p>	<p>Breastfeeding:</p> <ul style="list-style-type: none"> • enhances child's immunity to infections • reduces child's risk of allergies and asthma • helps mothers get back to pre-pregnancy weight • may reduce risk of obesity later in childhood 	<p>Breastfeeding is low, particularly among lower socio-economic groups – 59% of women in social class V breastfeed (national average 71%).</p> <p>Around 50% of mothers introduce solid foods before 16 weeks (should be 26 weeks).</p>
<p>Pre-school children (1 - 4½ years) Data from NDNS for children aged 1.5 years to 4.5 years</p>		
<p>Low intakes of iron and vitamins A, C and D</p>	<p>These nutrients:</p> <ul style="list-style-type: none"> • optimise growth and development • reduce risk of iron deficiency • reduce risk of rickets 	<p>Intakes and awareness of COMA advice on use of vitamin and mineral supplements for children age 6 months to 5 years particularly low in lower income groups and vulnerable groups.</p>
<p>Low intake of fruit and vegetables</p>	<p>Fruit and vegetable consumption:</p> <ul style="list-style-type: none"> • reduces iron deficiency • optimises growth and development 	<p>Low intakes in lower income groups and one-parent families.</p>
<p>Non-milk extrinsic sugar intakes averaged 18.7% of food energy</p>	<p>Reduced sugar intake:</p> <ul style="list-style-type: none"> • improves oral health and reduces risk of dental decay • reduces risk of excessive weight gain 	<p>Main sources for this age group:</p> <ul style="list-style-type: none"> • Soft drinks 29% • Chocolate and sugar confectionery 20% • Biscuits 8% • Breakfast cereals 5% • Table sugar 5%

Children and young people (4 - 18 years) <i>Data from NDNS for young people aged 4-18 year olds</i>		
Saturated fat	<p>Reduced saturated fat intakes:</p> <ul style="list-style-type: none"> • help development of good long-term eating habits • reduces risk of cardiovascular diseases • reduces risk of excessive weight gain 	<p>Main sources for this age group:</p> <ul style="list-style-type: none"> • Milk and milk products 21% • Biscuits, cakes & confectionery 21% • Meat and meat products 18% • Potatoes and savoury snacks 13% • Spreading fats 5%
SACN salt recommendations 2003 vary by age. E.g. average intakes 4-6 yr olds is 5g/day compared to recommended 3g/day	<p>Reduced salt intake:</p> <ul style="list-style-type: none"> • helps development of good long-term eating habits • reduces risk of cardiovascular diseases 	<p>Main sources for this age group:</p> <ul style="list-style-type: none"> • Cereals and cereal products 40% • Meat and meat products 23% • Vegetables and potatoes 9%
Non-milk extrinsic sugar intakes averaged 25% of food energy compared to 30% recommend for 15-18 year olds	<p>Reduced sugar intake:</p> <ul style="list-style-type: none"> • helps development of good long-term eating habits • reduces risk of dental caries • reduces risk of excessive weight gain 	<p>Main sources for this age group:</p> <ul style="list-style-type: none"> • Carbonated soft drinks 16% • Other soft drinks 8% • Chocolate and sugar confectionery 20% • Breakfast cereals 8% • Table sugar 7% • Biscuits 7%
Fruit and vegetables – average intake around 2 portions per day	<p>Increased fruit and vegetable consumption:</p> <ul style="list-style-type: none"> • helps development of good long-term eating habits • improves total dietary intakes 	<p>NDNS 4-18 year olds found that during a week, 1 in 5 had eaten no fruit in a week, and more than a half had eaten no citrus fruit, tomatoes or leafy green vegetables.</p>
Older people (over 65 years) <i>Data from NDNS for people aged 65 years and over</i>		
Vitamin D intakes - 98% in institutions had intakes below 10micrograms per day	<p>Increasing vitamin D intake improves bone health, reducing risk of vertebral, hip and wrist fractures.</p>	<p>People in nursing and residential homes vulnerable with low awareness of need for supplements among vulnerable groups.</p>

2.6. Inequalities issues

Action on nutrition will need to bear in mind inequalities and the diet. The above table touches on some inequalities issues. Here are some further, illustrative, facts, about:

Diet:

- There are wide social class differences in fruit and vegetable consumption. Children and adults in lower social class households consume around 50 per cent less than those in professional households.
- There are significantly lower intakes of protein and non-starch polysaccharides by adults in households receiving benefits, compared to those in non-benefit households. Women from benefit households also have significantly higher % energy from added sugars than those in non-benefit households.
- There are also significantly lower mean daily intakes of vitamins and minerals (with the exception of haem iron (both sexes) and sodium (females) among those from benefit households. Similar patterns are observed in children.
- NDNS shows that households receiving benefits consume:
 - less fruit and vegetables, salads, wholemeal bread and whole grain and high fibre cereals and oily fish; and
 - more full-fat milk, table sugar, processed meat products, often high in fat, such as burgers, kebabs, meat pies and pasties.

Health problems:

- Information from the Health Survey for England 2003 shows that 35% of women and 27% men in social class V (unskilled manual occupations) are obese compared to 16% of men and women in social class 1 (professional occupations). Over 30,000 deaths were attributable to obesity in 1998. Obesity predisposes people to other diseases including type 2 diabetes, heart disease, high blood pressures, some cancers, osteoarthritis and poor mental health.
- The prevalence of high blood pressure varies by income group for women – 30% of women in the highest income group are hypertensive compared to 37% of those in the lowest income group.
- The Health Survey for England 1998 found that raised blood cholesterol varied by social class for men but not women. 19.8% men in social class V (unskilled manual) had raised blood cholesterol, compared to 14.5% of men in social class I (professional).
- There is a relationship between higher rates of dental decay among children and areas of high deprivation (work done in the 1990s using data from the Public Health Common Data set, from dental surveys).

3. INFLUENCING ACTION TOWARDS THE NUTRITIONAL PRIORITIES

The following table sets out some of the broad ways, through production, supply and consumer demand, that we could influence the consumption of fruit and vegetables and the intake of salt, fat, added sugar and fibre in the national diet.

Food Chain - influences	Increasing fruit and vegetable	Reducing salt	Reducing added sugars	Reducing fat (sat)	Increasing fibre
Production					
• Agricultural policies	✓				✓
• Farming/horticultural policies	✓			✓	✓
• Manufacturers/ • Processors	?	✓	✓	✓	?
• Recipe formulation	?	✓	✓	✓	?
• Retailers' own brand	?	✓	✓	✓	?
Supply and Access					
• Catering	✓	✓	✓	✓	✓
• Procurement	✓	✓	✓	✓	?
• Food outlets	✓	✓	✓	✓	?
• Distribution	✓				
• Retailers' policies	✓	✓	✓	✓	✓
Consumer demand					
• Knowledge/skills	✓	✓	✓	✓	✓
• Labelling	✓	✓	✓	✓	✓
• Promotion/marketing	✓	?	?	✓	✓
• Price	✓			✓	✓

4. CURRENT ACTION WITHIN SPECIFIC SETTINGS

The following tables set out current – largely Government – action on nutrition and health, grouping them within specific “settings”.

EARLY YEARS SETTINGS

During pregnancy, good nutrition is essential for both mother and the expected child. It is important that mothers eat an appropriate diet themselves and introduce healthy eating practices to their child, from birth. A good diet, from early on, helps reduce the risk of coronary heart disease, type 2 diabetes, obesity, stroke and some cancers later in life and helps establish healthy lifetime eating patterns.

Early years settings are quite disparate, including SureStart settings (see below), nurseries, playgroups, mother and toddler groups and the home.

Examples of existing action:

Broad programmes:

- “Healthy Start” reform of Welfare Food Scheme during 2004. Proposals include increasing range of welfare foods; providing free milk or fruit to all under 5s, regardless of income; and giving practical advice and support to pregnant women and mothers.(DH)
- SureStart: Local Programmes, Children’s Centres, Early Excellence Centres and Neighbourhood Nurseries and childcare settings offering range of services providing guidance and support to young disadvantaged families on infant feeding, weaning, healthy eating and nutrition. (SureStart Unit)
- National Health Service, in various settings, delivering maternity services and post-natal care. (NHS)

Breastfeeding:

- Promotion of exclusive breastfeeding to 6 months, recognising it gives all the nutrients a baby needs and confers health benefits to mother and child, including a reduced risk of obesity. (DH/NHS)
- NHS Priorities and Planning Framework target to increase breastfeeding initiation by 2% a year between 2003 and 2006, focussing on disadvantaged groups, supported by the CHAI infant feeding indicator. Require maternity services to encourage mothers to initiate breastfeeding before leaving hospital. (NHS)

Food production:

- Children’s ranges of foods low in salt, sugar or fat. (food industry)

Relevant public sector performance management levers:

- Performance management of NHS by Strategic Health Authorities
- Commission for Healthcare and Audit Inspection (CHAI) - standards setting and star ratings

SCHOOLS AND COLLEGES

Schools have a role in shaping the habits and behaviour of attending children and are in a unique position to encourage and facilitate healthy eating. A partnership approach is essential to maximise the impact of this setting in changing dietary habits.

Examples of existing action:

Broad best practice programmes:

- National Healthy Schools Standard promoting a “whole school approach” to health of schoolchildren, teachers and parents. Healthy eating is one theme of the Standard. To meet it, schools must show that the taught curriculum is complemented by informed messages about eating and improved access to foods that can contribute to a balanced diet. (DH/DfES)
- Food in Schools programme to develop best practice for schools in promoting and encouraging healthier eating among children. Eight pilot projects, following the child throughout the school day, are looking at healthier breakfast clubs, tuck shops, vending machines, lunch boxes and cookery clubs, as well as water provision, growing clubs and the dining room environment. Also covers teacher training and professional development, as well as development of guidelines, resources and curriculum materials for teaching food technology. (DH/DfES)
- Identifying good practice in primary schools. Ofsted, with DfES and FSA, are surveying the range and quality of food and nutrition education provided for children in some nursery settings and primary schools in England. This will identify good practice in relation to all aspects of food and nutrition in schools and promote wider benefits to the school of involving food in a child's learning experience. (Ofsted/DfES/FSA)

Teaching skills and knowledge:

- National Curriculum coverage of healthy eating. Children learn about different types of food in the context of a balanced diet, nutrition, safety and hygiene. Opportunities to teach about food, nutrition, healthy eating and cooking are provided within Science; Design and Technology; and Personal, Social and Health Education. (DfES)
- Core competences on diet and nutrition for 14-16 year olds - DfES and FSA have consulted on what 14-16 year olds should know, and be able to do practically, to feed themselves healthily and safely. Subjects covered are: diet and health; consumer awareness; food preparation and handling skills; food hygiene and safety. (FSA/DfES):
- Practical cooking in primary classrooms. (DfES)
- “Growing Schools” - a resource for primary and secondary teachers to help them create growing areas in school grounds. Growing Schools National School Grounds week June 2003 had over 8,000 schools request the resource pack. (DfES)
- “Dish it up” - a CD-rom resource for secondary schools about selecting healthy diets (FSA)

School meals:

- National Nutritional Standards for School Lunches. Since Autumn 2003, DfES/FSA is monitoring schools' compliance with standards, regulations and associated guidance introduced in April 2001. Also considering whether the food on offer at lunchtime and the food chosen by the pupils meet the Expert Working Group's recommendations for nutrient

content of school meals. (DfES)

- Sustainable Procurement. DfES and DEFRA will be encouraging schools, through a forthcoming sustainable food procurement plan, to consider the sustainability of the food and ingredients they procure for their school meals. (DfES/Defra)

Other food provided in schools:

- National School Fruits Scheme, which, as part of the 5 A DAY programme, will entitle every 4 to 6 year old in infant school to a free piece of fruit every school day. Over 1 million children are currently receiving free fruit. The Scheme is being rolled-out across England during 2004. Vegetables are being piloted, as part of an expansion of the scheme. (DH/NOF)
- School Milk Scheme, which encourages schools to make milk available to their children, taking advantage of European Union (EU) subsidised milk. DfES, Defra, and DH are meeting jointly the cost of the £1.5m annual shortfall created when the EU reduced the level of subsidy under the Scheme in 2001. (Defra)

Relevant public sector performance management levers:

- Ofsted
- National Nutritional Standards for school lunches
- Best Value in procurement

NATIONAL HEALTH SERVICE

The NHS (NHS Trusts, Primary Care Trusts and Strategic Health Authorities) is important in promoting better nutrition both as an agent and as a setting.

As an agent, the NHS works with patients, with the public directly and in wider local strategic partnerships. Patients diagnosed as being at high risk of cardiovascular disease, diabetes and some cancers may be particularly receptive to healthy eating messages. All patients can receive primary prevention messages in health care settings e.g. GP surgeries, hospitals and care homes. Working with partners, the NHS can improve access to healthy food as well as the availability of information on healthy eating, especially for target populations.

As a setting for action, the NHS employs and provides occupational health services to over a million staff and serves over 300 million meals a year to staff, patients and visitors. This contributes to people's diets and also sends a message about healthy food that may influence both the individual and, through sustainable procurement, the food chain.

Examples of existing action:

Catering in the NHS:

- Better Hospital Food. This NHS Plan commitment aims to address standards of food in hospital, including nutrition and the contribution of food to the overall patient experience. Sets targets and performance indicators. (NHS/DH)
- NHS Sustainable Food Action Plan (NHS)

Advice and support on nutrition and diet:

- Health professionals' advice on diet, especially to patients on "at risk registers" for

coronary heart disease and diabetes. (DH/NHS)

- Health Development Agency guidance on obesity and overweight. (HDA)

Community initiatives:

- Healthy Living Centres and 5 A DAY community initiatives targeting the most disadvantaged in society. See action within local communities, below. Many of these projects cover diet and nutrition. (DH/NHS/lottery funders)
- Health Action Zones (HAZs), Healthy Communities Collaboratives (HCC). Each of the 26 HAZs, covering 13 million people, is implementing programmes that focus on diet and nutrition, including community cafes, health education and fruit tuckshops and free fruit schemes in schools. Dietary improvement is one of the focuses of HCCs (DH/NHS)

Sharing best practice:

- NHS Beacon Programme, supports the modernisation of the NHS by encouraging “beacons” to share their innovations in meeting specific healthcare needs. There are four beacons that relate to diet and nutrition (DH/NHS)

Relevant public sector performance management levers:

- NHS Priorities and Planning Framework (PPF) for Primary Care Trusts (PCTs) (diet advice to CHD/diabetes risk registers – targeting people with raised blood pressure, BMI over 30)
- Performance management of NHS by Strategic Health Authorities (SHAs)
- Commission for Healthcare and Audit Inspection (CHAI) - standards setting and star rating
- General Medical Service contracts for GPs

Opportunities for performance management through “Shifting the Balance of Power” where Strategic Health Authorities agree Local Delivery Plans for PCTs which need to reflect national priorities (PPF and Public Service Agreement, PSA targets) as well as local needs for health improvement as well as service. Commission for Healthcare Audit and Inspection (CHAI) is a key player in ensuring standards are met and criteria set for star rating the NHS. Opportunity for links with Local Authorities through the Comprehensive Performance Assessment (see below).

FOOD CHAIN

Retailers, producers, manufacturers and food service providers are in an ideal position to influence the food supply and provide options for consumers to make healthy choices. Over 9 out of 10 consumers do most of their shopping at a supermarket. In total, supermarkets supply around 85% of the groceries bought in the UK. Half of the country’s food is now sold from just 1,000 large stores. Eating outside the home is commonplace too:

- 25% of respondents to the 2003 Consumer Attitudes survey said that they regularly used some form of fast food or takeaway outlet.
- Between 1999 and 2000 alone, purchases of convenience foods rose by 24%.
- Food eaten out is higher in fat than food eaten at home (including takeaways). The National Food Survey showed that in 2000 food eaten out provided 11 per cent of energy intake per person but 12 per cent of energy intake from fat.

Examples of existing action

Food production:

- Availability of 'healthier' ranges of foods with reduced levels of fat, salt or added sugar from many retailers and manufacturers:
- Low fat versions of products across numerous product sectors, branded and own brand
- Commitment to programmes to reduce salt and emergence of reduced salt ranges e.g. 'Project Neptune', reducing salt in branded soups and sauces, and work by the industrial bakery sector to reduce salt content

Food supply/access to food

- Free transport provision to supermarkets
- Increase in convenience format stores in city centre locations
- Development of forecourt convenience stores in areas often remote from a major supermarket
- Many have developed a 'responsible' approach to promotion of foods to certain target groups and within certain settings
- Merchandising – some retailers have a policy of not displaying confectionery at the checkout.
- 'Catering for Health' – aimed at catering lecturers and others to improve access to a range of healthier options when eating out.
- British Hospitality Association/British Beer and Pub Association – preparing advice and information for members on salt.

[Food industry activity around consumer education is covered below, in section 5]

LOCAL COMMUNITIES AND LOCAL AUTHORITIES

Local authorities can be important both as an agent and as a setting. As a setting, local authorities may provide meals and an occupational health service to its staff. As with the NHS, this not only makes a contribution to the diets of staff and clients but also sends a message about healthier food that may influence them and, through sustainable procurement, the food chain.

As an agent, a local authority can influence healthy eating and improve access to healthy food, particularly in deprived areas, through its own services and functions, such as planning, housing and transport, and through a leadership role for its community. Its powers are matched by a statutory responsibility to promote well-being, by a Public Service Agreement to reduce health inequalities, , and by funding to address inequalities, for example, the single regeneration budget and neighbourhood renewal funds.

In their leadership role, local authorities are encouraged, as with the NHS, to work with all stakeholders in local communities within Local Strategic Partnerships. Partnerships with the NHS can also be reinforced by a local authority's scrutiny role over Primary Care Trusts (PCTs), and local authority members are often non-executive members of PCT Boards.

Examples of existing action

- Local initiatives to improve access to healthy food especially in disadvantaged areas, for example, under the 5 A DAY programme – there are 66 PCT-led community initiatives, supported with lottery funding, covering over 6 million people. A recent “Dr Foster” survey found that 5 A DAY initiatives were “almost universal” among PCTS. (DH/lottery funders)
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- Healthy Living Centres and 5 A DAY community initiatives targeting the most disadvantaged in society. See action within local communities, below. Many of these projects cover diet and nutrition. (DH/NHS/lottery funders)
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- Improving access to food retailers, for example, by of planning powers and local transport policies. (ODPM/DfT)
- “Food Vision” to help develop and run projects promoting the production of, and access to, safe, sustainable and nutritious food with the aim of improving community health and well-being. (FSA, LGA)
- Allotment regeneration initiative (ODPM/DfES)

Relevant public sector performance management levers:

- Local Authorities Comprehensive Performance Assessment (CPA). How to specify healthy eating objectives is being considered by a Performance Indicators Project Group and in wider work on “refreshing Comprehensive Performance Assessment.” (ODPM)

5. SOME CROSS-CUTTING ISSUES

Several important themes will cut-across the Action Plan:

- reducing health inequalities by addressing the specific needs of disadvantaged groups such as low income households;
- promoting healthy eating at all stages of the life course, such as, children, pregnant women, and older people;
- considering the drivers of food production, food supply and consumer demand that underpin and are common to the different options for action;
- improving communications, generally, recognising that much is also happening within the action in specific settings; and
- effective evaluation and monitoring of the success of action in contributing to the nutritional priorities and ultimately FAHAP aim and objectives.

COMMUNICATING WITH CONSUMERS

Consumers need balanced information to allow them to make healthy choices and easy decisions. Communication will be an important and integral part of the interventions of the FAHAP. Surveys have consistently shown that there is increasing awareness of the need to consume a healthy diet particularly with regard to some aspects such as the advice to cut down on fat, salt and sugar. Despite the high awareness only a small proportion of people consume what is classically known as the healthy diet.

Examples of existing action

Public education and awareness:

- As indicated in the “settings” tables above, many Government nutrition policies contain a public education or awareness element. Different agents, from central departments to individual health experts, are putting across messages in a variety of forms, including leaflets, CD-roms and the internet.

Advertising and promotion:

- Regulation of broadcast food advertising. Office of Communications (OFCOM) is examining the existing code, particularly in light of current work on food promotion and obesity. OFCOM has a programme of work over the next few months, which will include a major data collection study on the extent of food advertising on television, and primary research among parents, teachers, and children to get their views on the impact of food adverts. (OFCOM)
- Advice on promotion to children. This will be discussed by the Food Standards Agency Board at its March meeting, where it is expected the Board will agree a proposal for a number of actions. Following consultation with stakeholders on that proposal, the Agency’s final position will be established in the summer. (FSA)

Food industry sponsorship/support for consumer health education:

- The Food and Drink Federation’s “Foodfitness” campaign, the British Retail Consortium’s “Eat Well Drink Well Publication” and materials for schools provided by numerous companies as Key Stage 1 and 2 resource packs for schools.
- Retailer’s sponsorship of campaigns, for example Tesco “Fit for Life” sponsorship of Breast Cancer Research
- Support of 5 A DAY Campaign to promote increased consumption of fruit and vegetables
- In-store consumer leaflets on numerous subjects relating to healthy lifestyles
- Research sponsorship e.g. British Heart Foundation, Cancer Research UK by Tesco, World Cancer Research Fund by Safeway
- Web sites and consumer magazines - many retailers and food manufacturers include extensive sections on healthy eating and advice on exercise and diet
- Charity and health organisation endorsements - Such endorsements can be helpful in signposting to the consumer foods which might be beneficial to their health. However, it is important that there is transparency about the link between the food company and the charity/organisation. The FSA are currently considering guidance in this area.

Labelling and health claims:

- Guidance on clear labelling – putting information in a format that can be easily identified and read. (FSA)
- Requirements on nutrition labelling. These are currently only required by law on those products that make nutrition claims, but in practice such labelling appears on the majority of pre-packed food. A new European Commission proposal, expected this year, will probably suggest compulsory nutrition labelling on all pre-packed foods. (FSA)
- Nutrition and Health Claims. New European legislation currently under discussion in Brussels will allow a consistent approach to how such claims are made, to avoid confusing or misleading consumers. (FSA)

MONITORING AND EVALUATION

Monitoring and evaluation are essential to provide a sound evidence base for focussed action to improve diet and nutrition. A range of Government surveys provides information about the nation's diet and health and will provide much of the data to monitor FAHAP's progress, though other sectors may provide more opportunities for additional monitoring and evaluation.

- National Diet and Nutrition Survey programme, jointly funded by DH and FSA, provides comprehensive, cross-sectional information on dietary habits, and linked data on markers of nutritional status, for the population of Great Britain, including socio-economic, demographic and lifestyle characteristics. A programme of separate surveys covered different age groups (1.5-4.5 years, 4-18 years, 19-64 years and over 65s). Each survey collected detailed information on food consumption and nutrient intake using a weighed dietary record, provided by participants over 4 or 7 days, physical measurements including height, weight and blood pressure, an assessment of oral health and blood and urine samples
- Expenditure and Food Survey (which replaced the National Food Survey from 2001) is a continuous survey of UK households, commissioned jointly by the Office of National Statistics (ONS) and Defra. It gives information about food purchases and expenditure, food consumption (including that consumed outside the home) and nutrient intakes. Data is collected on a household basis and averaged across members of the household. An implication of this is that analyses such as by food consumption by age are restricted to, for example, household consumption by age of the person designated as household reference person.
- Health Survey for England is a series of annual surveys, commissioned by DH, on the health of people living in England. It provides reliable information about various aspects of people's health, and monitors selected health targets. The survey includes a module to monitor fruit and vegetable intake in the population through a structured questionnaire.

These ongoing surveys are supported by one-off surveys looking at particular groups or characteristics. For example, *ad hoc* diet and nutrition surveys have been carried out in the past looking at the Afro-Caribbean community and at vegetarians. A major survey is currently being undertaken by the FSA looking at food consumption, nutrient intakes and nutritional status and factors affecting these among low income/materially deprived consumers.

ANNEX A - POLICY CONTEXT FOR FAHAP

Consultation on Public Health (announced February 2004) will be a wide ranging debate with the public, media, industry, voluntary group and health professionals about how the nation can best tackle issues like obesity, smoking and sexually transmitted diseases. The consultation will contribute to proposals in a White Paper to be published in Summer 2004.

Strategy for Sustainable Farming and Food (December 2002) is the Government's response to the recommendations of Sir Don Curry and his Policy Commission on Farming and Food. FAHAP is a commitment in that strategy, which identified healthy eating as one of its key principles, with an explicit aim to:

- produce safe, healthy products in response to market demands; and
- ensure that all consumers have access to nutritious food and accurate information about food products.

Our Healthier Nation Saving Lives (1999) set targets for England to reduce in people under 75 years, by 2010, the death rate from cancer by 20%; and the death rate from coronary heart disease and stroke by at least 40%.

NHS Plan (2000) put diet and nutrition at the core of the Government's strategy to reduce deaths from heart disease and cancers by 2004 taking a life course approach, including:

- reform of the welfare food scheme and support for breastfeeding
- the 5-A-DAY programme and National School Fruit Scheme;
- initiatives with the food industry, including manufacturers and caterers, to improve the overall balance of diet including salt, fat and sugar in food

Public Service Agreement (PSA) targets

Department of Health:

- Reduce substantially the mortality rates from the major killer diseases by 2010: from heart disease by at least 10% in people under 75; from cancer by at least 20% in people under 75.
- By 2010 reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth

Food Standards Agency:

- Measurably improve consumer knowledge of and access to a healthy balanced diet compared to baseline set during SR2000.

With Department of Health, effect targeted movement towards a healthy balanced diet.

The Food Standards Agency's Service Delivery Agreement includes an operational target with the aim of with the aim of reducing average salt intake by 10% by 2005/6.

National Service Frameworks (NSFs) for the NHS

- NSF for Coronary Heart Disease requires NHS, working with local authorities, to implement local policies to promote healthy eating and reduce prevalence of overweight and obesity. Also requires targeted interventions in primary care, with advice on diet and weight management.

- NSF for Diabetes will require interventions to address prevention and reduction of prevalence of overweight and obesity in the general population, and in individuals at increased risk of developing type 2 diabetes, by promoting a balanced diet and physical activity.
- NSF for Children will include standards to promote healthy diets and lifestyles.

Tackling Health Inequalities: A Programme for Action (July 2003) sets out the Government's plans for delivering its strategy for narrowing the health gap between the most deprived areas and groups and the rest of the country. It will ensure departments deliver on their commitments from the cross-cutting spending review on inequalities and that local action reflects this. Local Strategic Partnerships (LSP) will be a key vehicle for this.

European Union Council Resolution of 14 December 2000 on health and nutrition emphasised the importance of nutrition as a key determinant of human health, and noted that the state of health of the population can be protected and improved by targeting action on nutrition. Also noted that action on diet and nutrition issues varied across the union, and invited Member States to develop their own national nutritional policies.

WHO draft Global Strategy on diet, physical activity and health (2003) will go to the World Health Assembly in May 2004. The draft recommendations are in line with FAHAP priorities and the Strategy will support FAHAP.

Physical activity – the Prime Minister's Strategy Unit published the "Game Plan" report aimed at increasing participation in sport and other forms of physical activity. The Activity Co-ordination Team (ACT), jointly chaired by ministers from the DH and DCMS, co-ordinates delivery of the Game Plan, towards a target of 70% of the population being moderately active by 2020.

Alcohol - The Government's national alcohol strategy recognises that alcohol is a commonplace part of many people's eating and drinking habits and sets out a comprehensive plan for harm reduction. A reduction in intakes will also help reduce obesity levels since alcohol can contribute significantly to total energy intake.

Food safety is the responsibility of the FSA. Its strategic plan has a number of related aims and targets, including reducing the incidence of food-borne diseases, ensuring that chemicals present in food do not compromise food safety and having safety assessment processes that protect consumers, are robust and are rigorously applied.

ANNEX B – SUMMARY OF THE MAIN FOOD SOURCES OF FAT, SATURATED FAT, SALT, AND NON-MILK EXTRINSIX SUGARS IN THE DIET IN 2000/01 (NDNS 2003)

Table 1 - Sources of sodium (salt) in the diet of adults aged 19 - 64 years (NDNS 2003)

<i>Foods</i>	<i>Proportion (%) contributing to sodium intake</i>
<i>Cereals & cereal products</i>	35
of which	
Pizza	2
White bread	14
Wholemeal bread	3
Soft grain and other bread	4
Breakfast cereals	5
Biscuits, buns, cakes & pastries	4
<i>Meat & meat products</i>	26
of which	
Bacon & ham	8
Beef, veal & dishes	3
Chicken, turkey & dishes including coated	5
Burgers & kebabs	2
Sausages	3
Meat pies & pastries	2
<i>Miscellaneous – includes soups, sauces and condiments</i>	9
<i>Milk and milk products</i>	8
of which	
Cheese	4
Milk	3
<i>Vegetables excluding potatoes</i>	7
<i>Potatoes and savoury snacks</i>	4
of which	
savoury snacks	2
<i>Fish and fish dishes</i>	4

Table 2 - Sources of non-milk extrinsic sugars (added sugars) in the diet of adults aged 19 - 64 years (NDNS 2003)

<i>Foods</i>	<i>Proportion (%) contributing to non-milk sugar intake</i>
<i>Drinks (including soft & alcoholic drinks)</i>	37
of which	
Fruit juice	7
Carbonated soft drinks (not low calorie)	12
Beer & lager	9
Concentrated soft drinks (not low calorie)	2
Ready to drink still soft drinks (not low calorie)	2
alcopops	1
<i>Sugars, preserves and confectionery</i>	32
of which	

Table sugar	19
Preserves & sweet spreads	3
Sugar confectionery	2
Chocolate confectionery	7
Cereals & cereal products	19
of which	
high fibre & whole grain breakfast cereals	3
other breakfast cereals	2
biscuits	5
buns, cakes & pastries	6

Table 3 - Intakes and sources of NMES in children by age group (NDNS 2000)

	Age group				Total
	4-6	7-10	11-14	15-18	
Average intakes					
Males	16.2	17.5	16.9	15.8	16.7
<i>% with intakes above the current recommendation</i>	85	89	88	79	85
Females	17.6	16.7	16.2	15.3	16.4
<i>% with intakes above the current recommendation</i>	88	85	83	78	83
Sources of NMES					
% NMES from Soft drinks	20.4	22.3	25.6	30.1	24.6
of which					
% NMES from carbonated soft drinks	9.9	12.3	18.4	24.3	16.2
% NMES from concentrated drinks	6.1	6.2	4.6	4.2	5.3
% NMES from ready-to drink soft drinks	4.4	3.9	2.5	1.6	3.1
% NMES from chocolate confectionery	10.0	11.3	13.0	12.0	11.6
% NMES from sugar confectionery	10.2	10.4	9.0	3.7	8.4
% NMES from Cakes & pastries	8.7	8.0	7.7	6.4	7.7
% NMES from Biscuits	8.4	8.2	6.5	5.0	7.0
% NMES from Breakfast cereals	8.5	8.4	7.7	5.5	7.6
% NMES from Table sugar & sweeteners	4.9	5.6	7.5	10.6	7.2
% NMES from yoghurt, fromage frais & dairy desserts	5.0	3.7	3.0	2.2	3.4
% NMES from ice-cream	3.2	3.3	2.9	2.0	2.9
% NMES from puddings	3.3	2.9	2.0	1.6	2.4
% NMES from fruit juice	6.6	5.8	6.0	7.2	6.4
% NMES from soups coffee tea etc	2.8	2.6	2.7	4.3	3.1
% NMES from preserves & spreads	3.1	3.0	1.9	2.0	2.5
% NMES from other foods	4.8	4.4	4.5	7.4	5.2

Table 4 - Sources of fat in the diet of adults aged 19 -64 years (NDNS 2003)

<i>Foods</i>	<i>Proportion (%) contributing to total fat intake</i>
<i>Meat & meat products</i>	23
of which	
bacon & ham	2
beef, veal & dishes	3
lamb & dishes	1
pork & dishes	1
coated turkey & chicken	1
chicken, turkey & dishes	4
burgers & kebabs	2
sausages	3
Meat pies & pasties	4
Other	1
<i>Cereals & cereal products</i>	19
of which	
pizza	2
white bread	2
biscuits	3
buns, cakes & pastries	4
<i>Milk and milk products</i>	14
of which	
whole milk	3
semi-skimmed milk	3
cheese (including cottage cheese)	6
<i>Fat spreads</i>	12
of which	
butter	4
margarines	1
Reduced fat spreads (60-80% fat)	5
Low fat spreads (40% fat or less)	1
<i>Potatoes and savoury snacks</i>	10
of which	
Chips	5
Other fried or roast potatoes	1
Savoury snacks	3
<i>Vegetable excluding potatoes</i>	4
<i>Fish and Fish dishes</i>	3

Table 5 - Sources of saturated fat in the diet of adults aged 19 -64 years (NDNS 2003)

<i>Foods</i>	<i>Proportion (%) contributing to saturated fat intake</i>
<i>Milk and milk products</i>	24
of which	
whole milk	4
semi-skimmed milk	5
cheese (including cottage cheese)	10
<i>Meat & meat products</i>	22
of which	
bacon & ham	2
beef, veal & dishes	4

lamb & dishes	1
pork & dishes	1
coated turkey & chicken	1
chicken, turkey & dishes	3
burgers & kebabs	2
sausages	3
Meat pies & pasties	4
Other	1
Cereals & cereal products	18
of which	
pizza	2
white bread	1
biscuits	4
buns, cakes & pastries	4
Fat spreads	11
of which	
butter	6
margarines	1
polyunsaturated reduced fat spreads (60-80% fat)	1
other reduced fat spreads (60-80%)	2
Low fat spreads (40% fat or less)	1
Potatoes and savoury snacks	7
of which	
Chips	3
Other fried or roast potatoes	0
Savoury snacks	3
Chocolate confectionery	5