

Blackpool Local Plan Part 2 SADMP Examination

Issue (xii) Question 7

Is Policy DM16 underpinned by robust evidence?

The draft policy is a hybrid of an incidence- and a proximity-based total ban, but with entire wards of the borough as the putative receptor. Whilst similar policies exist in Tyne and Wear, they do not have a proximity element, were generally unchallenged in preparation and seem unlikely to meet the tests of soundness.

Despite relying on child obesity data, the Managing the Location of Hot Food Takeaways Topic Paper accepts (paragraph 10.11) the lack of a link between incidence of obesity and the proximity of schools to hot food takeaways, but suggests (paragraph 10.12) that the link must therefore instead lie in their mere presence in an area.

The Topic Paper relies on the Food Environment Assessment Tool (FEAT) and incorrectly states that it identifies hot food takeaways by local authority.

In fact, FEAT uses Ordnance Survey Point of Interest codes rather than land uses. The closest “food outlet type” to hot food takeaways is “Takeaways” and includes “Fast food and takeaway outlets”, “Fast food delivery services”, “Fish and chip shops” and “Bakeries”. These differences significantly affect results.

In consequence, these data have no relationship to use classes (or now the definition of hot food takeaways as excluded from Class E), rendering them effectively unusable for the purpose of identifying proliferation of hot food takeaways. This also means that the policy’s effectiveness will be impossible to assess on that basis.

Many of the scatterplots correlate deprivation and numbers of hot food takeaways, which, apart from problems relating to the size of the geography used (wards vary significantly in size), is not something that the policy aims to tackle (or indeed is something that an applicant could be expected to tackle).

The conflation of deprivation, numbers of hot food takeaways and incidence of obesity or overweight conceals the facts that the causes of the latter are multivariate and that they are increasingly associated with deprivation. Town centres in decline sometimes have more hot food takeaways because other shops are not viable.

This is usually a result of there being insufficient footfall or spend, often characteristic of areas of deprivation. A delicate balance must be struck in these cases between avoiding too high a concentration of any one use and closing off remaining sources of footfall that might sustain remaining businesses such as convenience stores.

The rationale overall assumes the simple existence of hot food takeaways is causing obesity or overweight, regardless of numbers or density of hot food takeaways or other food and drink uses at present. Much of the evidence is on deprivation, which relates to neither a criterion nor an objective of the policy.

Is the evidence specific to Blackpool?

The Topic Paper relies heavily on national resources, such as the Food Environment Assessment Tool (FEAT) and Public Health England data.

The figures in Section 5 of the Topic Paper depict data that vary considerably across wards, with many comparable to or lower than England averages. Whilst we do not minimise the significance of any incidence, national policy intends measures only to be deployed in areas of high incidence and where proliferation is occurring.

It is not clear whether the hot food takeaway numbers in Figure 11 use the FEAT data or are based on local survey and records, whether they are increasing or, if correct, what they represent in terms of density per area or head of population in each case. Thus, neither the evidence nor policy relates to or tackles over-concentration.

Is there a clear link between obesity and takeaways?

The policy implicitly links the presence or proximity of specifically hot food takeaways over and above other land uses with obesity, a link for which there is little consistent evidence (Williams et al, 2014) and the basis for which seems to apply to premises in a wide range of use classes (Robinson et al, 2018).

Much of the primary survey work referenced invokes unhelpful terminology (e.g. 'fast food') that includes food types available at convenience and other stores and does not map to the use controlled by the policy. The speed at which food is prepared and the premises in which it is served do not map to nutritional value.

The Managing the Location of Hot Food Takeaways Topic Paper quite reasonably and fairly quotes the Strategic Review of Health Inequalities in England Post-2010 (Marmot et al, 2010) as a basis for tackling health inequalities, but does not quote findings specific to food environment and proximity to "healthy" food:

Marmot et al (2010) state (p.132), that studies that show association between proximity, or lack of, to healthy food, and health outcomes such as obesity or malnutrition "... should be approached with caution. They are most often observational and so do not show causality between inadequate access and health outcomes.

Hot food takeaways are a lower-order retail facility, relying on their local catchment for a relatively high proportion of their trade, particularly away from main roads, stations and stops. However, many exist in areas with low incidence of obesity, illustrating the wide range of other socio-economic factors that influence outcomes.

Furthermore, the policy would treat hot food takeaways whose operators commit 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 to ensure soundness.

Is it clear how 400 metres and 15% will be assessed?

No, neither is spelt out in the evidence. Whilst appeals in Greater London generally favour a real-world walk-distance, rather than radii, these appeals have dealt with specific putative point receptors such as schools. The subject policy invokes whole wards and the radii effectively become buffer zones.

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 specific to a school or area. The distance chosen significantly affects the number of residents whose access to food and drink facilities is impacted.

As Williams et al (2014) indicated, the evidence on proximity is weak and inconsistent. Currie et al (2010) reported a positive effect on incidence in schools 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.

Surprisingly for such a wide-ranging policy, there is no assessment of the numbers of people impacted. For comparison, a point zone covers just over 50 hectares. At 30 dwellings per hectare, this might contain 1,500 dwellings or 3,600 people, all of whose accessibility would be progressively reduced by the policy.

Similarly, there seems no clear explanation of why the specific incidence threshold has been chosen, beyond similarity with that chosen by Tyne and Wear councils. The distance ought to be that from HFTs at which supposed harm ceases or peaks, but no assessment has been made of this, or whether the harm is proximity-related at all.

It is worth bearing in mind that, unlike adult obesity, which is assessed by reference to body mass indices, child obesity is assessed by reference to percentiles and, for the UK National Child Measurement Programme, benchmarked to levels, so that a certain proportion of children always have and always will be so classified.

Overall is this policy soundly based?

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 tends to support the location of such uses in accessible places and aims to create and maintain retail balance. The fact that no exception is made for town centres in the draft policy highlights the fact that it will often work counter to the sequential test and general sustainability objectives.

Whilst clearly any incidence of obesity is problematic, the national guidance implicitly acknowledges the uncertainties and downside risks to such interventions and restricts them to areas of over-proliferation. The Topic Paper frequently mentions proliferation but seems to present no evidence it is occurring or causing harm.

Furthermore, we consider the policy not positively prepared as no assessment has been made of (a) what an appropriate retail balance would comprise, (b) how many food and drink premises might be needed or (c) collateral reductions in walkable choice of the large number of people who happen to live in or near affected wards.

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' *British Medical Journal* (363) 4982 (Extract)
- (c) Marmot, M et al, 2010. *Fair Society, Healthy Lives*. London: The Strategic Review of Health Inequalities in England post-2010. (Extract)
- (d) Croydon Local Plan Inspector's Report, January 2018. (Extract)
- (e) Currie, J et al, 2010. 'The effect of fast food restaurants on obesity and weight gain' *American Economic Journal: Economic Policy* 2, 32–63 (Extract)

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.

obesity reviews (2014) **15**, 359–374

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



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(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/>).

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

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

in these determinants. The London Congestion Charge is applied across central London only, but it has reduced the gradient in air pollution proportionately across the social gradient, with increasing impact in the more deprived areas – Figure 4.8.

Improving the food environment in local areas across the social gradient

Dietary change can also play a key role not only in mitigating climate change and adaptation strategies, but also in promoting health by reducing the consumption of saturated fat from meat and dairy sources. Food preparation and production contributes around 19 per cent of the UK's greenhouse gas emissions; half of these emissions are attributable to the agricultural stage.

Food systems have the potential to provide direct health benefits through the nutritional quality of the foods they supply.⁴³⁹ Improving the food environment involves addressing issues concerning the accessibility of affordable and nutritious food that is sustainably produced, processed and delivered.

Internationally, studies show that among low-income groups price is the greatest motivating factor in food choice. In the US, price reductions have seen positive increases in the sales of low-fat foods and fruit and vegetables.⁴⁴⁰ The era of cheap food may be approaching its end, but consumer expectations are still of low prices, which fail to include the full environmental costs.⁴⁴¹

There are studies that show association between proximity, or lack of, to healthy food, and health outcomes such as obesity or malnutrition, but these studies should be approached with caution. They are most often observational and so do not show *causality* between inadequate access and health outcomes.⁴⁴² One study in the UK on the greater access to unhealthy food has shown this *may* disproportionately affect those in more deprived areas.⁴⁴³ Data from the US shows more substantial links between schools and proximity to fast food outlets, as well as proximity to fast food outlets and obesity but the food environment in the US is very different to the UK's.⁴⁴⁴

Case Study Working in partnership to reduce fuel poverty

The UK Public Health Association (UKPHA) brings together individuals and organisations from all sectors who share a common commitment to promoting the public's health and it is leading the delivery of an innovative and integrated fuel poverty programme. Starting with understanding the current evidence, engaging with key partners then implementing a pilot, the project is a good example of the delivery of integrated and evidence-based interventions to reduce health inequalities.

The programme originates from the UKPHA's Health Housing and Fuel Poverty Forum, funded by DEFRA. The forum, made up of national figures from the health, housing and energy sectors, and practitioners from across England, developed the 'Central Clearing House' model. Their research concluded that a model of local area partnerships that linked health, housing and fuel poverty services was the most effective approach for directing services to the vulnerable. The CCH model identified the key systems and processes necessary to access the vulnerable fuel poor, identify high risk groups, streamline referral and delivery systems and implement monitoring and evaluation processes.

The CCH model was first piloted in Manchester, with the implementation of the Affordable Warmth Access Referral Mechanism (AWARM). Funded by the Department of Health, the pilot was a partnership with Salford City Council and Primary Care Trust. Manchester Business School is evaluating the programme for the mismatch between theory and practice and an assessment of what 'fit for purpose' should look like.

Greater Manchester invested approximately £100,000 each year into AWARM. Since April 2008 AWARM activity resulted in over £600,000 of investment and majority of cases are still open so many households will receive further investment. AWARM resulted in a dramatic increase in referrals from across the social and care sectors, but the number of referrals from health professionals (mainly GPs) remains low. In 12 months the programme trained 1,359 professionals, a third in health, with the remainder in social services, voluntary/community services, local government and housing.

The lessons learned from the pilot include:

- There are numerous opportunities to share data between local authorities, GPs and PCTs to improve how referrals are targeted
- A pop-up system on GP patient electronic records would help to immediately direct referral to a one-stop-shop
- Involving energy companies as active project partners can help identify novel ways to target vulnerable individuals and neighbourhoods.

The funding received ends in 2010, yet the project is improving local delivery systems, increasing the numbers receiving funding to reduce fuel poverty. Like many other ill health prevention projects, funding only invests in a pilot, regardless of the outcomes. In this case, this means a project showing successful short-term outcomes may not be rolled out.

For more information see www.ukpha.org.uk/fuel-poverty.aspx

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.

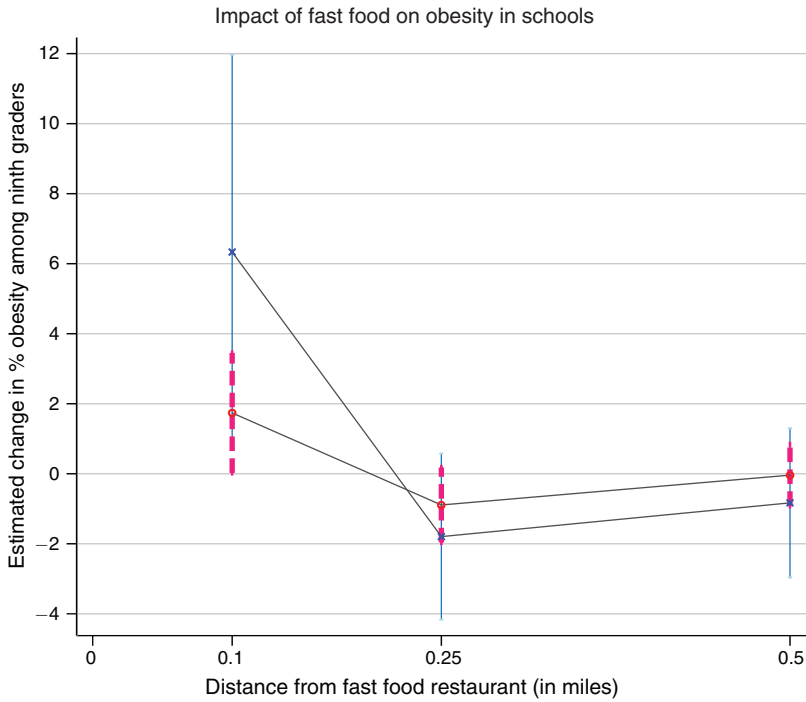


FIGURE 1A. IMPACT OF FAST FOOD AVAILABILITY ON OBESITY AMONG NINTH GRADERS

Notes: The vertical bar represents the 95 percent confidence interval using panel estimates; the dashed vertical bar represents the 95 percent confidence interval using cross-sectional estimates.

school fixed effects point to a statistically significant effect of the availability of a fast food restaurant within 0.1 miles of 6.33 percentage points, which is larger than in the cross-sectional estimates of columns 1 and 2. This fast food restaurant effect is the same in the specification without controls (column 3) and with controls (column 4 of Table 2, and Figure 1A), indicating that once we condition on school fixed effects, there is very limited selection on the other observables. There is no evidence of a positive additional effect of the availability of a fast food restaurant within 0.25 miles or 0.5 miles. The pattern is similar to what we see in models without school fixed effects. There is no significant effect of a fast food restaurant at 0.5 or 0.25 miles, and a large positive effect at 0.1 miles.

Next, we present estimates based on an event study methodology. We examine how the past, current, and future existence of a fast food restaurant in a given location affects the current obesity rates of students at that location. Estimates are from a single regression where we include indicators for availability of fast food in years $t - 3$, $t - 2$, $t - 1$, t , $t + 1$, $t + 2$, and $t + 3$ for a distance of 0.1 mile, 0.25 miles, and 0.5 miles.¹⁵ Figure 2 presents estimates of the impact of fast food availability within 0.1 miles for specifications both without and with school fixed effects. The

¹⁵ We also include (but do not show) seven indicators for non-fast food restaurants.