



# Hot Food Takeaways and Spatial Planning

## Public Health Advisory Note

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## Introduction

This public health advice note aims to assist Lancashire district local planning authorities (LPAs) in developing policies that restrict new sui generis hot food takeaways in defined areas, contributing to the development of environments that promote healthy weight. The note's recommendations are based on an analysis of local obesity rates and hot food takeaway prevalence data, coupled with a review of existing literature.

## Wider Determinants of Health

Nearly every aspect of our lives, including our employment, education, social connections, and the physical and natural surroundings within which we live, work and play, has an impact on our health.

These factors are often described as the building blocks, or wider determinants, of our health (see Figure 1)<sup>1</sup>.

The Director of Public Health at Lancashire County Council (LCC), in collaboration with the Health Equity, Welfare and Partnerships (HEWP) service, works to influence the wider determinants of health by informing policies that ultimately affect the lives of Lancashire residents, with a particular emphasis on reducing health inequalities across the county. One way in which we do this is by influencing spatial planning policy.

**Figure 1: Building Blocks of Health, based on the Health Foundation's How to talk about the building blocks of health toolkit [1].**



<sup>1</sup> For more information, visit <https://www.lancashire.gov.uk/council/strategies-policies-plans/public-health/foundations-for-wellbeing/>

## Use Classes Order

The Town and Country Planning (Use Classes) Order 1987 (as amended)<sup>2</sup> puts uses of land and buildings into various categories known as 'Use Classes'. In general, planning permission is needed to change from one use class to another.

New regulations which came into force from 1 September 2020, changed use classes including those relating to food premises such as hot food takeaways. Table 1 below provides an overview of the changes made, in relation to food retail premises only<sup>3</sup>:

**Table 1: Old versus the new Use Classes Order for food retail premises [2]**

| Use Class Order before 1 September 2020 | Use Class Order from 1 September 2020    |
|---|--|
| A3 Restaurants and cafés                | Class E Commercial, business and service |
| A4 Drinking establishments              | Sui generis                              |
| A5 Hot food takeaways                   | Sui generis                              |

According to guidance published by the Office for Health Improvement and Disparities (OHID)<sup>4</sup>, 'Sui generis' is a term used for premises that do not fall within a defined use class, and that cannot, generally, change to any other use, including other "*sui generis*" uses without obtaining express planning permission. In this way, OHID state that the change of the A5 hot food takeaway use class "allows local authorities to have greater control, through using the planning application process, to prevent the proliferation of hot food takeaways" [2].

It is acknowledged at the outset of this note that 'unhealthy food outlets' may encompass a broader range of planning uses than sui generis hot food takeaways alone and could also include restaurants and retail units. The focus of this note and the ensuing policy recommendations are, however, focussed on managing the proliferation of sui generis hot food takeaway uses only.

<sup>2</sup>The Town and Country Planning (Use Classes) (Amendment) (England) Regulations 2020: <https://www.legislation.gov.uk/uksi/2020/757/made>

<sup>3</sup> For more information on the change of use classes, see Appendix 1.

<sup>4</sup> OHID is a successor organisation to Public Health England (PHE). For more details about the role and responsibilities of this body, see: <https://www.gov.uk/government/organisations/office-for-health-improvement-and-disparities/about>

# Planning and Health

## Planning Perspective

The National Planning Policy Framework (NPPF) [3] sets out the government's planning policies for England and how these are expected to be applied. The Framework must be considered by local authorities when preparing their development plans and is a material consideration in planning decisions.

At the heart of the NPPF is a presumption in favour of sustainable development, with three dimensions to the concept: economic; social; and environmental. The social objective is outlined as follows:

**“to support strong, vibrant and healthy communities, by ensuring that a sufficient number and range of homes can be provided to meet the needs of present and future generations; and by fostering well-designed, beautiful and safe places, with accessible services and open spaces that reflect current and future needs and support communities’ health, social and cultural well-being” (2023, pg., 5).**

The Framework also sets out an aim for planning policies and decisions: to achieve healthy, inclusive and safe places, which "enable and support healthy lifestyles, especially where this would address identified local health and well-being needs", specifically referencing "**access to healthier food**" as a key example of how this aim should be achieved (2023, pg. 28)<sup>5</sup>.

The government's Planning Practice Guidance (PPG) [4] adds further context to the NPPF and provides practical tools and methods for LPAs, developers, solicitors, and consultants to improve the development, negotiation, and implementation of planning obligations. Within the section on 'healthy and safe communities', the guidance highlights the ability of planning policies to, where justified:

**"limit the proliferation of particular uses where evidence demonstrates this is appropriate (and where such uses require planning permission)" (2022).**

In doing so, they add that:

**"evidence and guidance produced by local public health colleagues...may be relevant" (2022).**

In addition, the guidance also states that when developing planning policies and proposals, special attention may be required for certain issues such as:

- **evidence indicating high levels of obesity, deprivation, health inequalities and general poor health in specific locations.**

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<sup>5</sup>Appendix 2 provides further detail on NPPF chapters and policies relevant to healthy weight environments.

- **proximity to locations where children and young people congregate such as schools.**

It is within this context that this advice note has been prepared.

## Health Perspective

The current health policy context establishes a clear ambition for taking decisive action on tackling numerous causes of poor health, including overweight and obesity [5]. The Prevention Green Paper, titled 'Advancing our health, prevention in the 2020s', for example, acknowledges obesity as a significant health challenge and commits the Government, in collaboration with its system partners, to addressing the issue [6].

Supporting healthy diets and a healthier weight is also a priority outlined within the Public Health England (PHE) Strategic Plan for 2020-2025 [7], which states an underlying commitment to:

**"help make the healthy choice the easy choice to improve diets and reduce rates of childhood obesity" (2019, pg. 7).**

Prior to the Plan, OHID initiated a project with the goal of conducting a UK-focused evidence review [8] analysing and illustrating the links between health and the built and natural environment. The review sought to offer a comprehensive summary of the robustness of the evidence regarding the effects of the built and natural environments on health, with the intention of guiding actions and policies.

The review focusses on five elements of the built and natural environment, one of which is healthier food. Specifically, it refers to research findings that suggest:

**"increased access to unhealthier food retail outlets is associated with increased weight status in the general population, and increased obesity and unhealthy eating behaviours among children residing in low-income areas" (2017, pg. 30).**

Building upon this work, OHID created a guidance document [5] with the aim of providing practical support for local authorities interested in utilising the planning system to achieve important public health outcomes in the areas of diet, obesity and physical activity. The document restated the role of planning in realising positive health outcomes, saying:

**"The planning system has a range of powers and levers to implement effective change at local levels. All local authorities are encouraged to consider how they can best use the planning system to improve their communities' health and reduce health inequalities." (2020, pg., 3).**

The document goes on to cite the **"strong connections and shared objectives between public health and town planning"** (2020, pg., 6) and how local planners can be seen as a **"pivotal factor for change"** with regard to supporting better health outcomes (2020, pg., 9).

# Obesity

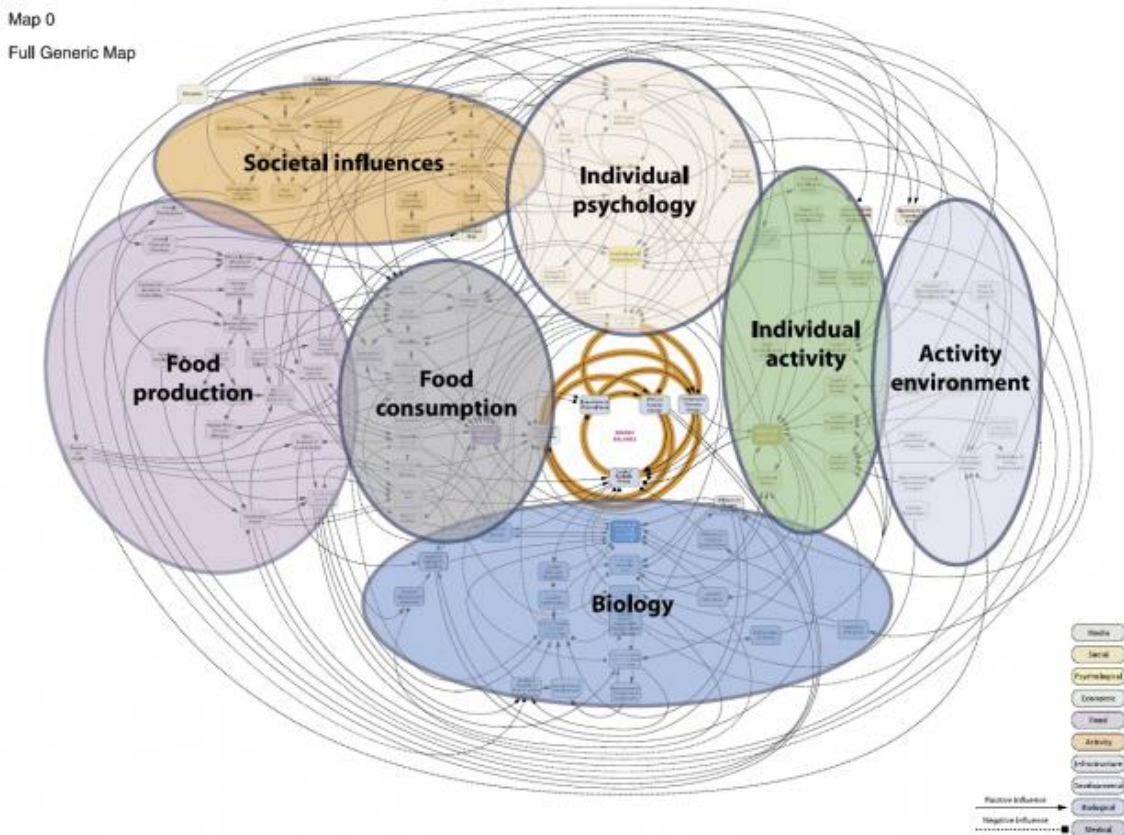
Obesity is a global public health concern. It is associated with reduced life expectancy and is a risk factor for a range of chronic diseases, including cardiovascular disease, type 2 diabetes, at least 12 kinds of cancer, liver, and respiratory disease, and can also impact on mental health [9]. The risk and severity of these diseases increases with a higher body mass index (BMI) – the current and most widely used criteria for classifying obesity [10]<sup>6</sup>.

## Risk Factors

Obesity is a complex and multi-faceted issue, with many drivers. Figure 2, the obesity systems map, provides one visual representation of the intricate network of factors seen to contribute to obesity levels, offering a more balanced perspective on the roles of the individual and the environment, and the interactions between the two [11].

The map also helps us to visualise the concept of a ‘whole systems approach,’ and the need to incorporate ‘systems thinking’ into how we seek to tackle the issue.

**Figure 2: The full obesity system map with thematic clusters, from the Tackling Obesities: Future Choices Report [12].**



<sup>6</sup>BMI: Body weight in kilograms, divided by height in meters squared. For adults, BMI ranges from underweight or wasting (<18.5 kg/m<sup>2</sup>) to severe or morbid obesity (≥40 kg/m<sup>2</sup>). A child or teenager's BMI is shown as a "centile". The centile result is shown as a percentage of how their BMI compares with other children or teenagers of the same age and sex.

The map contains seven key themes or clusters representing the risk factors of obesity [12].:

- **Physiology Cluster:** Focuses on the biological aspects of obesity, including genetic predisposition and metabolic factors that regulate body weight.
- **Individual Activity Cluster:** Examines the impact of personal and group physical activities, and how they are influenced by social and environmental factors.
- **Physical Activity Environment Cluster:** Looks at the external factors that affect physical activity, such as infrastructure, safety, and cultural attitudes.
- **Food Consumption Cluster:** Considers the consumer food market and its influence on dietary choices, including the variety and nutritional quality of available food.
- **Food Production Cluster:** Addresses the drivers within the food industry that affect food availability and consumption patterns, including economic and social pressures.
- **Individual Psychology Cluster:** Explores psychological attributes that influence eating behaviour and physical activity, such as self-esteem, stress, and parenting styles.
- **Social Psychology Cluster:** Captures societal influences on obesity, including education, media consumption, and societal norms related to weight and body image.

## Costs of Obesity

Obesity greatly increases risk of chronic disease morbidity<sup>7</sup>—namely disability, depression, type 2 diabetes, cardiovascular disease, certain cancers—and mortality. Childhood obesity results in the same conditions, with premature onset, or with greater likelihood in adulthood [10].

### *Overall mortality*

A comparative risk assessment study using Health Surveys for England (HSE)<sup>8</sup> and Scottish Health Surveys from 2003 to 2017 [13], found that adiposity (overweight or obesity) accounted for more deaths in England and Scotland than smoking, among people in middle- and old-age<sup>9</sup>. Overall, deaths attributable to current/former smoking declined from 23.1% in 2003 to 19.4% in 2017, whilst those attributable to adiposity increased from 17.9% in 2003 to 23.1% in 2017 with cross-over occurring in 2013. Cross-over occurred earlier in men (2011) than women (2014).

<sup>7</sup> Morbidity refers to the state of having an illness or disease.

<sup>8</sup> The Health Survey for England is a series of surveys commissioned by NHS Digital and carried out by NatCen Social Research and UCL. The surveys are representative of adults and children in England and are used to monitor the nation's health and health-related behaviours.

<sup>9</sup> Below 45 years, smoking remained the larger contributor to mortality.



## Diabetes

In England, adults who are obese are 5 times more likely to develop type 2 diabetes<sup>10</sup> than adults of a healthy weight, with 90% of adults with type 2 diabetes currently classed as being either overweight or obese [14].

In Lancashire, 7.6% of GP registered patients (aged 17+) are listed on the diabetes register. A more detailed distribution across the 12 districts is provided in Table 2. 4 districts (Burnley, Hyndburn, Pendle, and Wyre) have a percentage of registered diabetic patients that is significantly above the Lancashire average. Conversely, 6 districts (Chorley, Lancaster, Preston, Ribble Valley, South Ribble, West Lancashire) are identified as having a percentage that is statistically below the county average. The percentages for the remaining 2 districts (Fylde and Rossendale) are statistically comparable to the Lancashire average.

**Table 2: Number and prevalence of GP-registered patients on the Diabetes Register – Lancashire (2024)**

| Local Authority      | Patients On Diabetes Register | Registered Patients | %           | Benchmarked with Lancashire-12               |
|----------------------|-------------------------------|---------------------|-------------|--|
| Burnley              | 6,875                         | 80,146              | 8.6%        | Significantly above Lancashire-12            |
| Chorley              | 6,917                         | 97,243              | 7.1%        | Significantly below Lancashire-12            |
| Fylde                | 5,563                         | 72,129              | 7.7%        | No significant difference from Lancashire-12 |
| Hyndburn             | 6,183                         | 69,837              | 8.9%        | Significantly above Lancashire-12            |
| Lancaster            | 9,257                         | 133,101             | 7.0%        | Significantly below Lancashire-12            |
| Pendle               | 7,128                         | 81,904              | 8.7%        | Significantly above Lancashire-12            |
| Preston              | 9,693                         | 135,483             | 7.2%        | Significantly below Lancashire-12            |
| Ribble Valley        | 3,511                         | 54,320              | 6.5%        | Significantly below Lancashire-12            |
| Rossendale           | 4,308                         | 55,457              | 7.8%        | No significant difference from Lancashire-12 |
| South Ribble         | 6,794                         | 95,601              | 7.1%        | Significantly below Lancashire-12            |
| West Lancashire      | 6,845                         | 97,460              | 7.0%        | Significantly below Lancashire-12            |
| Wyre                 | 8,671                         | 98,736              | 8.8%        | Significantly above Lancashire-12            |
| <b>Lancashire-12</b> | <b>81,745</b>                 | <b>1,071,417</b>    | <b>7.6%</b> |  |

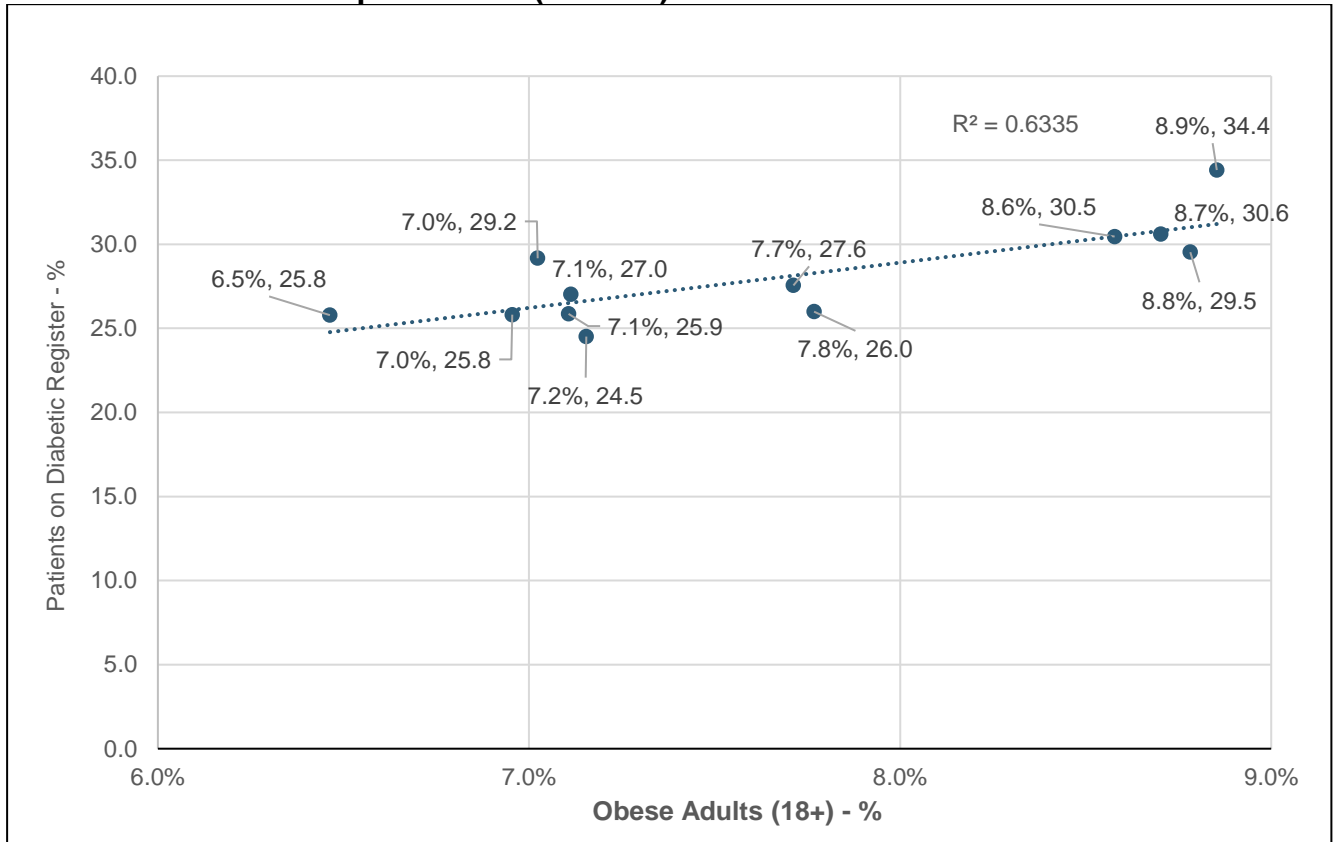
Source: NHS Midlands and Lancashire Commissioning Support Unit

When we compare the proportion of patients on the diabetes register across the 12 Lancashire districts with the prevalence of adult obesity across the same areas, we observe a moderate degree of positive correlation between the two variables (see Figure 3). This suggests that as the percentage of patients on the diabetes register increases, there is a tendency for the prevalence of adult obesity to also increase in these districts. However, it's important to note that correlation does not imply

<sup>10</sup> Type 2 diabetes accounts for at least 90% of all cases of diabetes. It occurs when the body either stops producing enough insulin for its needs or becomes resistant to the effect of insulin produced. The condition is progressive requiring lifestyle management (diet and exercise) at all stages. Over time most people with type 2 diabetes will require oral drugs and or insulin.

causation, and further investigation would be needed to understand the underlying factors contributing to this observed relationship.

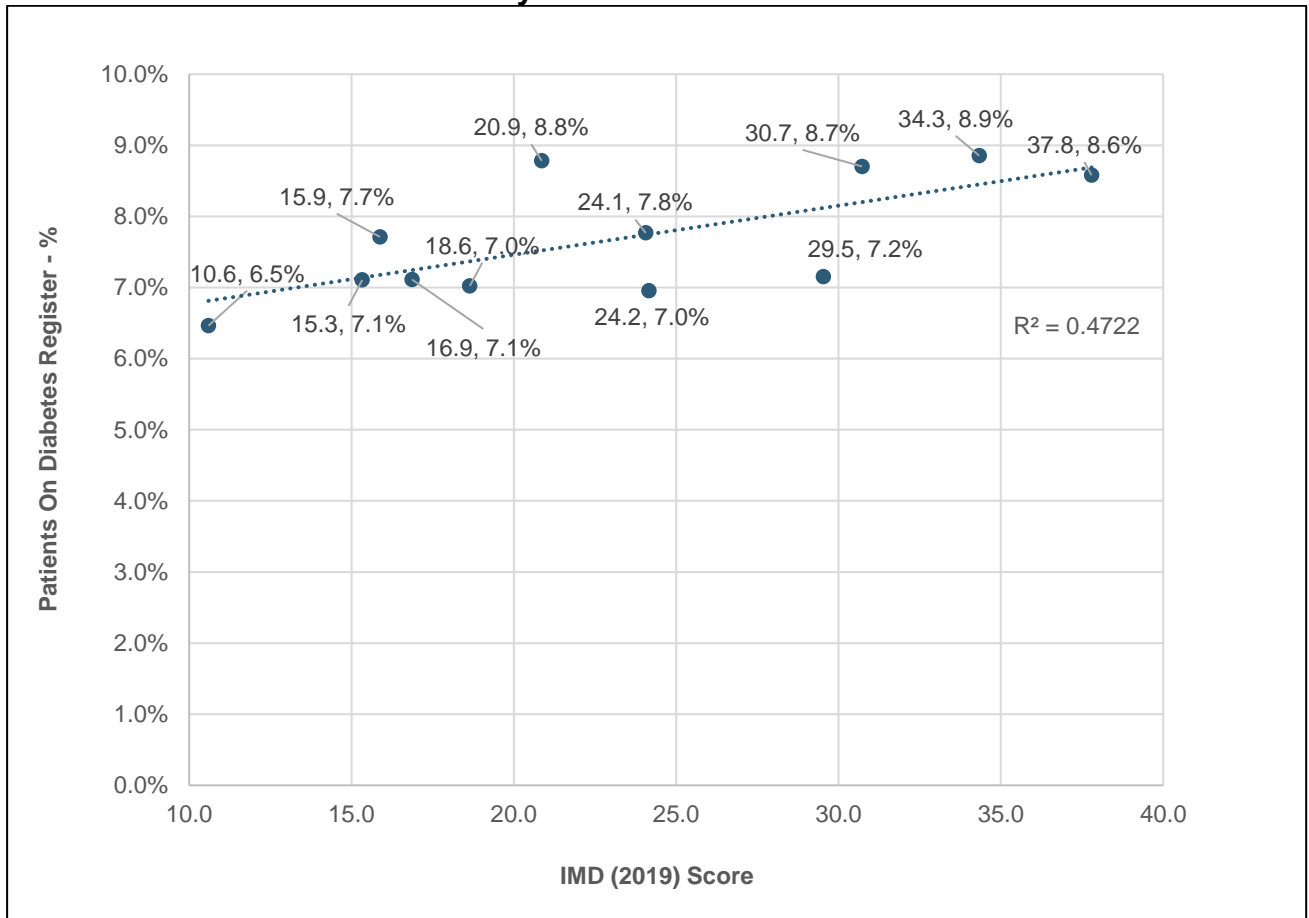
**Figure 3: Percentage of patients on diabetes register by adult obesity prevalence (2022/23) - Lancashire**



Source: NHS MLCSU and OHID, Fingertips

When we include 2019 Indices of Multiple Deprivation (IMD) data (as depicted in Figure 4), we can observe a moderate degree of positive correlation (with an  $R^2$  value of 0.5) between the proportion of GP-registered patients on the diabetes register and the deprivation score of the local authority where they are registered. This suggests that there is a moderate relationship between the level of deprivation in a local authority and the prevalence of diabetes among its registered patients (with further investigation also needed to understand underlying factors contributing to this).

**Figure 4: Percentage of patients on diabetes register (2024) by IMD (2019) local authority score - Lancashire**



Source: NHS MLCSU and OHID Fingertips

### **Cardiovascular Disease**

Cardiovascular disease (CVD) is an umbrella term for all diseases of the heart and circulation. It includes everything from conditions that are inherited or that a person is born with, to those that develop later, such as coronary heart disease (CHD), heart failure, and stroke [15].

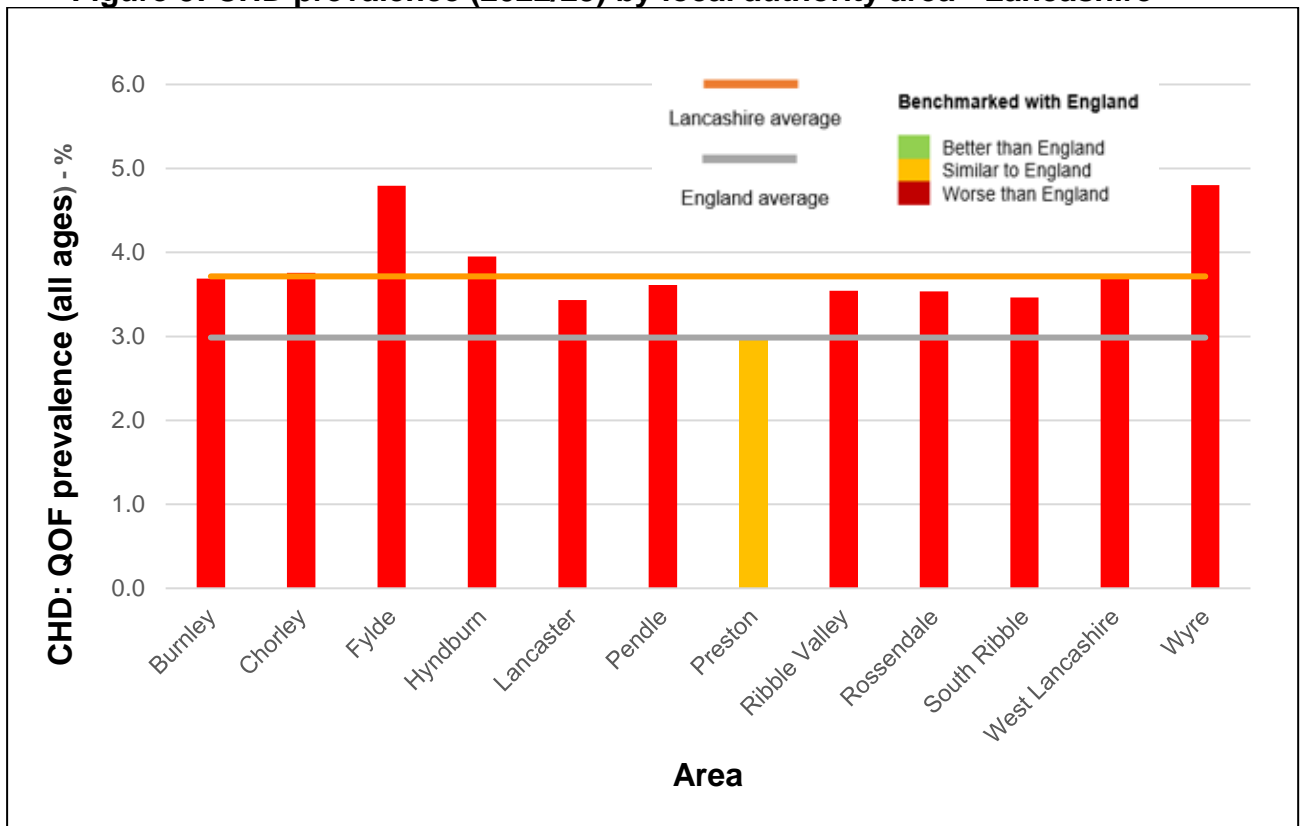
CVD is the primary cause of mortality globally [16] and is responsible for just over a quarter (26%) of all deaths in England; that's over 140,000 deaths each year – an average of 390 people each day or one death every four minutes [15]. Not only is CVD a significant contributor to mortality, but it also has a substantial impact on morbidity, posing a significant financial challenge to health and social care and broader society. The healthcare costs related to CVD in England alone are estimated to be around £8.3 billion per year, with the annual costs to the wider economy estimated at £21 billion [15].

One of the first medical consequences of obesity to be recognised was CVD [17] and in England around 1 in 6 heart and circulatory disease deaths are today associated with a high BMI [15].

In relation to CHD, it is noted that for the period of 2022/23, 11 of the 12 districts in Lancashire reported a GP-recorded prevalence significantly higher than the national

average (see Figure 5). Additionally, 3 of these districts (Fylde, Hyndburn, and Wyre) also reported a prevalence rate that significantly exceeded the Lancashire average.

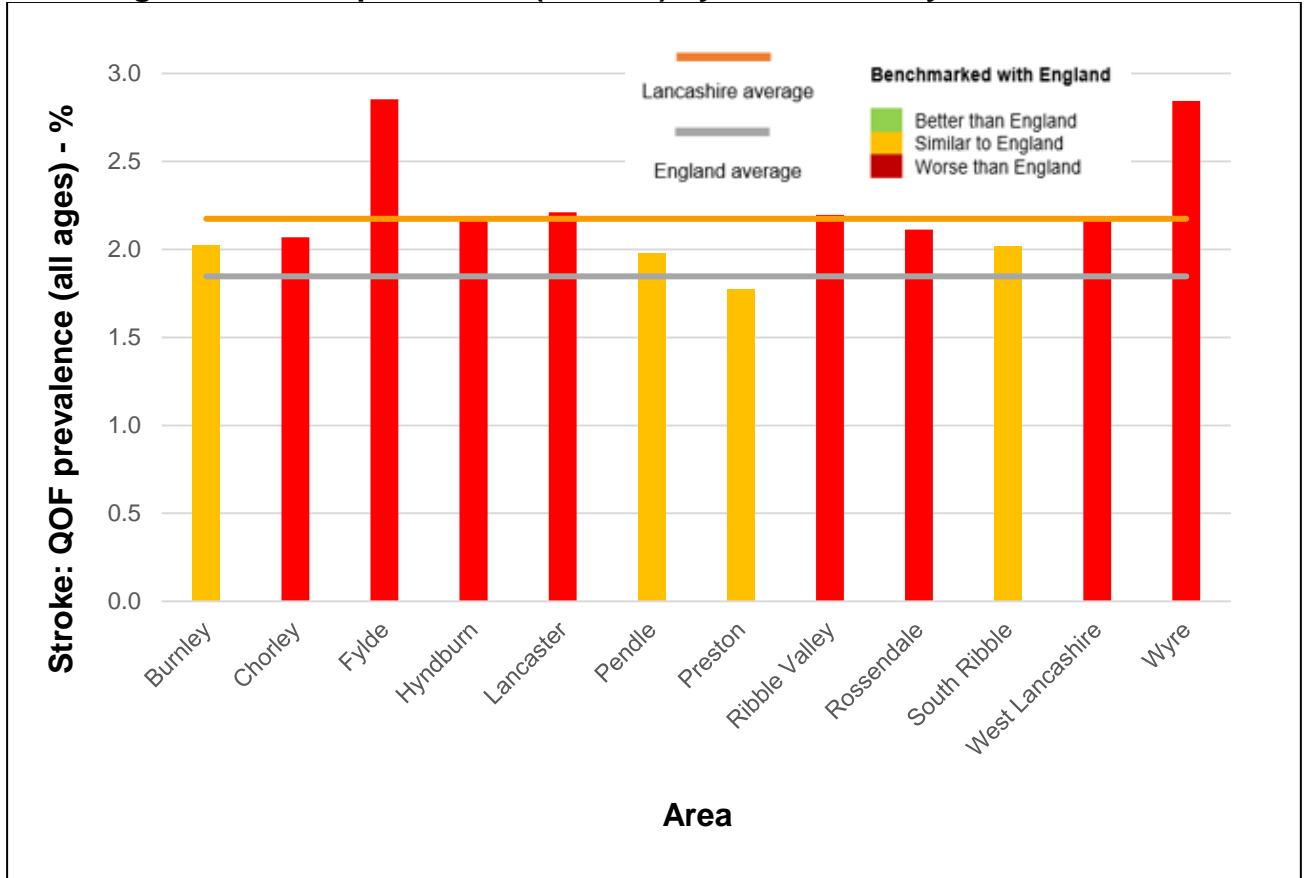
**Figure 5: CHD prevalence (2022/23) by local authority area - Lancashire**



Source: OHID, Fingertips

Furthermore, and as shown on Figure 6, 8 of the 12 districts (excluding Burnley, South Ribble, Pendle, and Preston), reported a GP-recorded prevalence of stroke that was significantly higher than the average for England, for the period 2022/23. Fylde and Wyre also recorded a significantly higher prevalence than the Lancashire average.

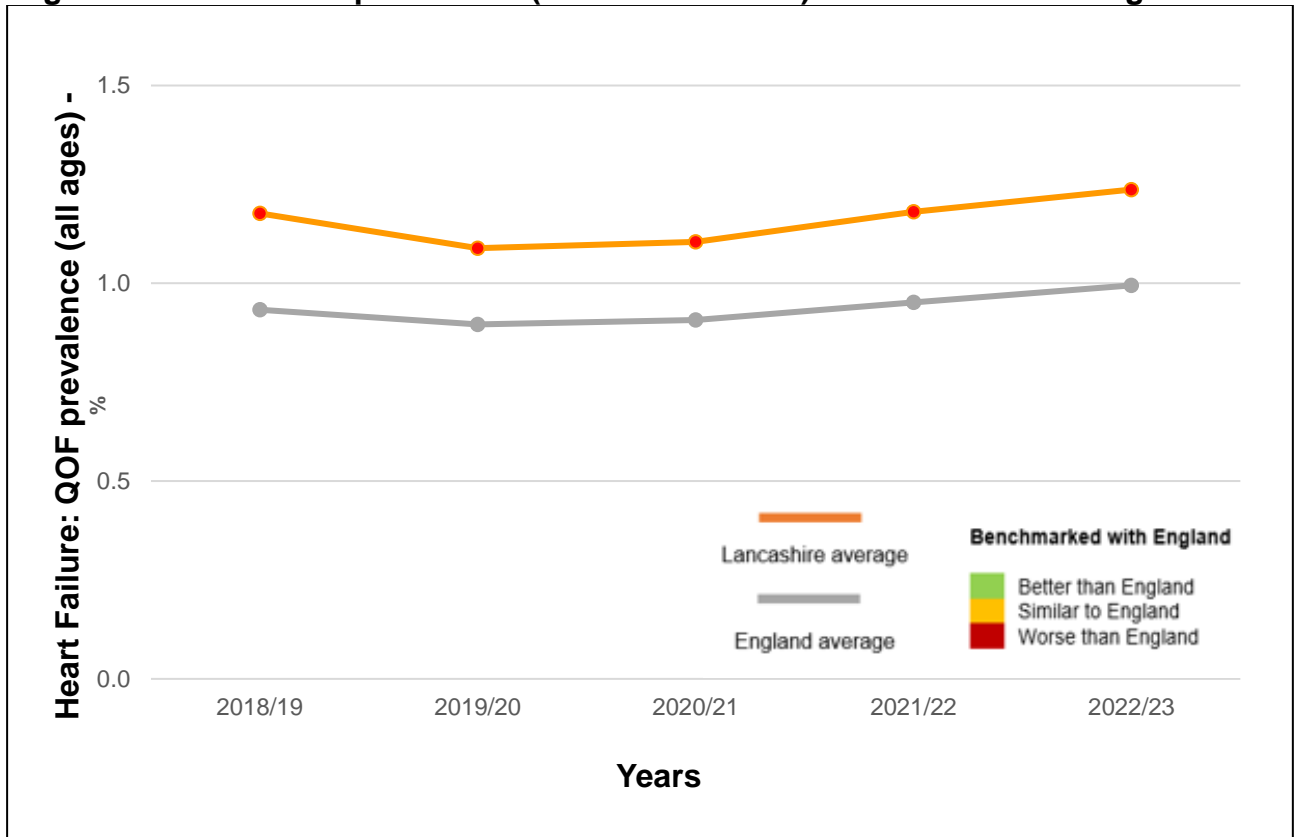
**Figure 6: Stroke prevalence (2022/23) by local authority area - Lancashire**



Source: OHID, Fingertips

With regard to heart failure, the latest data indicates that Lancashire has a prevalence significantly above the average for England (2022/23). This average is observed to be on an upward trend, indicating a worsening situation (refer to Figure 7). Moreover, when compared to its 15 NHS nearest statistical neighbours<sup>11</sup>, Lancashire ranks 3rd highest, trailing only Leicestershire and Hampshire.

<sup>11</sup> Nearest statistical neighbours (NHS England): [https://github.com/NHSDigital/ASC\\_LA\\_Peer\\_Groups](https://github.com/NHSDigital/ASC_LA_Peer_Groups)

**Figure 7: Heart failure prevalence (2018/19 - 2022/23) - Lancashire and England**

Source: OHID, Fingertips

### **Cancer**

Globally, approx. 4–8% of all cancers are attributed to obesity. In the UK, overweight and obesity are noted to be the second biggest causes of cancer (after smoking) – attributable to more than 1 in 20 cancer cases [18]. Several of the most common obesity-related cancers include breast, colorectal, oesophageal, kidney, gallbladder, uterine, pancreatic, and liver cancer [19].

Findings from a 2023 study suggest that excess body fat also results in an approximately 17% increased risk of cancer-specific mortality, although this relationship is not yet fully understood. It is, however, thought to involve altered factors such as fatty acid metabolism, immune dysregulation, and chronic inflammation. The study also found obesity to increase treatment-related adverse effects, as well as influence treatment decisions regarding specific types of cancer therapy [18].

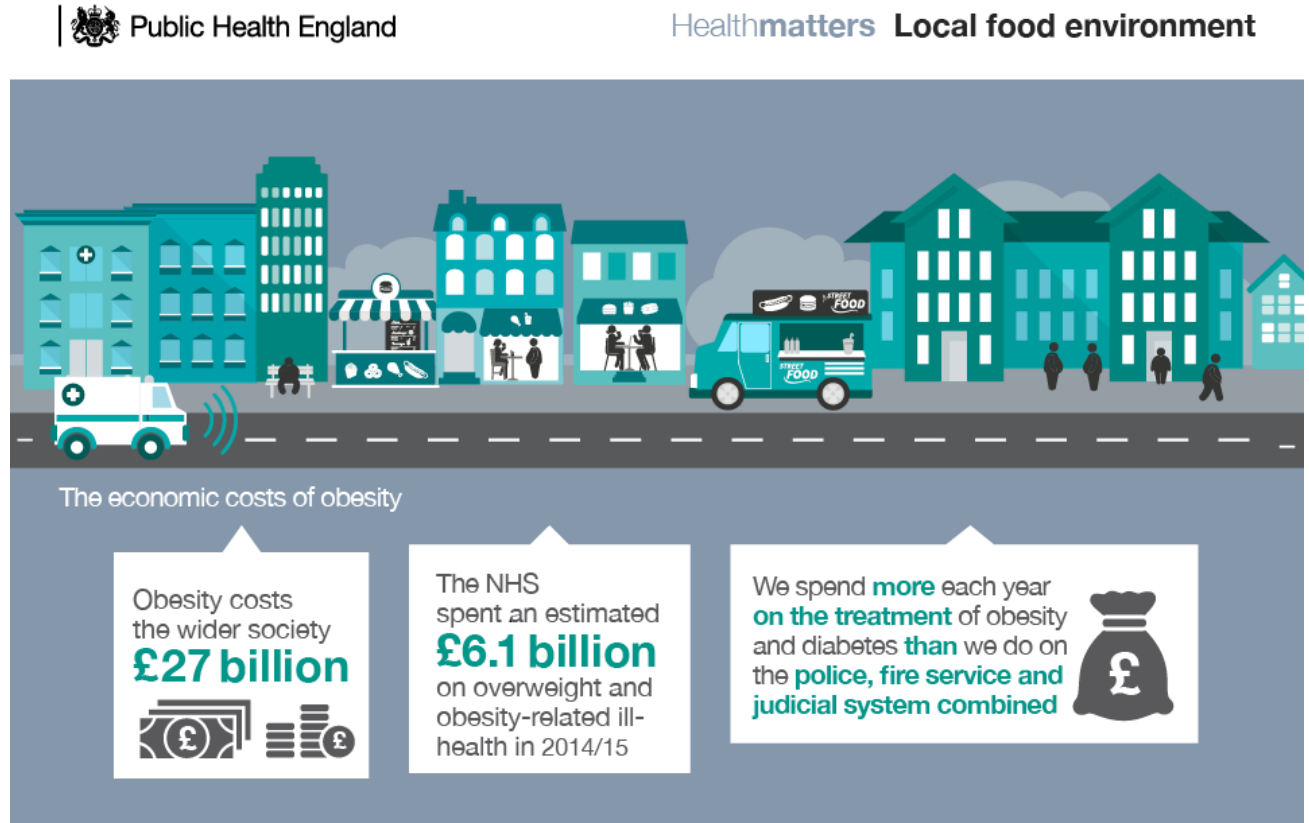
### **Economic**

The financial strain on the NHS caused by obesity and associated illness is widely acknowledged. The annual costs attributable to the NHS across the UK, adjusted for inflation, were estimated to be £6.1 billion during the period 2014 to 2015 [20]. The Government projects this amount to escalate to more than £9.7 billion annually by 2050 [21].

OHID further highlights that the overall national spend on treating obesity and diabetes annually, surpasses the combined spending on the police, fire service, and

judicial system, with costs to wider society estimated to be around £27 billion. Similar to the projected increase in annual NHS costs, these broader societal costs are anticipated to escalate to approximately £49.9 billion per year by 2050 [22].

**Figure 8: Health Matters Local food environment [22]**



## Public Health in Lancashire

Public health is the science and art of preventing disease, prolonging life, and promoting health through the organised efforts of society. It also considers the principles of social justice and equity, promoting and protecting better health for all, leaving no-one behind. Rather than focussing on the health of the individual, public health works to protect and improve the health of communities and populations at local, regional, national, and global level [23].

The 2013 transfer of public health from the NHS to local government and PHE is considered to be one of the most significant extensions of local government powers and duties in a generation. It represented a unique opportunity to change the focus from treating sickness to actively promoting health and wellbeing [24]. It enabled better collaboration with other local government functions, supporting public health teams to better address some of the key determinants at a local level.

LCC's Public Health, Wellbeing and Communities service sits within the Growth, Environment, Transport and Health (GETH) directorate and is responsible for a range of activity aimed at making Lancashire a safer, fairer and healthier county for all<sup>12</sup>.

With regard to supporting healthy lifestyles, and healthy weight in particular, LCC Public Health – alongside other county council departments - undertakes a range of upstream, preventative work to support the health of residents across the county:

### ***System Leadership***

#### **Healthy Weight Declaration**

In 2017, LCC became the first two-tier authority to adopt the Healthy Weight Declaration (HWD)<sup>13</sup>. This initiative, developed by Food Active, represents a comprehensive, strategic and system-wide commitment made by all council departments. Its aim is to promote healthy weight in local communities, safeguard the health and wellbeing of staff and residents, and make a positive economic impact on health and social care. By adopting the HWD, LCC has demonstrated its commitment to addressing a variety of factors that contribute to unhealthy weight locally, with the goal of mitigating their effects on the health and wellbeing of our residents.

Figure 9 provides an overview of the commitments within the declaration, including controlling the proliferation of hot food takeaways through the development of local planning policy.

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<sup>12</sup> LCC's Director of Public Health's Annual Report on the current position of our county's health: <https://council.lancashire.gov.uk/documents/s229428/Appendix%20A.pdf>

<sup>13</sup> For more information on Food Active's Healthy Weight Declaration, visit: <https://foodactive.org.uk/what-we-do/influence-policy/local-authority-declaration-on-healthy-weight>



**Figure 9: Healthy Weight Declaration**

|  |
|--|
| <p><b>The Healthy Weight Declarations shows commitment to reducing weight in our communities, protecting health and well-being of staff and citizens, and making an economic impact on health and social care and the local economy by striving to:</b></p>  |
| <p><b>Strategic / System Leadership</b></p>  |
| 1. Implement the Local authority HWD as part of a long-term, 'systems-wide approach' to obesity  |
| 2. Advocate plans that promote a preventative approach to encouraging a healthier weight with local partners, identified as part of a 'place-based system' (e.g. Integrated Care System)   |
| 3. Support action at national level to help local authorities promote healthy weight and reduce health inequalities in our communities (this includes preventing weight stigma and weight bias)  |
| 4. Invest in the health literacy of local citizens to make informed healthier choices; ensuring clear and comprehensive healthy eating and physical activity messages are consistent with government guidelines  |
| 5. Local authorities who have completed adoption of the HWD are encouraged to review and strengthen the initial action plans they have developed by consulting Public Health England's Whole System Approach to Obesity, including its tools, techniques and materials   |
| <p><b>Commercial Determinants</b></p>  |
| 6. Engage with the local food and drink sector (retailers, manufacturers, caterers, out of home settings) where appropriate to consider responsible retailing such as offering and promoting healthier foods and drink options, and reformulating and reducing the portion sizes of high fat, sugar and salt (HFSS) products   |
| 7. Consider how commercial partnerships with the food and drink industry may impact on the messages communicated around healthy weight to our local communities. Such funding may be offered to support research, discretionary services (such as sport and recreation and tourism events) and town centre promotions  |
| 8. Protect our children from inappropriate marketing by the food and drink industry such as advertising and marketing in close proximity to schools; 'giveaways' and promotions at schools; at events on local authority-controlled sites  |
| <p><b>Health Promoting Infrastructures / Environments</b></p>  |
| <p><b>9. Consider supplementary guidance for hot food takeaways, specifically in areas around schools, parks and where access to healthier alternatives are limited</b></p>  |
| 10. Review how strategies, plans and infrastructures for regeneration and town planning positively impact on physical activity, active travel, the food environment, and food security (consider an agreed process for local plan development between public health and planning authorities)  |
| 11. Where Climate Emergency Declarations are in place, consider how the HWD can support carbon reduction plans and strategies, address land use policy, transport policy, circular economy waste policies, food procurement, air quality etc   |
| <p><b>Organised Change / Cultural Shift</b></p>  |
| 12. Review contracts and provision at public events, in all public buildings, facilities and 'via' providers to make healthier food and drinks more available, convenient, and affordable and limit access to high-calorie, low-nutrient foods and drinks (this should be applied to public institutions and scrutiny given to any new contracts for food and drink provision, where possible) |
| 13. Increase public access to fresh drinking water on local authority-controlled site, (keeping single use plastics to a minimum) and encouraging re-usable bottle refills   |
| 14. Develop an organisational approach to enable and promote active travel for staff, patients and visitors, whilst providing staff with opportunities to be physically active where possible (e.g. promoting stair use, standing desk, cycle to work/school schemes)  |
| 15. Promote the health and wellbeing of local authority staff by creating a culture and ethos that promotes understanding of healthy weight, supporting staff to eat well and move more  |
| <p><b>Monitoring and Evaluation</b></p>  |
| 16. Monitor the progress of our action plan against commitments, report on and publish the results annually.   |

### **Lancashire Healthier Places**

To further support and progress the commitments of the Healthy Weight Declaration and strengthen existing activities, the county council has established a work programme with Food Active: Lancashire Healthier Places<sup>14</sup>.

Lancashire Healthier Places takes a system-wide approach to transforming the food environment, focusing on three levers for change: system leadership and the adoption of district-level HWDs, business engagement, and social movement. The dual strategy of top-down leadership and bottom-up community engagement aims to ensure that policies and actions resonate with the needs of local people, whilst seeking to align district policies to support public health, demonstrates a proactive stance towards building a healthier society.



### **Food Plan**

LCC is currently developing a Food Plan, looking at the whole food system and identifying areas for improvement to support health, the environment, and the economy, particularly across those areas that the council has direct control or influence over. Policies such as those outlined within this advice note, form part of this wider work to support an improved food system.

### **Targeted Support**

LCC in collaboration with each of the 12 Lancashire districts, commissions services to support people with healthy behaviours. Services are provided for adults and families.

### **Adult Healthy Weight Support (AHWS)**

AHWS aims to contribute to a reduction in rise of unhealthy weight prevalence in adults and reverse the trend. The service is accessible for adults aged 18+ years, primarily supporting those with a BMI >30, to improve health, lose weight and to improve knowledge and skills to maintain a healthier weight.

Local providers deliver a multi-component service linking with existing programmes, offering advice and motivation in relation to diet and behaviour change and promoting increased physical activity within their localities. This service forms an integral part of the NHS Health Check care pathway and wider obesity pathways.

### **Family Healthy Lifestyle Programme**

To support families to adopt healthy behaviours, a family healthy lifestyle programme, formerly known as PASTA (play and skills at Tea-time Activities), has also been implemented. These fun and friendly activity programmes provide opportunities for families to learn to cook easy and affordable meals, to get support,

<sup>14</sup> <https://www.lancashirehealthierplaces.org/home>

and to encourage the trying of new foods, taking part in fun activities, and socialising with other families. Over the past year (2023/24), 931 families across Lancashire have attended this programme.

### **Wider work**

#### **Food for Life Schools Award**

LCC also works with the Soil Association to implement the Food for Life Schools Award. The Food for Life programme "is about making good food the easy choice for everyone – making healthy, tasty and sustainable meals the norm for all to enjoy, reconnecting people with where their food comes from, teaching them how it's grown and cooked, and championing the importance of well-sourced ingredients".

The Award is a way for schools to demonstrate a commitment for healthy food and food education. As part of this, the county council's traded service for school meals earned the Food for Life silver catering award by providing menus containing locally sourced, organic food, reformulated to be low in fat, salt and sugar. By the end of 2025, LCC aims to have 145 schools enrolled on the award scheme across Lancashire.

#### **Lancashire Learning for Life Award**

The Lancashire Learning for Life Award<sup>15</sup> has been created by a steering group of professionals including LCC Advisors; Consultants; teaching professionals across all phases of education and the Lancashire Professional Development Team.



Personal development as well as personal, social, health and economic (PSHE) education are pivotal in developing learners' skills to navigate the world in which they live. An effective Personal Development programme is bespoke to the individual needs of a school demographic.

This inclusive award allows schools to evaluate their current practice and celebrate the opportunities that they offer to their pupils and the wider community. It is split into six key areas, including 'Our wellbeing', and invites schools to gather evidence of their good practice in demonstrating their commitment to go above and beyond the statutory guidance and promote pupils' learning for life in relation to each of these areas.

#### **Health Visiting and School Nursing Services**

The county council also commissions Health Visiting<sup>16</sup> and Public Health School Nursing<sup>17</sup> services. Service delivery is universal and offered to all local families, aiming to:

- Promote health and wellbeing and therefore improving the outcomes for children and young people.

<sup>15</sup> <https://www.lancashire.gov.uk/lpds/teaching-and-learning/pshe-education/lancashire-learning-for-life/>

<sup>16</sup> <https://lancsyounpeoplefamilyservice.co.uk/health-visiting/>

<sup>17</sup> <https://lancsyounpeoplefamilyservice.co.uk/school-nursing/>

- Identify need at the earliest opportunity.
- Reduce health inequalities by identifying and supporting vulnerable families or children/young people with identified need.

The Lancashire School Nursing services deliver the National Child Measurement Programme (NCMP), a nationally mandated public health programme providing national data on childhood obesity as part of the government's approach to tackling obesity. The service includes issuing advisory letters to families with regard to healthy weight and offering signposting to further support as required. The School Nursing services facilitate electronic health questionnaires to children in Years 6 and 9. These questionnaires aid school and population understanding of health needs, including with regard to diet and exercise.

The Health Visitor team offer five mandated visits to local families: The Ante-Natal Contact, New Birth Visits, 6-8-Week Contact, 12-Month Contact and 2 ½-year Review. Within these contacts, infant feeding information, advice, and support will be given, subject to the needs of the family. For example, the health visitor team will advise about breastfeeding, bottle feeding, introduction of complementary foods, healthy weight, and the importance of play and physical activity as appropriate at individual contacts.

The Health Visitor service also have a specialist Infant Feeding Team who provide enhanced levels of advice and care. They also facilitate the Baby Friendly Initiative (BFI) accreditation for LCC's commissioned Public Health services.

Lancashire's Infant Feeding Breastfeeding Peer Support service is also commissioned by the county council to provide flexible and timely support for mothers in the early weeks after giving birth, to support a mother's breastfeeding journey. The service works in partnership with both Lancashire's 0-19s Public Health Nursing Service and LCC's Children and Family Wellbeing Service as part of Lancashire's BFI award, to signpost mothers to local infant feeding provision to support their infant feeding journey.

## Local Context

### *Adult Obesity*

Over the last four decades, there has been an increase in the proportion of adults living with obesity in England:

- An analysis of data from the **1980** National Heights and Weights Survey estimated that the prevalence of obesity in England stood at **6%** of men and **9%** of women aged 16 and over, with 0.1% of men and 0.4% of women living with severe obesity [25].
- In **1993**, the HSE reported that the prevalence of obesity (including morbid obesity) among men and women in this same age group was **13%** and **16%** respectively [25].
- In more recent years (**2021**), the HSE reported prevalence of obesity (including morbid obesity) among men and women aged 16+ as standing at **25%** and **26%** respectively [26].

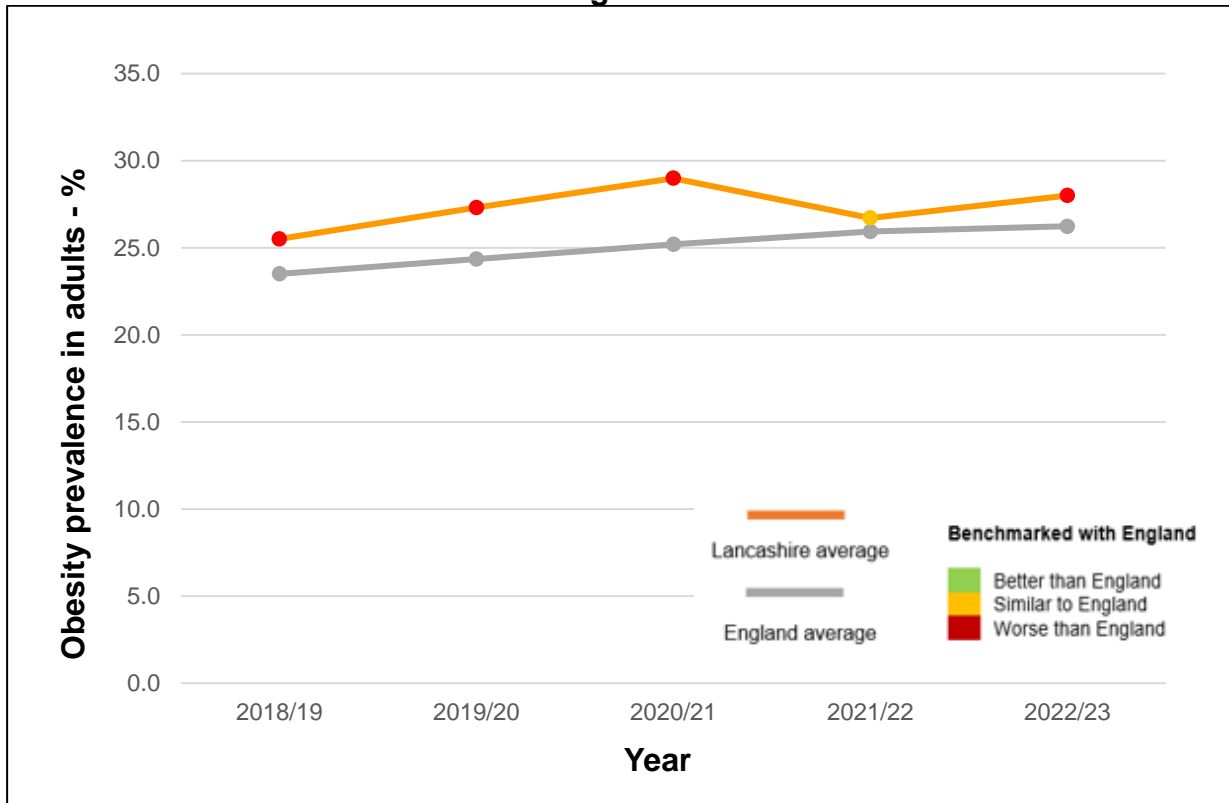
At a more localised level, there has been a noticeable upward trend in the prevalence of obesity among adults in Lancashire, with the percentage of adults identified as obese rising from 23.5% in 2017/18 to 28% in 2022/23 (see Figure 10). This increase is statistically significant, indicating a growing public health concern in the county<sup>18</sup>.

The statistical similarity of obesity prevalence among adults in Lancashire compared to the England average has fluctuated over time. Data indicates that Lancashire had a higher obesity prevalence than the England average from 2018/19 to 2020/21, then decreasing in 2021/22 to levels similar to the national average. In the most recent years (2022/23), however, prevalence in Lancashire has risen again to 28% - a value statistically worse than England.

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<sup>18</sup> The OHID obesity indicator for adults presents local authority estimates from Sport England's Active Lives Adult Survey (ALAS). ALAS has been chosen as the data source for this indicator as it provides routine, robust data for BMI calculations at local authority level which will support local monitoring of obesity estimates for the appropriate ages. HSE data is not used for this indicator as whilst data are available at regional level, the sample sizes do not allow for local authority estimates to be produced.

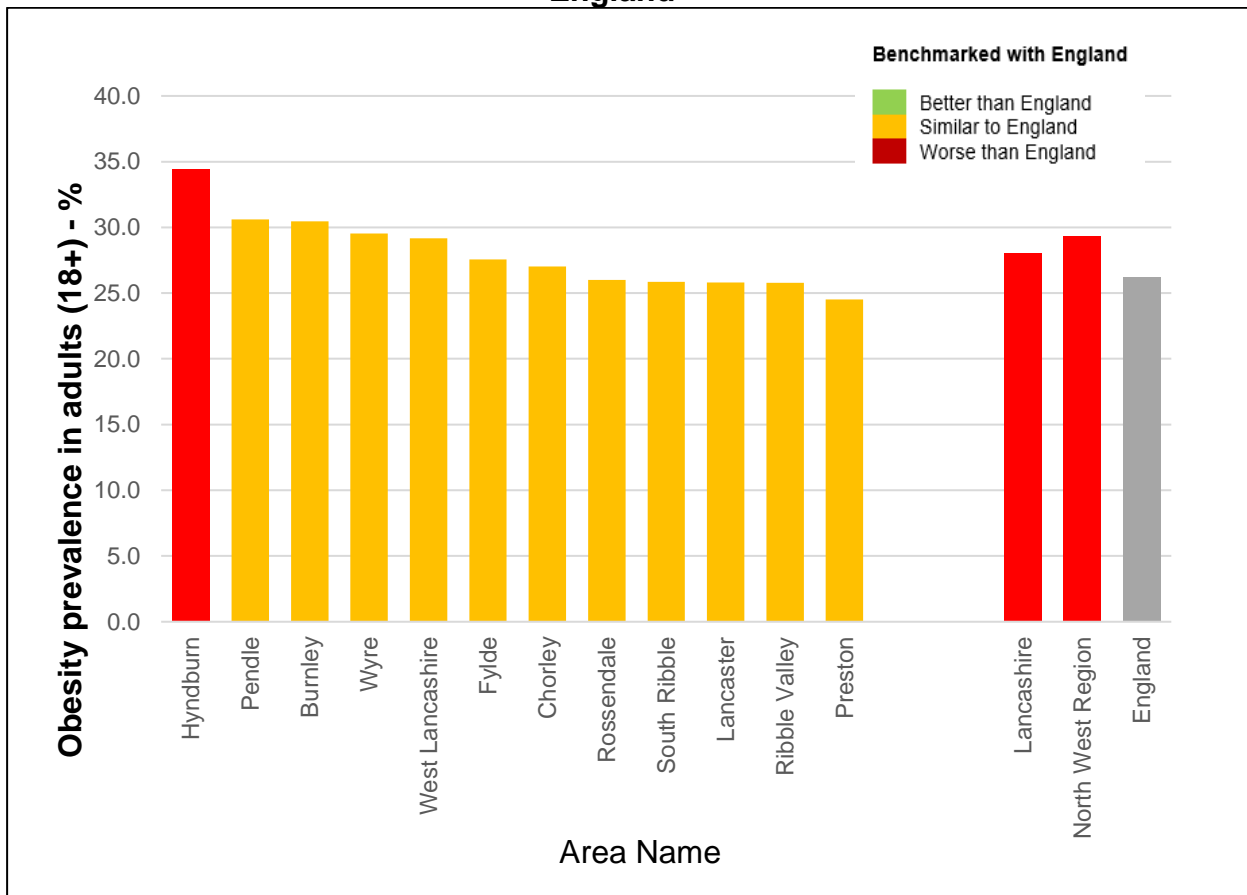
**Figure 10: Adult obesity prevalence (2018/19 - 2022/23) - Lancashire and England**



Source: OHID, Fingertips

Among its 15 closest NHS statistical neighbours, Lancashire ranks 3<sup>rd</sup> highest in terms of average values for adult obesity. Specifically, it falls behind only Essex and Staffordshire. Statistically, the Lancashire average is worse than 5 of its neighbouring regions: Hampshire, West Sussex, Cambridgeshire, Hertfordshire, and Surrey. Notably, Lancashire does not have a better statistical average than any of these 15 neighbours.

At a more hyper-local level, Hyndburn was the only Lancashire district to record an adult obesity rate significantly worse than both the England and Lancashire averages in the period 2022/23, at 34.4% (see Figure 11).

**Figure 11: Adult obesity prevalence (2022/23) - Lancashire, North West and England**

Source: OHID, Fingertips

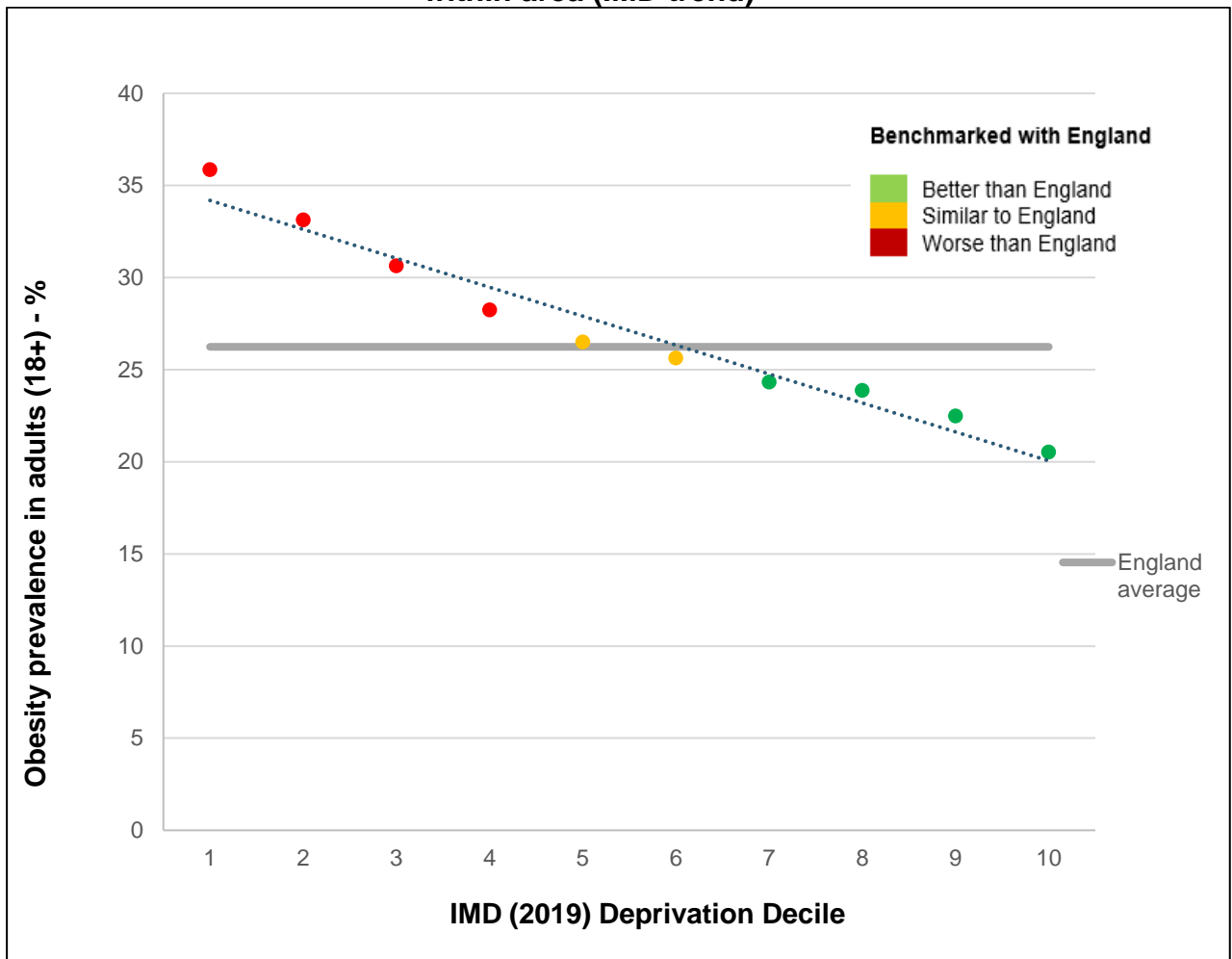
During the most recent 5-year period (2017/18 – 2022/23), only Pendle and Ribble Valley experienced a statistically significant increase in adult obesity prevalence when compared with the remaining 10 Lancashire districts. Pendle's rate rose from 20.9% to 30.6%, while Ribble Valley's increased from 17.8% to 25.8%. These changes align with the overall trends observed nationally (23.1% to 26.2%) and at the county-level (23.5% to 28.0%).

## Inequalities

When national adult obesity prevalence data is partitioned by data from the IMD (2019), a social gradient<sup>19</sup> can be clearly identified (Figure 12). Within Figure 12, the four least deprived deciles (deciles 7 – 10) are shaded green, showing statistically better rates than the England average, whilst the four most deprived deciles (deciles 1 – 4) are shaded red to show statistically worse rates.

<sup>19</sup> The social gradient in health is a term used to describe the phenomenon whereby people who are less advantaged in terms of socioeconomic position have worse health than those who are more advantaged.

**Figure 12: Adult obesity prevalence (2022/23) by LSOA11 deprivation deciles within area (IMD trend)**



Source: OHID, Fingertips



## **Childhood Obesity**

The risks of obesity and of future obesity-related ill health in adulthood are greater as children get older [27]. Studies tracking child obesity into adulthood have found that the probability of children who are overweight or living with obesity becoming overweight or obese adults increases with age [28] [29] [30].

In England, local authorities are mandated to collect data from mainstream state-maintained schools via the NCMP<sup>20</sup>. The NCMP collects height and weight measurements of children across both Reception and Year 6. The programme is recognised internationally as a world-class source of public health intelligence, holds UK National Statistics status and is used to inform local public health initiatives and services [31].

In the latest period (2022/23), the NCMP reported that 9.1% of Reception children and 22.1% of Year 6 children in Lancashire are classified as being obese, including severely obese. The latter figure has been on an upward trend when examined over the last 5 years (2017/18 to 2022/23)<sup>21</sup>. Figure 13 provides a comparative snapshot of this trend.

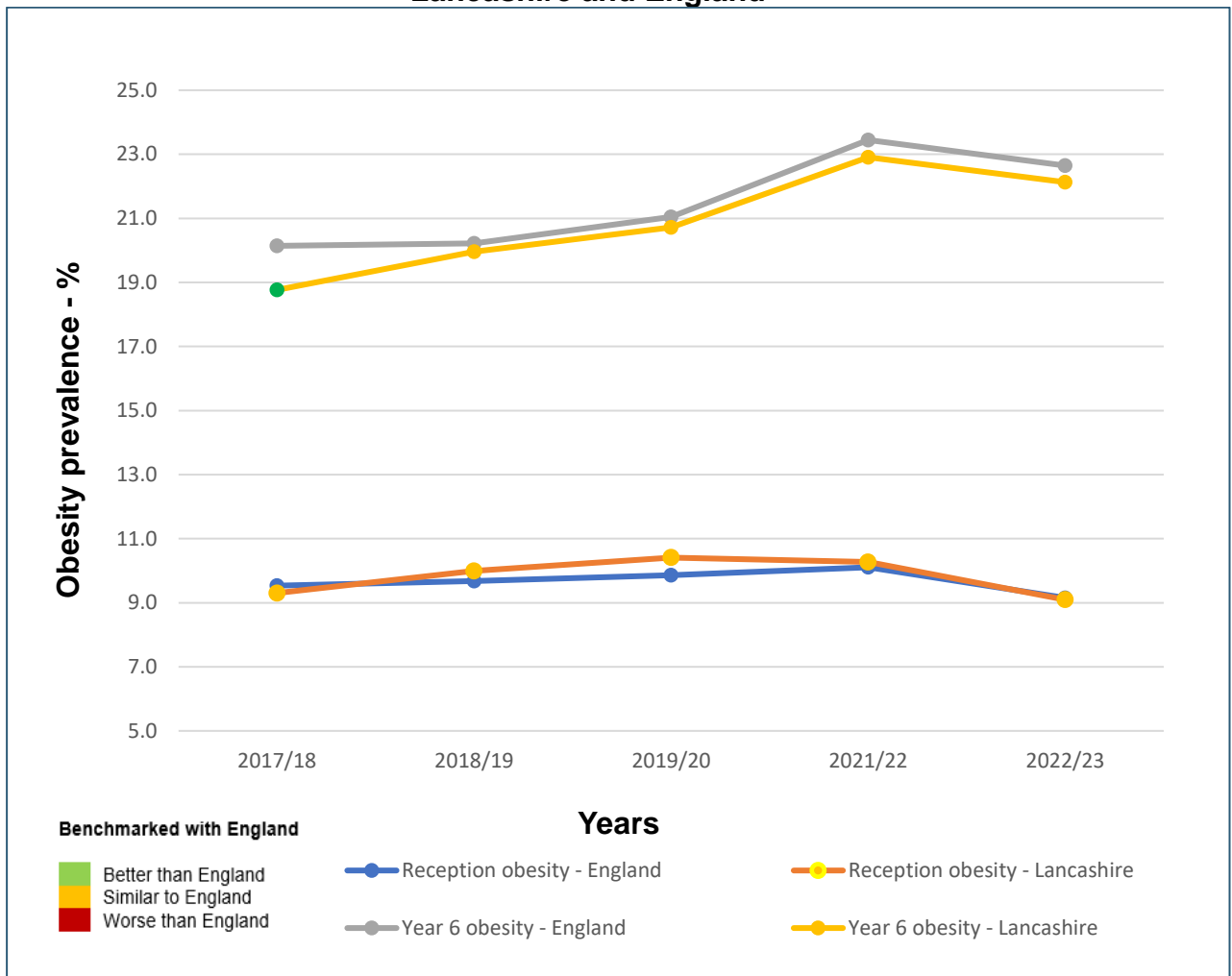
On a more local scale, among the 12 districts of Lancashire, Burnley currently records the highest average rate of childhood obesity across both age groups. Notably, these figures are significantly above the national averages, making Burnley the only district in Lancashire with this distinction.

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<sup>20</sup> Local authorities are mandated to collect data from mainstream state-maintained schools but collection of data from special schools (schools for pupils with special educational needs and pupil referral units) and independent schools is encouraged. Since the proportion of records from independent and special schools is low and varies each year, analysis of NCMP data by NHS England and Department for Health and Social Care (DHSC) excludes such records to ensure consistency over time. There are also concerns around how representative the participating independent and special schools would be. There is the potential for error in the collection, collation and interpretation of NCMP data (bias may be introduced due to poor response rates and selective opt out of children with a high BMI for age/sex which it is not possible to control for).

<sup>21</sup> 2020/21 data is excluded from the '5-years data combined' indicators due to the impact of the COVID-19 Pandemic.

**Figure 13: Reception and Year 6 obesity prevalence (2017/18 - 2022/23) - Lancashire and England**

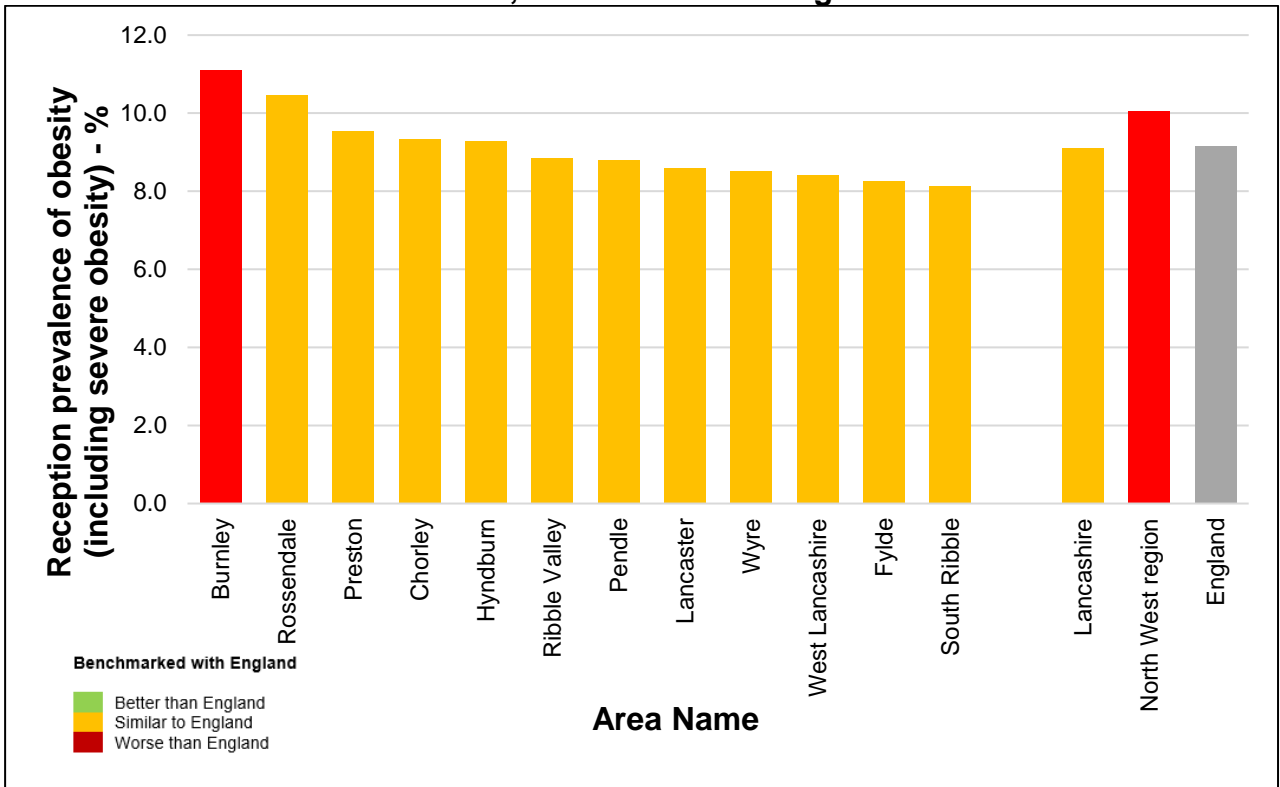


Source: OHID, Fingertips

In Lancashire, only 3 districts - South Ribble, Wyre, and Ribble Valley - have obesity rates for Year 6 children that are significantly lower than the national average. Interestingly, none of the county's 12 districts have obesity rates for Reception children that are significantly better than the England average.

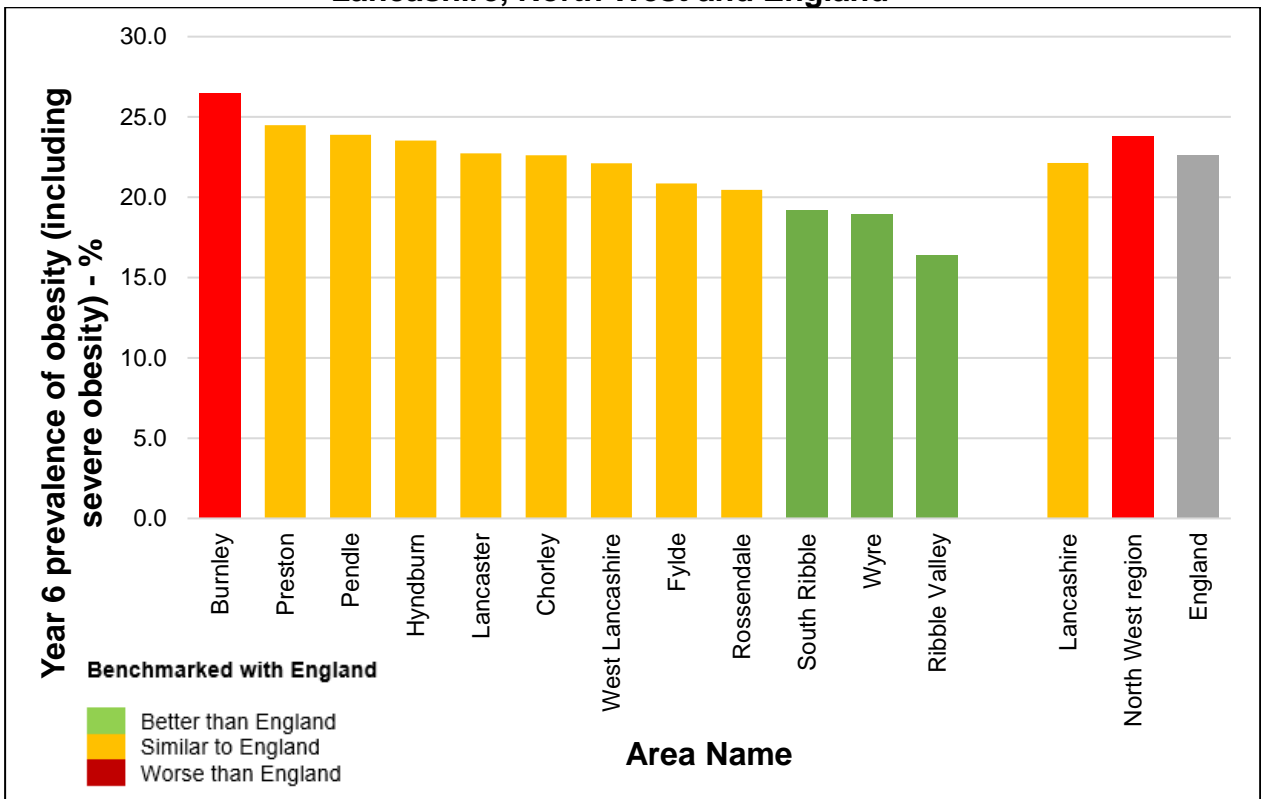
Figures 14 and 15 offer a detailed overview of the obesity rates for Reception and Year 6 children across all 12 districts in Lancashire. Each district has been compared to the England average and accordingly color-coded for easy interpretation.

**Figure 14: Reception prevalence of obesity (including severe obesity) (2022/23) - Lancashire, North West and England**



Source: OHID, Fingertips

**Figure 15: Year 6 prevalence of obesity (including severe obesity) (2022/23) - Lancashire, North West and England**



Source: OHID, Fingertips

## Inequalities

Over the past 5 years, across England, the gap in obesity rates between the most disadvantaged and the least disadvantaged socioeconomic groups has widened for both Reception Year and Year 6 children.

By integrating individual record-level NCMP data with data from the IMD (2019), we can investigate the existence and extent of a socioeconomic gradient in childhood obesity rates on the local scale.

Tables 3 and 4 present this analysis at the Lancashire-level, showing the gap in average obesity rates between children living within our most and least disadvantaged socioeconomic areas. A graded colour scale has been applied to better illustrate the social gradient:

**Table 3: Reception prevalence of obesity (including severe obesity) (%) (2019/20-2022/23) by IMD (2019) quintile - Lancashire.**



| 2019 IMD quintile      | Reception prevalence of obesity (including severe obesity) (4-5 years) (2019/20 – 2022/23) |
|------------------------|--|
| 1 (20% most deprived)  | 12.0%  |
| 2                      | 10.3%  |
| 3                      | 9.1%   |
| 4                      | 8.2%   |
| 5 (20% least deprived) | 7.2%   |

Source: OHID, Fingertips

**Table 4: Year 6 prevalence of obesity (including severe obesity) (%) (2019/20-2022/23) by IMD (2019) quintile - Lancashire.**

| 2019 IMD quintile      | Year 6 prevalence of obesity (including severe obesity) (10-11 years) (2019/20 – 2022/23) |
|------------------------|---|
| 1 (20% most deprived)  | 26.8%   |
| 2                      | 23.7%   |
| 3                      | 20.2%   |
| 4                      | 18.6%   |
| 5 (20% least deprived) | 15.4%   |

Source: OHID, Fingertips

This data suggests a clear socioeconomic gradient in obesity rates, with the 20% most deprived areas (quintile 1) experiencing significantly higher rates of obesity compared to less deprived areas. Moreover, the obesity rates in the most deprived areas also exceeded the overall Lancashire average for both measures, which stand at 9.8% and 22.0% respectively.

### Overweight and Obesity

The obesity indicator data used in this analysis is a subset of the broader indicator that measures the percentage of children (both Reception and Year 6 age groups) classified as overweight or obese, as also provided by the NCMP. OHID recommends integrating these two indicators to deepen our understanding of obesity trends. By tracking these indicators over time, for example, we can gain insights into how populations may shift between different BMI categories.

Figure 16 provides a theoretical depiction of how children in Lancashire progress across different BMI categories over time. By analysing NCMP data from 2016/17 and 2022/23, we aim to demonstrate weight changes among Reception and Year 6 students during their primary school years.

A notable observation from this analysis is that over the 6-year period from Reception to Year 6, the majority of children initially classified as ‘overweight’ at the start of primary school transitioned to being classified as ‘obese’ or ‘severely obese’ by the end of their primary education.

In parallel, a theoretical shift was also observed among some children who were initially considered to be of a healthy weight in Reception, who moved up the BMI scale to be classified as ‘overweight’ by Year 6.

**Figure 16: Prevalence of overweight (including obesity and severe obesity) in Reception (2016/17) and Year 6 (2022/23) pupils - Lancashire.**



Source: OHID, Fingertips

## Hot Food Takeaways

In the wake of the COVID-19 pandemic, the UK government laid out its latest policy to tackle obesity, entitled "Tackling obesity: empowering adults and children to live healthier lives". Whilst the policy itself is very broad, it does specifically reference the impact of takeaways on obesity:

**"On average the portions of food or drink that people eat out or eat as takeaway meals contain twice as many calories as their equivalent bought in a shop" [32].**

Prior to this publication, the Government also developed a toolkit (last updated September 2019) [33] which was focussed on encouraging healthier 'out of home' food provision. Within the document, they recognise the role the planning system has in improving our food environment especially with regards to restricting new hot food takeaways:

**"Planning documents and policies to control the over concentration and proliferation of hot food takeaways could form part of an overall plan for tackling obesity and can involve a range of different local authority departments and stakeholders.**

**Once appropriate planning policies are in place, supported by local evidence, local councils can refuse planning permission for a new food outlet if they can demonstrate that it will have an adverse impact on the health and wellbeing of the local population and will undermine the local authority's strategy to tackle obesity" (2019, pg. 27).**

The NICE Public Health Guideline on cardiovascular disease prevention [34] also recommends action to encourage LPAs to restrict planning permission for takeaways and other food retail outlets in specific areas (for example, within walking distance of schools).

### ***Evidence***

In England, two of the main types of planning policy used to promote a healthy food environment through the restriction of hot food takeaways include: 1) restricting new outlets if childhood obesity rates are above a certain threshold, and 2) restricting new outlets near schools [35].

In the subsequent section, we provide a concise overview of a series of research studies pertinent to these two areas of planning policy. The studies, structured by their aims, findings, and implications, are presented in reverse chronological order.

| Study  | Authors  | Aims   | Findings   | Implications   |
|--|--|--|--|--|
| Examining the interaction of fast-food outlet exposure and income on diet and obesity: evidence from 51,361 UK Biobank participants  | Burgoine, T; Sarkar, C; Webster, C.J; Monsivais, P (2018) [36] | The study investigates the relationship between neighbourhood fast-food outlet exposure, household income, diet, and obesity among UK adults.                        | <b>Both income and fast-food outlet exposure are independently associated with higher BMI, body fat, obesity, and frequent processed meat consumption.</b> The study also finds evidence of an additive interaction between low income and high fast-food outlet exposure, leading to greater odds of obesity. | <b>The results suggest that individuals with lower income living in areas with a high proportion of fast-food outlets face a double burden,</b> contributing to social inequalities in health. The findings support the use of targeted policies to regulate neighbourhood fast-food access.     |
| Weight gain in mid-childhood and its relationship with the fast food environment   | Pearce, M; Bray, I; Horswell, M (2017) [37]                    | The study aimed to assess the relationship between children's weight gain and the accessibility of fast-food outlets   | The research found that <b>children with greater access to fast-food outlets were more likely to experience significant weight gain</b> compared to those with less or no access   | <b>The paper suggests that the prevalence of fast-food outlets, especially in areas of deprivation, may contribute to childhood obesity.</b> It supports the idea that policies targeting the number of fast-food outlets could positively impact public health.                                 |
| Associations between exposure to takeaway food outlets, takeaway food consumption, and body weight in Cambridgeshire, UK: population | Burgoine, T; Forouhi, N; Griffin, S.J et al (2014) [38]        | The study investigates the relationship between exposure to takeaway food outlets and its impact on takeaway food consumption and body weight in Cambridgeshire, UK. | <b>Higher exposure to takeaway food outlets, especially at work, was associated with increased consumption of takeaway food and higher body mass index (BMI).</b> A dose-response relationship was observed, indicating that greater exposure led to   | <b>The study suggests that planning restrictions on takeaway food outlets, particularly around workplaces, may contribute to healthier diets and lower obesity rates.</b> The findings support the idea that environmental interventions could be effective in promoting better health outcomes. |

|   |   |   |  |  |
|---|---|---|--|--|
| <p>based, cross sectional study</p>   |   |   | <p>higher takeaway food consumption and BMI.</p>   |  |
| <p>The number and type of food retailers surrounding schools and their association with lunchtime eating behaviours.</p>        | <p>Seliske L, Pickett W, Rosu A, Jassen I (2013) [39]</p> | <p>The study sought to examine whether the presence of food retailers surrounding Canadian schools was associated with students' lunchtime eating behaviours.</p> | <p>The study found that the food retail environment surrounding schools is strongly related to student's eating behaviours during the school day.</p>  | <p><b>The findings of this study support the development of policies to improve eating behaviours among students by addressing the food retail environment surrounding schools.</b></p>  |
| <p>Does the local food environment around schools affect diet? Longitudinal associations in adolescents attending secondary</p> | <p>Smith, D; Cummins, S; Clark, C et al (2013) [40]</p>   | <p>The study investigates the impact of the local retail food environment around secondary schools on adolescents' diets over time in East London.</p>            | <p>Between 2001 – 2005, the number of grocers/convenience stores within 400m and 800m of schools increased. Longitudinal analysis showed a decrease in both 'healthy' and 'unhealthy' diet scores among students. <b>Small but significant relationships</b></p> | <p><b>The study suggests that the local food environment around schools may have a small influence on adolescent diet.</b> The findings highlight the need for further research on adolescents' food purchasing habits and the role of the food environment in shaping dietary choices. The paper calls for a more nuanced understanding of the classification of food outlets and their impact on diet.</p> |



|   |   |   |  |   |
|---|---|---|--|---|
| schools in East London  |   |   | <b>were found between the distance to grocers and healthy diet scores, as well as proximity to takeaways and unhealthy diet scores.</b>  |   |
| Obesogenic neighbourhoods: the impact of neighbourhood restaurants and convenience stores on adolescents' food consumption behaviours | He, M; Tucker, P; Irwin, J.D et al (2012) [41]      | The study investigates the relationship between adolescents' dietary intake and the neighbourhood food environment, focusing on the impact of nearby restaurants and convenience stores on food consumption behaviours. | Proximity to convenience stores correlates with lower HEI scores, indicating poorer diet quality. Similarly, <b>the presence of convenience and fast-food outlets near schools is associated with lower HEI scores among students.</b> | <b>The findings suggest that the neighbourhood food environment, particularly the availability of convenience stores and fast-food outlets, influences adolescents' dietary behaviours,</b> highlighting the need for strategies to support healthier food choices. |
| Do obesity-promoting food environments cluster around socially disadvantaged schools in Glasgow, Scotland?                            | Ellaway, A; Macdonald, L; Lamb, K et al (2012) [42] | The study investigates whether food environments that promote obesity cluster around secondary schools in Glasgow, particularly focusing on areas of social disadvantage.   | <b>The study found clustering of food outlets around schools, with a complex pattern in relation to deprivation.</b> There were numerous opportunities for pupils to purchase energy-dense foods near schools.                         | <b>The results suggest the need for policy interventions to address the food environment around schools to support healthier dietary behaviours among adolescents.</b> This includes considering local planning guidelines and promoting healthier food options.    |
| The effect of fast food restaurants on obesity and weight gain  | Currie, J; DellaVigna, S; Moretti, E;               | The study aims to identify the causal effect of the increase in fast food supply  | <b>Proximity to a fast-food restaurant within 0.1 miles of a school is linked to a 5.2% increase in obesity</b>  | <b>The research suggests that the presence of fast-food restaurants near schools significantly affects obesity rates among students, indicating that targeted policies to</b>   |

|  |                                    |   |   |  |
|--|------------------------------------|---|---|--|
|  | Pathania, V (2009) [43]            | on obesity rates among school children and weight gain among pregnant women   | <b>rates among 9th graders.</b> For pregnant women, a fast-food restaurant within 0.5 miles of residence is associated with a 1.6% increase in the probability of gaining over 20 kilos, with larger effects for African American and less educated women | <b>limit access to fast food for school children could be effective in reducing obesity rates.</b> The impact on adults is smaller, suggesting broader policies may be less effective. |
| Proximity of Fast-Food Restaurants to Schools and Adolescent Obesity | Davis, B; Carpenter, C (2008) [44] | The study investigates the impact of fast-food restaurant proximity to schools on adolescent obesity in California. | <b>Students in schools located near fast-food restaurants consumed fewer fruits and vegetables, more soda, and had higher odds of being overweight or obese</b> compared to students whose schools were not near fast-food restaurants.                   | <b>The study suggests that policy interventions limiting the proximity of fast-food restaurants to schools could be an effective strategy to reduce adolescent obesity.</b>            |

## **Local Context**

Since 2012, data collected by environmental health officers for the Food Standards Agency (FSA) Food Hygiene Rating Scheme (FHRS) including the geographical coordinates of all businesses/premises where food is consumed, sold or provided for all local authorities in England, Scotland, Wales and Northern Ireland have been made available online [45]. The types of premises listed include hot food takeaways<sup>22</sup>. Using this data, we are able to understand to a greater degree of accuracy, the localised picture with regard to takeaway prevalence, change over time, rates, and variation across space, at a range of geographic levels including national, regional, county and district<sup>23</sup>.

Table 5 shows the change in the total number of hot food takeaways across each Lancashire district, between the years of 2018 to 2024. A graded colour scale has been applied to each row to highlight change over time more clearly, whereby the darkest green colour shows the lowest values (i.e., the lowest count of total hot food takeaways) and the darkest red showing the highest values (i.e., the highest count of total hot food takeaways) within each individual district. The table has been ordered alphabetically by district.

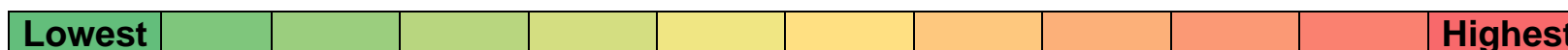
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<sup>22</sup>All local authorities are required to upload data of recently inspected premises at least every 28 days. This data is free and accessible via <https://ratings.food.gov.uk/open-data>. Historical data is available to access via the National Archives:

<https://webarchive.nationalarchives.gov.uk/ukgwa/20161220090742/http://ratings.food.gov.uk/search-a-local-authority-area/en-GB>

<sup>23</sup> FSA FHRS data was downloaded for each Lancashire district across the years 2018 – 2024. Data relating to all Business types other than those recorded as 'Takeaway/sandwich shop' were removed. Any outlet with no recorded postcode was also removed.

Table 5: Number of hot food takeaways recorded by Lancashire district (2018 – 2024)



| Area              | 2018        | 2019        | 2020        | 2021        | 2022        | 2023        | 2024        |
|-------------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|
|                   | Count       | Count       | Count       | Count       | Count       | Count       | Count       |
| <b>Lancashire</b> | <b>1223</b> | <b>1248</b> | <b>1287</b> | <b>1380</b> | <b>1408</b> | <b>1385</b> | <b>1385</b> |
| Burnley           | 132         | 128         | 147         | 149         | 155         | 144         | 138         |
| Chorley           | 106         | 114         | 115         | 121         | 120         | 121         | 121         |
| Fylde             | 79          | 78          | 80          | 82          | 77          | 70          | 64          |
| Hyndburn          | 109         | 112         | 119         | 121         | 136         | 128         | 129         |
| Lancaster         | 124         | 121         | 127         | 133         | 136         | 135         | 128         |
| Pendle            | 87          | 88          | 87          | 92          | 97          | 103         | 113         |
| Preston           | 177         | 189         | 195         | 205         | 207         | 197         | 200         |
| Ribble Valley     | 53          | 52          | 51          | 57          | 61          | 61          | 62          |
| Rosendale         | 76          | 74          | 80          | 106         | 108         | 108         | 108         |
| South Ribble      | 99          | 104         | 91          | 106         | 106         | 107         | 108         |
| West Lancashire   | 68          | 68          | 71          | 77          | 78          | 85          | 86          |
| Wyre              | 113         | 120         | 124         | 131         | 127         | 126         | 128         |

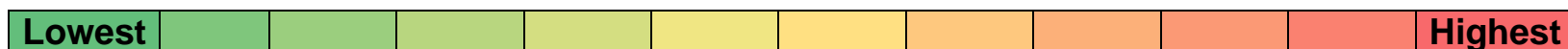
Source: FSA, FHRS

From Table 5, we can see that each of the 12 Lancashire districts recorded their highest counts of hot food takeaways within one of the four most recent years (2021-2024). At the time of publishing this note (2024), 6 of the 12 districts record a peak takeaway count (Chorley, Pendle, Ribble Valley, Rossendale, South Ribble, West Lancashire).

Table 6 also illustrates the variation in the number of takeaways per district between 2018 and 2024, along with the corresponding percentage change. The table is arranged in alphabetical order by district name, and a graded colour scale applied to highlight the districts with the highest and lowest percentage changes. Notably, Rossendale experienced the most significant percentage increase in hot food takeaways between 2018 and 2024, nearly doubling its count during this period. Pendle and West Lancashire followed closely, with the second and third highest percentage increases at 29.9% and 26.5%, respectively.

During the six-year period shown, 11 of the 12 districts experienced an overall increase in the total number of hot food takeaways located within their boundaries. Fylde, however, stood out as the only outlier, instead witnessing a decrease in takeaway numbers over time (-19%). On a broader scale, Lancashire as a whole saw a 13.2% increase in the total number of hot food takeaways, resulting in a net addition of 162 outlets of this type.

Table 6: Difference in number of hot food takeaways recorded by Lancashire districts (2018 – 2024)



| Area            | Difference (2018 - 2024) | Percentage Change (2018 - 2024) |
|-----------------|--------------------------|---------------------------------|
| Lancashire      | 162                      | 13.2%                           |
| Burnley         | 6                        | 4.5%                            |
| Chorley         | 15                       | 14.2%                           |
| Fylde           | -15                      | -19.0%                          |
| Hyndburn        | 20                       | 18.3%                           |
| Lancaster       | 4                        | 3.2%                            |
| Pendle          | 26                       | 29.9%                           |
| Preston         | 23                       | 13.0%                           |
| Ribble Valley   | 9                        | 17.0%                           |
| Rossendale      | 32                       | 42.1%                           |
| South Ribble    | 9                        | 9.1%                            |
| West Lancashire | 18                       | 26.5%                           |
| Wyre            | 15                       | 13.3%                           |

Source: FSA, FHRS

Table 7 depicts the count of hot food takeaways per district as a crude rate per 100,000 population between the years 2018 and 2022<sup>24</sup>. Crude rates can be a useful basis for initial comparison, also giving us a basic idea of how common a particular event, e.g., disease or condition, is within a population.

In April 2022, Lancashire recorded approximately 1,408 hot food takeaway outlets, resulting in a rate of 112.4 per 100,000 people (equivalent to 1 outlet for every 890 people)<sup>25</sup>. By comparison, the recorded England rate was 104.4 per 100,000 people (or 1 outlet for every 958 people)<sup>26</sup>. Table 7 provides both the count and rate of takeaway outlets for each of the 12 Lancashire districts during the same period. Notably, Hyndburn recorded the highest rate of outlets per 100,000 population in 2022 at 163.4 (136 premises, or 1 for every 612 people), while West Lancashire had the lowest rate at 65.3 (78 premises, or 1 for every 1,530 people).

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<sup>24</sup>Rate per 100,000 population cannot be calculated for 2023 and 2024 at the time of publication as the mid-year population estimates for these years have not yet been released.

<sup>25</sup> Rate is used when are concerned with the availability of, or exposure to, a variable by people. We have utilised ONS population statistics based on resident population across a local authority area. An ideal measure would require much more detailed information about the nature of population flows past takeaway outlets, which is not available.

<sup>26</sup>As calculated by FEAT: [Feat \(feat-tool.org.uk\)](https://www.feat-tool.org.uk) NB: FEAT uses a differing methodology to determine takeaway count. For more information on the methodology used by the FEAT, visit: <https://www.feat-tool.org.uk/?doc=about>

Table 7: Rate of hot food takeaways per 100,000 population by Lancashire district (2018 – 2022)

| Area                   | 2018         | 2019         | 2020         | 2021         | 2022         |
|------------------------|--------------|--------------|--------------|--------------|--------------|
|                        | Rate         | Rate         | Rate         | Rate         | Rate         |
| <b>Lancashire</b>      | <b>101.1</b> | <b>102.3</b> | <b>104.9</b> | <b>111.6</b> | <b>112.4</b> |
| <b>Burnley</b>         | 149.1        | 143.9        | 164.5        | 157.3        | 162.2        |
| <b>Chorley</b>         | 90.7         | 96.4         | 96.7         | 102.6        | 101.2        |
| <b>Fylde</b>           | 99.0         | 96.6         | 98.5         | 100.2        | 92.8         |
| <b>Hyndburn</b>        | 134.9        | 138.2        | 146.7        | 147.1        | 163.4        |
| <b>Lancaster</b>       | 86.0         | 82.9         | 85.7         | 93.6         | 94.2         |
| <b>Pendle</b>          | 95.2         | 95.5         | 94.4         | 96.0         | 100.9        |
| <b>Preston</b>         | 124.8        | 132.0        | 135.3        | 138.9        | 136.6        |
| <b>Ribble Valley</b>   | 88.2         | 85.4         | 82.2         | 92.1         | 96.7         |
| <b>Rossendale</b>      | 107.2        | 103.5        | 112.0        | 149.3        | 151.8        |
| <b>South Ribble</b>    | 89.6         | 93.9         | 81.9         | 95.3         | 94.5         |
| <b>West Lancashire</b> | 59.7         | 59.5         | 62.0         | 65.7         | 65.3         |
| <b>Wyre</b>            | 101.6        | 107.1        | 109.7        | 116.5        | 110.6        |

Source: FSA, FHRS & Office for National Statistics' Mid-Year Population Estimates.



## Inequalities

By analysing FSA data in conjunction with the IMD (2019), we can explore whether (and to what degree) a social gradient exists with regard to the prevalence of hot food takeaways across the county. This approach mirrors how we examined obesity data within the earlier section.

Table 8 provides an overview of hot food takeaway prevalence stratified by IMD deprivation quintile for the entire county. The graded colour scale highlights a clear social gradient: as deprivation decreases (indicating more affluent areas), the prevalence of hot food takeaways declines. Notably, just under half (46.4%) of all takeaways in Lancashire are concentrated within its 20% most deprived areas, while only 5.5% are located in its 20% least deprived areas.

**Table 8: Hot food takeaway prevalence (%) (2022) by IMD quintile (2019) - Lancashire**

| Lowest                 |  |  |  | Highest |
|------------------------|--|--|--|---------|
| 2019 IMD quintile      |  | Hot food takeaway prevalence (2022) - Lancashire |  |         |
| 1 (20% most deprived)  |  | 46.4%  |  |         |
| 2                      |  | 23.3%  |  |         |
| 3                      |  | 15.3%  |  |         |
| 4                      |  | 9.6%   |  |         |
| 5 (20% least deprived) |  | 5.5%   |  |         |

Source: FSA, FHRS

When examining the rate of hot food takeaways per 100,000 population, we observe a clear social gradient (as shown in Table 9). Specifically:

- In Lancashire's 40% most deprived areas, the rate of takeaway outlets is significantly higher than the 40% least deprived areas.
- Additionally, rates in Lancashire's 40% most deprived areas (quintiles 1 and 2) are statistically higher than the overall Lancashire rate.
- Conversely, the rates in the 40% least deprived areas (quintiles 4 and 5) are statistically lower than the overall Lancashire rate.

**Table 9: Rate of hot food takeaways per 100,000 population by IMD quintile (2019) - Lancashire**

| Lowest                 |                                      |                  |                               | Highest |
|------------------------|--------------------------------------|------------------|-------------------------------|---------|
| 2019 IMD quintile      | Mid-year population estimates (2021) | HFT count (2022) | Rate (per 100,000 population) |         |
| 1 (20% most deprived)  | 306,789                              | 653              | 212.8                         |         |
| 2                      | 231,599                              | 328              | 141.6                         |         |
| 3                      | 202,444                              | 215              | 106.2                         |         |
| 4                      | 275,857                              | 135              | 48.9                          |         |
| 5 (20% least deprived) | 218,656                              | 77               | 35.2                          |         |
| <b>Lancashire</b>      | <b>1,235,345</b>                     | <b>1408</b>      | <b>114.0</b>                  |         |

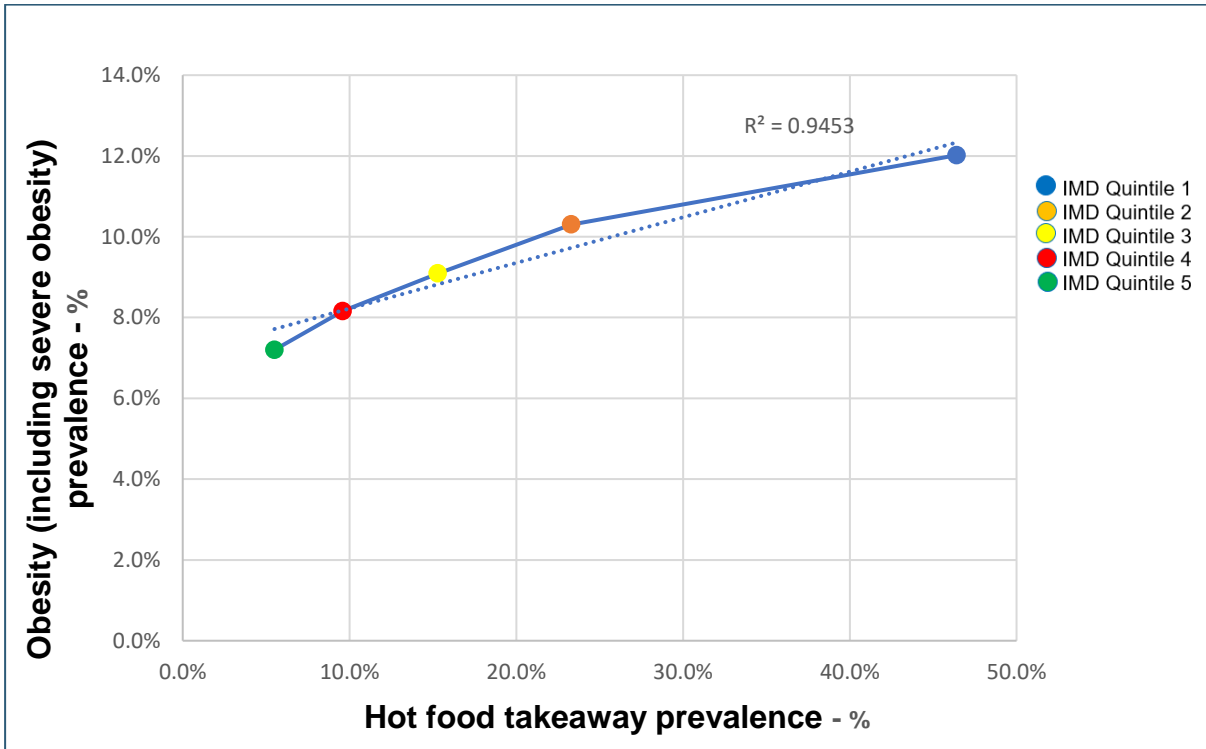
Source: FSA, FHRS; Office for National Statistics' Mid-Year Population Estimates; IMD (2019)

While we cannot establish causation, we can assess the correlation<sup>27</sup> between obesity amongst Reception-aged children and the percentage of hot food takeaways across deprivation quintiles 1 to 5. Figure 17 displays a scatter plot for Lancashire, illustrating these two indicators by deprivation quintile. Additionally, a regression line (or line of best fit) has been included to estimate the relationship between the variables. The high  $R^2$  value of 0.94 suggests that approx. 90% of the variation in the Y-axis (obesity) can be explained by the X-axis (hot food takeaway prevalence), indicating a strong positive correlation between the variables.

Figure 18 provides a scatter plot for Lancashire, illustrating the relationship between the percentage of hot food takeaways and percentage of obese Year 6-aged children in Lancashire, by deprivation quintile. The high  $R^2$  value of 0.89 indicates a similarly strong degree of positive correlation between the prevalence of obesity, the number of hot food takeaways and the deprivation score of the area.

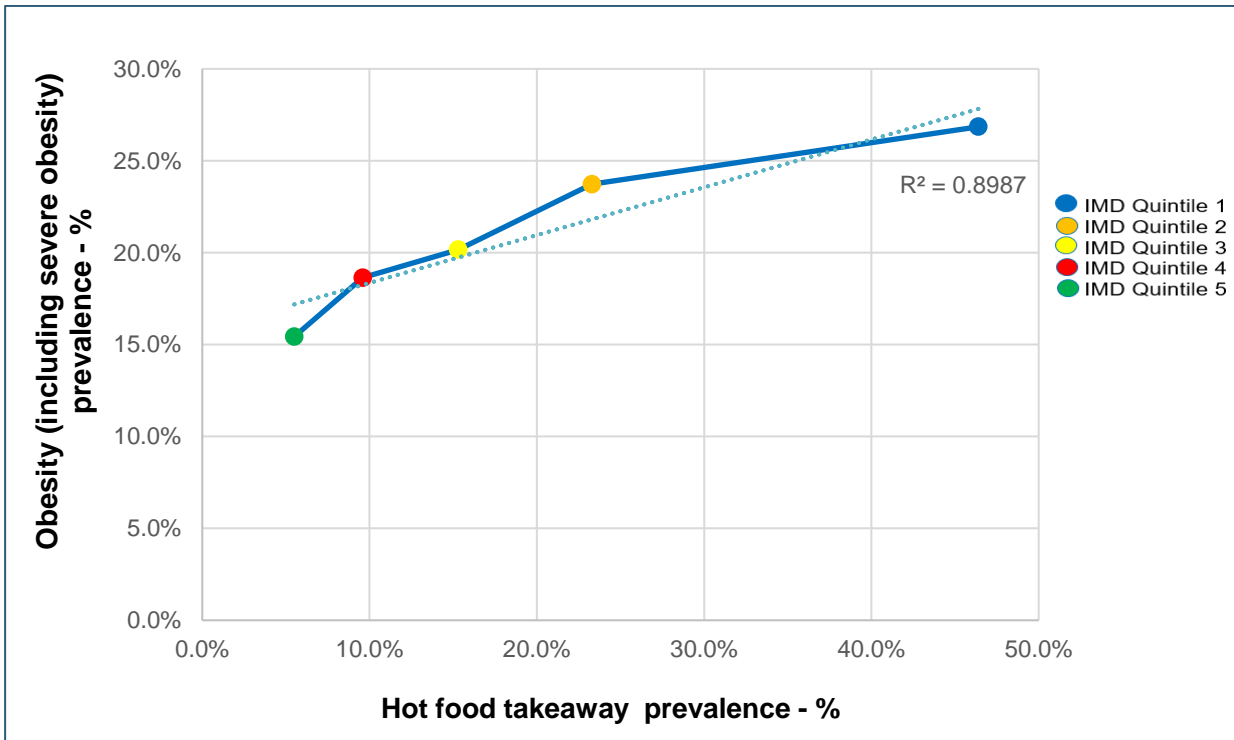
<sup>27</sup>Correlation refers to the connection or relationship between two or more facts, numbers, or variables. It measures how these variables tend to vary, be associated, or occur together, beyond what would be expected by chance alone.

**Figure 17: Reception obesity (including severe obesity) prevalence (2019/20 - 2022/23) and hot food takeaway prevalence (2022) by IMD quintile (2019) – Lancashire.**



Sources: OHID, Fingertips & FSA, FHRS

**Figure 18: Year 6 obesity (including severe obesity) prevalence (2019/20 - 2022/23) and hot food takeaway prevalence (2022) by IMD quintile (2019) – Lancashire.**



Sources: OHID, Fingertips & FSA, FHRS

## Recommendations for Lancashire

Considering the data and evidence summarised within this note, we make three recommendations to Lancashire district LPAs, relating to the development of new sui generis hot food takeaway outlets across the county:

In line with the stated aim of the government's plan to "halve childhood obesity" and "significantly reduce the gap in obesity between children from the most and least deprived areas by 2030" [46], we propose the following two policies, which support a targeted and equitable approach to reducing obesity:

- 1. Refusing new sui generis hot food takeaway uses within wards where the most recently published NCMP data classifies 10% or more of Reception pupils or 15% or more of Year 6 pupils as obese (including severely obese).**

*Rationale: Achieving the Government's goal of halving obesity would mean reducing the prevalence of obesity amongst Reception pupils to 5%, and amongst Year 6 pupils to 10%. The percentage triggers proposed are 5% above this target for each year group.*

- 2. Refusing new sui generis hot food takeaway uses within wards which fall within the 20% most deprived areas in England i.e., deprivation quintile 1.**

*Rationale: Both obesity and hot food takeaway prevalence across the county of Lancashire, are significantly higher in the most deprived quintile compared to the least. Following this approach will help us to tackle the inequalities in health experienced by our most deprived communities by limiting their already heightened exposure to an unhealthy food environment.*

Alongside policies targeting specific neighbourhoods, we also propose a county-wide policy affecting all areas:

- 3. Refusing new sui generis hot food takeaway uses which fall within a 400m radius of entry points to secondary schools.**

*Rationale: 400m provides a 5-minute walking distance around a school<sup>28</sup>. Stopping new outlets from opening within this vicinity will help to reduce the accessibility of takeaway foods to secondary school pupils during lunchtimes and after school.*

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<sup>28</sup> The Chartered Institution of Highways and Transportation considers 400m to equate to an approximate 5 minute walking distance, citing this distance as the traditional cut off point for bus stops in residential areas: [https://www.ciht.org.uk/media/4465/planning\\_for\\_walking\\_-\\_long\\_-\\_april\\_2015.pdf](https://www.ciht.org.uk/media/4465/planning_for_walking_-_long_-_april_2015.pdf)

## **Public Health Support**

LCC's HEWP service is keen to engage with all Lancashire district LPAs to support them to embed, implement and monitor the policy recommendations outlined within this advice note. The service can provide a range of support to district LPAs, including:

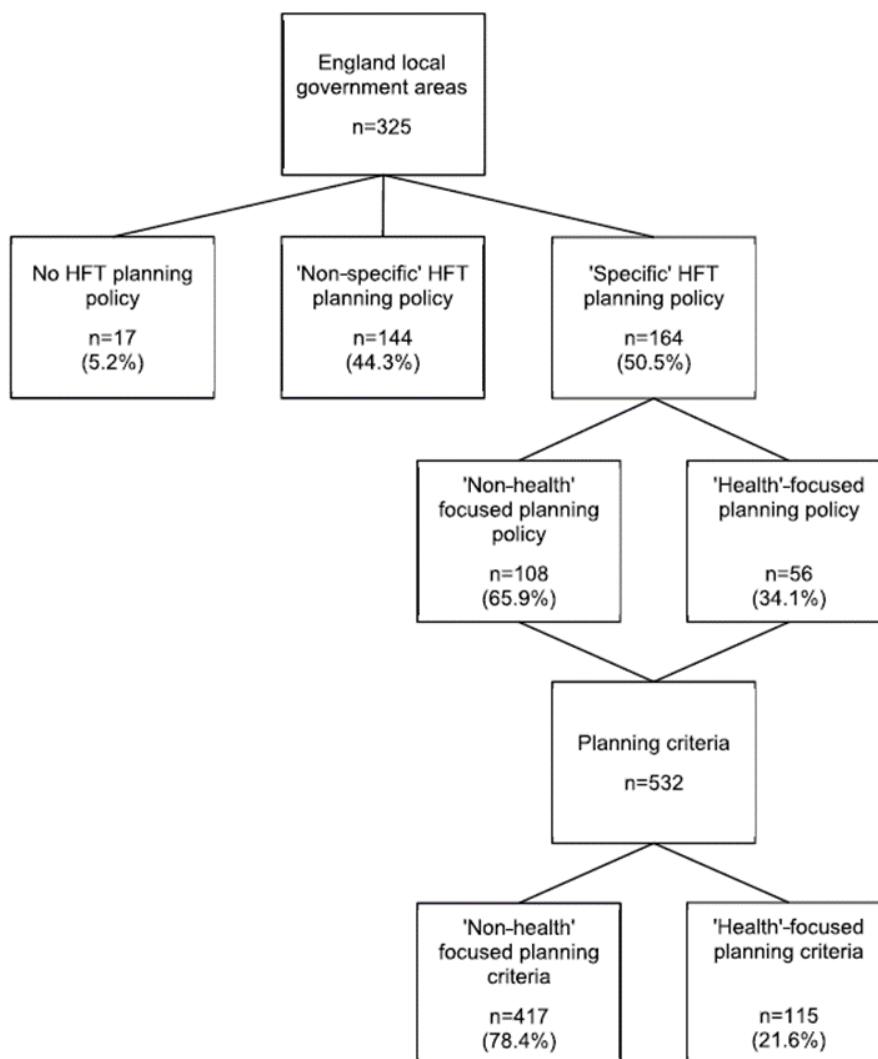
- 1) Involvement in Local Plan-making processes to support the embedding of the policy recommendations outlined above (including the submission of consultation responses, representation at district Local Plan Committee meetings, as well as attendance at Examinations in Public, as required).
- 2) Following adoption of the policy recommendations, responding to local planning applications for new hot food takeaway developments, including undertaking an analysis of required data
- 3) Delivering information sessions to district LPAs on the evidence, data and wider context as outlined within this note.
- 4) Providing 1:1 support (written and in-person) on how to locate and interpret local data on obesity and/or hot food takeaway prevalence, and variation across place.

## Implementation and Monitoring

### National Implementation

A review carried out in 2019 [47] found that of the 325 local government areas with planning powers in England, just over half (164 authorities, 50.5%) had a policy specifically targeting takeaway food outlets. Of these, 56 (34.1%) had health-focused policies and 108 (65.9%) had non-health focused policies. Across the specific policies there were 532 individual planning criteria; 115 (21.6%) were health focused<sup>29</sup> and 417 (78.4%) were not. 144 areas had non-specific policies that related to wider retail units and could in theory be used for takeaways. This breakdown can be seen below in Figure 19.

**Figure 19: Breakdown of planning policies relating to takeaway outlets [47].**



The study broadly categorised the planning criteria based on its action strategies. In terms of the criteria focused on health, the two predominant themes were:

<sup>29</sup> A single policy was likely to have multiple planning criteria; some had a mix of health and non-health criteria. A policy only needed one health focused criterium to be categorised as a health policy.

- Exclusion zones (33 criteria, 28.7%) - restricting the building of new takeaways around where children and families congregate including schools, parks and leisure facilities. They often also include restrictions on opening times such as school lunch times and after school.
- Density limitation (29 criteria, 25.2%) – limiting the number of consecutive takeaways or caps the proportion of all retail space occupied by this use.

Three local government areas had exclusion zones across a specified geographical area based on their childhood obesity rate. There were also a number of strategies employed to minimise the impact of takeaways on the local area, with other specific health-related criteria including the implementation of community infrastructure levies with funds allocated to obesity prevention initiatives; mandatory signups to a healthy catering commitment scheme; and requirements for submission of health impact assessments alongside planning applications.

## Local Implementation

Since its initial publication in 2018, LCC's HEWP service has sought to embed the recommendations outlined within this advice note within the Local Plans of each district LPA across Lancashire.

The service continues to raise objections to new hot food takeaway planning applications (where these infringe upon the recommendations set out above), using public health data and adopted Local Plan policy as our basis. For the districts of Lancaster and Rossendale (where a selection of the policy recommendations within this note have been adopted), of those applications we have submitted objections to, approximately 89% have been formally denied planning permission on health-related grounds. A more detailed analysis of decisions, categorised by local authority, can be found in Table 10.

**Table 10: Breakdown of hot food takeaway planning application decisions across Rossendale and Lancaster**

| Local Authority | Number of applications objected to | Number of applications approved (despite objection) | Number of applications refused (following objection) | Percentage of objections upheld |
|-----------------|------------------------------------|---|--|---------------------------------|
| Rossendale      | 3                                  | 0   | 3  | 100%                            |
| Lancaster       | 6                                  | 1   | 5  | 83.3%                           |

## Case studies

A 2016 publication by the Local Government Association (LGA) [48], provided seven case studies pertaining to local authorities across the UK who have developed policies with the objective of restricting the proliferation of hot food takeaways in defined areas, such as near schools.

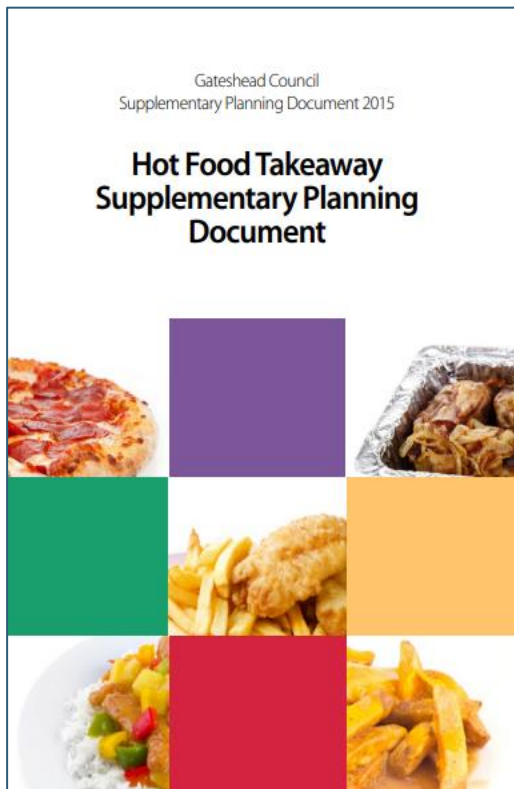
We undertook a further, rapid desktop review of a range of Local Plans including the two upper-tier local authorities within the Lancashire boundary. Our findings have been presented below as short case studies, acting as examples of how a range of

hot food takeaway planning policies can (and currently are) implemented in real-life situations:

### **Gateshead**

In 2015, Gateshead Council published its 'Hot Food Takeaway Supplementary Planning Document' (SPD)<sup>30</sup>, setting out the council's priorities and objectives in relation to planning control of hot food takeaways, elaborating upon existing and emerging policy in relation to health and wellbeing. The council was the first in the UK to go beyond traditional planning considerations, developing a hot food takeaway SPD, based on research, to justify criteria based purely on health. As a result, the council was awarded the Local Government Chronicle Award for Public Health in 2017<sup>31</sup>.

The council's SPD outlines two planning considerations related to health, aimed at preventing planning permission for new hot food takeaway uses in:



**1. Locations where children and young people congregate - within a 400m radius of entry points to secondary schools, youth centres, leisure centres and parks\*. \*Parks are categorised as playing areas, Area parks over 5 hectares in size and Neighbourhood Open Spaces over 2 hectares in size.**

**2. Locations where there are high levels of obesity - in wards where there is more than 10% of the year 6 pupils classified as obese.**

These considerations are derived from an analysis of the local hot food takeaway context, along with local obesity rates among both adults and children. With regard to takeaways, Gateshead had identified a rate of 1.03 takeaways uses per 1,000 people, higher than the national average of 0.86 (at the time of

publication - 2015). Nearly one quarter (23%) of 10- and 11-year-olds (Year 6) in Gateshead were also classified as obese at the time of publication, with the gap between the obesity rates among the most and least disadvantaged socioeconomic groups also identified to be widening for both Reception and Year 6 children.

Prior to Local Plan adoption, the Planning Inspector provided the following comments with regard to an objection concerning the SPD:

**"I note the objection to the statement in paragraph 12.10 that the Councils will consider controlling the proliferation of unhealthy food outlets in subsequent**

<sup>30</sup> <https://www.gateshead.gov.uk/article/3089/Hot-food-takeaway-Supplementary-Planning-Document>

<sup>31</sup> For more information, visit: <https://www.lgcplus.com/home/lgc-awards-2017-the-winners/public-health-7-08-03-2017/>



**plans. However, there is clear evidence of poor health in Gateshead and Newcastle which is partly caused by unhealthy eating, and easy access to clusters of unhealthy food outlets exacerbates the problem. In principle, therefore, such an approach is sound".**

Monitoring of the SPD's implementation is included in the council's Annual Monitoring Report (AMR)<sup>32</sup>. As part of this annual monitoring, the council have employed the following targets:

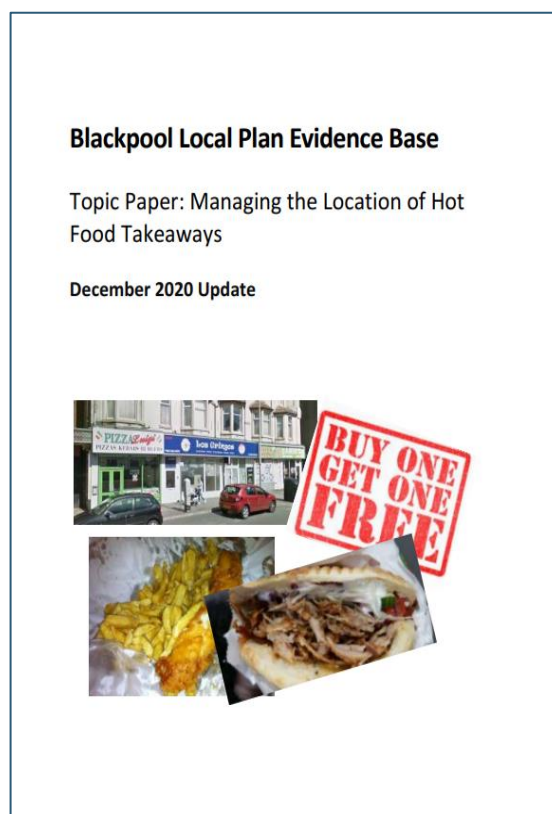
- Reduce the number of obese children in Gateshead to less than 10% by 2025.
- Fewer A5 uses per 1,000 residents than the England average (of 0.96 uses per 1,000 residents)

The latest AMR (2022/23) indicates that there are currently 185 hot food takeaways in Gateshead, which is a reduction of 13 since SPD adoption in 2015. The report also highlights a drop in obesity rates among Year 6 students, with the most recent data showing a decrease by 3.2% to 24.1% in 2022/23.

### **Blackpool**

Blackpool's topic paper entitled 'Managing the Location of Hot Food Takeaways' (published 2018, updated December 2020)<sup>33</sup> provides an overview of the council's priorities and objectives in relation to planning control of hot food takeaways, providing an analysis of the evidence base, planning policy context, as well as of local data with respect to obesity, deprivation and hot food takeaways. Based on this analysis, the paper offers the following public health recommendation, for adoption by the council's Local Plan:

- **To promote healthier communities, the council will prevent the development of A5 uses in or within 400m of wards where there is more than 15% of the year 6 pupils or 10% of reception pupils classified as very overweight.**



**\*(the ward data is updated annually by Public Health England)**

<sup>32</sup> <https://www.gateshead.gov.uk/article/3109/Annual-Monitoring-Reports>

<sup>33</sup> <https://www.blackpool.gov.uk/Residents/Planning-environment-and-community/Documents/Local-plan-2021/Hot-Food-Takeaways-Evidence-Base-Dec-2020-Accessible.pdf>

Blackpool's 'Local Plan Part 2: Site allocations and development management policies'<sup>34</sup> was adopted in February 2023, containing a policy specific to the control of hot food takeaways on health grounds (Policy DM16), in light of the recommendation of the topic paper and as outlined above. It is important to note that based on the most recent data, Policy DM16 does not permit new hot food takeaway development in any ward across Blackpool.

In relation to adoption of DM16 and upon his review of the Local Plan, the Inspector provided a range of comments, including:

**"Policy DM16 seeks to promote healthier communities by restricting new hot food takeaways in or within 400 metres of wards where there are more than 15% of year 6 pupils or 10% of reception age pupils which are classified as obese by Public Health England."**

**"The Council's Healthy Weight Declaration (EL4.001) commits the Council to working with other bodies on a range of actions including reducing unhealthy weight in Blackpool. It also recognises the potential for the planning system to contribute towards such as part of a broad multi-disciplinary package of measures."**

**"Setting thresholds based on the obesity of reception age and year 6 children is reasonable as the choices and behaviours learned are more likely than not to be carried through to later adult life."**

**"Public Health England maintain data on child excess weight and obesity at ward-level which is freely available and updated annually, the thresholds are reasonably set at a level that should Policy DM16 be effective alongside other measures, obesity levels could reasonably be expected to fall below the threshold making hot food takeaways permissible in some wards over the plan period. In any event, the evidence shows the borough is already very well served."**

### ***Blackburn with Darwen***

Adopted in January 2024, Blackburn with Darwen's (BwD) Local Plan (2021 – 2037)<sup>35</sup> contains a specific health-based policy (Policy DM01), encompassing planning restrictions on new hot food takeaway development, including in areas:

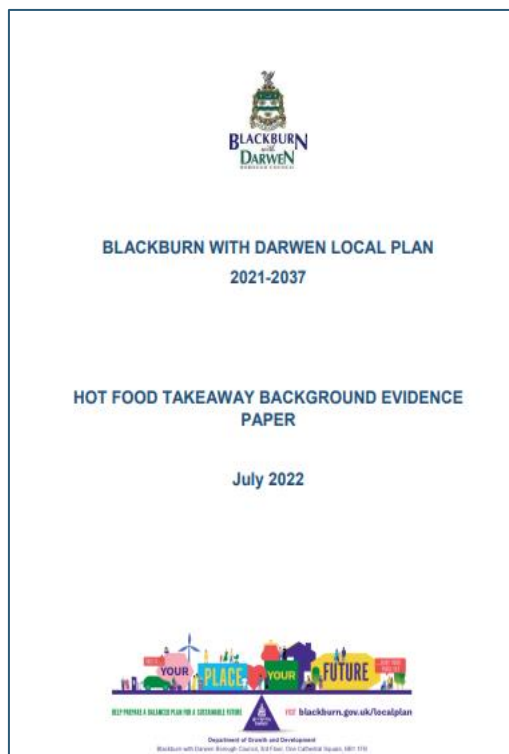
- **where more than 10% of year 6 pupils are classified as obese.**

Based on current data, this threshold prevents any new hot food takeaway development across the entirety of BwD.

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<sup>34</sup> <https://www.blackpool.gov.uk/Residents/Planning-environment-and-community/Planning/Planning-policy/Blackpool-local-plan/Site-allocations-and-development-management-policies.aspx>

<sup>35</sup> <https://www.blackburn.gov.uk/planning/directory-planning-policies-guides-and-strategies/local-plan-2021-2037>



Policy DM01 also stipulates that:

**"Where appropriate, the Council will consider imposing a condition restricting a business' opening hours to reduce the likelihood of it being visited by young people and impose personal permissions on hot food takeaway applications, working with the business to ensure a healthier offer."**

Support and justification for Policy DM01 is provided within the council's accompanying 'Hot Food Takeaway Background Evidence Paper'<sup>36</sup>. In brief, the paper identifies a direct correlation between high levels of childhood obesity, high levels of deprivation and high numbers of hot food takeaways across BwD's electoral wards, "providing local evidence that hot food takeaways are causing harm to residents' health" (2022, pg. 2).

The evidence paper also accompanies the broader 'Planning for Health' SPD<sup>37</sup>, originally adopted by BwD council in 2016. Whilst encompassing hot food takeaways, the SPD provides further analysis and supporting information on how the environment, and the planning decisions made, impact upon the health of local residents, acting as a material consideration in the determination of planning applications. The SPD is due to be updated in light of the recent Local Plan adoption.

The following monitoring indicators and targets have been applied to the abovementioned policies within DM01:

- **Indicator: Number of Year 6 pupils classed as obese within the Borough**
- **Target: No increase in levels of childhood obesity**
  
- **Indicator: Number of premises annually awarded 'Recipe 4 Health'**
- **Target: Increase in premises awarded Recipe 4 Health**

To date, Policy DM01 has been cited in one appeal decision issued by the Planning Inspector, dated February 2024. Within their response, the Inspector stated:

**"Confirmation has been provided by the Council that the prevalence of obesity (including severe obesity) of Year 6 children in the ward within which the appeal site is located (from data combined from the years 2021/22 and 2022/23) is 26%, slightly above the percentage of 22.5% for England overall. Alarmingly, the prevalence of Year 6 children in the ward who are classed as overweight (including obesity) for the same years is 42% against an England percentage of**

<sup>36</sup> <https://blackburn-darwen.org.uk/wp-content/uploads/E91-Hot-Food-Takeaway-Background-Paper-July-2022.pdf>

<sup>37</sup> <https://blackburn.gov.uk/sites/default/files/media/pdfs/SPD-Planning%20for%20Health.pdf>

**36.6%. Both figures are significantly above the 10% set out in Policy DM01 and as such, the proposal would conflict with Part 2 of this policy".**

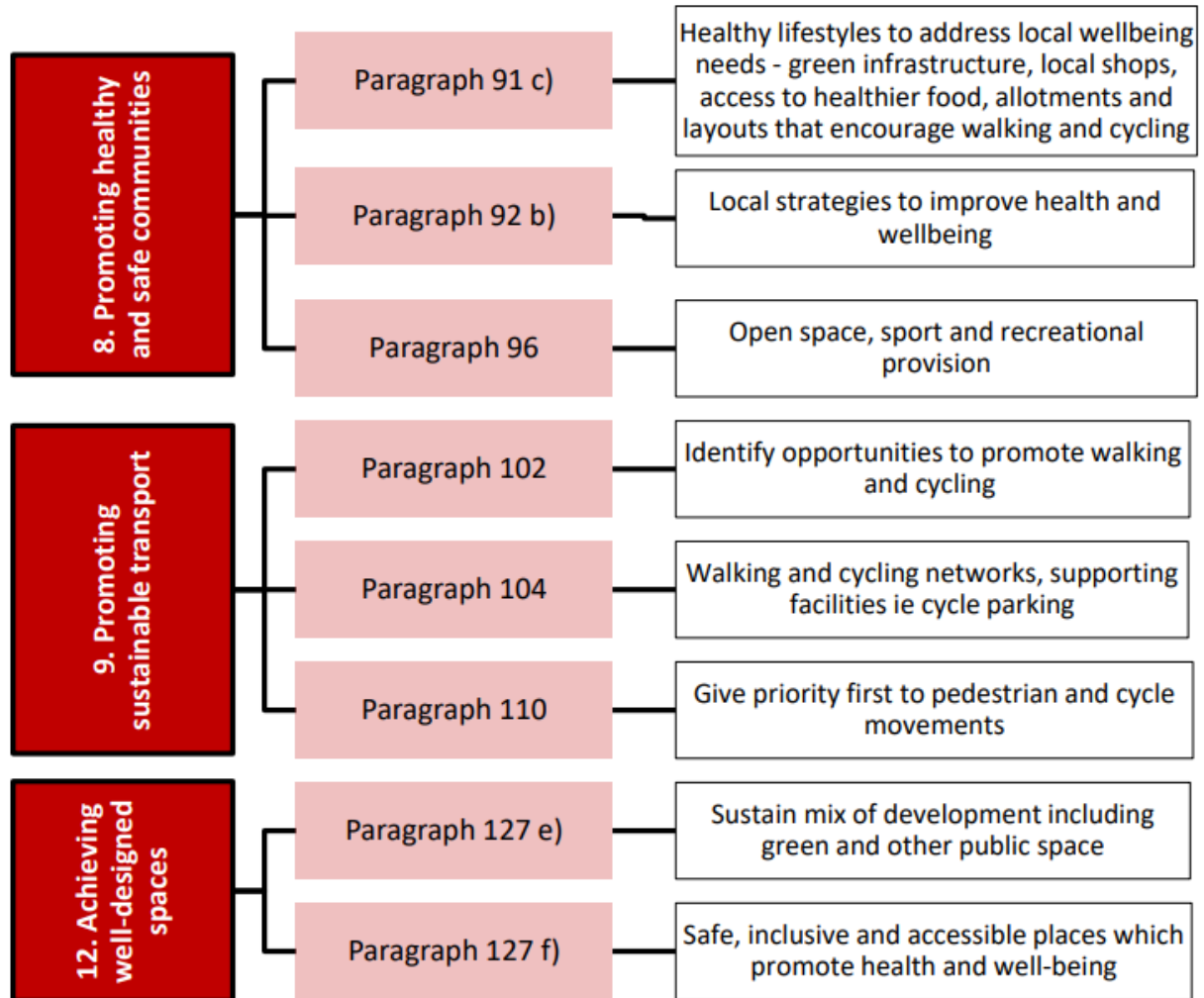
# Appendices

## Appendix 1: Use Classes [2]

Table 1 definitions:

- A3 Restaurants and cafés – for the sale of food and drink for consumption on the premises
- A4 Drinking establishments – public houses, wine bars or other drinking establishments including drinking establishments with expanded food provision.
- A5 Hot food takeaways – for the sale of hot food for consumption off the premises
- Class E Commercial, business and service – a range of other shops and non-food uses, including for the sale of food and drink principally to visiting members of the public where consumption of that food and drink is mostly undertaken on the premises.
- Sui generis (drinking establishments) – public house, wine bar, drinking establishment, or drinking establishment with expanded food provision.
- Sui generis (hot food takeaways) – hot food takeaway for the sale of hot food where consumption of that food is mostly undertaken off the premises.

## Appendix 2: NPPF Chapters and Policies relevant to Healthy Weight [3]



## References

- [1] Health Foundation, “How to talk about the building blocks of health,” July 2022. [Online]. Available: <https://www.health.org.uk/publications/how-to-talk-about-the-building-blocks-of-health>. [Accessed 19 July 2024].
- [2] Public Health England, “Addendum: Hot food takeaways use in the new Use Class Order,” 19 February 2021. [Online]. Available: <https://www.gov.uk/government/publications/healthy-weight-environments-using-the-planning-system/addendum-hot-food-takeaways-use-in-the-new-use-class-order>. [Accessed 18 07 2024].
- [3] Communities, Department for Levelling Up Housing and, “National Planning Policy Framework,” Department for Levelling Up, Housing and Communities, London, 2023.
- [4] Department for Levelling Up, Housing and Communities, “Healthy and safe communities,” Gov.UK, 7 8 2022. [Online]. Available: <https://www.gov.uk/guidance/health-and-wellbeing>. [Accessed 18 July 2024].
- [5] Public Health England, “Using the planning system to promote healthy weight environments,” PHE Publications, London, 2022.
- [6] HM Government, “Advancing our health: prevention in the 2020s,” London, 2019.
- [7] Public Health England, “PHE Strategy 2020-25,” 2019.
- [8] Public Health England, “Spatial Planning for Health: An evidence resource for planning and designing healthier places,” PHE Publications, London, 2017.
- [9] Office for Health Improvement and Disparities, “Obesity Profile: short statistical commentary July 2022,” 5 6 2022. [Online]. Available: <https://www.gov.uk/government/statistics/obesity-profile-update-july-2022/obesity-profile-short-statistical-commentary-july-2022>. [Accessed 18 July 2024].
- [10] A. Hruby and F. B. Hu, “The Epidemiology of Obesity: A Big Picture,” *Pharmacoeconomics*, vol. 3, no. 7, p. 673–689, 2015.
- [11] Government Office for Science, “Futures, Foresight and Horizon Scanning,” 4 10 2017. [Online]. Available: <https://foresightprojects.blog.gov.uk/2017/10/04/dusting-off-foresights-obesity-report/>. [Accessed 18 July 2024].
- [12] Government Office for Science, “Tackling Obesities: Future Choices - Project Report,” 2007.
- [13] F. K. Ho, C. Celis-Morales, F. Petermann-Rocha, S. L. Parra-Soto, J. Lewsey, D. Mackay and J. P. Pell, “Changes over 15 years in the contribution of adiposity and smoking to deaths in England and Scotland,” *BMC Public Health*, vol. 21, no. 169, 2021.
- [14] Public Health England, “Adult obesity and type 2 diabetes,” 31 July 2014. [Online]. Available: <https://www.gov.uk/government/publications/adult-obesity-and-type-2-diabetes>. [Accessed 18 July 2024].
- [15] British Heart Foundation, “CVD Statistics UK Factsheet,” January 2024. [Online]. Available: <https://www.bhf.org.uk/-/media/files/for-professionals/research/heart-statistics/bhf-cvd-statistics-uk->

- factsheet.pdf?rev=b88610e2495b4564821ab365bd8e1b2e&hash=294E7519486335830B73739235600CE7. [Accessed 18 July 2024].
- [16] British Heart Foundation, “Global Heart & Circulatory Disease Factsheet,” January 2024. [Online]. Available: <https://www.bhf.org.uk/-/media/files/for-professionals/research/heart-statistics/bhf-cvd-statistics-global-factsheet.pdf?rev=e61c05db17e9439a8c2e4720f6ca0a19&hash=6350DE1B2A19D939431D876311077C7B>. [Accessed 18 July 2024].
- [17] A. Perez, J. Y. Muñoz, C. B. Vicente and P. de Pablos Velasco, “Obesity and cardiovascular disease,” *Public Health Nutrition*, vol. 10, no. 10A, pp. 1156-63, 2007.
- [18] S. Pati, W. Irfan, J. Ahmad and R. K. Shahid, “Obesity and Cancer: A Current Overview of Epidemiology, Pathogenesis, Outcomes, and Management,” *Cancers (Basel)*, vol. 15, no. 2, p. 485, 2023.
- [19] Cancer Research UK, “How does obesity cause cancer?,” 2023. [Online]. Available: <https://www.cancerresearchuk.org/about-cancer/causes-of-cancer/bodyweight-and-cancer/how-does-obesity-cause-cancer>. [Accessed 18 July 2024].
- [20] NHS Digital, “Health Survey for England, 2021 part 1,” 15 December 2022. [Online]. Available: <https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2021/overweight-and-obesity-in-adults>. [Accessed 18 July 2024].
- [21] Department of Health and Social Care, “New obesity treatments and technology to save the NHS billions,” 27 November 2022. [Online]. Available: <https://www.gov.uk/government/news/new-obesity-treatments-and-technology-to-save-the-nhs-billions>. [Accessed 18 July 2024].
- [22] Public Health England, “Health matters: obesity and the food environment,” 31 March 2017. [Online]. Available: <https://www.gov.uk/government/publications/health-matters-obesity-and-the-food-environment/health-matters-obesity-and-the-food-environment--2>. [Accessed 18 July 2024].
- [23] Faculty of Public Health, “What is Public Health?,” [Online]. Available: <https://www.fph.org.uk/what-is-public-health/>. [Accessed 19 July 2024].
- [24] Local Government Association, “Public Health,” [Online]. Available: <https://www.local.gov.uk/topics/social-care-health-and-integration/public-health>. [Accessed 19 July 2024].
- [25] C. Hancock, “Patterns and trends in excess weight among adults in England,” 4 March 2021. [Online]. Available: <https://ukhsa.blog.gov.uk/2021/03/04/patterns-and-trends-in-excess-weight-among-adults-in-england/>. [Accessed 18 July 2024].
- [26] University College London, “Health Survey for England, 2021: Data tables,” 15 December 2022. [Online]. Available: <https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2021/health-survey-for-england-2021-data-tables>. [Accessed 18 July 2024].
- [27] Office for Health Improvement and Disparities, “Obesity Profile: Indicator Definitions and Supporting Information,” 2023. [Online]. Available: <https://fingertips.phe.org.uk/profile/national-child-measurement-programme/data#page/6/gid/8000011/pat/159/par/K02000001/ati/15/are/E92000001/iid/90316/age/200/sex/4/cat/-1/ctp/-1/yr/1/cid/4/tbm/1>.



- [28] S. S. Guo and W. C. Chumlea, "Tracking of body mass index in children in relation to overweight in adulthood.," *The American Journal of Clinical Nutrition*, vol. 70, no. 1, pp. 145S-8S, 1999.
- [29] M. K. Serdula, D. Ivery, R. J. Coates, D. S. Freedman, D. F. Williamson and T. Byers, "Do obese children become obese adults? A review of the literature," *Preventative Medicine*, vol. 22, pp. 167 - 77, 1993.
- [30] G. Starc and J. Strel, "Tracking excess weight and obesity from childhood to young adulthood: a 12-year prospective cohort study in Slovenia.," *Public Health Nutrition*, vol. 14, pp. 49-55, 2011.
- [31] NHS Digital, "National Child Measurement Programme," [Online]. Available: <https://digital.nhs.uk/services/national-child-measurement-programme#defining-overweight-and-obesity-in-children>. [Accessed 19 July 2024].
- [32] Department of Health and Social Care, "Tackling obesity: empowering adults and children to live healthier lives," 27 July 2020. [Online]. Available: <https://www.gov.uk/government/publications/tackling-obesity-government-strategy/tackling-obesity-empowering-adults-and-children-to-live-healthier-lives>. [Accessed 19 July 2024].
- [33] Public Health England, "Encouraging healthier 'out of home' food provision," 20 September 2019. [Online]. Available: <https://www.gov.uk/government/publications/encouraging-healthier-out-of-home-food-provision>. [Accessed 19 Jul 2024].
- [34] NICE, "Cardiovascular disease prevention," 2010.
- [35] H. Brown, X. Huasheng, V. Alban, L. Goffe, N. Akhter, A. Lake, S. Sorrell, E. Gibson and J. Wildman, "No new fast-food outlets allowed! Evaluating the effect of planning policy," *Socia Science & Medicine*, vol. 306, 2022.
- [36] T. Burgoine, C. Sarkar, C. J. Webster and P. Monsivais, "Examining the interaction of fast-food outlet exposure and income on diet and obesity: evidence from 51,361 UK Biobank participants," *International Journal of Behavioral Nutrition and Physical Activity*, vol. 15, no. 1, 2018.
- [37] M. Pearce, I. Bray and M. Horswell, "Weight gain in mid-childhood and its relationship with the fast food environment," *Journal of Public Health*, vol. 40, pp. 237-244, 2017.
- [38] T. Burgoine, N. G. Forouhi, S. J. Griffin, N. J. Wareham and P. Monsivais, "Associations between exposure to takeaway food outlets, takeaway food consumption, and body weight in Cambridgeshire, UK: population based, cross sectional study," *British Medical Journal*, vol. 348, 2014.
- [39] L. Seliske, W. Pickett, A. Rosu and I. Janssen, "The number and type of food retailers surrounding schools and their association with lunchtime eating behaviours in students," *International Journal of Behavioral Nutrition and Physical Activity*, vol. 10, no. 19, 2013.
- [40] D. Smith, S. Cummins, C. Clark and S. Stansfeld, "Does the local food environment around schools affect diet? Longitudinal associations in adolescents attending secondary schools in East London," *BMC Public Health*, 2013.
- [41] M. He, P. Tucker, J. D. Irwin, J. Gilliland, K. Larsen and P. Hess, "Obesogenic neighbourhoods: the impact of neighbourhood restaurants and convenience stores on adolescents' food consumption behaviours," *Public Health Nutrition*, vol. 15, no. 12, p. 2331–2339, 2012.

- [42] A. Ellaway, L. Macdonald, K. Lamb, L. Thornton, P. Day and J. Pearce, “Do obesity-promoting food environments cluster around socially disadvantaged schools in Glasgow, Scotland?,” *Health & Place*, vol. 18, no. 6, pp. 1335-40, 2012.
- [43] J. Currie, S. DellaVigna, E. Moretti and V. Pathania, “The Effect of Fast Food Restaurants on Obesity and Weight Gain,” *American Economic Journal: Economic Policy*, vol. 2, no. 3, pp. 32-63, 2009.
- [44] B. Davis and C. Carpenter, “Proximity of fast-food restaurants to schools and adolescent obesity,” *American Journal of Public Health*, vol. 99, no. 3, pp. 505-10, 2008.
- [45] S. Kirkman, B. Hollingsworth B, A. Lake, S. Hinke, S. Sorrell, T. Burgoine and H. Brown, “Field validity and spatial accuracy of Food Standards Agency Food Hygiene Rating scheme data for England,” *J Public Health (Oxf)*, vol. 43, no. 4, pp. e720-e727, 2021.
- [46] Department of Health and Social Care, “Childhood obesity: a plan for action, Chapter 2,” 2018.
- [47] M. Keeble, T. Burgoine, M. White, S. Summerbell, S. Cummins and J. Adams, “How does local government use the planning system to regulate hot food takeaway outlets? A census of current practice in England using document review,” *Health & Place*, vol. 57, pp. 171-178, 2019.
- [48] Local Government Association;, “Tipping the scales: Case studies on the use of planning,” 2016.
- [49] The National Audit Office, “Tackling Obesity in England,” The Stationery Office, London, 2001.
- [50] Department of Health and Social Care, “Tackling obesity: government strategy,” Department of Health and Social Care, 27 July 2020. [Online]. Available: <https://www.gov.uk/government/publications/tackling-obesity-government-strategy>. [Accessed 08 September 2021].
- [51] Public Health England, “Encouraging healthier ‘out of home’ food provision,” Public Health England, 2019. [Online]. Available: <https://www.gov.uk/government/publications/encouraging-healthier-out-of-home-food-provision>. [Accessed 08 September 2021].
- [52] J. L. Macdiarmid, W. J. Wills, L. F. Masson, L. C. A. Craig, C. Bromley and G. McNeil, “Food and drink purchasing habits out of school at lunchtime: a national survey of secondary school pupils in Scotland,” *International Journal of behavioural nutrition and physical activity*, vol. 12, 2015.
- [53] L. K. Fraser, G. P. Clarke, J. E. Cade and K. L. Edwards, “Fast food and obesity: a spatial analysis in a large United Kingdom population of children aged 13-15,” *American Journal of Preventative Medicine*, vol. 42, no. 5, pp. 77-85, 2012.