Evaluation table 7 – Other Significant Comments

	Respondent	Summary of significant points	CAP's evaluation:
7.1	AoS/CASH	Respondent said food and drink was the biggest cause of premature death and disability in the UK and resulted in a huge burden on the NHS. Too much salt caused increased blood pressure (second only as a cause of death to smoking) and too much saturated fat increased cholesterol which was another major cause of death. They pointed to HFSS foods' role in conditions like type-2 diabetes. They also pointed out that, in the UK, 67% of men and 57% of women were either overweight or obese and more than a quarter of children were also overweight or obese.	See Regulatory Statement section 4.1.4.
7.2	ABGPHT BGCBC	Respondent said the Child Measurement Programme in Wales, showed a fifth of all children aged 4-5 years in Gwent were overweight or obese. They said they had recently published *Fit for Future Generations: A childhood obesity strategy for Gwent to 2025*. They responded to the consultation as part of the action being taken to improve children's health in Gwent.	See Regulatory Statement section 4.1.4.
7.3	WG	Respondent said children and young people in Wales had sugar intakes around three times over the recommended maximum. They pointed to National Diet and Nutrition Survey data which showed intakes of soft drinks and cereals were contributing significantly to sugar consumption in children. Respondent said, in addition to the immediate health consequences of obesity and an unhealthy diet, early-life behaviours could continue into adulthood: it was estimated	See Regulatory Statement section 4.1.4.

		that around 70% of obese children or adolescents became obese adults.	
7.4	CRUK	Respondent said it was a priority to reduce the number of children who were overweight or obese; such children were five times more likely to become obese adults, placing them at risk of preventable cancers. They said obesity was the single biggest preventable cause of cancer after smoking. The respondent said their research estimated that obesity could cause 670,000 cases of cancer over the next 20 years.	See Regulatory Statement section 4.1.4.
7.5	CEDAR	Respondent said the diets of UK children were not healthy; only 13% of 11-18 year olds achieved the recommended five portions of fruit and vegetables per day; 77% consumed more saturated fat than recommended; and 71% more 'added' sugars than recommended. They said dietary patterns contributed to obesity rates. The respondent said, despite considerable efforts, substantial improvements in diet and obesity remained elusive.	See Regulatory Statement section 4.1.4.
7.6	FF	Respondent said the dietary habits of children and young people were particularly concerning; all children were exceeding their Recommended Daily Allowances (RDAs) of free sugars, almost all were eating too much saturated fat and the majority were eating too much salt. They said analysis had shown nearly half of children's dietary energy came from HFSS products. The respondent believed a multi-pronged approach was needed to tackle the problem, including the regulation of non-broadcast media.	See Regulatory Statement section 4.1.4.
7.7	SPHSU	Respondent maintained that dietary intake played an important role in observed health inequalities. Children living in areas of highest deprivation in Scotland had poorer diets accounting for much of the inequalities in rates of obesity and dental decay between children living in such areas.	See Regulatory Statement section 4.1.4.

7.8	SPHSU	Respondent said children's diets were not healthy. They said sugar intake was particularly high with 15.6% of 11-18 year olds energy intake derived from added sugars. They said the main sources of sugar intake in UK children's diets came from sugar sweetened beverages, followed by cereals, cakes and biscuits, all of which were extensively advertised. The respondent pointed out ha the WHO recommended that added sugar should make up no more than 5% of daily energy intake. They added that, at a UK level, a move to a diet in line with the recommendation was estimated as having the potential to save the NHS £500 million per year, with additional wider economic benefits.	See Regulatory Statement section 4.1.4.
7.9	PHE	Respondent said poor diets were the leading cause of morbidity and mortality in England. They said dietary surveys consistently showed that on average all children, and in particular adolescents consumed more salt, saturated fat and sugars and less fibre, fruit and vegetables than recommended. They estimated that all age groups also consumed more calories than recommended for a healthy weight. The respondent also pointed out that tooth extraction due to dental carries was the primary cause of children aged 5–9 years being admitted to hospital in England.	See Regulatory Statement section 4.1.4.
7.10	RSPH	Respondent said 59% of children were thought to have used social media by the age of 10, routinely ignoring age limits to sign up. They believed food advertisers had been keen to exploit that by signposting to their websites on social networking sites aimed at children, with 75% of websites advertising HFSS products. They believed children were being bombarded with advertising and called for regulatory action. They said their research had shown 75% of people supported stronger restrictions.	See Regulatory Statement section 4.1.4.

7.11	SG	Respondent said the scale of the problem was significant in Scotland; they believed Scotland had an obesity epidemic. They said just under 5% of the population had diabetes with type-2 accounting for 88.2% of that figure. They said 65% of adults aged 16 and over were overweight, including 28% who were obese. 17% of children were at risk of obesity and 14% at risk of being overweight. The respondent said the cost to the Scottish NHS of type 2 diabetes alone was estimated to be £1bn, alongside £2.37bn costs to the wider economy.	See Regulatory Statement section 4.1.4.
7.12	IPH	Respondent said poor diet and obesity were significant threats to public health across Ireland and the UK. In Northern Ireland, 21.2% of Primary 1 children and 27.8% of Year 8 children were overweight or obese. They were particularly concerned about the impact on heath inequalities and the burden of disease.	See Regulatory Statement section 4.1.4.
7.13	HoM	Respondent said there were increasing rates of overweight and obesity amongst infants and children. They were particularly concerned about prevalence among lower socio-economic groups. They said, in the North West, nearly 22.9% of the reception year children were overweight or obese and, by year 6, it had doubled to 33.8%.	See Regulatory Statement section 4.1.4.
7.14	LBH	Respondent said 14% of reception year children were recorded as overweight and 12% of reception children were recorded as obese in City and Hackney. They pointed out that Hackney was the 11th most deprived borough in England with considerable inequalities in health and income.	See Regulatory Statement section 4.1.4.
7.15	BASCD	Respondent were concerned that CAP had not placed sufficient emphasis on dental health. They said CAP had omitted mention of evidence relating to the role of sugar in oral health. They pointed out that sugar was one of the risk factors for dental caries and that SACN found that in children	CAP noted the impact of HFSS consumption on dental health in section 23 of the consultation document. It nevertheless notes the further information and data cited by respondents from the dental health field. This provides further evidence of the potential for poor dietary choices to cause harm and result in significant wider costs.

		and adolescents frequent consumption of sugar-containing foods and drinks were associated with a greater risk of dental caries in both deciduous and permanent teeth. The respondent said tooth decay accounted for nearly 30,000 children's admission to hospital each year.	See also Regulatory Statement section 4.1.4.
7.16	BASCD	Respondent said the CAP consultation document implied that it was the responsibility of the public health community to demonstrate with high quality research the harmful effects of any advertising approach. They said when there was a national obesity strategy there would be a presumption that any advertising of HFSS products could be potentially harmful, and that it would be the responsibility of the advertiser to demonstrate that their advertising approach was not harmful to children.	See Regulatory Statement section 4.1.
7.17	BDA (Dental)	Respondent said tooth extractions due to caries were the leading cause of hospital admissions for children aged five to nine years costing the NHS £35 million per year. They said the rates had increased significantly in recent years and, in 2014-15, almost 41,000 children in England underwent extractions under general anaesthetic. They pointed out that the figures did not take account of wider economic and social costs, or of the caries treated without need for extraction.	See Regulatory Statement section 4.1.4.
7.18	BDA (Dental)	Respondent said they were extremely disappointed that dental disease and its substantial effects had not been given greater consideration in the consultation.	See the evaluation of point 7.15 (above).
7.19	BDA (Dental)	Respondent supported the findings of the SACN report, Carbohydrates and Health (2015) on the need to reduce sugar consumption.	CAP notes the findings of the SACN report and that PHE is presently reviewing the DH nutrient profiling model to implement them; see Regulatory Statement section 4.3 for more information on CAP's decision to adopt the DH Model.

7.20	BDA (Dental)	Respondent maintained that children were particularly susceptible to marketing and should be protected from the advertising and promotion of unhealthy food and drink across all forms of media (including in cinemas, on posters, in print, online and in advergames). The said a systematic review by the former Food Standards Agency concluded that, "food promotion influences children's food preferences and their purchase behaviour". They pointed out that the review also found evidence that, "the more food adverts [children] saw, the more snacks and calories they consumed". Ofcom statistics indicate that a high proportion of children's viewing is outside dedicated children's programmes.	See Regulatory Statement section 4.1.6.
7.21	HoM	Respondent said there continued to be regional inequalities in oral health with almost 64% more five-year-olds suffering from the tooth decay in the North West of England than in the South East.	See Regulatory Statement section 4.1.4.
7.22	PHE	Respondent said it was well-established that food habits and dietary patterns developed in childhood continued into adulthood. They said persistent advertising and promotion of unhealthy foods and drinks to children encouraged them to adopt unhealthy food practices and dietary habits that could persist throughout later life, increasing the risk of obesity and other diet related diseases such as hypertension, Type 2 diabetes, cardiovascular disease and some cancers. They pointed out that children who were overweight or obese were more likely to experience bullying, stigmatisation and low self-esteem and are also more likely to be overweight or obese adults.	See Regulatory Statement section 4.1.4.
7.23	AoS/CASH, HF, OHA	Respondents said constant exposure to unhealthy food and drinks on TV, radio, the internet, social media, in magazines, and for some even at school made it very difficult for children and families to make healthy choices and greatly influenced	See Regulatory Statement section 4.1 on CAP's view of the case for regulatory change.

		the food they ate. They said one in five children in England were overweight or obese before they started primary school, and by the time they left, that had increased to almost one in three.	
7.24	AoS/CASH, CFC, SW	Respondents cited the Bulletin of the WHO (2016; 94:540-548), which stated: "A robust evidence base accumulated between 2003 and 2013 demonstrated how the extensive and persistent exposure to the powerful marketing of unhealthy food and drink products could affect the preferences and purchasing requests of children. Rigorous reviews have documented how often the sophisticated and integrated marketing communications of the food and drink industries continue to influence the dietary behaviour of young people and contribute to energy-dense and nutrient-poor diets, increased risks of unhealthy weight gain and negative health outcomes."	See the evaluation of point 4.1.1.10 (Question 4a).
7.25	CEDAR	Respondent said there was substantial evidence from systematic reviews that advertising had an effect on children's food knowledge, preferences, purchasing and consumption. As the majority of food marketing in the UK is for less healthy foods, they considered that food marketing likely contributed to consumption of unhealthy diets.	See Regulatory Statement section 4.1.
7.26	NEDPH	Respondent said non-broadcast advertising of HFSS products, especially online, had become more prevalent at a time when there were persistently high levels of childhood obesity, particularly in deprived areas. They said the growth of non-broadcast advertising might have been due to the introduction of restrictions on TV advertising.	See Regulatory Statement section 4.1.4.
7.27	NEDPH	Respondent cited the PHE review, which stated that children in England were not only exposed to a high volume of traditional and new forms of marketing and advertising,	See Regulatory Statement section 4.1 and the evaluation of point 1.a.1.47 (Question 1a).

		including cinema, press, social media and “advergames” but that “available research evidence shows that all forms of marketing consistently influence food preference, choice and purchasing in children and adults”.	
7.28	NEDPH	Respondent said food advertising worked at a subconscious level and for children, in particular, the boundaries between socialising, entertainment and marketing might not be clear. They said the ability of parents to mediate was limited by the range and scope of non-broadcast marketing techniques aimed at or appealing to children and young people.	CAP notes the respondent’s points.
7.29	PHE	Respondent said, although the drivers of poor diets in the UK were multifactorial (education, employment, food availability, food composition, price, promotions etc.), the systematic advertising of unhealthy foods and drinks was likely to be a significant contributing factor.	See Regulatory Statement sections 4.1.2 and 4.1.6.
7.30	PHE	Respondent said it was unlikely in the near future that there would be evidence of a direct link between advertising and obesity. They therefore recommended a pre-cautionary approach. The respondent also said much of the evidence was reliant on small scale, moderate quality experimental/controlled studies. However, they pointed out the complexity of researching consumer behaviour and the systemic nature that influences obesogenic environments.	CAP notes the respondent’s points.
7.31	LNCDU	Respondent believed CAP’s starting point was over simplistic in its assertion that: “there is evidence to establish that there is an impact on children’s food preferences, but the level of that impact is likely to be very small in absolute terms and certainly in comparison to other factors like parenting and education. In CAP’s view the academic evidence of advertising’s effect on children’s behaviour does not alone establish a case for tougher advertising restrictions” (consultation document pages	CAP notes the respondent’s view.

		46 and 47).	
7.32	LNCDU, ACAD2	Respondents said the evidence relied on must be accepted by the scientific community as independent and robust, and should therefore be validated by peer-review. They said the literature review CAP had commissioned, Clarke and Svaenes (2014), did not meet that standard and had several concerns about the findings.	The literature review was commissioned as a scoping exercise. Its role was to identify new and emerging evidence around online marketing of food and drink products to children. It successfully provided an up to date and detail picture of the evidence base in a new and rapidly evolving environment. The review was not commissioned to make policy recommendations. It was carried out as part of CAP's on-going work to ensure that its children's food rules remain effective.
7.33	LNCDU	Respondent said a significant body of evidence had accumulated over the years on the harmful impact of HFSS food marketing on children. They pointed to the evidence supporting the WHO Recommendations on restricting marketing and several studies relating to non-traditional media, and in particular the internet, carried out by the University of Liverpool.	See Regulatory Statement section 4.1 and the evaluation of point 4.a.1.10.
7.34	ADPH	Respondent pointed out that obesity levels were rising in line with the oversupply of available calories and while HFSS was important, messages about overall calorie intake needed to be considered. They also urged CAP to consider how so-called "healthier" foods were advertised, as over-supply of "healthy" food could still lead to increases in weight.	See Regulatory Statement section 4.4.3.
7.35	BSDA	Respondent said, as many children experienced advertising through social media and other online channels, in January 2016 the soft drinks industry collectively agreed to a voluntary commitment not to advertise HFSS soft drinks to children under 16 across all media channels, including online.	CAP notes the respondent's point.
7.36	AoS/CASH	Respondent said there was no justification for banning the advertisements of tobacco when unhealthy food and drink are a much bigger cause of death and disability in the UK.	See the evaluation of point 4.b.ii.1.41 (Question 4b).

7.37	BRC	Respondent said new provisions must allow industry to continue to operate in a competitive environment by avoiding the imposition of disproportionate burdens.	See Regulatory Statement section 4.1.
7.38	AoS/CASH, CFC, PUB1	Respondents said children had the right to participate in social life and to have their voices heard, but also had rights to health and to have their best interests considered. They believed children should be able to participate safely online and go about their daily lives without being subject to targeted marketing for products that have been demonstrated to have a negative effect on their health and well-being.	See the evaluation of point 1.a.1.20 (Question 1a).
7.39	ACAD2, AoS/CASH, CFC, LNCDU, PHE, SW	Respondent provided details of the WHO framework for addressing childhood obesity; including a key recommendation to reduce exposure to and the power of unhealthy food advertising.	See the evaluation of point 1.a.1.19 (Question 1a).
7.40	RSPH	Respondent cited their *Child's Obesity Strategy* report. They said the report was written with the help of young people providing solutions they believed would solve the childhood obesity crisis.	CAP notes the respondent's submission.
7.41	LNCDU	Respondent said, in line with the WHO Recommendations any HFSS food marketing to children should be banned, including via sponsorship of sports, cultural or other events popular with children, via displays at points of sale or via any other means (packaging, labelling) or in-school marketing.	See Regulatory Statement section 4.8.
7.42	LNCDU	Respondent said the relationship between European Union law and UK law currently stands, allowed the UK to restrict further the marketing of HFSS food to children	CAP notes the respondent's point.

7.43	FSS	Respondent said, in January 2016, FSS agreed that there was an urgent need to bring about change to the Scottish diet based on the current and forecast impacts of diet-related disease in Scotland and almost complete lack of progress in meeting the Scottish Dietary Goals over the past 15 years. They said a broad range of actions agreed were framed around the strong and increasing evidence of the effect of the food environment on consumer choices. These environmental factors included the way that food was placed, presented, and promoted in the environment.	CAP noted the efforts of the devolved nations to develop policy solutions to the diet and obesity issue in the consultation document (see section 27).
7.44	CRUK	Respondent believed CAP's proposals were only a first step in addressing the growing concern of marketing of HFSS products in non-broadcast media. They said there needed to be a comprehensive response to minimise children's exposure in order to help reduce childhood obesity.	See the evaluation of point 1.a.1.17 (Question 1a).
7.45	CRUK	Respondent said comprehensively reducing the number of HFSS adverts that children saw online would be good regulation as it would be great for child health. They encouraged CAP to abide by its public commitment to good regulation.	See the evaluation of point 1.a.1.17 (Question 1a).
7.46	CEDAR	Respondent said food marketing was one part of a complex system of factors influencing children's diets. They considered it naïve to think that there could be simple, single interventions that will achieve substantial change; any interventions, each with apparently small individual effects, were likely to be required.	CAP has acknowledged that advertising restrictions are one part of a much wider set of policy initiatives to address the childhood diet issue.
7.47	CEDAR	Respondent said interventions such as restrictions on food marketing can be described as "low agency, population interventions". They operated across the whole population irrespective of any individual's risk of disease (population interventions) and required little, if any, mental or physical	CAP notes the respondent's point.

		engagement from individual recipients (low agency) for them to benefit from the intervention. The respondent believed low agency interventions were crucial to addressing the childhood diet issue.	
7.48	CFC	Respondent believed children should be protected from the marketing and promotion of less healthy food and drink across all forms of media. They said, ideally, it should be the Government – through, for instance, the Childhood Obesity Strategy – which set the ambitious policy goals for CAP. The respondent said they should always seek to match international best practice, and adhere to WHO recommendations.	CAP's process is separate to the of the Government's obesity plan. However, CAP considers that advertising regulation can play a part in wider efforts to address policy challenges related to poor childhood diet and obesity.
7.49	CFC	Respondent said Brexit should not mean an end to efforts to reduce diet-related conditions. They urged CAP to seize the opportunity and show leadership. They were also concerned about the future of the health and nutrition claims rules, which originated from EU legislation and had been incorporated into the CAP Code.	CAP's position on Brexit is outlined on its website.
7.50	FF	Respondent said there was a strong consensus among the academic and third sector communities that the UK currently lacked adequate measures to protect children from marketing of less healthy foods through non-broadcast media. They provided details of the output of their Food Environment Policy Index (Food EPI), an internationally-validated benchmarking tool. The Food EPI included a good practice statement for non-broadcast media: "Effective policies are implemented by the government to restrict exposure and power of promotion of less healthy foods to children through non-broadcast media (e.g. internet, social l media, food packaging, sponsorship, outdoor advertising including around schools)".	CAP notes the consensus detailed by the respondent.

7.51	HF, OHA	Respondent said obese children were more likely to be obese adults, which heighten their risk of various medical conditions. Those conditions had huge individual and societal costs justifying far reaching action.	See Regulatory Statement section 4.1.4.
7.52	RCPCH	Respondent believed children would benefit from new restrictions, but also parents. They would be less likely to be put under pressure by their children to purchase HFSS foods if the children had reduced exposure to them in the first place.	Advertising approaches that encourage “pester power” in relation to food and soft drink products are already prohibited by rule 15.16.
7.53	RCPCH	Respondent said it was possible that industry might argue that new restrictions would adversely impact their businesses. However, they believed obesity had reached crisis levels and children were undoubtedly being harmed by obesogenic environment. The respondent said the food industry must take some responsibility and play its part in tackling the problem.	See Regulatory Statement section 4.1.
7.54	NS	Respondent said it was for government to determine the wider approach through legislation and for CAP to align its Code with that position.	See the evaluation of point 7.4.8 (above).
7.55	LBH	Respondent said obesity was a complex and multifactorial condition with a strong link to deprivation. They said people struggled to maintain healthy lifestyles; cost was a particular barrier. They said a wider approach was needed to address the obesogenic environment that made it harder for individuals to eat well and fit physical activity into their daily lives.	CAP agrees.
7.56	PACT	Respondent raised concerns around the significant reduction in investment in original children’s TV programming that came about after restrictions were placed on TV advertising in 2006. They pointed out that it fell by 95% over the last decade, from £58m in 2003 to £3m in 2013.	See the evaluation of point 1.a.27 (Question 1a).

7.57	PACT	Respondent urged CAP to consider the economic impact of any additional restrictions on UK children's broadcasters who invested in original UK children's programming. They said online platforms had also started to commission original content from the Independent sector too although those revenues remained limited. They said both public service and commercial sectors were already facing economic pressures and they could not allow further downward pressures on investment.	See the evaluation of point 1.a.27 (Question 1a).
7.58	PACT	Respondent welcomed the opportunity for further discussions about how regulatory change could be pursued in a way which would not harm the ability of the commercial and public PSBs to invest in high-quality, original, PSB content for children.	See the evaluation of point 1.a.27 (Question 1a).
7.59	TNA	Respondent said considerable scientific evidence pointed to nuts being part of "prudent" dietary patterns, as opposed to typical "Western" ones which were characterised by overconsumption of refined carbohydrates and added sugars, saturated fats and low fibre foods.	CAP notes the respondent's point.
7.60	TNA	Respondent said a growing number of families in the UK were non-animal protein eaters for cultural, belief or choice reasons. They believed children in such families should be able to benefit from media messages about nuts which encouraged better nutrition habits.	It is for expert authorities on nutrition to determine what products should be categorised as HFSS; see Regulatory Statement section 4.3 for more details of CAP's decision to adopt the DH nutrient profiling model.
7.61	ASDA	Respondent said businesses must be given a sufficient notice period to implement new procedures to ensure compliance with the new restrictions.	See the evaluation of point 1.a.3.21 (Question 1a).
7.62	ASDA	Respondent noted there was no pre-clearance system for non-broadcast advertising and asked CAP to consider how that might be addressed.	CAP offers a free pre-publication Copy Advice service to advertisers on issues of compliance with the CAP Code.

7.63	BRC	Respondent strongly believed that guidelines must be developed to support the new provisions, covering some of the practical application issues. They provided a list of areas where they felt clearer guidance would be useful and offered the assistance of their members in developing it.	CAP welcomes the respondents offer. As stated elsewhere in the evaluation documents, CAP is committed to providing guidance and other support to businesses in adapting to the new rules.
7.64	FDF	Respondent noted TV advertisements had to be cleared via Clearcast before broadcast. They believed such a pre-authorisation system for non-broadcast advertisements was not necessary and would be too burdensome to implement and maintain.	CAP offers a free pre-publication Copy Advice service to advertisers on issues of compliance with the CAP Code.
7.65	FDF	Respondent called for CAP to produce guidance on any new restrictions including how advertisers would be expected to identify media subject to them.	CAP will produce appropriate guidance resources to assist businesses in complying with the new restrictions.
7.66	FDF	Respondent urged CAP to implement the rules after a 12 month transitional period.	See the evaluation of point 1.a.3.21 (Question 1a).
7.67	Nestle	Respondent said CAP should ensure the language used in the Code was clear and avoided ambiguity and that guidance should be provided to assist advertisers in complying with the rules. They were particularly concerned about how advertisers would be expected to identify media subject to the restrictions.	One of CAP's general policy objectives is to ensure that its rules are easily understood, easily implemented and easily enforced.
7.68	Tesco	Respondent said the age at which the restrictions applied should be clearly set out in the guidance. They noted different age categories could apply for the content rules and placement restriction.	CAP will produce appropriate guidance resources to assist businesses in complying with the new restrictions.
7.69	Tesco	Respondent urged CAP to product an accessible piece of guidance including all the rules, definitions of an HFSS product, definitions of a child and how media subject to the restrictions should be identified.	CAP is committed to producing new guidance and other advice, including industry engagement and training, to ensure businesses have the resources to effectively comply with the new restrictions. CAP will consider the respondent's point as part of this work.

7.70	CFC, CFT	Respondents called on CAP to provide a clearer definition within the code of what constituted "condoning or encouraging poor nutritional habits or an unhealthy lifestyle in children". They believed it was too open to interpretation and could be significantly strengthened with a framework of questions and examples.	See the evaluation of point 7.69 (above).
7.71	FSS	Respondent said the general principles around diet and lifestyle (rules 15.11 and 15.12 of the CAP code) should be extended to the full population.	CAP does not consider there is a case to extend the HFSS restrictions beyond under-16s. See in particular the evaluation of point 1.a.1.47 (Question 1a).
7.72	FF	Respondent called for brand equity characters to be treated in the same way as licensed characters by both the CAP and BCAP Codes.	See the evaluation of point 3.3.2 (Question 3).
7.73	FSS	Respondent noted the scope of the CAP code did not include advertising or promotion in-store or on packaging but did in other cases include promotions, including price promotions. Given their potential impact, the respondent believed CAP should cover such practices.	See Regulatory Statement section 4.8.
7.74	FSS	Respondent called for more clarity on the remit of the code in relation to online grocery websites.	CAP extended the Code's remit in 2011 to cover marketing communications appearing on marketer's own websites
7.75	UKFPH	Respondent said, in addition to use of licences characters or celebrities, brands should not be able to associate themselves with sport related activities (e.g. McDonalds sponsoring the Olympics).	Sponsorship is outside the Code's remit.
7.76	NHS (Sco)	Respondent urged CAP to consider restrictions on HFSS product advertising for the wider population.	See the evaluation of point 1.a.1.47 (Question 1a).

7.77	RSPH	Respondent said they wanted promotions featuring on bus tickets to be regulated to ensure that children could not be targeted with HFSS advertising.	The remit of the Code applies to marketing communications, including promotions, appearing in paid for space.
7.78	ASDA	Respondent called for greater consistency between claims made in advertising and those made on-pack. They were concerned that on-pack claims came under the ASA's remit when featured in an advertisement. They encouraged CAP, the ASA and Trading Standards to work in partnership to improve consistency and reduce what they regarded as a "disconnect" between how the law was applied in store and online.	CAP works with Trading Standards on food advertising issues to ensure consistency in decision making on nutrition and health claims.
7.79	FSS	Respondent called on CAP to monitor and demonstrate the effectiveness of the implementation of any revised restrictions, given the potential impact of food advertising to children.	See the evaluation of point 1.a.3.20 (Question 1a).
7.80	CRUK	Respondent was concerned about the reactive nature of the ASA complaints system. They believed that effectively holding the food and drinks industry to account would be impossible without an efficient, proactive complaints process.	See the evaluations of point 6.3.25 and 6.3.33 (Question 6).
7.81	CFC	Respondent said their report on the ASA complaints process showed it was frustrating and time consuming. They maintained that the ASA tended to focus on the letter, not the spirit of the Code and could be inconsistent. Some decisions were taken in secret; they were "informally resolved" and not open to public scrutiny. The respondent was concerned that the system favoured parties with time and money to challenge rulings, which was usually the industry.	Points about the ASA's structure and processes are outside the scope of the consultation. Details of the ASA's procedures and approach to enforcement are available on the ASA website.
7.82	CFC	Respondent called for several changes to the system. They said more should be done to create a level playing field between citizens and industry, including by helping individual complainants and by increasing the amount of independent	On the issue of enforcement and sanctions, see the evaluations of point 6.3.25 and 6.3.33 (Question 6). Points about the ASA's structure and processes are outside the scope of the consultation.

		expert advice sought before making a ruling. They called on the ASA to toughen its sanctions and enforcement by using fines and requiring corrections that were as prominent as the misleading advert. The respondent urged the ASA to opens its compliance and informal resolution processes to public scrutiny. They said the ASA should regularly convene a parents' jury and children's panel to judge what is and isn't appropriate and what appeals to and/or is targeted at children.	
7.83	NS	Respondent said transparent monitoring and stronger enforcement mechanisms were also required, including effective sanctions for transgressions. They believed industry self-regulation had proven not to be strong enough mechanism to significantly alter advertising practices to put the health and well-being of children first.	See the evaluations of point 6.3.25 and 6.3.33 (Question 6).
7.84	PHDW	Respondent was concerned that the ASA's sanctions were ineffective. They noted the short term impact of adverse publicity following a ruling but they were concerned about the length of time it took to have a non-compliant advertisement removed. They believed it could be seen by large numbers of children. The respondent recommended that the ASA consider more effective sanctions.	See the evaluations of point 6.3.25 and 6.3.33 (Question 6).
7.85	IPH	Respondent was concerned about the self-regulating nature of advertising standards in the UK. They said studies showed there were inherent conflicts of interest (University of Liverpool et al, 2015) and that self-regulation was unlikely to lead to wholesale change in the balance of what food is marketed to children (Adams et al, 2012:5) was marketed to children.	See the evaluations of point 6.3.25 and 6.3.33 (Question 6).
7.86	BDA (Dietetic)	Respondent called for: an independent regulator as the production and enforcement of the CAP Code was conducted by the advertising industry; the immediate withdrawal of an advert / product placement as soon as it was called into	The CAP Code is enforced by the ASA, which is independent from CAP. On the issue of enforcement and sanctions, see the evaluations of point 6.3.25 and 6.3.33 (Question 6). On the issue of reviewing the implementation of the new restrictions, see the

		question and also during the investigation stages; heavier punishment for breaching the CAP Code to act as an effective deterrent to product manufacturers; regular review of the CAP code to address any developments in and increases in the opportunities and methods for companies to market HFSS products are kept up with; and an evaluation of the effects of introducing tougher restrictions to be conducted by an independent body.	evaluation of point 1.a.3.20 (Question 1a).
7.87	BASCD	Respondent noted compliance with the CAP Code was mandatory, but was concerned that the system was self-regulatory and did not involve the public or dental health communities.	See the evaluations of point 6.3.25 and 6.3.33 (Question 6).
7.88	Various respondents	Respondents made a variety of points about TV advertising and the BCAP Code. In general they called for further tightening of restrictions governing that media.	The BCAP Code is outside the scope of this consultation.