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Your ref:
Our ref: MH/RT/KM
Date: 6 December 2024

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Dear Mr Halton,

Regulation 19 Public Consultation - Pendle Local Plan Fourth Edition Publication Draft

Thank you for inviting Lancashire County Council to comment on the Pendle Local Plan Fourth Edition Publication Draft (the draft Local Plan). Please find the County Council's formal response below.

School Planning Team

The County Council is grateful for the communications that have been held with Pendle to date and welcome that the outcome of those discussions taken into consideration in the latest draft Local Plan.

Having already submitted representations about the impact of the identified sites in the Regulation 18 response the County Council would like to point out the following.

(1) Following communications with Pendle officers it was agreed to remove the initial call for school sites as long as the following 'but it is supportive of additional provision should this be required during the plan period' be kept into Policy DM36. And that that the County Council regularly revisits provision so should school need changes then the School Planning Team can include the updated requirement for a new school and/or land for expansion of an existing school or for a new school.

(2) The County Council would like to seek clarification on Pendle's use of Community Infrastructure Levy (page 69 SP12) and would seek reassurance that any Education Contributions to mitigate any of the development's impacts are ringfenced for education purposes only or that the Section 106 legal process is used for this purpose.

(3) With in the Infrastructure Delivery Plan 2021 –2040 there are a couple of factual errors:
   a. Section 14.60 is correct except that there is a predicted shortfall of places in the Brierfield Pupil Planning Area of over 2% for 2029; and,

b. Section 14.62 the information on Burnley Secondary schools is incorrect. The figures for 2029 show a shortfall of places of over 4% not the 21% surplus that is stated.

The School Planning Team look forward to further liaison with Pendle's planning service to determine how the education requirements from the draft Local Plan sites will be mitigated.

Housing

The County Council's housing service has been working with Pendle on the delivery of new supported living and has provided figures for predicted demand from research conducted by Housing Lin.

The County Council is pleased to see that in the sections on delivery of housing, in particular DM28 Specialist Housing, has included the County Council's figures for the delivery of adults needing support 53 new units and also new extra care provision 268 places.

Also in Section DM21 Design and Quality (of Housing) more provision of accommodation for people with disabilities the provision of M4(3) wheelchair adapted properties. Further, in section DM22 –Housing Mix, that encourages the delivery of more 2-bedroom bungalows and this is also welcomed.

Active Travel

The County Council welcomes the approach Pendle has taken with regard to promoting walking and cycling within the plan. In order to fully embed the latest national and county-wide active travel policy into the draft Local Plan you may consider alternative wording (removed in strikethrough and suggested in **bold**) as follows.

Foreword

With such riches, it's no surprise that our hills and dales are a mecca for walkers and cyclists **walking and cycling**.

2. A spatial portrait

2.23 Tourism has become increasingly important for Pendle. Visitors are attracted by spectacular rural landscapes, our rich industrial heritage and diverse cultural history. The area has proved to be a particularly popular destination for walkers and cyclists **walking and cycling.**

SP10: Healthy and vibrant communities

Policy Text

1. The Council will seek to promote **deliver** healthy and vibrant communities, and reduce health inequalities, by:

a. Retaining and improving local health facilities (Policy DM30) and community facilities (Policy DM35)

b. Encouraging **Enabling** active lifestyles by:

i. Supporting Active Design, improving the quality and accessibility of open space provision, sport and recreation facilities, and green infrastructure (Policies DM05, DM06, DM12, DM16, DM31 and DM45)

ii. ~~Encouraging~~ **Enabling** Active Travel, ~~promoting~~ **to increase levels of participation in** walking and cycling (Policies SP11, DM16, DM30 and DM32).

SP11: Transport and connectivity

Policy text

Strategic Links

1. The Council will support those strategic transport schemes as outlined in the most up-to-date versions of the Local Transport Plan and the East Lancashire Highways and Transport Masterplan. In addition, the Council will lobby for, and support the following strategic transport schemes:

a. Provision of a strategic road link towards Yorkshire

b. Reinstatement of the former Colne to Skipton railway line

c. Provision of a dedicated cycle route to North Yorkshire.

Comment
The County Council is unsure of the reason why the dedicated cycle route to North Yorkshire is more of a priority than other routes contained in the LCWIP. Whilst the LCWIP states the Colne-Earby-Skipton corridor is a strategic priority, there is also a potential policy conflict with any reinstatement of the railway line (as per point b above and point 2 below). A new railway could act as a catalyst (if a new active travel path was built adjacent to railway), but it could also act as a barrier (if there is no political or public support to upgrade the existing track bed to a greenway). No other routes were identified as being strategic into North Yorkshire, though the canal towpath does offer an off-highway alternative.

Other strategic routes in the district were identified in the LCWIP. It would be useful to understand the rationale for why this particular route as has been selected as a strategic transport scheme for the district, also given the long distances between the nearest urban centres in Pendle and those in North Yorkshire.

2. The route of the former Colne-Skipton railway line, as shown on the Policies Map, is protected for future transport **sustainable travel use**.

Comment
The term 'transport use' is vague and could also be interpreted as a future road scheme coupled to this it appears to duplicate with point b above.

DM13: Environmental Protection

Supporting text
5.207. The government's Clean Air Strategy (2019) highlights that active travel such as, cycling and walking creates less pollution. Our spatial strategy seeks to direct development to where it is needed and focus it in the most sustainable locations, helping to minimise trip lengths.
This reduces the need to travel by car and encourages **enables** walking, cycling or the use of public transport helping to reduce the emissions (Policy SP11).

Enhancing the built environment

5.247 The quality of our neighbourhood's impacts health and wellbeing. Streets that are safe and attractive encourage **enable** walking and cycling, in preference to car travel, increasing physical activity and reducing air and noise pollution. Pleasant

places encourage people to spend time outside, providing opportunities for exercise, social interaction and recreation.

DM16: Design and placemaking

Supporting text
5.258 Similarly good design is not just about appearance; a wide range of other factors must be considered if new development is to be successful:

- Context –New development should not be looked at in isolation from its surroundings. Even sites that are self-contained will impact the wider environment. The scale of new development will normally reflect its immediate surroundings. The design and materials used should make a positive contribution to the overall quality of the environment.
- Access –Permeable layouts help to promote **enable** walking and cycling. Larger developments should ideally have more than one access from the highway network to ensure that emergency vehicles are able to attend any incidents. The travelling distance from points of access should be as short as possible to reduce the potential for conflict between **highway** ~~road~~ users ~~pedestrians, and cyclists~~.

Comment
Shorter travel distances may not automatically result in less conflict between road users and in this connection the policy wording could also discuss how creating shorter, more direct walking and cycling routes within and into new developments will prioritise walking and cycling over car use, i.e. using 'shortcuts' that private motor vehicle users cannot access, therefore must by default travel a further distance and, thereby making driving a less attractive travel option in relation to walking and cycling.

DM19: Leeds and Liverpool Canal corridor

Supporting text
5.278 The canal is also an important green infrastructure resource (Policy DM06) and tourism asset (Policy DM45). The towpath, although not a public right of way (PROW), is a permissive path for walking and cycling. Some sections form part of the Sustrans National Cycle Network. The towpath is a valuable addition to the local network of footpaths and cycle ways. It provides an important link between local communities in Lancashire and North Yorkshire.

Comment
The County Council considers that it would be worthwhile describing how the canal towpath is referenced in the Burnley & Pendle LCWIP as a primary route, with lots of routes existing and proposed routes connecting with it. Where possible the County Council would like to ensure any future developments in the vicinity of the canal can help fund improvements to the towpath through developer contributions.

DM21: Design and quality of housing

Policy text
1. Residential development should make a positive contribution to the built and natural environment, and. Proposals should:

(g) Encourage **Enable** active travel by linking to safe and attractive pedestrian and cycling infrastructure connecting with nearby green infrastructure (including formal open space provision), community facilities, school provision, public transport services, shops and sources of employment.

Supporting text

6.41 Developments need to be planned to consider and be resilient to the predicted effects of Climate Change (Policy DM01). They need to be sited and have a layout which minimises the risk of flooding from all sources and promotes drainage through natural means (Policy DM02). They need to be orientated and make use of materials which minimises energy usage and reduces the effects and risk of damage from extreme weather events. Developments should be located and designed to promote **enable** walking and cycling to sources of recreation, access to services including education, community facilities and public transport to minimise the need to travel by car (Policy SP11).

6.47 The efficient use of land can help reduce the need to travel, promote **enable** walking and cycling, encourage **deliver** urban renewal and safeguard Pendle's most sensitive environments from inappropriate forms of development. Pendle is a relatively constrained borough. Its distinctive natural landscape and industrial heritage form important assets which must be safeguarded for the enjoyment of future generations to come. The development of housing plays an important role in supporting the urban regeneration and economic growth of the borough. Land made available for housing must therefore be used efficiently to ensure that the housing needs of the plan (and the diversity of this housing need) can be met in full.

DM32: Walking and cycling

Policy Text

1. Development proposals which affect an existing public right of way should, in the first instance, seek to incorporate this into the development as an exclusive route for walkers and cyclists **walking, wheeling and cycling**. Where this is not possible, the proposals should provide an alternative route that is safe and attractive for all users.

2. To help promote the use of sustainable modes of transport, the Council will require development proposals to:

(a) Maintain and where possible improve existing pedestrian and cycling infrastructure, including the Public Right of Way (PROW) network.
(b) Avoid adverse impacts on the safety of the pedestrian and cycling environment, including the PROW network.
(c) Provide appropriate access for all sections of the community.
(d) Use good **Use design standards that accord with the latest guidance**, and, where appropriate, **streets and paths should be well lit** lighting to improve for the safety and security of pedestrians and cyclists both within, and adjacent to, the development site.
(e) Encourage **Enable** greater opportunities for walking, **wheeling** and cycling by:
    i. Linking to the existing footpath, bridleway and cycleway networks
    ii. Providing secure cycle parking and storage facilities.
    iii. Being located close to **within walking distance of** existing services (including shops) and sources of employment.

3. To ensure future maintenance where appropriate new links **active travel infrastructure** should be the subject of a Section 106 agreement with the local highway authority.

Comments

The County Council considers a review of the above policy wording in 3 is required here given there are two aspects to this sentence –one is about securing developer funding for maintenance, which Pendle may wish to consider what ongoing maintenance money is or is

not possible through the Section 106 agreement process, the other is about securing developer funding for implementation of infrastructure.

4. Non-residential development that is likely to generate a significant level of footfall, should be located in highly accessible locations such as a town or local shopping centre**s**, ~~which provide good access for pedestrians and cyclists~~ **prioritise walking, wheeling and cycling above all else.**

Supporting text
6.172 Walking and cycling ~~travel~~ **is** ~~are~~ beneficial for personal health and the environment. They **It** can also bring economic benefits to an area through increased footfall and the promotion of tourism.

6.173 The local topography can be challenging in some areas. But Pendle's towns and larger villages are relatively compact. To take advantage of this we want to encourage **enable** people to walk or cycle to the places they visit on a regular basis. To become a viable alternative to the car, taxi or bus; development should be situated in locations accessible to the public footpath and cycling network. We need to maintain, improve and extend a network of safe and attractive routes. These will connect places of origin with common destinations. Our journeys for work, education, shopping, recreation and leisure tend to start from home, or the nearest bus or railway station.

6.174 All developments should seek to **must** provide safe and attractive linkages with existing footpaths, bridleways and cycle ways. To ensure future maintenance and to help protect routes from obstruction and interference new footpath and cycleway links should ideally be included in a Section 106 agreement.

6.175 The design of major developments should also promote **enable** walking and cycling through the layout and orientation of buildings on the site. They **Developments** should seek to create safe routes for walkers and cyclists **walking and cycling** by **adhering to the latest walking and cycling infrastructure design guidance**.

• Reducing the potential for conflict with other road users.
• Helping to slow the flow of traffic.
• Provide physical segregation, wherever possible, by providing wider pavements and well located crossing points.
• Provide appropriate levels of natural surveillance; artificial lighting; CTV and maintenance to increase security.

6.177 New (estate) roads should avoid following the route of an existing footpath, bridleway or cycle way, wherever possible. Where this is unavoidable a new route of equivalent benefit should be established for walkers and cyclists **walking and cycling**.

DM40: Employment land requirement and delivery

Policy text
3. In all cases proposals for employment land uses must:

c. Promote **Enable** access by sustainable modes of transport by:
   i. Directing investment to locations which are well served by existing public transport provision.
   ii. Improving walking and cycling connectivity by providing new links, and where possible enhancements, to the existing footpath/cycling network.
   iii. Encourage **Enable** commuting by bicycle by providing sufficient onsite secure cycling **cycle parking**, bicycle vouchers, and shower/changing facilities.

Public Health

The National Planning Policy Framework (NPPF) (2021) provides guidance on the role of health within the planning system. As part of the delivery of the social dimension of sustainable development, planning has the opportunity to support strong, vibrant and healthy communities. One of the core planning principles that underpins both plan-making and decision making is for planning to 'enable and support healthy lifestyles, especially where this would address identified local health and well-being needs –for example through the provision of safe and accessible green infrastructure, sports facilities, local shops, access to healthier food, allotments and layouts that encourage walking and cycling' (pg. 27). The County Council welcomes the work of the draft Local Plan and would like to offer the following comments in response to this consultation.

Health equity and reducing health inequalities.

As outlined above and further recognised in Section 6 (Social) of the draft Local Plan[1], there are significant ties between the natural and built environments in which people live, work, and play, and the health of our communities. The planning system plays a crucial role in managing the design of these environments, thereby promoting positive health outcomes.

The Couty Council recognises the acknowledgement to health inequalities by Pendle Borough Council in their Corporate Plan (2023-2027)[2], which identifies numerous key initiatives aimed at improving health inequalities across the district. The draft Local Plan highlights the priority of fostering healthy communities and the necessity of collaborating with local health and wellbeing providers to tackle health inequalities and improve outcomes for all.

The importance of identifying opportunities to reduce health inequalities across Pendle is highlighted by recent data, which shows Pendle as performing significantly worse than the England average[3] in several key indicators. These include:

- Life expectancy at birth and at 65 for both males and females (2020-2022);
- Suicide rates (2021-2023); and,
- Percentage of physically active adults (19+yrs) (2022-2023).

Pendle ranks the lowest in England for children in relative and absolute low-income families (under 16s) (2022-2023) and for the percentage of people in employment (2023-2024). Pendle was ranked as the 36th most deprived area out of 317 districts and unitary authorities in England, as measured by the rank of average Lower Layer Super Output Areas (LSOAs). Overall, 31.6% of the LSOAs in the authority were among the 10% most deprived in the country, with 35% of households classed as deprived in at least one dimension [4].

In order to fully recognise and drive forward the reduction of health inequalities across the borough of Pendle, the County Council welcomes the inclusion of LP08 as a Local Plan objective to:

'Reduce inequalities by ensuring that new community facilities and their services are accessible to all, and that new development promotes wider improvements to health and well-being.' (pg. 27).

[1] Local Plan Fourth Edition Publication consultation documents | Pendle Borough Council
[2] Corporate Plan 2023-2027 | Pendle Borough Council
[3] https://fingertips.phe.org.uk/profile/public-health-outcomes-framework
[4] Lancashire County Council - foundations for wellbeing

The County Council supports the comprehensive overview provided in Policy DM30, which outlines the actions to be taken to ensure, where practicable, developments contribute towards healthy places and lifestyles. Specifically, Policy DM30 states that developments:

'Should address the needs of an ageing population, support improvements in public health and a reduction in health inequalities' (pg. 188).

Accessibility

Health equity is an important principle when seeking to reduce inequalities within a defined population. One component of health equity relevant to planning policy is accessibility. The NPPF references this component within Chapter 12: 'Achieving well-designed places', in stating the need to 'create places that are safe, inclusive and accessible and which promote health and well-being' (pg. 39).

Whilst accessibility should not be considered in relation to age alone, this is an important factor. Census data (2021) showed the average (median) age within Pendle was 39 years, a figure which has remained the same over the last two censuses. Yet figures showed the number of people aged 65 to 74 years rose by around 2,100 (27%↑), while the number of residents aged 20 and 24 years fell by 500 (8.7% ↓). It is estimated 18% (17,244) of the Pendle population is aged 65 and over [5], with the number projected to be at 21,458 by 2043[6].

The estimated dementia diagnosis rate (for those aged 65 and over) measures the proportion of people living with dementia who have received a formal diagnosis. A higher estimated proportion indicates a greater likelihood that individuals have been or are in the process of being diagnosed with dementia. The purpose of this measure is to ensure that timely diagnoses can facilitate treatment and support, thereby improving health and care outcomes. In Lancashire, a higher proportion of people aged 65+ have a recorded diagnosis of dementia, when compared to the proportion for England (69.4% and 64.8 respectively), while in Pendle this figure falls to 61.1%[7].

The Royal Town Planning Institute's (RTPI) Dementia and Town Planning Report [8] states that 'if you get an area right for people with dementia, you can also get it right for older people, for young disabled people, for families with small children, and ultimately for everyone' (pg. 3). Within their report, the RTPI also acknowledge the work undertaken by the districts of Central Lancashire to consult with people living with dementia to identify what a dementia-friendly Local Plan would look like.

The Local Government Association has also produced a report providing suggestions of how local councils can support dementia-friendly communities through design[9]. These include the implementation of key design principles such as recognising the impact of good lighting; design and provision of adequate toilets; and the design of wider and pedestrian-only pavements with clearly defined edges (pg.22).

It is in light of the above, that the County Council welcomes the work Pendle has done to reflect the equity component of accessibility within Local Plan. The County Council particularly welcome the inclusion and guidance on the incorporation of dementia-friendly design principles in Policy DM28: Specialist Housing and DM30: Healthy Places and Lifestyles.

[5] How life has changed in Pendle: Census 2021 (ons.gov.uk)
[6] Pendle district - Lancashire County Council
[7] Dementia - Lancashire County Council
[8] https://www.rtpi.org.uk/media/6374/dementiatownplanningpracticeadvice2020.pdf
[9] Dementia friendly communities: guidance for councils (local.gov.uk)

Policy DM21: Design and quality of housing

Whilst all new dwellings must be built to the M4(1) Category 1: Visitable Dwellings standard, the optional M4(2) Category 2: Accessible and Adaptable Dwellings standard goes further, in requiring homes to be built in such a way that they can be adapted to an occupier's changing needs. The M4(3) Category 3: Wheelchair User Dwellings standard is specific for wheelchair users.

Requiring the use of the Government's optional technical standards for accessible and adaptable housing[10] for all development can ensure accessibility and inclusivity and promote better living opportunities across all ages. In their application, these optional standards are supportive in providing both equal and fair opportunities for all occupiers –from families with young children to older, less agile people and those living with a mobility impairment - to live in homes which can be adapted to meet their needs.

The draft Local Plan acknowledges this in objective LP05, which outlines a commitment to the delivery of 'quality housing that is both appropriate and affordable for current and future residents' (pp.27).

National Planning Practice Guidance[11] states local authorities should consider likely future need for housing for older and disabled people (including wheelchair-user dwellings) as well as the overall impact on viability, when determining whether to introduce the optional accessibility standards. The below points provide an overview of the current, and predicted, population structure of Pendle, accounting for older people, those with disabilities, and families:

- In Pendle, population size has increased by 7.1%, from 89,500 in 2011 to 95,800 in 2021. This rise is higher than the overall increase for England (6.6%) [12];
- The number of people aged 65 to 75 years rose by 27.3% (2,100) between 2011 and 2021, while the number of residents between 20 and 24 years decreased by 8.7% (500) [13];
- In 2021, 18.01% (17,247) of the population in Pendle was aged 65+, with this figure projected to rise to 22,400 by 2040 [14];
- The Pendle Housing and Economic Development Needs Assessment (2023)[15] states that 39% of households in Pendle include someone with a long-term health issue or disability. The data also indicates that individuals in the oldest age groups are more likely to have a long-term health problem or disability;
- The Needs Assessment (2023)[15] also projects a 17.7% increase in the number of people over 65 years old with mobility issues from 2022 to 2032. For those aged 16 to 64 with impaired mobility, the analysis predicts a 1.5% increase over the same period;
- Appropriate housing is considered to influence the employment status of disabled individuals[16]. In Pendle, it's estimated that 49.3% of working-age disabled people are

[10] https://www.gov.uk/guidance/housing-optional-technical-standards
[11] https://www.gov.uk/guidance/housing-for-older-and-disabled-people
[12] Pendle population change, Census 2021 –ONS
[13] How life has changed in Pendle: Census 2021 (ons.gov.uk)
[14] https://www.lancashire.gov.uk/lancashire-insight/census-2021/
[15] Housing and Economic Development Needs | Evidence base documents | Pendle Borough Council
[16] https://www.habinteg.org.uk/download.cfm?doc=docm93jijm4n1527

employed, compared to 77.1% of non-disabled working-age people, resulting in a disability employment gap of 27.8% as of 2022[17]; and,

- Additionally, 6.22% of Pendle's population, which is approximately 5,052 children, are under the age of 5 (as of 2021)[18]. Their families are also likely to benefit from the extra space provided by M4(2) dwellings.

National Planning Practice Guidance provides a link to the EC Harris Cost Impact study (2014)[19], for Councils to use when considering the implications of introducing the optional accessibility standards, locally. This study is also referenced in Pendle's Housing and Economic Needs Assessment (2023). The report outlines the range of additional costs associated with the construction of different types of M4(2) standard dwelling, which range from £940 for a 1-bed apartment to £520 for a 4-bed semi-detached property.

The long-term benefits of increasing the adaptability and accessibility of local housing provision should also be acknowledged by planning authorities, alongside the initial increased construction costs to developers, when considering the viability implications of adopting the optional standards[20]. A report by Habinteg[21] (2015) provides a cost-benefit assessment taking into account the current and anticipated costs of inaccessible housing. These cost considerations include: the avoidable cost of residential care; avoidable additional levels of social care; and avoidable hospital admissions (pg. 5). Habinteg concludes 'socio-economic needs, costs and benefits should be a part of assessing viability' (pg. 7). Overall, the report calls for 'Category 2 to be made the default standard for all new housing', stating that 'being able to access and use one's home is a basic right, not an optional extra' (pg. 2).

The 2020 Government consultation on the standards of adaptability and accessibility in new homes was developed in response to the rising concerns that in the drive to achieve housing numbers, the delivery of housing that suits the needs of the households (in particular those with disabilities) was being compromised on viability grounds. The Pendle Housing and Economic Development Needs Assessment (2023) refers to this consultation, affirming the Government's resulting commitment to raising the accessibility standards of new homes, by mandating 'the current M4(2) requirement in Building Regulations as a minimum standard for all new homes'.

The Pendle Housing and Economic Development Needs Assessment (2023) cites the district's ageing population and the predicted future rise in the number of people with disabilities, as highlighting a clear need to increase the supply of dwellings that are

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[17] From the 'Labour Force Survey User Guide –Volume 3: Details of LFS variables 2022' at: supplementary data table MSR001 'NOTES: please note the confidence intervals (20.4% for disability employment rate, 11.0% for non-disabled employment rate) and treat with caution. Disabled (current disability) includes those who have a long-term disability which substantially limits their day-to-day activities. Work-limiting disabled [also] includes those who have a long-term disability which affects the kind or amount of work they might do [and is therefore the metric used to calculate the disability employment gap]. The DDA disabled (current disability) [only] category within DISCURR is no longer the advised 'legal' definition of current disability. see: http://www.ons.gov.uk/ons/guide-method/harmonisation/primary-set-of-harmonised-conceptsandquestions/long-lasting-health-conditions-and-illnesses--impairments-and-disability.pdf

[18] Pendle district - Lancashire County Council

[19] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/353387/021c_Cost_Report_11th_Sept_2014_FINAL.pdf

[20] https://www.southlakeland.gov.uk/media/4174/updated-optional-housing-standards-evidence-paper-aug-2017.pdf

[21] https://www.housinglin.org.uk/_assets/Resources/Housing/OtherOrganisation/7_points_housing_standards.pdf

accessible and adaptable, locally. In the light of the evidence, the report recommends Pendle to require 'dwellings (in all tenures) to meet the M4(2) standards (which are similar to the Lifetime Homes Standards) and have a requirement for around 10% of homes to meet M4(3) –wheelchair user dwellings (a higher proportion in the affordable sector)' (pp 173-174).

In order to ensure everyone is provided with the opportunity to live in a home which is adaptable, the County Council welcomes Policy DM21's recognition that some new homes should meet the requirements of M4(2) or M4(3). The County Council continues to advocate for a more widely reaching policy definition as follows.

- **All new housing to be built in accordance with Building Regulations 'Access to and Use of Buildings M4(2) Category 2: Accessible and Adaptable Dwellings' unless there is a specified requirement to build to Building Regulations M4(3) Category 3: Wheelchair User Dwellings**

For further information, data, and evidence about the link between Housing and Health, please see the attached Public Health Advisory Note –Adaptable M4(2) Homes[22].

Policy DM33: Hot food takeaways

Both nationally and locally, planning authorities are actively utilising planning policy to restrict new hot food takeaways, in an equitable and targeted approach to addressing obesity. Two Lancashire planning authorities have now successfully embedded policy recommendations from the Lancashire Hot Food Takeaways and Spatial Planning Public Health Advisory Note[23] into their local plans, which restrict new hot food takeaways within defined areas around secondary schools and within wards that meet defined thresholds. Since these recommendations have been embedded, several applications for new hot food takeaways have been successfully refused in these areas.

The prevalence of obesity and excess weight is linked to numerous chronic physical and mental health conditions (including Type 2 diabetes, heart disease, depression, and anxiety). Both the burden that these conditions place on an individual, but also on wider society, are significant. Nationally, estimates suggest that the financial cost of overweight and obesity-related conditions to the NHS is £6.1 billion per year, with the Government projecting this amount to escalate to more than £9.7 billion annually by 2050[24].

Whilst obesity is a complex issue, the link between hot food takeaways, as part of the obesogenic environment, and the impact on people's weight is increasingly becoming apparents23.

Policy WRK 4 of Pendle's adopted Core Strategy (2011 –2030)[25] also recognises this link, in its stated commitment to resisting proposals for new hot food takeaways in areas of proximity to establishments primarily attended by children and young people, 'in support of initiatives to help reduce childhood obesity and improve the overall health prospects of young people' (pg. 182).

Data shows that the number of new hot food takeaways in Pendle has increased, and that the ability of residents across Pendle to access a hot food takeaway is therefore becoming easier. Between 2018 –2024, there has been an approximate 30% increase in the number

[22] https://www.lancashire.gov.uk/media/937927/adaptable-homes-advisory-note.pdf
[23] https://www.lancashire.gov.uk/media/954520/hft-and-spatial-planning_ph-advice-note.pdf
[24] https://www.gov.uk/government/news/new-obesity-treatments-and-technology-to-save-the-nhs-billions
[25] https://www.pendle.gov.uk/downloads/file/8723/pendle_local_plan_part_1_core_strategy

of new takeaways across the district23. This represents the second largest percentage increase in new takeaways among the twelve districts of Lancashire during this period.

Rates of obesity and overweight are also an issue across Pendle. The most recent data (2023/24) highlights that 72.7% of all adults (aged 18+), 38.5% of Year 6 children (11-year-olds), and 23.5% of Reception children (4-year-olds) in Pendle are classified as overweight (including obese). While these rates are largely comparable to the England averages, 33% (4) of wards in Pendle have significantly higher rates of obesity (including severe obesity) among Year 6 children (2021/22 –2023/24) than the England average. Additionally, around 8% of wards have notably higher rates of obesity and overweight among Reception-aged children compared to the England average (2021/22 –2023/24) [26].

The County Council's Hot Food Takeaway Advisory Note also draws on a growing body of evidence to present a link between obesity status and deprivation. Point 6.181 of the draft Local Plan also acknowledges this connection, noting that the prevalence of obesity and overweight is 'often greater in those wards with the highest levels of deprivation' (pg. 197).

Recent data further emphasises this link, highlighting a clear inequity in levels of obesity between the most and the least deprived areas. In Pendle, 20.8% of Year 6 pupils in the district's 40% most deprived wards are classified as obese (including severely obese) compared to 2.1% in the 40% least deprived wards. The same inequity can also be seen for Reception-aged pupils, with 9.1% classified as obese (including severely obese) in the 40% most deprived wards, compared to 1% in the 40% least deprived wards (2021/22 - 23/24).

Data also shows that the most deprived areas also witness, in general, a higher prevalence of hot food takeaways. According to the most recent, publicly accessible data, almost half (46.4%) of all hot food takeaways in Lancashire fall within its most deprived wards, compared to only 5.5% in the least deprived (2022)23.

Considering the evidence presented, the County Council welcomes point 2c of Policy DM33 within the Local Plan, which states that outside the boundary of a designated town or district centre, applications for new Hot Food Takeaways (Sui Generis) will only be considered for approval where: 'the proposal is in a ward that is not within the 20% most deprived wards in England' (pg. 196).

Therefore the County Council seeks an amendment to the policy wording of point 2b, to ensure that it aligns with the following recommendation, as set out within the County Council's refreshed Hot Food Takeaways and Spatial Planning Public Health Advisory Note23:

- **..the most recently published NCMP data does not classify 10% or more of Reception pupils or 15% or more of Year 6 pupils as obese (including severely obese).**

In relation to point 2a of Policy DM33, the County Council's Hot Food Takeaways and Spatial Planning Public Health Advisory Note draws on a range of evidence to provide the following recommendation:

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

[26] https://fingertips.phe.org.uk/search/obesity#page/9/gid/1/pat/401/par/E07000122/ati/8/are/E05013200/iid/93105/age/200/sex/4/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1

Rationale: 400m provides a 5-minute walking distance around a school[27]. 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.

For further information, data, and evidence, please see the attached Hot Food Takeaways and Spatial Planning Public Health Advisory Note23.

DM16: Design and placemaking

The health benefits of being physically active are well known, both physically and mentally, with active people living healthier, longer, and happy lives[28]. Conversely, physical inactivity is one of the leading risk factors for noncommunicable diseases (NCDs) and other poor health outcomes, with 1 in 6 deaths in the UK attributed to physical inactivity[29]. Within Pendle, 56.6% of adults are classified as physically active, meaning they engage in at least 150 minutes of physical activity per week (2022/23)[30]. Not only is this value the second lowest recorded value for the twelve districts of Lancashire, but it is also significantly worse than the Lancashire (62%) and England (63.4%) averages.

Across Lancashire, data from 2022/23 shows 26.8% (276,100) of adults walk for travel at least three days per week (England, 31.6%), while 3.7% (38,100) of adult's cycle for travel at least three days per week (England, 6.4%) –both proportions are significantly lower than England. Within Pendle, while data for cycling for travel is unavailable[31], 28.3% of adults walk for travel at least three days per week. This figure remains lower than the England average (31.6%) though higher than the figure reported in Lancashire (26.8%) [32]

As with the issue of excess weight, physical inactivity is a complex problem influenced by a wide range of factors. Some of these factors can be addressed at the local level, including through the design and master planning of development proposals which support the creation of active environments. Recent research from Sport England has revealed the annual social value of community sport and physical activity is £107.2 billion, with improved health from participation in sport and physical activity relieving pressure on the NHS by £10.5 billion a year in health and social care savings[33].

Sport England, support by the Office for Health Improvement and Disparities have created the Active Design guidance[34], intended to support planners, designers, and developers (amongst other stakeholders) to create environments that encourage physical activity and promote health and well-being. The guidance seeks to create spaces that encourage and facilitate physical activity, making it both easy and appealing for people to stay active. To achieve this, the guidance recommends that all new developments, as far as is relevant to the specific development proposals, adhere to the following Active Design principles:

[27] 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

[28] Physical activity (who.int)

[29] Physical activity: applying All Our Health - GOV.UK (www.gov.uk)

[30] Active Lives | Adult Data (sportengland.org)

[31] Please note that some local authorities have lower response numbers than others, and as a result, there may be missing data points where sample size does not permit analysis of data

[32] Active Lives | Adult Data (sportengland.org)

[33] Sport and physical activity generates over £100 billion in social value | Sport England

[34] Active Design | Sport England

1. Activity for all
All environments should support physical activity equitably across all ages, ethnicities, genders, and abilities, enabling everyone to be active and build long-term active habits and behaviours. This is essential for the delivery of all the principles of Active Design and is its foundational principle.

2. Walkable communities
Facilities for daily essentials and recreation should be within easy reach of each other by active travel means, making it more likely that people will make the journey by using active travel modes (defined in Theme 1). Good active travel connections should be provided to extend the range of services that are accessible while remaining physically active.

3. Providing connected active travel routes
Encourage active travel for all ages and abilities by creating a continuous network of routes connecting places safely and directly. Networks should be easy to use, supported by signage and landmarks to help people find their way.

4. Mixing uses and co-locating facilities
People are more likely to combine trips and use active travel to get to destinations with multiple reasons to visit. Places with more variety, higher densities, and a mix of uses also reduce the perception of distance when travelling through spaces. They also generate the critical mass of travel demand to better support public transport services.

5. Network of Multifunctional Open Spaces
Accessible and high-quality open space should be promoted across cities, towns and villages to provide opportunities for sport and physical activity, as well as active travel connections and natural or civic space for people to congregate in and enjoy. Providing multifunctional spaces opens up opportunities for sport and physical activity and has numerous wider benefits.

6. High Quality Streets and Spaces
Streets and outdoor public spaces should be Active Environments in their own right. They should be safe, attractive, functional, prioritise people and able to host a mix of uses, with durable, high quality materials, street furniture in the right places and easy-to-use signage. High quality streets and spaces encourage activity, whereas poor quality streets and spaces are much less likely to be used to the same degree.

7. Providing activity infrastructure
Infrastructure to enable sport, recreation and physical activity to take place should be provided across all contexts including workplaces, sports facilities and public space, to facilitate activity for all.

8. Active buildings, inside and out
Buildings we occupy shape our everyday lives, both when users are inside and outside. Buildings should be designed with providing opportunities for physical activity at the forefront, considering the arrival experience, internal circulation, opportunities to get up and move about, and making the building an active destination.

9. Maintaining high-quality flexible spaces
Spaces and facilities should be effectively maintained and managed to support physical activity. These places should be monitored to understand how they are used, and flexible so that they can be adapted as needed.

10. Activating spaces
The provision of spaces and facilities which can help to improve physical activity should be supported by a commitment to activate them, encouraging people to be more physically active and increasing the awareness of activity opportunities within a community.

It is in the light of the above, the County Council welcomes Policy DM16's acknowledgement that proposals for all new developments should:

- **'Have regard to the 10 principles of Sport England's Active Design Guidance' to promote sustainable development through ensuring that buildings and spaces are accessible and usable:**

and be:

'Encouraging active lifestyles through compliance with the Active Design…standards' (pg. 136).

The County Council also welcomes reference to the Active Design principles within Policy DM30 with acknowledgment of the role the principles have in helping to support improvement in public health, and a reduction in health inequalities by stating developments should support:

- **'healthy lifestyles through Active Design (Policy DM16)' (pg.196)**

I trust that you find the above comments valuable and should you require further information or clarification on the contents of this letter please contact me at the email address provided.

Yours sincerely,

Marcus Hudson
Head of Service Planning and Transport

Lancashire County Council

Adaptable M4(2) Homes

Public Health Advisory Note

Director of Public Health and Wellbeing, Dr Sakthi Karunanithi MBBS MD MPH FFPH

Introduction

This Public Health Advisory Note covers how local planning authorities can help to ensure accessible, sustainable, and lifelong communities by increasing the minimum adaptability standard of new build houses within Lancashire. It outlines the increasing need for adaptable homes at all levels of society and provides examples of similar policies elsewhere in the country.

Wider Determinants of Health

The health and wellbeing of individual people and local communities is affected by a wide range of factors. Some factors concern the environment, including the built environment. Spatial planning can be used to address a range of health issues such as air quality, physical inactivity, social isolation, and obesity.

Within the National Planning Policy Framework[1] (NPPF, 2021) guidance is provided on how health should be considered by the planning system. As part of the delivery of the social dimension of sustainable development, planning has a role in supporting and developing strong, vibrant, and healthy communities.

One of the core planning principles that underpin both plan-making and decision-taking is for planning polices and decisions to ensure that developments "create places that are safe, inclusive and accessible and which promote health and well-being, with a high standard of amenity for existing and future users " (paragraph 130, point f) NPPF). This is accompanied by footnote 49 which states "Planning policies for housing should make use of the Government's optional technical standards for accessible and adaptable housing, where this would address an identified need for such properties."

Lancashire County Council's Director of Public Health, through the Health Equity, Welfare and Partnerships service, is collaborating with Lancashire's local planning authorities (LPAs) to take account of local health issues and considerations, through the provision of local health data and advice.

Housing and Health

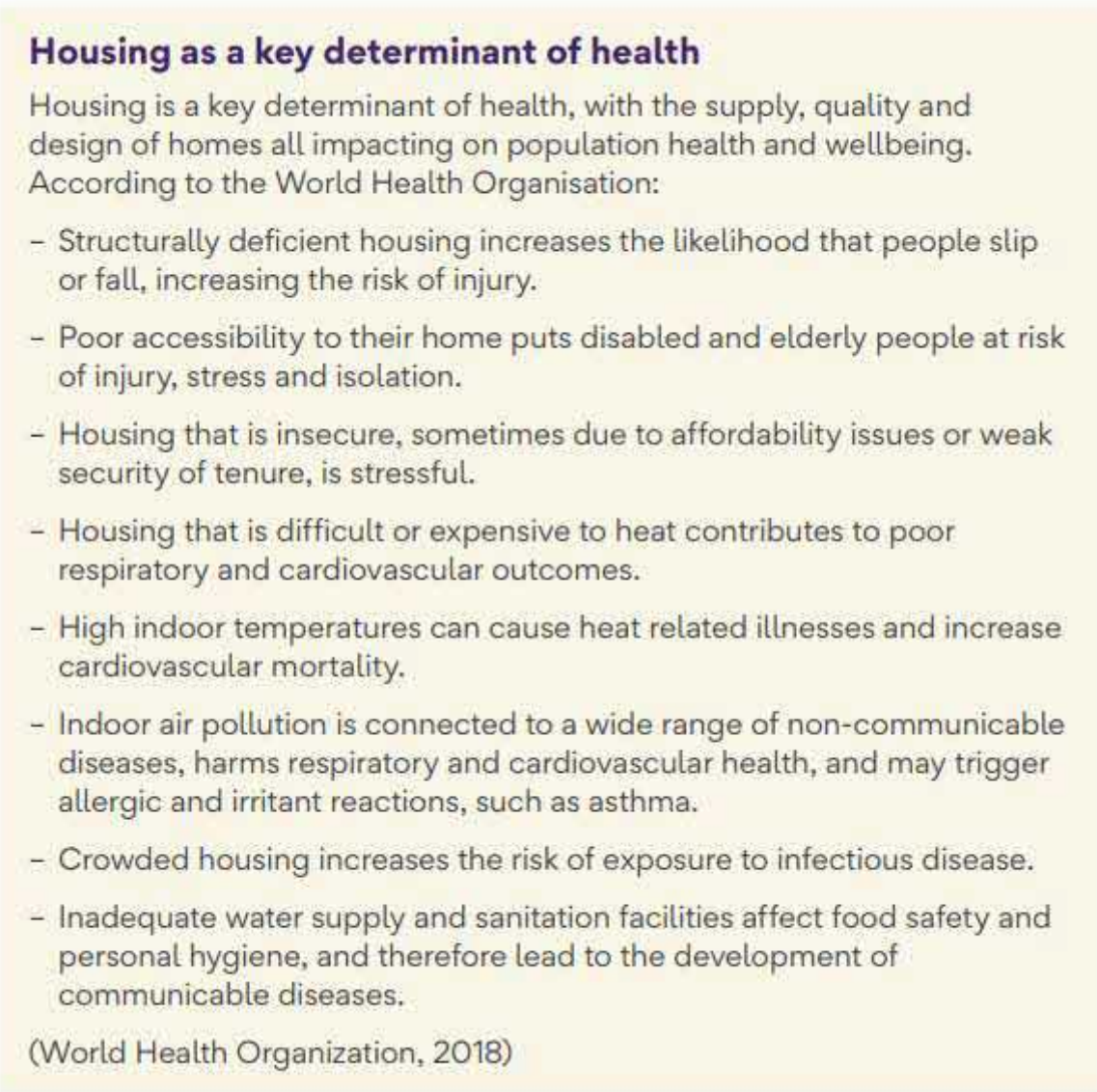
Where we live plays an enormous part in our health and wellbeing. Living in a home where we feel comfortable and is safe and secure allows us to prosper. Housing has such a big role in our wellbeing that in 2018 the World Health Organisation (WHO) produced a report[2] dedicated to the topic. They stated "Improved housing conditions can save lives, prevent disease, increase quality of life, reduce poverty, and help mitigate climate change. Housing is becoming increasingly important to health in light of urban growth, ageing populations and climate change."

Using the WHO report, the Centre for Aging Better summarised the impacts of housing on health which can be seen below in Figure 1. The Centre for Aging Better also states "Despite this evidence, an estimated 10 million people in England are at risk because they live in a poor-quality home. This is the equivalent of 4.3 million homes, close to

[1] National Planning Policy Framework – https://www.gov.uk/government/publications/national-planning-policy-framework--2
[2] WHO Housing and health guidelines – https://www.who.int/publications/i/item/9789241550376

half of which are homes lived in by someone over 55 years old and a million with at least one child." [1]

Figure 1: Housing as a key determinant of health [1]



Housing as a key determinant of health

Housing is a key determinant of health, with the supply, quality and design of homes all impacting on population health and wellbeing. According to the World Health Organisation:

- Structurally deficient housing increases the likelihood that people slip or fall, increasing the risk of injury.
- Poor accessibility to their home puts disabled and elderly people at risk of injury, stress and isolation.
- Housing that is insecure, sometimes due to affordability issues or weak security of tenure, is stressful.
- Housing that is difficult or expensive to heat contributes to poor respiratory and cardiovascular outcomes.
- High indoor temperatures can cause heat related illnesses and increase cardiovascular mortality.
- Indoor air pollution is connected to a wide range of non-communicable diseases, harms respiratory and cardiovascular health, and may trigger allergic and irritant reactions, such as asthma.
- Crowded housing increases the risk of exposure to infectious disease.
- Inadequate water supply and sanitation facilities affect food safety and personal hygiene, and therefore lead to the development of communicable diseases.

(World Health Organization, 2018)

Mainstream Accessible housing is "housing that is not age-specific but with design criteria that ensure accessibility and inclusivity to promote better living among all ages" [2]. This is a concept that is popular amongst the vast majority of the population with 72% of people agreeing that "homes should, as standard, be built to be suitable for people of all ages and abilities" [3] and 81% of people saying they would buy homes with accessible features such "level access entrances, walk-in showers or handrails" [3].

Housing Policy

A Decent Home

The government outlines what classifies a 'decent' home in A decent home: definition and guidance[3]. The document outlines four criteria for a decent home and in what circumstances a property fails to meet these criteria. It uses the Housing Health and Safety Rating System (HHSRS)[4] to assess the hazards which could cause harm to health. A home can be categorised as non-decent for more than one measure. The criteria and domains of the HHSRS can be seen below in Figure 2.

Figure 2: Criteria for a decent home and HHSRS domains adapted from A decent home: definition and guidance [4] **and HHSRS Operating guidance** [5].

Criterion:	It meets the current statutory minimum standard for housing	It is in a reasonable state of repair	It has reasonably modern facilities and services	It provides a reasonable degree of thermal comfort
Dwellings which fail to meet this criterion are those...	...containing one or more hazards assessed as serious ('Category/Class 1') under the Housing Health and Safety Rating System (HHSRS) There are 29 hazards in the HHSRS split into four domains: A. Physiological requirements – Hygrothermal conditions (i.e. damp and extremes of temperatures), and Pollutants (non-microbial, e.g. Asbestos) B. Psychological requirements – Space, Security, Light, and Noise C. Protection against infection – Hygiene, Sanitation, and Water supply D. Protection against accidents – Falls, Electric shock, Burns and Scalds, and Building related Collisions Category 1 hazards are those with the most extreme outcomes including death, lung cancer, and paralysis	...where either: • One or more of the key building components are old and because of their condition, need replacing or a major repair; or • Two or more of the other building components are old and because of their condition, need replacing or major repair Key building components are those which, if in poor condition, could have an immediate impact on the integrity of the building and cause further deterioration in other components. E.g. walls, roofs, windows/doors, heating, plumbing, and electrics	...which lack three or more of the following: • A reasonably modern kitchen (20 years old or less) • A kitchen with adequate space and layout • A reasonably modern bathroom (30 years or less) • An appropriately located bathroom and WC • Adequate insulation against external noise (where external noise is a problem) • Adequate size and layout of common areas for blocks of flats	...which lack both effective insulation and efficient heating.

26% of homes where residents are aged 55-64 are classified as non-decent, this is higher than any other age band [1]. Across all ages, the presence of a Category 1 hazard is the most common reason for being classed as non-decent [1]. In homes with residents aged over 55, around 85% of the Category 1 hazards were as a result of Risk of Falls and Excess Cold [1]. Building to an adaptable standard can greatly reduce the risk of falls in the home.

[3] A decent home: definition and guidance – https://www.gov.uk/government/publications/a-decent-home-definition-and-guidance

[4] Housing health and safety rating system (HHSRS) guidance - https://www.gov.uk/government/collections/housing-health-and-safety-rating-system-hhsrs-guidance

Accessible and Adaptable Housing

Approved Document M Volume 1 –Access to and use of buildings[5], outlines the standards to which new dwellings should be built in order to comply with The Building Regulations 2010. This document identifies three categories of dwelling [6]:

- M4(1) Category 1: Visitable Dwellings –Mandatory
- M4(2) Category 2: Accessible and Adaptable Dwellings –Optional
- M4(3) Category 3: Wheelchair User Dwellings –Optional

In order for reasonable provision to be met for the relevant type of occupant, each type of dwelling has a series of requirements that need to be implemented within the property. These requirements can be seen below in Figure 3. All new dwellings must meet the requirements for M4(1) and, for every requirement, there are two subsequent levels with increasing accessibility for M4(2) and M4(3) [6]. The document then goes on to outline a series of standards that, if implemented successfully, would achieve reasonable provision for each level.

These standards came into effect in 2015 and replaced the existing ones; The M4(2) standard replaced The Lifetime Home Standard and the M4(3) standard replaced the Wheelchair Housing Standards [7].

The Local Authority Building Control (LABC) has outlined the key differences between M4(1) and M4(2) on their website [8]. These are stated below:

"To help you plan and budget, here's a simple roundup of the main differences between M4(1) (the basic standard) and M4(2) (the intermediate standard):

External differences

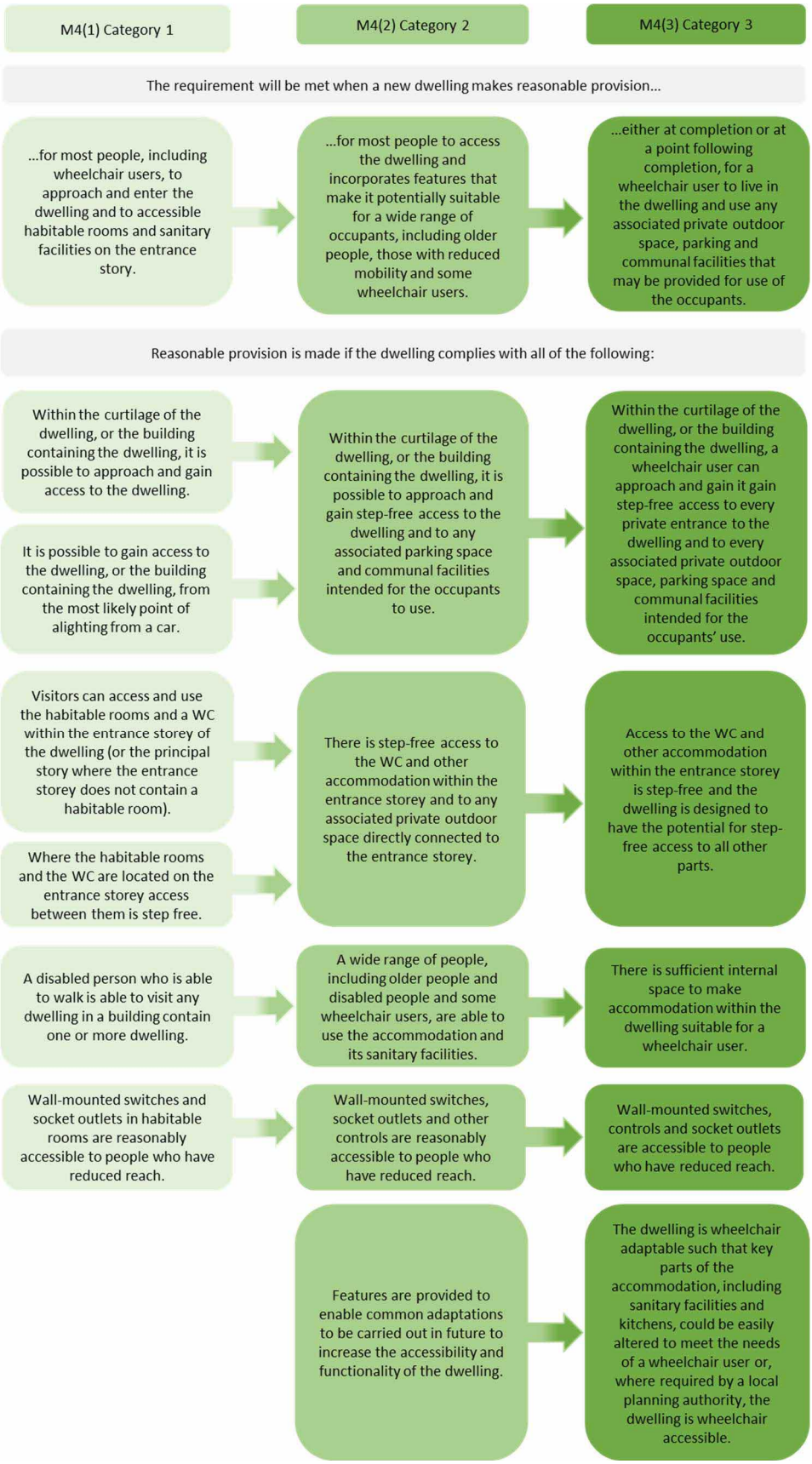
- All external doors must have a level threshold - the lower standard is just one door
- Approach routes must have a minimum clear width of 900mm or 750mm where there are obstructions, the gradient should be between 1:20 and 1:12
- Every gateway must have an 850mm clear opening, with a 300mm nib on the leading edge to allow users to reach the handle
- Parking spaces within the private curtilage of the dwelling (but not a car port or garage) must include at least one standard parking bay that can be widened at a later date to 3.3m
- Every principal entrance must have a canopy covering a minimum width of 900mm and depth of 1200mm. This can't be a porch
- External doors must have an openable width of 850mm and have a 300mm nib on the leading edge (see diagram 2.2 ADM)

Internal differences

- Stairs must be a minimum width of 850mm to allow the future installation of a stair lift

[5] Approved Document M Volume 1 –Access to and use of buildings – https://www.gov.uk/government/publications/access-to-and-use-of-buildings-approved-document-m

Figure 3: Dwelling requirements for different categories, details adapted from Approved Document M [6]



- At least one bedroom must have a 750mm clear access zone from the foot of the bed and on both sides. Every other double bedroom will need a clear access zone on one side and the foot of the bed. Plans of furniture layouts in this case will need to be provided to show compliance
- Walls, ducts and boxings on all WC, bathroom and wet rooms must be strong enough to support grab rails, shower seats and other adaptations, which can take a load of 1.5kn/m3.
- A bathroom must be located on every floor that has a bedroom
- Ground floor WC must have a hidden drainage connection and be large enough to accommodate a shower
- Consumer units must be mounted at a height between 1350mm and 1450mm above floor level
- Handles for windows, unless on a remote opening system, must be located between 450mm and 1400mm above floor level"

Population Need

The Habinteg Housing and Disabled People Toolkit states: "To ensure that the Local Plan meets statutory requirements, local authorities will need to have gathered sufficient information on the current and projected demand for accessible and adaptable housing, and reflected this in their proposals." [9] As such, the following section outlines the need for adaptable housing in Lancashire by identifying those that would benefit from these houses.

Aging Population

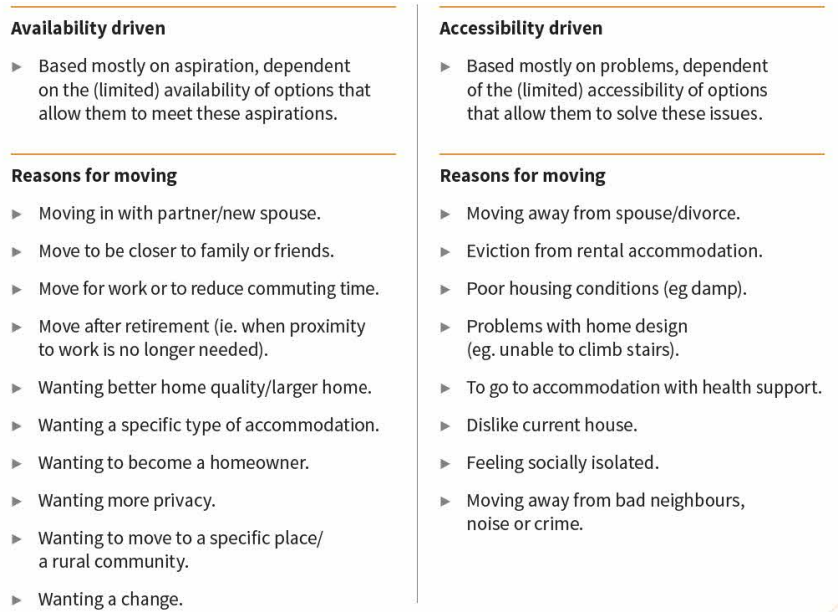
When planning for housing for older people, many assume that this is specialist housing or care homes but, in reality, 95% of people over 65 live in mainstream housing, with only a quarter of over 55s saying they are currently considering moving home [2]. Despite this, just 7% of our current homes meet the lowest level of accessibility [10] and only one new accessible home is planned for every 15 people over 65 by 2030 [3].

There is also a misconception that when older people do move, it will be to downsize to a smaller property, but this often is not the case. Only 39% of older homeowners who moved to a new build home between 2010 and 2016 downsized; a third kept the same number of bedrooms and 28% upsized to a home with additional bedrooms [10].

When asked what their strongest motivations were for moving home seven in ten adults wanted to live in housing better designed to meet their needs, prioritising at least one of the following requirements "ground floor living, enabling independent living or being adaptable to changing needs" [2]. However due to limited housing, 60% of older people are unable to move from their current home even if it becomes unsuitable [10].

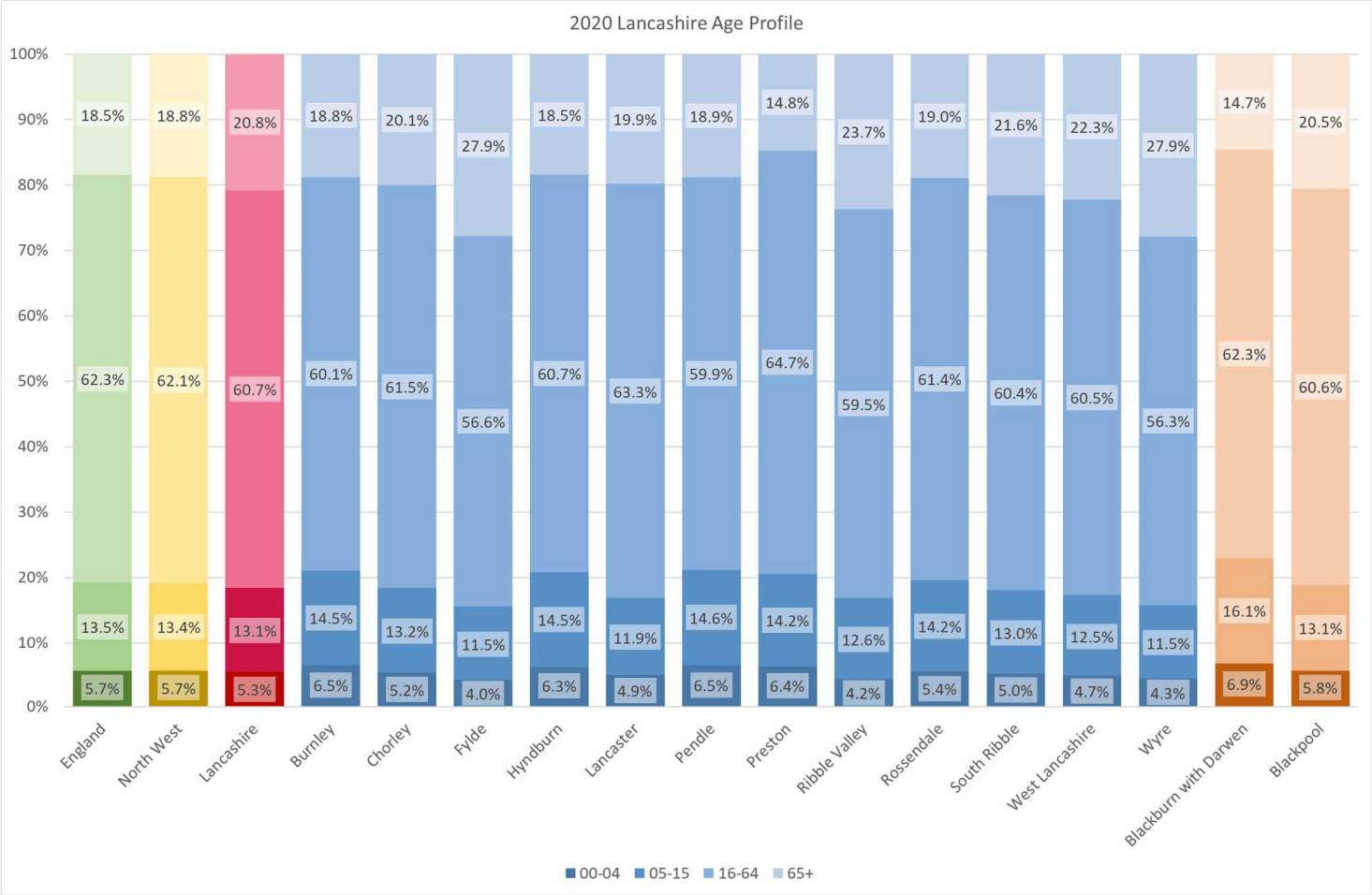
The Manchester School of Architecture proposes the idea of Rightsizing –"it is an older person's active, positive choice to move home as a means of improving their quality of life" [10]. They identify two types of older movers, those that are availability driven and those that accessibility driven (including poor home design). The differences between the two can be seen below in Figure 4.

Figure 4: Two types of older movers [10]



In Lancashire, roughly a fifth (20.8%) of the population is 65 or over, this works out at an estimated 255,637 people. The full 2020 age profile of Lancashire and the districts can be seen below in Figure 5 a) and Figure 5 b) shows the proportion of 2020 population that is aged 65 or over.

Figure 5: a) Lancashire 2020 ONS population, broken down by age bands



Source: ONS Mid-year Estimates, Lancashire JSNA[6]

As can be seen from these graphs, whilst the 60.7% of the population is of working age, 16-64, Lancashire (20.8%) has a 65+ population that is significantly higher than both the England (18.5%) and North West (18.8%) proportions.

There is a quite a lot of variation amongst the districts:

- Fylde and Wyre have the highest proportion of 65 or over both at 27.9% each.
- Preston has the lowest rate of over 65's at 14.8%

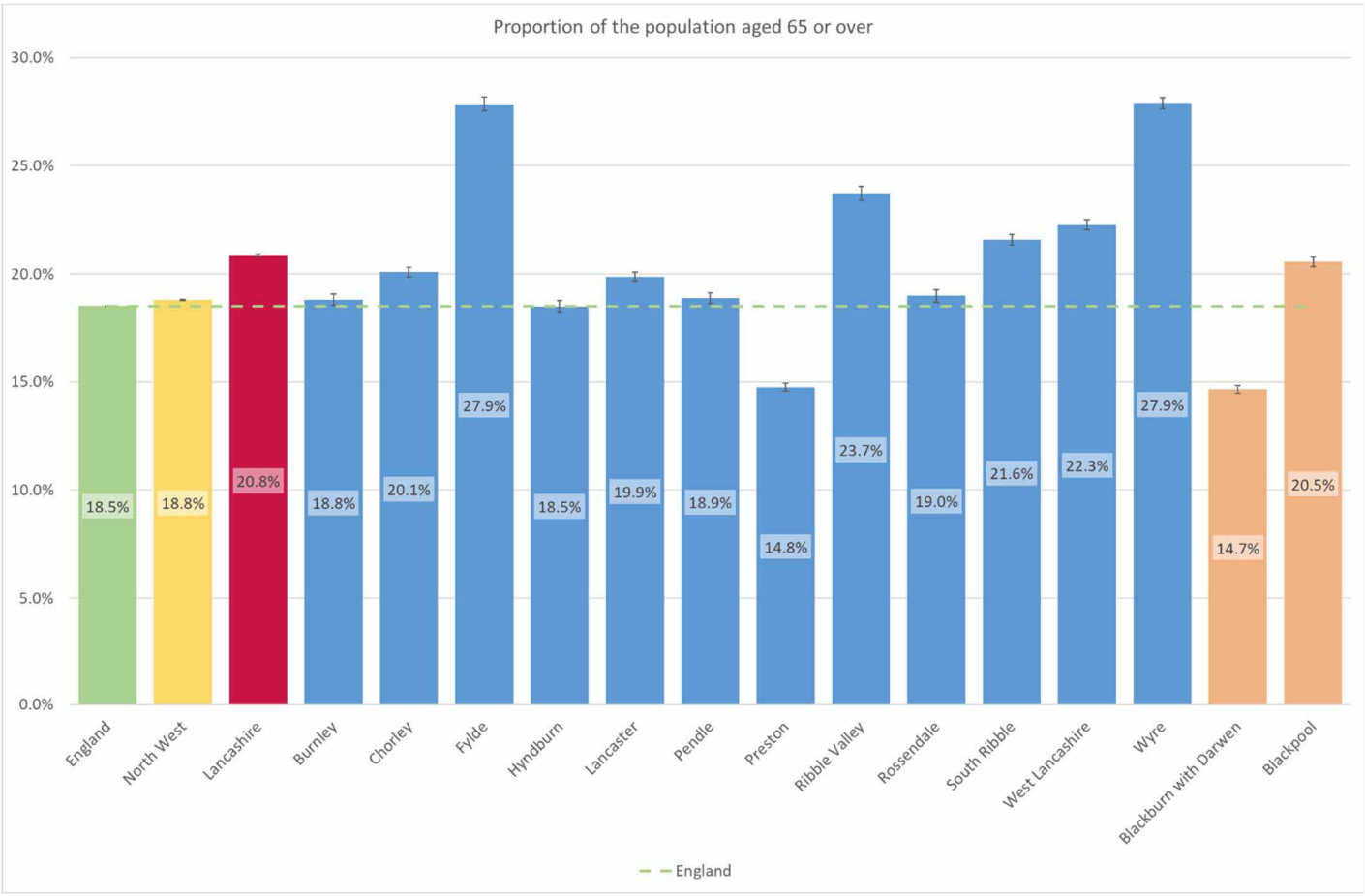
- With the exception of Hyndburn (18.5%) and Preston (14.8%), all of the districts have proportions of over 65s that are significantly higher than England

[6] ONS Mid-Year Estimates, Lancashire JSNA - https://www.lancashire.gov.uk/lancashire-insight/population-and-households/population/mid-year-population-estimates/

- Chorley (20.1%), Fylde (27.9%), Lancaster (19.9%), Ribble Valley (23.7%), South Ribble (21.6%), West Lancashire (22.3%) and Wyre (27.9%) are all significantly higher than the North West
- Hyndburn (18.5%) and Preston (14.8%) are significantly lower than the North West

- Fylde (27.9%), Ribble Valley (23.7%), South Ribble (21.6%), West Lancashire (22.3%) and Wyre (27.9%) are significantly higher than Lancashire
- Burnley (18.8%), Chorley (20.1%), Hyndburn (18.5%), Lancaster (19.9%), Pendle (18.9%), Preston (14.8%), and Rossendale (19.0%) are significantly lower than Lancashire

Figure 5: b) Proportion of the 2020 ONS population that is aged 65 or over



Source: ONS Mid-year Estimates, Lancashire JSNA[7]

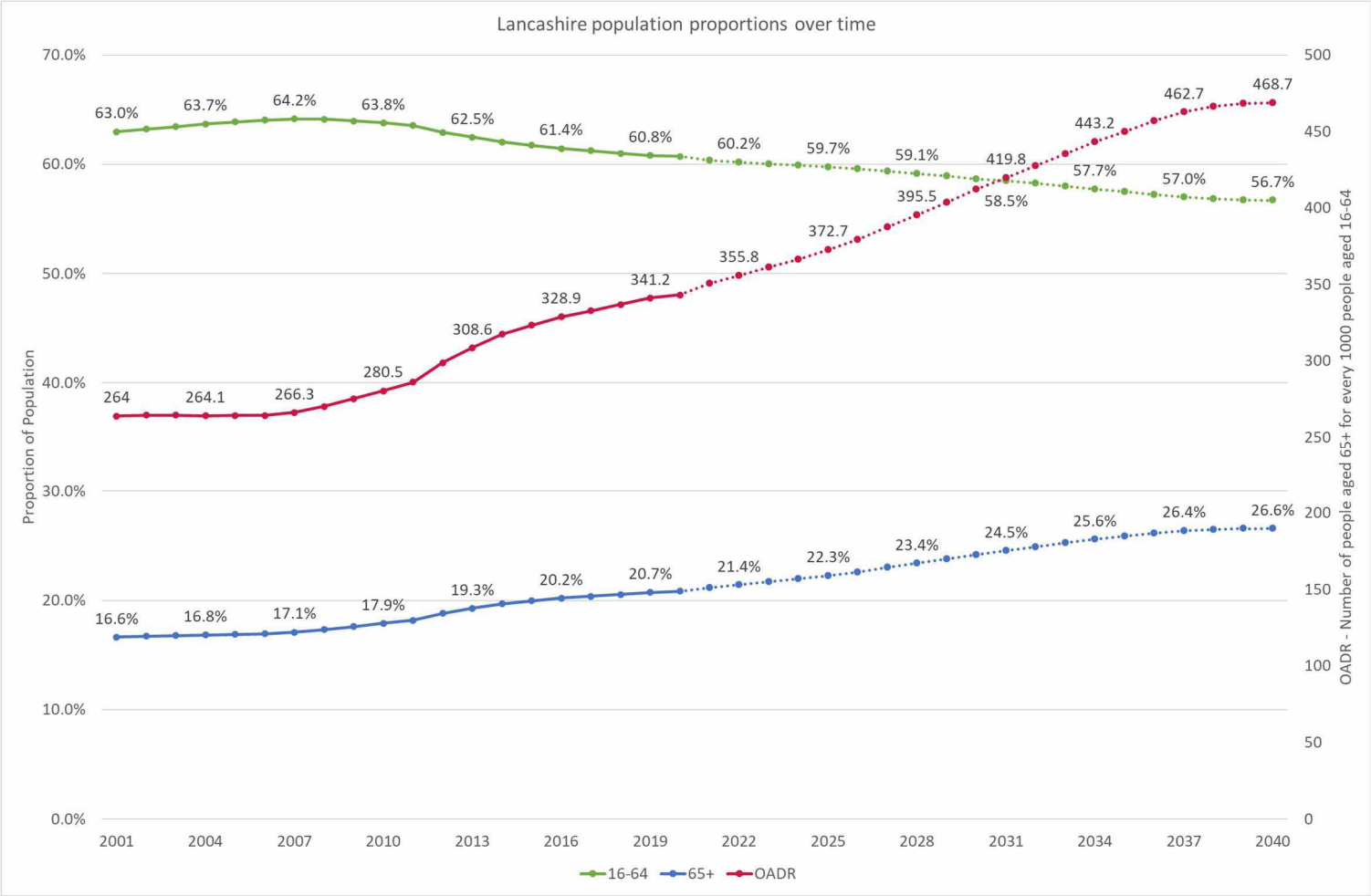
As mentioned above, falls are one of the biggest risks of unsuitable housing to older people. In Lancashire, in 2019/20, there was a directly standardised rate of 1963.41 per 100,000 people for emergency hospital admissions due to falls in people aged 65 and over. Whilst this lower than the England (2221.76) and North West (2437.38) rates, it translates to 4920 people in a single year [11]. This fact is more concerning when you consider that in the 2011 Census 13.3% of all houses contained only a single adult over the age of 65 and 61.7% of these had a long-term condition [12].

[7] ONS Mid-Year Estimates, Lancashire JSNA - https://www.lancashire.gov.uk/lancashire-insight/population-and-households/population/mid-year-population-estimates/

Furthermore, the number of older people in our population is increasing. In 2001 there were 188,986 people in Lancashire that were aged 65 or over; this made up 16.6% of the population. In 2020 this had increased to 255,637 people aged 65 or over making up 20.8% of the population. ONS population projections predict this trend will continue and by 2040 the 65 and over age bracket will make up 26.6% of the total Lancashire population. This in turn goes with a decrease in the number of working age people (16-64) as shown below in Figure 6.

Also shown in Figure 6 is the increase in The Old Age Dependency Ratio (OADR). This is a measure that considers the impact of an ageing population. It works out the number of people aged 65 and over per 1000 people aged 16-64. Table 1 shows the 2020 district figures for this ratio showing that Lancashire has a higher OADR ratio at 343.1 compared to England (297.0) and the North West (302.7).

Figure 6: Time Series showing Lancashire population proportions alongside the OADR between 2001 and 2040



Source: ONS Mid-year Estimates, Lancashire JSNA[8] and ONS Population Projections[9]

[8] ONS Mid-Year Estimates, Lancashire JSNA - https://www.lancashire.gov.uk/lancashire-insight/population-and-households/population/mid-year-population-estimates/

[9] ONS Population Projections - https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1

Table 1: 2020 Old Age Dependency Ratio

Area	Number of people aged 16-64	Number of people aged 65 or over	OADR
England	35233879	10464019	297.0
North West	4572870	1384396	302.7
Lancashire	745117	255637	343.1
Burnley	53701	16798	312.8
Chorley	73154	23863	326.2
Fylde	45942	22622	492.4
Hyndburn	49277	15004	304.5
Lancaster	93779	29435	313.9
Pendle	55225	17392	314.9
Preston	93266	21270	228.1
Ribble Valley	36895	14712	398.8
Rossendale	43883	13549	308.8
South Ribble	67063	23965	357.4
West Lancashire	69234	25496	368.3
Wyre	63698	31531	495.0
Blackburn with Darwen	93526	21986	235.1
Blackpool	83865	28433	339.0

Source: ONS Mid-year Estimates, Lancashire JSNA[10]

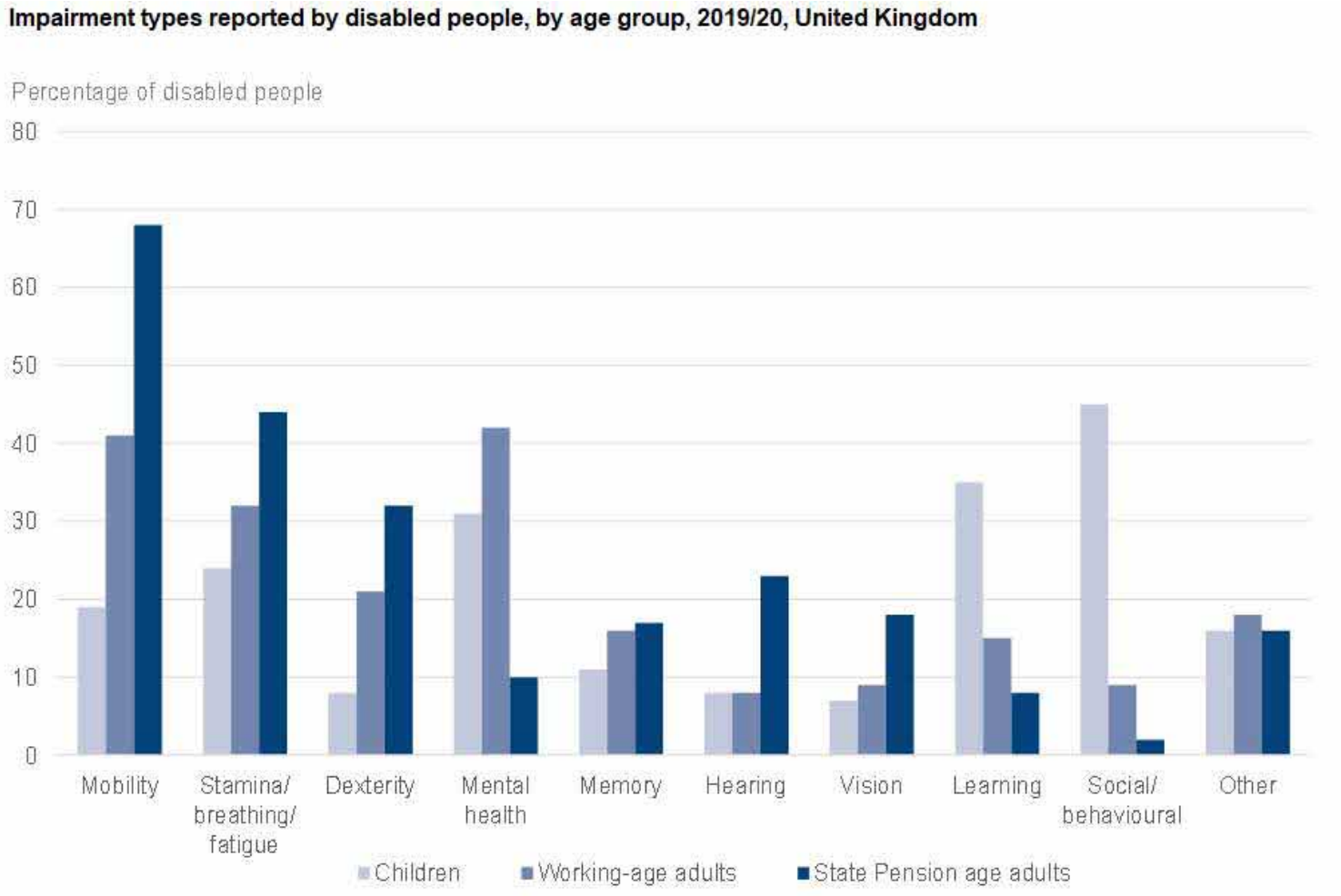
This data indicates that in Lancashire older people already make up a significant part of the population and this is likely to increase. The population in Lancashire is aging and as it does so, the need for adaptable homes increases. By building all homes to the M4(2) standard as a baseline we allow individuals to 'age in place', with their home adapting to meet their additional needs as they arise. If all properties are built to this standard, individuals will not be limited to the type of property they can purchase, and houses will meet both their needs and their desires.

[10] ONS Mid-Year Estimates, Lancashire JSNA - https://www.lancashire.gov.uk/lancashire-insight/population-and-households/population/mid-year-population-estimates/

People Living with Disability

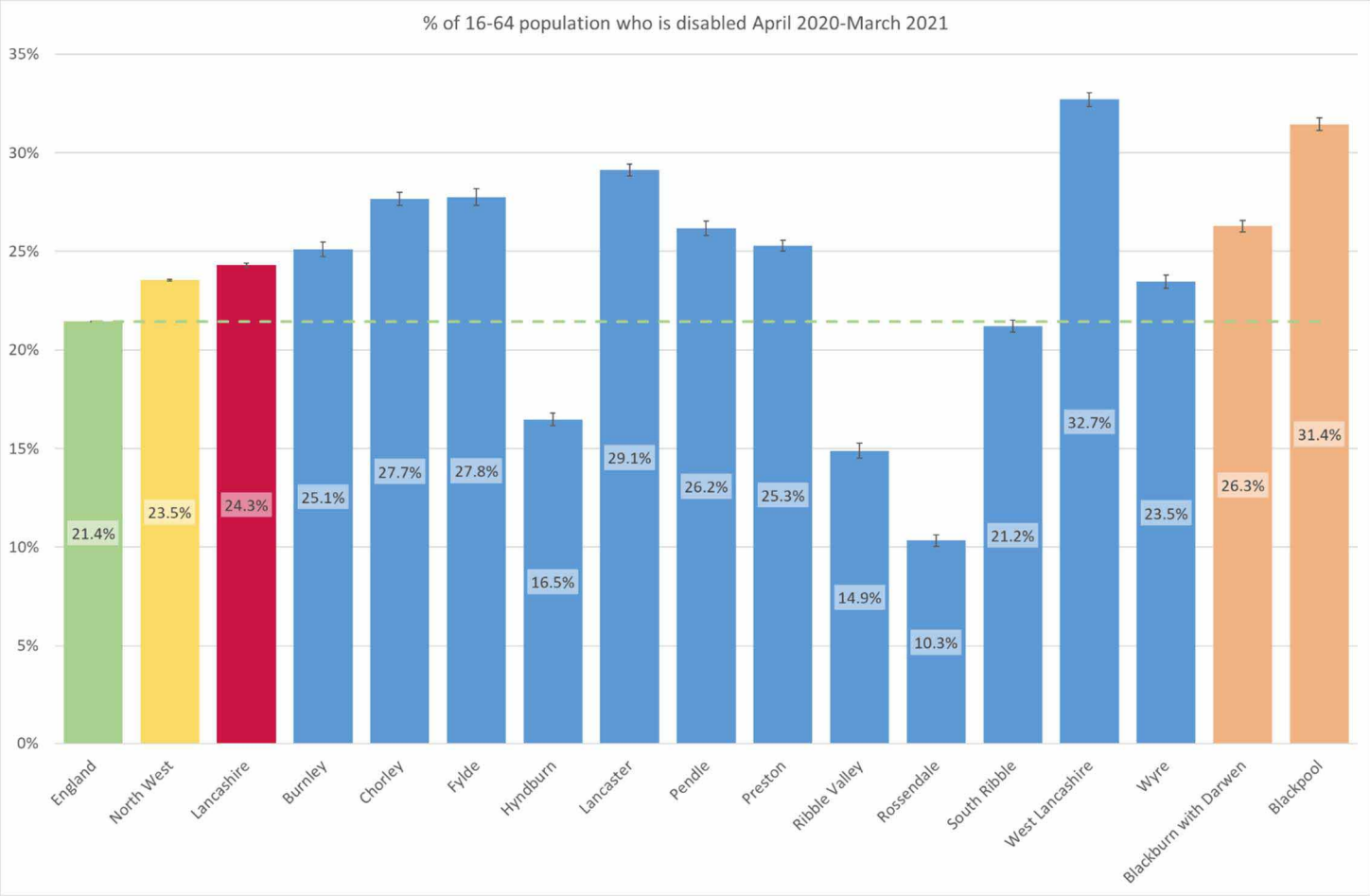
The 2019/20 Family Resources Survey estimated that 22% of people in the UK have a disability; 56% of these are working aged adults [13]. Across all age groups the most common type of disability is a mobility impairment which makes up 49% of all disabilities. There is variation across the age groups with older people more likely to have physical impairments, working age equally likely have physical or mental health impairments, and children more likely to have behavioural or learning impairments [13]. The breakdown by age groups can be seen in Figure 7.

Figure 7: Impairment type by age band, from the Family Resources Survey [13]



The Annual Population Survey states that between April 2020 and March 2021, in Lancashire, 24.3% of the working age population had some form a disability or condition that limited the work they could do [14]. This is significantly higher than both the England (21.4%) and the North West (23.5%) rates [14]. The district breakdown can be seen below in Figure 8.

Figure 8: Proportion of working age population that has a disability, April 2020-March 2021



Source: Annual Population Survey[11]

Research carried out by Habinteg and Papworth Trust in 2015 found that "people with unmet need for accessible housing are four times more likely to be unemployed or not seeking work because they are sick or disabled than those whose needs are met or who are disabled but do not need accessible housing." [15].

Their research suggests that the reason for this is people in unsuitable housing have to spend considerably more time and energy on everyday living tasks than those in suitable housing, leaving them unable to hold down a job [15]. These individuals are also more likely to experience "increasing dependence on others and are at higher risk of social isolation" [15].

As can be seen in Table 2, in Lancashire, 54.3% of disabled working age people are in employment compared to 82.2% of non-disabled working age people; this is a difference in percentage of 27.9% [14]. This is greater difference than the England figure of 25.5%

[11] Annual Population Survey –Nomis - https://www.nomisweb.co.uk/datasets/apsnew

Table 2: Difference in employment rates between disabled and non-disabled working age people, April 2020-March 2021

Area	Employment rate aged 16-64 - disabled			Employment rate aged 16-64 - not disabled			Difference in percentage between non-disabled employment rate and disabled employment rate
	Number employed	Total disabled	Proportion employed	Number employed	Total not disabled	Proportion employed	
England	4,130,100	7,474,500	55.3%	20,788,100	25,755,700	80.7%	25.5%
North West	537,000	1,056,000	50.9%	2,549,300	3,181,100	80.1%	29.3%
Lancashire	95,000	175,100	54.3%	446,900	543,700	82.2%	27.9%
Burnley	8,200	13,300	61.7%	30,900	39,700	77.8%	16.2%
Chorley	7,500	19,000	39.5%	41,200	49,700	82.9%	43.4%
Fylde	8,000	12,100	66.1%	25,600	31,600	81.0%	14.9%
Hyndburn	5,500	8,400	65.5%	32,900	42,600	77.2%	11.8%
Lancaster	16,000	25,000	64.0%	51,000	60,600	84.2%	20.2%
Pendle	7,200	14,600	49.3%	35,000	41,200	85.0%	35.6%
Preston	9,200	22,500	40.9%	50,400	66,600	75.7%	34.8%
Ribble Valley	3,700	5,300	69.8%	24,200	30,300	79.9%	10.1%
Rossendale	2,400	4,400	54.5%	32,400	37,000	87.6%	33.0%
South Ribble	8,600	14,100	61.0%	44,100	52,200	84.5%	23.5%
West Lancashire	11,700	22,500	52.0%	37,400	46,300	80.8%	28.8%
Wyre	7,100	14,100	50.4%	42,000	46,000	91.3%	40.9%
Blackburn with Darwen	9,900	23,700	41.8%	39,000	54,300	71.8%	30.1%
Blackpool	12,500	25,500	49.0%	35,100	43,000	81.6%	32.6%

Source: Annual Population Survey[12]

The 2019/20 English Housing Survey reports that nationally there are 1.9 million households that have a need for accessible housing; just shy of 760,000 are households with working age residents [16]. Within Lancashire, in 2011 Census 36% of all households contained at least one person with a long-term disability or illness [12]. Addressing the housing needs of these individuals, by building to M4(2) standard, would have considerable benefit both on their personal wellbeing and also on the local economy by adding labour to the workforce.

Family Friendly Housing

In 2020, 5.3% of the population in Lancashire were children under 5; this works out at roughly 65,000 children. The Census 2011 found 28.2% of all households had a dependent child living at the property [12].

Adaptable homes would not only benefit older people and those with disabilities, the larger surface area, wider doorframes, and step free access of homes built to M4(2) standard will help families, especially those with young children (i.e. in a pushchair).

[12] Annual Population Survey –Nomis - https://www.nomisweb.co.uk/datasets/apsnew

Cost Benefit

The Ministry of Housing, Communities & Local Government produced a consultation paper in September 2020 entitled "Raising accessibility standards for new homes". Within this paper, they estimated the additional cost to build to M4(2) standard rather than M4(1), including the extra space required, was roughly £1,400 per dwelling [17]. A full breakdown of costs can be seen in Figure 9 below, taken from the Local Authority Toolkit from Habinteg.

Figure 9: The additional cost for meeting Category 2 and 3 standards compared to the standard of Category 1 [9]

	Access (build) cost	Access-related space cost (after space cost recovery)		Total cost
Category 2				
1 bed apartment	£940	+1sq.m	£289	£1,229
2 bed apartment	£907	+1sq.m	£289	£1,196
2 bed terraced	£523	+2sq.m	£578	£1,101
3 bed semi-detached	£521	+3sq.m	£866	£1,387
4 bed detached	£520	+3sq.m	£866	£1,386
Category 3 Adaptable				
1 bed apartment	£7,607	+8sq.m	£2,310	£9,908
2 bed apartment	£7,891	+14sq.m	£4,043	£11,934
2 bed terraced	£9,754	+21sq.m	£6,065	£15,819
3 bed semi-detached	£10,307	+24sq.m	£6,931	£17,244
4 bed detached	£10,568	+24sq.m	£6,931	£17,499
Category 3 Accessible				
1 bed apartment	£7,767	+8sq.m	£2,310	£10,077
2 bed apartment	£8,048	+14sq.m	£4,043	£12,091
2 bed terraced	£22,238	+21sq.m	£6,065	£28,303
3 bed semi-detached	£22,791	+24sq.m	£6,931	£29,722
4 bed detached	£23,052	+24sq.m	£6,931	£29,983

The costs of adapting an existing home far outweighs building to the adaptable standard as a baseline. It is estimated it would cost £7,000 in Disabled Facilities Grant to adapt a Category 1 home to a Category 2 level [3]. Additionally, if your house becomes unsuitable for your needs to the point where you need to move, it would cost £29,000 per year in residential care costs [3].

Furthermore, unsuitable and poor housing has wider costs to the society. It is estimated that the cost of poor housing to the NHS across all ages is £1.4 billion per annum in the first year of treatment alone [1]. In the over 55 age bracket it estimated that poor housing costs the NHS £513 million in avoidable treatment, with £177 million of this being as a result of falls [1]. There is also the impact on: employment, due to lost working days and leaving the workforce early because of poor health; social care, due to increase demands from avoidable incidents; and welfare benefits, due to higher unemployment and disability payments [1].

Further National Policy

Housing for older and disabled people

Outlined on the Government's website is guidance from 2019 entitled Housing for older and disabled people[13]. The guidance states:

"Accessible and adaptable housing enables people to live more independently, while also saving on health and social costs in the future. It is better to build accessible housing from the outset rather than have to make adaptations at a later stage –both in terms of cost and with regard to people being able to remain safe and independent in their homes.

Accessible and adaptable housing will provide safe and convenient approach routes into and out of the home and outside areas, suitable circulation space and suitable bathroom and kitchens within the home. Wheelchair user dwellings include additional features to meet the needs of occupants who use wheelchairs, or allow for adaptations to meet such needs." [18]

Healthy ageing: consensus statement

Public Health England and the Centre for Aging Better have set out a "shared vision for making England the best place in the world to grow old" in the Healthy ageing: Consensus Statement[14]. Within this statement they make five principles across a range of areas that all have an impact on health. One these area's is Ensuring good homes and communities and they make the commitment to:

"Ensuring good homes and communities to help people remain healthy, active and independent in later life. Poor housing can contribute to and exacerbate many long-term health conditions. We want to improve the quality of our existing mainstream housing stock and future-proof new homes, ensuring they are built to be accessible and adaptable" [19].

National Disability Strategy

Following a public consultation, the Government outlined the National Disability Strategy[15] in July 2021. This strategy considers the difficulties faced by disabled people in the UK and makes a commitment to improve conditions in all aspects of their lives. The strategy is split into three parts: Part 1, Practical steps now to improve disabled people's everyday lives; Part 2, Disabled people's everyday experience at the heart of government policy making and service delivery; and Part 3, A cross-government effort to transform disabled people's everyday lives. Within each part there are relevant sections relating to accessible housing [20].

Part 1 –Practical steps now to improve disabled people's everyday lives.
Housing is identified as one of eight key areas where work can be carried out to improve the lives of disabled people, with the strategy stating, "A decent home is the

[13] Housing for older and disabled people - https://www.gov.uk/guidance/housing-for-older-and-disabled-people
[14] Healthy ageing: Consensus Statement – https://www.gov.uk/government/publications/healthy-ageing-consensus-statement
[15] National Disability Strategy – https://www.gov.uk/government/publications/national-disability-strategy

foundation for an independent life." [20]. The importance of an accessible home is recognised within this section of the strategy and the government has committed to "boost the supply of housing for disabled people by rising accessibility standards for new homes" [20]. As part of this work a consultation into raising the accessibility standards was carried out in 2020 by the Ministry of Housing, Communities & Local Government. The results should be published in December 2021 [20].

Part 2 –Disabled people's everyday experience at the heart of government policy making and service delivery.
As quoted above, the Government has recognised that good quality housing is crucial to ensuring an independent life. Supporting independent living is one of the five areas that will underpin all commitments around disability made by Government. The list of five areas can be seen below in Figure 10. Also relevant to housing areas 1. Ensuring fairness and equality and 2. Consider disability from the start, as building to M4(2) would allow individuals to access and live in any community they wished and enable people to stay in their homes should disability arise later in life.

Figure 10: National Disability Strategy, five areas which will guide the Government's work [20]

We will work across government departments to embed the following elements, which underpin our future approach to disability:

1. **Ensure fairness and equality** – we will empower disabled people by promoting fairness and equality of opportunities, outcomes and experiences, including work and access to products and services.
2. **Consider disability from the start** – we will embed inclusive and accessible approaches and services to avoid creating disabling experiences from the outset.
3. **Support independent living** – we will actively encourage initiatives that support all disabled people to have choice and control in life.
4. **Increase participation** – we will enable greater inclusion of a diverse disabled population in the development and delivery of services, products and policies.
5. **Deliver joined up responses** – we will work across organisational boundaries and improve data and evidence to better understand and respond to complex issues that affect disabled people.

Part 3 –A cross-government effort to transform disabled people's everyday lives.
The Government's commitment to "boost housing supply for disabled people" falls under the control of The Ministry of Housing, Communities and Local Government (MHCLG)[16]. The full list of commitments under MHCLG control to improve accessibility across society can be seen below in Figure 11.

[16] The Ministry of Housing, Communities and Local Government changed its name in September 2021 to The Department for Levelling Up, Housing and Communities as part of the post-COVID levelling up agenda- https://www.gov.uk/government/news/ambitious-plans-to-drive-levelling-up-agenda

Figure 11: MHCLG commitments to improving accessibility [20]

The department will take action across housing and planning to create more accessible homes and communities.

MHCLG commits to:

- boost England's housing supply for disabled people by setting out plans to increase the accessibility of new homes, options for supported housing and home ownership
- ensure the safety of disabled people in buildings, for when there are emergencies
- consider how we can support projects that will increase high street accessibility for disabled people, through the design of any future local growth funding
- accelerate the roll out of specialist Changing Places toilets across the country
- encourage local authorities to build and refurbish more inclusive playgrounds for disabled children

Adaptable Homes Planning Policies

Aligned to the National Planning Policy Framework, many local authorities across the UK are beginning to implement policies requiring houses to be built to the adaptable standard. The Habinteg Forecast for Accessible Homes 2020 found that of the 324 local planning areas in England, 48% (154) had a policy within their local plan setting a percentage of new homes to be built to adaptable standard [21]. 119 of these specified the use of the Building regulations M4(2) and M4(3) standards [21].

In the North West, only 9 Local Plans out of the 39 planning areas had policies requiring M4(2)/M4(3). 4 areas had requirements for old Lifetime Homes and Wheelchair Housing Design Standards [21].

Between different local authorities, the minimum number of new homes built to the adaptable standard varies but over the past several years areas have started to commit to all new homes being built to M4(2) as a baseline, with a some further specifying a percentage should be built to M4(3). Whilst not an exhaustive list, presented below are series of case studies which can be used as examples when developing policies within Lancashire.

London[17]

The Greater London Authority was the first area to implement full coverage of the adaptable home standards [22]. They did this through a Minor Adaptation to their Local Plan18. The finalised policy required 90% of homes to be built to M4(2) standard and the remaining 10% be built to M4(3) standard. The policy reads:

> "Standard 11: 90 per cent of new build housing should meet Building Regulation requirement M4(2) 'accessible and adaptable dwellings' with the remaining 10 per cent meeting Building Regulation requirement M4(3) 'wheelchair user dwellings'."[19]

Huntingdonshire[20]

Within Huntingdonshire's 2016-2036 Local Plan Policy LP25 outlines their plan for Housing Mix. This includes a section specifically about Accessible and Adaptable homes where they commit to all new homes being built to M4(2) standard unless impractical or unviable. Their policy reads:

> "Accessible and adaptable homes
>
> A proposal that includes housing will be supported which meets the optional Building Regulation accessibility standards (or replacement standards) as

[17] Greater London Authority Housing SPD – https://www.london.gov.uk/sites/default/files/housing_spg_revised_040516.pdf
[18] Greater London Authority Housing Standards Minor Alterations to The London Plan – housing_standards_malp_for_publication_7_april_2016.pdf (london.gov.uk)
[19] Please note: in the published standard there is a typo where requirement is spelt requirment –for clarity this has been corrected in the quoted extract.
[20] Huntingdonshire Local Plan – https://www.huntingdonshire.gov.uk/media/3872/190516-final-adopted-local-plan-to-2036.pdf

set out below, unless it can be demonstrated that site-specific factors make achieving this impractical or unviable:

f. ensuring 100% of new dwellings, across all tenures provided, meet Building Regulation requirement M4(2) 'accessible and adaptable dwellings' (or replacement standards); and

g. within a large scale development proposal the construction standards of a proportion of new market

dwellings should be further enhanced to meet Building Regulation requirement M4(3) 'wheelchair adaptable dwellings' (or replacement standards); and

h. for all affordable housing an appropriate proportion meeting Building Regulation requirement M4(3) 'wheelchair adaptable dwellings' (or replacement standards) should be negotiated with the Council's Housing Strategy team."

South Lakeland[21]

South Lakeland produced an evidence review into the need for the optional housing standards in 2017. After considering their population demographics (e.g. age and disability) and their existing housing stock they concluded that all new housing should be built to M4(2) standard as a minimum and 5% of dwellings on sites over 40 homes should be built for M4(3). The only exception to these rules is when it is physically infeasible to achieve the requirements of an M4(2) property. Their policy states:

"The evidence presented in this paper clearly demonstrates the need for more accessible and adaptable homes in South Lakeland. The Council is taking the approach that it is logical and justified that all new homes should be flexible and to be built to a standard that is suitable for a range of different people with different characteristics and at different life stages. The proposed policy recognises the situations whereby it may not be feasible or practical to meet these requirements (e.g. due to topography or flood risk) and allows for exceptions where justified. However the Council proposes that the general expectation is that all new homes should meet these standards where possible."

"…it is proposed that a requirement for 5% of Category 3 dwellings on residential sites of 40 units or more would generate a realistic supply of wheelchair adaptable dwellings to meet unmet need. …Applying this requirement to only larger sites will also help ensure wheelchair user dwellings are provided in the most suitable and sustainable locations as larger housing sites are steered towards these locations through the Local Plan…"

[21] South Lakeland Optional Housing Standards Evidence Paper - https://www.southlakeland.gov.uk/media/4174/updated-optional-housing-standards-evidence-paper-aug-2017.pdf

Cambridge[22]

In October 2018 Cambridge adopted their Local Plan and it will last until 2031. There is a specific policy relating to adaptable homes requiring all new homes be built to M4(2) and a 5% of affordable homes be built to M4(3). The wording for Policy 53: Accessible Homes is below:

> "In order to create accessible homes:
>
> a. all housing development should be of a size, configuration and internal layout to enable Building Regulations requirement M4 (2) 'accessible and adaptable dwellings' to be met; and
>
> b. 5 per cent of the affordable housing component of every housing development providing or capable of acceptably providing 20 or more self-contained affordable homes42, should meet Building Regulations requirement M4 (3) 'wheelchair user dwellings' to be wheelchair accessible, or be easily adapted for residents who are wheelchair users"

Reading[23]

Reading adopted their Local Plan in November 2019 and it will last until 2036. Policy H5: Standards for New Housing outlines the requirements that new housing should be built to. This includes the requirements for all new homes to be M4(2) unless built to M4(3) standard. The policy reads:

> "New build housing should be built to the following standards, unless it can be clearly demonstrated that this would render a development unviable: …
>
> ..e. All new build housing will be accessible and adaptable in line with M4(2) of the Building Regulations, unless it is built in line with M4(3) (see below).
>
> f. On developments of 20 or more new build dwellings, at least 5% of dwellings will be wheelchair user dwellings in line with M4(3) of the Building Regulations. Any market homes provided to meet this requirement will be 'wheelchair adaptable' as defined in part M, whilst homes where the Council is responsible for allocating or nominating an individual may be 'wheelchair accessible'"

Bristol[24]

Bristol is currently (Nov 2021) reviewing their Local Plan. In March 2019 they published their Draft Polices and Development Allocations. Within this document they have highlighted the need for more adaptable and accessible homes and therefore have proposed Draft Policy H9: Accessible Homes which reads:

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[22] Cambridge Local Plan – https://www.cambridge.gov.uk/media/6890/local-plan-2018.pdf
[23] Reading Local Plan – https://images.reading.gov.uk/2019/12/Local_Plan_Adopted_November_2019.pdf
[24] Bristol Local Plan Review: Draft Policies and Development Allocation – https://www.bristol.gov.uk/documents/20182/34536/Local+Plan+Review+-+Draft+Policies+and+Development+Allocations+-+Web.pdf/2077eef6-c9ae-3582-e921-b5d846762645

"To ensure new homes are accessible to all, residential development should include:

At least 10% of new build housing in proposals of 50 dwellings or more designed to be wheelchair accessible, or easily adaptable for residents who are wheelchair users (compliant with Building Regulations M4(3) Category 3: Wheelchair user dwellings).

All new build housing designed to be accessible and adaptable (compliant with Building Regulations M4(2) Category 2: Accessible and adaptable dwellings) except for those dwellings that are designed to be wheelchair accessible, or easily adaptable for residents who are wheelchair users."

Recommendation

The evidence presented in this document demonstrates an existing and growing need for adaptable and accessible homes across Lancashire and provides sufficient justification for introducing the optional standards M4(2). With only 7% of existing homes meeting accessibility standard [10] and only one new accessible home is planned for every 15 people over 65 by 2030 [3], there is not enough housing neither currently available nor planned to meet demand. If only a proportion of new homes were built to M4(2) standard in the future, individuals will not have a fair and equal opportunity to live in homes that are adaptable. We want houses that offer a lifetime home and can grow with a person and family as they age. Therefore, to ensure equity and fairness across the county, we recommend:

100% of all new build homes should be built in accordance with the requirements laid in out in M4(2) Accessible and Adaptable Dwellings unless this is superseded by M4(3) building regulations or other specialist requirements.

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Hot Food Takeaways and Spatial Planning

Public Health Advisory Note

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July 2024

Contents

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.

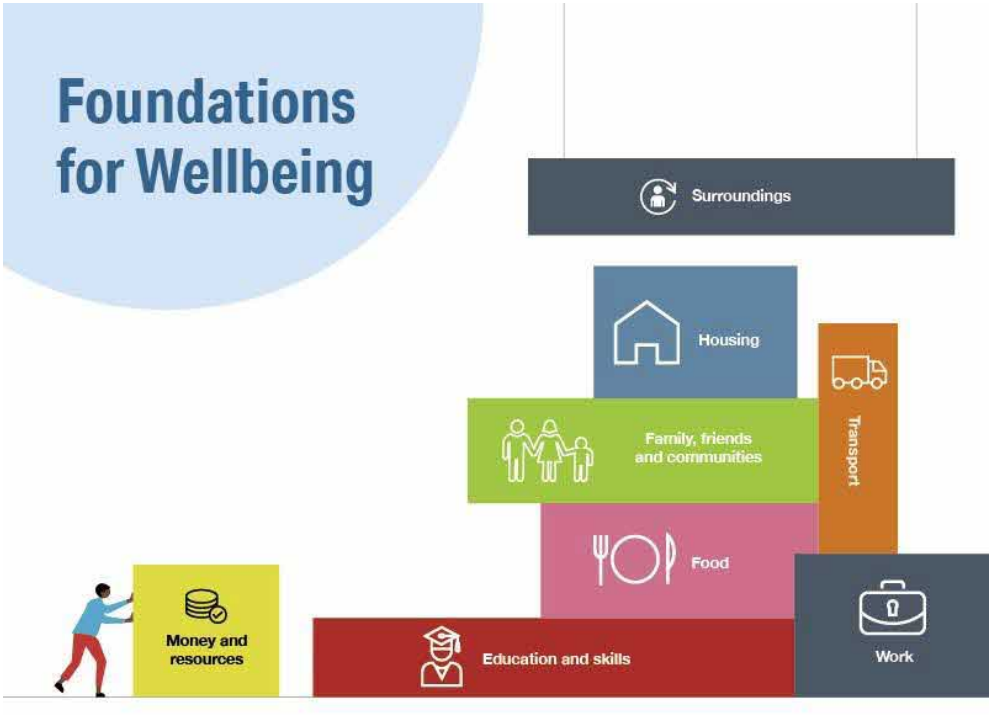
Wider Determinants of Health

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)[1].

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]**.**



[1] 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)[2] 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[3]:

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)[4], '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.

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

[3] For more information on the change of use classes, see Appendix 1.

[4] 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)[5].

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.

[5]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

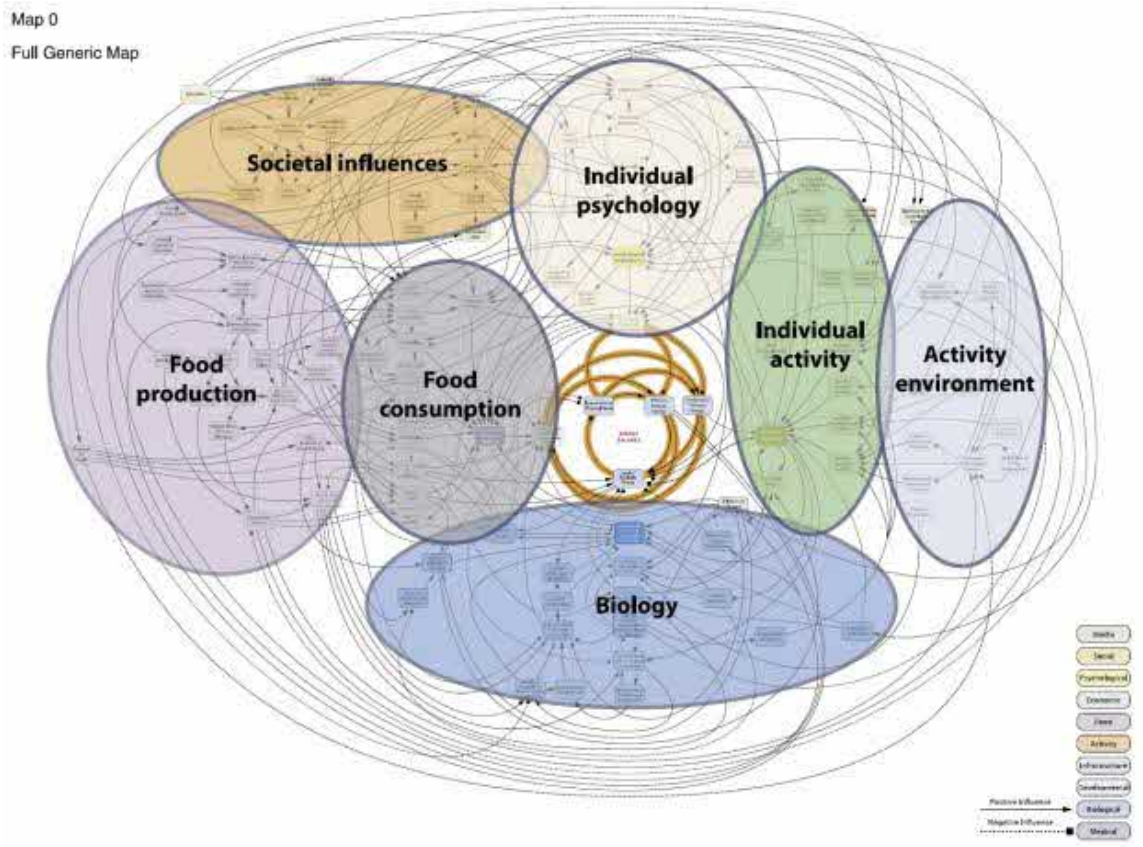
Obesity is a global public health concern. It is associated with reduced life expectancy and is a risk factor for a range of chronic diseases, including cardiovascular disease, type 2 diabetes, at least 12 kinds of cancer, liver, and respiratory disease, and can also impact on mental health [9]. The 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][6].

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]**.**



[6]BMI: Body weight in kilograms, divided by height in meters squared. For adults, BMI ranges from underweight or wasting (<18.5 kg/m2) to severe or morbid obesity (≥40 kg/m2). 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[7]—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)[8] 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[9]. 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).

[7] Morbidity refers to the state of having an illness or disease.
[8] 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.
[9] 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[10] 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 higher than the Lancashire average. Conversely, 6 districts (Chorley, Lancaster, Preston, Ribble Valley, South Ribble, West Lancashire) are identified as having a percentage that is statistically lower than 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)

↓ Worse than Lancashire ↓ Better than Lancashire → Similar to Lancashire

Local Authority	Patients On Diabetes Register	Registered Patients	%	Benchmark with Lancashire
Burnley	6,875	80,146	8.6%	
Chorley	6,917	97,243	7.1%	↓
Fylde	5,563	72,129	7.7%	→
Hyndburn	6,183	69,837	8.9%	
Lancaster	9,257	133,101	7.0%	↓
Pendle	7,128	81,904	8.7%	
Preston	9,693	135,483	7.2%	↓
Ribble Valley	3,511	54,320	6.5%	↓
Rossendale	4,308	55,457	7.8%	→
South Ribble	6,794	95,601	7.1%	↓
West Lancashire	6,845	97,460	7.0%	↓
Wyre	8,671	98,736	8.8%	
Lancashire	**81,745**	**1,071,417**	**7.6%**	

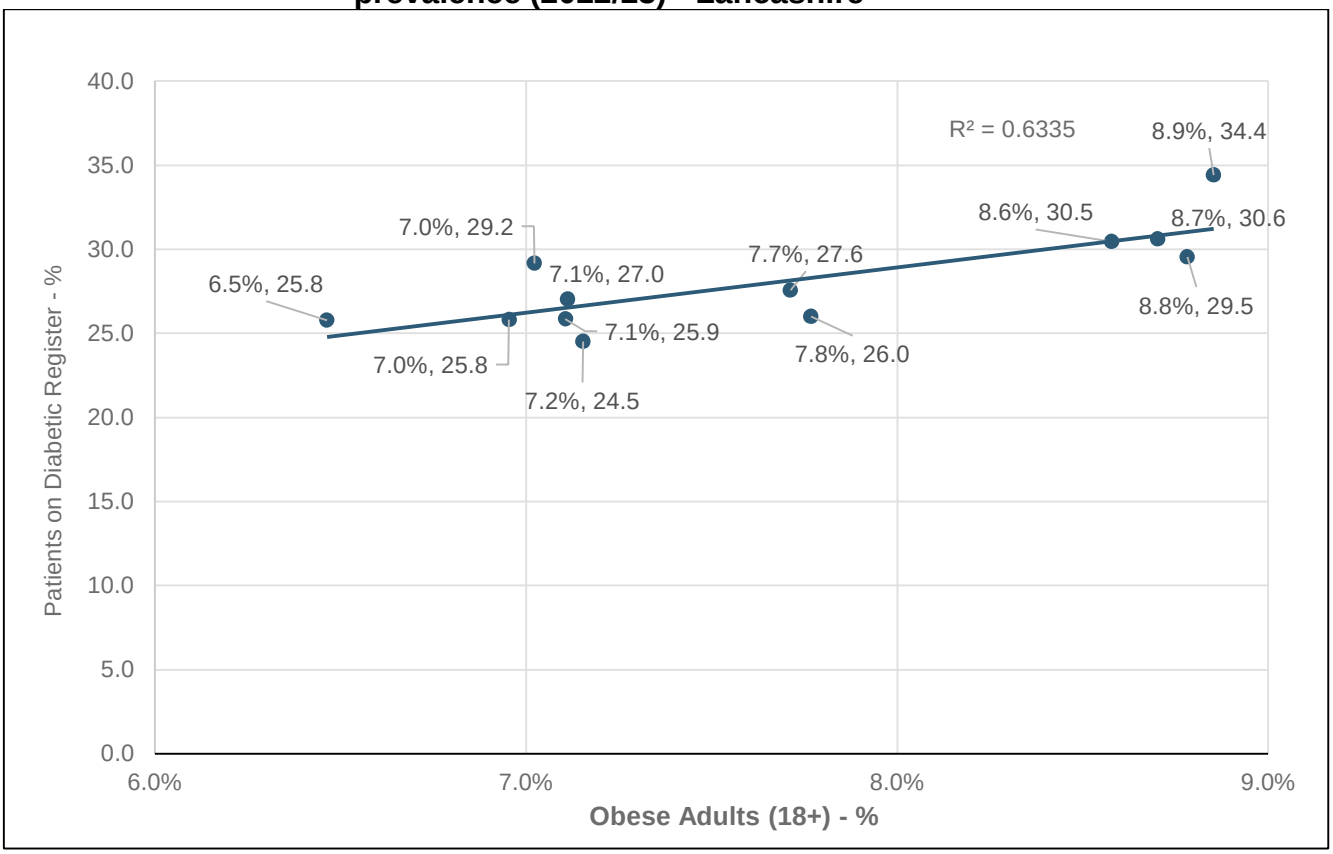
Source: NHS Midlands and Lancashire Commissioning Support Unit

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

[10] 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.

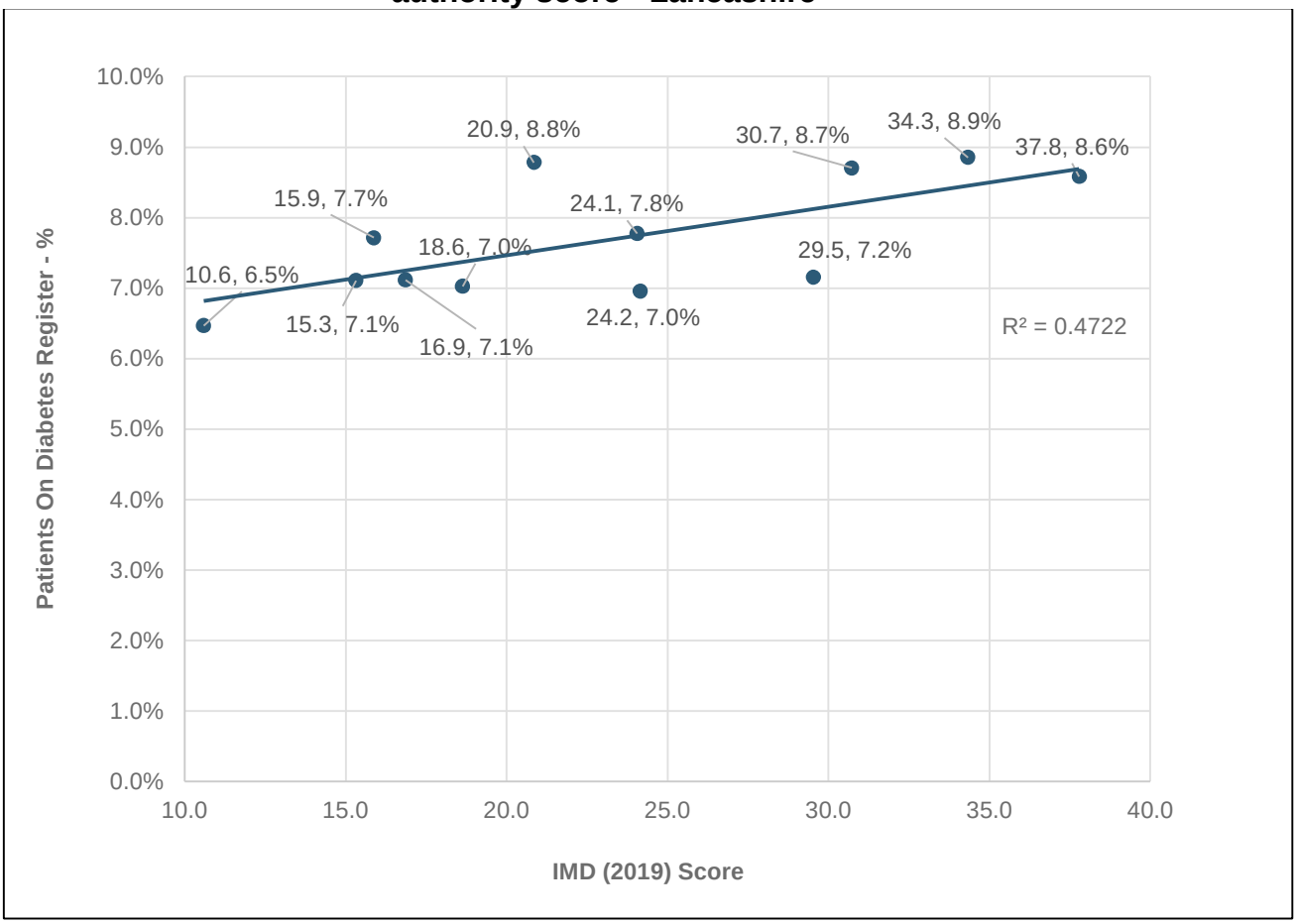
Figure 3: Percentage of patients on diabetes register by adult obesity prevalence (2022/23) - Lancashire



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].

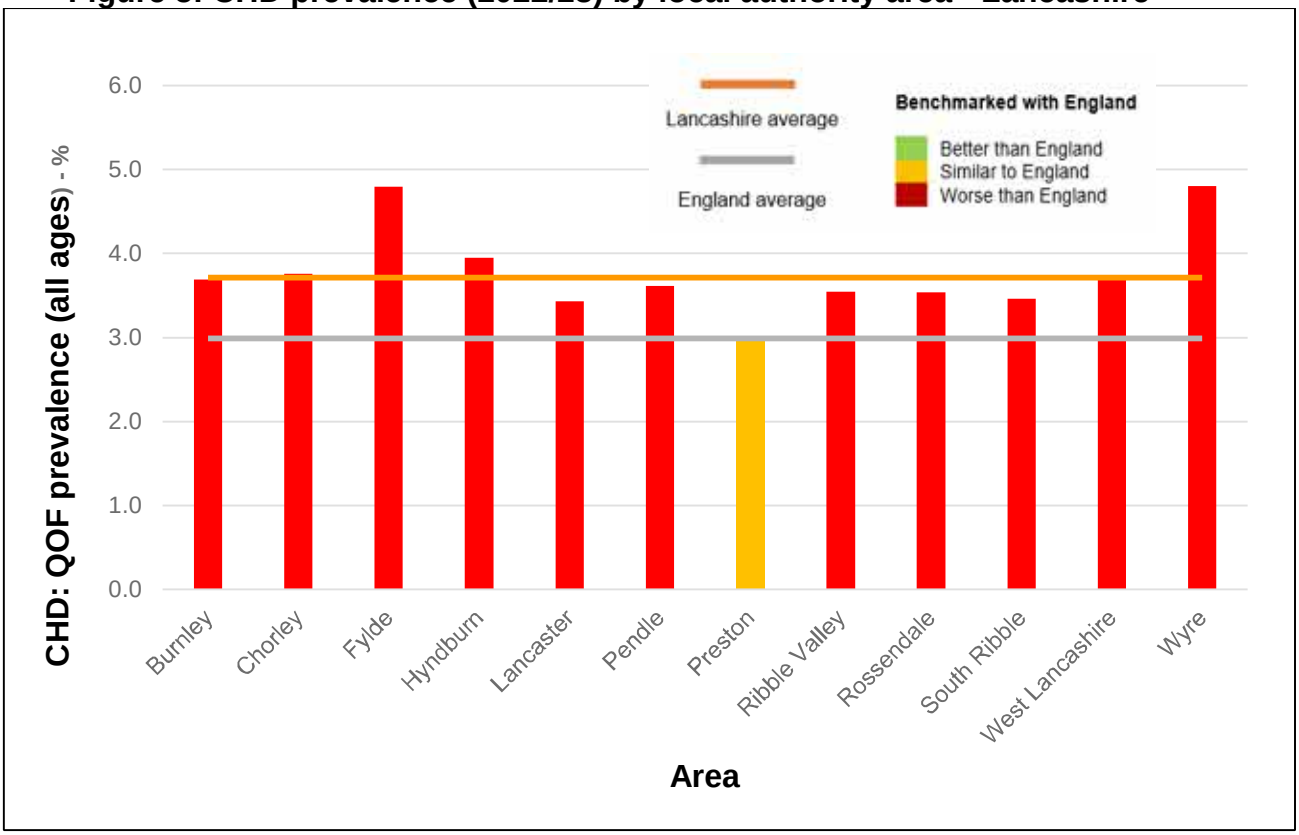
CVD is the primary cause of mortality globally [16] and is responsible for just over a quarter (26%) of all deaths in England; that's over 140,000 deaths each year – an average of 390 people each day or one death every four minutes [15]. Not only is CVD a significant contributor to mortality, but it 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.

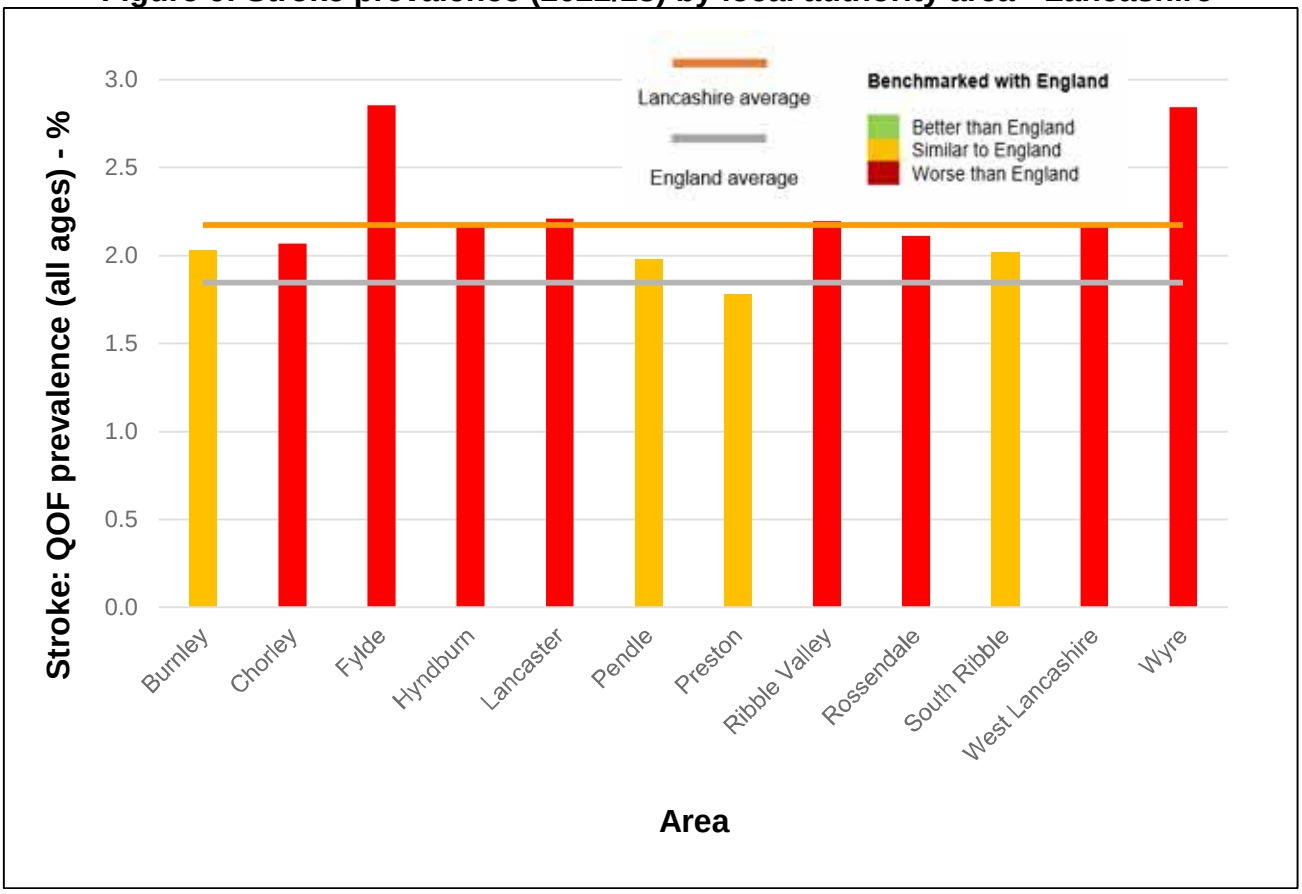
Figure 5: CHD prevalence (2022/23) by local authority area - Lancashire



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

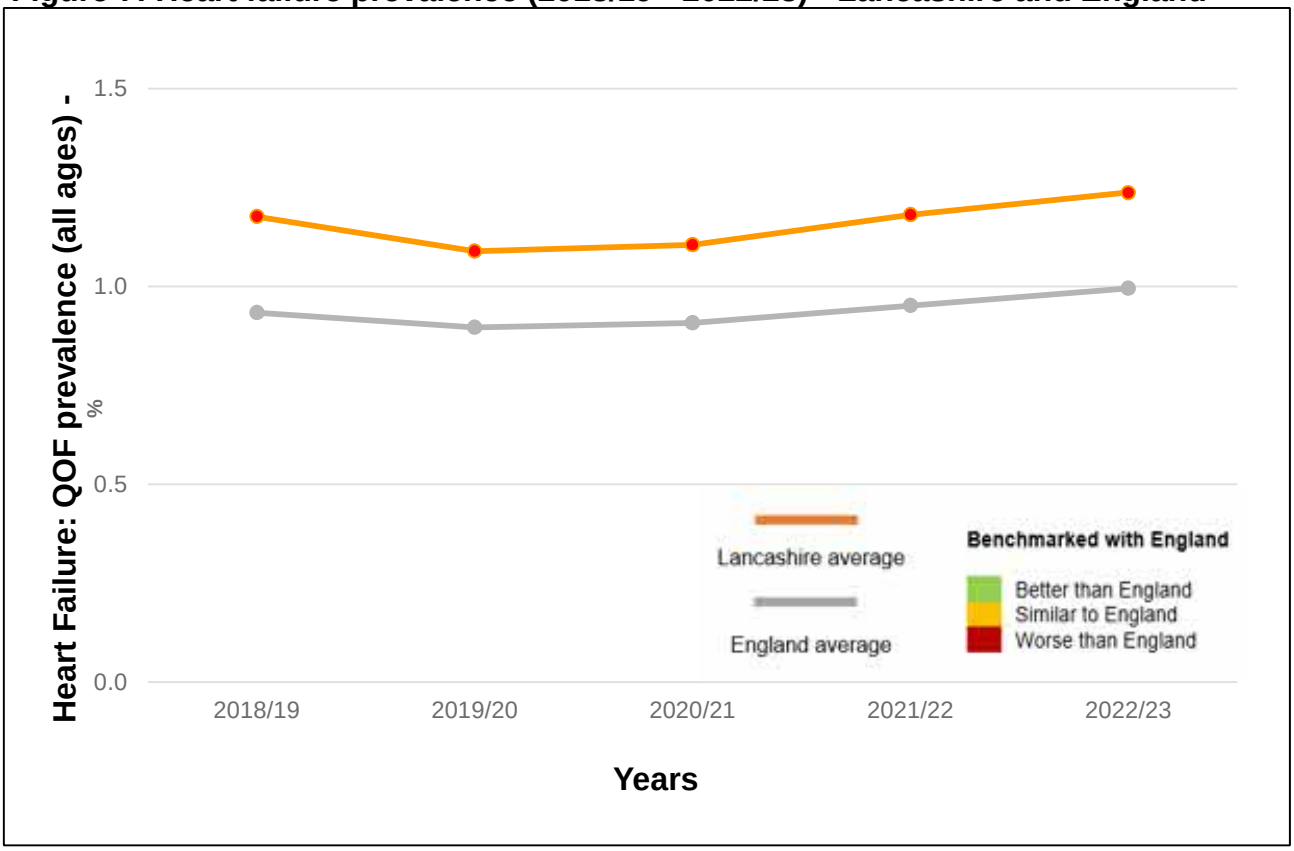


Source: OHID, Fingertips

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[11], Lancashire ranks 3rd highest, trailing only Leicestershire and Hampshire.

[11] Nearest statistical neighbours (NHS England): 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].

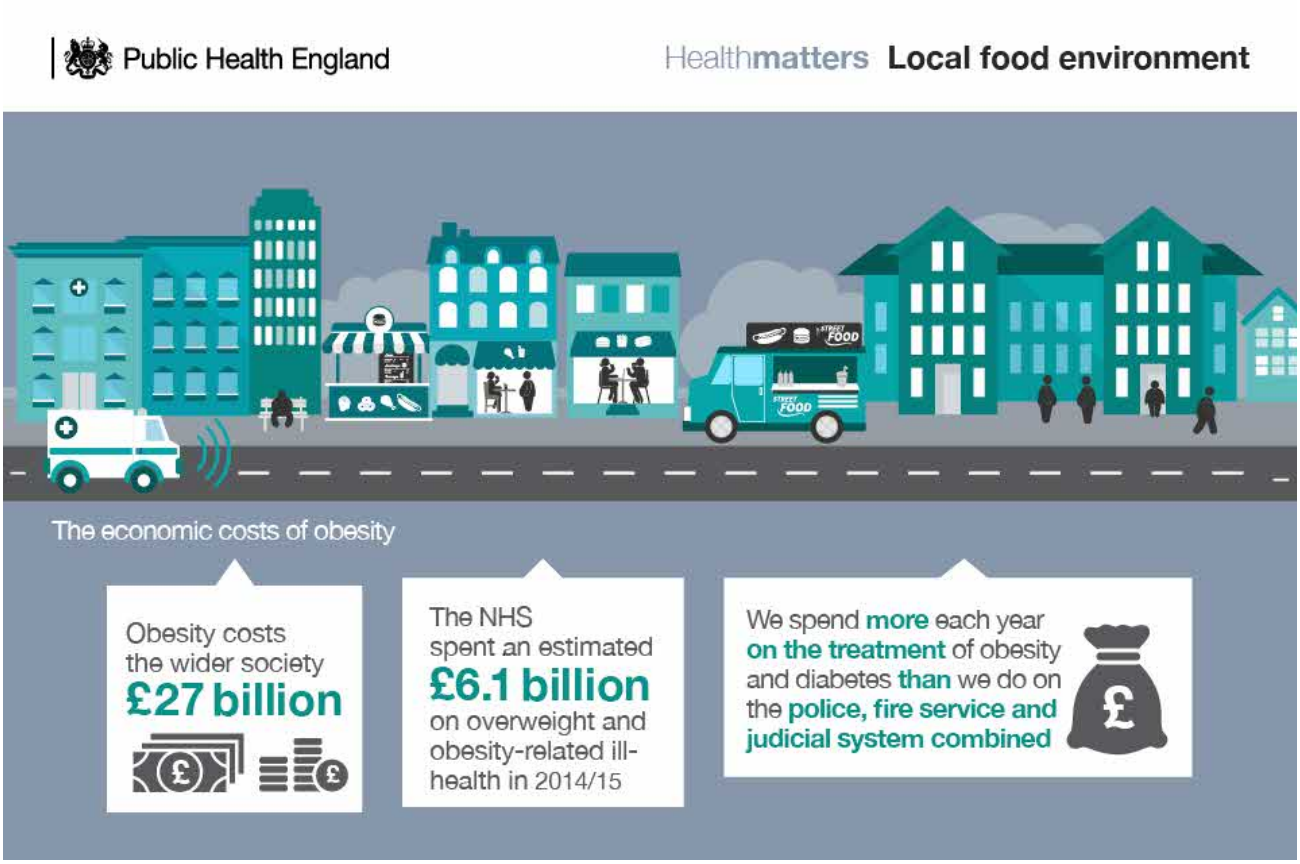
Economic

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[12].

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)[13]. 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.

[12] 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

[13] 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

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:
Strategic / System Leadership
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
Commercial Determinants
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
Health Promoting Infrastructures / Environments
9. Consider supplementary guidance for hot food takeaways, specifically in areas around schools, parks and where access to healthier alternatives are limited
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
Organised Change / Cultural Shift
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
Monitoring and Evaluation
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[14].

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,

[14] 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 earnt the Food for Life silver catering award by providing menus containing locally sourced, organic food, reformulated 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[15] 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[16] and Public Health School Nursing[17] 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.

[15] https://www.lancashire.gov.uk/lpds/teaching-and-learning/pshe-education/lancashire-learning-for-life/
[16] https://lancsyoungpeoplefamilyservice.co.uk/health-visiting/
[17] https://lancsyoungpeoplefamilyservice.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:

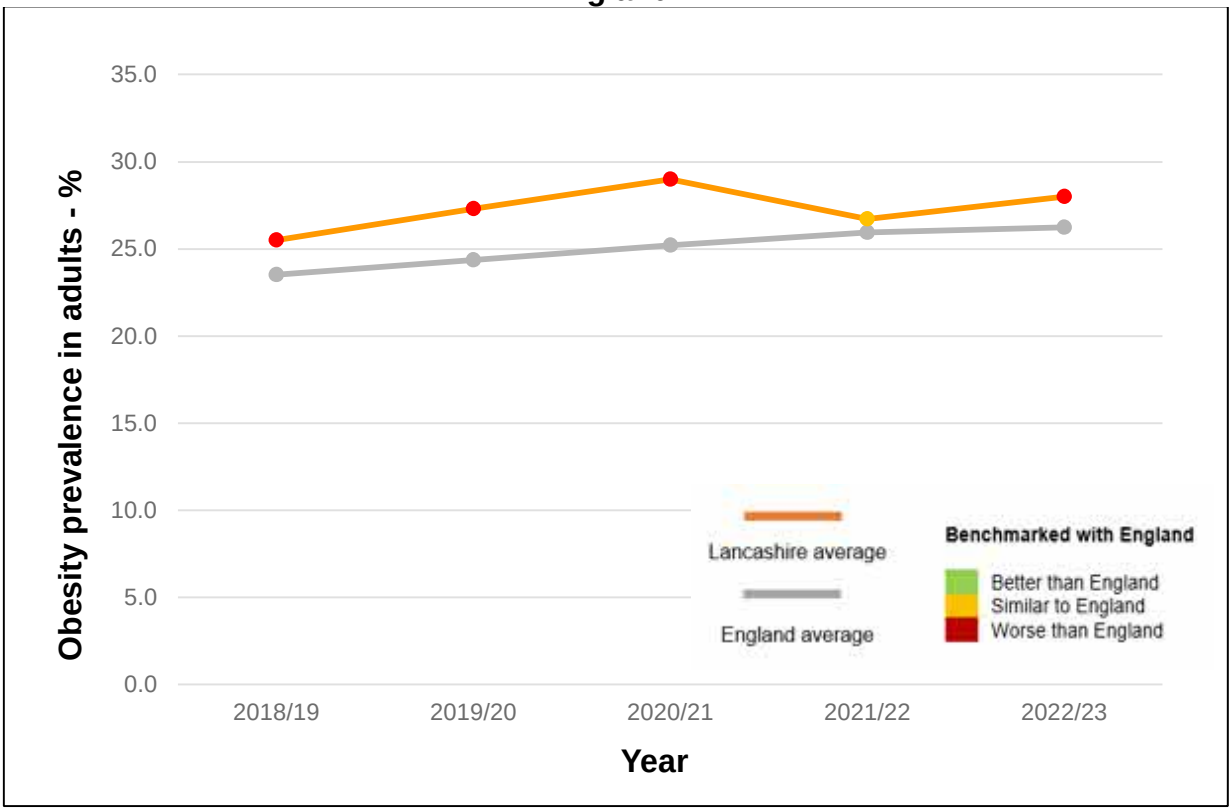
> An analysis of data from the **1980** National Heights and Weights Survey estimated that the prevalence of obesity in England stood at **6%** of men and **9%** of women aged 16 and over, with 0.1% of men and 0.4% of women living with severe obesity [25].
> In **1993**, the HSE reported that the prevalence 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[18].

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.

[18] 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

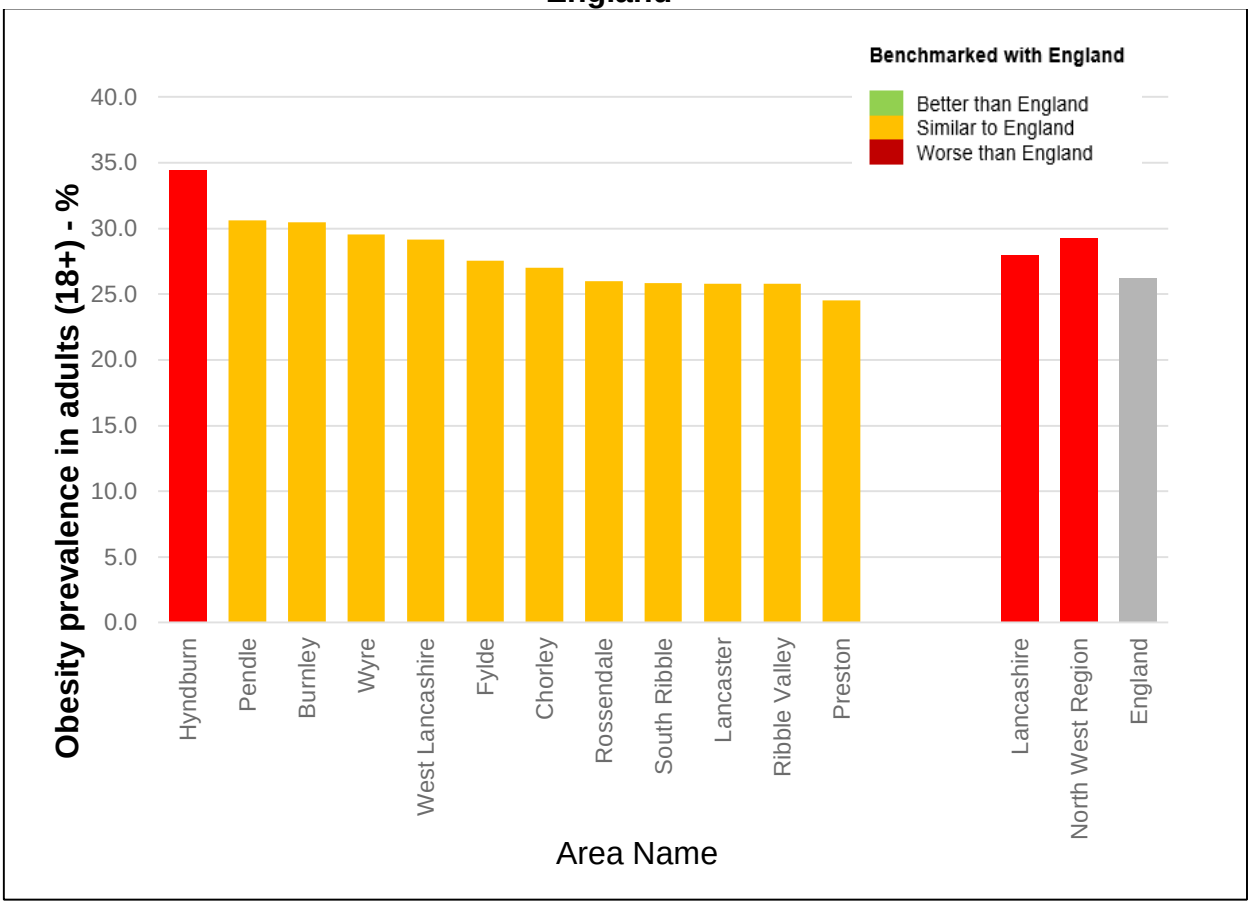


Source: OHID, Fingertips

Among its 15 closest NHS statistical neighbours, Lancashire ranks 3rd 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[19] 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.

[19] 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[20]. 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].

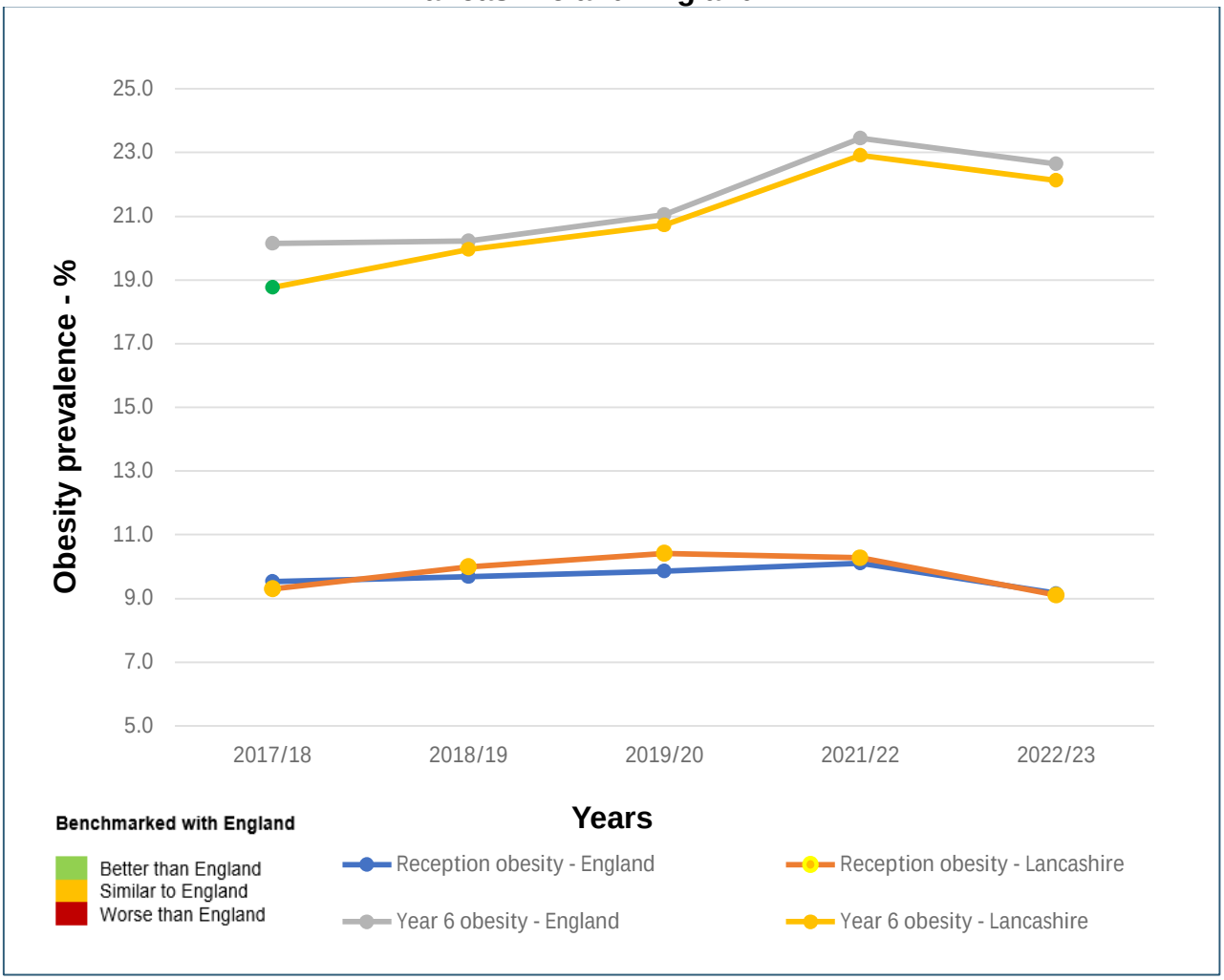
In the latest period (2022/23), the NCMP reported that 9.1% of Reception children and 22.1% of Year 6 children in Lancashire are classified as being obese, including severely obese. The latter figure has been on an upward trend when examined over the last 5 years (2017/18 to 2022/23) [21]. Figure 13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

[20] 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 concern 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.

[21] 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

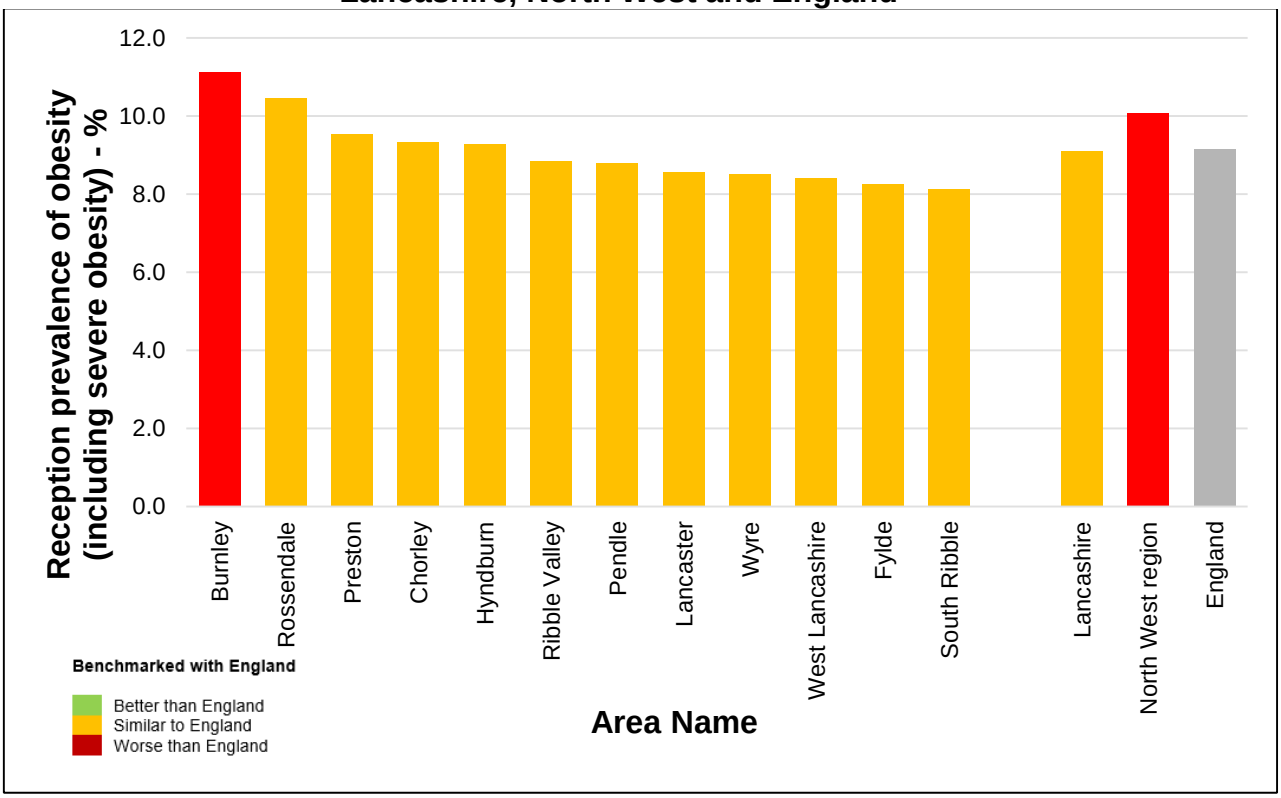


Source: OHID, Fingertips

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.

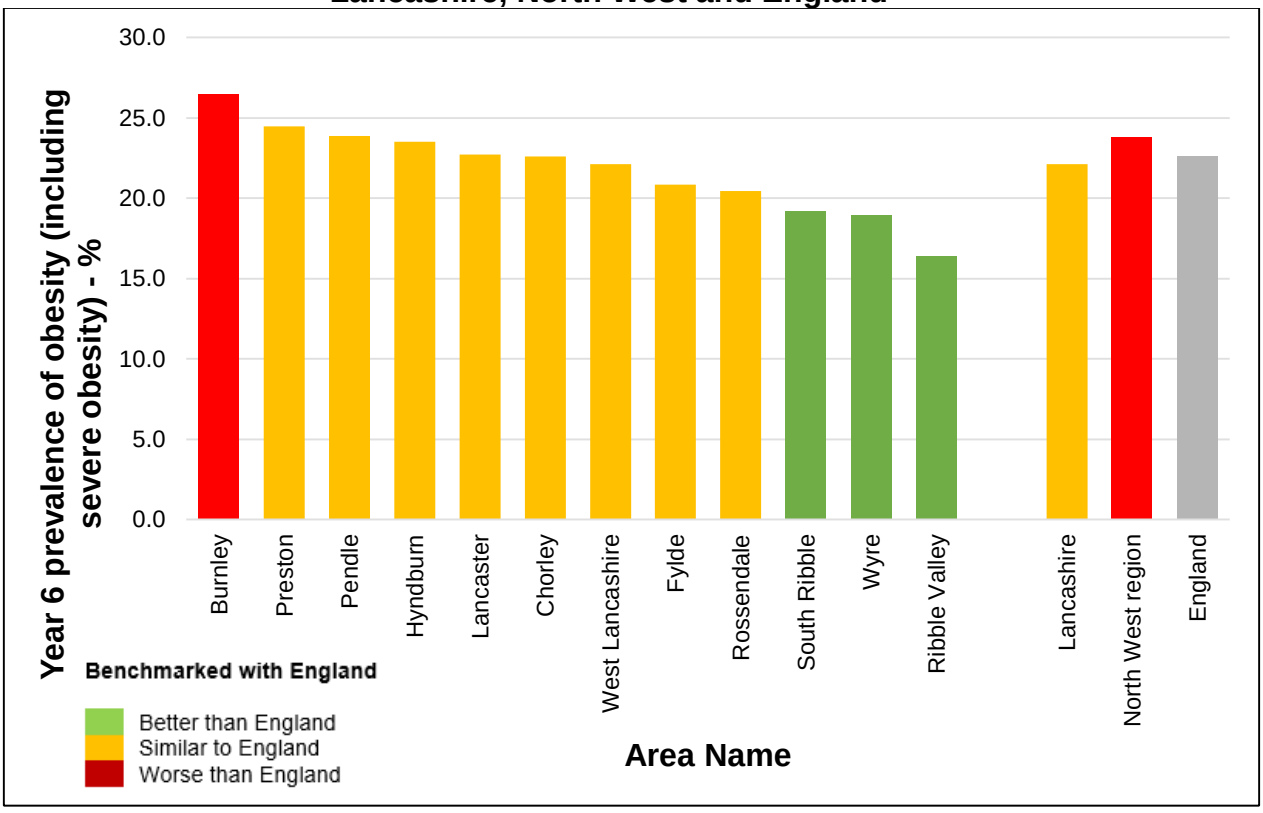
Figures 14 and 15 offer a detailed overview of the obesity rates for Reception and Year 6 children across all 12 districts in Lancashire. Each district has been compared to the England average and accordingly color-coded for easy interpretation.

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.

Lowest **Highest**

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

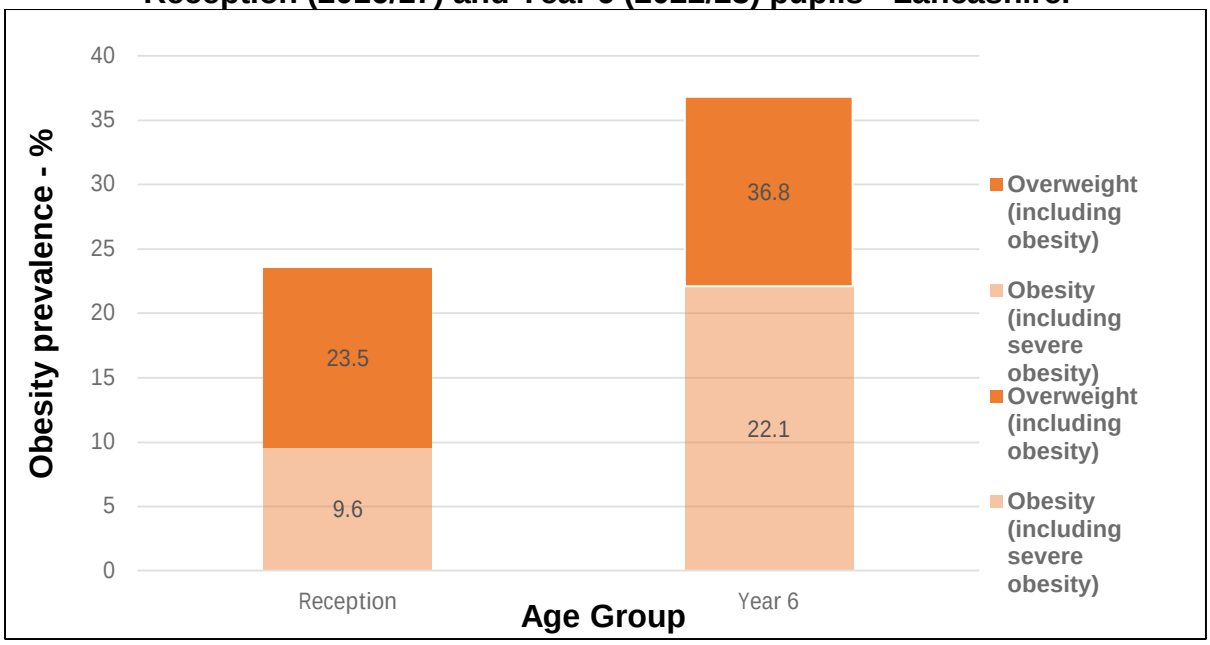
The obesity indicator data used in this analysis is a subset of the broader indicator that measures the percentage of children (both Reception and Year 6 age groups) classified as overweight or obese, as also provided by the NCMP. OHID recommends integrating these two indicators to deepen our understanding 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.	**Both income and fast-food outlet exposure are independently associated with higher BMI, body fat, obesity, and frequent processed meat consumption**. The study also finds evidence of an additive interaction between low income and high fast-food outlet exposure, leading to greater odds of obesity.	**The results suggest that individuals with lower income living in areas with a high proportion of fast-food outlets face a double burden,** 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 **children with greater access to fast-food outlets were more likely to experience significant weight gain** compared to those with less or no access	**The paper suggests that the prevalence of fast-food outlets, especially in areas of deprivation, may contribute to childhood obesity.** 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.	**Higher exposure to takeaway food outlets, especially at work, was associated with increased consumption of takeaway food and higher body mass index (BMI).** A dose-response relationship was observed, indicating that greater exposure led to	**The study suggests that planning restrictions on takeaway food outlets, particularly around workplaces, may contribute to healthier diets and lower obesity rates.** The findings support the idea that environmental interventions could be effective in promoting better health outcomes.

based, cross sectional study			higher takeaway food consumption and BMI.	
The number and type of food retailers surrounding schools and their association with lunchtime eating behaviours.	Seliske L, Pickett W, Rosu A, Jassen I (2013) [39]	The study sought to examine whether the presence of food retailers surrounding Canadian schools was associated with students' lunchtime eating behaviours.	The study found that the food retail environment surrounding schools is strongly related to student's eating behaviours during the school day.	**The findings of this study support the development of policies to improve eating behaviours among students by addressing the food retail environment surrounding schools.**
Does the local food environment around schools affect diet? Longitudinal associations in adolescents attending secondary	Smith, D; Cummins, S; Clark, C et al (2013) [40]	The study investigates the impact of the local retail food environment around secondary schools on adolescents' diets over time in East London.	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. **Small but significant relationships**	**The study suggests that the local food environment around schools may have a small influence on adolescent diet.** 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.

schools in East London			**were found between the distance to grocers and healthy diet scores, as well as proximity to takeaways and unhealthy diet scores.**	
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**, the presence of convenience and fast-food outlets near schools is associated with lower HEI scores among students.**	**The findings suggest that the neighbourhood food environment, particularly the availability of convenience stores and fast-food outlets, influences adolescents' dietary behaviours**, 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.	**The study found clustering of food outlets around schools, with a complex pattern in relation to deprivation.** There were numerous opportunities for pupils to purchase energy-dense foods near schools.	**The results suggest the need for policy interventions to address the food environment around schools to support healthier dietary behaviours among adolescents**. 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	**Proximity to a fast-food restaurant within 0.1 miles of a school is linked to a 5.2% increase in obesity**	**The research suggests that the presence of fast-food restaurants near schools significantly affects obesity rates among students, indicating that targeted policies to**

	Pathania, V (2009) [43]	on obesity rates among school children and weight gain among pregnant women	**rates among 9th graders**. 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	**limit access to fast food for school children could be effective in reducing obesity rates**. 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.	**Students in schools located near fast-food restaurants consumed fewer fruits and vegetables, more soda, and had higher odds of being overweight or obese** compared to students whose schools were not near fast-food restaurants.	**The study suggests that policy interventions limiting the proximity of fast-food restaurants to schools could be an effective strategy to reduce adolescent obesity.**

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[22]. 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[23].

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.

[22]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

[23] 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)

Lowest **Highest**

Area	2018	2019	2020	2021	2022	2023	2024
	Count	Count	Count	Count	Count	Count	Count
Lancashire	**1223**	**1248**	**1287**	**1380**	**1408**	**1385**	**1385**
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
Rossendale	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[24]. 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)[25]. By comparison, the recorded England rate was 104.4 per 100,000 people (or 1 outlet for every 958 people) [26]. 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).

[24]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.
[25] 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.
[26]As calculated by FEAT: Feat (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
Lancashire	**101.1**	**102.3**	**104.9**	**111.6**	**112.4**
Burnley	149.1	143.9	164.5	157.3	162.2
Chorley	90.7	96.4	96.7	102.6	101.2
Fylde	99.0	96.6	98.5	100.2	92.8
Hyndburn	134.9	138.2	146.7	147.1	163.4
Lancaster	86.0	82.9	85.7	93.6	94.2
Pendle	95.2	95.5	94.4	96.0	100.9
Preston	124.8	132.0	135.3	138.9	136.6
Ribble Valley	88.2	85.4	82.2	92.1	96.7
Rossendale	107.2	103.5	112.0	149.3	151.8
South Ribble	89.6	93.9	81.9	95.3	94.5
West Lancashire	59.7	59.5	62.0	65.7	65.3
Wyre	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
Lancashire	**1,235,345**	**1408**	**114.0**

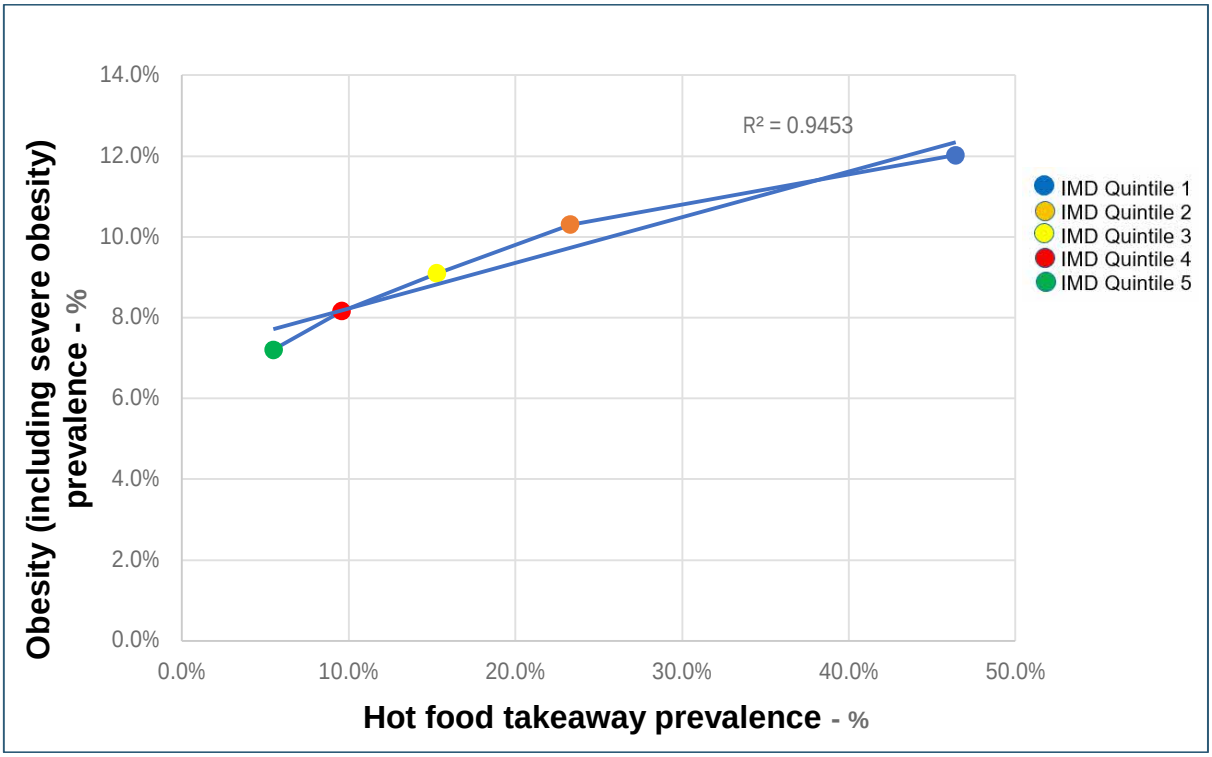
Source: FSA, FHRS; Office for National Statistics' Mid-Year Population Estimates; IMD (2019)

While we cannot establish causation, we can assess the correlation[27] 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.

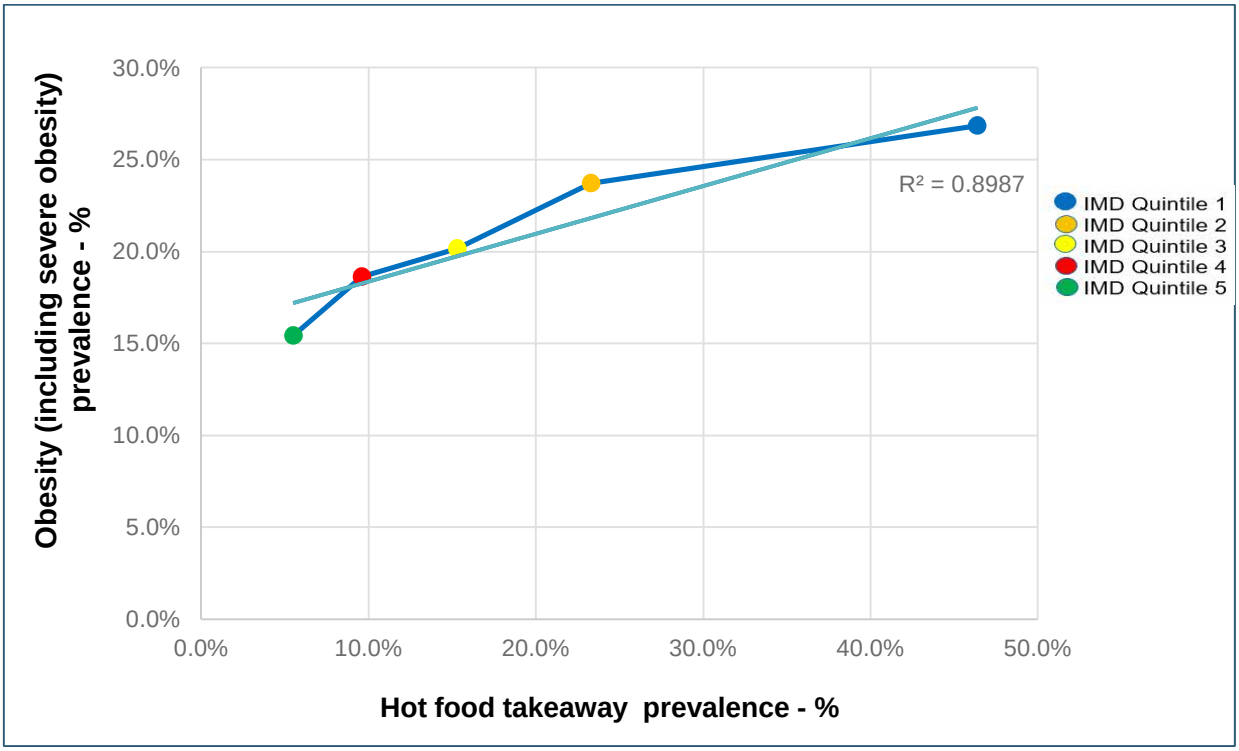
[27]Correlation refers to the connection or relationship between two or more facts, numbers, or variables. It measures how these variables tend to vary, be associated, or occur together, beyond what would be expected by chance alone.

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[28]. 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.

[28] 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

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:

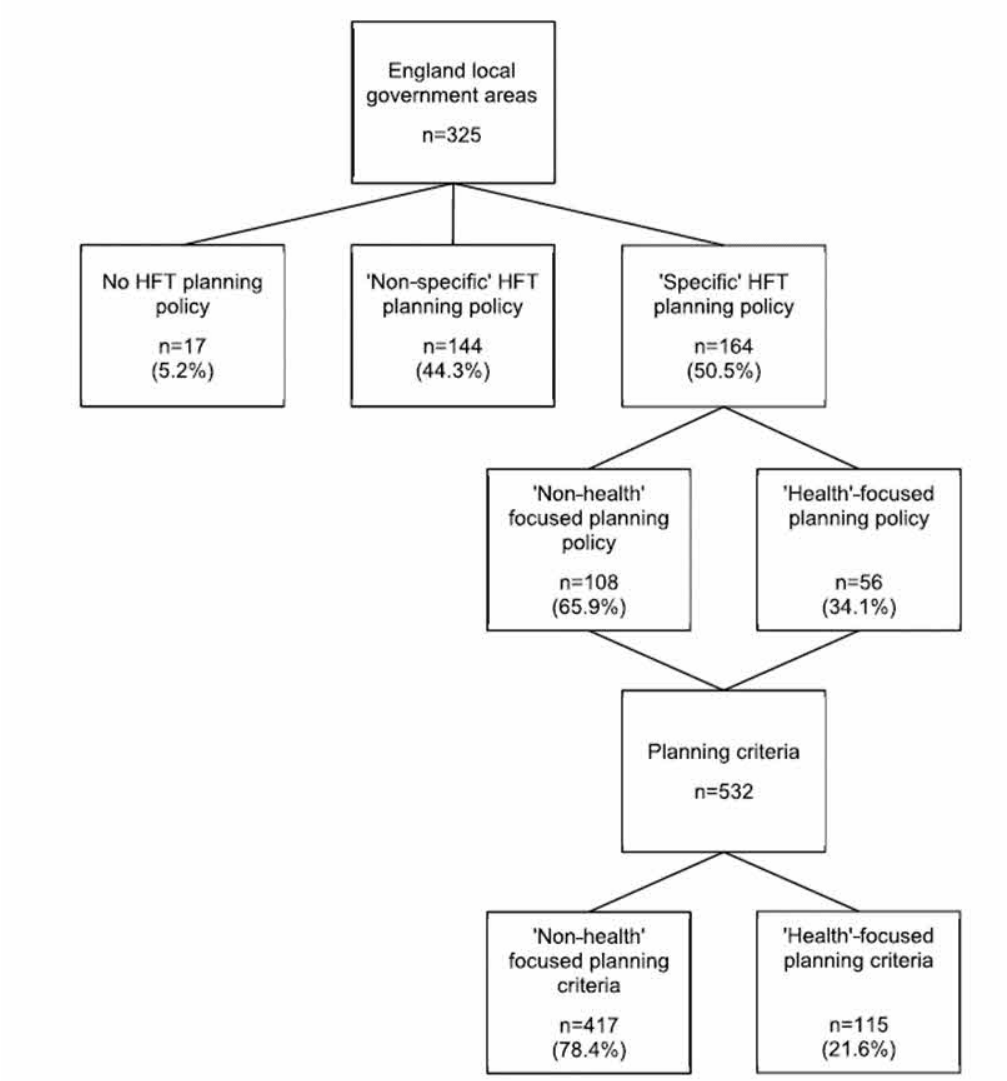
1) Involvement in Local Plan-making processes to support the embedding of the policy recommendations outlined above (including the submission of consultation responses, representation at district Local Plan Committee meetings, as well as attendance at Examinations in Public, as required).
2) Following 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[29] 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:

[29] 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.

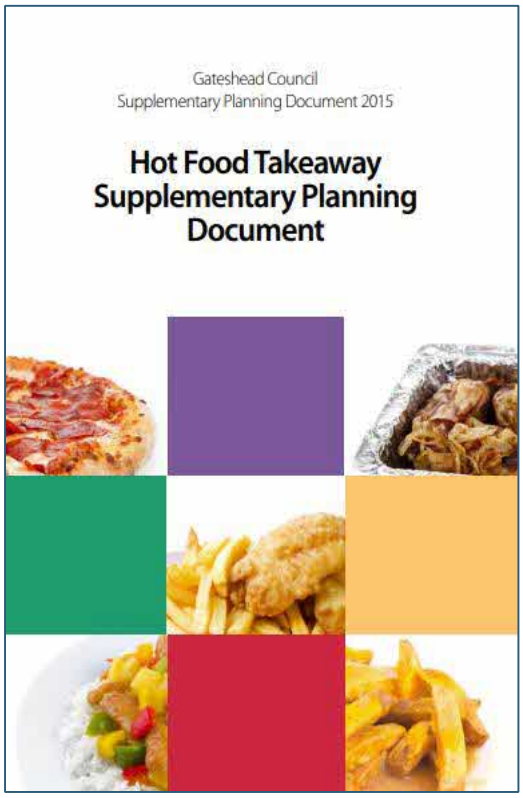
We undertook a further, rapid desktop review of a range of Local Plans including the two upper-tier local authorities within the Lancashire boundary. Our findings have been presented below as short case studies, acting as examples of how a range of

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)[30], 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[31].

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

[30] https://www.gateshead.gov.uk/article/3089/Hot-food-takeaway-Supplementary-Planning-Document
[31] 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".

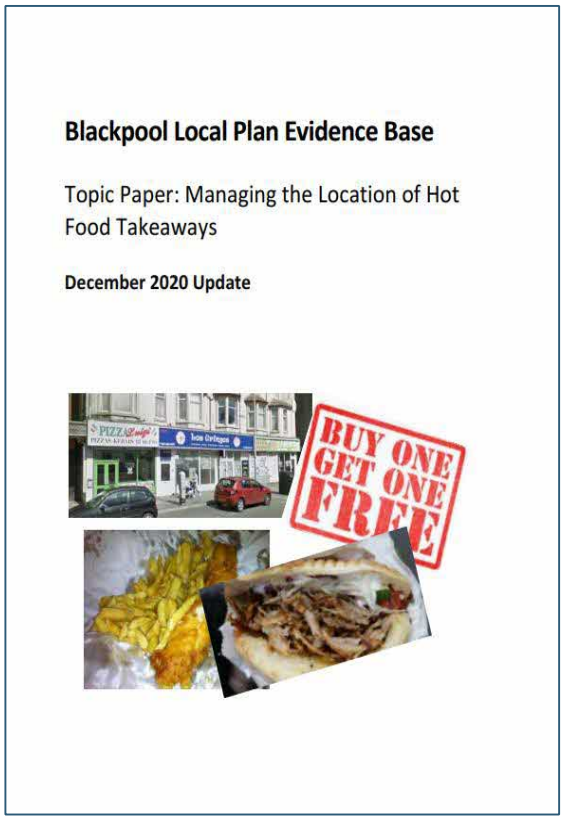
Monitoring of the SPD's implementation is included in the council's Annual Monitoring Report (AMR)[32]. As part of this annual monitoring, the council have employed the following targets:

> 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)[33] 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)**

[32] https://www.gateshead.gov.uk/article/3109/Annual-Monitoring-Reports
[33] 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'[34] 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."

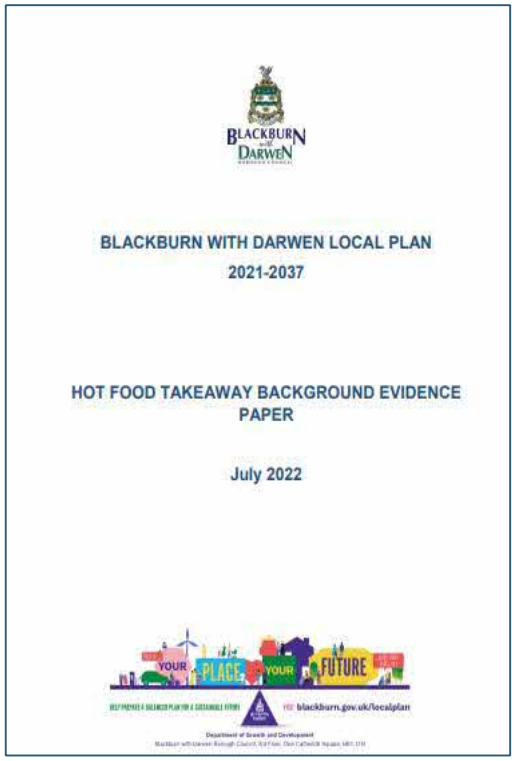
Blackburn with Darwen

Adopted in January 2024, Blackburn with Darwen's (BwD) Local Plan (2021 – 2037)[35] 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.

[34] https://www.blackpool.gov.uk/Residents/Planning-environment-and-community/Planning/Planning-policy/Blackpool-local-plan/Site-allocations-and-development-management-policies.aspx
[35] 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'[36]. 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[37], 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

[36] https://blackburn-darwen.org.uk/wp-content/uploads/E91-Hot-Food-Takeaway-Background-Paper-July-2022.pdf
[37] 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.

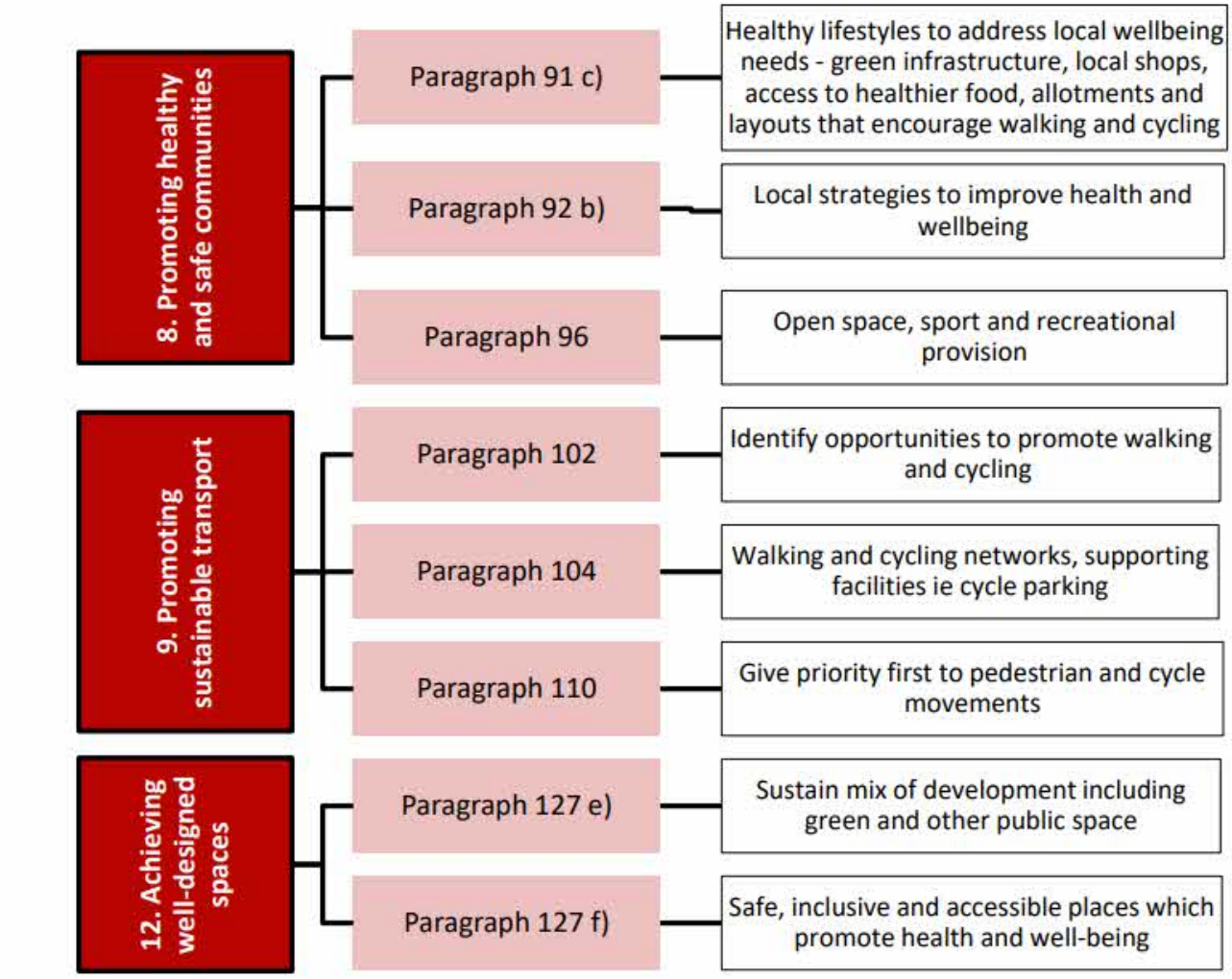
A5 Hot food takeaways – for the sale of hot food for consumption off the premises

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]



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