Cheshire East Local Plan Examination

Is the restriction on the hours of opening of hot food takeaways within 400m of secondary schools and 6th form colleges in criterion 3 of Policy RET5 justified based on the evidence provided and consistent with national policy?

Planning Practice Guidance (Reference ID: 53-004-20190722) has indicated that policies can, where justified, seek to limit the proliferation of particular uses where evidence demonstrates this is appropriate and may need to have particular regard to proximity to schools, community centres and playgrounds.

This still requires local justification and, notably, does not specify a particular use or uses that can be controlled on this basis (albeit implicitly this must be uses where food and drink are purchased). It does not explicitly support the creation of zones within which takeaway uses will be refused, but rather seeks to limit proliferation.

Indeed, national policy supports the location of such town centre uses in accessible places and aims to create and maintain retail balance. Criterion 3 of Policy RET5 will work counter to this and, as it is not based on any assessment of what appropriate provision would comprise, is furthermore not positively prepared.

No assessment has been made of collateral reductions in walkable choice of the large number of people who happen to live near secondary schools, the distance at which the supposed harm ceases, peaks or even occurs at all, whether schools have 'open gates' policies or where walking or public transport routes are in relation to zones.

Whilst it is noted that the policy excludes weekends, it does not exclude school or bank holidays, which account for a significant portion of the year.

The policy would treat hot food takeaways whose operators committed to reformulate and offer healthier choices in the same way as those that have not, limiting innovation. This point was taken by the Examining Inspector in the Croydon Local Plan (2018), policies of which were modified in order to ensure soundness.

We do not consider the third criterion of Policy RET5 justified, as it implicitly links the proximity of a particular land use to schools with obesity, a link for which there is little consistent evidence (Williams et al, 2014) and the basis for which applies to premises in range of use classes, as recent research (Robinson et al, 2018) demonstrates.

What regard has been given to guidance from local public health services on this issue and to evidence of obesity levels in Cheshire East or the concentrations of hot food takeaway uses within close proximity of secondary schools and colleges?

It is unclear whether the Hot Food Takeaway Background Report [ED50] has been prepared by local public health services, but it relies heavily on national resources, such as the Food Environment Assessment Tool (FEAT) and Public Health England (PHE) Local Authority Health Profiles.

Whilst the FEAT data appears to demonstrate proliferation, the footnote to Table 2.1 explicitly acknowledges that its definition of takeaway includes bakeries and refers to brands by name, rather than their land use or class, rendering the data unusable for the purpose. The derived mapping also fails to report actual distances or uses.

Table 2.2 of its section on Local Context contains non-benchmarked obesity data. Unlike adult obesity, which is assessed by reference to body mass indices, child obesity is assessed by reference to percentiles, so that a certain proportion always have and always will be so classified.

Without information as to which dataset this is benchmarked against (for example, the 1990 UK data is a common reference), this is difficult to interpret. Following the link to the latest (2018) PHE Local Authority Health Profile for Cheshire East establishes that Year 6 obesity is actually "significantly better" than the average for England.

Whilst we do not minimise the significance of any incidence of obesity, national policy clearly intends measures to tackle proliferation only to be deployed in areas of high incidence and where proliferation can actually be shown to be occurring. This does not appear to be the case in Cheshire East.

ED50 also seeks at paragraph 4.19 to justify the distance threshold with a 2008 report by Sinclair and Winkler on pupil food purchases near schools, which was a small pilot study that was neither peer-reviewed nor intended as a basis for policy. Incidentally, the study found most such purchases were made in convenience stores.

As Williams et al (2014) indicated, the evidence on proximity is weak and inconsistent. Currie et al (2010) reported a positive effect on incidence at 160 metres, but the effect reported became negative at 400 metres. The latter study was also based on a much wider definition of fast-food outlet than the policy addresses.

Plan-making authorities often seek to justify the distance threshold uses as a typical walking distance, but research suggests purchases are often made along commuting routes and not specifically close to school. The distance chosen significantly affects the number of residents whose access to food and drink facilities is impacted.

References:

(a) Williams, J et al, 2014. 'A systematic review of the influence of the retail food environment around schools on obesity-related outcomes ' *Obesity Reviews* 15, 359-374 (Extract)

(b) Robinson, E et al, 2018. '(Over)eating out at major UK restaurant chains: observational study of energy content of main meals' *BMJ* 2018 (363) 4982 (Extract)

(c) Croydon Local Plan Inspector's Report, January 2018. (Extract)

(d) Public Health England Local Authority Health Profile 2018 - Cheshire East.

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Public Health

A systematic review of the influence of the retail food environment around schools on obesity-related outcomes

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Summary

The high prevalence of childhood obesity has led to questions about the influence of 'obesogenic' environments on children's health. Public health interventions targeting the retail food environment around schools have been proposed, but it is unclear if they are evidence based. This systematic review investigates associations between food outlets near schools and children's food purchases, consumption and body weight. We conducted a keyword search in 10 databases. Inclusion criteria required papers to be peer reviewed, to measure retailing around schools and to measure obesity-related outcomes among schoolchildren. Thirty papers were included. This review found very little evidence for an effect of the retail food environment surrounding schools on food purchases and consumption, but some evidence of an effect on body weight. Given the general lack of evidence for association with the mediating variables of food purchases and consumption, and the observational nature of the included studies, it is possible that the effect on body weight is a result of residual confounding. Most of the included studies did not consider individual children's journeys through the food environment, suggesting that predominant exposure measures may not account for what individual children actually experience. These findings suggest that future interventions targeting the food environment around schools need careful evaluation.

Keywords: Child obesity, food environment, schools, systematic review.

Abbreviations: AOR, adjusted odds ratio; BMI, body mass index; CS, convenience store; FF, fast food; FFR, fast food restaurant; FO, food outlet; FRI, food retail index; HEI, healthy eating index; HFAI, healthy food availability retail index; HFSS, high in fat, sugar or salt; HFZ, healthy fitness zone; IRR, incidence rate ratio; OR, odds ratio; OW, overweight; SE, standard error; SM, supermarket; TA, takeaway.

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Introduction

The prevalence of childhood obesity in the world has increased dramatically over the past three decades and is considered by the World Health Organization to be one of the most serious public health problems of the 21st century (1,2). Overweight or obese children are likely to remain overweight as adults and have an increased risk of developing chronic conditions such as cardiovascular disease or type 2 diabetes. Swinburn and Egger coined the term the

(Over)eating out at major UK restaurant chains: observational study of energy content of main meals

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ABSTRACT

OBJECTIVES

To examine the energy content of main meals served in major UK restaurant chains and compare the energy content of meals in fast food and "full service" restaurant chains.

DESIGN

Observational study.

SETTING

Menu and nutritional information provided by major UK restaurant chains.

MAIN OUTCOME MEASURES

Mean energy content of meals, proportion of meals meeting public health recommendations for energy consumption (≤600 kcal), and proportion of meals with excessive energy content (≥1000 kcal).

RESULTS

Main meals from 27 restaurant chains (21 full service; 6 fast food) were sampled. The mean energy content of all eligible restaurant meals (13 396 in total) was 977 (95% confidence interval 973 to 983) kcal. The percentage of all meals that met public health recommendations for energy content was low (9%; n=1226) and smaller than the percentage of meals with an excessive energy content (47%; 6251). Compared with fast food restaurants, full service restaurants offered significantly more excessively calorific main meals, fewer main meals meeting public health recommendations, and on average 268 (103 to 433) kcal more in main meals.

CONCLUSIONS

The energy content of a large number of main meals in major UK restaurant chains is excessive, and only a minority meet public health recommendations. Although the poor nutritional quality of fast food meals has been well documented, the energy content of full service restaurant meals in the UK tends to be higher and is a cause for concern.

REGISTRATION

Study protocol and analysis strategy pre-registered on Open Science Framework (https://osf.io/w5h8q/).

WHAT IS ALREADY KNOWN ON THIS TOPIC

Eating out of the home is common in the UK

The poor nutritional quality of "fast food" has been well documented

The energy content of traditional "full service" restaurants has received less attention

WHAT THIS STUDY ADDS

The average energy content of main meals served in both fast food and full service restaurants in the UK is higher than public health recommendations

The proportion of main meals in UK restaurant chains that meet public health recommendations for energy content is smaller than the proportion that have an excessive energy content

Compared with fast food restaurants, full service restaurant meals in the UK contain significantly more kilocalories on average

Introduction

The prevalence of overweight and obesity has increased markedly across most of the developed world.[1] Increases in energy intake caused by major changes to the food environment have been identified as a key factor explaining weight gain at the population level.[2-4] In the UK, meals are regularly consumed out of the home; data collected from 2008-12 showed that a quarter of UK adults ate out once a week or more often.[5] However, a more recent report from the UK Food Standards Agency in 2016 indicates that eating out of the home may be becoming more common, with 39% of UK adults reporting eating out at least once a week.[6] Several studies suggest that people who eat out of the home more often are at increased risk of weight gain and obesity.[7] Fast food restaurants in particular have been highlighted as providing meals that are low in nutritional quality.[8 9] Some evidence also suggests that a higher geographical density of fast food restaurants is associated with an increased risk of obesity.[10 11] Because of this, public health calls have been made to limit where fast food restaurant outlets can operate in the UK.[12 13] However, more traditional "full service" restaurants also contribute substantially to the out of home dining market in the UK.[14]

Recent public health recommendations made by Public Health England suggest that adults should aim to consume 600 kcal or less for their main lunch and dinner meals to avoid excess daily energy intake and maintain a healthy body weight.[15] This is in part motivated by Public Health England's estimate that the average adult in the UK is consuming an excess of 195 kcal a day.[15] Because the amount of energy a person consumes during a meal is strongly influenced by the energy density and portion size of the food served,[16-19] meals provided to consumers that are high in energy promote excess energy intake and are problematic for public health. However, public health action on improving the nutritional quality of food prepared outside of the home has to date focused largely on encouraging the food industry to make reductions to the energy content of supermarket food,[20] rather than focusing on the restaurant sector. To date, the number of kilocalories in main meals served by major UK restaurant chains has not been examined, so whether consumers can adhere to public health recommendations for meal energy consumption when eating in these establishments is unclear. Moreover, legislation has been passed that will result in kilocalorie labelling of all food products

Take-aways

258. I am less convinced by the way these policies apply to new or additional uses in the A5 Use Class (hot-food take-aways). The effects of policies DM5-DM9 would be to allow these in just twenty areas; Croydon Metropolitan, District and Local Centres but not in shopping parades in Neighbourhood Centres or elsewhere or in any edge of centre or out of centre location. The reasons given in paragraph 5.37 are to retain a greater choice of local retail services (but other sections of the policy allow loss of local retail services up to a limit; if the loss is allowable anyway, there is little reason for the new use not to be in the A5 use class), to limit waste and delivery issues (but policy could require that these be dealt with; a complete ban is not necessary to achieve the desired result); and to support healthier food options (but not all A5 uses produce unhealthy food; the Council's own campaign to persuade take-away proprietors to adopt healthy food options would be as stymied by this policy as would purveyors of less healthy food).

259. That last observation is not intended to belittle the Council's concerns with tackling the phenomenon of obesity as a health concern. The authorities quoted in the Council's observations on the suggested modifications to the plan demonstrate the seriousness of the matter and the government's recognition of the issue as a public health issue. But the quoted research demonstrating associations between obesity and ease of access to takeaway food and between obesity, deprivation and access to hot food takeaways has led the Council to adopt a policy which fails to distinguish between healthy and unhealthy takeaway food, which confounds its own efforts to improve the healthiness of the food provided by takeaway outlets and which fails to address the undoubted demand for the provision of convenience food.

260. Because the Council's reasons for this policy do not withstand scrutiny, they must be regarded as unsound and so a modification is required. In the light of the Council's representations on the suggested modifications, I now adjust the modification previously consulted upon in order to reflect what appears to be the Council's three main concerns; (a) to retain a sufficiency of A1 uses (b) to prevent an excessive concentration of take-aways and (c) to ensure that the food provided in a takeaway is healthy. (**MMs D17, D18, D21**).

Public houses

261. The Council's concern with promoting healthy eating habits through limiting the growth of hot food take-aways is not paralleled by promoting a reduction in places to drink alcohol. Instead, policy DM22 would seek their retention even if there is no defined need.

262. Such an indiscriminate policy is not supported by the Council's own evidence (document LBC-05-601). This distinguishes a variety of types of pub and emphasises the value of those which serve a social role as a meeting place, hosting a wide variety of community-oriented events, which it calls community pubs. It also realistically recognises that a few pubs become foci for crime and anti-social behaviour, a distinction not made in the Council's policy.

Public Health England

Protecting and improving the nation's health

Cheshire East

Unitary authority

This profile was published on 3 July 2018

Local Authority Health Profile 2018

This profile gives a picture of people's health in Cheshire East. It is designed to help local government and health services understand their community's needs, so that they can work together to improve people's health and reduce health inequalities.

Health in summary

The health of people in Cheshire East is varied compared with the England average. About 10% (6,400) of children live in low income families. Life expectancy for both men and women is higher than the England average.

Health inequalities

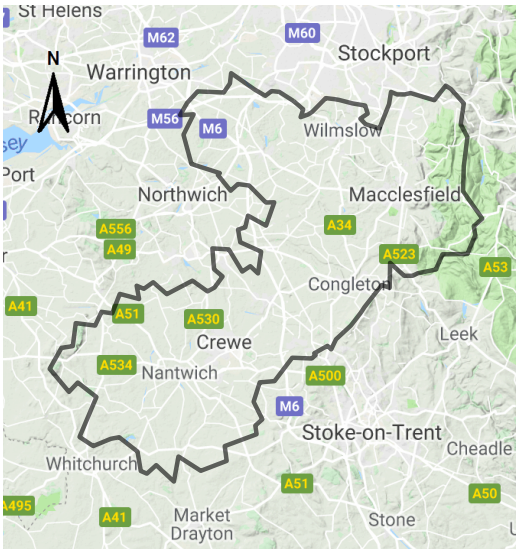
Life expectancy is 10.1 years lower for men and 8.9 years lower for women in the most deprived areas of Cheshire East than in the least deprived areas.**

Child health

In Year 6, 15.4% (539) of children are classified as obese, better than the average for England. The rate of alcohol-specific hospital stays among those under 18 is 41*. This represents 31 stays per year. Levels of GCSE attainment are better than the England average.

Adult health

The rate of alcohol-related harm hospital stays is 634*. This represents 2,428 stays per year. The rate of self-harm hospital stays is 207*, worse than the average for England. This represents 730 stays per year. The rate of people killed and seriously injured on roads is worse than average. Rates of sexually transmitted infections and TB are better than average. Rates of statutory homelessness, violent crime, early deaths from cardiovascular diseases and early deaths from cancer are better than average.



For more information on priorities in this area, see:

- www.cheshireeast.gov.uk
- www.cheshireeast.gov.uk/jsna

Visit www.healthprofiles.info for more area profiles, more information and interactive maps and tools.

Local Authority Health Profiles are Official Statistics and are produced based on the three pillars of the Code of Practice for Statistics: Trustworthiness, Quality and Value.

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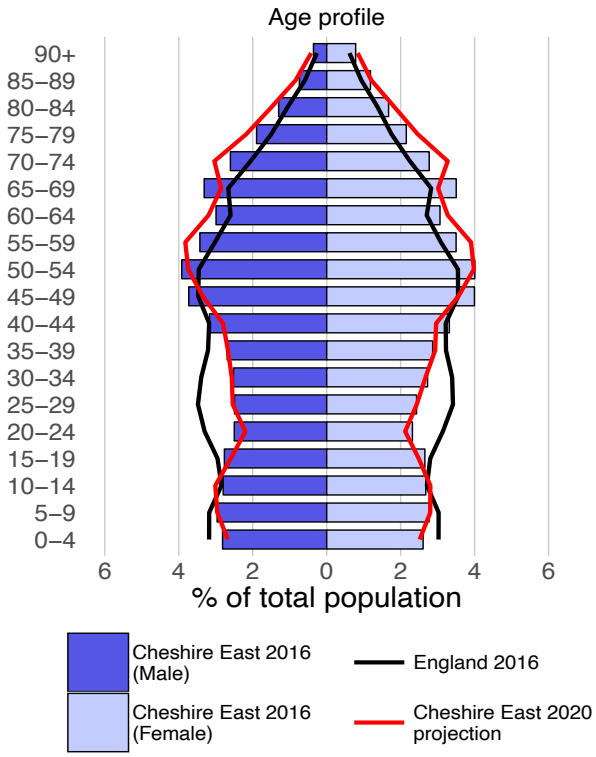
* rate per 100,000 population

** see page 3

Population



Understanding the sociodemographic profile of an area is important when planning services. Different population groups may have different health and social care needs and are likely to interact with services in different ways.

	Cheshire East (persons)	England (persons)
Population (2016)*	377	55,268
Projected population (2020)*	382	56,705
% population aged under 18	20.0%	21.3%
% population aged 65+	22.2%	17.9%
% people from an ethnic minority group	2.1%	13.6%

* thousands

Source:
Populations: Office for National Statistics licensed under the Open Government Licence
Ethnic minority groups: Annual Population Survey, October 2015 to September 2016

Deprivation

The level of deprivation in an area can be used to identify those communities who may be in the greatest need of services. These maps and charts show the Index of Multiple Deprivation 2015 (IMD 2015).

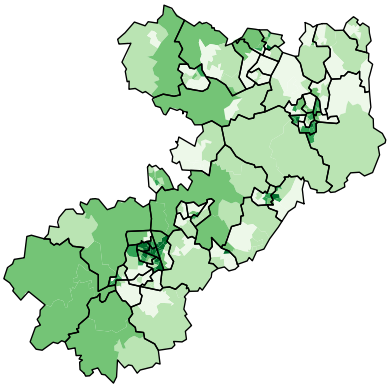
National

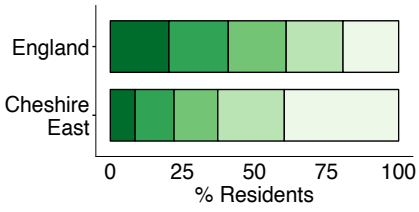
The first of the two maps shows differences in deprivation in this area based on national comparisons, using national quintiles (fifths) of IMD 2015, shown by lower super output area. The darkest coloured areas are some of the most deprived neighbourhoods in England.

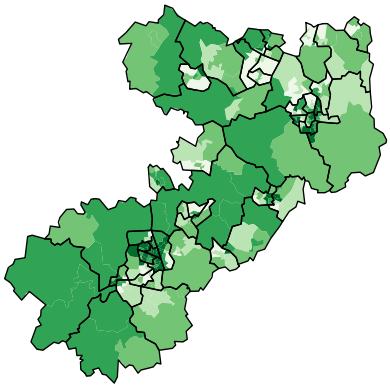
The chart shows the percentage of the population who live in areas at each level of deprivation.

Local

The second map shows the differences in deprivation based on local quintiles (fifths) of IMD 2015 for this area.







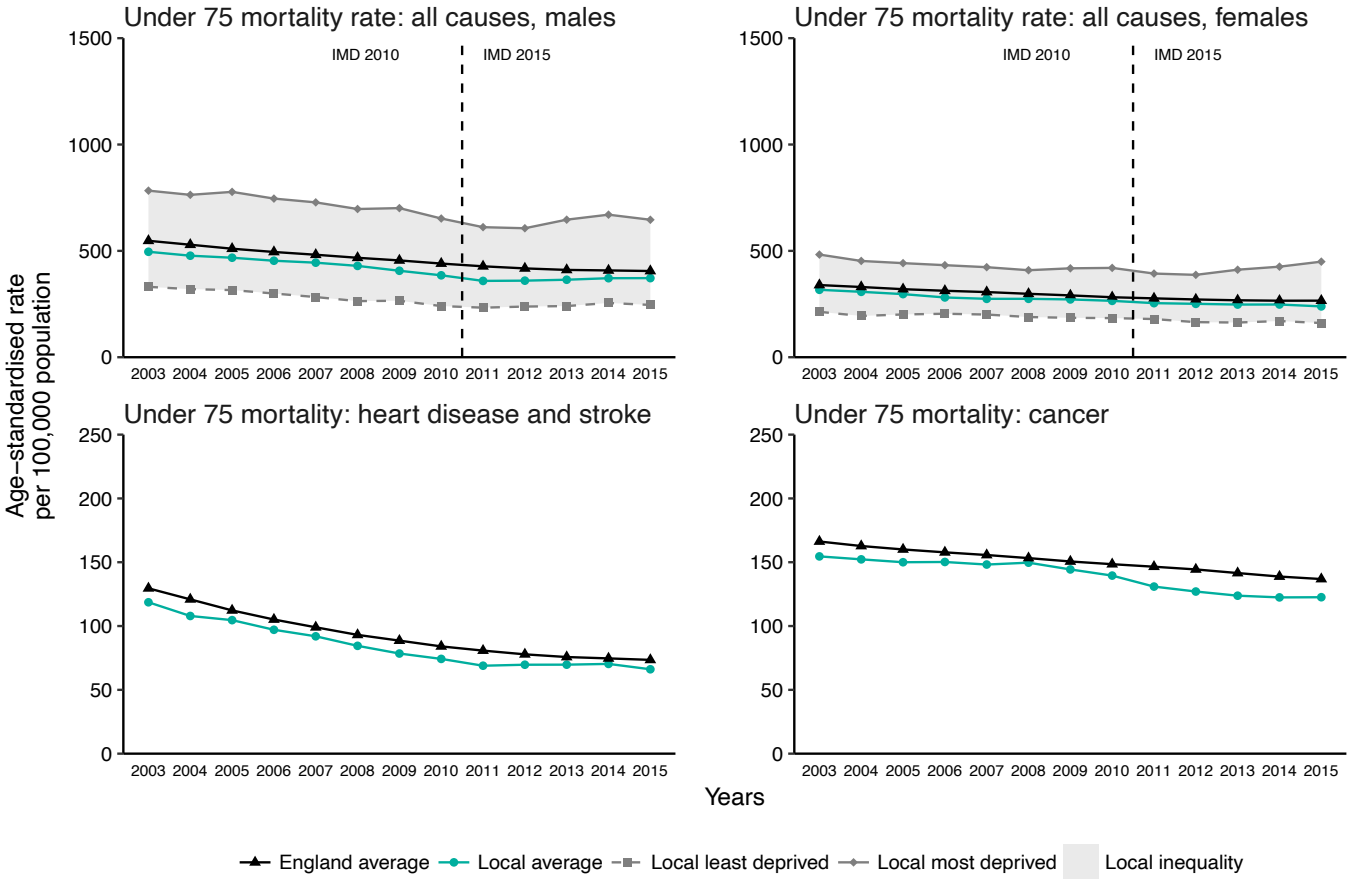
Lines represent electoral wards (2017). Quintiles shown for 2011 based lower super output areas (LSOAs). Contains OS data © Crown copyright and database rights 2018. Contains public sector information licensed under the Open Government Licence v3.0

Health inequalities: life expectancy

The charts show life expectancy for males and females within this local authority for 2014-16. The local authority is divided into local deciles (tenths) by deprivation (IMD 2015). The life expectancy gap is the difference between the top and bottom of the inequality slope. This represents the range in years of life expectancy from most to least deprived within this area. If there was no inequality in life expectancy the line would be horizontal.

Trends over time: under 75 mortality

These charts provide a comparison of the trends in death rates in people under 75 between this area and England. For deaths from all causes, they also show the trends in the most deprived and least deprived local quintiles (fifths) of this area.



Data from 2010-12 onwards have been revised to use IMD 2015 to define local deprivation quintiles (fifths), all prior time points use IMD 2010. In doing this, areas are grouped into deprivation quintiles using the Index of Multiple Deprivation which most closely aligns with the time period of the data. This provides a more accurate way of examining changes over time by deprivation.

Data points are the midpoints of three year averages of annual rates, for example 2005 represents the period 2004 to 2006. Where data are missing for local least or most deprived, the value could not be calculated as the number of cases is too small.

Health summary for Cheshire East

The chart below shows how the health of people in this area compares with the rest of England. This area's value for each indicator is shown as a circle. The England average is shown by the red line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator. However, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- Not compared

	Indicator names	Period	Local count	Local value	Eng value	Eng worst	Eng best
Life expectancy and causes of death	1 Life expectancy at birth (Male)	2014 – 16	n/a	80.3	79.5	74.2	83.7
	2 Life expectancy at birth (Female)	2014 – 16	n/a	83.7	83.1	79.4	86.8
	3 Under 75 mortality rate: all causes	2014 – 16	3,331	303.9	333.8	545.7	215.2
	4 Under 75 mortality rate: cardiovascular	2014 – 16	730	66.1	73.5	141.3	42.3
	5 Under 75 mortality rate: cancer	2014 – 16	1,359	122.6	136.8	195.3	99.1
	6 Suicide rate	2014 – 16	106	10.6	9.9	18.3	4.6
Injuries and ill health	7 Killed and seriously injured on roads	2014 – 16	590	52.4	39.7	110.4	13.5
	8 Hospital stays for self–harm	2016/17	730	206.9	185.3	578.9	50.6
	9 Hip fractures in older people (aged 65+)	2016/17	493	574.6	575.0	854.2	364.7
	10 Cancer diagnosed at early stage	2016	961	55.8	52.6	39.3	61.9
	11 Diabetes diagnoses (aged 17+)	2017	n/a	75.7	77.1	54.3	96.3
	12 Dementia diagnoses (aged 65+)	2017	3,833	71.7	67.9	45.1	90.8
Behavioural risk factors	13 Alcohol–specific hospital stays (under 18s)	2014/15 – 16/17	92	40.8	34.2	100.0	6.5
	14 Alcohol–related harm hospital stays	2016/17	2,428	634.3	636.4	1,151.1	388.2
	15 Smoking prevalence in adults (aged 18+)	2017	49,490	16.4	14.9	24.8	4.6
	16 Physically active adults (aged 19+)	2016/17	n/a	69.2	66.0	53.3	78.8
	17 Excess weight in adults (aged 18+)	2016/17	n/a	59.4	61.3	74.9	40.5
Child health	18 Under 18 conceptions	2016	98	15.5	18.8	36.7	3.3
	19 Smoking status at time of delivery	2016/17	372	10.4	10.7	28.1	2.3
	20 Breastfeeding initiation	2016/17	2,285	*65	74.5	37.9	96.7
	21 Infant mortality rate	2014 – 16	44	3.9	3.9	7.9	0.0
	22 Obese children (aged 10–11)	2016/17	539	15.4	20.0	29.2	8.8
Inequalities	23 Deprivation score (IMD 2015)	2015	n/a	14.1	21.8	42.0	5.0
	24 Smoking prevalence: routine and manual occupations	2017	n/a	35.0	25.7	48.7	5.1
Wider determinants of health	25 Children in low income families (under 16s)	2015	6,365	10.1	16.8	30.5	5.7
	26 GCSEs achieved	2015/16	2,281	62.1	57.8	44.8	78.7
	27 Employment rate (aged 16–64)	2016/17	170,900	76.4	74.4	59.8	88.5
	28 Statutory homelessness	2016/17	104	0.6	0.8		
	29 Violent crime (violence offences)	2016/17	5,710	15.2	20.0	42.2	5.7
Health protection	30 Excess winter deaths	Aug 2013 – Jul 2016	691	19.8	17.9	30.3	6.3
	31 New sexually transmitted infections	2017	1,176	509.8	793.8	3,215.3	266.6
	32 New cases of tuberculosis	2014 – 16	47	4.2	10.9	69.0	0.0

For full details on each indicator, see the definitions tab of the Health Profiles online tool: www.healthprofiles.info

Indicator value types
1, 2 Life expectancy - Years 3, 4, 5 Directly age-standardised rate per 100,000 population aged under 75 6 Directly age-standardised rate per 100,000 population aged 10 and over 7 Crude rate per 100,000 population 8 Directly age-standardised rate per 100,000 population 9 Directly age-standardised rate per 100,000 population aged 65 and over 10 Proportion - % of cancers diagnosed at stage 1 or 2 11 Proportion - % recorded diagnosis of diabetes as a proportion of the estimated number with diabetes 12 Proportion - % recorded diagnosis of dementia as a proportion of the estimated number with dementia 13 Crude rate per 100,000 population aged under 18 14 Directly age-standardised rate per 100,000 population 15, 16, 17 Proportion - % 18 Crude rate per 1,000 females aged 15 to 17 19, 20 Proportion - % 21 Crude rate per 1,000 live births 22 Proportion - % 23 Index of Multiple Deprivation (IMD) 2015 score 24, 25 Proportion - % 26 Proportion - % 5 A*-C including English & Maths 27 Proportion - % 28 Crude rate per 1,000 households 29 Crude rate per 1,000 population 30 Ratio of excess winter deaths to average of non-winter deaths (%) 31 Crude rate per 100,000 population aged 15 to 64 (excluding Chlamydia) 32 Crude rate per 100,000 population

€"Regional" refers to the former government regions.
*65 Value not published for data quality reasons

If 25% or more of areas have no data then the England range is not displayed.

Please send any enquiries to healthprofiles@phe.gov.uk