

Public health nutrition Challenges for the 21st century



A report produced for
the Caroline Walker Trust's
first **Eating Well** conference
25 November 2008

- Caroline Walker's legacy to public health nutrition
- Nutritional health in the UK: where are we now?
- What could change and how?
- CWT: the next 20 years
- CWT achievements – 1988-2008



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With thanks to Anne Dillon Roberts for reflections on the early days of the Trust, and to Oliver Gillie, Rosie Leyden and Lisa Wilson.

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Disclaimer

This report contains the opinions of the author and CWT Trustees and is intended as a discussion document to open up debate, rather than as an erudite scientific text.

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Eating Well: Children and Adults with Learning Disabilities

Eating Well for Under-5s in Child Care

Eating Well at School

Eating Well for Looked After Children and Young People

Eating Well for Older People

Eating Well for Older People with Dementia (published by VOICES)

Caroline Walker's legacy to public health nutrition

Caroline Walker was one of the first campaigners for a coherent food strategy in the UK. She was a crusader, an author, a campaigner and a passionate believer in the rights of everyone to have a safe, affordable and nutritious food supply.

Caroline Walker 1950 – 1988



Caroline was known for her courage as a whistle-blower and exposé of the lack of transparency between Government, research and the food industry, for her anger at the complacency surrounding food and health, and for her ability to communicate her message as widely as possible. She was widely mourned after her untimely death at the age of 38, but she had achieved change in her lifetime and has continued to inspire change since her death.

Reading her obituaries 20 years after her death, we were struck by how many of the seeds she had sown have grown and flourished – for example: the greater transparency now required of researchers in explaining their funding, the development of food labelling, and the need for better nutritional standards for school meals. There has been a sea change of understanding about the role of diet in health since Caroline's death but, despite the rise of food up the public and political agendas, much remains to be done to ensure that all members of society are enabled and supported to eat well. Had Caroline survived, she would be frustrated and saddened that the diets of so many children and young adults living in the UK in the 21st century remain tied to the nutritionally depleted high-fat, high-

salt and high-sugar foods that she so eloquently exposed during her campaigning.

Caroline's principles and beliefs helped to shape the Trust that would live on in her name. The main aim of The Caroline Walker Trust (CWT) is to raise the profile of **good food** itself and place it firmly on the political and public agendas.

The key objectives of the Trust are:

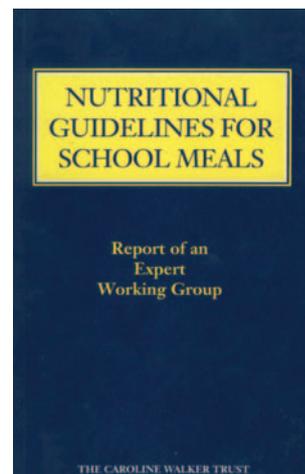
- to promote good food
- to ensure that public food policy protects the vulnerable, particularly children
- to encourage graduate nutritionists in their first steps in the profession, and
- to continue Caroline's work in whatever way Trustees feel it is most needed.

At the time CWT was formed in 1988, food was not seen as a central issue in health care or in health promotion. The NHS was busy dismantling kitchens and introducing cook/chill food systems, compulsory competitive tendering meant that public service catering contracts went to the cheapest bidder, nutritional guidelines that protected the nutritional quality of school meals disappeared, and highly processed 'fast food' started to dominate domestic and commercial catering food provision. In the 1970s and 80s undernutrition was seen as a matter of concern only in the developing world. It was regarded almost as immoral to suggest that poor nutrition might be associated with wealthy countries which had worked hard in the post-war years to provide cheap, attractive food with a long shelf-life, that was accessible to all. Unfortunately, the post-war food revolution produced products typically high in fat, saturated fat, salt and sugar, and a globalisation of food commodities saw an ever-increasing rise in the dissociation of the population from food production.

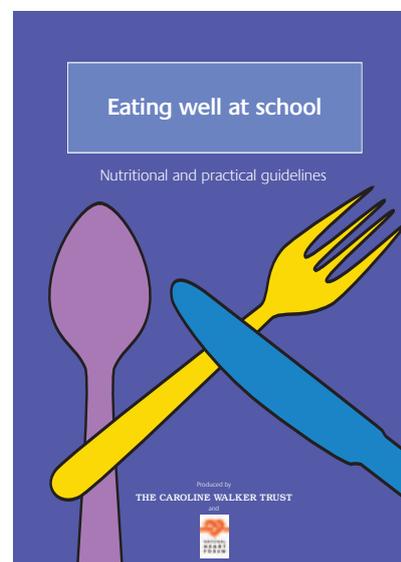
The initial plan for CWT was to raise the profile of those issues of interest to Caroline, and in particular to challenge government thinking and approach on food issues and to do it in a way that was stimulating, practical and inclusive.

The importance of a healthy population of children was always a central concern of Caroline and in 1992 CWT published its first CWT expert report on nutritional guidelines for school meals.¹ The abolition of the standards for school meals in 1980 impacted on the quality of free school meals for the most vulnerable children in society. The idea that food was a service to be provided at the lowest possible cost remains embedded in the provision of much of the food served to vulnerable people today.

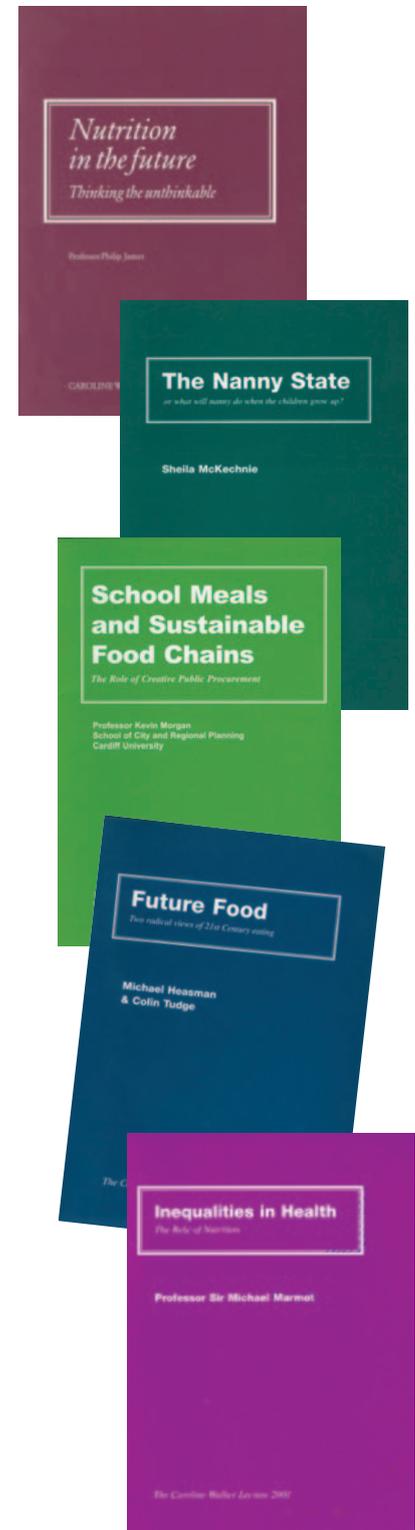
The publication of the school meals report placed CWT as an organisation that would be called upon to speak on a broad range of food-related issues as they began to be raised by an increasingly curious media.



CWT's first expert report: *Nutritional Guidelines for School Meals*



In its series of annual lectures by eminent speakers from academia, food policy and across the food chain, CWT has also highlighted key issues around public health nutrition policy.



CWT has held annual lectures since 1990. See page 23.

By the mid-1990s, CWT's efforts to place eating well for all on the public and political agendas were beginning to bear fruit. Many of the CWT reports published over the past 20 years have pre-empted much of current government thinking in terms of providing clear guidance for catering for key vulnerable groups in the public sector. The resources produced by CWT fill a unique role in providing clear, evidence-based, scientifically sound information to a wide audience and the evidence is used to make recommendations and provide numerical nutritional standards. There are no other resources available in these areas which fulfil this function.

In 2008, CWT is celebrating its 20th anniversary by looking forward, as Caroline would have done, and assessing what still needs to be achieved in public health nutrition. Despite nutrition rising up the health agenda and government commitment to eating well, there has not been a significant improvement in nutritional health.

It remains a scandal that, despite unequivocal evidence linking diet to disease, many vulnerable people are not enabled to eat well when their food is provided by public sector organisations. Caroline herself discovered, within days of having major surgery, "the inadequacy of hospital food and the nutritional ignorance of surgeons," and vowed to write a book on hospitals when she recovered. During research and writing of all the CWT reports we have often found woefully little interest in enabling many vulnerable people to eat well in various settings.

In this report we look at some of the current issues around public health nutrition and suggest some recommendations for change. We also discuss our themes for future action and hope that our supporters will contribute to the debate about how the Trust can most effectively move forward.

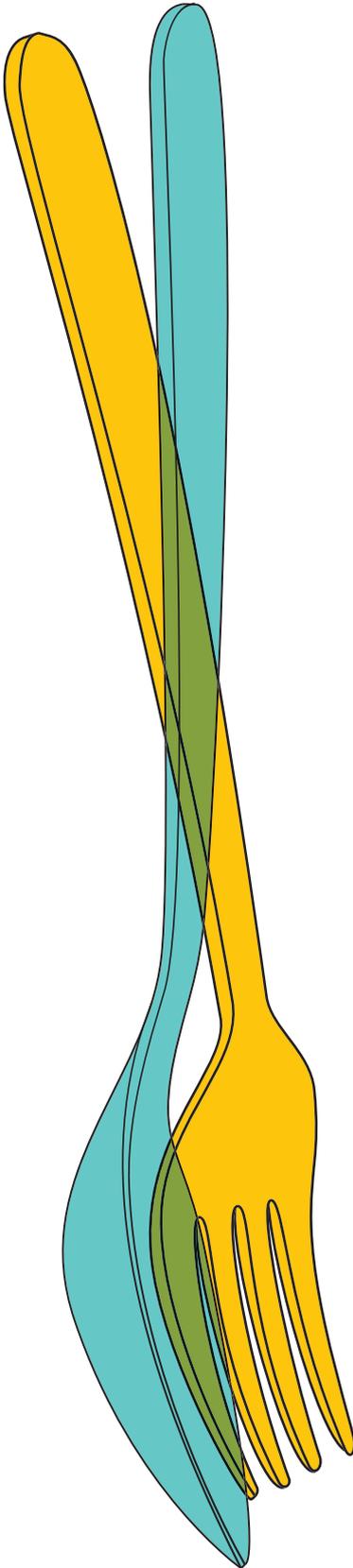
The Caroline Walker Trust

In writing this report we owe a debt to all those who were involved in setting up CWT, particularly Caroline's husband Geoffrey Cannon, and all those who have joined CWT as Trustees and Officers, Supporters and Friends. As a small charity without offices or full-time paid staff, the Trustees themselves have worked on each of the projects, and in fund-raising and awareness-raising, and many did so because they felt a strong connection to Caroline's passion for good food.

Particular thanks go to those who have been chairs of the Trust over the past 20 years: Jonathan Aitken MP, Maggie Sanderson (who expertly chaired CWT from 1992 to 2000 and also chaired the first school meals guidelines expert working group, but who sadly died in 2003), David Dickinson, Moira Howie, Professor Martin Wiseman and Joe Harvey. Sincere thanks must also go to Anne Dillon Roberts who chaired four of our Expert Working Groups and Professor Annie Anderson who chaired the 2005 *Eating Well at School* report. Thanks are also due to Sarah Ivatts and Pauline Styles who have expertly managed the Trust's administration for much of the past two decades.

We hope that all those who knew Caroline, or who were inspired by her, will continue to support the work of the Trust and to lobby for better public health through good food.





Nutritional health in the UK: where are we now?

There is no doubt that food and nutrition are now higher up in both political and personal agendas. However, despite considerable investment in promoting healthy eating, we have not seen the step change in food choices and nutrient intakes needed to make a significant impact on nutritional health across the UK.

Current nutrient and food intakes

There have been considerable changes in the UK diet over the past few decades, mirroring changing lifestyles. There have also been major developments in food availability, processing and cooking methods. Loss of food preparation skills, and changing living arrangements and work patterns have contributed to a rise in the purchase of ready-prepared foods and food eaten outside the home. Innovation and investment in the food industry have led to a significant rise in the range of food and drink products available to consumers and the attitude of much of the population to food has changed, with consumers demanding better quality food of greater variety. There is optimism that healthier foods and foods with a smaller impact on the environment will be increasingly requested by consumers, but evidence to date suggests that we are yet to see significant positive changes in food choice translated into improvements in average food and nutrient intakes.

It is difficult to summarise nutrient and food intakes simply, as average figures for populations mask enormous variations by age, gender and personal circumstances. Also, much of the data from dietary surveys and food purchase

studies can be debated and it is likely that the intakes of some foods (particularly snack foods such as confectionery) are typically under-reported.

Some of the more obvious and consistent trends, however, have been:

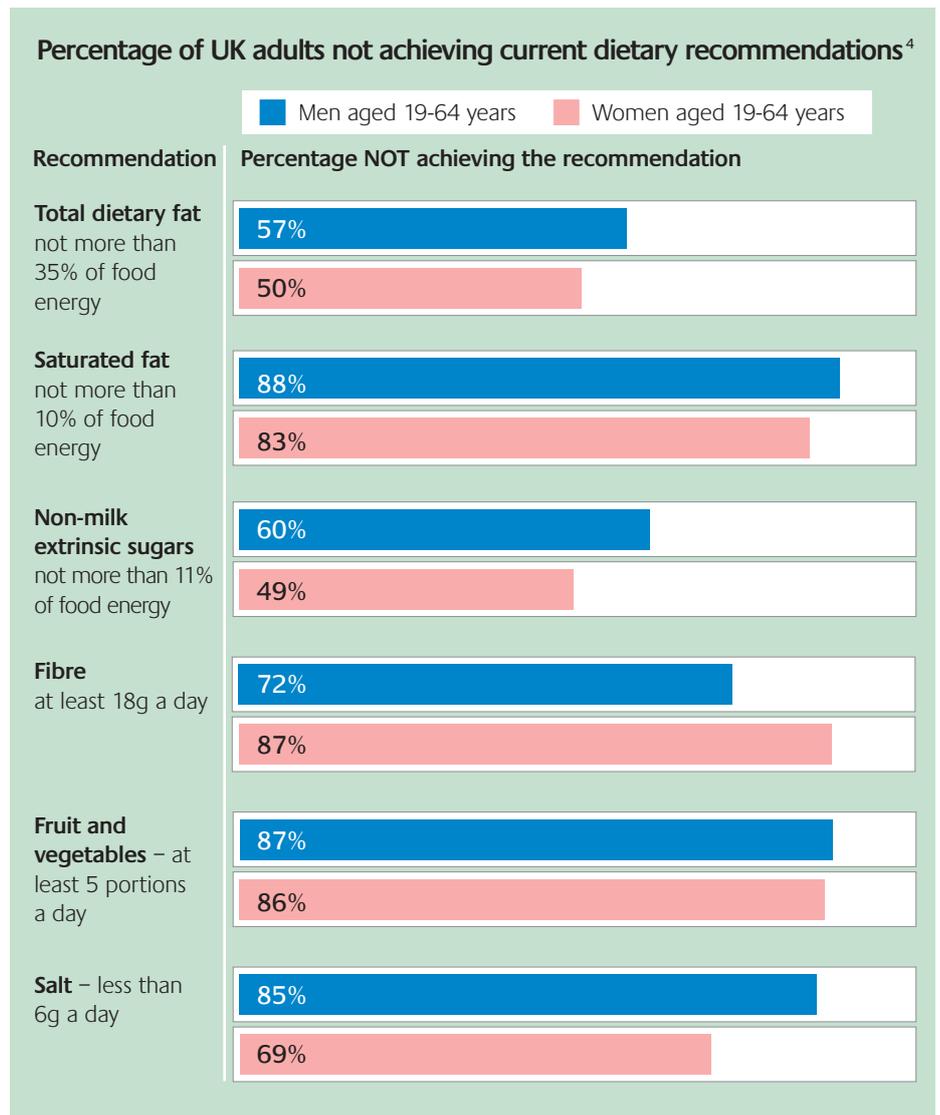
- A **reduction in energy intake** mirroring the decline in energy expenditure, but a **rise in overweight and obesity**.
- A shift towards a **lower-fat diet**, with reductions in the consumption of higher-fat meats and high-fat dairy products, but with average **intakes of saturated fats still higher than recommended**.
- **Low intakes of fibre**, but **intakes of sugars higher than recommendations**, particularly for children and young adults.
- An increasing contribution to energy and sugar intake from **alcoholic beverages**.
- Average **salt intakes above recommendations**, with particularly high intakes among younger adults.
- **Intakes of fruits and vegetables remain lower than recommended**. The average intake of fruit and vegetables remains at just under 3 portions a day, and intakes are considerably lower among young adults (aged 16-24 years) who consume on average less than 2 portions a day.
- **Reductions in intakes of foods such as potatoes, some vegetables and bread**.

- Increases in intakes of soft drinks, sweet and savoury snack foods and take-away foods.

Few adults in the population consume a diet that meets current dietary recommendations (see box opposite), even though 90% of the population claimed, in a survey funded by the Food Standards Agency (FSA) in 2007, that “healthy eating is important to them”.² There is no doubt of the growing complexity of the relationship the British have with their food. While it may now be acceptable to publicly embrace healthy eating, data from another survey carried out for the FSA in 2007 suggest that almost a third of the population could be described as “convenience-driven health rejectors” – defined by a low enthusiasm for healthy eating and an endorsement of convenience food.³ Certainly the data collected in quantitative dietary surveys, as well as the rising incidence of overweight and obesity, might suggest that the relationships many people have with food and health are conflicting.

The most visible and best funded health promotion campaign around food has been the 5-A-Day campaign to encourage increased intakes of fruits and vegetables. The campaign has certainly been successful in increasing people’s awareness of the importance of eating fruit and vegetables, with the latest FSA data suggesting that 78% of the UK population are aware of the 5-A-Day message.² There has also been a small but significant increase in the intake of total fruits and vegetables, but progress to a population eating an average of at least 5 portions of fruit and vegetables a day is slow and is proving very difficult to achieve. Despite optimism at rising purchases of fruit and vegetables in 2007, market research data reported a 12% decline in fruit and vegetable intakes in 2008 as food prices started to rise. Healthy eating may be a lower priority when people find themselves in more difficult circumstances, and protecting the health of vulnerable people may require greater intervention.

There are other areas where dietary



changes have been less well documented and where there have been fewer calls to change behaviour. For example, young adults in Britain have high intakes of ‘added’ sugars – men and women aged 16-24 years have over 17% and 14% of their daily energy intake from added sugars, compared to a recommended intake of no more than 11%.⁴ What is more startling is where these sugars come from: 50% of all sugars in the diets of young men, and 46% in the diets of young women, come from soft drinks (excluding fruit juices) and alcoholic beverages. The greatest contributor to sugar intake is non-diet carbonated soft drinks, which are regularly consumed by over 90% of young men and 64% of young women. Young men consume over 300ml of these drinks a day, and young women consume over 250ml a day.⁴ It is known that when people consume soft drinks

they do not recognise they have taken in extra calories and that they are therefore likely to increase normal energy intakes.⁵ Just one can of soft drink a day leads to a surplus calorie intake over a week of about 1,000kcal. It seems surprising therefore that there have been few high-profile public calls for a population-wide reduction in the intakes of soft drinks.

If people are aware that eating well is desirable, but fail to change their food choices, greater practical and regulatory intervention may be required, particularly to support those who are less able to access good food choices. As Professor Philip James noted in his lecture for CWT ‘Nutrition in the future: Thinking the unthinkable’:⁶ **“If we’re serious about nutrition, we have to be serious about the public’s access to good quality food.”**

Low-income households

The first ever national Low Income Diet and Nutrition Survey (LIDNS), published by the Food Standards Agency in 2007,⁷ examined the food and nutrient intakes and nutritional status of people living in households in the bottom 15% of the UK population in terms of material deprivation. The findings, which have been expertly discussed in the context of how we define deprived households and their diversity and complexity by Elizabeth Dowler,⁸ were to many unsurprising:

- A considerable proportion of people in low-income groups failed to meet population dietary targets, and consumed diets which were low in micronutrients such as vitamin A, riboflavin, folates, vitamin C and iron.
- Obesity and high blood pressure rates were high.
- The population was generally inactive.
- Participants – particularly those in the

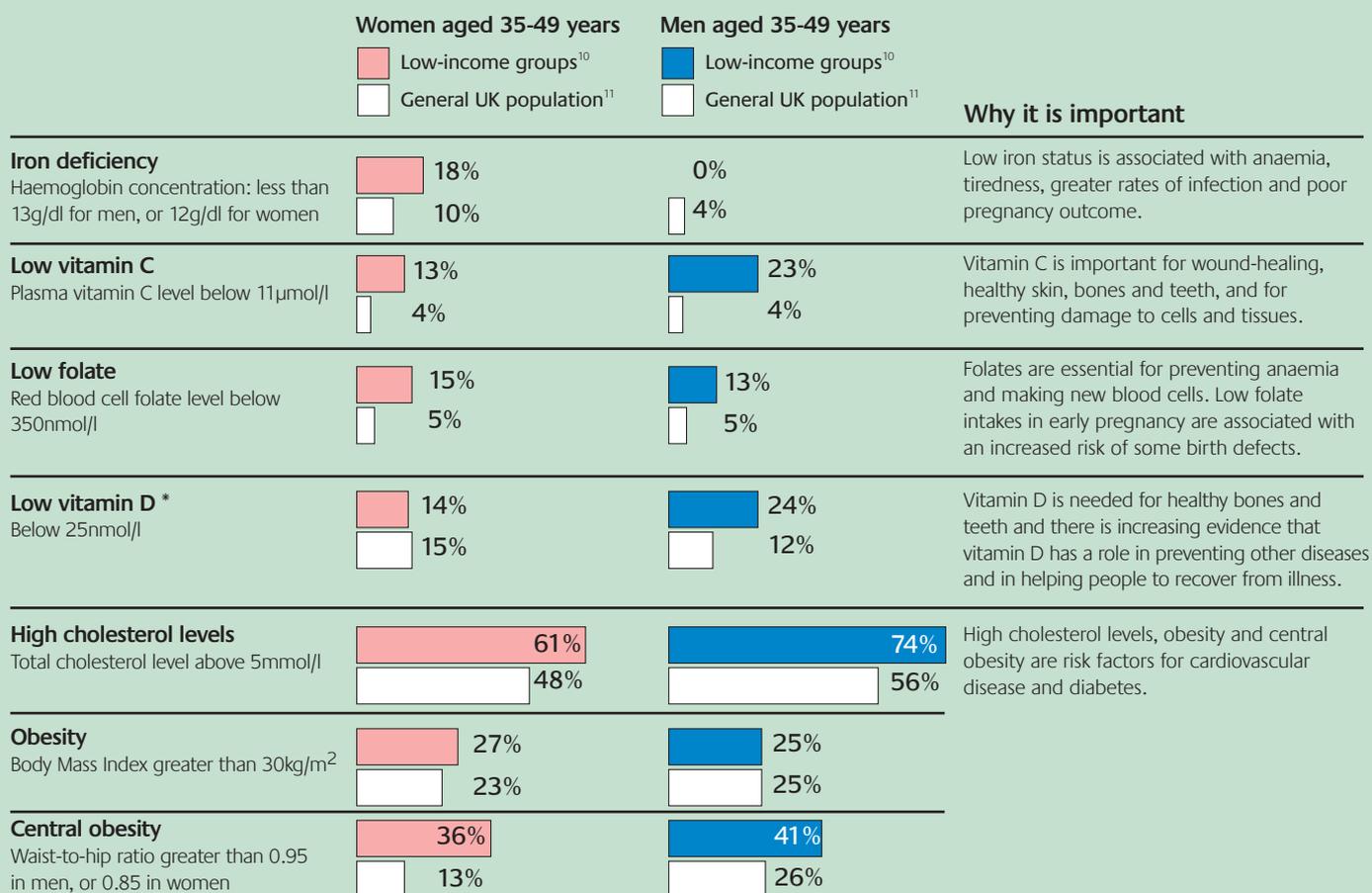
younger age groups – were more likely to consume high-fat, high-sugar, processed foods and snack foods, and were less likely to eat the sorts of foods generally recommended for good health than the rest of the population.

The survey showed that, while intakes of foods and nutrients were on average similar to those of the rest of the population, the *nutritional status* of those in low-income households was noticeably poorer. The box below demonstrates some of the observed differences in nutritional status for men and women aged 35 to 49 years between those in low-income households and the UK population as a whole. The findings are similar in other age groups.

The press release which accompanied the publication of the LIDNS report suggested that low-income households are not a “distinguishable group with

considerably worse nutrition than the rest of the population”. It has therefore been argued that, since many UK households do not meet current dietary guidelines, those in low-income households are no different and do not merit special attention.⁹ While reported food and nutrient intakes may be comparable (and there must always be debate about the accuracy of reported food intake data), nutritional status is clearly poorer among those in low-income households. For example, three times as many adult women aged 35-49 years in low-income households have low vitamin C and low folate status and almost twice as many are iron deficient compared to the UK population as a whole. In addition, men in this age group in low-income households are twice as likely to have low vitamin D status than their better-off peers. For both men and women total cholesterol levels and waist-to-hip ratios, both of which are linked to heart disease risk are

Nutritional status of 35-49 year olds: how do low-income groups compare with the general UK population?



* See page 19 for more information on vitamin D.

considerably higher among those in low-income households, and women in low-income households have a higher average Body Mass Index.

This picture of significantly poorer nutritional status among those in our poorest households should stimulate more urgent debate about how we ensure that, wherever possible, we act to improve the food and nutrient intake of those who are most vulnerable to malnutrition.

It should also be remembered that we know little about the food intakes and nutritional status of those families and individuals in even greater poverty and insecurity in the UK: those who fall outside official surveys and registers because they are homeless, transient or in residential care, or are asylum-seekers or without citizenship.

Positive initiatives around food and health

We have seen unprecedented funding to address health inequalities over the past 10 years, as well as many reports and action plans. Health Action Zones, Education Action Zones, 5-A-Day programmes, free school fruit and vegetables, Sure Start, Healthy Schools, Healthy Start and equivalent schemes in the devolved administrations have all aimed in some way to improve food and nutrition, particularly among those in areas of deprivation or those living in low-income households.⁸ There have also been clear nutrient-based and food-based standards for school meals introduced across the UK, increasing investment in cooking in schools, restrictions on the advertising of high-fat, high-salt and high-sugar foods on children's TV, and a range of initiatives to promote activity. The *Healthy weight, Healthy lives* strategy in England, launched in 2008, highlights greater investment in promoting breastfeeding, identifying 'at-risk families', promoting healthier food choices and creating incentives for better health as strategies to reduce obesity. The Department of Health-led social marketing strategy,

Change 4 life, aims to bring together health and education professionals, industry and the third sector with the shared aims of improving children's diets and levels of activity. These and other initiatives across the UK demonstrate the considerable investment now being placed in tackling those nutritional health issues considered of greatest priority.

Despite the investment to date, however, health inequalities have widened and, while evaluations of some national and smaller-scale interventions have demonstrated some improvements in food patterns and, importantly, greater engagement with and enjoyment of food, the actual impact on nutrient intakes and nutritional status has been small. Most health inequalities however are due to income and social inequality and it is suggested that many health promotion initiatives get 'washed away' in the tide of relative disadvantage, with most of the beneficial effects of better nutrition being seen among higher-income groups.¹² Continued and rigorous debate about the ability of those on low incomes to access a healthy diet is still needed.

Community food projects

In the last 10 years, community food projects in the UK have evolved from small, locally run initiatives using food as a way of bringing people together, to independent groups which have a vital role to play in public health nutrition. Community food projects have not only demonstrably had a positive impact through increasing skills, confidence and community cohesion, but have also increasingly become a significant force for change among communities by providing information, training and support to local people based on the needs of the community they work in. It is often difficult to quantify the impact these projects have, as health impact assessments can miss the point of the approach many projects take and can focus too closely on specific nutrient and food intake changes. There is strong

CWT Awards

As part of its role in championing and highlighting good practice, courage and achievement in promoting good food, CWT has given a number of annual awards to recognise individuals, organisations, campaigns and companies who have made a real difference in promoting better nutritional health across the UK.

Through this award scheme, CWT has praised the work of many successful community food projects over the years as part of its commitment to raising the profile of good food in communities. Examples include:

- Magic Breakfast, based in London, which delivers healthy breakfast food to children
- Isle of Wight Healthy Eating Alliance, which has been promoting and enabling healthy eating for households on the Isle of Wight since 2000
- Greenwich Co-operative Development Agency, which supports the development of food co-ops and other food access initiatives which the local community then take on and run independently
- Liverpool Food Workers
- Grimethorpe Community Café
- The Food Chain, who deliver food and nutrition advice to individuals and families living with HIV in London.

Other organisations and projects commended by CWT include the work of Baby Milk Action, Sustain, The Food Commission and the Food Ethics Council, as well as many other committed and talented individuals and organisations. For a full list of award winners, see www.cwt.org.uk.

CWT has also awarded the Maggie Sanderson student awards annually to encourage graduates in their work as nutritionists and encourage nutritionists and dietitians to consider a career in public health.

qualitative evidence that more people are aware of, understand and can purchase and cook healthy food after taking part in community food projects, but the longer-term impact of this on eating patterns is not known.

The most notable projects have married community involvement with improved access to more healthy, affordable food. These include food co-ops, lunch clubs, community cafés and cooking and training programmes. The most successful projects are those that have gone on to become long-term, sustainable projects, creating at least some of their own income, or finding long-term funding and diversifying according to their capacity and the needs of the local community.

There are hundreds of projects working across the UK tackling food and nutrition issues, ranging from growing food to encouraging the socially

excluded to cook with new and healthy foods. There remain problems with long-term funding for many projects and with the efficacy of some programmes, but with better support than ever in every area of the UK through national and regional networks, community food projects are helping to shift food culture for all.

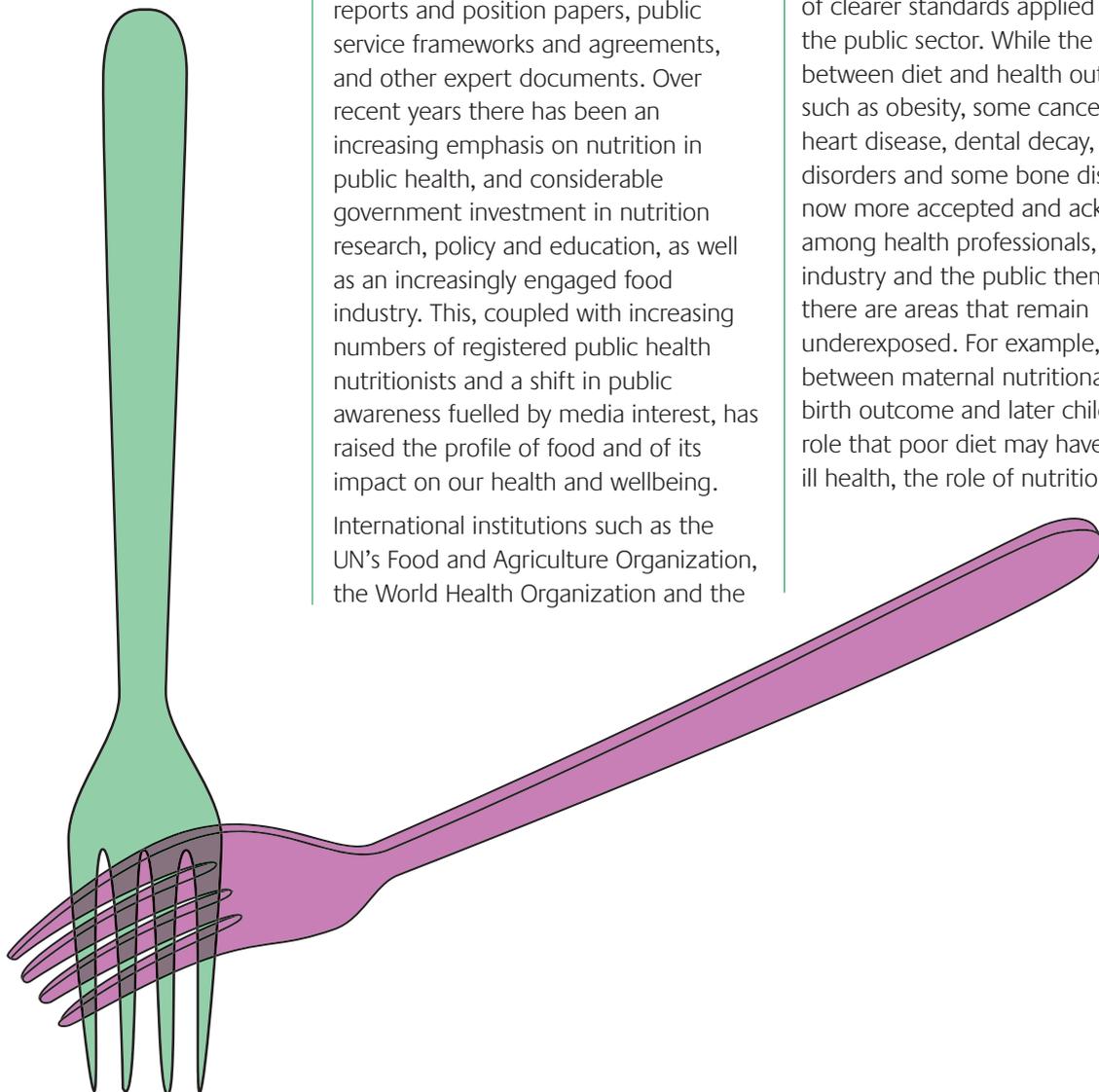
Food policy

The UK has not had a comprehensive food policy since the Second World War. It has a number of policies that relate to food – whether to do with its production (for example, agricultural and environmental policy), or its consumption (for example, policy to reduce food-borne illness or to promote better health of infants) – but in policy terms they are rarely inter-related. Policies relating to promoting better health through good food are distributed through an enormous range of evidence-based, health-related reports and position papers, public service frameworks and agreements, and other expert documents. Over recent years there has been an increasing emphasis on nutrition in public health, and considerable government investment in nutrition research, policy and education, as well as an increasingly engaged food industry. This, coupled with increasing numbers of registered public health nutritionists and a shift in public awareness fuelled by media interest, has raised the profile of food and of its impact on our health and wellbeing.

International institutions such as the UN's Food and Agriculture Organization, the World Health Organization and the

Codex Alimentarius Commission are increasingly focussing on food policy, including the *Second European Action Plan for Food and Nutrition Policy* agreed in 2006.¹³ With devolution in the UK there has also been an increasing complexity in differing food strategies and policies. For example, the Scottish Executive is developing a national food policy for Scotland,¹⁴ Wales is developing a new Quality of Food Strategy¹⁵ and Northern Ireland has had a strategy focussing on food and activity for young people since 2006.¹⁶ CWT is currently preparing a report looking at differences in nutrition policy in the four administrative areas of the UK, which will be available on the CWT website at the end of 2008 (see www.cwt.org.uk).

Food policy in the UK is now shifting from one focussed on informing consumers and encouraging them to make better choices, to one which considers the wider implications of food marketing, food availability and sustainability, as well as the introduction of clearer standards applied to food in the public sector. While the links between diet and health outcomes – such as obesity, some cancers, diabetes, heart disease, dental decay, gut disorders and some bone diseases – are now more accepted and acknowledged among health professionals, the food industry and the public themselves, there are areas that remain underexposed. For example, the links between maternal nutritional status and birth outcome and later child health, the role that poor diet may have in mental ill health, the role of nutrition in infancy



and early years on later outcomes, and the impact of ageing on nutritional status and nutritional needs – are all areas that remain outside the main nutrition agenda for the majority of the population.

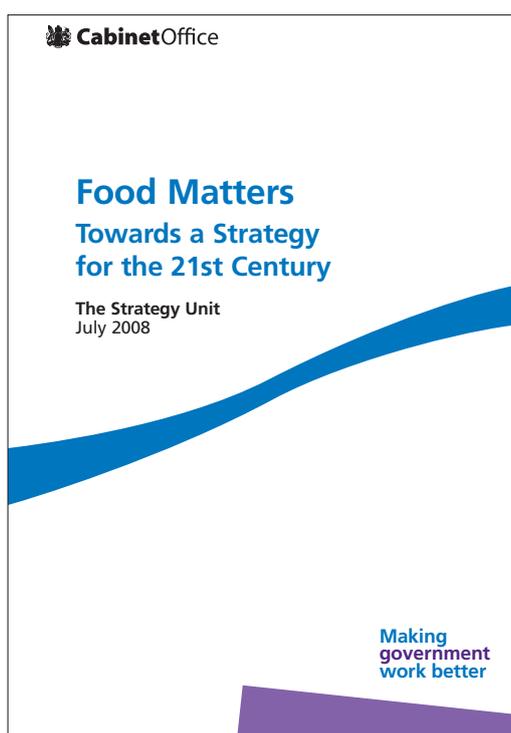
Food Matters

In July 2008 the Cabinet Office published *Food Matters: Towards a Strategy for the 21st Century*,¹⁷ which reviews the main trends in food production and consumption in the UK, analyses how current food trends are likely to impact on our economy, society and the environment, and determines objectives for future food strategies. *Food Matters* highlights the changing social and political climate in which food consumption and food production sit, and reinforces the now unequivocal understanding that changes in eating patterns would bring huge health gains in the UK. Readers are encouraged to read the *Food Matters* report carefully.

The key actions and conclusions in the *Food Matters* strategy document relevant to public health nutrition are outlined below. *Food Matters* recommends:

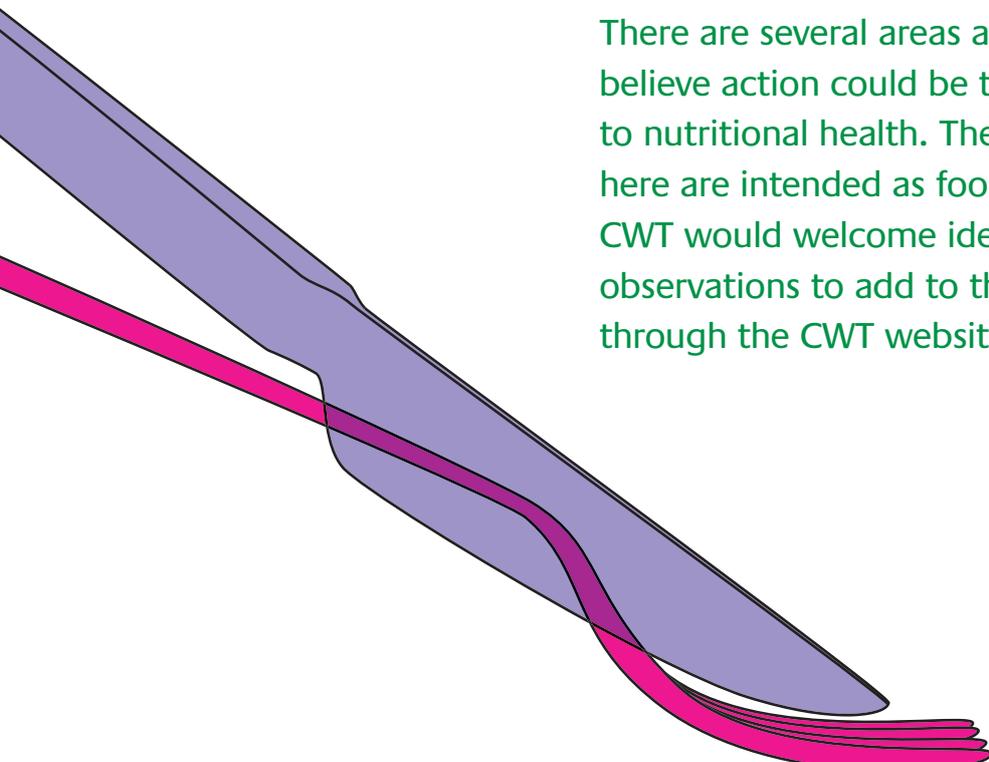
- Bringing together, for the first time, integrated information and advice for consumers on the **impacts of food on health and the environment**
- Making it easier for consumers to make **healthier choices when eating out**
- Recognising that **community groups, voluntary organisations and social enterprises** have an important role to play in supporting activities that promote healthy eating
- Making further progress with the **5 A DAY** campaign to increase **average daily intakes of fruit and vegetables**, particularly among low-income families
- Developing a **Healthier Food Mark for public sector catering**, to encourage provision of healthier food in hospitals, government departments and prisons.

The Cabinet Office plans to establish and support a Food Strategy Task Force to drive forward these recommendations. While we commend this work and all those who have pushed this agenda forward in Government, many of the strategies suggested have been in policy documents for 10 years or more and greater urgency, confidence and a broader brush are needed if there is a real desire to make a positive change in nutritional health.



What could change and how?

There are several areas across the lifespan where we believe action could be taken to make a real difference to nutritional health. The ideas and suggestions given here are intended as food for thought and debate. CWT would welcome ideas, suggestions, additions and observations to add to the debate. Please add yours through the CWT website at www.cwt.org.uk.



Since 1992, CWT has produced expert reports which make nutritional and practical recommendations that aim to improve the nutritional health of:

- children under the age of five
- school-aged children
- looked after children and young people
- children and adults with learning disabilities, and
- older adults.

In 2009 we will publish recommendations for women for pregnancy.

All of the recommendations and practical guidelines suggested in the above reports remain relevant, and many have already been put into practice at local or national level. We commend these recommendations to

all those who make, implement and enforce policy and legislation, and believe that they remain current and relevant. All of the recommendations made by CWT can be downloaded from the CWT website (see www.cwt.org.uk), either on their own or as part of the whole report.

Here we highlight some of the challenges we face across the lifespan and make suggestions for possible solutions. We also highlight some areas of particular concern:

- the lack of investment in breastfeeding promotion
- the need to expand entitlement to free school meals
- the need for clear nutritional labelling on foods
- the lack of training and support to enable people with learning disabilities to eat well
- the need for an urgent review of policy around vitamin D, and
- the need for greater investment in supporting older people in their own homes to eat well.

Pregnancy

Some of the challenges

Nutritional status of young mothers and their partners

We have a rising birth rate but many young women are nutritionally unfit for pregnancy, through obesity or diet, or both. Many of their young male partners have diets that are low in fruits and vegetables and poor nutritional status which may impact on fertility as well as on eating patterns within the household during pregnancy.

The percentage of low-birthweight babies born in the UK remains one of the highest in Europe.

There is substantial evidence that obesity in pregnancy contributes to increased morbidity and mortality for both mother and baby. Maternal death, stillbirth and neonatal deaths are all higher among obese mothers.¹⁸

Possible solutions

- Offer all pregnant women, at an early stage of their pregnancy, expert one-to-one advice on eating well for their families, from a dietitian or registered public health nutritionist.
- Make Healthy Start supplements for pregnant women easily available at minimal or no cost and ensure all health professionals understand the importance of consistently promoting their use.
- Extend the Healthy Start food voucher scheme to other groups of vulnerable women, including asylum-seeking women, those who are on low incomes but not currently in receipt of income support, and all women under 21 years of age.
- Ensure all health professionals who have contact with women during pregnancy have access to clear, expert, detailed and practical guidance on what eating well means.

Breastfeeding

Investing in future health: why breastfeeding promotion deserves greater investment

The evidence for the importance of breastfeeding in protecting the health of both mothers and their infants is unequivocal. Despite a wealth of evidence supporting the importance of breastfeeding in health terms for both the baby (such as reduced rates of infections, and less likelihood of some chronic diseases) and the mother (such as reduced risk of breast cancer and ovarian cancer), and a majority of mothers wanting to breastfeed their baby, the support needed to do this effectively is sorely lacking. Current recommendations advise that all infants are exclusively breastfed for the first six months of life and that breastfeeding is then continued alongside complementary foods throughout the first year (and beyond if the mother wishes).

Until 2008 there was minimal government investment in the

promotion of breastfeeding, and while there has been an increase in the percentage of women putting the baby to the breast in the first instance, very few mothers are exclusively breastfeeding their babies at six weeks and a negligible number at six months. In Scotland, greater investment following the Scottish Diet Action Plan saw substantial increases in the rates of breastfeeding. There was also a change in the law in Scotland to make it illegal “to prevent a child being milk fed in any public place he is entitled to be” which made the commitment to breastfeeding explicit. Since 2002, the Department of Health in England has funded a range of activities promoting breastfeeding and infant feeding and most of this funding was spent centrally in developing promotional and educational materials. With about 700,000 births in England a year, however, Department of Health expenditure of £729,011 in 2006-07 amounted to only about £1 per child born. Recent estimates from NICE indicate that the effects of not breastfeeding on the cost of treatment of breast cancer alone justifies

investment in national breastfeeding peer support programmes, even without taking into consideration the reduced cost to the NHS of the lower rate of hospitalisation of breastfed babies and the many other longer-term health benefits for mothers and children.¹⁹ The recent announcement of £2 million from the Department of Health in 2008 to increase the number of hospitals with UNICEF Baby Friendly status and to increase support around breastfeeding is to be welcomed and it is hoped that increased investment will be continued in the longer term.

According to figures from Baby Milk Action,²⁰ companies spend around £20 a year, per baby, promoting infant feeding products, and ineffective adherence to the WHO code of marketing of breast milk substitutes means that advertising suggesting that formula milks can be ‘as good as’ breast milk is widespread. Such advertising undermines women’s confidence in their ability to successfully exclusively breastfeed their children. There should be no advertising of any milk used as a breast milk substitute, including follow-on formula and other

Infant feeding

Some of the challenges

Breastfeeding

The number of mothers in the UK who initially breastfeed their babies has increased, but exclusive breastfeeding even after two weeks remains very low, and few younger mothers and mothers from poorer households breastfeed at all.

For more on breastfeeding, see page 11.

Possible solutions

- Ensure that the right of every infant to receive breast milk exclusively for the first six months of its life is given priority and that all women, regardless of their circumstances, are supported and encouraged to breastfeed. This includes women in prison or in detention centres and women in any form of residential accommodation.
- Instigate a sustained investment in a high-profile breastfeeding promotion campaign at a national level across the UK.
- Teach all children in school – male and female – about the benefits of breastfeeding, as a regular part of the school curriculum.

Infant formula

The nutritional composition of infant formula (baby milk) is not independently monitored in the UK, even though this product uniquely is the sole source of nutrition for a large percentage of infants.

Evidence for health claims made by formula companies are inadequately scrutinised. The advertising of follow-on formula milk continues to undermine breastfeeding and is inadequately monitored.

- Make independent analysis of formula milk composition a routine part of UK food surveillance.
- Ensure that the WHO code of marketing of breast milk substitutes²¹ is fully implemented, and extend the ban on advertising to all milks designed for babies (not just breast milk substitutes for use in the first six months of life), including follow-on formula and other milks.

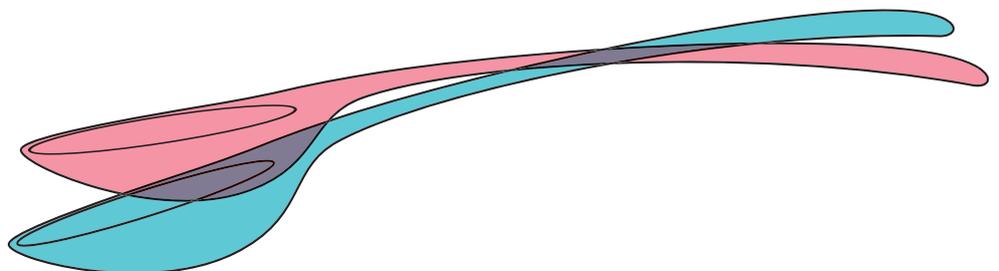
Vitamin D

There is some evidence that some babies receive insufficient vitamin D and this can lead to rickets and bone problems in later life.

- Review current policy on the provision of vitamin D to babies and infants and the current supplementation levels recommended, including consideration of the need for a supplement by babies who are breastfed.

milks. There is also a need for greater investment in the promotion of breastfeeding at a national level to shift public attitudes. In addition, better education of young people about the importance of breast milk as a safe, health-promoting and sustainable resource is essential.

CWT is currently preparing a report on the composition of infant milks. Many health professionals themselves are unclear about the types of milks available, and in an information vacuum will rely on information provided by the companies themselves rather than an independent source.



Children under the age of 5

Some of the challenges

We have little recent data on food intakes for pre-school children. The evidence we do have suggests that many pre-school children have too few fruits and vegetables and too many sugary foods and drinks, as well as too little of some nutrients such as vitamin A, vitamin D, iron and zinc.

Foods aimed at children often contain colourings, flavourings and other non-nutritive substances which are not subject to sufficient and rigorous scrutiny.

Pre-school children are frequently looked after outside the home and at present there are no mandatory guidelines for the nutritional content of the food and snacks served to children in child care settings.

Recent rapid changes in body fatness, fat distribution and the prevalence of overweight among pre-school children suggest significant changes in diet and lifestyle among this population group which mirror the changing children's food culture in the UK.

Tooth decay

By the age of five, more than a third of British children have suffered tooth decay, missing teeth or fillings, and in some parts of the country three-quarters of children are affected.²²

Possible solutions

- Make available to parents of pre-school children clear, simple advice on safe and nutritious food and drink choices, including clearer advice on avoiding food components about which there might be concerns.
- Introduce mandatory food and nutritional guidelines for all pre-school settings (in the same way as we now have for school meals) in a format which makes it practical for inspectors to assess them.
- Make training in eating well mandatory for all early years workers, as part of commissioning policy.
- Local authorities to publish a clear, evidence-based policy for supporting early years nutrition across all settings in their local authority area, and to employ a dietitian or registered public health nutritionist to support implementation of the policy consistently across the area.
- Review the current recommendations on vitamin supplementation levels for under-5s, and increase expenditure on raising awareness of the current recommendations on vitamin supplements for under-5s.
- Ensure oral health promotion is consistently promoted in all settings for under-5s. Consider greater regulation on the sugar content of foods and drinks marketed for children, and clearer labelling about erosive potential.
- Strategic health authorities and directors of public health should encourage the fluoridation of local water supplies.

Looked after children and young people, including those in young offenders' institutions

Some of the challenges

Looked after children and young people are likely to be highly vulnerable nutritionally and are often cared for by support staff who themselves have little knowledge and few practical skills in how to budget for, shop for and cook good food. Issues around choice, independence and the right to good nutritional health for looked after young people require more vigorous debate.

Possible solutions

- Make training on eating well mandatory for all those who support looked after children and young people and those in young offenders' institutions.
- Ensure all young people leaving any care setting have the skills and tools to enable them to budget for, shop for and cook good food for themselves and their families and friends.
- Offer additional nutritional support to young women in the care system who might experience pregnancy at a young age, to ensure that they are nutritionally fit for pregnancy and breastfeeding.
- Ensure any young person who spends little time outside or has little opportunity to be outside in summer sunshine is considered for vitamin D supplementation.

School-aged children and young adults

Some of the challenges

Some children from poorer families who are not currently eligible for free school meals may not benefit from the improved school meals now available. The packed lunches provided to many children by parents fail to provide the equivalent nutrients expected in a school meal.

Rising obesity and poor nutritional status among many teenage girls put them at risk of complications in pregnancy and can contribute to poorer birth outcomes.

Teenagers and young adults have high intakes of soft drinks which can lead to a surplus energy (calorie) intake and impact on their energy balance and their oral health.

Teenagers and young adults who drink alcohol are likely to obtain significant energy and sugar from these drinks but may be unaware of the role of alcohol on weight gain.

Possible solutions

- Increase the provision of free school meals, and provide free fruit and vegetables at school breaks for more children at school.
- Provide all schools with simple and clear guidance about which packed lunch foods and drinks to encourage, and ensure that cooperation with the school packed lunch policy is written into the home-school contract.

- Teenage girls who may become pregnant or who become pregnant should be given clear, tailored support around eating well and being active. Those who become pregnant should be encouraged to take up their entitlement to the Healthy Start scheme and should be offered regular peer support to encourage breastfeeding and to ensure young women have the skills they need to help their children eat well.

- A reduction in the intake of soft drinks should be clearly and explicitly encouraged.

- All alcoholic drinks should be clearly labelled with their alcohol content in units, their energy (calorie) content, and their sugar content and a labelling scheme developed which makes these contents explicit.

School meals

Need for more free school meals

There have been welcome improvements in school meal composition and food choice for children in schools, but there is a danger that improved school meals (particularly in secondary schools) will be consumed only by those from more affluent households and will fail to engage those who need them most. Also, improvements in school meals do not help the diets of those children who bring packed lunches or eat outside school.

Substantially increasing the proportion of children and young people in the UK entitled to free school meals (for example from 16% of children – 1 in 6

children – to all those children in the bottom third by household income – 1 in 3 children) could make a significant difference to the nutritional status of all school-aged children and particularly those in low-income families.

All children in special schools should be offered free school meals, and particular attention paid to the promotion of healthy eating, including among those who have special dietary needs or disordered eating.

Increasing the uptake of school meals would create significant public purchasing power for local authorities to encourage locally and sustainably sourced food. An expanded service would create employment and training around food and cooking for many parents in low-income families.

If better local facilities (such as kitchens and equipment) and skills (trained school cooks) are made available, food could be provided for other community and local projects such as lunch clubs and community meals delivered to older people at home.

Adults and their families

Some of the challenges

Nutritional status of adults

Poor nutritional status remains unrecognised among many people in the UK and national surveys consistently show that many free-living adults have inadequate intakes, and often inadequate blood levels of, vitamin A, riboflavin, iron, folate, thiamin, vitamin B₆ and vitamin C.

People in low-income households and other vulnerable adults

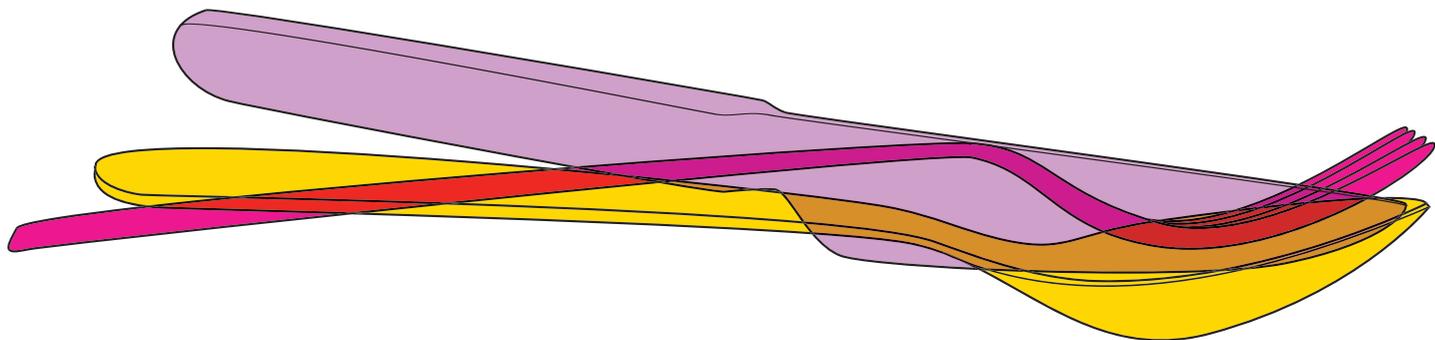
Adults living in low-income households and other vulnerable adults (such as those who are in temporary accommodation or homeless) are more likely to have poorer nutritional health and to eat a smaller variety of foods of poorer nutritional quality. Choice of a better diet is not always a realistic prospect for those living in complex and difficult circumstances.

Among those in low-income households, a greater proportion of adults have inadequate blood levels of iron, folate, vitamin C and vitamin D and higher blood cholesterol levels and bodyweight measurements associated with increased risk of heart disease.

Possible solutions

- Make clear, front-of-pack traffic-light labelling on all foods and drinks compulsory, to ensure that consumers are able to make informed decisions about the foods they buy.
- Provide incentives, to all those who provide food in publicly funded settings for staff, residents or visitors, to ensure good food which meets healthy eating guidelines is always available to all at a reasonable price. This includes, for example, all local and national government offices, educational settings, sports facilities, hospitals, law courts, armed forces home bases, and prisons.
- Use public purchasing power more effectively to improve food quality by introducing minimum quality standards for foods and ingredients purchased for use in publicly funded settings.
- A range of good-quality, low-priced, universally accepted food commodities could be developed in partnership with Government and made available in all areas, to reduce the financial pressure on low-income households.
- For working-age and older adults in low-income households, provide vouchers to buy fruits and vegetables, in addition to current benefits.
- Increase longer-term, sustained funding for local and community projects which offer food access, food skills and support to those in deprived areas.
- Urgently review the advice about vitamin D supplements and/or increase the number of fortified foods for adults, in the light of increasing evidence of links between vitamin D insufficiency and chronic disease.

For more on vitamin D, see page 18.



People with physical or learning disabilities

Some of the challenges

There have been enormous improvements in the way that people with learning disabilities are supported across the UK, but in almost all areas of nutritional health, people with learning disabilities do worse than the rest of the population.²³ A comprehensive review of nutritional issues for people with physical disabilities does not appear to have been conducted in the UK.

There is a lack of training and knowledge among support staff and some health professionals about the importance of eating well and how to manage common eating difficulties among people with learning disabilities. This is likely also to be the case for many people with physical disabilities. Promoting good health for all has remained a lower priority than the treatment of acute and chronic health issues.

For people with learning disabilities, confusion over the need to allow everyone choice and the role of support staff in enabling a health-promoting environment also need wider debate and discussion.

Possible solutions

- Make training about eating well mandatory for all those who support someone with a physical or learning disability in the UK – in the same way that support staff are currently required to undertake fire and safety training in order to meet registration requirements.
- All local authorities to have a clear policy which outlines in detail how the nutritional health of people with physical and learning disabilities will be supported. Local authorities also to employ a dietitian or registered public health nutritionist to support implementation of the policy consistently across the local authority area.
- Make available clear, accessible guidance for people with physical or learning disabilities themselves, to ensure that everyone can make informed choices about the food they eat.
- Ensure anyone who spends little time outside, or who has little opportunity to be outside in summer sunshine, is considered for vitamin D supplementation.

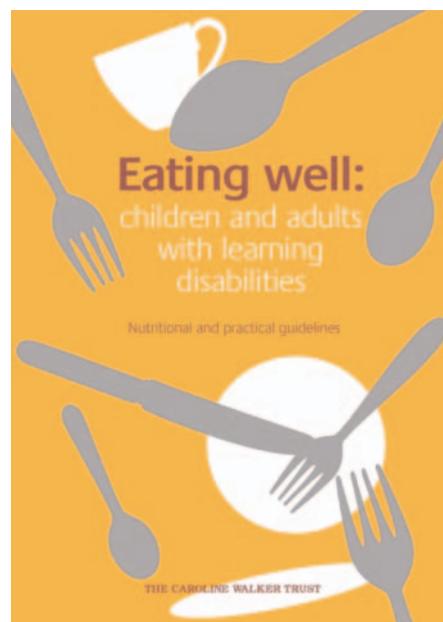
Children and adults with learning disabilities

There is considerable evidence that people with learning disabilities are more likely than those in the general population to have nutritionally-related ill health and that this is less recognised by support staff and professionals than it is when it occurs in the general population. Issues relating to body weight (overweight and underweight), swallowing difficulties, gastro-oesophageal reflux disorder, bowel disorders and oral ill health are frequently reported among people with learning disabilities. People with learning disabilities are also at the same risk of disorders that affect the rest of the population – such as cardiovascular diseases, diabetes, cancer, hypertension and stroke – but may be less likely to receive health promotion advice and support or to have risk factors for these conditions recognised. People with

learning disabilities and their families are also frequently poorer, live in more challenging circumstances and may be socially excluded – all factors which contribute to poorer eating patterns.

The CWT report *Eating Well: Children and Adults with Learning Disabilities*,²³ published in 2007, provides a rationale

for greater support in this area and makes nutritional and practical recommendations. In many areas of the country, however, service commissioners and policy makers have yet to consider the important role of nutrition and good food in all the services they provide and there is an urgent need for training of support staff. CWT is currently preparing training materials to accompany our recent report, which we hope to make freely available to all in early 2009, via our website cwt.org.uk.



People with mental ill health

Some of the challenges

The link between diet, behaviour and mental ill health is poorly understood and investigated, and little attempt is being made to ensure that at a minimum those at risk of or diagnosed with mental ill health achieve a diet in line with current healthy eating guidelines.

Possible solutions

- Provide all those with mental ill health with clear and simple advice on how to eat well, using simple, low-cost and easily available foods.
- All settings which care for people with mental ill health could make healthy eating a priority.
- Give people with mental ill health vouchers for free healthy meals or snacks in local drop-in or community centres. The vouchers could be given either with medicine prescriptions or at GP consultations.

Prisoners and those in detention centres

Some of the challenges

The role of good food and education of prisoners around eating well has not been appropriately tackled, despite the obvious vulnerability of the prison population.

Pregnancy

Women in prison and detention centres who are pregnant are unlikely to be able to access an appropriate diet and supplementation, and may be at risk of low micronutrient intake. Evidence also suggests that food in prison may encourage excessive calorie intake leading to weight gain which reduces the chances of a successful birth outcome for mother and infant.

Infant feeding

Women who give birth in prison or detention centres should be enabled to breastfeed their infants until the infants are six months old, or be given appropriate and dignified access to formula milk and appropriate foods and supplements.

Possible solutions

- The role of good food in prisons needs urgent review, and teaching food skills to the prison population should be seen as a priority.
- There is an urgent need to review the nutritional support available to women in prison or detention centres who are pregnant or breastfeeding, and the rights of children born to mothers in these settings to be breastfed.
- Enable women in prison to develop skills and knowledge which will enable them and their families to eat well.
- Consider vitamin D supplementation for all prisoners since they get little exposure to sunlight because exercise time is limited and often will not coincide with bright sunshine.

Older people in the community

Some of the challenges

Coordination between support services

An increasing number of older people remain living in their own homes as they become increasingly frail, and the support services offered can be highly variable. There is often little coordination between services such as home helps, meals-on-wheels (community meals) and day centres, and many older people can slip through the net in terms of their nutritional health.

Community meals

Community meals remain a vital safety net for many older people but often the nutritional quality of these meals is unknown.

Possible solutions

- Each local authority could have a clear nutritional policy which covers all areas of food service to older people in the community in its area – for example, through lunch clubs, community clubs, day centres, community meals, and home helps. This policy could be managed and coordinated by a dietitian or public health nutritionist, to ensure the policy is consistently implemented across all settings.
- Make training mandatory for all those who support older people in the community in all settings, to ensure they work consistently within the local nutrition policy and understand how to offer practical support to older people to eat well.

Vitamin D deficiency

Link with chronic disease requires urgent review of policy

There is evidence that a significant proportion of the UK population has low vitamin D status.²⁴ Deficiency of vitamin D leads to bone problems such as rickets in children, and osteoporosis in later life. Low vitamin D status is now implicated in a number of diseases, including some cancers, cardiovascular disease, multiple sclerosis, tuberculosis, diabetes and a number of other chronic diseases.²⁵

There is some debate about how vitamin D deficiency is measured. Traditionally a plasma vitamin D concentration less than 25nmol/l has been regarded as an index of low vitamin D status.* Recently, higher thresholds have been proposed, although the consequences of vitamin D status below these thresholds are currently unclear.²⁵ Even using a conservative cut-off point for low status, national surveys show evidence of deficiency of vitamin D in all population age groups, especially older children, young adults, and older people living in residential settings. For example, a quarter of young men aged 19-24 have low vitamin D status and as many as 40% of older people in residential care homes. Almost a third of young women aged 19-24 years are also likely to have

low vitamin D status and, if they become pregnant, they are therefore likely to start their pregnancy with low maternal stores so putting themselves and their baby at risk of chronic disease in later life.

Oliver Gillie has reviewed the role of vitamin D in health in Scotland²⁶ and makes a case for raising awareness of the need for adequate sun exposure and for a review of guidance on sun exposure that gives consideration to the benefits in terms of prevention of chronic disease and not just to the risk of skin cancer. In addition, revised guidelines on the use of supplements, particularly for vulnerable groups, and a review of fortification of foods with vitamin D are recommended.

CWT has made clear recommendations in all its reports about the need to consider vitamin D supplementation for all those who may have limited access to sunlight (for example older people, all those in residential care including people with learning disabilities, and young offenders) and has supported current government guidance around supplementation. There remains however a policy gap since, despite government guidelines in some areas, insufficient support has been given to ensure that these recommendations are fulfilled. For example, it is currently

recommended that all pregnant women take a vitamin D supplement throughout their pregnancy. However the Government's own product – Healthy Start vitamins (which contain vitamin D) – is only given free to women under 18 years of age or to those on income support. It is not easily available in many areas of the country, and is often recommended by health professionals only to women at high risk because they have dark skin or wear clothing which restricts sun contact with their skin. Guidelines recommend commercially available vitamin mixtures such as Abidec or Dalivit as an alternative where access to Healthy Start may be limited, but these vitamin mixtures are not adequate because they are formulated with vitamin D₂, which is less potent than D₃ (the natural human molecule) and the recommended doses are too low.

The Scientific Advisory Committee on Nutrition (SACN) reviewed policy on vitamin D in 2007.²⁵ However, SACN itself said it was unable to review all the evidence linking vitamin D with chronic disease and that a thorough expert review of evidence and current guidelines concerning vitamin D is urgently required.

* Plasma 25-hydroxyvitamin D or 25(OH)D concentration less than 25nmol/l (10ng/ml)

Older people and vulnerable adults in residential care

Some of the challenges

Those involved in the care of older people and vulnerable adults

The food skills and nutritional knowledge of many people who are responsible for supporting and caring for older people and vulnerable adults are poor, and insufficient effort has been made to ensure that there is access to adequate training and support.

Possible solutions

- Make training in eating well – including how to support older people to eat well and how to recognise the signs of malnutrition – mandatory for all those who work with older people in residential care.
- Train all those who support older people in residential care to understand the role of dementia on eating well, and ensure that they have the skills to support people with dementia to eat well.

Registration and inspection of residential care facilities

There are currently no detailed guidelines for those who register and inspect adult residential care facilities to enable them to make an informed judgement about the quality of the food served and the nutritional health of residents.

- Make available clear standards and guidance for those who register and inspect residential settings, to allow them to make informed judgements about the quality of nutritional care given.

Vitamin D

All those in residential care are at risk of low vitamin D status if they rarely spend time outside in summer sunshine.

For more on vitamin D, see page 18.

- Offer vitamin D supplements to all adults in residential care settings.
- Review the levels of appropriate supplementation for this group.

Older people

Ensuring vulnerable older people living in their own homes eat well

Current government policy to support people to live in their own homes for as long as possible is the right policy, but there is concern that the fragile home care system and the community meals service cannot adequately support the rapidly rising numbers of older people with complex needs around the country.

While the number of hours of home care funded by councils has doubled in the last decade to over 3.5 million hours per week (as those remaining in their homes become older and frailer and require greater support), fewer people are actually receiving home care provided by their local council now than in the mid-1990s.²⁷ The current tough eligibility thresholds exclude thousands of people who would benefit hugely from a small amount of additional

home care support, and the very high prices of home care (which have risen more steeply than inflation and can be up to £15.50 an hour) put many off.

The Council for Social Care Inspection (CSCI) in their first review of home care services in 2006²⁷ concluded that this sector is a fragile one, already struggling to provide services of sufficiently high quality for those who need them, with concerns that the sector may find it difficult to rise to the challenge to expand.

For those who do receive home care, the service they receive can be highly variable and, despite the essential role home care staff have in ensuring older people eat and drink well, there is no mandatory training in this area and few staff know how to provide nutritious snacks and meals or to spot signs of malnutrition.

Since about a third of older people entering hospital and residential care

are likely to be malnourished, there is obviously insufficient support around good nutrition in the community, and expanding the role of home care in this area is essential. Added to this are continued concerns about meals-on-wheels and other home meal delivery services. The nutritional value of these meals at point of service is unknown and the amount of nutrients that they provide is not likely to make a significant enough contribution to the daily intake of someone who is too frail to prepare their own meals. Those who commission meals-on-wheels need to work more closely with nutrition professionals in local authorities to ensure that the nutritional value of this service is appropriate. There remains a lack of rigour or expectation that commercial organisations will provide clear information and evidence about the nutritional content of the food they provide.

Food labelling

Why we need clear and simple nutritional labelling as a matter of urgency

There are basically two forms of front-of-pack nutritional labelling in use in the UK:

- **Traffic-light labelling**, where a red, orange or green tab or colour code is used to indicate, for example, whether a product is high, medium or low in fat, sugar or salt. (See the example below.)
- **GDA labelling**, which indicates the amount that a serving of the product provides as a percentage of the Guideline Daily Amount. (See the example below right.)

Consumers welcome, and want, front-of-pack labelling which clearly states, in traffic-light format, whether products are high, medium or low in fat, salt and sugar – and are frequently using them to inform their choices, according to

data from the Food Standards Agency published in 2008.²⁸ Other data suggest that almost half (45%) of adults currently find it difficult to know from the label whether a product is healthy.²⁹

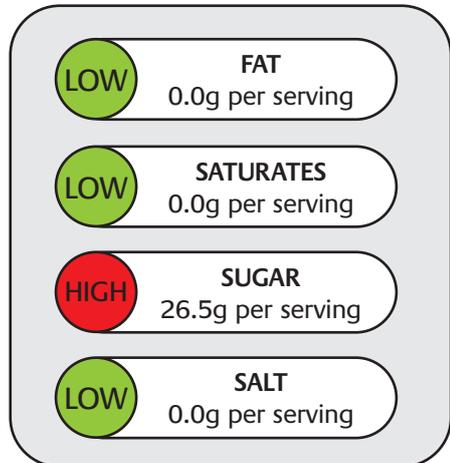
Why GDA labels are misleading

The GDA label below reassuringly asserts that a 250ml serving of this soft drink provides only 5% of a person's daily calories and 29% of sugar. But this information is misleading and unhelpful for a number of reasons:

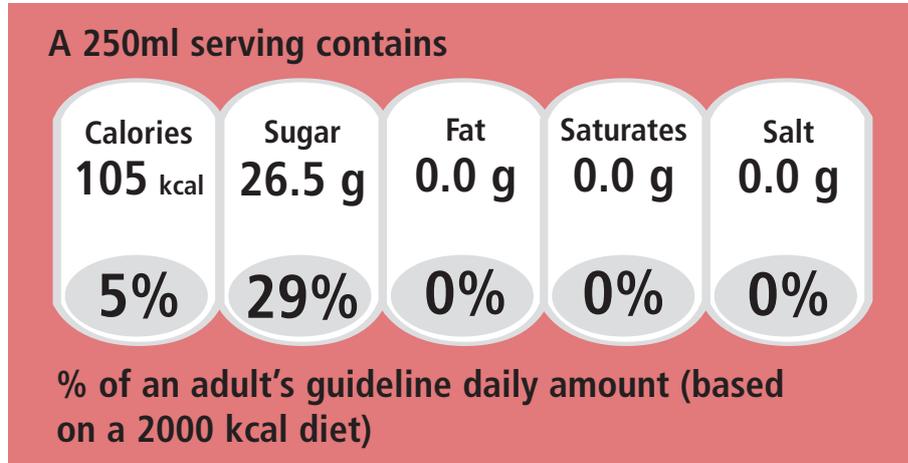
- The GDA for sugar is estimated for 'total sugar' – that is, it includes both non-milk extrinsic sugar (NME sugar or 'added sugars') and some intrinsic and milk sugars – even though there is no recognised health-related recommendation in the UK for total sugar. The sugar in this soft drink is all NME sugar, so it actually represents almost 50% of the total maximum recommended NME sugar intake for a day for an adult woman.

- The percentages given may not be relevant to all population groups. For example, for a girl aged 7-10 years, the same serving provides about 55% of their daily recommended NME sugar intake.
- The choice of portion size is arbitrary. GDA labels can be based on any portion size, regardless of the pack size. (For example, it could be $\frac{3}{4}$ of a bottle of soft drink or 1 square of a bar of chocolate.) If a 7-10 year old drank the whole bottle of the soft drink represented in the GDA label, it would provide 65% of their recommended NME sugar intake.
- The labelling offers no value judgements in the colours of the tabs. A clear, red traffic-light label on the product would indicate clearly that this is a high-sugar product.

For more information on food labelling, see the National Heart Forum report *Misconceptions and Misinformation: The Problems with Guideline Daily Amounts*.³⁰



Example of a traffic-light label



Example of a GDA label for a soft drink

CWT: the next 20 years

As part of its 20th anniversary reflections, CWT has been looking ahead to the role it can play in promoting public health through good food in the 21st century. As we have demonstrated, there remain many challenges for public health nutrition, and no doubt others will arise that we do not foresee. It is important that independent voices remain to challenge policy decisions and to lobby for better nutritional standards for those whose voices may not be heard.

CWT has produced nutritional recommendations and guidelines for various groups (see page 10), but there remain some areas for which we have not yet provided these and where they are much needed – most notably for people in hospitals, for those in prisons, for infants, and for children and adults with physical disabilities and

mental ill health. We also plan to provide more tools and practical guidance for practitioners to ensure that they can translate our recommendations into good practice.

CWT Trustees have suggested a number of roles for the future: a more effective lobbying role; the development of an international profile and greater partnership working with European and worldwide health organisations; and a bigger role in taking the eating well message to the wider population. All suggestions and discussions on CWT's future roles are welcomed but in the first instance we propose the following three key overarching themes to frame the work that CWT does over the next 20 years.

Food quality

The importance of ensuring a safe and nutritious food supply is fundamental to all discussions on nutrition and health. Everyone should have access to good-quality food that can meet their nutritional needs at prices they can afford. The regular and routine nutritional analysis of foods available for sale in the UK should remain rigorous, and where foods make a major contribution to the nutrient intake of a particular population group this should be done independently and regularly by independent public analysts. There also remains a need to review the use of non-nutritive additives in food such as colourings and flavourings and to ensure that any nutrients added to foods have a clear and appropriate purpose. Food fortification with micronutrients should not be permitted primarily to gain a market advantage and modelling should be undertaken to ensure that this does not lead to potentially harmful intakes of some nutrients by vulnerable groups. There also needs to be careful review of food industry and catering company claims relating to nutritional quality, and more accountability to clearly outline nutritional changes in their products, and a review of the methods used by commercial companies to assess nutritional content.

As part of this strand CWT could:

- Lobby for regular, independent nutritional analysis of infant formula (baby milk) available in the UK
- Encourage consumers to request simple front-of-pack nutritional labelling
- Encourage local authorities to request detailed data on the nutritional content, at the point of consumption, of all meals delivered by meals-on-wheels and similar services
- Promote the work of public analysts and ensure that their role in ensuring a safer food supply is protected.

Breaking the cycle of vulnerability

The provision of nutritional and practical guidelines for vulnerable groups has been at the heart of the work of CWT over the past 20 years and should continue to be so. While we have seen increasing acceptance of the role of good food and good nutrition in good health, progress in ensuring better standards in many areas has been slow or non-existent. For example, considerable work is still needed to promote better nutritional health among those with physical and learning disabilities, older people (particularly those with dementia), looked after children and young people, and vulnerable children and adults across the lifespan.

As part of this strand CWT could:

- Review and reissue its practical and nutritional guidance for looked after children and for older people with dementia
- Provide practical and nutritional guidance for people with physical disabilities, mental ill health, and those in hospital settings and prisons
- Lobby for recommendations made for all the groups listed above to be given greater priority by local and national government
- Provide suitable training resources on eating well, for use among those working with and supporting particular population groups
- Support local authorities in devising food policy for specific vulnerable population groups.

Challenging evidence on food and nutrition: the importance of a clear and independent voice

It has been suggested that food industry money still manipulates public debate about food and health. It is known that many researchers, campaigners and organisations receive funding from industry and there remains concern that the food industry uses secretive financial ties to distort public debate about food and health.³¹ As public private partnerships even begin to invade public health, the need for a clear and independent voice to challenge – or to support – the information provided elsewhere has never been more needed. Caroline Walker fought for transparency in public health nutrition, and that tradition should remain core to the work of the Trust.

As part of this strand CWT could:

- Offer clear and independent nutrition advice to other non-governmental organisations to support their work in challenging claims, reviewing scientific evidence and making comments on consultations
- Support regulatory bodies in ensuring that evidence used to make claims is fair, accurate and true.

We hope that CWT supporters will contribute to the debate about these themes and how the Trust can most effectively move forward. There is an opportunity to add to the debate on these issues on our website www.cwt.org.uk

CWT achievements 1988-2008

	Publications	Annual lectures
2008	<i>Public Health Nutrition. Challenges for the 21st Century</i>	
2007	<i>Eating Well: Children and Adults with Learning Disabilities</i>	Bad science Dr Ben Goldacre
2006	<i>Eating Well for Under-5s in Child Care</i> (report) Second edition <i>Eating Well for Under-5s in Child Care – Training Materials</i>	Diet and chronic disease: How well can we – and need we – establish causation? Professor George Davey-Smith
2005	<i>Eating Well at School</i> Published with the National Heart Forum	New guidelines for school meals Dr Michael Nelson, Joe Harvey and Dr Helen Crawley
2004	<i>Eating Well for Older People</i> Second edition	School meals and sustainable food chains Professor Kevin Morgan
2003		The fate of nations Geoffrey Cannon
2002	<i>Eating Well for Looked After Children and Young People</i> Reprinted by the Food Standards Agency and promoted nationally	The role of nutrition in human evolution Professor Michael Crawford
2001	<i>Eating Well for Looked After Children and Young People</i>	Inequalities in health Professor Sir Michael Marmot
2000	<i>CHOMP</i> Menu planning computer program for use by child carers	The Food Standards Agency: A vision for the future Sir John Krebs
1999		Future food: Two radical views of 21st century eating Michael Heasman and Colin Tudge
1998	<i>Eating Well for Under-5s in Child Care</i> <i>CORA Menu Planner for Older People in Residential Care</i>	The nanny state Sheila McKechnie
1997		Nutrition in the future: Thinking the unthinkable Professor Philip James
1996		The making of modern malnutrition Suzi Leather
1995	<i>Eating Well for Older People</i>	Food and the public interest Christopher Haskins
1994		Content with a vegetable love Professor John Potter
1993		No nation can rise above the level of its women Margaret and Arthur Wynn
1992	<i>Nutritional Guidelines for School Meals</i>	New concepts in human nutrition in the 20th century: The special role of micronutrients Sir Francis Avery Jones
1991		The CAP and GATT James Goldsmith
1990		Labour's Healthy Food Policy Dr David Clark MP, Shadow Minister for Food and Agriculture

References

- 1 Caroline Walker Trust (1992) *Nutritional Guidelines for School Meals. Report of an Expert Working Group*. Caroline Walker Trust.
- 2 Food Standards Agency (2008) *Consumer Attitudes to Food Standards. Wave 8. UK Report Final*. London: Food Standards Agency. Accessed from: <http://www.food.gov.uk/multimedia/pdfs/cas2007ukreport.pdf>
- 3 TNS, on behalf of the Food Standards Agency (2007) *Updated CAS Additional Analysis. Report of Findings*. Accessed from: <http://www.food.gov.uk/multimedia/pdfs/consumersegmentationreport.pdf>
- 4 Data from the *National Diet and Nutrition Survey: Adults Aged 19-64 Years* (Volumes 1-4, 2002-2004) can be accessed from: <http://www.food.gov.uk/science/dietarysurveys/ndnsdocuments/>
- 5 House of Commons Health Committee (2004) *Obesity: Third Report of Session 2003-2004*. London: The Stationery Office.
- 6 James P (1997) *Nutrition in the Future: Thinking the Unthinkable*. London: Caroline Walker Trust. Accessed from: www.cwt.org.uk
- 7 Nelson M, Erens B, Bates B, et al, on behalf of the Food Standards Agency (2007) *Low Income, Diet and Nutrition Survey. Summary of Key Findings*. London: TSO. Accessed from: <http://www.food.gov.uk/multimedia/pdfs/lidnssummary.pdf>
- 8 Dowler E (2008) Policy initiatives to address low-income households' nutritional needs in the UK. *Proceedings of the Nutrition Society*; 67: 289-300.
- 9 Food Standards Agency (2007) *FSA publishes findings of the Low Income Diet and Nutrition Survey*. Press release 15 July 2007. Accessed from: www.food.gov.uk/news/pressreleases/2007/jul/lidns
- 10 Nelson M, Erens B, Bates B et al, on behalf of the Food Standards Agency (2007) *Low Income, Diet and Nutrition Survey. Volume 3: Nutritional Status, Physical Activity, Economic, Social and Other Factors*. London: TSO. Accessed from: <http://www.food.gov.uk/multimedia/pdfs/lidnsvol03.pdf>
- 11 Ruston D, Hoare J, Henderson L et al, on behalf of the Food Standards Agency and the Departments of Health (2004) *The National Diet and Nutrition Survey: Adults Aged 19 to 64 Years. Volume 4: Nutritional Status (Anthropometry and Blood Analytes), Blood Pressure and Physical Activity*. London: TSO. Accessed from: <http://www.food.gov.uk/multimedia/pdfs/ndnsfour.pdf>
- 12 Written response from Kraemer S (2008) In: House of Commons Health Committee (2008) *Health Inequalities. Volume II Written Evidence*. London: TSO. Accessed from: <http://www.parliament.the-stationery-office.com/pa/cm200708/cmselect/cmhealth/422/422ii.pdf>
- 13 WHO (2006) *Proposed Outline for the Second Action Plan for Food and Nutrition Policy*. Accessed from: http://www.euro.who.int/document/nut/istanbul_conf_edoc09.pdf
- 14 The Scottish Government (2008) *Food and drink in Scotland*. Press release 19 June 2008. Accessed from: <http://www.scotland.gov.uk/News/Releases/2008/06/19101648>
- 15 Welsh Assembly Government (2008) *Quality of Food Strategy*. Accessed from: <http://new.wales.gov.uk/consultation/dphhp/qualityoffood?lang=en>
- 16 Department of Health, Social Services and Public Safety (2006) *Fit Futures: Focus on Food, Activity and Young People*. Accessed from: <http://www.dhsspsni.gov.uk/fit-futures-implementation-plan.pdf>
- 17 Cabinet Office (2008) *Food Matters: Towards a Strategy for the 21st Century*. Accessed from: www.cabinetoffice.gov.uk
- 18 Confidential Enquiry into Maternal and Child Health (CEMACH) *Obesity in Pregnancy*. Accessed from: <http://www.cemach.org.uk/Programmes/Maternal-and-Perinatal/Maternal-Obesity.aspx>
- 19 National Institute for Health and Clinical Excellence (2007) *Modelling the Cost Effectiveness of Interventions to Promote Breastfeeding*. London: NICE. Accessed from: www.nice.org.uk/nicemedia/pdf/MCNEconomicReviewCostEffectivenessofBreastfeeding.pdf
- 20 www.babymilkaction.org
- 21 The International Code of Marketing of Breastmilk Substitutes. Accessed from: <http://www.ibfan.org/english/resource/who/fullcode.html>
- 22 British Association for the Study of Community Dentistry. *Dental Caries Experience of 5-year-old Children in Great Britain 2005 / 2006*. Accessed from: <http://www.bascd.org/viewdoc.pool.php?id=72>
- 23 Caroline Walker Trust (2007) *Eating Well: Children and Adults with Learning Disabilities*. London: Caroline Walker Trust. www.cwt.org.uk
- 24 Hypponen E, Power C (2007) Hypovitaminosis D in British adults at age 45 y: nationwide cohort study of dietary and lifestyle predictors. *American Journal of Clinical Nutrition*; 85: 860-868.
- 25 Scientific Advisory Committee on Nutrition (2007) *Update on Vitamin D. Position paper on Vitamin D by the Scientific Advisory Committee on Nutrition*. London: TSO. Accessed from: http://www.sacn.gov.uk/pdfs/sacn_position_vitamin_d_2007_05_07.pdf
- 26 Gillie O (2008) *Scotland's Health Deficit: An Explanation and a Plan*. London: Health Research Forum.
- 27 CSCI (2006) *Time to Care? An Overview of Home Care Services for Older People in England, 2006*. London: CSCI. Accessed from: http://www.csci.org.uk/about_csci/publications/time_to_care.aspx
- 28 Food Standards Agency (2008) *Update on independent evaluation of nutritional labelling*. Press release 23 October 2008. Accessed from: <http://www.food.gov.uk/news/newsarchive/2008/sep/pmp>
- 29 TNS, on behalf of the Food Standards Agency and COI (2007) *Consumer Attitudes to Food Standards*. London: Food Standards Agency. Accessed from: <http://www.foodstandards.gov.uk/multimedia/pdfs/cas07uk.pdf>
- 30 Lobstein T, Landon J, Lincoln P (2007) *Misconceptions and Misinformation: The Problems with Guideline Daily Amounts*. London: National Heart Forum.
- 31 Rowan D (2005) How food industry money manipulates public debate. *The Times*: 10 September 2005. Accessed from: <http://www.davidrowan.com/2005/09/times-how-food-industry-money.html>

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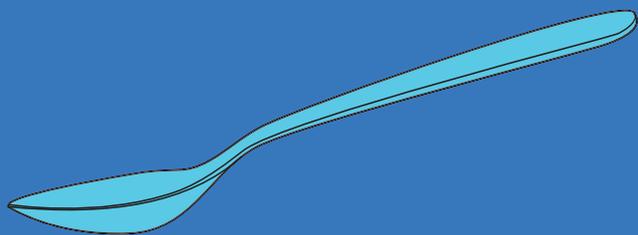
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