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The development, implementation, monitoring and evaluation of a food and nutrition policy within a local health plan

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Local food and health policies were initiated in the UK in the early 1980s, and this paper traces developments in Leicestershire, England. The first policy was launched in 1987, which promoted the nutrition education messages of that time (less fat, more fibre and less sugar), primarily within the National Health Service. As a result of the publication of the *Health of the Nation* Green Paper in 1991, a local health plan was developed for Leicestershire, in which nutrition formed an integral part. Wider perspectives on nutrition have evolved reflecting the multidisciplinary approach to developing the Food and Nutrition Policy. In addition, updating of the nutrition messages in the local Food and Nutrition Policy has occurred to reflect the shift in emphasis towards nutritional adequacy and balance. The scope for implementation is now much wider, involving several key settings in the community, and there is an increased emphasis on monitoring and evaluation.

Key words: community, food policy, nutrition education.

Introduction

Local food policies were first initiated in the UK in the early 1980s in response to growing consensus about the role of diet in the prevention of disease. The development of local food and health policies began in 1981 in South Manchester (Montague, 1986). However, the largest growth in development was after 1983, following the publication of the NACNE report in 1983 and later the COMA report on coronary heart disease (DHSS, 1984).

Gibson & Champion (1989) carried out a postal survey in 1986 which found that most health authorities in the UK had their own food

policy, i.e. 91% of health authorities either had or were in the process of developing a policy. The most popular area for action was catering services within the National Health Service (NHS), however a substantial number did report at least one or more activities within the community. Gibson & Champion suggested that the emphasis on the NHS might reflect the difficulties of devising and carrying out a strategy for food and health work in the community, where access can be more difficult. Also, they noted that there were two clear approaches to food and health work—the provision of healthy food choices and education of consumers/those working with consumers.

In addition to the value of food and nutrition policies at a local level, the need has been identified for comprehensive policies at a national level, which emphasize health promotion and disease prevention (WHO, 1996).

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The purpose of this paper is to describe our experience of developing and implementing a food and nutrition policy in Leicestershire, and the approaches we have developed for monitoring and evaluating aspects of it.

Leicestershire Nutrition & Dietetic Service

Leicestershire is one of the largest health authorities in the UK. The population of nearly 1 million residents is culturally diverse, with 25% of Leicester City residents of South Asian origin. Fifty dietitians working for the Leicestershire Nutrition & Dietetic Service (provided from the community trust) give a service to three teaching hospital trusts, a mental health trust and nine community hospitals. In the community, dietitians work in several specialist clinical areas (e.g. HIV/AIDS, home enteral feeding, tissue viability and childhood diabetes). In addition, there is a team of 10 community dietitians, whose roles encompass clinical work (community clinics, home visits and community hospitals), training (particularly of other health professionals) and health promotion. The community team has been well established for over 10 years and is integrated within the whole service.

Leicestershire Health Plan

Following publication of the Government Green Paper *Health of the Nation* (DoH, 1991a), staff from a range of authorities and organizations in Leicestershire worked together to prepare the county's first Health Plan, which was launched in 1993 (Leicestershire Health Plan, 1993). The plan focused activity on the five nationally identified issues adopted from the White Paper (DoH, 1992), i.e. accidents, cancers, coronary heart disease (CHD) and stroke, mental health, and sexual health and HIV/AIDS. Other health areas identified locally were alcohol abuse, asthma, child health, diabetes, maternal health and young people. The plan was introduced to complement national and regional initiatives, particularly the *Health of the Nation* report. One of the key goals of the plan was to target

inequality in health through multi-sectoral collaboration. Key working groups were established for each of the above health topics. Healthier eating formed part of the CHD programme group, which comprised three subgroups—Healthy Eating, Active Living and Smoking.

The Healthy Eating Subgroup

The Healthy Eating Subgroup was established in April 1993. The group is led by the Leicestershire Nutrition & Dietetic Service and membership is drawn from a wide range of agencies (i.e. local authorities, universities, school meals service, community health groups, community dental service, public health medicine, health promotion service (physical activity), primary care development, occupational health and environmental health). The group's remit was to develop a public health nutrition strategy by devising a 3-year action plan aimed at achieving the nutrition targets set in the *Health of the Nation* White Paper (DoH, 1992). This was based on describing current nutrition interventions, mostly the activity of community dietitians, and prioritizing areas where interventions were needed for additional resources.

The aim of the action plan was to develop a strategy to:

'improve the nutritional health of Leicestershire residents by having a positive influence on behaviour, knowledge and attitudes to food choice, ultimately reducing the incidence of diet related disease' (Leicestershire Health Plan, 1993).

The overall objectives of the action plan were to target people at increased risk of poor nutrition (i.e. lower income groups, minority ethnic groups) and increase public awareness of healthier eating.

Initial work from 1993 to 1995 of the Healthy Eating Subgroup resulted in a 3-year project (1995–1998) funded from Leicestershire Health Strategy money, to co-ordinate the development and implementation of the Food & Nutrition Policy. This has formed the core from which other projects have evolved. The priorities for funding were identified and agreed by the Healthy Eating Subgroup, and

were managed within an overall project plan. Two of the projects that evolved were also funded through the Leicestershire Health Strategy.

The first project to be funded was a 2-year (1995–1997) joint project 'Vitality for Life' with the Exercise & Health Research & Development Group at Loughborough University targeting 14–16-year-olds in schools. This project incorporated a more holistic approach than previous work with young people in Leicestershire, with three key elements—eating well, active living and improving self-esteem. The second funded project is a primary care nutrition training project funded for 3 years (1966–1999), which aims to develop and evaluate a model of good practice in general practices within Leicestershire.

The third project identified for funding is a 3-year (1997–2000) community development project in a deprived area of the city, which has received funding from the National Lottery Charities Board. This was a joint proposal between the local community association, the Nutrition & Dietetic Service and the Centre for Research in Social Policy, Loughborough University. All of these projects have in-built evaluation and none of them could have evolved as they did without the intersectoral collaboration involving several of the agencies represented on the Healthy Eating Subgroup. This has involved a move away from a health professional-focused programme, even though projects are eventually delivered by health professionals. Vaandrager *et al.* (1993) emphasized the importance of a multi-disciplinary approach and the need to link promotional activities to existing social networks. They describe how a combined contribution becomes more than the sum of the contributions of individual agencies, which is certainly our experience.

There have been a number of positive consequences of the formation of the Healthy Eating Subgroup. In particular, an increased profile for public health nutrition issues and their importance in the prevention of disease by the purchasing health authority, as well as by other agencies, notably local councils. In addition, the profile of the Nutrition & Dietetic Service has been enhanced as the key service provider and advisor to purchasers on contracting for services relating to public

health nutrition. This profile was further enhanced by the publication of three reports by the Department of Health (DoH, 1994a,b,c). Wider perspectives on nutrition education have also evolved reflecting the multi-agency membership of the Subgroup, for example innovative alliances have formed with other subgroups in the development of intervention strategies.

One of the current roles of the Subgroup is to assist in overseeing the progress of the Food & Nutrition Policy implementation.

Food and Nutrition Policy formulation

The creation of the Healthy Eating Subgroup enabled an update of the Leicestershire District Food Policy (LHA, 1987). This provided the political mandate and support for implementation that is thought to be essential for success (Helsing, 1986; Denton, 1990; Oshaug, 1992; Tiplady, 1987). The need for political support is demonstrated by Tiplady's experience of developing a food and health policy in East Cumbria and finding that: 'changes are only likely to occur if the authority has a degree of commitment to achieving change'.

The revised Food and Nutrition Policy (Holdsworth, 1994) was launched at the first 'Healthy Leicestershire' conference in November 1994 and has been widely distributed since then. The need to revise this policy arose from the publication of *Dietary Reference Values* in 1991 (DoH, 1991b). Although diet was incorporated into the CHD programme of the local health strategy, the issues relating to promoting a 'healthy diet' are much wider than CHD prevention, and cover not only recommendations for average intakes of macro-nutrients, but also the recommended intakes of vitamins and trace elements to ensure an adequate diet. A summary version of the policy was produced the following year (Holdsworth, 1995) to reach a wider audience.

Why is a local Food and Nutrition Policy necessary?

The purpose of the policy was:

- To encourage consistent nutrition messages given by health professionals and other

Table 1. Levels of promotion of the Food and Nutrition Policy

	Target audience
Food and Nutrition Policy (1994) Full extensive version with scientific commentary and implementation plan.	Purchasers, NHS managers, medical practitioners, nursing staff, health promotion officers, dietitians.
Food and Nutrition Policy (1995) Summary version with dietary guidelines, practical advice and implementation summary.	As above, plus voluntary agencies, community groups and centres, local food courses, secondary schools and the general public.
Healthy eating leaflets designed for Leicestershire population.	General public. One leaflet specifically aimed at South Asian population.

agencies who have a role in nutrition education.

- To make available to a wide audience a scientific, up-to-date document describing what constitutes a 'healthy diet'.
- To provide advice for certain groups within the population who have specific nutritional needs, e.g. some hospital patients, children, older people.
- To recommend a scheme for implementing the policy in key settings.
- To provide the general population with appropriate dietary information to allow them to make an informed choice about their own diet.
- To ensure by collaboration with other local agencies and employers, that Leicestershire residents who choose to take a healthy diet are given the opportunity to do so.
- To target programmes at those who are nutritionally 'at risk', e.g. lower socio-economic groups and minority ethnic groups.
- To market nutrition so as to assist the consumer in making an informed choice regarding their diet and health.
- To facilitate a wider choice of foods in establishments within and outside the NHS, so that a healthier diet can be selected.

What are the nutritional targets of the Food and Nutrition Policy?

The updated Food and Nutrition Policy shifts emphasis from the 'reducing fat and sugar, increasing fibre' messages, towards nutritional adequacy for all population groups by incorporating the National Food Guide (Gatenby *et al.*, 1995), which promotes a

balanced diet in food terms rather than focusing on nutrients. As well as describing what a healthier diet is and why, the policy describes how it can be implemented in key settings in Leicestershire. To meet the targets within the wider recommendations of COMA, the Food and Nutrition Policy recognizes that a significant change in patterns of food consumption will be required, and that a whole diet approach is crucial if a healthy balanced diet is to be achieved. Any reduction in fat consumption will need a corresponding increase in the consumption of basic staple foodstuffs—starchy, fibre-rich foods such as bread, potatoes, pasta and rice, and vegetables and fruit. This means a substantial change in the eating habits of the population at large.

Food and Nutrition Policy implementation

Table 1 illustrates how the policy has been promoted at three different levels to increase its reach.

The implementation plan illustrated in Table 2 describes how the Healthy Eating Subgroup proposed that the policy be executed, monitored and evaluated in a range of settings throughout Leicestershire, targeting the socio-economic and cultural groups most at risk of nutritional inadequacy. The plan was divided into five sections: setting and target group; strategies; how the strategies will be achieved; support needed; nutrition indicators for monitoring/evaluation. Additional resources were required for many of these activities to be carried out and the priorities for funding

were identified by the Healthy Eating Subgroup and submitted to Leicestershire Health as described earlier.

Implementation in the community

Recommendations for implementation of the policy in the community focus on the key settings of education, the general public, the workplace, primary health care, homeless facilities, day nurseries, social services and residential homes. They are described in more detail in Table 2. All interventions described are aimed at the primary prevention of disease and are multi-level within settings, i.e. targeted at individuals, groups, organizations, communities and institutions. This multi-level approach is suggested by Winett *et al.* (1993).

Implementation in hospitals

The NHS *Patient's Charter* (DoH, 1995) states that all hospital trusts should adopt and promote a food policy to patients. In Leicestershire all wards have been supplied with a food and nutrition policy, and a poster and leaflets designed to promote this. The Charter states that each patient's individual requirements/appetite and cultural eating habits should be met through a varied menu choice which promotes sound nutritional status and offers healthy options. Personal preference should also be catered for as far as practicable, ensuring a nutritionally adequate dietary intake in all situations.

Patients with specific nutritional needs are catered for within the policy document, e.g. elderly/older people, sick children, pregnant/breast-feeding women. It is also stated that therapeutic diets should be provided, preferably with a choice of items.

Leicestershire Health Authority now states that all specifications for the contracting of hospital catering services must conform to the Food and Nutrition Policy. Nutritional criteria are included which must be considered when planning menus to ensure that the nutritional needs of all patients are met. Many patients in hospital are 'at risk' of malnutrition (Lennard-Jones, 1992) and the policy includes a simple nutrition assessment tool to identify these 'at risk' patients who need to be seen by a dietitian.

Monitoring/evaluation of the Food and Nutrition Policy

No accurate data on local eating patterns are available because there is no funding for a local lifestyle survey to monitor changes in health behaviour. There are, however, limitations to the value of lifestyle surveys in monitoring meaningful data. Dawson (1994) echoes this view, describing how most surveys do not investigate barriers to adopting healthier lifestyles. Due to the lack of local data, national sources of monitoring data have been investigated, with the *National Food Survey* (MAFF, 1994) being the key source, which describes data at the East Midlands level, but is not county specific. On a health authority level, there is no choice but to use the indicators described in the *Health of the Nation* document (DoH, 1992), with nutrition targets relating to fat, saturated fat, obesity and overweight, because the health authority is monitored/evaluated against these.

In addition to the need for Leicestershire-wide monitoring of lifestyle change to provide outcome measures which assess overall shifts in behaviour patterns and disease rates, a need had also been identified for the monitoring of individual projects using process related measures to gauge success and possible shifts in behaviour. One of the related challenges is how to demonstrate a relationship between the level of activity and the degree of change, in order to persuade purchasers of the validity of programmes. Fraser *et al.* (1995) state that for measurements to provide meaningful information, there needs to be a link between the variables of interest and the indicators used to quantify these variables. It may be that a programme on its own is insufficient, but that the 'community of action' may be effective and may increase the likelihood of change.

There is a demand for indicators of activity to be reported year on year. A profile of possible indicators of success and a data collection system that fits into the existing framework of activity has been developed. Monitoring techniques therefore need to be realistic and flexible enough to evolve with programmes.

There is a clear need for evaluation to assess the effectiveness of current nutrition education interventions in improving nutritional behaviour for all residents, and to consider if

Table 2. Outline for implementation of the Food and Nutrition Policy (1995–1998)

Setting and target group	Strategy	How the strategy is achieved	Support	Nutrition indicators for monitoring/evaluation
Education Pupils/students Teachers Governors Parents	<ul style="list-style-type: none"> Health Promoting Schools Charter Leicestershire Food and Nutrition Policy Heartbeat Award (HBA) Scheme in secondary schools Vitality for Life project for 14–16-year-olds School Nutrition Action Groups (SNAGs) 	<ul style="list-style-type: none"> School meals liaison working group. School nurse support and training. Production of appropriate nutrition resources. Encourage nutrition in national curriculum. Dietitian working directly with catering services for school meals. 	<ul style="list-style-type: none"> Teachers Parents Pupils School nurses Community dietitians Health promotion workers School meals service County Council County governors Active living group 	<ul style="list-style-type: none"> An improvement in the nutritional standards of school meals using an audit process. An increased number of secondary schools with HBA Scheme. An increased number of schools with a nutrition policy/SNAG.
Public All of Leicestershire residents, especially 'at risk' groups (i.e. minority ethnic communities, socio-economic groups C2, D, E).	<ul style="list-style-type: none"> Leicestershire Food and Nutrition Policy 	<ul style="list-style-type: none"> Healthy Leicestershire public exhibitions. HBA Scheme. Develop links with local media—radio, TV and newspaper, e.g. slots on Asian radio station and newspaper. Availability of healthy food at retail outlets. 	<ul style="list-style-type: none"> Health promotion workers Health professionals Community dietitians Public interest Community workers Local media Environmental health officers Primary care Leicestershire Health Authority 	<ul style="list-style-type: none"> An increased number of HBAs in establishments for the public using the HBA database. Review audience/attendance profile at public exhibitions. Assess customer perspective of the HBA Scheme. Changes in media contacts.
Workplace All employees, especially manual workers.	<ul style="list-style-type: none"> Leicestershire Food and Nutrition Policy HBA Scheme 	<ul style="list-style-type: none"> Promotion of HBA Scheme. 	<ul style="list-style-type: none"> Managers/executives Community dietitians Environmental health officers Health promotion officers Employees NHS Units/Trusts Catering managers 	<ul style="list-style-type: none"> An increased number of HBAs. An evaluation of the effectiveness of HBA in changing attitudes and eating habits in a range of workplace settings.
Primary health care Clients/patients and primary health care teams (PHCTs)	<ul style="list-style-type: none"> Leicestershire Food and Nutrition Policy PHCT Resource Pack Infant Feeding Policy 	<ul style="list-style-type: none"> Training PHCTs. Production of appropriate nutrition resources. Promotion of food policy to patients. 	<ul style="list-style-type: none"> PHCTs, i.e. GPs, practice nurses, health visitors, school nurses, district nurses Leicestershire Health Authority Community dietitians General dental practitioners 	<ul style="list-style-type: none"> Number of practices working to minimum nutrition standards. Number of PHCTs receiving training. Enhanced nutritional knowledge and practice of PHCTs. An increased uptake of appropriate nutrition resources.

contd

Table 2. -contd

Setting and target group	Strategy	How the strategy is achieved	Support	Nutrition indicators for monitoring/evaluation
Homeless and those living in: Hostels Nightshelter Facilities for homeless people Bed and breakfast establishments	<ul style="list-style-type: none"> Leicestershire Food and Nutrition Policy 	<ul style="list-style-type: none"> Appropriate nutrition resources. Nutrition information pack for homes providing meals. Developing nutritional standards for meals provided. 	<ul style="list-style-type: none"> Community dietitians City and Borough Councils Health promotion officers Staff at nightshelters, hostels and bed and breakfast establishments 	<ul style="list-style-type: none"> Improved nutritional quality of meals provided. Improved nutritional knowledge of catering staff and home leaders.
Social services and residential homes Elderly Homes for those with learning disabilities Long-stay mental health accommodation	<ul style="list-style-type: none"> Leicestershire Food and Nutrition Policy Food policy for older people 	<ul style="list-style-type: none"> Community mental health team nutrition pack. Lunches at day care centres. Training carers, e.g. Age Concern. Nutrition package to Social Services/residential homes for the Foodwise Award (adapted HBA). 	<ul style="list-style-type: none"> Carers Community dietitians Social Services Residents Private home care Mental health dietitians Community mental health teams 	<ul style="list-style-type: none"> Improved nutritional quality of meals provided. Improved nutritional knowledge of carers. Uptake of appropriate nutrition resources. Number of key workers receiving training. Number of homes applying for the Foodwise Award.
Under 5s at day nurseries, playgroups and childminders	<ul style="list-style-type: none"> Nutrition policy for under 5s 	<ul style="list-style-type: none"> Training health professionals. Advising on meals at nurseries. Training of day nursery staff. Nutrition guidelines for nurseries. 	<ul style="list-style-type: none"> Health visitors GPs Midwives Community dietitians Day nursery staff Under 8s advisors 	<ul style="list-style-type: none"> Number of key workers receiving training. Improved knowledge of workers related to nutrition of under 5s. Improved quality of meals at day nurseries.
Hospitals Staff and patients	<ul style="list-style-type: none"> Leicestershire Food and Nutrition Policy Delivered meals HBA Scheme 	<ul style="list-style-type: none"> Distribute policy to key groups. Support nutritional guidelines in the Delivered Meals Strategy. Promote HBA Scheme for staff meals. 	<ul style="list-style-type: none"> Hospital dietitians Catering staff Hospital management WRVS 	<ul style="list-style-type: none"> Audit of nutritional value of delivered meals. Audit of food policy promotion and awareness in hospitals.

current strategies are appropriate for lower income groups. An example of this is the evaluation of the Heartbeat Award Scheme that is being conducted in the workplace and public eating places (Holdsworth *et al.*, 1997). Effective programmes need to be developed that reach lower income groups. There is an increasing requirement to demonstrate the health benefits of nutrition interventions to purchasers, and to assess if the current dietetic resource is used most effectively. Methods for monitoring and evaluation are integrated in the implementation strategy described in Table 2. A combination of quantitative and qualitative techniques are being used to assess programme effectiveness. The evaluation of food policy implementation is based on assessing the effectiveness of interventions in meeting their objectives, e.g. changing attitudes and behaviour. Measuring behavioural outcomes is supported by St Pierre (1982), rather than focusing solely on health outcomes relating to disease incidence.

One dilemma is the justification of the cost of the evaluation process itself, which can be more expensive than the actual cost of implementing programmes. It is essential, therefore, to achieve an appropriate balance between expenditure on implementation and evaluation.

Learning experiences in implementing the Food and Nutrition Policy

It is important to involve all key players from the beginning and to negotiate a strategic direction with shared agendas. As dietitians we have moved away from using 'our agenda' as the focus of work, but have developed work in a broader context, with a wide range of agencies offering advice on targets and project direction, the inputs a project receives are therefore intersectoral. Priorities for the funding of new projects should be identified by a multidisciplinary group if they are to represent community needs. Clear programme objectives have to be defined to gain funding, even though ongoing evaluation may mean these evolve and change as the programme develops.

It is crucial to have links with appropriate university departments to develop the skills for evaluation of ongoing and new work. In our experience, this is an added resource that offers a more objective approach to monitoring and evaluation. It is essential to properly evaluate the ongoing work. In Leicestershire it was decided that it was a better use of time and resources to carry out in-depth evaluation of key projects/nutrition education activities rather than to try to evaluate all aspects of food and nutrition implementation. In addition to this, there is a need to develop meaningful monitoring data at the district level.

Awareness of the pressures and changes occurring in other organizations which may affect food policy implementation is essential, for example, local government reorganization has meant that some of the initial plans for food policy implementation have been postponed until post-reorganization.

Although we would regard the operation of the Healthy Eating Subgroup as a success (for the reasons mentioned earlier), other health authorities will undoubtedly have their own nutrition priorities and local political structures. The most appropriate way of working together and implementing food and nutrition policy will evolve as a result of this.

Future

The local health plan is currently changing to reflect the movement in Leicestershire towards locality purchasing, with a subsequent need for generic community dietitians to collaborate more actively within localities. This may enhance the likelihood of identifying resources for community development projects with communities at risk of poor nutrition. To consider just one target set in the *Health of the Nation* document, to reduce the incidence obesity, clearly this is not being achieved, and innovative collaborative approaches need to be developed to counteract this worrying trend.

The demand for greater accountability in resource use, combined with increased pressure to justify the effectiveness of future programmes by purchasers, are adding momentum to the need to assess the value of nutrition education activities.

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