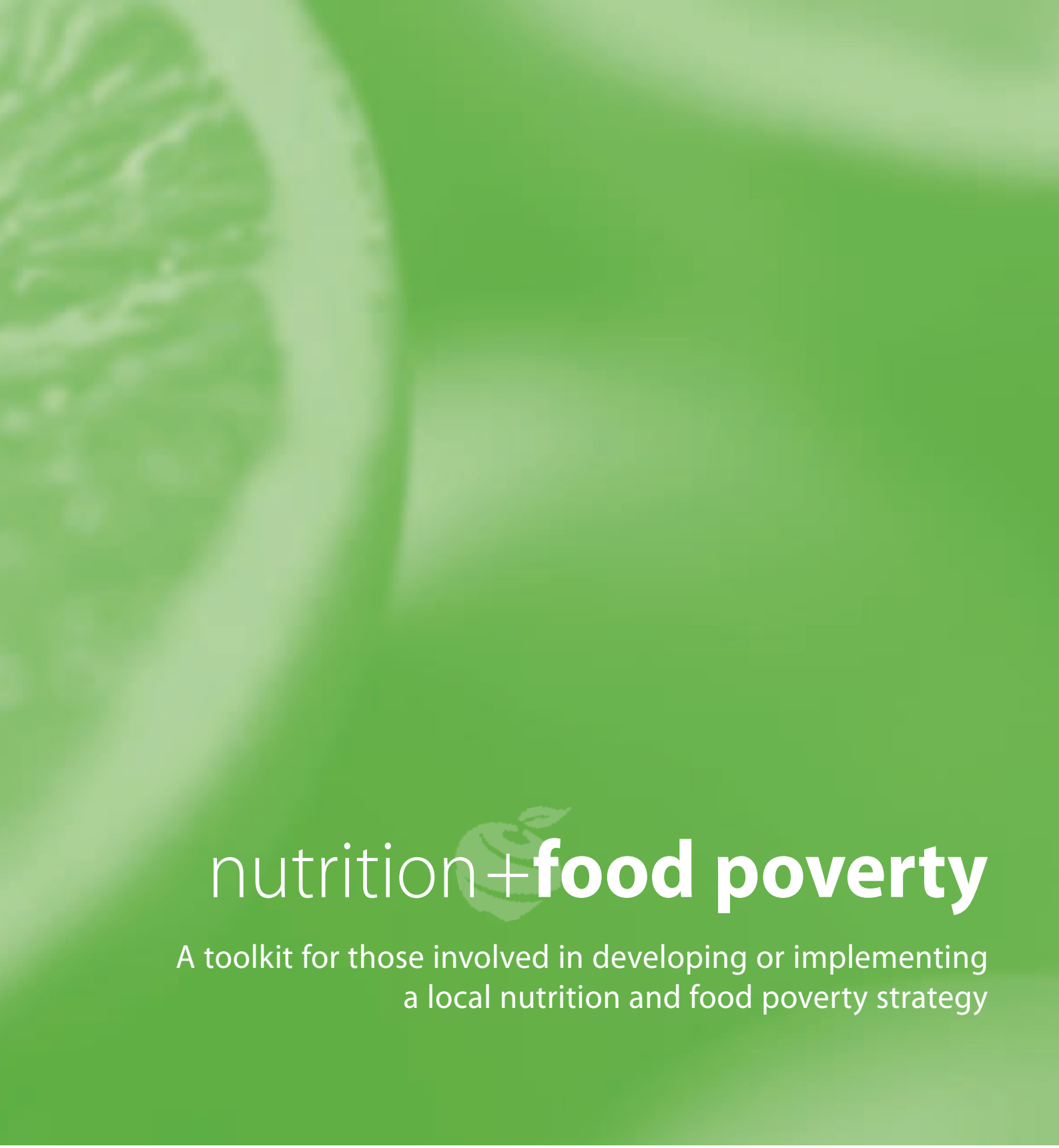

nutrition+**food poverty**

A toolkit for those involved in developing or implementing a local nutrition and food poverty strategy

Written by Dr Vivienne Press
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Produced by the **National Heart Forum**; the **Faculty of Public Health**; the **Public Health Group**, **Government Office for the North West**; the **Public Health Unit**, **Government Office for the West Midlands**; and the **West Midlands Public Health Observatory**

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"It makes little sense to expect individuals to behave differently from their peers; it is more appropriate to seek a general change in behavioural norms and in the circumstances which facilitate their adoption."

Geoffrey Rose, 1982

Foreword

Health professionals have recognised for many years that poor diet is a risk factor for the major UK killers of cancer, coronary heart disease and diabetes. Yet it is only recently that the immense size of that contribution has been quantified: poor diet is related to 30% of life-years lost in early death and disability.[1]

The inequalities in what people eat – depending on their socioeconomic group, where they live in the UK, and their ethnic background – have not been so widely recognised. Nor has the magnitude of the resultant health inequalities. One of the many startling statistics is that diabetes, which is a diet-related disease, is one and a half times more likely to develop in people in the most deprived 20% of the population, compared with the average.[2]

Action to reduce nutrition-related health inequalities has to be much more wide-ranging than health professionals giving advice to individuals. It must change the food environment in which we live. We are surrounded by advertising for fatty, salty and sugary foods, by unclear labelling, by large portion sizes, by cheap 'junk foods' and by expensive fruit and vegetables. In addition, access to affordable healthy foods is made difficult by poor transport and housing, deprived neighbourhoods and limited opportunities to obtain practical cooking skills. Many recent government policies have been clearly directed at tackling these issues. However, there is much more to achieve. Public health professionals need to take the lead in persuading the UK government, the European Union and the food industry that they need to develop policies and practices which will lower the remaining barriers to healthy eating and reduce food poverty.

The production of this toolkit is timely, following the publication in 2003 of the government's programme for action on tackling health inequalities, and anticipating the government's Food and Health Action Plan. It provides clear evidence and information in one place for all those concerned with developing and implementing local nutrition and food poverty strategies and programmes. It will be helpful to those professionals who are working with individuals as well as those who are working in the NHS, in local government or in other local organisations to improve access to healthy, affordable foods.

Professor Siân Griffiths
Faculty of Public Health

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Labels – *Food Standards Agency*
Healthy Eating for Strong Bones – *National Osteoporosis Society*
Eating for Your Heart – *British Heart Foundation*
Your Blood Pressure: Changing Your Lifestyle – *Blood Pressure Association*

These leaflets are included only in the printed version of the toolkit. Some of them are available online on the organisations' websites.

Executive summary

In the UK, the poorer people are, the worse their diet and the more diet-related diseases they suffer from. This toolkit illustrates why it matters what people eat, and outlines the underlying causes of food poverty and what affects food acceptability and choices. It also shows how primary care trusts (PCTs), in association with other local organisations, can develop strategies and programmes to reduce the barriers to healthy eating. Significant improvements in health and a reduction in health inequalities are the prize for PCTs that develop effective programmes to reduce food poverty.

The aim of the toolkit

The aim of this toolkit is to help professionals within primary care trusts and Local Strategic Partnerships (LSPs) to develop strategies and programmes which take a lifecourse and food chain approach, to improve the nutrition of those living in food poverty.

Who the toolkit is for

The toolkit has several target audiences including strategic planners in the NHS and local government, Local Strategic Partnerships, nutritionists, dietitians, health promotion specialists and 5 A DAY coordinators, National Service Framework (NSF) coordinators and leads, primary care professionals, physical activity specialists and community food workers.

How to use the toolkit

The *Nutrition and Food Poverty* toolkit is arranged in six sections. Each one has its own objectives and is aimed at particular audiences. The Tools at the end of the sections give more in-depth information. You can refer to these when you need to for a particular strategy, programme or intervention. The toolkit also contains examples of leaflets and booklets for the public which you can order for your programme.

Section A: What is healthy eating?

This section gives the main healthy eating messages for most individuals, explains the beneficial effects of food on health, and provides practical tips on how people on low incomes can achieve a healthier diet.

Eating healthily – messages for individuals

The main messages for healthy eating for adults and children over 5 years old are:

- Enjoy your food! Healthy eating can be tasty and interesting. The key is to eat a variety of different foods.
- Eat at least 5 portions of a wide variety of fruit and vegetables a day.
- Eat lots of starchy foods. Base your healthy eating on foods such as bread, potatoes, rice and pasta. Eat a variety of foods from this group and go for wholegrain or wholemeal starchy options as they are also high in fibre.
- Eat moderate amounts of meat, fish and alternatives. Aim to eat at least 1 portion a week of oily fish such as sardines, pilchards, salmon or mackerel.
- Eat moderate amounts of milk and dairy foods. Choose low-fat options such as skimmed milk, low-fat yogurt and lower fat cheese where possible.
- Try not to have foods and drinks that are high in sugar too often, and when you do have them have them in small amounts (see *Checking the labels* below).
- Eat small amounts of foods that are high in fat (see *Checking the labels* below).
- Eat small amounts of foods that are high in salt (see *Checking the labels* below).
- If you drink alcohol, drink within the sensible limits.

See Tool A1 *Research evidence of the benefits of healthy eating.* This summarises the evidence underpinning the healthy eating messages.

See Tool A2 *The Balance of Good Health.* The Balance of Good Health summarises the basic principles of healthy eating. Tool A2 is a short version of this, for use by health professionals.

Managing weight

Body weight is determined by the balance between energy consumed from food and drink (calories) and energy used up through maintaining the body's functions and physical activity.

The Body Mass Index provides an indication of whether a person is the right weight for their height. It is calculated by dividing a person's weight in kilos by their height in metres squared, using the units kg/m^2. As a guide, adults should aim to maintain a Body Mass Index of between 20 and 25. The ideal BMI for children varies with age and sex. Height/weight charts also allow people to check what their ideal weight is.

See Tool A8 *Height/weight chart for adults.*

See Tool A9 *Children's BMI charts.*

Checking the labels

You cannot tell what pre-prepared foods contain unless you check their labels. Table 1 below is a quick guide to reading food labels in order to choose healthier options.

Table 1 Checking food labels

	A lot: These amounts or more	**A little:** These amounts or less
Sugars	10g	2g
Fat	20g	3g
Saturated fat	5g	1g
Sodium	0.5g	0.1g
Salt	1.3g	0.3g

The figures are for a single serving of a food. With foods that are eaten in small amounts check the 'per 100g' amount given on the label.
Adapted and reproduced with permission of the Food Standards Agency.

Guideline Daily Amounts

Guideline Daily Amounts outline the target dietary intake levels for key nutrients, for the average-sized man and woman with an average level of physical activity (see Table 2). They are based on the government's nutrient-based recommendations for the population (see Tool C4). Although there are no population-based recommendations for energy, the average man is estimated to require 2500Kcal per day and the average woman 2000Kcal per day. Guideline Daily Amounts are provided on food labels by some retailers and manufacturers in the UK to help consumers understand the information in the context of the recommended diet.[1]

Table 2 Guideline Daily Amounts for men and women in the UK

	Men	Women
Fat	95g	70g
Saturates	30g	20g
Sodium	2.5g	2g
Fibre	20g	16g
Sugar	70g	50g

Source: See reference 1.

Why and how to eat healthily

This section summarises how foods in the different food groups affect health, and provides comprehensive lists of practical tips on how people on low incomes can choose and prepare healthier options from each group. The food groups covered include:

- Bread, other cereals and potatoes (starchy foods)
- Fruit and vegetables
- Meat, fish and alternatives
- Milk and dairy products
- Foods containing sugar, fat and salt.

Other minerals and vitamins and dietary supplements

Most people eating a variety of foods and a good balance of food types will not need to take mineral and vitamin supplements. Among those who may need supplements are women who are planning to be pregnant, or who are pregnant. They may need extra folic acid. Some teenage girls and young women may benefit from calcium and iron supplements, and older people may need extra iron, calcium and vitamin D. Certain black and ethnic minority groups who follow the tradition of wearing clothes that cover up most of the body may be at risk of vitamin D deficiency, due to lack of exposure to the sun.

Alcohol

Alcohol can add enjoyment to life, but only if it is drunk in moderation. Long-term, moderate consumption of alcohol can lower the risk of coronary heart disease and stroke. However, excessive alcohol consumption is associated with crime and accidents in the short term, and over long periods it can lead to conditions such as liver cirrhosis and some cancers.[2] The recommended daily benchmarks for sensible alcohol intake are a maximum of between 3 and 4 units a day for men, and between 2 and 3 units a day for women. In Britain, 38% of men and 24% of women exceed these limits every week. Among young people aged 19-24, 54% of men and 50% of women exceed these limits every week.[3]

A list of practical tips for sensible drinking is given on page 33.

Table 3 Number of units of alcohol found in common drinks

Drink	Number of units
Half a pint of standard strength beer, lager, or cider	1
One small glass of wine	1
Alcopops	1.5
One standard measure of spirits	1

Undernutrition

Although the main dietary problems in the UK are caused by overnutrition, there are still some groups of people who are at risk of undernutrition. The risk factors for undernutrition include:

- severe physical illness
- times before, during and after admission to hospital
- physical difficulty in eating
- vulnerable psychosocial situations
- psychological illness.

Tool A10 *Assessing undernutrition* provides information on the groups of people vulnerable to undernutrition.

Tool A11 *Malnutrition Universal Screening Tool (MUST tool).* This is a screening tool to identify adults who are malnourished, at risk of malnourishment or obese. It can be used in hospitals, community and other care settings and can be used by all care workers.

Section B: Why consider what people eat?

Modern malnutrition and obesity

Levels of overweight and obesity are high and rising in the UK, due to excessive energy intakes compared with energy spent. Eleven per cent of nine year olds are obese, while over 59% of all adult women and 68% of all adult men are overweight or obese.[4] The combination of obesity and a diet dominated by sweet, salty and fatty foods with too little fruit and vegetables and fibre is known as modern malnutrition.

Poor nutrition is a major health risk

Poor nutrition contributes to at least 30% of coronary heart disease deaths and 33% of all cancer deaths.[5, 6]

The wider effects of poor nutrition

Poor nutrition may have wider effects. For example, it has been linked to behavioural problems and a lack of concentration in children at school.[7, 8]

Inequalities in diet-related diseases

There are considerable inequalities in diet-related diseases in England. For example, socioeconomic differences account for nearly 6,000 premature deaths from cardiovascular diseases a year in men under 65 years.[9] This trend is seen in people on lower incomes across all age groups.

There are also significant geographical differences in diet-related diseases across the UK. Finding out what these are is an essential first step in developing a local nutrition and food poverty strategy.

Inequalities in what people eat

The term 'food poverty' has been applied to people who are unable to choose, buy, prepare and eat an adequate quantity of good-quality foods in keeping with social norms. Those most likely to be in food poverty are older people, people with disabilities, households with dependent children or someone who is unemployed, and members of black and minority ethnic groups.

Section C: Why prioritise strategies for nutrition and food poverty?

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

Developing a local nutrition and food poverty strategy:

- will help tackle national and local priorities and targets for PCT and local government plans
- can be an excellent basis for a health equity audit
- can form an excellent basis for working in local partnerships, and
- can provide a good basis for a health scrutiny report.

The government's health agenda related to food poverty

The most important government priorities related to food poverty are health inequalities and the priority health areas. Reducing health inequalities is a national priority for both the NHS and local government. They share the same Public Service Agreement target of reducing inequalities in health outcomes by 10% by 2010.

Nutrition and food poverty are central to the government's priority health areas of cancer, coronary heart disease, older people, and improving life chances for children.

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

Socioeconomic and environmental circumstances (the wider determinants of health) play an important role in health inequalities. The policies, PSAs and programmes of several government departments such as the Home Office and Department for Work and Pensions, support action around the wider determinants of health. These are outlined in Table 11 on page 74, and described in Tool C2.

Local authorities can also develop Local Public Service Agreements to reflect local and national priorities.

The Common Agricultural Policy and food poverty

The government is seeking reform of the Common Agricultural Policy away from subsidies for production towards a food supply chain which meets consumers' requirements and delivers more customer-focused, competitive and sustainable food and farming.

The economic benefits of improving diets

Treating diet-related ill health costs the NHS an estimated £2 billion each year. However, this grossly underestimates the total cost to the economy from production losses through illness and informal carers.[10]

Section D: Developing a local nutrition and food poverty strategy

The first stages of developing a local nutrition and food poverty strategy involve reviewing the health benefits of action on reducing food poverty and establishing food poverty as a priority issue. These stages are covered in the earlier sections of this toolkit.

This section gives further background information to help develop and write a local nutrition and food poverty strategy. The following issues need to be considered when developing a local strategy:

- Recognising the underlying barriers to healthy eating
- Identifying target groups and communities
- Identifying the community's views on needs, barriers and opportunities
- Choosing a theoretical model to underpin the strategy
- Choosing local interventions
- Working in partnership
- Deciding on aims and objectives
- Developing targets and indicators
- Evaluation
- Dissemination
- Sources of funding
- Promotional plan
- Education and training on nutritional issues for professionals involved in the project
- Project management
- Risk management

Section E: Choosing interventions to reduce food poverty

This section looks at those barriers to healthy eating for which actions can be organised and delivered locally. For interventions to be effective they need to tackle a range of barriers and be supported by coordination between local planning authorities, health authorities and other key players.[11]

This section also outlines the different settings for local food programmes and underlying principles for success. Examples of good practice are provided for programmes and for individual project components of programmes in the different settings.

Settings for local food programmes

The community

Community projects can have an effect on eating habits and can improve skills and confidence in purchasing and preparing food. However, assessment of the success of food projects should include their wider effect on regeneration and social capital.

Schools
There are several types of school food projects that can be effective in improving diets, but to maximise their effectiveness they need to be part of a whole-school approach.

Workplaces
Workplaces offer opportunities to promote healthier lifestyles – including healthy eating – as they have a stable population, a constant environment and opportunities for peer support or competition. Workplace nutrition interventions are generally aimed at weight loss, healthy eating and healthy catering.

Primary care
Nurse-led lifestyle modification programmes can result in modest changes in risk factors. It is suggested that the most appropriate role for GPs is to give their endorsement to the importance of nutrition both to patients and to other members of the primary care team. Lay 'food health advisors' who are trained to work with primary care teams can help to increase the coverage of community initiatives and act as a link between formal health services and the community.

Individual components of local food programmes

Examples of individual components of local food programmes are provided for projects in the school and community settings, along with details of sources of further guidance.

Projects in the school setting
Examples include school food policies, breakfast clubs, school lunches, school cooking clubs and healthy snacks.

Projects in the community setting
Examples include information projects, transport to supermarkets, community cafés, cooking clubs, locally grown food projects, community shops, community food co-operatives, food redistribution, and services for older people.

Local communities and PCTs may also be interested in joining campaigns to tackle areas which have not yet been adequately addressed by government policies, such as food advertising on children's TV and reform of the Common Agricultural Policy (CAP) to support healthy diets.

Section F: Resources

This section gives details of useful publications, organisations and websites.

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Introduction

The aim of the toolkit

The aim of the *Nutrition and Food Poverty* toolkit is to help professionals within primary care trusts (PCTs) and Local Strategic Partnerships (LSPs) to develop strategies and programmes to improve the nutrition of those living in food poverty. Taking a lifecourse and food chain approach, these strategies will increase people's control over what they eat by:

- offering help to individuals to improve understanding about what a healthy diet is
- emphasising the *benefits* of a healthy diet
- supporting individuals and communities to change to a more healthy diet through local programmes which address local barriers to change, and
- ensuring that these local nutrition and food poverty strategies include local implementation of the many relevant national strategies, including strategies in health, social welfare, food and farming, retailing, sustainable development, regeneration, transport and education.

Who the toolkit is for

The toolkit has several target audiences and the box below shows how the toolkit can help each one.

Target audience	How the toolkit can help
Strategic planners in the NHS Including: • **directors of public health in strategic health authorities and primary care trusts (PCTs)** • **board members of primary care trusts** • **health promotion specialists** • **dietitians**	To help strategic planners to include practical action on tackling food poverty within their Local Delivery Plans and PCT plans, addressing health improvement and reducing health inequalities.
Strategic planners in local government	To inform the development of community strategies, local neighbourhood renewal strategies and Local Public Service Agreements so that they will target issues related to food poverty and so reduce inequalities in health and well-being.

Continued on next page

Local Strategic Partnerships	To help those working on food-related issues in health, education, social services and environmental services to understand each other's agendas, increasing the success and sustainability of strategies which impact on food poverty.
Registered public health nutritionists **Dietitians** **Health promotion specialists** **5 A DAY coordinators** **Community food workers**	To help these professionals to make the case for action on addressing food inequalities as well as changing diets and behaviour, particularly when addressing colleagues in primary care and in Local Strategic Partnerships.
National Service Framework (NSF) coordinators and leads	To contribute to the delivery of the National Service Frameworks for coronary heart disease, older people and diabetes, the *NHS Cancer Plan*, and the National Service Framework for children.
Primary care professionals	To inform primary care professionals about the damaging effects of poor diets and about positive messages for patients about healthier diets.
Physical activity specialists	To help in the management of clients who are overweight or obese, and to prevent overweight and obesity in clients.

How to use the toolkit

The Nutrition and Food Poverty toolkit is arranged in six sections. They are not meant to be read in one sitting! Each one has its own objectives and is aimed at particular audiences. The Tools at the end of the sections give more in-depth information. You can refer to these when you need to for a particular strategy, programme or intervention. The toolkit also contains examples of leaflets and booklets for the public which you can order for your programme. Some are available free of charge. The six sections are:

Section A: What is healthy eating?

This section gives the main healthy eating messages for most individuals, explains the beneficial effects of food on health, and provides practical tips on how people on low incomes can achieve a healthier diet.

This section can be used by a range of health professionals, including primary care professionals to help in consultations, and by physical activity specialists to help in the management of clients who are overweight or obese.

Section B: Why consider what people eat?

This section shows the importance of poor diets in the development of avoidable chronic diseases, and in health inequalities.

This section can be used by public health professionals, registered public health nutritionists, dietitians, community food workers and other professionals as background information on which to base strategies on nutrition and food poverty, or for making the case for action to colleagues in primary care.

Section C: Why prioritise strategies for nutrition and food poverty?

This section shows how nutrition and food poverty strategies can help to achieve local targets and how they are central to the government's health agenda. It also shows how such strategies give benefit to and receive support from the government's environment, social and education policies and programmes, and outlines the effects of the Common Agricultural Policy.
This section will help professionals to establish food poverty as a priority issue.

Section D: Developing a local nutrition and food poverty strategy

This section gives background information to help you develop and write a local nutrition and food poverty strategy. It covers a range of issues which need to be considered when developing a strategy, including information on the barriers to healthy eating. It also gives an outline of a local strategy. The first section – *Recognising the underlying barriers to healthy eating* – will also be useful for health and physical activity professionals.

Section E: Choosing interventions to reduce food poverty

This section describes the types of settings for local food programmes, and the range of local projects that can be successful in tackling food poverty and the barriers to healthy eating. It includes several examples of good practice.

Section F: Resources

This section lists sources of further information – publications, organisations and websites – on the scientific basis of healthy eating and on developing strategies to improve nutrition and alleviate food poverty.

What is healthy eating?

A

This section gives the main healthy eating messages for most individuals, explains the beneficial effects of food on health, and provides practical tips on how people on low incomes can achieve a healthier diet. This information can be used by a range of health professionals, including primary care professionals to help in consultations, and by physical activity specialists to help in the management of clients who are overweight or obese. Please note that some individuals have additional nutritional needs, such as people with certain illnesses, the very elderly, and children aged under 5. If there are any concerns, a GP, dietitian or practice nurse should be consulted.

Most people can improve their health by achieving long-term changes in the balance of foods that they eat, to ensure that starchy carbohydrates (cereals, bread and potatoes) and fruit and vegetables make up the main part of most meals and snacks.

Eating healthily – messages for individuals

The main messages for healthy eating for adults and children over the age of 5 years are:

- Enjoy your food! Healthy eating can be tasty and interesting. The key is to eat a variety of different foods.
- Eat at least 5 portions of a wide variety of fruits and vegetables a day.

See Tool A3 *What is a portion of fruit and vegetables?*

- Eat lots of starchy foods. Base your healthy eating on foods such as bread, potatoes, rice and pasta. Eat a variety of foods from this group.
- Increase the amount of fibre you eat by choosing wholegrain or wholemeal starchy foods and increasing your fruit and vegetable intake.
- Eat moderate amounts of meat, fish and alternatives. Choose the leanest meat you can afford and choose lower fat products when you can. Aim to eat at least 1 portion a week of oily fish such as sardines, pilchards, salmon or mackerel.
- Eat moderate amounts of milk and dairy foods. Choose low-fat options such as skimmed milk, low-fat yogurt and lower fat cheese where possible.
- Try not to have foods and drinks that are high in sugar too often and when you do have them, have them in small amounts. Choose reduced-sugar or diet options where possible.
- Eat small amounts of foods that are high in fat. Choose low-fat options where possible.
- Eat small amounts of foods that are high in salt. Avoid adding salt during cooking and before tasting. Use herbs and spices as an alternative seasoning.
- If you drink alcohol, drink within the sensible limits.

The basic principles of healthy eating are summarised in *The Balance of Good Health*. This translates the government's nutrient-based dietary recommendations for healthy eating into food-based guidelines. The government's nutrient-based recommendations (outlined in Tool C4 of Section C) are geared to the population as a whole. The food-based *Balance of Good Health* is targeted at individuals and aims to help people adapt to healthier eating.

The *Balance of Good Health* identifies five main food groups and provides a guide to the proportions of food from each group that needs to be consumed on a regular basis to form a healthy diet. The five main food groups are:

- Bread, other cereals and potatoes
- Fruit and vegetables
- Milk and dairy foods
- Meat, fish and alternatives
- Foods containing fat, and foods and drinks containing sugar.

Eating a variety of foods from each of the food groups, in the proportions indicated in the *Balance of Good Health*, will enable individuals to achieve the recommended nutrient intake levels outlined in the population dietary recommendations. The *Balance of Good Health* applies to most of the population, except for those with special dietary needs including children under 5 and those on therapeutic diets for medical reasons.

See Tool A1 *Research evidence of the benefits of healthy eating,* for details of the main research findings behind the healthy eating messages.

See Tool A2 *The Balance of Good Health*. The *Balance of Good Health* summarises the basic principles of healthy eating. Tool A2 is a short version of this, for use by health professionals. Copies of the full version can be obtained from the Food Standards Agency (address on page 159).

Managing weight

Body weight is determined by the balance between energy consumed from food and drink (calories) and energy used up through maintaining the body's functions and physical activity. Individuals vary in the amount of food they need to eat, but regardless of the amount they need, the proportions of food from the five food groups will be the same.

Everyone should try to maintain a healthy body weight. The Body Mass Index (BMI) provides an indication of whether a person is the right weight for their height. It is calculated by dividing a person's weight in kilos by their height in metres squared, using the units kg/m^2. As a guide, adults should aim to maintain a BMI of between 20 and 25 and not increase this during adult life. Height/weight charts allow people to see if they are overweight and also what their ideal weight is. However, for people who are obese, losing even 10kg will greatly improve their health.[1] (See Section B.)

See Tool A8 *Height/weight chart for adults.*

As children are growing, the normal range of BMI varies with age and sex. International cut-off points for BMI for overweight and obesity have been developed for children between the ages of 2 and 18 years. These children's cut-off points have been developed by sex, and are linked to the corresponding adult cut-off points for overweight ($25kg/m^2$) and obesity ($30kg/m^2$).[2] Children's weight can also be assessed by using new height/weight charts.

See Tool A9 *Children's BMI charts.*

Body shape is also important for good health. People who put on weight around their abdomen, so that their stomach girth is larger than their hips, are at higher risk of developing diabetes and heart disease. This is known as central obesity. As a guide, adult men should maintain a waist measurement of under 37 inches (94cm) and adult women a waist measurement of under 32 inches (80cm).[3] (To measure waist circumference, place a tape measure around the abdomen at the mid-point between the last rib and the hip. The tape should be snug but should not compress the skin. It should also be parallel to the floor. Take the measurement at the end of a normal expiration.)

This toolkit does not concentrate on weight loss. However, there are many programmes and

publications on weight loss, including *Tackling Obesity: A Toolbox for Local Partnership Action*, which is available from the Faculty of Public Health.[4] For details of other publications and programmes on weight loss, see Section F *Resources*.

Checking the labels

You cannot tell what pre-prepared foods contain unless you check their labels. These always have a list of their ingredients, which are listed in descending order of amount. They may also have a summary of their nutritional content in terms of fat, salt (sodium) and sugar. Sugars are a type of carbohydrate, so they will be listed as *Carbohydrates (of which sugars)* on food labels.

Ready meals and pre-prepared foods often have high levels of hidden salt (sodium) and fat in them. Salt content may be expressed as 'salt' or 'sodium'. As a rough guide the amount of salt is roughly two and a half times the sodium value. Table 4 gives a quick guide to reading food labels in order to choose healthier options.

Table 4 Checking food labels

	A lot: These amounts or more	**A little:** These amounts or less
Sugars	10g	2g
Fat	20g	3g
Saturated fat	5g	1g
Sodium	0.5g	0.1g
Salt	1.3g	0.3g

The figures are for a single serving of a food. Where foods are eaten in small amounts, check the 'per 100g' amount given on the label.
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Guideline Daily Amounts

Guideline Daily Amounts outline the target dietary intake levels for key nutrients, for the average-sized man and woman with an average level of physical activity. They are based on the government's nutrient-based recommendations for the population (see Tool C4), and cover fat, saturates, sodium, fibre and sugar. Although there are no population-based recommendations for energy, approximate values are often listed on labels: the average man is estimated to need 2,500Kcal per day and the average woman 2,000Kcal per day. Guideline Daily Amounts are provided on food labels by some retailers and manufacturers in the UK to help consumers understand the information in the context of the recommended diet.[5]

Table 5 Guideline Daily Amounts for men and women in the UK

	Men	**Women**
Fat	95g	70g
Saturates	30g	20g
Sodium	2.5g	2g
Fibre	20g	16g
Sugar	70g	50g

Source: See reference 5.

Why and how to eat healthily

Some of the key problems people on low incomes face when it comes to healthy eating include the prohibitive cost of certain foods, poor variety and availability of healthier options at their local food stores, and lack of opportunities to experiment and develop cooking skills. These and other barriers to healthy eating are covered in detail in Section D *Developing a local nutrition and food poverty strategy*. Below is a summary of how different foods affect health, and practical tips on how people on low incomes can achieve a healthier diet.

It is not necessary to achieve the recommended balance of foods at every meal. It would be good to aim to achieve it every day, but it would also be acceptable to achieve it over a period of a week or two.

See the leaflets and booklets in the pocket at the end of this toolkit. These are examples of publications, targeted at different population groups, which explain the main messages for healthy eating in terms that can be easily understood.

Starchy foods are good for your health!

Eat lots of starchy foods (carbohydrates). They include cereals such as breakfast cereals, bread, pasta, rice, noodles, maize and millet. Potatoes, yam and plantain are also included in this food group, as are beans and pulses.

Starchy foods provide energy, and should form the main source of energy in the diet. As they are derived from complex plant structures, starchy foods also provide fibre (see below), some calcium, iron and B vitamins. Diets that are high in starchy foods tend to be filling and are digested more slowly, helping to reduce the urge to snack between meals. They may also be lower in fat.

Fibre

Brown, wholegrain and wholemeal varieties of cereals, as well as beans, pulses, fruit and vegetables, are all good sources of dietary fibre (non-starch polysaccharide, or NSP). A diet high in soluble fibre (found in pulses and in some fruit and vegetables) can also help in the control of blood cholesterol, reducing the risk of developing cardiovascular disease. Fibre also reduces colon/bowel cancer and pancreatic cancer risk. It leads to faster throughput of food in the intestines and increased stool weight, decreasing the risk of constipation.

Practical tips

- Where possible, go for wholemeal or wholegrain bread, pasta and cereals, to increase your fibre intake.
- Choosing beans and pulses adds variety and fibre to the diet and they can be used to make more expensive ingredients such as meat and poultry go further.
- Avoid having fried starchy foods too often – such as chips. Where possible go for alternatives such as baked potatoes or oven chips.
- Avoid adding too much fat to starchy foods – for example, adding butter to potatoes, or having thickly spread butter or margarine on bread.
- Avoid adding rich sauces and dressings – such as cream or cheese sauce on pasta.
- When increasing fibre in the diet, increase your fluid intake – by drinking plenty of water – to avoid getting constipation.

See Tool A4 *Sources of dietary fibre.*

Fruit and vegetables are good for your health!

Healthy eating involves eating lots of fruit and vegetables. The recommendation is to eat at least 5 portions of a variety of fruit and vegetables a day. Fruit and vegetables contain several substances – including vitamin C, carotenes, folates, fibre, and some carbohydrate – which are known to be good for health. It is important to eat a variety of fruit and vegetables as part of a healthy diet because different fruits and vegetables are rich in different nutrients. For example, *citrus fruits* such as oranges, tangerines and grapefruits are rich sources of vitamin C; *dark green vegetables* such as kale, broccoli, Brussels sprouts and green beans are rich sources of folates; and *orange and yellow fruit and vegetables* such as carrots, squash, and peaches are good sources of carotenes.

Practical tips to reach at least 5 portions of fruit and vegetables a day

- One portion of fruit is, for example, one apple or 2 small satsumas or half a large grapefruit. One portion of vegetables is, for example, 3 heaped tablespoonfuls of cooked carrots or peas or sweetcorn.
- Beans and pulses count but only once each day.
- Potatoes do not count as they belong to the starchy food group.
- 100% or pure fruit juice counts, but only for 1 portion each day.
- Less expensive varieties such as frozen and canned fruit and vegetables all count.
- Seasonal fruit and vegetables can be less expensive to buy.
- Fruit and vegetables in convenience foods such as ready meals, pasta sauces, soups and puddings can contribute towards 5 portions a day. But convenience foods can also be high in salt, sugar and fat – which should be eaten in moderation. It is always important to check the labels.
- Some food packets may feature the 5 A DAY logo. This means that a typical serving of the product contains at least 1 portion of fruit or vegetables. For further information see the 5 A DAY booklet *Just Eat More (Fruit and Veg)*, in the pocket at the end of this toolkit.

Tips for children

- Children can eat smaller portions than adult-sized ones.
- Bite-sized portions of fruit and vegetables are perfect for children. And they make great party foods.
- The natural sweetness in sweetcorn, strawberries, grapes and cherry tomatoes makes these popular with children.
- Try blending cooked vegetables into casseroles, soups and sauces, or giving them raw.
- Liven up lunchboxes with brightly coloured fruit or vegetables such as carrots.
- Add fruit to jelly.
- Treat your children to bite-sized fruits such as strawberries and grapes instead of sweets.

See Tool A3 *What is a portion of fruit and vegetables?*
See the booklet *Just Eat More (Fruit and Veg).* A copy is included with this toolkit. The booklet is also available from www.dh.gov.uk

Preparing fruit and vegetables in a healthy way

When preparing vegetables avoid adding extra fat, salt or rich sauces. For example, avoid glazing carrots with butter. When preparing fruit, avoid adding sugar or a rich dressing. Drain sugary syrups from tinned fruit before serving.

Meat, fish and alternatives

Eat moderate amounts of meat, fish and alternatives such as eggs, beans, pulses and nuts as part of a healthy diet. These are good sources of protein, iron and B vitamins – especially vitamin B_{12}, zinc and magnesium.

Meat

Meat is a good source of protein, vitamin B_{12}, zinc, magnesium and easily absorbed iron. Foods in this group include red meat, chicken, pork, offal such as liver, and processed products such as ham. Meat – particularly cuts that are not lean, and processed meat products such as pies and sausages – are high in saturated fat. Some processed meat products may also be high in salt. Excessive meat intake is associated with an increased risk of colon cancer, and may possibly increase the risk of other cancers.[6] Therefore, as a rough guide, people should eat no more than 140g of meat per day, which is roughly the equivalent of 2 portions.

See Tool A6 *Portion sizes of meat.*

Fish is good for your health!

Fish is an excellent source of protein. White fish, such as cod and haddock, is naturally low in fat compared with some meats. White fish is low in fat as long as it is not coated and fried, or served with a fatty sauce. Oily fish are also rich sources of omega-3 fatty acids. Omega-3 fatty acids have been shown to protect against coronary heart disease, through improving the blood lipid profile and preventing thrombosis (clotting) and inflammation in the blood vessels. Oily fish includes sardines, mackerel, salmon, trout, herring and fresh tuna. The recommendation for healthy eating is to eat at least 2 portions of fish each week, one of which should be an oily fish.

Meat and fish alternatives

Eggs are rich sources of protein, vitamin B_{12} and other minerals, making them an excellent alternative to meat. They are inexpensive and versatile, but it is important to avoid adding too much fat through frying them etc. Beans, pulses and nuts – including dried and tinned varieties of kidney beans, haricot beans (the type used in baked beans), soya beans, lentils, dhal, chickpeas and peanuts – are good sources of protein, carbohydrates and iron, making them good alternatives to meat or fish. Soya mince, quorn and tofu are also good sources of protein. All meat and fish alternatives can be used to bulk up meat dishes. Beans and pulses in particular have the advantage of being high in fibre and low in fat. Meat and fish alternatives are often cheaper than traditional meat or fish products.

Practical tips on eating foods from the meat, fish and alternatives food group

Selecting a mix of options from the meat, fish and alternatives food group will add variety and help with eating healthily:

- Check the labels and choose low-fat and low-salt varieties of meat, fish and alternatives where possible. Choose the leanest meat you can afford and make it go further by using more pulses and vegetables in dishes such as casseroles and stir-fries.
- Avoid eating breaded or battered coatings on deep-fried foods such as fish, as these soak up lots of fat. Don't eat the visible fat or skin on meat and poultry. If possible, remove any fat or skin before cooking.
- Fish provide an excellent low-fat alternative to processed meat. Cheaper varieties such as canned sardines or frozen fish fingers or cod fillets are just as good as fresh varieties.
- Eat at least 1 portion of oily fish a week. As a rough guide, oily fish have dark rather than white

flesh. Examples include mackerel, sardines, salmon and fresh tuna. Canned oily fish are inexpensive sources of omega-3 fat, except for canned tuna. Canned tuna does not count as an oily fish (because much of the omega-3 fat is lost during the processing), but is still a good low-fat alternative to meat.

- Choose unsalted nuts and avoid eating excessive amounts, as they are also high in fat.

Preparing meat, fish and alternatives in a healthier way

- Grill, bake, steam or microwave fish, and grill or bake meat instead of frying or roasting with oil. Stir-frying foods with tiny amounts of oil is also better than frying.
- Trim the visible fat and skin off meat and poultry (such as chicken or turkey). This can substantially reduce the total fat content. For example, roast chicken with skin on is 14% fat, while roast chicken with skin off is 5% fat.
- If cooking mince, heat it in a saucepan then drain off the excess fat before continuing with the recipe.
- Add beans and pulses to stews and casseroles. Add extra vegetables.
- Skim the fat off stews and casseroles during cooking or before serving.
- Drain the salty water or oil from canned fish before serving.
- Avoid adding extra salt during cooking. Use herbs and spices as an alternative seasoning to salt.

Milk and dairy foods

The *Balance of Good Health* recommends that people eat or drink moderate amounts of milk and dairy products and choose low-fat options where possible. Milk and dairy products include milk, cheese, yogurt and fromage frais. They are rich sources of calcium, protein, vitamin B_{12} and vitamins A and D. An adequate intake of calcium and good plasma vitamin D levels are essential to maintain healthy bones.

The average level of calcium intake for adults in the UK is above the recommended level of 700mg per day. However, intakes among young women and women from households in receipt of benefits are lower than the recommended level.[7] Calcium intakes are also low among teenage girls and boys.[8] People on a low-fat diet which excludes dairy foods may also be at risk.

See Tool A7 *Sources of dietary calcium and vitamin D.*

Practical tips

- Eat some foods from this food group every day.
- Check the labels to compare the fat content.
- Choose lower fat versions of milk (semi-skimmed or skimmed milk) and dairy products wherever possible – for adults and children over the age of 5 years.
- Choose low fat (0.1g per 100g) yogurt and fromage frais.

Foods containing sugar, fats and salt

Fats

Most people in the UK eat twice or three times as much fat as their bodies actually need. Fat is high in calories and a high-fat diet can make it easy to overeat and consume excess calories, leading to overweight and obesity. Obesity is associated with an increased risk of coronary heart disease, diabetes and some cancers. A high-fat diet can also raise blood cholesterol, increasing the risk of heart attack and stroke.

There are three main types of fat – saturated fats, polyunsaturated fats and monounsaturated fats. *Saturated fats r*aise cholesterol levels, leading to the development of atheroma which forms in the walls of the arteries, restricting the flow of blood. This causes coronary heart disease, stroke and peripheral vascular disease depending on the arteries affected. Saturated fats are not essential to the body, so it is best to limit your intake of them as far as possible. Saturated fats are found mainly in animal products such as sausages, burgers, hard cheeses and cooking fats such as lard, as well as hard margarines.

Small amounts of *monounsaturated fats* and *polyunsaturated fats* including the essential fatty acids – omega-3 fatty acid and omega-6 fatty acids – are required for health. These types of fat have beneficial effects on blood lipid/cholesterol levels. Sources of polyunsaturated fats include some soft margarines, and vegetable oils. Omega-3 fatty acids are found in oily fish (see *Meat, fish and alternatives* on page 28) and omega-6 fatty acids are found in cooking oils such as corn oil and sunflower oil. Sources of monounsaturated fats include some margarines and spreads, olive oil, rapeseed oil (canola), walnut oil and avocado.

Daily guidelines for fat intake will depend on whether or not you are trying to lose weight or lower your cholesterol level. However, as a rough guide, for people who are seeking to maintain their current weight and cholesterol levels, men should be eating less than 95g of fat a day and women less than 70g a day.

Practical tips for reducing fat intake

- Limit intake of fat and fatty foods (see *Checking the labels* on page 25).
- Avoid cooking with lard or hard margarines altogether.
- Grill or bake instead of frying.
- Replace saturated fats – such as butter and lard – with polyunsaturated and monounsaturated fats, such as margarines labelled high in polyunsaturates/monounsaturates, sunflower oil and olive oil. Whichever spread you choose, use it sparingly.
- Be aware that some processed foods have high levels of hidden fat – such as cakes and biscuits and pastry-based dishes. Check the labels and limit intakes of high-fat foods.
- Some animal-based products such as meat and hard cheese are good sources of other nutrients, despite being high in saturated fat. Therefore rather than avoiding them altogether, choose low-fat options and eat moderate amounts to limit saturated fat intake. For further information see *Meat, fish and alternatives* on page 28.
- Remember that, while *small* amounts of polyunsaturated and monounsaturated fats are required for health, foods and oils rich in these are also high in calories, so do not eat or use excessive amounts in your diet.

See Tool A5 *Choosing healthier fats*. This shows the effects of different types of fat on cholesterol levels, and describes which foods contain which fats.

Sugars

Sugars are one of the two main types of carbohydrates; the other type is the starches. Sugars are simple carbohydrates and as a result have no nutritional value apart from adding calories. They include table sugar and added sugars in pre-prepared foods and drinks. If consumed too frequently, they can lead to tooth decay. Calories from sugars are rapidly available to the body due to their simple structure. As sweetened foods are pleasant to eat, it is easy to eat too much of them, and they can contribute to weight gain and obesity.

Practical tips for consuming less sugar

- Try not to have foods and drinks that are high in sugar too often, and when you do have them have them in small amounts.

- Choose reduced-sugar or diet options where available.
- Avoid having sugary drinks, snacks and dried fruits (which stick to teeth) between meals, to avoid tooth decay.

Salt (sodium)

Sodium plays an important role in the functioning of healthy cells and muscles in the human body. However, most people in the UK eat too much sodium – much of it in the form of salt. The recommended salt intake for adults is 6g (2.4g sodium per day), but most adults are consuming around 50% more at 9g per day. High levels of sodium in the diet lead to high blood pressure (essential hypertension) which is an important risk factor for coronary heart disease, stroke and kidney disease.

Around three-quarters of the salt we eat is hidden within pre-prepared foods. Soups, stock cubes, sauces such as soy sauce, ham, bacon, pre-prepared meals and savoury snacks are particularly high in salt. However, even bread, breakfast cereals and biscuits can have a high salt content. For example, some cornflakes have the same salinity as sea water! People should try to limit the amount of salt they eat.

The daily maximum recommended levels for children for salt are lower than the adult recommendation of 6g.[9] (See Table 6.)

Table 6 Target salt intakes

Adults:	6g a day
Children:	
11-14 years	6g a day
7-10 years	5g a day
4-6 years	3g a day
1-3 years	2g a day
7-12 months	1g a day
0-6 months	Less than 1g a day

As a rough guide, 1g sodium = 2.5g salt.

The target salt intakes set for adults and children are substantially greater than the salt intake required to maintain the sodium content of the body. They do not represent ideal or optimum consumption levels, but achievable population goals.

Source: See reference 9.

Practical tips for limiting salt intake and the effects of sodium

- Avoid adding salt to foods during cooking. Use herbs and spices as an alternative seasoning.
- Stock cubes can be high in salt. Choose 'low-salt' versions, or make your own stock. Or use herbs and spices instead.
- Limit your intake of salty foods and snacks such as crisps and bacon and pre-prepared sauces and soups.
- Choose canned vegetables and pulses that are marked 'no added salt'.
- Cut down on sauces such as soy and brown sauce, as these are high in salt.
- Don't add salt to food before tasting it.
- Check the labels on savoury foods such as sauces and meat products for other forms of sodium such as monosodium glutamate and sodium bicarbonate. These are used as preservatives or flavour enhancers but can contribute to excessive sodium intakes.
- Eat plenty of fruit and vegetables. Many are good sources of potassium. This can help control blood pressure by counteracting the effects of sodium from dietary salt.
- To help control blood pressure, keep to a healthy weight and be physically active.

Other minerals and vitamins, and dietary supplements

Most people are able to meet their nutritional needs by eating a balanced, varied diet including plenty of fruit and vegetables, and therefore do not need to take dietary supplements. The exceptions are as follows.

- Women intending to become pregnant are advised to take a daily 400 microgram supplement of folic acid before conception up to the 12th week of pregnancy, to help prevent neural tube defects.
- Asian women and girls who follow the tradition of wearing clothes that cover up most of the body are routinely advised to take supplements of vitamin D as they are more prone to deficiency.
- Older people may need extra iron, calcium and vitamin D.
- Teenage girls and young women may benefit from calcium and iron supplements.
- Women who are pregnant or breastfeeding may benefit from vitamin D supplements in order to ensure that their infants get enough vitamin D.

As a safety net, vitamin supplements are available for women and children on the Welfare Food Scheme. These contain vitamin A (low dose) and vitamins C and D.

There is a need to exercise caution in the use of high doses of purified supplements of vitamins and minerals as their impact on long-term health may not have been fully established and they cannot be assumed to be without risk. Anyone concerned about their diet should speak to their doctor or practice nurse or to a dietitian.

For more information on vitamins and minerals see the British Nutrition Foundation website www.nutrition.org.uk/information/energyandnutrients

Alcohol

Alcohol can add enjoyment to life, but only if it is drunk in moderation. Long-term, light to moderate consumption of alcohol has been shown to lower the risk of coronary heart disease and stroke in men over 40 and in postmenopausal women. However, excessive alcohol consumption (heavy or binge drinking) is associated with crime and accidents in the short term, as well as excessive calorie intake, raised blood pressure and increased risk of liver cirrhosis and some cancers in the long term.[10]

The optimum health advantage for men and women is associated with a daily alcohol consumption level of between 1 and 2 units.[10] The recommended daily benchmarks for sensible/moderate alcohol intake are a maximum of between 3 and 4 units a day for men, and between 2 and 3 units a day for women. This works out as 21 units a week for men and 14 units a week for women.

In Britain, 38% of men and 24% of women exceed the maximum recommended alcohol consumption levels each week. Binge drinking among young people is a particular cause for concern as 54% of young men and 50% of young women aged 19-24 exceed the maximum recommended weekly alcohol intake levels every week.[11]

Table 7 Number of units of alcohol in common drinks

Drink	Number of units
Half a pint of standard strength beer, lager, or cider	1
One small glass of wine	1
Alcopops	1.5
One standard measure of spirits	1

Practical tips for sensible drinking

- If you drink, keep within the recommended limits.
- If you are pregnant or trying to get pregnant, drink no more than one or two units, once or twice a week.
- If you are breastfeeding, avoid having alcohol immediately before a feed.
- Go for diet mixers or sugar-free mixers.
- Avoid alcohol if you intend to drive, do energetic physical activity or operate machinery.
- After an episode of binge drinking, avoid alcohol for at least 48 hours, to allow the body's tissues to recover.

Undernutrition

Although the main dietary problems in the UK are caused by overnutrition, there are still some groups of people who are at risk from undernutrition. The risk factors for undernutrition include:

- severe physical illness
- times before, during and after admission to hospital
- physical difficulty in eating
- vulnerable psychosocial situations
- psychological illness
- poverty or social isolation.

It is important for primary care professionals to recognise those groups of people who are particularly vulnerable to undernutrition and to be able to assess whether action is needed. The messages for individuals described on pages 26-31 may not apply to people who are undernourished. Undernourished people may need nutrient-dense foods such as fortified milk products and milky drinks. They may also find starchy foods too filling and will need to get more of their calories from fatty foods.

See Tool A10 *Assessing undernutrition* for more information on the groups of people vulnerable to undernutrition.

See Tool A11 *Malnutrition Universal Screening Tool (MUST tool).* This is a screening tool to identify adults who are malnourished, at risk of malnourishment or obese. It can be used in hospitals, community and other care settings and can be used by all care workers.

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Research evidence of the benefits of healthy eating

This section outlines the research evidence for the beneficial effects of food on health. It contains data from various interventional and epidemiological studies, as well as reviews. All the research is referenced in full on page 37.

Reducing overall mortality

- Among men who had had a heart attack, those who were advised to eat oily fish had a 29% reduction in two-year all-cause mortality compared with those who did not receive this advice.[1]
- Obese patients who lose just 10kg of weight have a 20%-25% decrease in overall mortality.[2]

Reducing sudden cardiac death

- Among previously healthy people, eating 2 portions of fish a week reduces the risk of sudden cardiac death by up to 50% in men[3] and 30% in women.[4]
- Linolenic acid (e.g. from soya and rapeseed oils) reduces fatal heart attacks in women by 45%, but does not reduce non-fatal heart attacks.[5]

Reducing the risk of coronary heart disease and stroke

- Fruit and vegetables have a strong protective effect against stroke and a weaker protective effect against coronary heart disease.[6]
- Eating another portion of fruit or vegetables a day decreases the risk of coronary heart disease by 4% and stroke by 6%.[7]
- Among obese people, the cardiovascular benefits that can be achieved from 5%-10% weight loss are:[8]
  - symptoms of angina reduced by 91%
  - 33% increase in exercise tolerance
  - a fall of 30%-50% in fasting plasma glucose
  - a fall of 10mmHg systolic and diastolic blood pressure
  - a fall of 15% in LDL cholesterol; a fall of 30% in triglycerides; an increase of 8% in HDL cholesterol.
- Advice to reduce dietary sodium intake may enable people with well-treated hypertension to stop taking their medicines and remain normotensive.[9]
- Reducing dietary sodium intake further lowers both systolic and diastolic blood pressure in those already on the 'DASH' diet – a diet rich in fruit and vegetables, and with low-fat dairy products and a reduced overall fat intake.[10]
- Following a low-fat diet on average lowers blood cholesterol by 5.3% after six months.[11]
- Healthy diets can reduce the risk of a second heart attack. For example, the Lyon diet (low fat, olive oil, lots of fruit and vegetables and starchy foods) was associated with a reduction in the risk of deaths from heart attacks by 35% as well as deaths from all causes by 44%.[12]
- 0.8mg of folic acid a day reduces serum homocysteine by 3mmol. This leads to a 16% reduction in coronary heart disease, a 25% reduction in deep venous thrombosis, and a 24% reduction in stroke.[13]
- Increased wholegrain consumption is associated with a decrease in the risk of coronary heart disease of up to 25%.[14]

Reducing the risk of diabetes

- In people with impaired glucose tolerance, dietary intervention led to a 31% reduction in the incidence of diabetes. Diet plus exercise led to a reduction of 42%.[15]
- In people with impaired glucose tolerance, lifestyle intervention to increase physical activity and reduce weight led to a reduction in diabetes of 58%[16] and was significantly more effective than metformin (a drug used to treat people with diabetes).[17]

Reducing the risk of cancer

- Childhood fruit consumption may have a long-term protective effect on cancer risk in adults.[18]
- Higher levels of energy intake in childhood increase the risk of mortality from non-smoking-related cancer in adult life: an increased energy intake of 240Kcal per day is associated with a 20% increased risk of mortality.[19]
- Around 40% of endometrial cancer, 25% of kidney cancer and 10% of breast and colon cancers would be avoided by maintaining a healthy weight with a BMI of under 25.[20]
- In people aged under 75 years, changing to a diet that is high in fruit and vegetables is associated with a decreased risk of cancer at many sites, particularly colorectal, stomach and breast cancer, in the following 10 years.[21]
- Increased dietary fibre is associated with a decreased risk of colorectal and pancreatic cancer.[22]
- The risk of developing colorectal cancer among high consumers of red and processed meats – i.e. those eating an average of 140g cooked weight or more a day – may be almost double that of average consumers who eat 90g a day.[22] (140g per day is equivalent to about 12-14 portions a week.)

See Tool A6 *Portion sizes of meat*, for examples of how much meat is in 90g and 140g.

- High intakes of red or processed meat may also increase the risk of breast, lung, prostate and pancreatic cancer.[22]

Reducing arthritis and osteoporosis

- Weight loss of 5%-10% in obese people leads to a marked improvement in mobility and reduction in musculoskeletal pain.[8]
- Dietary supplementation with calcium and vitamin D in older people is effective in reducing hip and other non-vertebral fractures. The reduction is around 5% and starts within eight months for hip fractures and three months for other non-vertebral fractures.[23]

Improving sense of well-being

- In obese people, 5%-10% weight loss leads to:[8]
  – a marked improvement in both quality and quantity of sleep, with reduced snoring, and
  – increased regularity of menstrual cycle and improved fertility.

Improving mental health

- Improving the vitamin C intake of older people improves mental function.[24]

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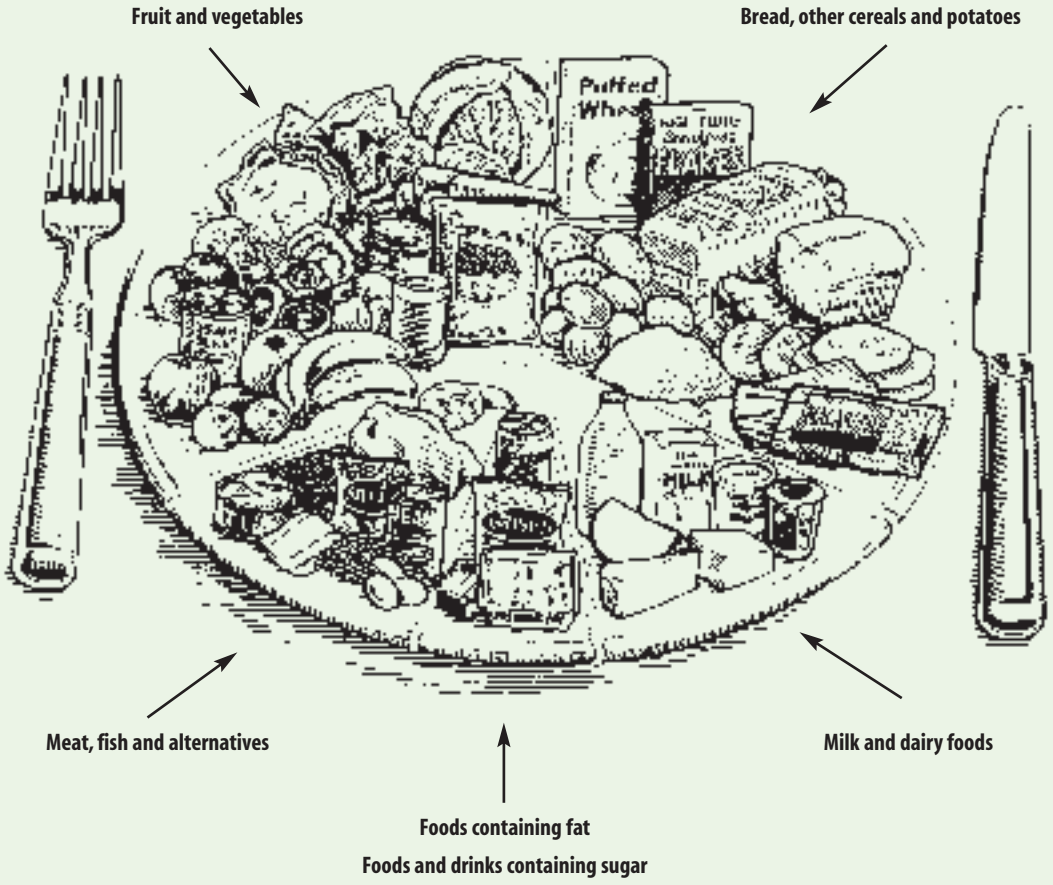
There are five main groups of valuable foods.



See overleaf for information about each of the food groups.

The five food groups

	What's included	Main nutrients	Message	Recommendations
Bread, other cereals and potatoes	Other cereals means foods such as breakfast cereals, pasta, rice, oats, noodles, maize, millet and cornmeal. This group also includes yams and plantains. Beans and pulses can be eaten as part of this group.	Carbohydrate (starch) 'Fibre' (NSP*) Some calcium and iron B vitamins	Eat lots.	Try to eat wholemeal, wholegrain, brown or high-fibre versions where possible. Try to avoid: • having them fried too often (e.g. chips) • adding too much fat (e.g. thickly spread butter, margarine or low-fat spread on bread) • adding rich sauces and dressings (e.g. cream or cheese sauce on pasta).
Fruit and vegetables	Fresh, frozen and canned fruit and vegetables and dried fruit. A glass of fruit juice also counts. Beans and pulses can be eaten as part of this group.	Vitamin C Carotenes Folates 'Fibre' (NSP*) and some carbohydrate	Eat lots – at least 5 portions a day. Fruit juice counts as only 1 portion, however much you drink in a day. Beans and pulses count as only 1 portion, however much you eat in a day.	Eat a wide variety of fruit and vegetables. Try to avoid: • adding fat or rich sauces to vegetables (e.g. carrots glazed with butter, or parsnips roasted in a lot of fat) • adding sugar or syrupy dressings to fruit (e.g. stewed apple with sugar, or chocolate sauce on banana).
Milk and dairy foods	Milk, cheese, yogurt and fromage frais. This group does not include butter, eggs and cream.	Calcium Protein Vitamin B_{12} Vitamins A and D	Eat or drink moderate amounts and choose lower fat versions whenever you can.	Lower fat versions means semi-skimmed or skimmed milk, low-fat (0.1% fat) yogurts or fromage frais, and lower fat cheeses (e.g. Edam, half-fat Cheddar and Camembert). Check the amount of fat by looking at the nutrient information on the labels. Compare similar products and choose the lowest – for example 8% fat fromage frais may be labelled 'low fat', but is not actually the lowest available.
Meat, fish and alternatives	Meat, poultry, fish, eggs, nuts, beans and pulses. Meat includes bacon and salami and meat products such as sausages, beefburgers and pâté. These are all relatively high-fat choices. Beans, such as canned baked beans and pulses, are in this group and they are a good source of protein for vegetarians. Fish includes frozen and canned fish such as sardines and tuna, fish fingers and fish cakes. Aim to eat at least 1 portion of oily fish such as sardines or salmon each week.	Iron Protein B vitamins, especially B_{12} Magnesium	Eat moderate amounts and choose lower fat versions whenever you can.	Lower fat versions means things like meat with the fat cut off, poultry without the skin, and fish without batter. Cook these foods without added fat. Beans and pulses are good alternatives to meat as they are naturally very low in fat.
Foods containing fat; foods and drinks containing sugar	*Foods containing fat* Margarine, butter, other spreading fats and low-fat spreads, cooking oils, oil-based salad dressings, mayonnaise, cream, chocolate, crisps, biscuits, pastries, cakes, puddings, ice cream, rich sauces and gravies. *Foods and drinks containing sugar* Soft drinks, sweets, jam and sugar, as well as foods such as cakes, puddings, biscuits, pastries and ice cream.	Fat, including some essential fatty acids, but also some vitamins.	Eat foods containing fat sparingly and look out for the low-fat alternatives. Foods and drinks containing sugar should not be eaten too often as they can contribute to tooth decay.	Some foods containing fat will be eaten every day, but should be kept to small amounts, for example, margarine and butter, other spreading fats (including low-fat spreads), cooking oils, oil-based salad dressings and mayonnaise. Foods containing fat such as cakes, biscuits, pastries and ice cream should be limited and low-fat alternatives chosen where available. All foods and drinks containing sugar should be eaten mainly at mealtimes to reduce the risk of tooth decay.

* Fibre is more properly known as non-starch polysaccharides (NSP).

What is a portion of fruit and vegetables?

Eat at least 5 portions of a variety of fruit and vegetables a day.
Fresh, frozen, chilled, canned, and dried fruit and vegetables, and 100% juice, all count.

To get the maximum benefits, you need to eat different types as they all contain different combinations of fibre, vitamins, minerals and other nutrients.

100% or pure fruit juice counts, but only for 1 portion a day, no matter how much you drink. (This is because drinking too much is not recommended because of its high sugar content. Also, in some cases there is less fibre in fruit juice than in whole fruit.)

Beans and pulses count only once a day, however much you eat.

Potatoes do not count as they are a starchy food.

Fruit and vegetables in takeaways and pre-prepared foods can also count. However, these foods are often high in salt, sugar and added fat.

For more information see the five a day website at www.dh.gov.uk

FRUIT

Portion equivalent to 80g *As eaten. Edible portion, and drained if canned.*

Apple, dried rings	4 rings
Apple, fresh	1 medium apple
Apple, purée	2 heaped tablespoons
Apricot, canned	6 halves
Apricot, dried	3 whole
Apricot, fresh	3 apricots
Apricot, ready to eat	3 whole
Avocado	half an avocado
Banana chips	1 handful
Banana, fresh	1 medium banana
Blackberries	1 handful (9 to 10 blackberries)
Blackcurrants	4 heaped tablespoons
Blueberries	2 handfuls (4 heaped tablespoons)
Cherries, canned	11 cherries (3 heaped tablespoons)
Cherries, dried	1 heaped tablespoon
Cherries, fresh	14 cherries
Clementines	2 clementines
Currants, dried	1 heaped tablespoon
Damsons	5 to 6 damsons
Dates, fresh	3 dates
Fig, dried	2 figs
Fig, fresh	2 figs
Fruit juice	1 x 150ml
Fruit salad, canned	3 heaped tablespoons
Fruit salad, fresh	3 heaped tablespoons
Fruit smoothie	1 x 150ml
Gooseberries	1 handful
Grapefruit segments, canned	3 heaped tablespoons (8 segments)
Grapefruit, fresh	half a grapefruit
Grapes	1 handful
Kiwi fruit	2 kiwi fruit
Kumquat	6-8 kumquats
Lychee, canned	6 lychees
Lychee, fresh	6 lychees
Mandarin orange, canned	3 heaped tablespoons
Mandarin orange, fresh	1 medium orange
Mango	2 slices (2-inch slice)
Melon	1 slice (2-inch slice)
Mixed fruit, dried	1 heaped tablespoon
Nectarine	1 nectarine
Orange	1 orange
Passion fruit	5 to 6 fruit
Paw paw (papaya), fresh	1 slice
Peach, canned	2 halves or 7 slices
Peach, dried	2 halves
Peach, fresh	1 medium peach
Peach, ready to eat	2 halves
Pear, canned	2 halves or 7 slices

Continued overleaf.

Pear, dried	2 halves
Pear, fresh	1 medium pear
Pear, ready to eat	2 halves
Pineapple, canned	2 rings or 12 chunks
Pineapple, crushed	3 tablespoons
Pineapple, dried	1 heaped tablespoon
Pineapple, fresh	1 large slice
Plum	2 medium plums
Prune, canned	6 prunes
Prune, dried	3 prunes
Prune, ready to eat	3 prunes
Raisins	1 tablespoon
Raspberries, canned	20 raspberries
Raspberries, fresh	2 handfuls
Rhubarb, canned chunks	5 chunks
Rhubarb, cooked	2 heaped tablespoons
Satsuma	2 small satsumas
Sharon fruit	1 sharon fruit
Strawberry, canned	9 strawberries
Strawberry, fresh	7 strawberries
Sultanas	1 heaped tablespoon
Tangerine	2 small tangerines

VEGETABLES

Portion equivalent to 80g *As eaten. Edible portion, and drained if canned.*

Ackee, canned	3 heaped tablespoons
Artichoke	2 globe hearts
Asparagus, canned	7 spears
Asparagus, fresh	5 spears
Aubergine	1/3rd aubergine
Beans, black eye, cooked	3 heaped tablespoons
Beans, broad, cooked	3 heaped tablespoons
Beans, butter, cooked	3 heaped tablespoons
Beans, cannelloni, cooked	3 heaped tablespoons
Beans, French, cooked	4 heaped tablespoons
Beans, kidney, cooked	3 heaped tablespoons
Beans, runner, cooked	4 heaped tablespoons
Beansprouts, fresh	2 handfuls
Beetroot, bottled	3 'baby' whole, or 7 slices
Broccoli	2 spears
Brussels sprouts	8 Brussels sprouts
Cabbage sliced	1/6th small cabbage or 2 handfuls
Cabbage, shredded	3 heaped tablespoons
Carrots, canned	3 heaped tablespoons
Carrots, fresh, slices	3 heaped tablespoons
Carrots, shredded	1/3 cereal bowl
Cauliflower	8 florets
Celery	3 sticks
Chick peas	3 heaped tablespoons
Chinese leaves	1/5th head of Chinese leaves
Courgettes	Half a large courgette
Cucumber	2-inch piece
Curly kale, cooked	4 heaped tablespoons
Karela	Half a karela
Leeks	1 leek (white portion only)
Lentils	3 tablespoons
Lettuce (mixed leaves)	1 cereal bowl
Mangetout	1 handful
Mixed vegetables, frozen	3 tablespoons
Mushrooms, button	14 button or 3 handfuls of slices, 3-4 heaped tablespoons
Mushrooms, dried	2 tablespoons or handful porcini
Okra	16 medium
Onion, dried	1 heaped tablespoon
Onion, fresh	1 medium onion
Parsnips	1 large
Peas, canned	3 heaped tablespoons
Peas, fresh	3 heaped tablespoons
Peas, frozen	3 heaped tablespoons
Pepper, canned	Half a pepper
Pepper, fresh	Half a pepper
Pigeon peas, canned	3 heaped tablespoons
Radish	10 radishes
Spinach, cooked	2 heaped tablespoons
Spinach, fresh	1 cereal bowl
Spring greens, cooked	4 heaped tablespoons
Spring onion	8 onions
Sugarsnap peas	1 handful
Swede, diced and cooked	3 heaped tablespoons
Sweetcorn, baby	6 baby corn
Sweetcorn, canned	3 heaped tablespoons
Sweetcorn, on the cob	1 cob
Tomato purée	1 heaped tablespoon
Tomato, canned plum	2 whole
Tomato, fresh	1 medium, or 7 cherry
Tomato, sundried	4 pieces

These lists are available at www.dh.gov.uk

Sources of dietary fibre

Adults are advised to eat 18g of dietary fibre a day.

Sources of dietary fibre include:

- **Wholegrain cereals** – brown rice, wholewheat pasta, wholemeal bread
- **Wholegrain or bran-enriched breakfast cereals** – muesli, bran flakes, etc
- **Beans, peas and lentils**
- **Fruit** – fresh, frozen, canned or dried
- **Vegetables** – fresh, frozen or canned.

The list below indicates the amount of dietary fibre contained in some average portions of commonly eaten foods.

FOOD	AMOUNT OF DIETARY FIBRE	WEIGHT OF PORTION OF FOOD
Cereals		
All Bran	9.8g	40g
Fibre 1 breakfast cereal	9.2g	30g
Muesli	3.8g	50g
Cornflakes	0.3g	30g
Weetabix	1.9g	20g
Rice, white, boiled	0.3g	150g
Wholemeal spaghetti	7.7g	220g
Wholemeal bread	2.2g	38g
White bread, sliced	0.5g	36g
Pitta bread, white	1.6g	75g
Pulses		
Lentil dhal	4.2g	210g
Baked beans	5.1g	135g
Kidney beans	3.7g	60g
Vegetables		
Sweet potato, baked	4.3g	130g
Carrots, boiled	1.5g	60g
Baked potato with skin	4.9g	180g
Peas, frozen	3.5g	70g
Sweetcorn	1.9g	85g
Cabbage	2.6g	95g
Broccoli	2.0g	90g
New potatoes in skins	2.6g	175g
Tomato, raw	0.9g	85g
Fruits		
Baked apple, no skin	3.2g	190g
Apricots, dried, ready to eat	2.5g	40g
Oranges	2.7g	160g
Fruit salad	2.1g	140g
Apple, e.g. Cox	2.0g	100g
Kiwi fruit	1.4g	60g
Banana	1.1g	100g
Plums, raw	1.0g	55g
Pears	4.1g	170g
Blackcurrants, stewed	4.3g	140g

Choosing healthier fats

The chart below shows how to choose healthier fats and so improve cholesterol levels in the blood. Most cholesterol is made in our bodies from fats in our food. Cholesterol levels can be improved by:

– cutting down on overall fats and
– eating smaller amounts of saturated fats.

A high-fibre diet may also help in the control of blood cholesterol.

The risk of heart attack and stroke increases with the blood levels of total cholesterol, LDL cholesterol and triglycerides, and decreases with higher levels of HDL cholesterol. That is why HDL cholesterol is often referred to as 'good' or 'protective' cholesterol.

Choosing healthier fats

To help reduce your cholesterol level, cut down on saturated fats and replace them with small amounts of monounsaturated and polyunsaturated fats. Omega-3 fats are good for your heart too.

	UNSATURATED FATS			SATURATED FATS
	Monounsaturated fats	**Polyunsaturated fats**	**Omega-3 fats**	
What do they do?	Monounsaturated fats can help lower LDL levels and do not lower the HDL cholesterol level (the 'protective' cholesterol).	Polyunsaturated fats can help lower LDL cholesterol, but they also lower HDL cholesterol.	Omega-3 fats are a particular type of polyunsaturated fat. They can help prevent blood clotting, and help reduce triglyceride levels.	Saturated fats increase LDL cholesterol levels.
Which foods are they found in?	Monounsaturated fats are found in: • olive oil • walnut oil • rapeseed oil • avocado. Some margarines and spreads are made from monounsaturated fats.	Polyunsaturated fats are found in: • cornflower oil • sunflower oil • soya oil • fish oil. Some margarines and spreads are made from polyunsaturated fats.	Omega-3 fats are found in: • fish oil • oily fish such as herring, kippers, mackerel, pilchards, sardines, salmon, trout and fresh tuna. Our bodies can also make omega-3 fats from rapeseed oil, and from the oil in walnuts and soya.	Saturated fats are found in: • butter • hard cheese • lard • dripping • suet • ghee • coconut oil • palm oil.

Portion sizes of meat

People in the UK eat on average 90g of cooked red and processed meat per day. If you eat more than this amount, and especially if you eat more than 140g a day, you should consider reducing the amount you eat.

90g

Examples of a 90g-size portion of cooked meat (Examples are approximate only.)

1 x 90g portion =

about 3 slices of roast beef, lamb or pork
1 small portion of meat sauce on pasta
2 rashers of back bacon and 1 large sausage
2 standard beefburgers and 1 slice of streaky bacon
1 lamb chump chop
1 pork rib end chop
1 lean pork escalope
1 average beef minute steak

140g

If you are eating more than 140g of cooked red and processed meat a day, you should consider reducing the amount you eat. Below are some examples of what would make up 140g of meat – for example from a breakfast and dinner, or from a lunch and dinner.

Examples of 140g of cooked meat (Examples are approximate only.)

140g =

2 rashers of back bacon or 2 slices of ham in a salad or sandwich	*plus*	about 3 slices of roast beef, lamb or pork
1 sausage and 2 rashers of back bacon	*plus*	1 individual (or 1 portion of) steak and kidney pie
1 sausage and 1 rasher of bacon	*plus*	1 portion of spaghetti bolognese, lasagne, moussaka or shepherd's pie
1 individual pork pie	*plus*	1 quarter-pound burger
1 individual (or 1 portion of) steak and kidney pie		
4 standard beefburgers		
3-4 sausages		
2 large lamb cutlets		
2 average lamb or pork chops		
1 raw-weight steak 6-7oz (170-200g)		

Sources of dietary calcium and vitamin D

Calcium

Good sources of calcium include:

- hard cheeses, cheese spread, soya cheese
- canned sardines or salmon, drained and mashed up with the bones
- fish paste
- tofu (soya bean)
- milk or yogurt
- soya drink with added calcium
- soya mince
- egg yolk
- bread (except wholemeal bread), crumpets, muffins, plain and cheese scones
- beans, lentils, chickpeas
- ready-to-eat or stewed figs and apricots.

- Adults should opt for low-fat forms of dairy foods.
- White flour has added calcium, so products (such as bread) which are made from white flour will have a higher calcium content than those made with wholemeal flour. However, it is inadvisable for most people to rely on products made from white flour as a source of calcium at the expense of wholemeal products. Wholemeal products are good sources of fibre and most adults in the UK are failing to achieve the recommended fibre intakes of 18g per day.[1]
- Chapattis decrease the absorption of calcium because yeast is not added to them during preparation, resulting in high levels of phytic acid. Phytic acid binds with calcium and prevents it from being absorbed. Yeast (which is added to leavened breads) neutralises phytic acid. Phytic acid also combines with iron, making it difficult to absorb iron, too.

Vitamin D

There are no recommended intake levels for vitamin D as most people will have sufficient levels from exposure of their skin to sunlight. Those most at risk from vitamin D deficiency include:

- pregnant and breastfeeding women
- elderly people living in institutions – due to lack of exposure to sunlight
- Asian women and children – due to lack of exposure to sunlight and limited dietary intake of vitamin D from vegetarian diets.

- Vitamin D supplements are available to women and children on the Welfare Food Scheme.
- Most vitamin D in our diets is from fortified foods such as margarine and other spreading fats and cereals. Oily fish, meat and eggs are good natural sources.
- Remember that some of these foods – margarine, other spreading fats and meat – are also high in saturated fats, so use low-fat versions whenever you can.

For details of the calcium and vitamin D content of foods and dishes see Annex 4 of *Nutrition and Bone Health.*[2]

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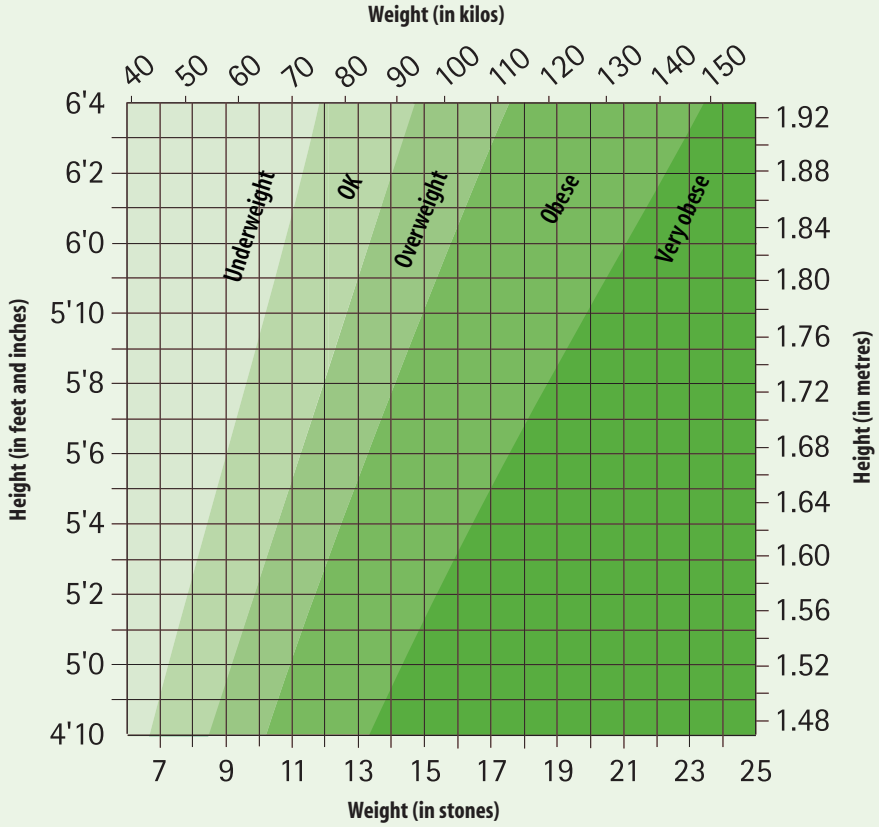
Height/weight chart for adults



Take a straight line across from the person's height (without shoes), and a line up or down from their weight (without clothes). Put a mark where the two lines meet to find out if the person needs to lose weight.

Underweight
More food may be needed. In cases of very low weight a doctor should be consulted.

OK
The right quantity of food is being eaten to maintain energy balance. If a person falls into the lower end of the weight range, they should maintain their weight and not be tempted to aim for the underweight category.

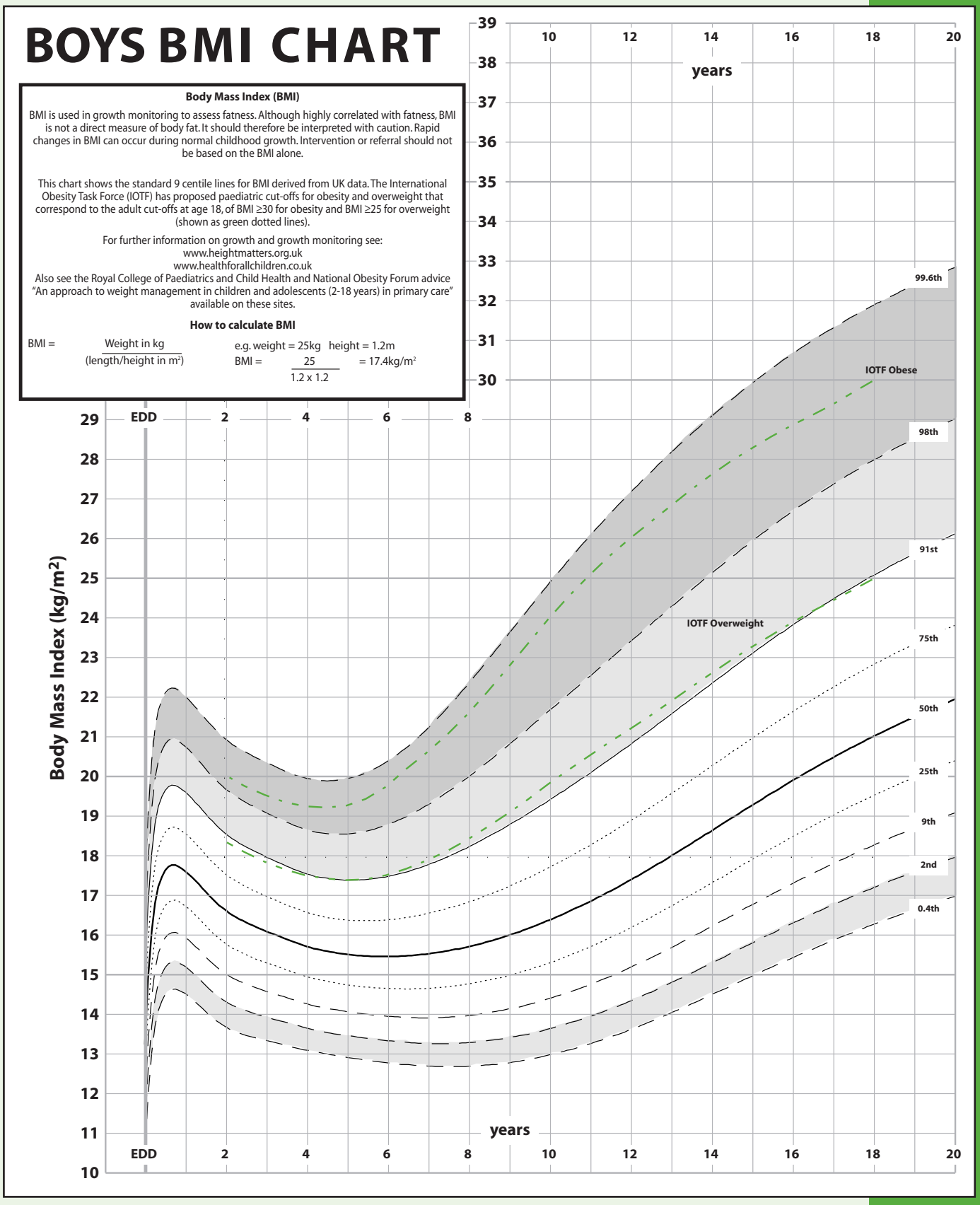
Overweight
Some loss of weight might be beneficial to health.

Obese
There is a need to lose weight.

Very obese
There is an urgent need to lose weight. It is advisable to consult a doctor or dietitian.

The chart above is reproduced with kind permission of the British Heart Foundation. It is adapted from *Treat Obesity Seriously* by J Garrow. Published by Churchill Livingstone, in 1981.

Children's BMI charts



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GIRLS BMI CHART

Body Mass Index (BMI)

BMI is used in growth monitoring to assess fatness. Although highly correlated with fatness, BMI is not a direct measure of body fat. It should therefore be interpreted with caution. Rapid changes in BMI can occur during normal childhood growth. Intervention or referral should not be based on the BMI alone.

This chart shows the standard 9 centile lines for BMI derived from UK data. The International Obesity Task Force (IOTF) has proposed paediatric cut-offs for obesity and overweight that correspond to the adult cut-offs at age 18, of BMI ≥30 for obesity and BMI ≥25 for overweight (shown as green dotted lines).

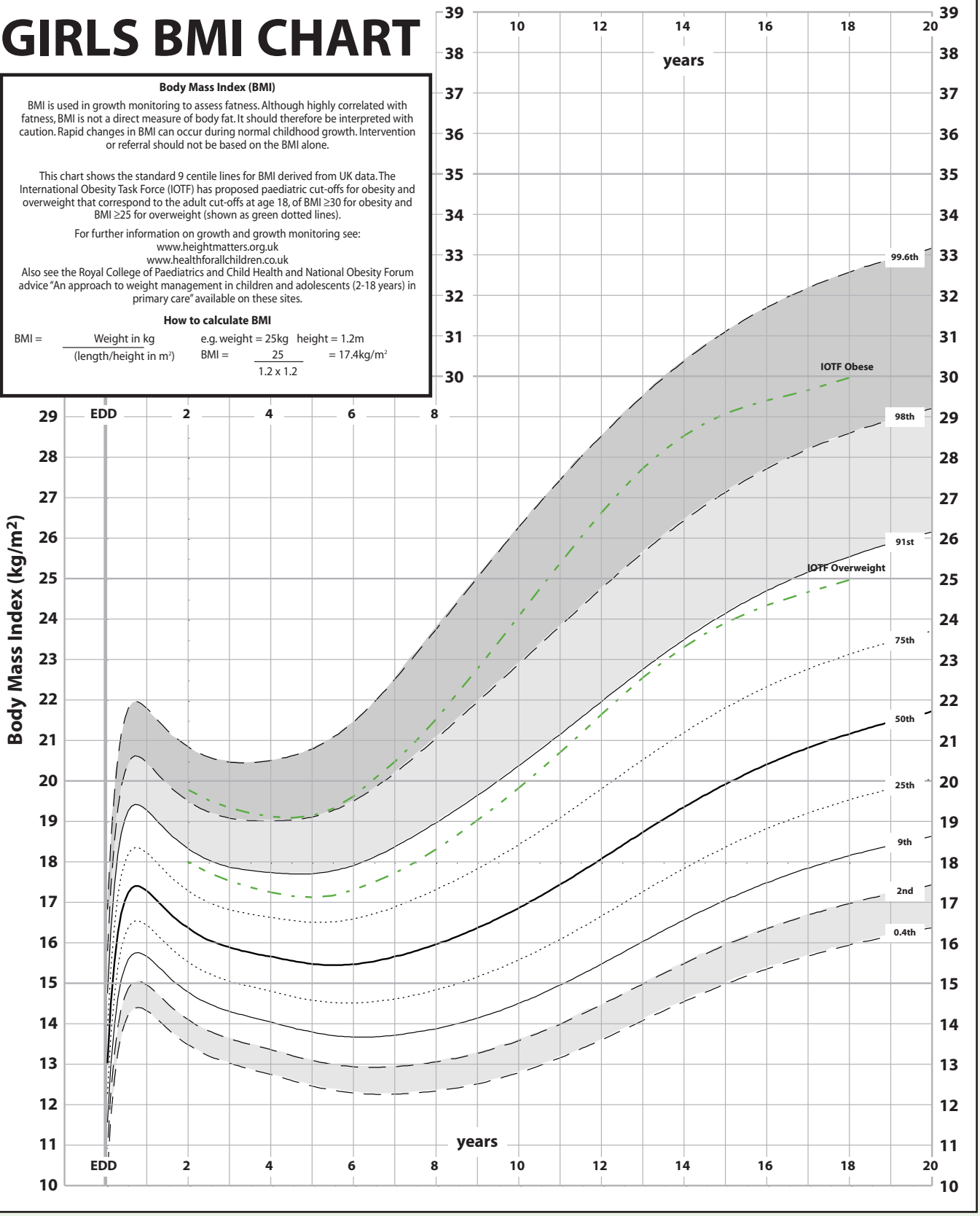
For further information on growth and growth monitoring see:
www.heightmatters.org.uk
www.healthforallchildren.co.uk
Also see the Royal College of Paediatrics and Child Health and National Obesity Forum advice "An approach to weight management in children and adolescents (2-18 years) in primary care" available on these sites.

How to calculate BMI

$$\text{BMI} = \frac{\text{Weight in kg}}{(\text{length/height in m}^2)}$$

e.g. weight = 25kg height = 1.2m

$$\text{BMI} = \frac{25}{1.2 \times 1.2} = 17.4\text{kg/m}^2$$



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Assessing undernutrition

Groups of people vulnerable to undernutrition

People with illness-related undernutrition

- Those with severe disorder of any body system
- Those with malignant disease

People in need of nutritional support before or after surgery

- People with undernutrition which is correctable before surgery
- Those convalescing after major surgery or severe illness

People with difficulty in eating

Those with:

- poor dentition or a sore mouth
- chewing or swallowing disorders
- sensory loss
- disorder of the upper limbs.

Those in a vulnerable psychosocial situation

- Elderly people living alone, especially after the loss of a spouse
- People with learning disabilities who are living alone
- Those affected by poverty or social isolation
- People in nursing or residential homes

People suffering from psychological illness

- Those with depression or other mental disorders
- People with behavioural eating disorders

Information on how to treat and who can help can be found in *Nutrition and Patients: A Doctor's Responsibility* by the Royal College of Physicians (see details below).

Malnutrition Universal Screening Tool ('MUST')

'MUST'

'MUST' is a five-step screening tool to identify **adults**, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

It is for use in hospitals, community and other care settings and can be used by all care workers.

This guide contains:

- A flow chart showing the 5 steps to use for screening and management
- BMI chart
- Weight loss tables
- Alternative measurements when BMI cannot be obtained by measuring weight and height.

The 5 'MUST' Steps

Step 1

Measure height and weight to get a BMI score using chart provided. *If unable to obtain height and weight, use the alternative procedures shown in this guide.*

Step 2

Note percentage unplanned weight loss and score using tables provided.

Step 3

Establish acute disease effect and score.

Step 4

Add scores from steps 1, 2 and 3 together to obtain overall risk of malnutrition.

Step 5

Use management guidelines and/or local policy to develop care plan.

Please refer to *The 'MUST' Explanatory Booklet* for more information when weight and height cannot be measured, and when screening patient groups in which extra care in interpretation is needed (e.g. those with fluid disturbances, plaster casts, amputations, critical illness and pregnant or lactating women). The booklet can also be used for training. See *The 'MUST' Report* for supporting evidence. Please note that 'MUST' has not been designed to detect deficiencies or excessive intakes or vitamins and minerals and is of **use only in adults.**

Malnutrition Universal Screening Tool ('MUST')

Step 1
BMI score

BMI kg/m^2	Score
>20(>30 Obese)	= 0
18.5 -20	= 1
<18.5	= 2

+

Step 2
Weight loss score

Unplanned weight loss in past 3-6 months

%	Score
<5	= 0
5-10	= 1
>10	= 2

+

Step 3
Acute disease effect score

If patient is acutely ill and there has been or is likely to be no nutritional intake for >5 days
Score 2

If unable to obtain height and weight, see page 61 for alternative measurements and use of subjective criteria.

Step 4
Overall risk of malnutrition

Add Scores together to calculate overall risk of malnutrition.
Score 0 Low Risk Score 1 Medium Risk Score 2 or more High Risk

Step 5
Management guidelines

0 Low Risk
Routine clinical care

- Repeat screening

  Hospital – weekly
  Care Homes – monthly
  Community – annually
  for special groups
  e.g. those >75 yrs

1 Medium Risk
Observe

- Document dietary intake for 3 days if subject in hospital or care home
- If improved or adequate intake – little clinical concern; if no improvement – clinical concern - follow local policy
- Repeat screening
  Hospital – weekly
  Care Home – at least monthly
  Community – at least every 2-3 months

2 or more High Risk
Treat*

- Refer to dietitian, Nutritional Support Team or implement local policy
- Improve and increase overall nutritional intake
- Monitor and review care plan
  Hospital – weekly
  Care Home – monthly
  Community – monthly

* Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

All risk categories:

- Treat underlying condition and provide help and advice on food choices, eating and drinking when necessary.
- Record malnutrition risk category.
- Record need for special diets and follow local policy.

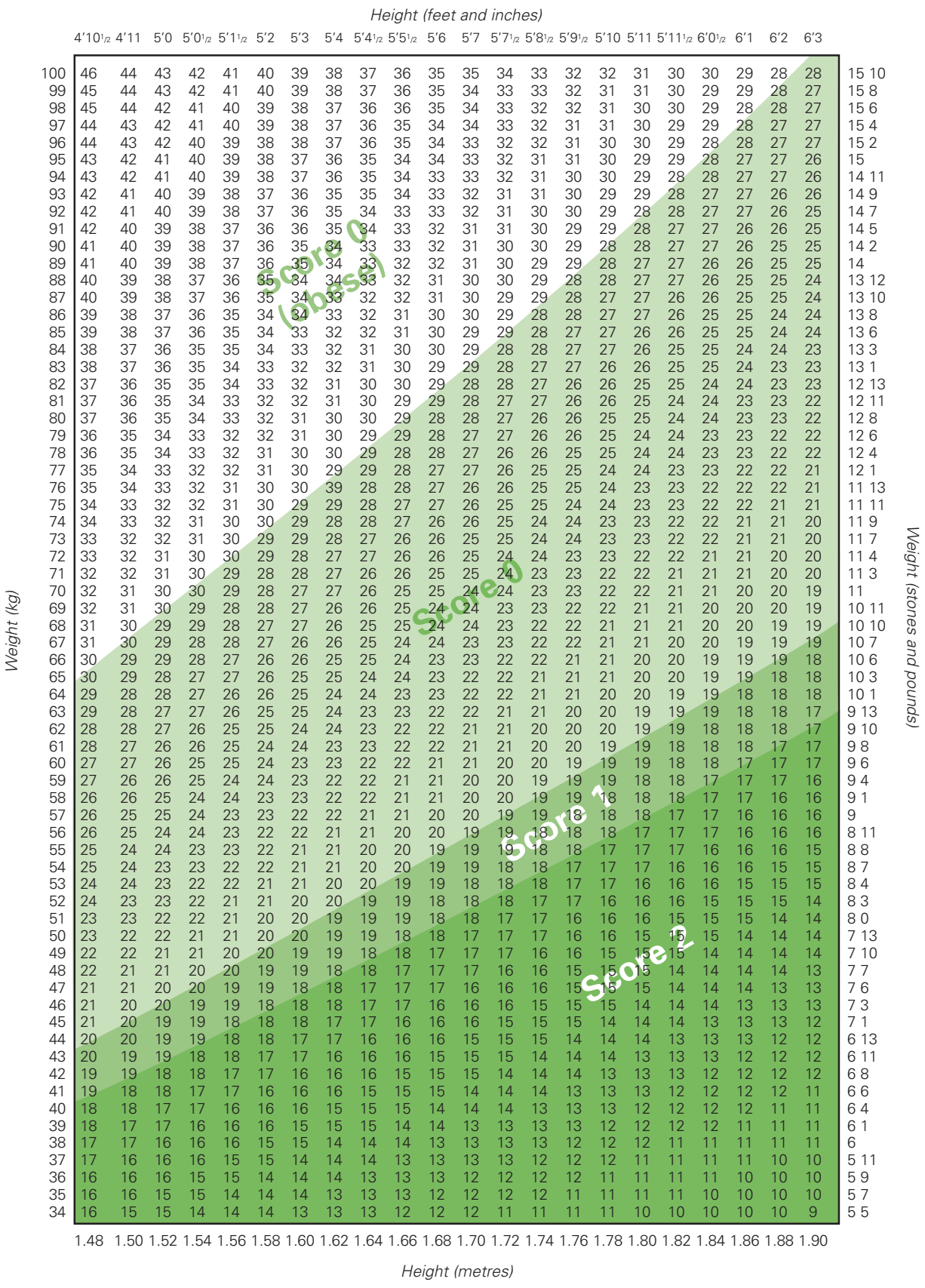
Obesity:

- Record presence of obesity. For those with underlying conditions, these are generally controlled before the treatment of obesity.

Re-assess subjects identified at risk as they move through care settings.
See *The 'MUST' Explanatory Booklet* for further details and *The 'Must' Report* for supporting evidence.

Malnutrition Universal Screening Tool ('MUST')

Step 1 – BMI score (and BMI)



Malnutrition Universal Screening Tool ('MUST')

Step 2 – Weight loss score

Weight before weight loss (kg)

	Score 0 Wt Loss <5%	Score 1 Wt Loss 5-10%	Score 2 Wt Loss >10%
34 kg	<1.70	1.70 – 3.40	>3.40
36 kg	<1.80	1.80 – 3.60	>3.60
38 kg	<1.90	1.90 – 3.80	>3.80
40 kg	<2.00	2.00 – 4.00	>4.00
42 kg	<2.10	2.10 – 4.20	>4.20
44 kg	<2.20	2.20 – 4.40	>4.40
46 kg	<2.30	2.30 – 4.60	>4.60
48 kg	<2.40	2.40 – 4.80	>4.80
50 kg	<2.50	2.50 – 5.00	>5.00
52 kg	<2.60	2.60 – 5.20	>5.20
54 kg	<2.70	2.70 – 5.40	>5.40
56 kg	<2.80	2.80 – 5.60	>5.60
58 kg	<2.90	2.90 – 5.80	>5.80
60 kg	<3.00	3.00 – 6.00	>6.00
62 kg	<3.10	3.10 – 6.20	>6.20
64 kg	<3.20	3.20 – 6.40	>6.40
66 kg	<3.30	3.30 – 6.60	>6.60
68 kg	<3.40	3.40 – 6.80	>6.80
70 kg	<3.50	3.50 – 7.00	>7.00
72 kg	<3.60	3.60 – 7.20	>7.20
74 kg	<3.70	3.70 – 7.40	>7.40
76 kg	<3.80	3.80 – 7.60	>7.60
78 kg	<3.90	3.90 – 7.80	>7.80
80 kg	<4.00	4.00 – 8.00	>8.00
82 kg	<4.10	4.10 – 8.20	>8.20
84 kg	<4.20	4.20 – 8.40	>8.40
86 kg	<4.30	4.30 – 8.60	>8.60
88 kg	<4.40	4.40 – 8.80	>8.80
90 kg	<4.50	4.50 – 9.00	>9.00
92 kg	<4.60	4.60 – 9.20	>9.20
94 kg	<4.70	4.70 – 9.40	>9.40
96 kg	<4.80	4.80 – 9.60	>9.60
98 kg	<4.90	4.90 – 9.80	>9.80
100 kg	<5.00	5.00 – 10.00	>10.00
102 kg	<5.10	5.10 – 10.20	>10.20
104 kg	<5.20	5.20 – 10.40	>10.40
106 kg	<5.30	5.30 – 10.60	>10.60
108 kg	<5.40	5.40 – 10.80	>10.80
110 kg	<5.50	5.50 – 11.00	>11.00
112 kg	<5.60	5.60 – 11.20	>11.20
114 kg	<5.70	5.70 – 11.40	>11.40
116 kg	<5.80	5.80 – 11.60	>11.60
118 kg	<5.90	5.90 – 11.80	>11.80
120 kg	<6.00	6.00 – 12.00	>12.00
122 kg	<6.10	6.10 – 12.20	>12.20
124 kg	<6.20	6.20 – 12.40	>12.40
126 kg	<6.30	6.30 – 12.60	>12.60

Weight before weight loss (st lb)

	Score 0 Wt Loss <5%	Score 1 Wt Loss 5-10%	Score 2 Wt Loss >10%
5st 4lb	<4lb	4lb – 7lb	>7lb
5st 7lb	<4lb	4lb – 8lb	>8lb
5st 11lb	<4lb	4lb – 8lb	>8lb
6st	<4lb	4lb – 8lb	>8lb
6st 4lb	<4lb	4lb – 9lb	>9lb
6st 7lb	<5lb	5lb – 9lb	>9lb
6st 11lb	<5lb	5lb – 10lb	>10lb
7st	<5lb	5lb – 10lb	>10lb
7st 4lb	<5lb	5lb – 10lb	>10lb
7st 7lb	<5lb	5lb – 11lb	>11lb
7st 11lb	<5lb	5lb – 11lb	>11lb
8st	<6lb	6lb – 11lb	>11lb
8st 4lb	<6lb	6lb – 12lb	>12lb
8st 7lb	<6lb	6lb – 12lb	>12lb
8st 11lb	<6lb	6lb – 12lb	>12lb
9st	<6lb	6lb – 13lb	>13lb
9st 4lb	<7lb	7lb – 13lb	>13lb
9st 7lb	<7lb	7lb – 13lb	>13lb
9st 11lb	<7lb	7lb – 1st 0lb	>1st 0lb
10st	<7lb	7lb – 1st 0lb	>1st 0lb
10st 4lb	<7lb	7lb – 1st 0lb	>1st 0lb
10st 7lb	<7lb	7lb – 1st 1lb	>1st 1lb
10st 11lb	<8lb	8lb – 1st 1lb	>1st 1lb
11st	<8lb	8lb – 1st 1lb	>1st 1lb
11st 4lb	<8lb	8lb – 1st 2lb	>1st 2lb
11st 7lb	<8lb	8lb – 1st 2lb	>1st 2lb
11st 11lb	<8lb	8lb – 1st 3lb	>1st 3lb
12st	<8lb	8lb – 1st 3lb	>1st 3lb
12st 4lb	<9lb	9lb – 1st 3lb	>1st 3lb
12st 7lb	<9lb	9lb – 1st 4lb	>1st 4lb
12st 11lb	<9lb	9lb – 1st 4lb	>1st 4lb
13st	<9lb	9lb – 1st 4lb	>1st 4lb
13st 4lb	<9lb	9lb – 1st 5lb	>1st 5lb
13st 7lb	<9lb	9lb – 1st 5lb	>1st 5lb
13st 11lb	<10lb	10lb – 1st 5lb	>1st 5lb
14st	<10lb	10lb – 1st 6lb	>1st 6lb
14st 4lb	<10lb	10lb – 1st 6lb	>1st 6lb
14st 7lb	<10lb	10lb – 1st 6lb	>1st 6lb
14st 11lb	<10lb	10lb – 1st 7lb	>1st 7lb
15st	<11lb	11lb – 1st 7lb	>1st 7lb
15st 4lb	<11lb	11lb – 1st 7lb	>1st 7lb
15st 7lb	<11lb	11lb – 1st 8lb	>1st 8lb
15st 11lb	<11lb	11lb – 1st 8lb	>1st 8lb
16st	<11lb	11lb – 1st 8lb	>1st 8lb
16st 4lb	<11lb	11lb – 1st 9lb	>1st 9lb
16st 7lb	<12lb	12lb – 1st 9lb	>1st 9lb

Malnutrition Universal Screening Tool ('MUST')

Alternative measurements and considerations

Step 1: BMI (Body Mass Index)

If height cannot be measured

- Use recently documented or self-reported height (if reliable and realistic).
- If the subject does not know or is unable to report their height, use one of the alternative measurements to estimate height (ulna, knee height or demispan).

If height & weight cannot be obtained

- Use mid-upper arm circumference (MUAC) measurement to estimate BMI.
  If MUAC is <23.5cm, BMI is likely to be <20kg/m^2.
  If MUAC is >32.0cm, BMI is likely to be >30kg/m^2.

Step 2: Recent unplanned weight loss

If recent weight loss cannot be calculated, use self-reported weight loss (if reliable and realistic).

Subjective criteria

If height, weight or BMI cannot be obtained, the following criteria which relate to them can assist your professional judgement of the subject's nutritional risk.

1. BMI

- Clinical impression – thin, acceptable weight, overweight. Obvious wasting (very thin) and obesity (very overweight) can also be noted.

2. Unplanned weight loss

- Clothes and/or jewellery have become loose fitting (weight loss).
- History of decreased food intake, reduced appetite or swallowing problems over 3-6 months and underlying disease or psycho-social/physical disabilities likely to cause weight loss.

3. Acute disease effect

- No nutritional intake or likelihood of no intake for more than 5 days.

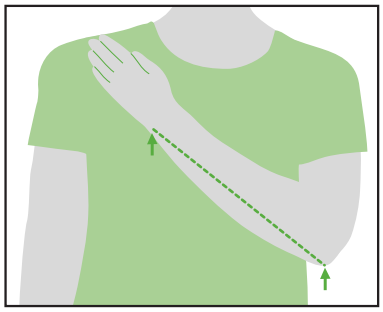
Further details on taking alternative measurements, special circumstances and subjective criteria can be found in *The 'MUST' Explanatory Booklet*. A copy can be downloaded at www.bapen.org.uk or purchased from the BAPEN office. The full evidence-base for 'MUST' is contained in *The 'MUST' Report* and is also available for purchase from the BAPEN office.

Malnutrition Universal Screening Tool ('MUST')

Alternative measurements: instructions and tables

If height cannot be measured use length of forearm (ulna) to calculate height using tables below. *(See The 'MUST' Explanatory Booklet for details of other alternative measurements (knee height and demispan) that can be used to estimate height).*

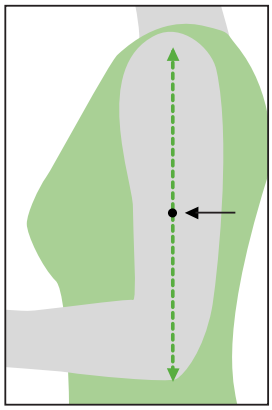
Estimating height from ulna length



Measure between the point of the elbow (olecranon process) and the midpoint of the prominent bone of the wrist (styloid process) (left side if possible).

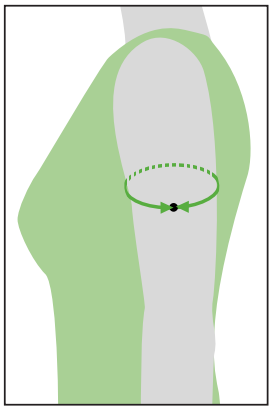
HEIGHT (m)	Men (<65 years)	1.94	1.93	1.91	1.89	1.87	1.85	1.84	1.82	1.80	1.78	1.76	1.75	1.73	1.71
	Men (>65 years)	1.87	1.86	1.84	1.82	1.81	1.79	1.78	1.76	1.75	1.73	1.71	1.70	1.68	1.67
	Ulna length (cm)	32.0	31.5	31.0	30.5	30.0	29.5	28.5	28.0	27.5	27.0	26.5	26.5	26.0	25.5
HEIGHT (m)	Women (<65 years)	1.84	1.83	1.81	1.80	1.79	1.77	1.76	1.75	1.73	1.72	1.70	1.69	1.68	1.66
	Women (>65 years)	1.84	1.83	1.81	1.79	1.78	1.76	1.75	1.73	1.71	1.70	1.68	1.66	1.65	1.63
HEIGHT (m)	Men (<65 years)	1.69	1.67	1.66	1.64	1.62	1.60	1.58	1.57	1.55	1.53	1.51	1.49	1.48	1.46
	Men (>65 years)	1.65	1.63	1.62	1.60	1.59	1.57	1.56	1.54	1.52	1.51	1.49	1.48	1.46	1.45
	Ulna length (cm)	25.0	24.5	24.0	23.5	23.0	22.5	22.0	21.5	21.0	20.5	20.0	19.5	19.0	18.5
HEIGHT (m)	Women (<65 years)	1.65	1.63	1.62	1.61	1.59	1.58	1.56	1.55	1.54	1.52	1.51	1.50	1.48	1.47
	Women (>65 years)	1.61	1.60	1.58	1.56	1.55	1.53	1.52	1.50	1.48	1.47	1.45	1.44	1.42	1.40

Measuring from mid upper arm circumference (MUAC)



The subject's left arm should be bent at the elbow at a 90º angle, with the upper arm held parallel to the side of the body. Measure the distance between the bony protrusion on the shoulder (acromion) and the point of the elbow (olecranon process). Mark the mid-point.

Ask the subject to let arm hang loose and measure around the upper arm at the mid-point, making sure that the tape measure is snug but not tight.



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Why consider what people eat?

B

This section shows the importance of poor diets in the development of avoidable chronic diseases, and in health inequalities. It will be useful to public health professionals, registered public health nutritionists, dietitians and other professionals as background information on which to base strategies on nutrition, particularly for people on low incomes, or for making the case for action to colleagues in primary care.

Modern malnutrition and obesity

Overall, adults in England are eating:[1-3]

- 50% more saturated fat than the maximum recommended
- around 50% more than the maximum amount of salt recommended
- half the fruit and vegetables recommended
- insufficient amounts of fibre which are up to a third less than recommended
- half the fish recommended.

Overall, children aged 4 to 18 in England are eating: [4, 5]

- a quarter of the fruit and vegetables recommended
- more than twice the maximum recommended salt intake
- 50% more saturated fat than recommended
- 50% more sugar than recommended, and
- teenagers are getting insufficient calcium and iron.

Levels of overweight and obesity in the UK are high and rising dramatically:

- Eleven per cent of 9 year olds are obese.[6]
- Obesity becomes more common throughout childhood and adult life.
- More than a third of young people aged 16-24 are overweight or obese.[6]
- Fifty-nine per cent of all adult women and 68% of all adult men in England are overweight or obese.[7]
- The proportion of obese adults in England has tripled since the mid-1980s.[7]
- The number of obese boys aged 2-15 doubled to 6%, and increased from 5% to 8% among girls between 1995 and 2002.[6]

Obesity results when a person's energy intake from food and drink exceeds the energy they use up, over a prolonged period of time. This imbalance is known as positive energy balance. The combination of obesity and a diet dominated by sweet, salty and fatty foods with too little fruit and vegetables and fibre is known as *modern malnutrition*. It is more common in those from lower socioeconomic groups. In spite of this imbalance of foods, *average* blood levels of micro-nutrients are still well above the recommended levels.[1] However, there are important deficiencies in some

population groups, such as deficiencies of iron and calcium in teenagers. Also, as people reduce their calorie intake, for example when dieting, care must be taken to ensure that their nutrient levels do not fall. With prolonged extreme diets involving daily calorie intakes of less than 1,200Kcal per day, it becomes difficult to achieve a diet that is sufficient in all nutrients.

Although the levels of obesity are rising, the average energy intake from food eaten in the home has apparently decreased steadily in adults and children over the past decades.[8] The reasons for this apparent contradiction are: firstly, the increase in the amount of snacks and fast food eaten outside the home (which it is difficult to measure); and secondly, the fall in people's levels of physical activity. That is why most programmes which aim to prevent a further rise in overweight and obesity must also consider local initiatives to increase physical activity levels.

Poor nutrition is a major health risk

Poor nutrition contributes to:

- at least 30% of coronary heart disease deaths,[8] and
- 33% of all cancer deaths.[9]

Poor nutrition and lack of physical activity together are responsible for:

- 30% of years of life lost in early death and disability[10] in developed countries, attributable to:
  - lack of fruit and vegetables: 3.9%
  - overweight and obesity: 7.4%
  - raised blood cholesterol: 7.6%
  - hypertension: 10.9%
  - overweight and obesity which lead to 58% of diabetes and 21% of coronary heart disease deaths globally.

Poor nutrition also contributes to:

- loss of independence and increased falls and fractures in older people[11]
- low birthweight leading to increased mortality and morbidity throughout childhood, and increased risk of cardiovascular disease in adult life[12]
- increased incidence of stillbirths and neural tube defects (such as spina bifida),[13] and
- increased dental caries in children.[13]

All these diseases are more common in lower socioeconomic groups.

The wider effects of poor nutrition

There is growing evidence to support the link between poor diets and anti-social behaviour. In a placebo-controlled study in a men's prison, vitamin, mineral and essential fatty acid supplements were associated with a decrease of 37% in serious incidents.[14] Another study in the US suggests that improved diet is associated with improved behaviour in 20% of young offenders.[15]

There is considerable anecdotal evidence, but little research evidence, of the beneficial effects of improved diet and easy access to drinking water on children's behaviour and their ability to concentrate at school. However, there is currently a trial in US schools to see if improved diets will improve behaviour among schoolchildren. A study carried out in Scotland has shown that breakfast clubs can improve attendance and behaviour at school.[16] There is fairly good evidence of improvement in cognitive function and school achievement from treating iron-deficient children aged over 2 years old with iron.[17,18] There is also a body of evidence suggesting such benefits in younger children.[19]

Inequalities in diet-related diseases

There are considerable inequalities in diseases related to diet across socioeconomic groups, in the different regions of England, and across ethnic groups.

Socioeconomic inequalities in diet-related diseases

Socioeconomic differences account for 5,000 premature diet-related deaths a year in men aged under 65.[12]

In all age groups, people living on a low income have higher rates of diet-related diseases than other people.

- The premature death rate from coronary heart disease is over twice as high in female manual workers compared with female non-manual workers.[7] For men, the rate is over 50% higher.
- Diabetes is one and a half times more likely to develop at any age in those in the most deprived 20% of the population compared with the average. [20]
- The prevalence of obesity among women in social class V is twice that of women in social class I. The corresponding prevalence figure for men is 50% higher.[21]
- Central obesity* is more common in adults from manual social classes than non-manual classes. This pattern is stronger in women than in men: the prevalence of central obesity is 50% higher for women in social class V than in social class I.[7]
- There is a slight increase in hypertension in women from social class I to social class V but there is no such trend for men.[7]
- People from deprived backgrounds are more likely to get some types of cancer and are less likely to survive. For example, breast cancer and colon cancer five-year survival rates are 7% and 4% less, respectively, in the most deprived groups compared with the most affluent.[22]
- Babies with fathers in social classes IV and V have a birthweight on average 130g lower than babies with fathers in social classes I and II.[12]
- Dental carries is more prevalent in children from lower socioeconomic groups.[12]

Geographical inequalities in diet-related diseases

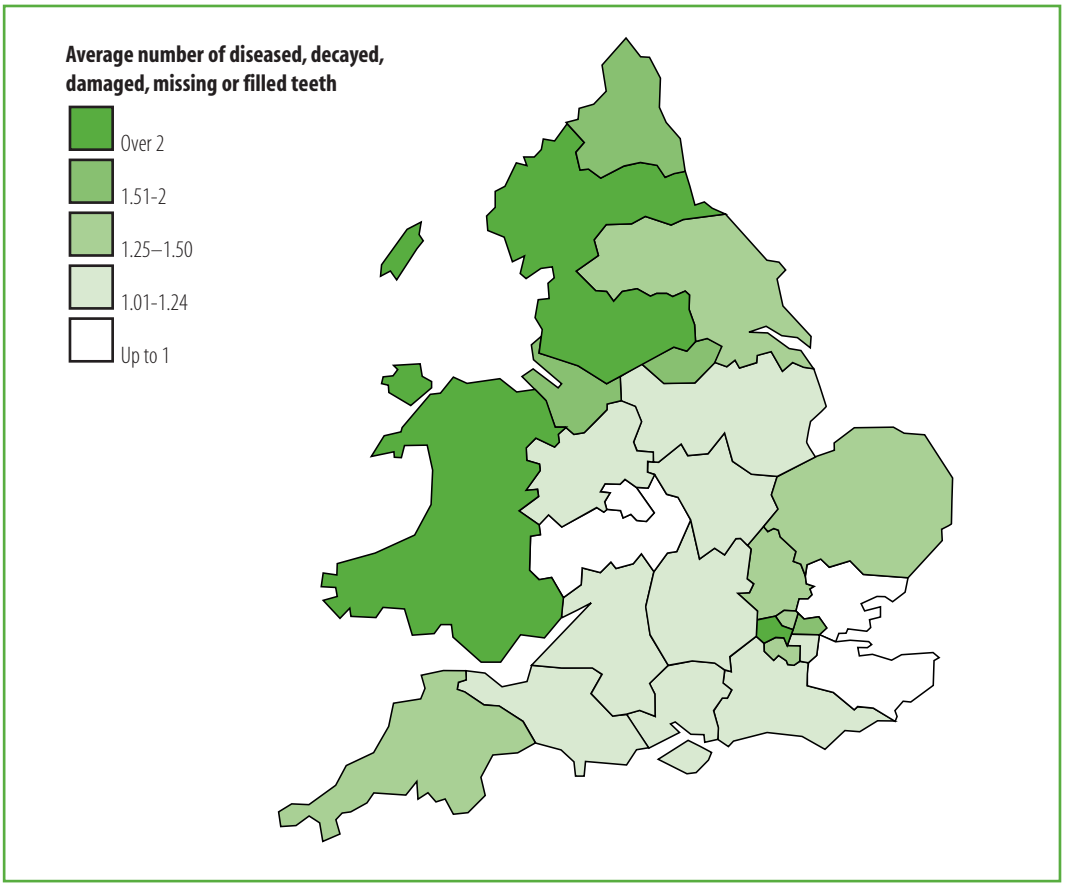
There are significant differences in diet-related diseases between the four countries of the UK and between regions, and there are also major differences between much smaller areas.[23] Finding out what these inequalities are is an essential first step in developing a local nutrition and food poverty strategy. (See also Section C *Why prioritise strategies for nutrition and food poverty*?)

See Tool D3 *Sources of data at ward level.*

Generally, obesity is a significant problem across the whole of England, and for men there is a steady rise in obesity rates the further north they live. There is also a similar north/south gradient for coronary heart disease, but no clear pattern of regional differences for type 2 diabetes. Marked regional differences in dental caries are seen in children as young as 5 years old. (See Figure 1 and Table 8.)

* Central obesity is when fat accumulates mainly around the abdomen. The definition is a waist/hip ratio of 0.95 or more for a man and 0.85 or more for a woman. As a guide, a waist measurement of 32 inches (80cm) or more for a woman or 37 inches (94cm) for a man denotes central obesity.

Figure 1 Dental caries experience of 5 year old children in England and Wales, 2001/02



Source: BASCD co-ordinated NHS Dental Epidemiology Programme survey of 5-year-old children, 2001/2002. See reference 24.

Table 8 Regional differences in Body Mass Index, and prevalence of type 2 diabetes and treated coronary heart disease

Former NHS region	Body Mass Index % of adult men with BMI 30 or above, 1998	Prevalence of type 2 diabetes Standardised rate per 1,000 male patients, 1994-98	Prevalence of coronary heart disease Standardised rate per 1,000 female patients, 1994-98
Northern and Yorkshire	23	9.0	28
Trent	24	9.5	21.8
West Midlands	22	10.1	19.3
North West	20	10.3	25.7
North Thames	21	11.3	16.1
South Thames	18	8.8	16.3
South and West	19	9.9	17.2
Anglia and Oxford	19	9.5	18.4

Source: See reference 23.

Ethnic variations in diet-related diseases

- Coronary heart disease mortality is around 50% higher in South Asian men and women living in the UK than the average in England and Wales.[8]
- Stroke mortality rates are around 50% higher in South Asians and black Caribbean men and women, and nearly three times higher in West African men, than the average in England and Wales.[8]
- Diabetes is three times higher in Pakistani and Bangladeshi men and women, two and a half times higher in black Caribbean men, and four times higher in black Caribbean women than in the general population in England.[8]
- Babies born in the UK whose mothers were born in the Indian subcontinent are on average 200g lighter at birth than those whose mothers were born in the UK.[12]

Inequalities in what people eat

There are considerable differences in what people eat depending on their socioeconomic group, where they live in the UK, and their ethnic background.

Socioeconomic inequalities in diet

- People in the UK living in households without an earner consume more total calories, and considerably more fat, salt and non-milk extrinsic sugars than those living in households with one or more earners.[25] (See Table 9.)
- People on low incomes eat less variety of foods.[26] This is related to economies of scale and fear of potential waste.
- People on low incomes eat more processed foods which are much higher in saturated fats and salt – such as fast food, white bread, processed vegetables, and meat products.[12]
- According to the National Diet and Nutrition Survey, people living on state benefits eat less fruit and vegetables, less fish and less high-fibre breakfast cereals than those not on benefits. One in three people on benefits ate no fruit at all in the week of the survey.[1]
- Social classes D and E have not increased their fresh fruit consumption and have had a greater decline in vegetable consumption than social class A over the period 1979-1995.[27]
- Men and women living on benefits eat more sugar and sweets, and women also eat more whole milk, burgers and kebabs, meat pies and pasties, than those not on benefits.[1]
- Children of semi-skilled and unskilled manual workers eat more fatty food more often, and less fruit and vegetables, than children of professionals and managers.[28]
- Fish consumption has declined markedly in social classes D and E but remained steady in social class A.[27]
- Children in lower socioeconomic groups tend to have lower blood levels of vitamins such as folate, riboflavin, vitamin D and iron.[4]

Table 9 Average daily intakes of calories and fatty, salty and sugary foods: differences by household income and between households with and without an earner, United Kingdom, 2000

	Gross weekly income of head of household						
	Households with one or more earner				Households without an earner		
	Over £725	£375-£725	£180-£375	Less than £180	Over £180	Less than £180	OAP
Total calories (Kcal)	1,930	1,895	1,945	1,890	2,245	2,130	2,280
Total fat (g)	83	79	83	83	97	88	99
Sodium (g)	2.74	2.82	2.84	2.68	3.09	2.96	3.02
Non-milk extrinsic sugars (g)	52	53	56	60	69	61	65

Source: National Food Survey 2000. See reference 25.

Geographical inequalities in diet

- For fresh fruit and vegetables, there is a strong north/south gradient, with people in the South East eating 33% more than those in the North West.[29]
- For fibre, regional differences are not so pronounced, but the lowest consumption is in the North West (11.6g per day) and the highest in the South East (13.5g per day).[29]

Ethnic variations in diet

- There is considerable variation in eating habits between minority ethnic groups.[30] Bangladeshi men and women eat more red meat and fatty foods, and less fruit, than any other minority ethnic group. Pakistani men and women have the lowest vegetable consumption of minority ethnic groups. Chinese men and women eat the most fruit and vegetables.
- The practice of adding salt to cooking is almost universal among South Asian and Chinese groups and is more common in black Caribbean adults than in the general population.

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Why prioritise strategies for nutrition and food poverty?

C

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

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

Your PCT plans and local government plans need them!

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

Planning a health equity audit

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

Further guidance

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

Working in local partnerships

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

Local transport plans

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

Value for Money and Best Value targets

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

Health scrutiny

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

Further guidance

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

The government's health agenda related to food poverty

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

Tackling health inequalities

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

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

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

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

The priority health areas

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

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

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

The Food and Health Action Plan

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

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

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

Table 10 The health agenda

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

Continued on next page

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

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

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

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

Local authorities can develop Local Public Service Agreements (LPSAs) in agreement with the Office of the Deputy Prime Minister (ODPM). These LPSAs reflect local as well as national priorities. Each local authority has about 12 LPSAs and at least one of these has to relate to health and social services. If these are 'stretched targets', (i.e. targets above that which would normally be expected), and the target is achieved, the authority will receive a grant award of up to $2^{1}/_{2}$% of its total budget. Authorities in areas with low life expectancy are encouraged to adopt health inequalities targets.

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

Table 11 The agenda for the wider determinants of health

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

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

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

The Common Agricultural Policy and food poverty

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

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

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

The economic benefits of improving diets

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

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

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The health agenda related to food poverty

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

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

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

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

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

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

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

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

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

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The agenda for the wider determinants of health

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

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

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

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

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

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

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Young@heart policy recommendations

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

A national strategy for improving nutrition among children and young people

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

POLICY ACTION

LA = Local action

A Improve nutrition in women before and during pregnancy.

Supporting actions

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

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

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

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

B Improve infant and pre-school nutrition.

Supporting actions

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

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

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

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

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

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

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

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

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

Supporting actions – Investment

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

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

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

Supporting actions – School policies

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

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

Supporting actions – Quality and uptake of school meals

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

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

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

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

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

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

Supporting actions

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

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

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

Supporting actions

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

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

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

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

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

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

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

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

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

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

Research and development agenda

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

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

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

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

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Population dietary recommendations for England

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

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

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

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

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

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Developing a local nutrition and food poverty strategy

D

The first stages of developing a local nutrition and food poverty strategy involve reviewing the health benefits of action on reducing food poverty and establishing food poverty as a priority issue. These stages are covered by the earlier sections of this toolkit.

This section gives further background information to help you to develop and write your strategy. It has been organised to help you in this process but, when you come to write the strategy, you will not necessarily follow these steps in the order given here. For a menu of the types of local food projects that can be successful, see Section E *Choosing interventions to reduce food poverty*.

The following issues to consider are covered in this section:

- Recognising the underlying barriers to healthy eating
- Identifying target groups and communities
- Identifying the community's views on needs, barriers and opportunities
- Choosing a theoretical model to underpin your strategy
- Choosing local interventions
- Working in partnership
- Deciding on aims and objectives
- Developing targets and indicators
- Evaluation
- Dissemination of good practice
- Sources of funding
- Promotional plan
- Education and training on nutritional issues for professionals involved in the project
- Project management
- Risk management

See Tool D1 *Outline of a local nutrition and food poverty strategy*. This tool gives an action plan for writing a strategy and shows where to find the relevant help in this toolkit.

Recognising the underlying barriers to healthy eating

Among people on low incomes, cost is the main determinant of what food is bought.[1] However, choice of food also depends on a range of factors which affect the availability and accessibility of buying and preparing healthy foods, as well as attitudes to and awareness of healthy eating.

See Tool D2 *Framework of the barriers to healthy eating on a low income*. This shows a framework of the factors involved.

The main areas of barriers to healthy eating on a low income are:

- Low income and debt
- Poor accessibility to affordable, healthy foods
- Sociocultural factors
- Factors in food production and the food chain
- Lack of opportunities to experiment and to develop cooking skills for healthy meals
- Lack of accessible and accurate information
- Food labelling
- Food marketing
- Poor literacy and numeracy skills.

Low income and debt

Household incomes depend on a range of income sources, including wages, pensions, family support, benefits and tax credits. The proportion of the population in Great Britain living in poverty has declined from a peak of 21% in the early 1990s to 17% in 2001/02. However, it remains well above the early 1980s level of 10%-15%.

Children are disproportionately present in low-income households. In 2001/02, 2.7 million children were living in low-income households (before deduction of housing costs). After rising to a peak of 27% in the early 1990s, the proportion has fluctuated, but has fallen in recent years, to 21% in 2001/02.[2]

The government has introduced several measures to reduce poverty, particularly for families with children. However, benefit levels have not been devised with an allowance for a healthy diet, and those living on benefits for prolonged periods will often be in food poverty. Low benefits levels are compounded when people do not claim their full benefit entitlement. Debt and automatic deductions from benefits (including for utility bills and credit cards) can build up, eating their way into money for food.[3]

Poor accessibility to affordable, healthy foods – 'food deserts'

The development of out-of-town supermarkets and the closure of shops in socially deprived areas over the last 30 years has led to poor quality and choice and high prices in the remaining small, local shops. Even if discount stores are available locally, they often offer only a limited range of foods, particularly of fresh foods. Lack of convenient and affordable transport to reach supermarkets means that the poorest people often have to pay higher prices for a healthy range of foods than those who are better off.[4] This has led to the concept of 'food deserts'.[5, 6]

There is currently debate over whether food deserts do exist. Research has identified some areas where people live too far away (more than 500 metres) to walk to good-quality food shops.[7] The preliminary results of one study indicate that opening a food superstore in a 'food desert' significantly increases fruit and vegetable consumption.[8] However, a recent analysis has indicated that poorer people tend to live near shops with good food choices, but tend to shop in discount shops where availability and quality are less but the food is cheaper. Food deserts can therefore be a result of poverty rather than of retail geography.[9]

Sociocultural factors

There are many sociocultural factors which affect our taste, food preferences and choices.[10, 11] Those which have frequently been shown to be associated with inhibiting dietary change include family food norms/preferences, family resistance/lack of support and childcare demands.[12] Beliefs and values attributed to certain foods may also act as barriers to change.[13] The area of food acceptability and choice is now the subject of a research programme by the Food Standards Agency.[14]

Factors in food production and the food chain

Eating a healthier diet is, in several respects, made more difficult by the nutrient content of the foods that are easily available to buy. For example, 75% of our very high salt intake comes from processed food[15] and, although people are eating less whole milk, the fat of the milk is finding its way back into our diets by being used in pre-prepared foods.

Lack of opportunities to experiment and to develop cooking skills for healthy meals

Many people of all income groups now lack the skills and confidence needed to cook and they rely more on convenience pre-prepared foods. This disproportionately affects people on low incomes. In addition, people on low incomes may lack basic cooking equipment, especially if living in temporary accommodation or bed and breakfast. Poor families often choose convenience foods because these are relatively cheap, acceptable to children, come in regular portion sizes and there is no waste. Heating convenience foods can also save money on fuel bills, as cooking from basic ingredients uses more fuel.

Lack of accessible and accurate information

Understanding what makes a healthy diet and how to choose appropriate foods is fundamental to eating well, although advice by itself is not usually successful in changing behaviour. We receive information on foods from a wide variety of sources, including the press, food packaging and labelling, food marketing, TV programmes, books and the internet, schools and health education. Some of this information may not be accurate or may not be accessible if it is not in the reader's language, or if there are poor literacy and numeracy skills. Much of the information that people receive is contradictory. It is therefore most important that health professionals put out consistent, evidence-based messages.

Food labelling

Labelling of foods is often difficult to interpret, particularly in the context of shopping in limited time. Sometimes food labels can be misleading – for example, claims that fatty foods have 0% cholesterol. Further regulations on food labelling to ensure that they are more informative and not misleading would be helpful.

Food marketing

In 2001, £594 million was spent advertising food in the UK and £116 million (around 20%) was contributed by the top four confectionery manufacturers. Much of this advertising is targeted at young children because they have a significant influence on the foods their parents buy. This is known by marketers as 'pester power'.[16] Children engage with and enjoy food promotion. A systematic review of the research literature has shown that food promotion has an effect on children's preferences, purchase behaviour and consumption. This effect is independent of other factors and influences both choice of brands and overall purchasing of foods within the advertised categories.[17]

Ninety-nine per cent of foods and drinks advertised to children during Saturday morning children's TV were high in fat, or sugar or salt.[18] Cakes, biscuits and confectionery make up 46% of food advertising on children's ITV. However, on late evening TV their combined proportion was just 13%.

Poor literacy and numeracy skills

People who have difficulty in reading are at even greater disadvantage. Poor literacy and numeracy skills are barriers to information, cooking, managing the household budget and

employment. People with poor literacy, numeracy or language skills tend to be on lower incomes or unemployed and they are more prone to ill health and social exclusion. In 1999 there were 7 million people who could not read to the level that would be expected of an 11 year old, and even more have trouble with numbers. Of these, 1 million are under 25 years old and 4 million are aged between 26 and 55. Half are in low-paid employment and one-third of unemployed people have poor literacy skills.[19]

Identifying target groups and communities

Sizeable areas of poverty will be well known to local health and public health professionals. Those people most likely to be experiencing food poverty are: those who are living on low incomes or who are unemployed; older people; people with disabilities; households with dependent children; and members of black and minority ethnic communities.

Quantifying the extent of need is vital for prioritising, securing funding and evaluation. Quantitative data can be obtained from local information on the prevalence of and deaths from diet-related diseases, and by identifying areas of deprivation. Your public health observatory may already have the information you need or will be able to offer further advice (www.pho.org.uk).

Further guidance

Local basket of inequalities indicators
Produced by the Association of Public Health Observatories and the Health Development Agency. Available from: www.lho.org.uk
Gives a selection of local health inequality indicators.

See Tool D3 *Sources of data at ward level.*

Identifying the community's views on needs, barriers and opportunities

Qualitative information on the community's own views of their needs and on current barriers to eating well is a vital foundation to a successful programme and can only be obtained by asking the community. This can be achieved in the following ways.

Community mapping

Community mapping is a process that uses participatory appraisal methods to engage communities in assessing their own needs around food and food access. The process of community mapping produces a map of an area which illustrates the local food economy. The process also aims to inform and empower local people in order to build their capacity to address their own problems.

Community meetings and local surveys

Holding community meetings, discussion groups or focus groups, or conducting local surveys, can help fill the gaps in readily available information. The questions you ask will depend on the broad objectives of your programme and should be based on a prior understanding of the wide range of possible barriers. (See *Recognising the underlying barriers to healthy eating*, on page 93.)

Food mapping

Maps can be produced using Geographic Information System (GIS) software showing which roads are within reasonable walking distance of shops where food is reasonably priced and which sell a variety of fruit and vegetables.

Further guidance

Reaching the Parts ...
Published by Sustain. Price £20.
A guide to community mapping.

Making Links: a Toolkit for Local Food Projects
Published by Sustain.
See section 2 for a guide to developing and conducting local surveys, and sample questionnaires.

Community Mapping Project
A project where participatory appraisal methods are being used.
For more information, see www.sustainweb.org/poverty_commap.asp

Choosing a theoretical model

Underpinning your strategy with an appropriate theoretical model will help to ensure that your interventions are appropriate to your target audience. It will also help you to clarify the programme's aims and objectives and to plan the evaluation. The main theoretical models that have been used successfully in nutrition interventions are:

- The Health Belief model
- The Theory of Planned Behaviour
- The Stages of Change model
- The Food Access model.

Further guidance

A Local 5 A DAY initiative. A Handbook for Delivery
Produced by the Department of Health. Available from www.dh.gov.uk
This contains a summary of the theoretical models listed above.

Choosing local interventions

If local programmes are to relieve food poverty in sustainable ways, they must identify and address a significant range of the underlying barriers to healthy eating. Many of the barriers to healthy eating are clearly outside the scope of the health services but some can be addressed by nutrition and food poverty strategies if health, social, education and environmental services and local communities work together where their agendas overlap. Section E of this toolkit offers a menu of the range of actions that can lower the barriers to healthy eating on a low income and that can be addressed by local projects.

Other local policies may contribute to some of the barriers to healthy eating. Health impact assessment can be used to estimate the consequences of current policies and the likely consequences of proposed changes.

Further guidance

Introducing Health Impact Assessment: Informing the Decision-making Process
Produced by the Health Development Agency. Available from www.hda-online.org.uk.
Provides a simple overview of the health impact assessment approach.

Working in partnership

Involving potential partners from the outset with a common planning process and joint needs assessment will make the task of reconciling agendas much easier. Partnership working between local authorities and health organisations is now directed by government policies and enabled by

the Local Government Act 2000, the Health Act 1999 and the Crime and Disorder Act 1998. These give powers of flexibility, enabling budgets to be pooled to serve the common objectives of improving well-being and health. There is currently some confusion about what flexibilities are allowed by various government departments. The Health Development Agency has conducted a survey of all government departments' flexibilities (see *Pooling Resources across Sectors*, in *Further guidance* below).

As well as the **local communities** and **local food networks**, partners can include the following.

Local authorities

Many departments within local authorities may be interested in becoming a partner or supporting the local nutrition and food poverty strategy as part of their community plan. These include: social services, anti-poverty, community safety, trading standards, lifelong learning and education, housing, tenants' and residents' associations, environmental health, leisure services, neighbourhood renewal plans, Sure Start, Local Agenda 21, and rural and urban planners.

National charities

Partners might include charities with a related agenda in health, environment, education or social care, or those with a focus on your target groups and illnesses.

Local organisations

Other partners could include retailers, transport providers, local employers (including the NHS and local authorities), local growers and caterers, local media and higher education institutes.

See Tool D4 *Working in partnership with local authorities*. This gives an outline of the types of local authorities in the UK and the types of services they provide which can impact on nutrition.

Further guidance

Partnership Working. A Consumer Guide to Resources
Produced by the Health Development Agency. Available from www.hda-online.org.uk/documents/partnership_working.pdf
This is a useful review of the many different resources available in printed form or on the web.

Pooling Resources Across Sectors: A Report for Local Strategic Partnerships
Produced by the Health Development Agency. Available from www.hda-online.org.uk

Reducing Inequalities: Local Government and the NHS Working Together
Published by the Health Development Agency in association with the Local Government Chronicle and the Health Service Journal.
Available free from: www.hda-online.org.uk/documents/hsj_lgc_hda_supplement.pdf

Prevention is Better than Cure
Produced by the Faculty of Public Health Medicine, the Local Government Association, NEXUS and the NHS Confederation.
Available free from the Faculty of Public Health website www.fph.org.uk
Based on a conference held in 2002, this publication examines the potential for joined up working between the health services, local government, the voluntary sector and other organisations and agencies which work to improve and support public health.

Food: The Local Vision
Published by the Food Standards Agency, the Local Government Association and LACORS, 2002. Downloadable free from the websites of any of these organisations. (For website addresses see page 159.)
Promotes the vision of local councils in community health and the importance of providing access to safe, sustainable and nutritious food. The publication contains a number of good practice examples on food issues.

Health and Neighbourhood Renewal
Produced by the Department of Health and the Neighbourhood Renewal Unit.
Available free from www.dh.gov.uk. Printed copies can be ordered from Department of Health Publications on 08701 555 455.
A comprehensive guidance document that is an essential read for all those who work within or with local authorities. It is particularly useful for Local Strategic Partnerships, New Deal for Communities, Healthy Living Centres, Healthy Schools/Workplace initiatives and the Neighbourhood Renewal Strategies.

Making the Connection. Trading Standards: Contributing to Public Health
Produced by the Trading Standards Institute (TSI).
This document challenges the trading standards profession to be more involved in nutrition issues and provides a strong case for the profession to be seen as part of the 'wider public health workforce'.

Deciding on aims and objectives

The aims and objectives of your strategy will depend on the local needs of the target groups and also on the agendas of the various local organisations that could be valuable partners. Although these agendas will overlap with health agendas in some areas, in others they will not, and may even conflict. For example, the main purpose of school breakfast clubs from the school's perspective may be to get children to school on time and having eaten something. However, in many breakfast clubs, the children are offered rather unhealthy food. It is therefore important that organisations understand these different agendas so that they can be acknowledged and reconciled. Your aims and objectives should clearly reflect your joint agendas and they must be measurable through indicators of progress and/or targets.

Further guidance

An Evaluation Resource for Healthy Living Centres
By J Meyrick and P Sinkler. Published by the Health Development Agency, 1999.
Available free online from the Health Development Agency (www.hda-online.org.uk).
This excellent guide goes through the evaluation process, starting with setting the aims, objectives and targets, and has many ideas for indicators of progress.

A Local 5 A DAY Initiative. A Handbook for Delivery
Published by the Department of Health. Available free from www.dh.gov.uk

Developing targets and indicators

You and your partners will need to decide what the local strategy can achieve and in what timescale. Developing targets is an excellent way of thinking through your strategy and planning the evaluation. (See *Evaluation* on page 100.) Holding a workshop of partners and participants, facilitated by experienced researchers, can be very productive in this process.

The benefits of developing targets and indicators include the following:

- Targets turn your objectives into reality with definite timelines and specific goals. They can be quantitative or qualitative and concern actions or outcomes.
- Indicators describe change and can be used to monitor progress towards your targets.
- The process of developing and publishing the results of indicators of progress and targets can further identify needs and promote local action.
- Your targets can contribute to the targets that LSPs are expected to set for tackling deprivation, including local health inequalities.
- With targets, the strategy can be part of a local equity audit and you can demonstrate how it will contribute to the national inequalities targets for health and local authorities (see Section C).

Examples of types of targets and indicators

Input

Partners involved
Level of funding secured
Numbers of health professionals involved

Process or action

Numbers and types of services developed
Numbers of people attending
Lobbying MPs about food labelling

Intermediate outcomes

Improved health literacy
Raised self-esteem
Increase in fruit and vegetable consumption
Improved access to wider food choices
Whether food poverty has become a consideration in related local policies, e.g. transport planning
Community empowerment

Final outcomes

Change in well-being and health
Community development
Change in local and national policies

Further guidance

Closing the Gap: Setting Local Targets to Reduce Health Inequalities
By J Bull and L Hamer. Published by the Health Development Agency, 2002.
A guide to developing local targets.

The Food Indicator Toolkit
By the SAFE Alliance. Available from Sustain.

An Evaluation Resource for Healthy Living Centres
By J Meyrick and P Sinkler. Published by the Health Development Agency, 1999.
Available free online from the Health Development Agency (www.hda.nhs.uk).
This excellent guide goes through the evaluation process, starting with setting the aims, objectives and targets, and has many ideas for indicators of progress.

Evaluation

There are two basic rules for successful evaluation:

1 The evaluation process must be thought through from the start, at the same time as you develop the strategy's aims, objectives and targets.
2 Adequate funding must be set aside for the evaluation. A good guide is 10% of the total budget. Ten per cent of the total budget may seem a lot of money that could otherwise go directly into services. However, a robust evaluation is needed to ensure that the project is effective and efficient (value for money) and sustainable, as it will be essential to secure continuing funding or mainstreaming. It will also add to the evidence base, which is currently not large, thus increasing the likelihood of future funding for other community initiatives.

Evaluation of community projects is not easy and not everything can be evaluated. The rationale for evaluation can include:

- to inform the day-to-day running of the project, to try to improve interventions and possibly to develop new ones
- to demonstrate worth and value for money to the funder, in order to support requests for continued or additional funding
- to define and examine successes and failures with all stakeholders, and to know how and why something works, as well as attempting to understand why it may not

- to develop models of good practice that are then disseminated to others
- to contribute to the debate on food poverty.[20]

The key areas to evaluate must be agreed among the partners, including the participants, to reflect their different agendas. Evaluation will include:

- measuring indicators of progress, including progress towards any targets
- assessing how well various aspects of the strategy were perceived to work from the viewpoint of professionals and communities
- assessing whether the changes were a result of the intervention.

It is essential to include in your project team someone with expertise in the evaluation of community projects. This could be someone from the health or environment departments of a local university or further education college, a local dietitian, or someone from the nutritional department of a hospital or the community.

See Tool D5 *HEBS Research & Evaluation Toolbox.*
See Tool D6 *Validated dietary questionnaires.* This gives examples of validated questionnaires suitable for assessing diets in community or primary care projects.

Further guidance

Self-evaluation. A Handy Guide to Resources
From the New Opportunities Fund (www.nof.org.uk).

An Evaluation Resource for Healthy Living Centres
By J Meyrick and P Sinkler. Published by the Health Development Agency (www.hda.nhs.uk).
This excellent guide is available free online from the Health Development Agency. It goes through the evaluation process, starting with setting the aims, objectives and targets, and has many ideas for indicators of progress.

A Recipe for Success? An Evaluation of a Community Food Project
Published by the Centre for Research in Social Policy, Loughborough University.
This is a helpful account of an evaluation.

A Critique of Evaluation Resources for the Public Health Development Library
Available from the Public Health Electronic Library (PHEL) evaluation website www.phel.gov.uk
This document provides a critique of evaluation resources, guides and toolkits aimed at those working in public health and health improvement.

Dissemination

A robust evaluation will enable others planning community initiatives to benefit from your experiences. However, they first of all have to hear about your successes. Your dissemination plans could include:

- placing a description of your project on Sustain's Food Poverty Project database (www.foodpovertyprojects.org.uk)
- giving presentations at conferences
- writing articles for professional magazines and newsletters, for example for *Let Us Eat Cake!*, the newsletter of the Food Poverty Network
- a paper in a peer-reviewed journal
- local media, and
- community and school newsletters and meetings.

Sources of funding

There is a wide range of potential sources of funding for your strategy, apart from health funds. A full list and contacts are given in *SRBs to PCTs* which is published by Sustain.[21] The sources include:

- government-funded initiatives
  - Education Action Zones
  - 5 A DAY projects
  - National Healthy Schools Programme
  - Sure Start
  - Active Communities Programme
  - Children's Fund
  - Community Empowerment funds
  - Neighbourhood Renewal funding
  - Single Regeneration Budgets
- potential partners (see page 97)
- research and development funding
- National Lottery funds
- national charities with an interest in the focus of your strategy
- grant-giving trusts and foundations
- commercial sponsorship (but you will need to consider any potential conflicts of interest).

Promotional plan

There will have to be publicity in order to encourage sufficient numbers of people to use the projects organised within your nutrition and food poverty strategy. However, there will be several other areas of your strategy which will also benefit from promotional activities. You will need to develop a promotional plan whose objectives may include:

- to encourage participation in the projects by members of the target audience
- to raise awareness of the messages on nutrition among people who do not attend the projects
- to create a favourable public profile for the key partners, particularly political and funding partners, to increase the chances of sustainability
- to generate support among health care and other local professionals in related areas of the environment, education and social care.

You will want to make sure that several target audiences know about your programmes. These will include the potential users, health care staff, teachers and school governors, community development staff, various local authority departments, sponsors and potential future sponsors. Each target audience will need its own messages aimed at achieving specific objectives. For example:

Target audience:	Health care staff including GPs, practice nurses, dentists and community nurses.
Message:	Poor nutrition is a major source of early death and disability from many diseases.
Desired outcomes:	Increased interest, enabling uptake of educational programmes on nutrition, consideration of nutrition in consultations and encouragement of patients to be involved in local programmes.

Your programmes will benefit from a range of ways to obtain publicity. These include:

- having a high profile launch with a local or national personality
- direct contact between project workers and the target audience

- publicity through existing groups and networks
- offering features to local radio and newspapers
- distributing written, audio or video information in appropriate languages through local organisations and venues.

Involve your PCT communications lead from the outset as they will be able to advise you and will also have useful contacts with the media.

Education and training

Your interventions will have a greater chance of success if there is a sufficient level of knowledge of nutritional issues and support from the health professionals and other professionals either directly or indirectly involved with the project. Do not assume any level of knowledge. For example, the average GP in England has had only minimal education on nutrition. Short sessions as part of routine practice programmes – for example 15 minutes in a lunchtime meeting, backed up by handouts – can be effective. You can use the Tools in Sections A and C of this toolkit to prepare handouts for such sessions.

Project management

There will need to be a review of the progress of the programmes of the strategy at regular intervals and at key points. One way of doing this is to set up an advisory group involving the partners (including the users), funders and others who can add specific expertise, for example in evaluation and publicity.

Your strategy will also need at least one named individual who will have responsibility for developing and managing the programme. Larger strategies may need a team with an overall project manager. The main management roles will include:

- overseeing the day-to-day management and implementation of the programmes
- overseeing and taking responsibility for the evaluation
- managing the promotional plan
- overseeing education and training
- overseeing the financial management, and
- developing links to promote sustainability.

Risk management

The success of your project will depend on many underlying assumptions. Both these and the risks of events interfering with them, should be identified. This process is called risk management. The steps involved are:

- *identifying*: highlighting potential risks
- *prioritising*: scoring the risks both by potential harm and likelihood of occurrence
- *managing*: planning action to manage risks
- *reviewing*: periodically assessing the effectiveness of any action taken
- *reporting*: providing feedback to senior management.

There are several areas of food poverty projects in which risks will be present. These are shown in Table 12 on the next page.

Table 12 Examples of areas of risk for food poverty projects		
Area of risk	**Nature of risk** (examples)	**Consequences** (examples)
Political	Government priorities may change.	Sustainability will decrease.
Legal	A food programme may break hygiene regulations.	The programme may be shut down.
Financial	Inflation may exceed forecasts and reduce the effective size of your budget.	A decrease in activities may lead to failure to meet objectives and targets.
Criminal	Fraud or theft.	Increased costs, including legal costs with reduced activities and negative publicity.
Human	Loss of key management.	Loss of coordination and momentum, and delays.

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21 Watson A. 2002. *SRBs to PCTs. Understanding Local Structures and Area-based Initiatives to Tackle Food Poverty.* London: Sustain.

Tools

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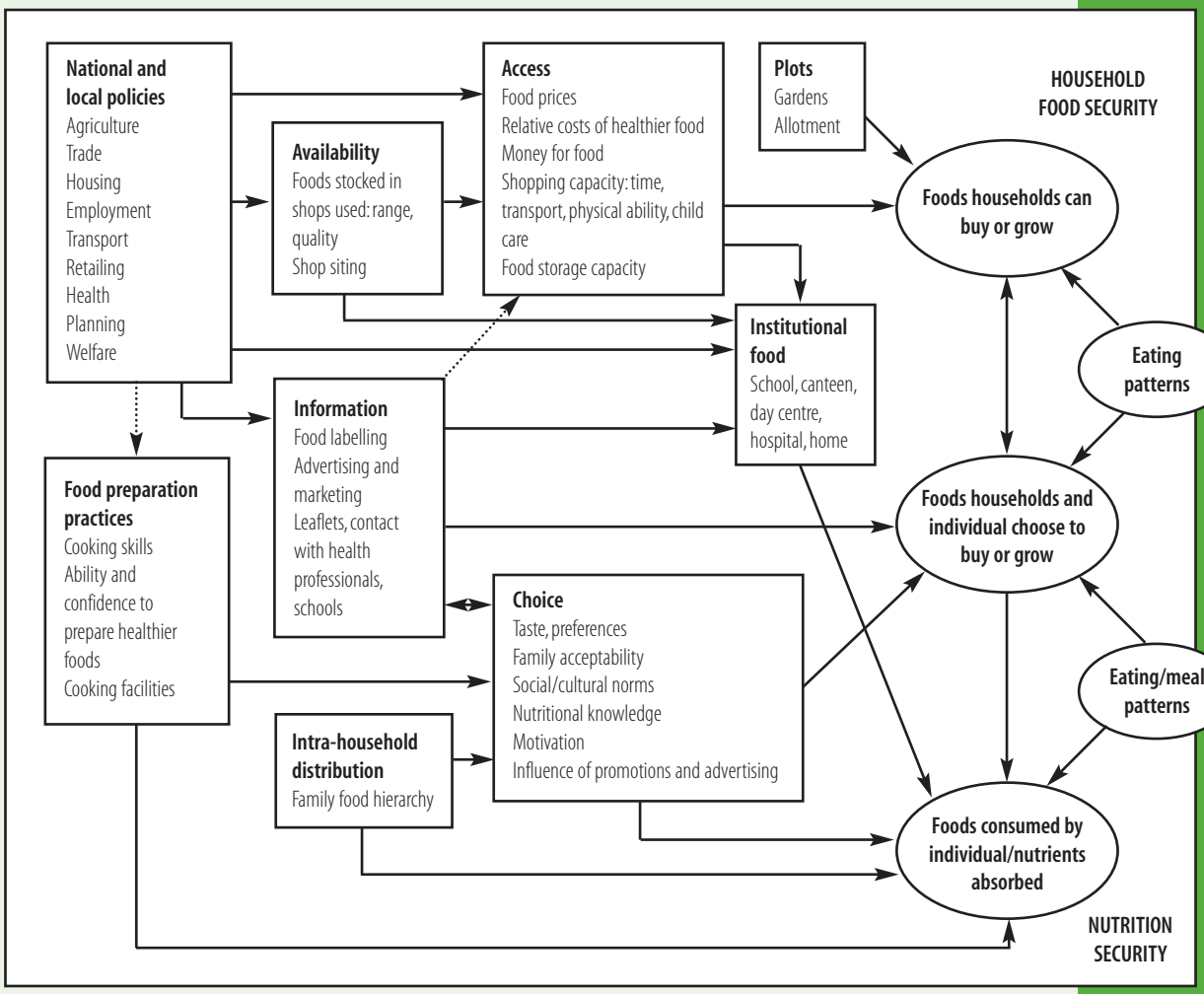
Outline of a local nutrition and food poverty strategy

	Strategy contents	Sections of this toolkit which can help
1	**Introduction** A few lines giving the essence of your strategy.	
2	**The benefits of a local nutrition and food poverty strategy** An outline of the health benefits of better nutrition, the inequalities related to poor nutrition and the social, environmental and educational benefits related to your interventions.	Sections A and B
3	**National policies, priorities and targets related to food poverty**	Section C
4	**Partners** The main partners, the relevance of the strategy to their aims, and relevant local policies, priorities and targets.	Sections C and D
5	**Aims, objectives and targets**	Section D
6	**Barriers, needs and opportunities** Results of the local assessment of barriers, needs and opportunities.	Section D
7	**Priorities and target groups** The chosen priorities and target groups and the rationale behind the choice.	Sections A, B, C and D
8	**Interventions** The chosen interventions and the evidence for their effectiveness.	Section E
9	**Evaluation** An outline of the planned evaluation.	Section D
10	**Cost** The cost of the strategy, and sources of funding.	Section D
11	**Sustainability** A description of how the individual programmes of the strategy will be sustained after the initial period of funding.	Section D
12	**Action plan** An action or implementation plan for the programmes including: • details of the interventions • project management • details of the evaluation • education and training • promotion and publicity • dissemination of progress and of the results of the evaluation.	Section D
13	**Risk management**	Section D

Framework of the barriers to healthy eating on a low income



Reproduced, with permission, from: Dowler EA, Turner S, Dobson BM. 2001. *Poverty Bites: Food, Health and Poor Families*. London: Child Poverty Action Group.

Sources of data at ward level

This Tool gives suggestions on where you can find data at ward level.

Ward level data on prevalence of diet-related diseases

- Coronary heart disease (CHD) registers in general practices. An early milestone in the National Service Framework for coronary heart disease was a practice register of all those diagnosed with coronary heart disease and this is now also a quality indicator in the new GMS contract.
- Diabetes and cancer registers in general practice and blood pressures of all those over 45 years are now quality indicators in the GMS contract.
- A diabetes prevalence model is available. This can estimate the prevalence of diagnosed and undiagnosed diabetes for any district or locality level for which age, sex and ethnicity data are available.[1]
- PCT-level data on dental caries is available from the surveys coordinated by the British Association for the Study of Community Dentistry (available from www.dundee.ac.uk/dhsru/cdh/text2008.htm#f1)

Ward level data on mortality from diet-related diseases

- The Office for National Statistics (ONS) compiles mortality statistics – including statistics on infant mortality – which are based on registrations of death. The Public Health Mortality File is available down to ward and PCT level and postcode areas.[2] A charge is made for the data.

Ward level data on low birthweight

The public health birth file, complied by the ONS, gives information on low birthweight down to PCT and ward level. ONS will supply local data to a named contact person in a health authority.

Identifying local areas of deprivation

- The Index of Multiple Deprivation 2000 is available down to ward level from the Office for National Statistics' website www.statistics.gov.uk under 'neighbourhood statistics'. It is based on the following six domains:
  - income
  - employment
  - health and disability
  - education, skills and training
  - housing
  - general access to services.
- The Rural Services survey, compiled by the Countryside Agency, has data at ward level on the availability of a range of services, including general stores, village shops and supermarkets. Available from www.countryside.gov.uk/ruralservices
- People living in council tax bands A and B or paying no council tax use primary care services more often than people living in other bands. This appears to be an excellent way of identifying the poorest people who have the worst health.[3]

Quality of life data

- The Audit Commission and the Improvement and Development Agency (IDeA) are developing a range of quality of life indicators, including community safety and community involvement. This is available from the Library of Local Performance Indicators at www.local-pi-library.gov.uk. Local authorities and LSPs may already be using these indicators. Some indicators are served by data that already have to be collected for other purposes; others will not be available unless a local survey has been carried out.
- The Department for Environment, Food and Rural Affairs has produced *Local Quality of Life Counts – A Handbook for a Menu of Local Indicators of Sustainable Development*, which contains 29 indicators for local authorities in England. It is available online at www.sustainable-development.gov.uk/indicators/local

References

1 Coyler E. *Implementing the Diabetes NSF. A Diabetes Prevalence Model*. Trent Public Health Observatory. Accessed from: www.trentpho.org.uk/products/diabetes/diabetesfinalmodel.xls

2 Office for National Statistics. Public Health Mortality File. Information accessed from: www.statistics.gov.uk

3 Beale N. 2000. Council tax valuation band as a marker of deprivation and general practice workload. *Public Health*; 114: 260-64.

Working in partnership with local authorities

Types of local authorities

For largely historic reasons, related in part to the geographical and population size, there are five types of local authorities in England. These are:

County Councils (CC)

District Councils (DC)
These can be called District, Borough or City Councils.

Metropolitan Districts (M)
These are called Metropolitan Borough or City Councils.

Shire English Unitaries
Shire English Unitaries (U) can be called a council (e.g. Medway Council), and also in some cases a District, City or Borough Council (e.g. Nottingham City, Reading Borough Council), and in one case only Rutland which is called a County Council.

London Boroughs (LB)
These include the Corporation of London. London also has the Greater London Authority (GLA).

Metropolitan Districts, English Unitaries, and London Boroughs provide all local authority services to the population in their area – including social services, education, environmental health, trading standards, housing etc – making them all-purpose authorities or single-tier councils.

In other areas (mostly rural) the system is split between the County Council and the District Councils, with the county providing some services (education, social services, trading standards, etc) and the District Councils providing other services (housing, environmental health, etc). The County Council provides around 80% of the services in these areas.

Joint working

The simplest situation for joint working is where there is a unitary local authority with a coterminous primary care trust (PCT). Examples include Milton Keynes, Solihull, Islington and the developing system in Wales. More complicated situations, such as the following, are common:

- PCTs relating to two tiers of local authority
- counties and districts which contain several PCTs
- counties and districts which surround a unitary metropolitan authority and its PCT or PCTs.

Services provided by local authorities

The list on the next page describes the main services provided by local authorities. Each service can have an impact on nutrition and food poverty, e.g. access, hygiene, or education of or contact with, or feeding 'at-risk' groups.

The contribution by a local authority to Local Strategic Partnerships can be managed from the Chief Executive's office (if there is one), a corporate department or a development service department, or a range of directorates. Local Strategic Partnerships are involved in the development of a number of strategies such as the community strategy and the neighbourhood renewal strategy so there will be a number of 'entry' points for PCTs to consider.

Within a local authority there will be an interest in food within an economic regeneration department with links to food industry, food production, farmers' markets and planning as well as

in the education department and social services due to catering and purchasing. The health scrutiny role is usually found in social services but could also be situated within a corporate department or development service department. The links within the local authority are critical to the PCT, particularly if there is more than one tier, when addressing nutrition and food poverty in any more than an *ad hoc* way.

More information on the services that local authorities provide is available from the Local Government Association website www.lga.gov.uk

Services provided by local authorities

Transport services

- Planning and delivering schemes to improve the transport network, including new roads, bus lanes, park-and-ride and traffic calming schemes
- Ensuring the efficient management of the transport network
- Maintaining the highway, which includes roads, footpaths, cycle-ways and bridges
- Supporting public transport; financial support for bus services that are socially necessary but unprofitable; and providing concessionary travel, transport and travel information
- Controlling car parking, including charging for on-street parking
- Providing bus travel to school, and transport services for people with special needs
- Community safety

Environmental services

- The collection, recycling and disposal of domestic waste
- Cleaning of streets and public places
- Provision of lighting to streets and public places
- Monitoring atmospheric pollution and noise from non-domestic premises and investigating complaints
- A range of public protection activities, e.g. safety of premises such as petrol stations, entertainment centres and shops
- Local Agenda 21

Education services

- Community education
- Student awards, grants and loans
- Education, including admission to schools, and exclusions
- Educational psychology
- Education welfare
- Special education and special needs teaching
- Governor services
- Lifelong learning and education
- Sure Start

Social services

- Day care and home care services
- Residential care
- Meals on wheels
- Supported living and personal support
- Children and family services
- Advocacy
- Hospital social work
- Equipment and aids to daily living
- Referral to other appropriate services

- Providing information on services
- Assessment of people's needs
- Anti-poverty and debt strategies

Planning services

- Preparing all statutory plans regarding land use and development
- Giving expert advice to developers to help ensure that developments take place
- Scrutinising and approving planning applications
- Investigating contraventions of planning approvals and regulations and taking appropriate action

Cultural and recreational services

- Arts, music, festival and dance development
- Sports and leisure facilities
- Library services, including mobile libraries
- Museums and heritage services
- Neighbourhood and community centres
- Grant aid to local voluntary groups
- Managing parks and open spaces, including playing fields, nature reserves, woodland and allotments

Trading standards services

- Inspection of business sites
- Advice to businesses or consumers
- Food sampling and food-related projects
- Weights and measures checks
- Checking accurate pricing, and sell-by dates
- Issuing licences for animal movements
- Product safety (for example electric blanket testing)
- Testing proof-of-age retail schemes, using volunteers
- Seizure of counterfeit goods
- Money/credit advice
- Doorstep sellers
- Home safety advice

Housing services

- Support and management of council-owned homes
- Housing maintenance of council-owned homes
- Housing advice centre
- Housing applications from homeless people
- Managing hostels for homeless people
- Emergency alarm systems (advice and grants)
- Grants for adaptations to homes of disabled people
- Advice on improving home energy efficiency
- Housing benefit and council tax benefit
- Identifying and meeting the current and future housing needs of local citizens
- Tenants' and residents' associations

Note: This is not a comprehensive list of the services provided by local authorities.

This Tool was written by Dr Naomi Rees, Partnership Manager, Birmingham City Strategic Partnership. It is based on the definitions given on the Local Government Association's website.

HEBS Research & Evaluation Toolbox

The HEBS *Research & Evaluation Toolbox* is available from www.hebs.com/research/retool

What is it?

The *Research and Evaluation Toolbox* has been produced by the Health Education Board for Scotland (HEBS) to help practitioners in health and related fields think through how research can help them in planning and evaluating their work. It was developed in response to the clear need expressed by practitioners for advice in this area and builds on HEBS experience of doing, commissioning and using research and evaluation across a range of settings, topics and population groups.

The Toolbox won't give ready-made answers to specific problems but it will offer helpful tips and general guidance on using research in project development and evaluation. These can easily be adapted to specific situations. It is also a gateway to useful resources produced by others in Scotland and beyond.

Who is it for?

The Toolbox has been developed primarily to help professionals working to improve public health. It is in particular for those who have a basic understanding of research and evaluation but no specialist expertise. The resource is open to everyone following a brief registration process.

What's in it?

Main sections	Brief description
Why research?	The role of research and evaluation at different stages in the planning and development of health initiatives.
Methods	How research questions shape research design and what research methods might be used.
Data sources	Health and related information available from national surveys and other sources.
Reviews	Why and how to carry out reviews of published research and other literature.
Needs assessment	Why and how to assess health needs in a population when planning an initiative.
Evaluation	Forms of evaluation relevant at each stage in programme planning and development.
Quality	Different quality assurance systems concerned with improving performance and raising standards of practice.
Commissioning	Procedures for buying in research and evaluation services and for managing commissioned research.
Dissemination	Strategies for communicating research findings and improving research impact.
Funding	Information and links regarding sources of funding for health and related research.
Links and references	Links to websites and key references from each Toolbox section.

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Validated dietary questionnaires

This Tool contains two questionnaires:
• the Five-A-day Consumption and Evaluation Tool (FACET), and
• the DINE questionnaire.

Five-A-day Consumption and Evaluation Tool (pages 118-121)

The Five-A-day Consumption and Evaluation Tool (FACET) has been developed for assessing the effectiveness of 5-A-DAY activities nationally. It is a validated dietary questionnaire which aims to assess changes in knowledge of, awareness of and access to fruits and vegetables. Guidance has been developed to assist in using the FACET questionnaire. This is available online at www.dh.gov.uk

This questionnaire has been reproduced on pages 118-121 with permission of the Department of Health.

DINE questionnaire (pages 122-124)

The Dietary Instrument for Nutrition Education (DINE) was designed and validated by the Department of Primary Care at Oxford University, which holds the copyright. DINE is a brief, structured dietary questionnaire that was designed to be administered by an interviewer. It can be used to make a quick initial assessment of the amount of fat and dietary fibre in an individual's usual diet, and to provide a basis for nutrition counselling for the reduction of disease risk factors. Distribution of the questionnaire is controlled to ensure that it is used appropriately. For further information and permission to use DINE, please contact Liane Roe, Research Nutritionist, at lsr7@psu.edu

This questionnaire has been reproduced on pages 122-124 with permission of the Department of Primary Care, Oxford University.

PART 1

For each question, please indicate the answer (or answers) by crossing the relevant box(es)

Try to make sure the crosses are clearly in the box they refer to, like this ☒, not like this ☒

Please use black or blue biro

If you make a mistake, just blank out the mistake like this ■ and carry on

Q.1 Please write in today's date.

Day	Month	Year

Q.2 Have you eaten any of the following foods in the last 24 hours ?

PLEASE "X" THE NUMBER OF PORTIONS OF FOODS EATEN FOR EVERY ROW

FOR EXAMPLE:

	1	2	3	4+
Fruit as a dessert	☒	☐	☐	☐

NUMBER OF PORTIONS

	1	2	3	4+
Breakfast cereal	☐	☐	☐	☐
Fruit for breakfast, e.g. on cereal	☐	☐	☐	☐
Crisps	☐	☐	☐	☐
Fruit as a between meal snack	☐	☐	☐	☐
A glass of pure, unsweetened fruit juice (not squashes or fruit drink)	☐	☐	☐	☐
Fruit as a starter to a meal	☐	☐	☐	☐
A baked potato	☐	☐	☐	☐
A bowlful of home-made style vegetable soup	☐	☐	☐	☐
Portions of vegetables with main meals (include baked beans and pulses as vegetables but not potatoes)	☐	☐	☐	☐
Any type of meat	☐	☐	☐	☐
A vegetable based meal	☐	☐	☐	☐
Any type of fish	☐	☐	☐	☐
A bowlful of salad	☐	☐	☐	☐
Fruit as a dessert	☐	☐	☐	☐

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PART 2

Please read each question carefully and "X" the answer that most accurately reflects your circumstances or views. In some questions you will be asked for your opinion on a topic, please write your answers in the box provided.

Q.1 How many portions of a combination of fruit and vegetables do you think health experts would recommend eating every day ?

PLEASE "X" ONE BOX ONLY

None	☐ 1	Five	☐ 6
One	☐ 2	Six	☐ 7
Two	☐ 3	Seven or more	☐ 8
Three	☐ 4	Don't know	☐ 9
Four	☐ 5		

Q.2 How many portions of fruits and vegetables do each of the following provide ?

PLEASE "X" ONE BOX ONLY IN EACH ROW

	1	2	3	4	Don't know
A small glass (150 mls) of unsweetened orange juice	☐	☐	☐	☐	☐
One glass of orange squash (diluted)	☐	☐	☐	☐	☐
A thin slice of tomato	☐	☐	☐	☐	☐
Three heaped tablespoons of carrots	☐	☐	☐	☐	☐
One medium-sized apple	☐	☐	☐	☐	☐
One small raspberry flavoured yoghurt	☐	☐	☐	☐	☐

Q.3 How important are the following to you in deciding how much fruit and vegetables that <u>you eat</u> ?

PLEASE "X" ONE BOX ONLY IN EACH ROW

	Very unim-portant		Unim-portant		Neither unim-portant nor important		Important		Very important		Don't know	
The money I have available to spend on fruit and vegetables	☐	1	☐	2	☐	3	☐	4	☐	5	☐	6
Price of fruit and vegetables	☐	1	☐	2	☐	3	☐	4	☐	5	☐	6
My knowledge about ways to prepare fruit and vegetables	☐	1	☐	2	☐	3	☐	4	☐	5	☐	6
The time I have available to prepare fruit and vegetables	☐	1	☐	2	☐	3	☐	4	☐	5	☐	6
How easy it is for me to get the shops*	☐	1	☐	2	☐	3	☐	4	☐	5	☐	6
How heavy my shopping is to carry	☐	1	☐	2	☐	3	☐	4	☐	5	☐	6
Likes and dislikes of my household for fruit and vegetables	☐	1	☐	2	☐	3	☐	4	☐	5	☐	6
The quality of fruit and vegetables available	☐	1	☐	2	☐	3	☐	4	☐	5	☐	6

*any shops within walking distance

2

Q.4 Do you think you will increase the amount of fruit and vegetables you eat in the next year ?

PLEASE "X" ONE BOX ONLY

No, definitely not	No, probably not	Possibly	Yes, probably	Yes, definitely	Don't know
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

Q.5 By eating more fruit and vegetables, I think that people can reduce their chances of getting....

PLEASE "X" ONE BOX ONLY IN EACH ROW

	Agree strongly	Agree slightly	Neither agree nor disagree	Disagree slightly	Disagree strongly	Don't know
Stroke	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Cancer	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Back pain	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Hearing problems	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Heart disease	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

PART 3

To help us in analysing this survey, please provide the following information

Q.1 Your date of birth

Day	Month	Year

Q.2 Sex

PLEASE "X" ONE BOX ONLY

Male ☐ 1

Female ☐ 2

Q.3 Which of these apply to you?

PLEASE "X" ONE BOX ONLY

Current smoker ☐ 1

Ex smoker ☐ 2

Never smoked ☐ 3

Q.4 How many people live in your household (including yourself)?

PLEASE "X" ONE BOX ONLY IN EACH ROW

	0	1	2	3	4+
Adults and children aged 16 and over including yourself		☐	☐	☐	☐
Children under 16	☐	☐	☐	☐	☐

Q.5 To which of these groups do you consider you belong?

PLEASE "X" ONE BOX ONLY

- White ☐ 1
- Indian ☐ 2
- Pakistani ☐ 3
- Bangladeshi ☐ 4
- Chinese ☐ 5
- Black Caribbean ☐ 6
- Black African ☐ 7
- Black (other) ☐ 8
- Mixed ethnic group ☐ 9
- None of the above ☐ 10
- Prefer not to say ☐ 11

We are interested to know how diet relates to income and would like you to complete the question below. If you prefer not to answer this question please leave it blank.

Q.6 What is your total gross household income before tax and including benefits ? (for example, pensions, working family tax credit and/or jobseekers allowance etc)

PLEASE "X" ONE BOX ONLY

Gross Weekly Income (before tax)		**Gross Monthly Income (before tax)**		**Gross Annual Income (before tax)**	
Less than £100 a week	☐ 1	Less than £430 a month	☐ 1	Less than £5,000 p.a.	☐ 1
£100 - £150 a week	☐ 2	£431 - £650 a month	☐ 2	£5,000 - £7,800 p.a.	☐ 2
£151 - £200 a week	☐ 3	£651 - £870 a month	☐ 3	£7,801 - £10,000 p.a.	☐ 3
£201 - £250 a week	☐ 4	£871 - £1,080 a month	☐ 4	£10,001 - £13,000 p.a.	☐ 4
£251 - £300 a week	☐ 5	£1,081 - £1,300 a month	☐ 5	£13,001 - £15,500 p.a.	☐ 5
£301 - £400 a week	☐ 6	£1,301 - £1,730 a month	☐ 6	£15,501 - £21,000p.a.	☐ 6
More than £400 a week	☐ 7	More than £1,730 a month	☐ 7	More than £21,000 p.a.	☐ 7

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DINE: Dietary Instrument for Nutrition Education

1. About how many **pieces or slices per day** do you eat of the following types of bread, rolls, or chapatis? (Choose one answer on each line)

Breads & Rolls	None	Less than 1 a day	1 to 2 a day	3 to 4 a day	5 or more a day
White bread or rolls	0	1	4	9	13
Brown or granary bread or rolls	0	2	7	15	22
Wholemeal bread or rolls	0	3	8	18	26

Bread	

2. About how many **servings per week** do you eat of the following types of breakfast cereal or porridge? (Choose one answer on each line)

Breakfast cereals	None	Less than 1 a week	1 to 2 a week	3 to 5 a week	6 or more a week
Sugared type: Frosties, Coco Pops, Ricicles Sugar Puffs Rice or Corn type: Corn Flakes, Rice Krispies, Special K	0	0	0	1	2
Porridge or Ready Brek Wheat type: Shredded Wheat, Start, Weetabix, Fruit 'n Fibre, Puffed Wheat Muesli type: Alpen, Jordan's	0	1	2	5	7
Bran type: All-Bran, Bran Flakes, Country Bran	0	2	5	12	18

Cereal	

3. About how many **servings per week** do you eat of the following foods? (Choose one answer on each line)

Vegetable foods	None	Less than 1 a week	1 to 2 a week	3 to 5 a week	6 to 7 a week	8 to 11 a week	12 or more a week
Pasta or rice	0	0	1	3	4	6	8
Potatoes	0	0	1	3	5	8	10
Peas	1	1	3	8	12	16	24
Beans (baked, tinned, or dried) or lentils	1	1	4	10	15	20	30
Other vegetables (any type)	0	0	1	2	3	5	6
Fruit (fresh, frozen, or canned)	0	0	1	3	5	8	10

Vegetables	

Fibre Rating			
	Less than 30	=	Low Fibre Intake
	30 to 40	=	Medium Fibre Intake
	More than 40	=	High Fibre Intake

Total	

4. About how many **servings per week** do you eat of the following foods? (Choose one answer on each line)

	None	Less than 1 a week	1 to 2 a week	3 to 5 a week	6 or more a week
Cheese (any except cottage)	1	1	2	6	9
Beefburgers or sausages	1	1	2	4	6
Beef, pork, or lamb (for vegetarians: nuts)	1	1	2	6	9
Bacon, meat pie, processed meat	1	1	2	5	8
Chicken or turkey	0	0	1	3	5
Fish (NOT fried fish)	0	0	0	1	2
ANY fried food: fried fish, chips, cooked breakfast, samosas	1	1	2	6	9
Cakes, pies, puddings, pastries	1	1	2	5	8
Biscuits, chocolate, or crisps	1	1	2	4	6

Score

5. About how much of the following types of milk do you yourself use **per day**, for example in cereal, tea, or coffee? (Choose one answer on each line)

Milk	None	Less than a quarter pint	About a quarter pint	About half a pint	1 pint or more
Full cream (silver top) or Channel Islands (gold top)	0	1	3	6	12
Semi-skimmed (red striped top)	0	0	1	3	6
Skimmed (blue checked top)	0	0	0	0	0

Milk

6. About how many **rounded teaspoons per day** do you usually use of the following types of spreads, for example on bread, sandwiches, toast, potatoes, or vegetables? (Choose one answer on each line)

Spreads	None	1	2	3	4	5	6	7 or more
Regular margarine, butter or **Reduced fat spread** such as sunflower or olive spread, Flora, Vitalite, Clover, Olivio, Stork, Utterly Butterly	0	4	8	12	16	20	24	28
Low fat spread such as Flora Light, St. Ivel Gold, Half-fat butter, Olivite, Flora Pro-activ, Light spread	0	2	4	6	8	10	12	14

Spread

Fat Rating			
	Less than 30	=	Low Fat Intake
	30 to 40	=	Medium Fat Intake
	More than 40	=	High Fat Intake

Total

7. What type of fat do you usually use for the following purposes?
(Choose one answer on each line)

	Butter, lard, or dripping	**Solid cooking fat** (White Flora, Cookeen) **Half-fat butter Hard margarine** (Stork)	**Soft margarine** (sunflower, soya) **Reduced fat spread** (olive, Flora Buttery, Olivio)	**Vegetable oil** or **Low fat spread** (Flora Light, Olivite, St. Ivel Gold)	**No fat used**
On bread and vegetables	1	2	3	4	3
For frying	1	2	3	4	3
For baking or cooking	1	2	3	4	3

Unsaturated Fat Rating			
	Less than 6	=	Low Unsaturated Fat
	6 to 9	=	Medium Unsaturated Fat
	More than 9	=	High Unsaturated Fat

Total	

Choosing interventions to reduce food poverty

E

Section D described the many types of barriers to healthy eating experienced by people in food poverty. This section looks at those barriers to healthy eating for which actions can be organised and delivered locally. However, tackling one barrier by an individual local food project will only have a very limited impact, because of the multi-factorial nature of food poverty. At local level food poverty needs to be addressed by integrated programmes of activity. To be effective they need to tackle a range of barriers and be supported by coordination between local planning authorities, health authorities and other key players.[1]

Many local food projects are also supported by the national health, social and environmental programmes described in Section C. However, there are clearly some areas – such as food advertising on children's TV and reform of the Common Agricultural Policy (CAP) to support healthy diets – which have not yet been adequately addressed by government policies. Local communities and PCTs may be interested in joining campaigns to tackle them.

This section also outlines the different settings for local food programmes and underlying principles for success. Examples of good practice are provided for programmes and for individual project components of programmes in the different settings.

See Tool E1 *Local actions that can lower barriers to healthy eating on a low income.*

Settings for local food programmes

There are three main settings for local food programmes: the community, schools, and workplaces. A local nutrition and food poverty strategy can include projects that cover one or more of these settings, and can be complemented by actions in primary care. Examples of individual components of different programmes are provided on pages 130-137.

The community setting

Community food projects can have some, if not a large effect on eating habits and can improve skills and confidence in food purchasing and preparation. Long-term indications of changes in nutrition, such as blood vitamin levels, are harder to find. However, many argue that assessment of the success of food projects should include their wider effects on regeneration and social capital. In this context they can:[2]

- decrease social isolation
- give people a new sense of worth and increase feelings of well-being
- raise levels of skills and training
- enable individuals to take more control of their health and welfare.

The underlying principles of successful local community programmes on healthy eating

Although there are many different types of project, the following are some underlying principles which are key to success:[2,3]

- Focusing on diet alone or diet and physical activity rather than tackling a range of different health risk factors.
- Developing imaginative partnerships between the public sector, the local community and the private sector.
- Having clear goals based on a proven, effective theoretical base to encourage changes in people's behaviour through changes in knowledge and attitudes, the development of practical skills and through improving access to a healthier diet.
- Using multiple strategies which include the development of a supportive environment in which healthier choices are affordable and available and in which the culture is supportive of healthy eating.
- Ensuring that programmes are of sufficient intensity and duration and have sustainable funding rather than short-term start-up funding. (It is increasingly being recognised that it takes a minimum of two years to establish community food initiatives such as food access projects.)
- Developing interventions with the real involvement of local people, and creating projects which respond to local needs and have shared ownership and credibility.
- Ensuring that the different agendas of professionals, volunteers and users are reconciled.
- Generating and maintaining true support from community members.
- Energy and commitment from key workers, whether paid or voluntary.

See Tool C1 *The health agenda related to food poverty* for information on government programmes specifically targeting the community, such as 5 A DAY.

Examples of good practice

The projects described below are examples of good practice for programmes that tackle eating on a low income. More examples of good practice can be found in:

- *Making Links: A Toolkit for Local Food Projects* by Sustain (see details on page 134).
- www.healthaction.nhs.uk
- reports of the 5 A DAY pilot projects on www.dh.gov.uk

The Expanded Food and Nutrition Education Programme (EFNEP)

The EFNEP services have been available to people on low incomes for over 30 years in all 50 states of the US and have been applied to groups of low-income women in the UK.[4] An evaluation has shown significant short- and long-term changes in knowledge, attitudes and behaviour in all ethnic groups. The keys to its success are that:

- it trains people from the local community to educate other homemakers in food/nutrition topics under the supervision and support of trained professionals or a community nutrition educator
- it is tailored towards clients' needs
- it builds on the positive aspects of clients' existing diets, and
- it develops skills/competences (menu planning, shopping and cooking on a limited budget, food storage, meeting nutritional requirements) for providing nutritious diets within available resources.

Promoting Healthy Eating through a Dorset-wide Strategic Partnership
Partners include the local council and West Dorset Food and Land Trust. The interventions include: Grow it, Cook it, Eat it; fruit breakfast and healthy lunch boxes; hot meals in schools; a local food directory and cook book; and teaching cookery skills.
For more information contact 01202 858350.

Yeovil Healthy Food Project
This project began with community mapping and then identifying local producers and shopkeepers interested in supplying healthy food and asking the community to identify practical ways to meet their needs. So far the project has set up a food distribution centre to supply food co-ops, local shops and school fruit tuck shops. It is also supporting the development of community-led growing projects, and developing work with local shops and a local wholesaler. The health benefits so far are reduced social isolation and increased fruit and vegetable consumption.
For a copy of the report of the project, contact 01935 412838.

I (Community Action for Food and the Environment)
This programme aimed to make improvements in health, the economy and the environment by increasing access to a healthier diet, particularly for those people on low incomes. It also aimed to encourage greater production and consumption of local produce. It included Fresh Ideas, a programme to support community food initiatives which aim to improve access to a healthier diet. I's work is now part of the East Sussex Food and Health Partnership.
For more information contact 01273 485304.

HELI Forum (Healthy Eating on a Low Income)
This Forum is part of the Isle of Wight Anti-poverty Initiative and has over 50 members. The programme identifies local food poverty issues, and includes eating habits and shopping basket surveys, cookery demonstrations, planning a food poverty conference, producing a healthy eating calendar with budget cookery tips and food-in-season recipes, and circulating a quarterly newsletter.
For more information contact 01983 535 437.

Airedale and Craven Primary Care Trust
A 5 A DAY pilot in Airedale and Craven focuses on specific population groups and works through five main areas: community development, primary health care, schools, retailers, and the media. Two local food networks were set up, bringing together local workers with an interest in food, and working groups were then formed on childhood nutrition, nutrition for the elderly, and local food production. A particularly interesting programme is the 5 A DAY training session for local cooks which was organised with the Bradford Community Dietetics Department. Seventy-five per cent of the cooks taking part in the session have since tried out new ideas for including fruit and vegetables in their school meals.
For more information see www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCare/Topics/FiveADayGeneralInformation

The school setting

Children's and parents' awareness of healthy eating, and their desire to be more informed and involved in the food provided by schools, are generally increasing. However, although most children know what a healthy diet is, this does not mean that they eat healthily.[5]

There are several types of school food project that can be effective in improving diets but, to maximise their effectiveness, they need to be part of a whole-school approach. (This means that the project involves not just the taught curriculum, but also school catering, tuck shops and extra-curricular activities.) Programmes which take a whole-school approach appear to be more effective in improving diet than teaching alone.[6] They can be even more effective if supported by family involvement and interventions in the wider community.[3]

See Tool C1 *The health agenda related to food poverty* for information on government programmes specifically targeted at the school setting, such as the National Healthy School Standard and Food in Schools.

Examples of good practice

5 A DAY the Bash Street Way

This is a whole-school intervention aimed at increasing the consumption of fruit and vegetables among primary schoolchildren. The programme includes school tuck shops and school lunches, tasting opportunities, point-of-purchase marketing (posters and quizzes), newsletters for children and parents, and curriculum materials. The evaluation of the programme indicates that, compared with control schools, there was a modest but significant effect on cognitive and attitudinal variables and on fruit intake.

For a copy of the final report contact the Enquiry Desk, Library and Information Services, Food Standards Agency (020 7276 8000 or e-mail: library&info@foodstandards.gsi.gov.uk).

Food Dudes

Food Dudes, a project developed by the Bangor Food Research Group, appears to have increased the amount of fruit and vegetables eaten at primary school during lunch and break times. This is a whole-school package with two main elements: a video featuring the heroic Food Dudes, and tasting opportunities with associated small rewards such as stickers, pens and pencil cases.

For more information see www.psychology.bangor.ac.uk/research/bfru

The workplace setting

The workplace offers opportunities to promote healthier lifestyles – including healthy eating – as workplaces have a stable population, a constant environment and opportunities for peer support or competition. However, there are no evaluated examples of workplace programmes which target those lower paid workers who work after main office hours – such as cleaners or security guards.

Workplace nutrition interventions are generally aimed at weight loss, healthy eating and healthy catering.

Weight loss programmes

Weight loss programmes in the workplace commonly involve an element of competition. Competitions between teams are more effective than individual competitions and these programmes tend to be more effective for men. (Women tend to prefer programmes which

encourage cooperation rather than competition.) Recruitment rates are high, but most weight loss is regained once the intervention has finished.[7]

Healthy eating programmes

Healthy eating programmes based on screening and individual counselling are more effective than those based on group activities and workplace-wide programmes.[7]

Healthy catering

A review by the Health Education Authority concluded with four main recommended strategies for healthy catering initiatives:[8]

- Adapting popular choices to make them more healthy.
- Implementing healthy catering practices across the board, e.g. small reductions in the fat content of meals, and increasing the proportions of vegetables and starchy foods.
- Taking care to present healthier items appetisingly.
- Promotion of specific menu items in larger outlets where there are a number of choices.

Actions in primary care

A well motivated, informed and skilled primary care team could play a major part in facilitating dietary change in their patients. It is suggested that the most appropriate role for GPs is to give their endorsement to the importance of nutrition both to patients and to other members of the primary care team. There is good evidence that nurse-led lifestyle modification programmes in primary care can result in modest changes in risk factors. There is also currently a mismatch between the needs and expectations of patients and the level of involvement in nutrition by primary care professionals.[9]

Lay 'food and health advisors' are local people who are recruited and trained to work in primary care teams and alongside community dietetic services. They appear to increase the coverage of community initiatives, and act as a link or 'culture broker' between formal health services and health professionals and members of socially deprived communities.[10] There are now 50 such schemes across the country.

Health professionals such as midwives, health visitors, community nutritionists and dietitians also have an important role to play in facilitating dietary change through a range of initiatives such as Sure Start projects, increasing breastfeeding rates and raising uptake of the Welfare Foods Scheme/Healthy Start.

Examples of good practice

Fruit and vegetable project for adults on low incomes

A recent randomised trial showed that brief interventions by nurses in primary care were effective in increasing consumption of fruit and vegetables among adults on low incomes. There were two groups – one receiving nutrition counselling and the other behavioural counselling. Within each group, each patient received two 15-minute consultations two weeks apart, and written information to support the consultations. Although nutrition counselling was effective, behavioural counselling based on social learning theory and the Stages of Change model was more effective.[11]

The Bolton Community Nutrition Assistants' Project

This project began in 1995 and has achieved Beacon status. Local people are trained by food and health advisors to develop practical activities to address the food and health needs of their local communities. Interventions include discussions, cooking and tasting sessions, food games, shopping, food co-operatives and grow-your-own food schemes. An evaluation indicated that over half the respondents shopped and ate more healthily as a result.[12] More than two-thirds said that they preferred a local person advising them, rather than a health professional.

For more information contact Julie Holt, Food and Health Advisor, Nutritional and Dietetic Services on 01204 360094.

Further guidance

Information on food and food poverty programmes in general is available from:

Cancer Prevention: A Resource to Support Local Action in Delivering the NHS Cancer Plan
Produced by the Health Development Agency.
Available online at www.hda-online.org.uk or free from the Health Development Agency.

Poverty Bites: Food, Health and Poor Families
By E Dowler, S Turner and B Dobson. Published by the Child Poverty Action Group. Price £9.95.

Hunger from the Inside: The Experience of Food Poverty in the UK
Published by Sustain. Price £10 (to Food Poverty Network members), or £20.

Developing Local Networks to Tackle Food Poverty
Published by Sustain. Price £5 (to Food Poverty Network members), or £10.

See also the websites www.modernnhs.nhs.uk/nhsbeacons and www.haznet.org.uk

Individual components of local food programmes

This section provides examples of individual components which can form part of local food poverty programmes. The projects have been listed according to the different programme settings in the community.

Projects in the school setting

Further guidance

General guidance can be found in:

Sodexho School Meals and Lifestyle Survey 2002
Published by Sodexho Limited. Price: £120.
This includes eating patterns, children's and parents' views on school food and regional differences.

Eating Well at School: Dietary Guidance for School Food Projects
Part 1: For school governors and head teachers
Part 2: For policy makers
Part 3: For catering contract managers
Published by the Department for Education and Skills.

School food policies

Many schools now have food policies which set a framework for all food-related activities in school, ensuring that children receive consistent messages and support. The setting up of a school food committee or a school nutrition action group (SNAG) involving staff, pupils and caterers and, when appropriate, health and education professionals, is a useful step in drawing up a school food policy. Only 12% of schools in the UK have such committees and there has not been an increase since 1998.[5] Schools which do have a committee are far more likely to encourage healthy eating at home and in schools. However, pupil participation in some school food committees is low, and only around 3% of the secondary school population are really involved with the food that is served at their school.

The school food policy can be part of the healthy eating option of the National Healthy School Standard, which all local education authorities are now signed up to. Schools could be encouraged to choose this option.

Further guidance

Chips are Down
Published by the Health Education Trust (E: enquiries@HealthEdTrust.com).
Contains detailed information on developing school food policies and school nutrition action groups.

The Grab 5! Pack
Published by Sustain. Price £40 plus p&p, or downloadable from www.grab5.com.
The *Grab 5! Pack* includes an action pack (with useful contacts and tips on how to set up practical initiatives that promote fruit and vegetables, such as school gardens, cooking schemes and breakfast clubs), a key stage 2 curriculum pack, and a model school food policy.

See Tool E2 *Model school food policy*. This reproduces the model school food policy from the *Grab 5! Pack* described above.

Breakfast clubs

The proportion of children not eating breakfast increases with age and the trend is rising. Currently, 18% of boys and 21% of girls in England aged 15-16 have nothing to eat before school. The food that many other children eat is not breakfast at home, but sweets, crisps, chocolate, and fizzy drinks bought on the way to school.[5]

There is good evidence which shows the physiological benefits of eating breakfast:[13]

- The daily percentage of energy from fat is lower.
- Breakfast-eaters tend to be thinner.
- Serum cholesterol levels are lower.

There is also anecdotal evidence that children who eat a good breakfast concentrate better during morning school.

In response, schools have been encouraged by the Department of Health and the Department for Education and Skills to set up breakfast clubs. There are several different models, ranging in complexity from simply supplying tea and toast to running a catering service and providing planned activities. An evaluation of 58 breakfast clubs showed that their aims include improving health and nutrition, improving education, developing social skills, and improving the relationship of the school with parents.[14] However, the food supplied was not always nutritious and well balanced.

Further guidance

Two detailed and practical guides to setting up and running a breakfast club are available free on the web:

Breakfast Clubs.... A Head Start
Published by the Scottish Diet Project. Available from: www.dietproject.co.uk/toolkit/headstart

Breakfast Clubs: A How to Guide
Published by the New Policy Institute and funded by Kelloggs. Available from: www.breakfast-club.co.uk.
This site will also take you to the evaluation of 58 breakfast clubs mentioned on page 131 which is called *Improving Breakfast Clubs: Lessons from the Best.*

See Tool E3 *Checklist for running a breakfast club.* This is reproduced from *Breakfast Clubs: A How to Guide*, described above.

School lunches

Compulsory nutritional standards for schools meals were re-introduced in 2001. They apply to all lunches supplied by schools during term time, whether or not they are free. They also apply to packed lunches provided by the school for school outings. The Food Standards Agency is carrying out a survey to assess compliance with these standards and associated guidance. However, offering children healthy choices does not mean that they will choose them. The top five foods that children think schools should provide are: pizza, burgers, fresh fruit, squash/fizzy drinks and sandwiches.[5] It is at least encouraging to see fresh fruit on the list!

Schools meals can make a significant difference to children's diets and 24% of parents suggest that their child would not have a proper meal if it was not available at school.[5] Families on low incomes claiming free school meals can find it much harder to feed the family in the school holidays.

Fifty-four per cent of children in social classes D and E are entitled to free school meals. However, the uptake of free school meals is very low and decreases with age: 30% of 8-10 year olds take their free meal, falling to 12% of 15-16 year olds.[5] There are several reasons for not claiming free meals, including the considerable stigma, embarrassment and bullying of children when openly claiming their free meal. Their choice may also be limited, as the value of the free meal may not cover the food they wish to choose. The issue of claiming free meals is being addressed in some schools by the introduction of smart cards for all children. This benefits all children by reducing the risk of losing cash or having it stolen.

Further guidance

Healthy School Lunches for Pupils in Primary Schools
Healthy School Lunches for Pupils in Secondary Schools
Available from www.dfes.gov.uk/schoollunches
This is a guide for caterers, school governors and head teachers on implementing the nutritional standards. It includes information on special diets for pupils from religious and ethnic groups.

Nutritional Guidelines for School Meals
Published by The Caroline Walker Trust. Available from The Caroline Walker Trust, 22 Kindersley Way, Abbots Langley, Hertfordshire WD5 0DQ.

Top tips for a healthier lunchbox
Available from www.food.gov.uk/news/newsarchive/toplunchboxtips
This guidance from the Food Standards Agency provides practical tips and suggestions to help parents put together varied and balanced lunchboxes.

See Tool E4 *Nutritional standards for school lunches.* This gives the compulsory nutritional standards.
See Tool E5 *Nutritional guidelines for school meals.* This gives a summary of the Caroline Walker Trust guidelines.

School cooking clubs

There is little opportunity within the national curriculum for children to learn about cooking and to develop their cooking skills. However, 82% of parents wish their children to be taught cooking at school and 68% of children would like to be taught.[5] There are two major projects in this area: Cooking for Kids and Focus on Foods. These clubs take place out of school hours or in holidays, and may provide a one-day experience only. For some children, they may be one of the few opportunities they have to cook. The cooking clubs also give children the opportunity to handle, taste and prepare foods that are new to them.

Further guidance

Cooking for Kids Manual
Published by the Department of Health. Available free from Joe Monks at the Department of Health (T: 0207 972 2000).

Focus on Food
Details of the Focus on Food campaign and curriculum materials to support classroom learning can be downloaded from www.waitrose.com/focusonfood

Materials are also available by e-mailing cookschool@designdimension

Healthy snacks

The evidence suggests that fruit tuck shops may be effective in increasing fruit intakes when part of a whole-school approach.[15] However, by themselves they do not have a significant effect on intake.[16]

The National School Fruit Scheme is being rolled out to all schools in 2004. This will supply a free piece of fruit to all children aged 4 to 6. The results of the pilots have been published in *The National School Fruit Scheme Evaluation Summary*,[17] which is available from the Department of Health website.

Some schools have devised a healthy snack policy which includes food sold in school vending machines as well as food brought in by the children.

Further guidance

Set Up a Fruit Tuck Shop
A guide from the Ideas Bank section of *Grab 5*. See www.grab5.com

National School Fruit Scheme
For information see www.dh.gov.uk

Projects in the community setting

Further guidance

General information can be found in:

Food Projects and How They Work
By P McGlone. Published by the Joseph Rowntree Foundation.

Making Links: A Toolkit for Local Food Projects
Published by Sustain. Price £5 (to Food Poverty Network members), or £10.

5 A DAY guidance, published by the Department of Health:
Booklet 1: A Local 5 A DAY Initiative: Increasing Fruit and Vegetable Consumption – Improving Health
Booklet 2: A Local 5 A DAY Initiative. A Handbook for Delivery.
Available from: www.dh.gov.uk

The Food Poverty Project Database
www.foodpovertyprojects.org.uk
This has details and contact points for food poverty projects across the country. You may find it helpful to arrange to visit a selection of projects to see how they operate.

Let Us Eat Cake!
This quarterly newsletter from the Food Poverty Network has ideas for projects, and information on funding sources, new publications, and regional and national events. To subscribe, call 020 7837 1228 or e-mail foodpoverty@sustain.web.org

Information projects

People on low incomes have requested more information about healthy diets,[18] although their knowledge levels are about the same as for most other people except for those on the highest incomes. A recent review showed that self-help resources were as effective as advice from dietitians and nurses, and better than advice from doctors, in achieving lower blood cholesterol levels through dietary changes.[19]

Further guidance

Hassle Free Food: A Guide to Cheap, Quick, Healthy Eating
Published by the Health Education Board for Scotland. Available to download from www.hebs.org.uk.

So You Want to Lose Weight for Good
Published by the British Heart Foundation. Available from: www.bhf.org.uk

Transport to supermarkets

'Transport to supermarket' schemes involve local authority subsidised public transport, supermarket-run buses or local projects. They are particularly helpful for older people and people with disabilities, but can help anyone living in a 'food desert' to bring heavy and bulky shopping home. They can therefore improve access to shopping for fruit and vegetables, and also enable users to buy better quality food at cheaper prices.

Further guidance

Community Transport Association
Highbank
Halton Street
Cheshire SK14 2NY
W: www.communitytransport.com
T: 0161 367 8780.
A free advice and information service on a wide range of community transport initiatives.

Feguslie Park Access to Shopping Project Report
Available free from Annette Beattie on 0141 887 9650.

Food co-operatives

A food co-operative is a membership organisation which organises to buy food in bulk, either direct from wholesalers or from farmers. The savings of buying in bulk can be a third to a half of local shop prices, with fruit and vegetables offering the biggest savings. Some schemes also deliver food to people who are elderly, disabled or housebound. They are often run by local unpaid volunteers who gain new skills and can increase their chances of obtaining paid employment.

Community food co-operatives can improve local access to affordable fruit and vegetables and allow people to try new foods at affordable prices. They also help develop self-confidence, self-esteem and new skills in those running the co-op. They are often staffed by unpaid volunteers but do need start-up funds. Grants may be available from the Neighbourhood Renewal Fund, New Deal for Communities and the Single Regeneration Budget. The Co-operative Wholesale Society (CWS) offers small grants under the Community Dividend Scheme (0161 827 5349).

Further guidance

Food for Thought
Available from Wolverhampton Food Co-ops Umbrella Group (T: 01902 304 851). Price £1.
A report and video.

Starting Your Own Community Food Co-op
Available free from the Co-operative Wholesale Society (T: 0161 827 5349).
The Co-operative Wholesale Society also runs the Community Dividend Scheme (T: 0161 827 5950) which can help by offering small grants for setting up co-ops.

Community cafés

Community cafés provide a place where people can eat a cheap meal in a sociable setting. They do not necessarily provide healthy food. They can, however, be used as a point of access for information and advice about health and welfare and may develop new skills in volunteers.

Further guidance

Just for Starters
Published by and available from the Health Education Board for Scotland (T: 0131 536 5500). Price £60.
An information and advice pack on community cafés.

Community Catering Initiatives
Published by Community Health UK. Available from Community Health UK (T: 01273 234868; www.chuk.org). Price £7.50 + p&p.
A report of six community cafés including a checklist of criteria necessary for a successful community café.

Cooking clubs

Cooking clubs involve local people working with a health professional in one or a series of practical cooking sessions. As well as teaching cooking skills, the clubs give people a chance to try different foods without the fear of wasting money if they do not like them. Evaluation shows that they can increase nutritional knowledge and improve food-related skills as long as the people have a go themselves and the examples are relevant to participants' cultural, social and economic circumstances.[20]

Further guidance

Get Cooking, Get Shopping
Published by the Co-operative Group. Can be downloaded from www.co-op.co.uk.
A free resource which shows people how to run a cooking club and learn to cook for themselves. It comes in two sections, one for organisers and tutors and the other for participants.

OK Let's Cook
Available from Healthy Norfolk 2000 (T: 01603 487 990). Price £2.
A book of healthy low-cost recipes produced by the community food group of Norwich Community Health Partnership.

No Dosh, Good Nosh
Produced by Nightsafe, a charity that works with homeless people. Available from Nightsafe (T: 01254 587 687). Price £1. Contains cheap, healthy and easy-to-cook recipes.

www.lutonpct.nhs.uk/cookclub.htm
This website, produced by Luton Health Action Zone Asian Cookery Club (see below), includes some recipes.

Examples of good practice

Asian Cookery Club in Luton
Around 500 people have attended classes which are run by paid local club leaders. These are local women who have completed the accredited training course devised by the project. This project has been awarded Beacon status.
For more information contact 01582 497 162.

Locally grown food projects

These include grow-your-own schemes, farmers' markets and box schemes. The objectives include not only healthy eating but also sustainability, transport, neighbourhood renewal, education, leisure and increased social capital. There is evidence that farmers' markets offer good value for money, provide an opportunity to buy fresh, local produce and give people a sense of well-being and belonging. They can also revitalise the local rural economy. There is similar evidence of positive effects of farmers' markets as there is for community growing schemes.[3] Another initiative is box schemes, where a box of produce is delivered to or collected by an individual consumer. Most current box schemes are concerned with organic foods and do not involve deprived areas.

Further guidance

The Soil Association
T: 0117 929 0661
Provides training on setting up and running a farmers' market.

Growing Food in Cities
A toolkit produced by Sustain. Available from Sustain. Price £10.

City Harvest
Published by Sustain. Available from Sustain. Price: full report £30, summary £5.
A report on food production in London.

Community shops

Community shops are set up as a response to the closure of existing local shops, particularly on housing estates and in rural areas. They rely on volunteers and grants or subsidies. There are no formal evaluations available.

Further guidance

How to Make Your Community Shop Succeed
Published by Community Enterprise Ltd (0131 475 2345).

If the Village Shop Closes ... A Handbook on Community Shops
Published by Oxford Rural Community Council (01865 883488). Price £3.50.

Village Shops and Post Offices: A Guide to Village Investment
Published by VIRSA (Village Retail Services Association – 01305 259 383). Price £15.

Food redistribution

These schemes redistribute surplus food from shops and supermarkets to day centres and hostels for the homeless. Supermarkets are often reluctant to take part due to hygiene concerns about un-refrigerated foods and food eaten after the use-by dates. Also, the schemes may not be empowering to the people receiving the food, and can mask the underlying issue of overproduction of food.

Further guidance

Crisis Fareshare
T: 0870 011 3335
Crisis Fareshare has developed a rollout scheme and can offer information on how to set up a food redistribution scheme.

South and West Lancashire Food Bank
T: 01695 555 717 (Linsey Pavsia)
An example of a redistribution scheme.

Services for older people

Meals on wheels provide essential support to help older people live in their own homes when they can no longer cook for themselves. They are recognised as an essential component of community care. There is also the potential for them to provide social support, although many people find that the meals are left in a rush.

Lunch clubs not only provide food but are also sociable and give carers a rest. However, there are insufficient schemes to provide for all those who could benefit, and some are too expensive. They are run by a range of voluntary organisations or through local authorities.

Many people living in residential homes and sheltered accommodation are undernourished. There are many underlying reasons for this, including long-term poverty and illness and, in residential homes, also inappropriate food and food that does not meet nutritional guidelines.

Further guidance

The following two organisations are both major providers of lunch clubs.
Age Concern Lunch Clubs T: 020 8679 8000
Women's Royal Voluntary Service T: 01235 442900

Eating Well for Older People: Practical and Nutritional Guidelines for Food in Residential and Nursing Homes and for Community Meals
Published by The Caroline Walker Trust.

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14 *Improving Breakfast Clubs: Lessons from the Best.* Accessed from www.breakfast-club.co.uk

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Tools

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Local actions that can lower barriers to healthy eating on a low income

Providing help with money matters

- Local authority anti-poverty unit
- Debt counselling from Citizens Advice Bureaux
- Cheaper credit from credit unions
- Bartering of goods and services through Local Economy Trading Schemes (LETS)
- Claiming benefit entitlements
- Discretionary benefits from the Benefits Agency
- Increasing literacy and numeracy skills

Providing information and support to improve knowledge and skills in:

- healthy diets
- budgeting
- shopping
- food labelling
- food storage
- foods that can be prepared at home quickly and easily
- cooking
- structuring time for eating as a family
- breastfeeding
- improving literacy and numeracy skills.

Providing better housing conditions to tackle:

- lack of cooking equipment or no kitchen
- lack of storage to enable bulk buying
- lack of access to gas, meaning higher fuel bills.

Improving access to cheap, good-quality foods, especially fruit and vegetables

- Better range, quality and price of foods, particularly fruit and vegetables, in readily accessible shops.
- Cheaper, more convenient and easier to use transport to supermarkets for those without cars.
- Supporting shopping-carrying schemes, food vans and home or community delivery schemes from retailers.
- Safer streets to reduce the fear of crime which limits walking even for those who can carry heavy shopping.

Helping to change food preferences for adults and children

- Providing opportunities to try different foods without fear of waste.
- Supermarket tours, helping people to select foods and to interpret food labels and health claims.

Improving nutrition in schools

- Providing breakfast before school, to help children who are not given breakfast at home.
- Offering healthy snacks from tuck shops or vending machines.
- Offering healthier school meals.
- Addressing organisational issues – including long queues and overcrowding – to make school meals a better experience.
- Organising payment for school meals so that it is not obvious which children are claiming free school meals, thus leading to better uptake.
- Ensuring that a school food policy is chosen as part of the National Healthy School Standard.
- Raising awareness of the power of advertising.

Model school food policy

The model school food policy reproduced below is supported by a series of appendices that outline a range of issues to consider when developing and implementing a food policy. These appendices can be downloaded from the Grab 5! website www.grab5.com.

The *Grab 5!* Model School Food Policy

1 Responsibilities

The Board of Governors recognises the important connection between a healthy diet and a student's ability to learn effectively and achieve high standards in school. The Board also recognises the role a school can play, as part of the larger community, to promote family health, and sustainable food and farming practices.

The Board of Governors recognises that sharing food is a fundamental experience for all people; a primary way to nurture and celebrate our cultural diversity; and an excellent bridge for building friendships, and inter-generational bonds.

2 Mission

The educational mission is to improve the health of the entire community by teaching students and families ways to establish and maintain life-long healthy and environmentally sustainable eating habits. The mission shall be accomplished through food education and skills (such as cooking and growing food), the food served in schools, and core academic content in the classroom.

3 Aims

3.1 To improve the health of pupils, staff and their families by helping to influence their eating habits through increasing their knowledge and awareness of food issues, including what constitutes a healthy and environmentally sustainable diet, and hygienic food preparation and storage methods.

3.2 To increase pupils' knowledge of food production, manufacturing, distribution and marketing practices, and their impact on both health and the environment.

3.3 To ensure pupils are well nourished at school, and that every pupil has access to safe, tasty, and nutritious food, and a safe, easily available water supply during the school day.

3.4 To ensure that food provision in the school reflects the ethical and medical requirements of staff and pupils, e.g. religious, ethnic, vegetarian, medical, and allergenic needs.

3.5 To make the provision and consumption of food an enjoyable and safe experience.

3.6 To introduce and promote practices within the school to reinforce these aims, and to remove or discourage practices that negate them.

4 Objectives

4.1 To work towards ensuring that this policy is both accepted and embraced by:

- Governors
- School management
- Teachers and support staff
- Pupils
- Parents
- Food providers
- The school's wider community

4.2 To integrate these aims into all aspects of school life, in particular:

- Food provision within the school
- The curriculum
- Pastoral and social activities

5 Methods

5.1 Establish an effective structure to oversee the development, implementation, and monitoring of this policy, and to encourage a participatory approach to meeting the objectives. For ideas see www.sustainweb.org/g5fp/index.htm.

5.2 Develop an understanding and ethos within the school of safe, tasty, nutritious, environmentally sustainable food, through both education and example. Refer to appendix B for ideas.

5.3 Create an environment, both physical and social, conducive to the enjoyment of safe, tasty, nutritious, environmentally sustainable food. Refer to appendix C for ideas.

5.4 Help to promote and raise awareness of environmentally sustainable food production methods and socially responsible food marketing practices. Refer to appendix D for ideas.

Signed _____

Chair of Governors

Date _____

Checklist for running a breakfast club

Here is a checklist of the things that you should do when setting up a breakfast club, and a list of the things that you could do to help the club develop.

		Yes	Not yet
Must do's	Be clear about what you want to achieve – and assess parental interest in your plans and likely demand.	☐	☐
	Prepare the budget, identify fundraising needs, decide how to collect breakfast club fees from the children/families.	☐	☐
	Check legislation and insurance requirements.	☐	☐
	Determine premises and purchase essential equipment.	☐	☐
	Agree catering arrangements/menus and plan activities.	☐	☐
	Recruit/appoint staff and volunteers; enlist support from head and other teachers in the school, school nurse, etc. Set up management committee (if required).	☐	☐
	Devise strategies for encouraging attendance.	☐	☐
	Confirm procedures for children registering on arrival, accidents, etc. Check need for school crossing supervisor.	☐	☐
	Prepare promotional information and circulate.	☐	☐
	Plan how to evaluate the club.	☐	☐
Could do's	Develop more extensive programmes of activities and study support that provide learning opportunities.	☐	☐
	Hold themed breakfast weeks. Vary or expand the menus.	☐	☐
	Invite other children/schools to use the club (perhaps to increase club size).	☐	☐
	Identify ways to give the children more responsibility for running the club.	☐	☐
	Advertise the club further afield; start a club newsletter or other marketing.	☐	☐
	Link your club's activities into the wider aims of the school or community.	☐	☐

Nutritional standards for school lunches

These are the minimum nutritional standards for school lunches set by the Department for Education and Skills. If your education authority or school has set higher nutritional standards, you should meet those. The standards below apply to all lunches for students during term time, whether they are free or lunches which students pay for. They also apply to hot and cold food, including packed lunches provided by the school for students on school trips.

Primary schools

Lunches for primary school pupils must contain at least one item from each of the following food groups:

- Starchy foods such as bread, potatoes, rice and pasta. Starchy food cooked in oil or fat should not be served more than three times a week.
- Fruit and a vegetable must be available every day. Fruit-based deserts must be available twice a week.
- Milk and dairy foods.
- Meat, fish and alternative sources of protein. Red meat must be served at least twice a week. Fish must be served at least once a week.

Cheese may be included in the meat/fish protein group for primary children.

Secondary schools

At least two items from each of the following food groups must be available every day and throughout the lunch service:

- Starchy foods such as bread, potatoes, rice and pasta. At least one of the foods available in this group should not be cooked in oil or fat. (For example, if one option is roast potatoes, another option could be boiled rice.)
- Vegetables and fruit
- Milk and dairy foods
- Meat, fish and alternative (non-dairy) sources of protein. Red meat must be served at least three times a week. Fish must be served at least twice a week.

For more information see www.dfes.gov.uk/schoollunches

Nutritional guidelines for school meals

The Department for Education and Skills now has minimum nutritional standards for school meals (see Tool E4). These are food-based standards which interpret the Caroline Walker Trust guidelines for nutritional guidelines for school meals for children aged 4-18.[1] A summary of the Caroline Walker Trust guidelines is provided below. Further details of the nutritional guidelines for school meals can be found at www.dfes.gov.uk/schoollunches/annexcii.htm.

Caroline Walker Trust nutritional guidelines for school meals

The overall aim of these nutritional guidelines for school meals is to contribute to a diet which contains more bread, cereals and other starchy foods, more fruit and vegetables, and less fat, sugar and salty foods, and which is richer in minerals and vitamins.

The report of the Committee on Medical Aspects of Food Policy (COMA) *Dietary Reference Values for Food Energy and Nutrients for the United Kingdom*,[2] forms the basis for these recommendations on nutritional standards.

The CWT guidelines provide figures for the recommended nutrient content of an average school meal provided for children over a one-week period. In practical terms this is the total amount of food provided, divided by the number of children eating it, averaged over a week.

Summary of nutritional guidelines for school meals for children aged 4-18 years

Energy	30% of the Estimated Average Requirement (EAR)
Fat	Not more than 35% of food energy
Saturated fatty acids	Not more than 11% of food energy
Carbohydrate	Not less than 50% of food energy
Non-milk extrinsic sugars	Not more than 11% of food energy
Non-starch polysaccharides (fibre)	Not less than 30% of the Calculated Reference Value
Protein	Not less than 30% of the Reference Nutrient Intake (RNI)
Iron	Not less than 40% of the Reference Nutrient Intake (RNI)
Calcium	Not less than 35% of the Reference Nutrient Intake (RNI)
Vitamin A (retinol equivalents)	Not less than 30% of the Reference Nutrient Intake (RNI)
Folate	Not less than 40% of the Reference Nutrient Intake (RNI)
Vitamin C	Not less than 35% of the Reference Nutrient Intake (RNI)

Sodium should be reduced in catering practice.

References

1 Sharp I (ed.) *Nutritional Guidelines for School Meals*. London: The Caroline Walker Trust.

2 Department of Health. 1991. *Dietary Reference Values for Food Energy and Nutrients for the United Kingdom. Report of the Panel on Dietary Reference Values of the Committee on Medical Aspects of Food Policy*. London: HMSO.

Guidelines for catering for schoolchildren with special diets

Religious diets

Hindus	No beef.	Mostly vegetarian; fish rarely eaten.	Period of fasting common.
Jews	No pig meat.	Meat must be kosher. Only fish with fins and scales eaten.	Meat and dairy foods must not be consumed together.
Muslims	No pig meat.	Meat must be halal; no shellfish.	Regular fasting, including Ramadan.
Rastafarians	No animal products except milk.	Foods must be I-tal or alive, so no canned or processed food, no added salt, no coffee.	Food should be organic.
Sikhs	No beef.	Meat must be killed by one blow to the head.	

Be aware of the content of meat products. For example, turkey burgers sometimes contain pork.

Vegetarians

Many people are vegetarians. You should make every effort to offer a variety of vegetarian options.

Allergies

Food allergies are estimated to affect 1% or 2% of the adult population and are more prevalent in infants and children. The most common allergenic foods are eggs, milk, fish, shellfish, peanuts, soya, wheat, tree nuts and seeds. Allergies to certain foods, such as peanuts and peanut products, other nuts, seeds and their derivatives, and shellfish can be particularly acute. People suffering from a severe food allergy need to know the exact ingredients in their food, because even a tiny amount of the allergenic food could kill them.

How can you help?

- Make sure you know which children suffer from an allergy and to which food.
- Make sure your staff are aware of the potential hazards from the use of severe allergens such as nuts and nut products through training sessions or notices.
- If you use severe allergens in a recipe, find ways of passing information to those such as dinner nannies who supervise nursery children during lunch. This should be by clearly labelling it in words or symbols "contains nuts", making it clear from the name of the dish or by verbal communication. The school should ensure that dinner nannies are aware of those children who may suffer severe allergic reactions to nuts or nut products.

- Remember also that any oil that has previously been used to cook products containing nuts can carry minute traces of nut proteins and thus have the same effect as nut oils.
- Beware of accidentally transferring food from one dish to another. Cooking equipment can be a means of cross-contaminating foods with peanut or nut protein. Allergy sufferers can react to the smallest amount of protein and even minute amounts transferred through cross-contamination could cause a severe reaction.
- Ask the catering supplier to provide information as to whether the ingredients or flavourings used in their products contain nuts or seeds.
- If you prepare food, check the complete recipes of all your products so that you can answer questions if asked.
- Be clear about the school's policies regarding first aid and administering medication, and whether a member of staff has been trained to administer medication in the event of an allergic reaction by a student. **If you think someone is suffering from a severe allergic reaction, call an ambulance immediately.**

Resources

F

Publications

This section gives a list of publications which may be useful for developing knowledge on food and health and for developing a nutrition and food poverty strategy. Many of these have been referenced or described in other sections of this toolkit. They are assembled here along with additional resources. Contact details of the organisations producing these documents are given on page 159. Guidance and tools for developing individual local projects as part of a wider strategy are shown throughout section E but are not duplicated here.

For information on obesity and physical activity see:

Tackling Obesity: A Toolbox for Local Partnership Action
By Alan Maryon Davis, Alison Giles and Roberta Rona.
Published by the Faculty of Public Health Medicine.

Let's Get Moving: A Physical Activity Handbook for Developing Local Programmes
By the Faculty of Public Health Medicine and the National Heart Forum.
Published by the Faculty of Public Health Medicine, 2001.

The scientific basis of healthy eating

Committee on Medical Aspects of Food Policy and Nutrition Policy (COMA) reports
Nutritional Aspects of Cardiovascular Disease. Report No 46, 1994
Nutrition and Bone Health. Report No 49, 1998
Nutritional Aspects of the Development of Cancer. Report of the Working Group on Diet and Cancer of the Committee on Medical Aspects of Food and Nutrition Policy. 1998.
Available from The Stationery Office. The *Nutritional Aspects of the Development of Cancer* report is also available from www.dh.gov.uk

Salt and Health
By the Scientific Advisory Committee on Nutrition.
Published by The Stationery Office, 2003. Available from the Department of Health website www.dh.gov.uk

Nutrition: A Handbook for Community Nurses
Available from the British Nutrition Foundation.
Briefing papers on various subjects.

Publications from the former Health Education Authority
The following publications are available for downloading from the Health Development Agency website: www.hda-online.org.uk
Dietary Fats
Sugars in the Diet
Nutritional Aspects of Cardiovascular Disease
Scientific Basis of Nutrition Education

Dietary Reference Values: A Guide
By the Department of Health.
Available from The Stationery Office or the Department of Health website www.dh.gov.uk

Nutrition and Patients. A Doctor's Responsibility.
By a Working Party of the Royal College of Physicians.
Published by the Royal College of Physicians, London.

Developing a local nutrition and food poverty strategy

Independent and voluntary sector publications – England

The Atlas of Food. Who Eats What, Where and Why
By Eric Millstone and Tim Lang.
Published by Earthscan Publications Ltd, 2003. Price £11.99.

Eating Well for Older People. Practical and Nutritional Guidelines for Food in Residential and Nursing Homes and for Community Meals
Published by The Caroline Walker Trust, 1995.

The Food Indicator Toolkit. The Toolkit to Develop Local Food Indicators
Published by the SAFE Alliance, 1999. Available from Sustain. Price £2.50 (to Food Poverty Network members), or £10.

Food Poverty: Policy Options for the New Millennium
Published by Sustain, 2002. Price £20.

From SRBs to PCTs. Understanding Local Structures and Area-based Initiatives to Tackle Food Poverty
By Anna Watson.
Published by Sustain, 2002. Price £10 (to Food Poverty Network members), or £25.

Good Food on the Public Plate: A Manual for Sustainability in Public Sector Food and Catering
Published by Sustain, 2003. Price £55 (to Food Poverty Network members), or £115.

Health and the Food Chain
Edited by David I Thurnham and Terry A Roberts.
British Medical Bulletin Series, vol 56, No 1.

Hunger from the Inside. The Experience of Food Poverty in the UK
Published by Sustain, 2002. Price £10 (to Food Poverty Network members), or £20.

Inconvenience Foods. The Struggle to Eat Well on a Low Income
By Caroline Hitchman et al.
Published by Demos, 2002. Price £10.

Let's Get Moving. A Physical Activity Handbook for Developing Local Programmes
By the Faculty of Public Health Medicine and the National Heart Forum.
Published by the Faculty of Public Health Medicine, 2001.

Looking to the Future. Making Coronary Heart Disease an Epidemic of the Past
By the National Heart Forum.
Published by The Stationery Office, 1999.

Low Income but Acceptable. A Minimum Income Standard for the UK: Families with Young Children
Edited by Hermione Parker.
Published by the Family Budget Unit, 1998.

Making Health Scrutiny Work: The Toolkit
By the Democratic Health Network. Available from the Democratic Health Network (020 7554 2802 or www.dhn.org.uk). Price £15.

Making Links. A Toolkit for Local Food Projects
Published by Sustain, 2000. Price £10 (to Food Poverty Network members), or £20.

The Making of Modern Malnutrition. An Overview of Food Poverty in the UK
By Suzi Leather.
Published by The Caroline Walker Trust, 1996. Price £10.

Myths about Food and Low Income
Published by the National Food Alliance, 1997. Available from Sustain.

Nutrition and Diets in Lone-parent Families in London
By Elizabeth Dowler and Claire Calvert.
Published by the Family Policy Studies Centre, 1995.

Poverty Bites. Food, Health and Poor Families
By Elizabeth Dowler and Sheila Turner with Barbara Dobson.
Published by the Child Poverty Action Group, 2001. Price £9.95.

Prevention is Better than Cure
A report from a conference on joined up thinking on public health.
Published by the NHS Confederation, the Local Government Association and the Faculty of Public Health Medicine, 2003.

Public Health and Nutrition. The Challenge
By Barbara Maria Kohler, Elfriede Feichtinger, Elizabeth Dowler and Gertrude Winkler.
Published by Sigma, Germany. 1999.

Social Inequalities in Coronary Heart Disease. Opportunities for Action
By the National Heart Forum.
Published by The Stationery Office, 1998.

Tackling Obesity. A Toolbox for Local Partnership Action
By Alan Maryon Davis, Alison Giles and Roberta Rona.
Published by the Faculty of Public Health Medicine, 2000.

Too Much and Too Little. Debates on Surplus Food Redistribution
Published by Sustain, 2000. Price £12.

The Well-being of Children in the UK
Published by Save the Children, 2002.

Resources for consumers

Shape-up. A Lifestyle Programme to Manage Your Weight
By Jane Wardle, Lih-Mei Liao, Lorna Rapoport, Melvyn Hillsdon, Helen Croker and Carolyn Edwards.
Published by Weight Concern, 2001.

Weight Wise
An interactive website on weight management for consumers, produced by the British Dietetic Association. See: www.bdaweightwise.com

The DASH Eating Plan. A Low-salt Plan to Help Lower Blood Pressure
Produced by the US Department for Health and Human Services. Can be downloaded from: www.nhlbi.nih.gov/health/public/heart/hbp/dash/

Healthy Eating and Blood Pressure
Published by the Blood Pressure Association (www.bpassoc.org.uk)

Government publications – England

Publications addressing the wider health agenda

Child Poverty
Published by the Department for Work and Pensions, 2002.
Available from www.dwp.gov.uk/consultations/2002

Factsheets from the Neighbourhood Renewal Unit, 2002:

No 3 Health and Neighbourhood Renewal
No 5 Neighbourhood Wardens and Street Wardens
No 8 The Role of Local Strategic Partnerships in Neighbourhood Renewal
No 13 Skills and Knowledge for Neighbourhood Renewal

Community Strategies and Health Improvement. A Review of Policy and Practice
Published by the Health Development Agency, 2002.

Evaluation of Local Strategic Partnerships. Report of a Survey of all English LSPs
Published by the Office of the Deputy Prime Minister and the Department of Transport, 2003.

Food: The Local Vision – A Joint Statement by the LGA, LACORS and the FSA
Published in 2002. Available from the Local Government Association, or Local Authorities Coordinators of Regulatory Services, or the Food Standards Agency.

Improving Shopping Access for People Living in Deprived Neighbourhoods. Report of Policy Action Team 13
Published by the Social Exclusion Unit, 1999.

Introducing Health Impact Assessment: Informing the Decision-making Process
Published by the Health Development Agency. Available from www.hda.nhs.uk

The Learning Curve. Developing Skills and Knowledge for Neighbourhood Renewal
Published by the Office of the Deputy Prime Minister, 2002.

Local Government Scrutiny of Health. Using the New Power to Tackle Health Inequalities
By L Hamer.
Published by the Health Development Agency, 2003. Available from hda-online.org.uk

Low Income, Food, Nutrition and Health: Strategies for Improvement. A Report by the Low Income Project Team for the Nutrition Task Force
Published by the Department of Health, 1996.

The Management of Obesity and Overweight: An Analysis of Reviews of Diet, Physical Activity and Behavioural Approaches
Published by the Health Development Agency, 2003. Available from www.hda.nhs.uk

The National Healthy Schools Standard. Confirming Healthy School Achievement
Published by the Health Development Agency, 2003. Available from hda-online.org.uk

Planning Across the LSP: Case Studies of Integrating Community Strategies and Health Improvement
By Lucy Hamer and Nick Easton. Published in 2002.
Available from the Neighbourhood Renewal Unit www.renewal.net

Tackling Health Inequalities through Local Public Service Agreements
Produced by the Department of Health. Available from www.dh.gov.uk

Tackling Obesity in England
By the National Audit Office.
Published by The Stationery Office, 2001.

Health sector publications

Cancer Prevention. A Resource to Support Local Action in Delivering The NHS Plan
Produced by the Health Development Agency, 2002.

Coronary Heart Disease: Guidance for Implementing the Preventative Aspects of the National Service Framework
Produced by the Health Development Agency, 2000.

Health Visitor Practice Development Resource Pack
Published by the Department of Health, 2001.

Health promotion effectiveness reviews
The following reviews are produced by the former Health Education Authority. They are available for downloading from the Health Development Agency website: www.hda-online.org.uk
Effectiveness of interventions to promote healthy feeding in infants under one year of age: a review (1998)
Effectiveness of interventions to promote healthy eating in pre-school children aged 1-5: a review (1998)
Effectiveness of interventions to promote healthy eating in pregnant women and women of childbearing age: a review (1998)
The effectiveness of interventions to promote healthy eating in the general population: a review (1997)
The effectiveness of health promotion interventions in the workplace: a review (1997)
Effectiveness of interventions to promote healthy eating in people from minority ethnic groups: a review
Effectiveness of interventions to promote healthy eating in elderly people living in the community: a review
The effectiveness of public health interventions to promote the initiation of breast feeding (2003)
Opportunities for and barriers to good nutritional health in minority ethnic groups (1997)
Opportunities for and barriers to change in dietary behaviour in elderly people (1998)
Opportunities for and barriers to good nutritional health in women of child-bearing age, pregnant women, infants under 1 and children aged 1-5 (1998)

National Service Frameworks: A Practical Aid to Implementation in Primary Care
Published by the Department of Health, 2002.

5 A DAY Guidance and Evaluation
All the following publications are available from www.dh.gov.uk

Reports on the 5 A DAY pilot initiatives:
5 A DAY Community Pilots Initiatives: Key Findings
Evaluation Summary
5 A DAY in Airedale and Craven
5 A DAY Community Project, County Durham and Darlington
Making Fruit and Vegetables the Easy Choice. Report of a 5 A DAY Pilot Project in Hastings and St Leonards, September 2000 – August 2001
Give Me 5. Report of a 5 A DAY Pilot Project in Sandwell, August 2000 – July 2001
5 A DAY Keeps the Doctor Away: Report of a 5 A DAY Pilot Project in Somerset, August 2000 – August 2001

Guidance booklets:
Booklet 1: A Local 5 A DAY Initiative: Increasing Fruit and Vegetable Consumption – Improving Health
Booklet 2: A Local 5 A DAY Initiative. A Handbook for Delivery.

Target setting and evaluation support

Closing the Gap: Setting Local Targets to Reduce Health Inequalities
By Julie Bull and Lucy Hamer.
Published by the Health Development Agency, 2002.

Consumer Attitudes to Food Standards
Published by the Food Standards Agency, 2003.
See Section 5 *Healthy eating and nutrition*, and Section 9 *Food labelling*.

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

Health Inequalities Indicators
By MHA Research and Consultancy. Draft Final Report. 2003.
Produced by the Association of Public Health Observatories and the Health Development Agency.
Available from www.hda-online.org.uk.

Index of Multiple Deprivation 2000
Available from www.urban.odpm.gov.uk/research/summaries/03100/pdf
Gives ward-level data.

National Strategy for Neighbourhood Renewal. Report of Policy Action Team 18: Better Information. Annex D Neighbourhood Statistics
Available from www.statistics.gov.uk/StatBase

Quality of Life: Using Quality of Life Indicators
Published by the Audit Commission, 2002.

Publications from Scotland and Wales

Eating for Health: A Diet Action Plan for Scotland
Published by the Scottish Office, 1996.

Healthy Food Policy: On Scotland's Menu?
Edited by James McCormick.
Published by the Scottish Council Foundation, 2000.

Scottish Community Diet Project. Guide to Funding for Community Food Projects
Published by the Scottish Consumer Council, 2002

Food and Well-being. Reducing Inequalities through a Nutrition Strategy for Wales
Published by FSA Wales and Welsh Assembly, 2003.

WHO and European publications

The First Action Plan for Food and Nutrition Policy. WHO European Region 2000-2005
Published by the WHO Regional Office for Europe.

Food and Health in Europe: A New Basis for Action
Published by the WHO Regional Office for Europe. Draft, 2002.

Food, Nutrition and Cardiovascular Disease Prevention in the European Region: Challenges for the New Millennium
Published by the European Heart Network, 2002.

Health at the Heart of the CAP
By the Gastein Opinion Group.
Published by the Faculty of Public Health Medicine, 2002.

Joint WHO/FAO Consultation on Diet, Nutrition and the Prevention of Chronic Diseases
Published by the World Health Organization, 2002.

Status report on the European Commission's work in the field of nutrition in Europe
Published by the European Commission, 2002.

World Health Report 2002: Reducing Risks, Promoting Healthy Life
Published by the World Health Organization, Geneva.

Organisations

Age Concern England
Astral House
1268 London Road
London SW16 4ER
T: 020 8765 7200
W: www.ageconcern.org.uk
E: ace@ace.org.uk

Blood Pressure Association
60 Cranmer Terrace
London SW17 0QS
T: 020 8772 4994
W: www.bpassoc.org.uk

British Dietetic Association
5th floor
Charles House
148-9 Great Charles Street
Queensway
Birmingham B3 3HT
T: 0121 200 8080
W: www.bda.uk.com

British Heart Foundation
14 Fitzhardinge Street
London W1H 6DH
T: 020 7935 0185
Heart information line: 08450 708070
W: www.bhf.org.uk

British Nutrition Foundation
High Holborn House
52-54 High Holborn
London WC1V 6RQ
T: 020 7404 6504
W: www.nutrition.org.uk

Cancer Research UK
PO Box 123
Lincoln's Inn Fields
London WC2A 3PX
T: 020 7242 0200
W: www.cancerresearchuk.org

The Caroline Walker Trust
PO Box 61
St Austell PL26 6YL
T: 01726 844107
W: www.cwt.org.uk

Child Poverty Action Group
94 White Lion Street
London N1 9PF
T: 020 7837 7979
W: www.cpag.org.uk

Department of Health
W: www.dh.gov.uk

Diabetes UK
10 Parkway
London NW1 7AA
T: 020 7424 1000
Helpline: 020 7424 1030
W: www.diabetes.org.uk
E: info@diabetes.org.uk

Faculty of Public Health
4 St Andrews Place
London NW1 4LB
T: 020 7935 0243
W: www.fph.org.uk

Food Standards Agency
Aviation House
125 Kingsway
London WC2B 6NH
T: 020 7276 8000
W: www.food.gov.uk

Health Development Agency
Holborn Gate
330 High Holborn
London WC1V 7BA
T: 020 7430 0850
W: www.hda.nhs.uk

Health Education Trust
18 High Street
Broom
Alcester
Warwickshire B50 4HJ
W: www.healthedtrust.com/
E: enquiries@HealthEdTrust.com

Help the Aged
207-221 Pentonville Road
London N1 9UZ
T: 020 7278 1114
W: www.helptheaged.org.uk
E: info@helptheaged.org.uk

International Obesity Task Force
231 North Gower Street
London NW1 2NS
T: 020 7691 1900
W: www.iotf.org
E: obesity@iotf.org

LACORS
(Local Authorities Coordinators of Regulatory Services)
10 Albert Embankment
London SE1 7SP
T: 020 7840 7200
W: www.lacors.com

Local Government Association
Local Government House
Smith Square
London SW1P 3HZ
T: 020 7664 3131
W: www.lga.gov.uk

National Osteoporosis Society
Camerton
Bath BA2 0PJ
T: 01761 471771
Helpline: 0845 450 0230
W: www.nos.org.uk
E: info@nos.org.uk

Royal College of Physicians
11 St Andrews Place
Regent's Park
London NW1 4LE
T: 020 7935 1174
W: www.rcplondon.ac.uk

Save the Children
17 Grove Lane
London SE5 8RD
T: 020 7703 5400
W: www.savethechildren.org.uk

Scottish Community Diet Project
c/o Scottish Consumer Council
Royal Exchange House
100 Queen Street
Glasgow G1 3DN
T: 0141 226 5261
Minicom: 0141 226 8459
E: info@scotconsumer.org.uk

Sustain
94 White Lion Street
London N1 9PF
T: 020 7837 1228
W: www.sustainweb.org

WRVS
Milton Hill House
Milton Hill
Steventon
Abingdon
Oxfordshire OX13 6AD
T: 01235 442900
W: www.wrvs.org.uk

Glossary

BMI	Body Mass Index
CAP	Common Agricultural Policy
COMA	Committee on Medical Aspects of Food and Nutrition Policy
GMS contract	General Medical Services contract
LA	Local authority
LETS	Local Economy Trading Standards
LPSA	Local Public Service Agreement
NSF	National Service Framework
ODPM	Office of the Deputy Prime Minister
PCT	Primary care trust
PPF	Priorities and Planning Framework
PPG	Planning and Policy Guidance
PSA	Public Service Agreement

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