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ROYAL SOCIETY FOR PUBLIC HEALTH
VISION, VOICE AND PRACTICE

PAY DAY LOANS

BOOKMAKERS

FAST FOOD

HEALTH ON THE HIGH STREET

CLINIC & DOCTORS SURGERY

CHEMIST + PHARMACY

SWIM & GYM

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FOREWORD

Where we live can have a profound effect on our health and our local high streets are an important part of this. High streets are quite literally the shop window of a local community and a place where many of us may undertake a spot of retail therapy, meet friends to socialise or simply take a stroll to unwind.

High streets are an important part of vibrant communities and a critical engine for economic growth in local areas. In this regard high streets have an important role to play in supporting the public's health. A healthy high street can provide the public with healthy choices, support community cohesion and social interaction, promote access to health services and do much to support individual wellbeing.

However, high streets can also be a home to business activities which can have a detrimental effect on our health.

We believe businesses have a responsibility to ensure that what they offer doesn't undermine the public's health, and it is in the interest of business to ensure that the public, who are ultimately their customers live longer and healthier lives.

Our Health on the High Street campaign is about recognising that while we should applaude and recognise the important contribution business makes to a vibrant and healthy high street, this shouldn't be at any cost. There are some business practices which may negatively impact on the public's health, and make the job of building healthy, vibrant communities that little bit more difficult.

We want to work with businesses to persuade them of the need to be more aware of the impact their activities can have on their customer's health and help make their offer more health promoting. We want to ensure that local authorities have the powers they need in order to curtail those business practices which may undermine the public's health and the great work that many public health teams are doing.

Building dynamic, diverse and health promoting high streets is not just the right thing to do for the public's health, but will make high streets more appealing and a destination of choice.

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Shirley Cramer CBE Chief Executive
Royal Society for Public Health

1. INTRODUCTION: A VISION FOR HEALTHY HIGH STREETS

Much has been made in recent years of reinventing the high street. In an attempt to support local businesses, increase high street footfall and reduce the vacancy rate, the Government has adjusted business rates, altered planning rules and restrictions around parking and the use of buildings and supported campaigns such as the Love Your Local Market campaign.

Within the plethora of reports released over the past few years by Government departments, sector experts and research organisations, a consensus has emerged: the high street must reinvent itself to survive. Put simply, the rise of out of town, internet and mobile shopping, alongside the economic downturn, has led to significant changes in the high street, including the closure of once prominent high street brands, an increase in the number of empty shops and the 'clustering' of charity shops, fast-food restaurants and bookmakers. The high street should now look to provide customers with an experience beyond retail in order to compete; health improvement initiatives could be a key part of this.

As the centre of a community, a location visited by all corners of society, from young and old, to the most and least deprived, the high street has a vital role to play in encouraging healthier lifestyles amongst the public. However, in many towns and cities, high streets are being overtaken by businesses with potentially damaging consequences for public health.

Making high streets a diverse place in which to have fun, and enhance health and wellbeing will make them a more attractive destination for the public, which in turn may help rejuvenate many. The nation's high streets have huge potential to support the public's health and wellbeing. As places for people to interact, high streets can play an important role in bringing people together and help foster a sense of community.

Making high streets a diverse place in which to have fun and enhance health and wellbeing will in turn make them an attractive destination for the public, which in turn may help rejuvenate many.

In providing destinations for people to visit, they can encourage walking or cycling, which in itself can support active lifestyles. High streets can be the home to a range of cultural venues and community activities that may enhance individual wellbeing, as well as the setting for a range of health-promoting activities and services, from pharmacies to health clubs.

Unfortunately high streets can also be home to business activities which may undermine and potentially harm the public's health.

In order to make our high streets as health promoting as possible, it is worth setting out what the characteristics of a healthy high street are.

Firstly there is the high street environment itself. A healthy high street environment is one in which there is clean air, less noise, more connected neighbourhoods, things to see and do, and a place where people feel relaxed. The architecture of the high street would foster active urban design principles including pavements, seating, shade and shelter. Above all the high street would provide a safe environment where the public don't live in fear of crime, violence, harassment, or accidents.

Work undertaken by Transport for London has identified ten indicators of a healthy street environment which help us understand what the positive aspects are on a street and which aspects could be improved.

Indicators of a healthy street environment

Source: L Saunders in Improving the health of londoners: transport action plan (2014).

Wheel labels (clockwise from top): Pedestrians from all walks of life · Easy to cross · Shade and shelter · Places to stop · People choose to walk and cycle · Not too noisy · People feel safe · Things to see and do · People feel relaxed · Clean air

In addition to the environment the health of a high street will inevitably be affected by the types and diversity of businesses which are located on them.

On a healthy high street businesses would create opportunities for health optimisation. This could include signposting customers to health services, high street employees engaging customers in healthy conversations, health promotions in local shops, such as health shopping trolleys and outreach activities in pubs and bars, including smoking cessation or health checks.

The businesses on a healthy high street would not only enable basic needs, including access to affordable healthy food and affordable financial services, to be met but would actively promote healthy choices. There would be access to essential services whether that is health services, cultural amenities, places to be active, leisure centres or green spaces. A healthy high street would also create opportunities to minimise harm whether that is ensuring that health is included as a condition for licensing and a consideration for planning consent.

And as destinations, healthy high streets would go some way to supporting the 6 Ways to Wellbeing by providing opportunities to meet friends and support communities. The businesses on a healthy high street would be inclusive and meet the needs of local people so that there is something for everyone, including those on lower incomes and older adults. Healthy high streets are places that can support social capital, connect people and be there for the whole community, an inclusive place meeting the needs of those who are vulnerable.

While our Health on the High Street campaign is focussed on what business can do to make the high street a more health promoting place, it should ultimately make them a more attractive place for people to go and support local economies. The twin goals of creating a health promoting high street whilst stimulating investment in local economies should not be mutually exclusive.

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2. IDENTIFYING HEALTH ON THE HIGH STREET (INCLUDING THE RICHTER SCALE OF HEALTH)

High streets contain an almost endless array of businesses, from food outlets, such as cafes and restaurants, service outlets, such as hairdressers and beauty salons, to retailers and cultural venues.

Our campaign and research is focussed on the positive and negative impact that businesses on the high street can have on the public's health. High streets contain an almost endless array of businesses, from food outlets, such as cafes and restaurants, service outlets, such as hairdressers and beauty salons, to retailers and cultural venues.

Based on a review of the evidence as well as the input of public and expert opinion we have attempted to identify those businesses which could be considered to be the 'best' and 'worst', the most health promoting and those which evidence shows to be the most detrimental to public health.

Most health promoting	Least health promoting
Health services	Tanning shops
Pharmacies	Fast food takeaways
Leisure centres/Health clubs	Bookmakers
Libraries	Payday lenders
Museum and art galleries	
Pubs and bars	

In order to score the positive or negative impact each of these businesses may have, we have also had to agree how we are going to measure health.

Richter scale of health - how we define health

To recognise the many dimensions of health, we have developed a Richter scale, which breaks health down into four areas. This holistic approach seeks to capture the positive and negative aspects of each venue rather than simply counting the total number of different types of businesses on a high street. We have sought to capture, for example, that while an outlet may provide foods that are high in salt, fat and sugar, or alcoholic products, they may also provide a place to socialise, thus promoting mental wellbeing. The four areas of health we have scored businesses on are the extent to which the business:

1. Encourages healthy lifestyle choices

2. Promotes social interaction

3. Allows greater access to health care services and/or health advice

4. Promotes mental wellbeing

For each of these categories, the business has been given a score ranging from -2 (most negative impact on health) to +2 (most positive impact on health). A score of 0 is given if it is considered to be neutral or if the category is not relevant to the outlet. The scores given to each outlet, shown in Table 1, have been informed by extensive desk-based research, consultation with public health experts and a survey of a representative sample of 2,000 members of the public.

What do the public think?

We asked the public whether they think these businesses help or hinder their health.
This is what they said.

Scored well on health impact

Leisure centres

- 4 in 5 (81%) believe they promote healthy choices
- Almost 3 in 4 (72%) believe they promote social interaction
- Over half (54%) believe they support access to health services and advice
- Three quarters (75%) believe they support mental wellbeing

Health clubs

- Almost 4 in 5 (78%) believe they support healthy choices
- Over two thirds (68%) believe they promote social interaction
- Over half (56%) believe they support access to health services and advice
- Two thirds (66%) believe they support mental wellbeing

Libraries

- Over half (55%) believe they support healthy choices
- Over half (52%) believe they support social interaction
- Almost half (44%) believe they promote access to health services and advice
- Two thirds believe they support mental wellbeing needs

Pubs and bars

- Almost two thirds (59%) believe they discourage healthy choices
- However, three quarters believe they support social interaction
- One third believe they have a positive effect on mental wellbeing

Didn't score so well

Tanning shops

- Two thirds (62%) believe they discourage healthy choices
- The majority believe they have no effect on promoting social interaction (54%) or access to health services (60%)
- One fifth (20%) say that they support mental wellbeing
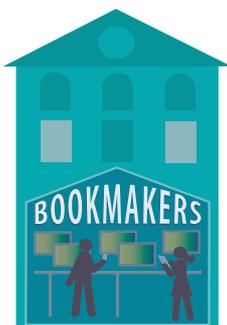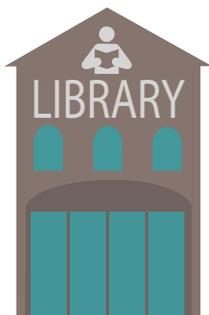
Fast food takeaways

- Over two thirds (69%) believe that they discourage healthy choices
- Over half (52%) believe that they have a negative impact on mental wellbeing
- The majority (60%) say they have no effect on providing access to health services

Bookmakers

- Over half (54%) believe they discourage healthy choices
- Almost half (49%) say they have no effect on promoting social interaction
- Over half (52%) believe they have a negative impact on mental wellbeing

Payday loan shops

- Over two-thirds (68%) believe that they discourage healthy choices
- Two-thirds (65%) believe they have a negative impact on mental wellbeing
- Over half (57%) believe they have no effect on providing access to health services

Based on a combination of feedback from public and expert opinion, plus a review of the evidence related to the health impact of each of these types of businesses we have developed our Richter scale score which is the total positive or negative health rating based on looking across these four areas of health.

Table 1: Richter scale of health

Outlet	Total Richter scale score	1. Healthy choices	2. Social interaction	3. Access to services and advice	4. Mental wellbeing
Leisure centres	7	2	2	1	2
Health services	6	2	0	2	2
Pharmacies	5	2	0	2	1
Health clubs	5	2	1	0	2
Libraries	4	1	1	1	1
Museums and art galleries	3	0	1	0	2
Pubs and bars	2	-1	2	0	1
Tanning shops	-1	-2	0	0	1
Fast food takeaways	-2	-2	0	0	0
Bookmakers	-2	-1	0	0	-1
Payday loan shops	-4	-2	0	0	-2

Applying the scoring to high streets

We procured data from the Local Data Company mapping the total number of each of these different types of businesses in the main retail areas in the largest 70 towns and cities in the UK, excluding London.

For London we have taken a slightly different approach and are looking in greater depth at the local areas within the city and have identified the London high streets using the Mayor's London Plan. For the purposes of this research, we are focusing on the 144 district centre high streets in London. An integral part of a 'high street', as we are defining it, is its role in serving a local community. The international, metropolitan and major centres are arguably far larger, almost city centre areas serving a greater and wider ranging population. We are also excluding the neighbourhood and more local centres category as they are too small to be classed as high streets and would add an unmanageable number of areas beyond the scope of this research. By excluding these categories, we are ensuring that we adhere to a more consistent definition of 'high street' throughout the research.

Within each of these district centres, we have then isolated the main high street through the use of desk-based research to find out what the local authority classes as the primary retail core, speaking with local residents and Google Street View. Some district centres have been excluded due to data being unavailable or difficulty in identifying the high street.

We have included different types of businesses depending on whether we are looking at the main retail area for towns or cities, or the more defined high streets in London. For the London high streets research, we have excluded leisure centres, health services such as health clinics and medical centres, health clubs, libraries and museums/arts galleries as one would not normally expect to find these on a single high street, but may expect to find them over a wider city/town centre area like the core retail boundary.

70 towns and cities	London high streets
• Leisure centres • Health services • Pharmacies • Health clubs • Libraries • Museums and art galleries • Pubs/bars • Tanning shops • Fast food takeaways • Bookmakers • Payday lenders	• Health services – dentists and opticians only • Pharmacies • Pubs/bars • Tanning shops • Fast food takeaways • Bookmakers • Payday lenders

Using Local Data Company data, we have assigned the Richter scale score to each outlet, calculated the total Richter scale score and divided this by the total number of businesses in either the retail area for the towns or cities or high streets (in London) to provide us with the final score for each area.

In addition, we have sought to capture the detrimental impact of the clustering of pubs/bars, betting shops, payday loan shops and fast food takeaway by removing one Richter score point for each successive outlet in these categories once the proportion of them in an area hits a threshold of more than 5% of total outlets.

Limitations

Whilst we have tried to minimise these as much as possible, we acknowledge that there are limitations to our research. They are as follows:

• There may be other businesses on the high street which could contribute to or detract from promoting health and wellbeing which were beyond the scope of this research.

• As we were unable to visit each particular outlet on each high street there is a limitation in terms of classifying all types of one outlet. For example, the data categories do not distinguish between tanning shops offering spray tan and sun beds and pawnbrokers, payday loan shops or cheque cashing venues.

• Another limitation is that we have excluded approximately seven high streets from the London research due to the data being unavailable or difficulty in identifying the high streets.

Before we look at the results we set out some of the background about the venues we have selected and what the evidence says about how these businesses may actively support or undermine the public's health.

The data on the number of each type of business was procured from the Local Data Company and is accurate as of December 2014 for towns/cities data and February 2015 for London high streets.

3. HAZARDS ON THE HIGH STREET
PAYDAY LENDERS

Payday loan shops have become an increasingly common sight on our high streets with over 2,000 of them located across the UK. They provide high-interest, short-term loans for people needing money to tide them over until their next wage or salary cheque (BBC, 2013). Research from a payday loan company suggests that the typical borrower of a payday loan is single, earns less than £20,000 per year, and has at least one child (Thisismoney.co.uk, 2013).

Many people access the loans and pay them back within the agreed timescale. However, an increasing number of people are becoming trapped in a cycle of debt; rolling over loans they can never pay back (The Guardian, 2013a). The link between severe debt and poor mental health is clear (Richardson et al, 2013). Half of those with debt also have a mental health problem (Royal College of Psychiatrists, 2012) and people with mental health issues are six times more likely to have severe debt than those who are free from mental health problems (Money Saving Expert, 2014). There is also a strong positive correlation between debt and suicide completion, drug and alcohol abuse (Richardson et al, 2013). Debt can also negatively impact upon physical health (Lenton & Mosley, 2008).

While the causality between debt and poor health is hard to establish, it is vital that those with poor health are protected from a potential greater risk of developing debt, and that those in debt are protected from a potential greater risk of developing mental and physical health problems. The presence of payday loan companies on high streets and online is worrying at a time when increasing numbers of individuals and families are finding themselves in financial difficulty and vulnerable to the easy cash that payday loan companies appear to offer.

The implications of severe debt also include increased domestic violence, worse infectious disease rates, food poverty, fuel poverty, increased suicide risk and strains on family relationships, especially impacting the children of parents in problem debt (Elliott et al, 2014). Indirect effects on household psychological wellbeing over time impacts on feelings of economic pressure, parental depression, conflict based family relationships, and potential mental health problems among children (Fitch et al, 2009).

Personal debt in the UK is at an all time high with an estimated eight million households nationally having no savings at all (Centre for Social Justice, 2013). Average consumer credit debt was £6,322 in December 2014 (The Money Charity, 2015). In 2012 alone, payday loan companies, pawnbrokers and home-collected credit providers lent out £4.8 billion of high-interest credit. Furthermore, the amount being spent on advertising has grown 64% from 2011 to 2012 with some individual companies producing up to 397,000 adverts (IBTimes, 2014). Half of all payday loan users (600,000) have no other access to credit due to poor credit history (Department for Business, Innovation and Skill, 2013). The people most likely to use payday loans are also those who struggle with low incomes, low levels of savings and lack of financial education which leaves payday lenders as generally being seen as highly predatory (Ben Cave Associates, 2014). A report from the Office of Fair Trading identified 60% of people taking out payday loans as 'vulnerable' (Office of Fair Trading, 2013). The most vulnerable groups include the unemployed, single parents and older people (Centre for Social Justice, 2013).

Many vulnerable people who find themselves turning to payday loans are more concerned with paying back their debts than buying everyday essentials for themselves. A 2012 survey found that 24% of people who had taken out a payday loan prioritised debt repayments over paying for food (ComRes, 2012). Despite this worrying trend, research suggests that payday loan companies frequently lend to people they know may not have the means to pay back loans and would therefore end up accumulating large interest debt as a result of rolling over loans (Citizens Advice Bureau, 2014).

The proliferation of high street payday loan shops is a result of the withdrawal of 'mainstream', high-street-based financial service structure (Fuller et al, 2008) and the introduction of flexible changes to premises function. As with betting shops, payday loan shops have the usage class of A2 and shops that were formerly food shops, takeaways or wine bars can convert to become

payday lending shops without the need for planning permission. This relaxation in planning law was designed to attract more businesses back to the declining high streets of the UK. However, it has opened the door for payday lenders to cluster on high streets which is concerning for the health and wellbeing of local residents and the wider public health. As highlighted in the section on bookmakers, the proposed used of Article 4 directions is not sufficient to overcome these planning issues.

Until recently there has been no cap on interest rates of payday loan companies, or advertising controls. However, the Financial Conduct Authority has recently introduced a number of new rules. From July 2014, the number of times a loan could be rolled over by payday lenders and others offering high-cost short-term credit was limited to two. In addition, firms offering high-cost, short-term credit must now include a prominent risk warning on all

financial promotions. When someone defaults the company must also provide an information sheet that explains where and how to get free debt advice. From January 2015, interest and fees on a loan were capped at 0.8% a day, with the total cost capped at 100% of the original sum (FCA, 2014). However, Stella Creasy MP and others have argued that that this cap is far too high to make a difference. A cap of 0.8% means companies can charge £24 per £100 borrowed on a 30 day loan. In its market study the OFT found the average cost of providing credit to be £25 per £100 borrowed, so this would only make a £1 difference (Waltham Forest Guardian, 2014).

Protecting the most susceptible individuals from entering the downward spiral of severe debt, poor health and poor mental wellbeing should be a priority. By limiting the ways in which payday lenders can advertise, pursue and deal with customers we can help to curb the number of individuals entering the cycle of problematic debt and improve overall public health. It is also important that debt advice and help is easily accessible to those who need it. This means improved signposting, a reduction in the social stigma associated with people in debt and maintaining pressure on payday loan companies both on the high street and online, to be more socially responsible with regards to the communities they operate in.
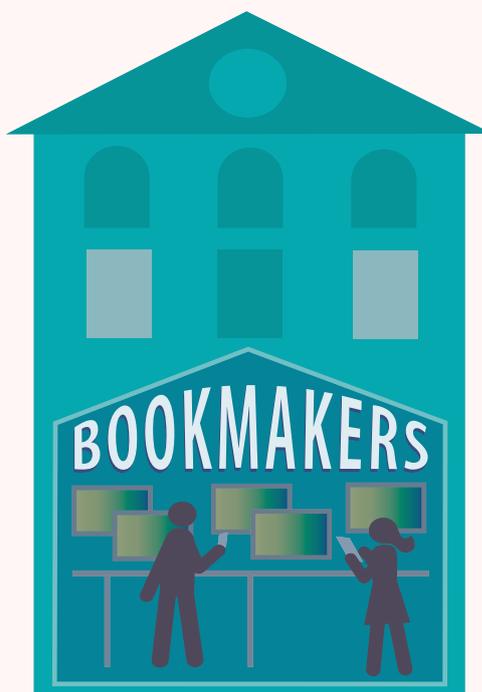
RICHTER SCALE SCORE -2

There are approximately 8,700 bookmakers in the UK (ABB, 2013) and they play host to a range of different activities including over the counter (OTC) betting, primarily on horse and dog racing and sports, and the use of fixed odds electronic machines (FOBMs). Legally, only four of the latter are allowed in each betting shop (House of Commons, 2015).

Around 1 in 10 of the UK population participates in OTC betting in book-makers and 4% of the UK population use electronic machines (Gambling Data, 2012). Most individuals that use betting shops only bet once a year, around 9% place OTC bets two or more times a week, and 13% use electronic machines two or more times a week. OTC betting produces £1.5 billion in gross gaming revenue (GGR) annually, machines £1.3 billion, and the trend is towards a decrease in OTC betting and an increase in the use of machines (Gambling Data, 2012). Average annual spend is considerably higher in regular machine users (£1209) than those who bet OTC (£427) (Gambling Data, 2012). FOBMs allow players to stake up to £100 a time on a game that can be played rapidly and repeatedly, posing a real issue for gambling addiction (George and Bowden-Jones, 2014). Numbers of FOBMs are increasing year on year in the UK, with current estimates suggesting there were over 34,000 B2 terminals (fixed odds betting machines) in use in 2013/14 (Gambling Commission, 2014a).

Although research suggests that individuals who only gamble very occasionally can experience increased mental wellbeing from the odd bet (Forrest, 2013), and gambling has been described as a form of adult play that can provide connectedness and socialisation (Shaffer and Korn, 2002), the health consequences of problem gambling are severe and negative. Addiction to gambling is classed as a psychological disorder and its effects are not just linked to the loss of money, but include preoccupation with gambling to the detriment of other relationships and activities and the use of gambling to escape problems or relieve dysphoric mood (Reilly and Smith, 2013). Hiding gambling-associated debt is common amongst problem gamblers, with research suggesting that the dishonest and untrustworthy behaviour it requires challenges a sense of self-worth and value, resulting in guilt, stress and worry (Downs and Woolrych, 2010). Perhaps unsurprisingly, a systematic review of the economic and social impacts found that one of the clearest impacts of introducing gambling facilities into an area was the increase in problem gambling and its related indices, including suicide (Williams et al, 2011).

It is estimated that there are around 450,000 problem gamblers in the UK (George and Bowden-Jones, 2014) and the number is increasing (Wardle et al, 2010). The 2010 gambling prevalence survey confirms that problem gambling rates are highest in those living in the most deprived areas and those who are unemployed. Young males, aged 16-24 are the most likely to be problem gamblers, as are individuals with an Asian/Asian British ethnic origin (Wardle et al, 2010). Gambling addiction is frequently comorbid with other conditions, including depression, alcoholism, obsessive compulsive behaviours and substance abuse (Lorains et al, 2011). It has been shown that these other conditions can increase the severity of problem gambling and also its associated consequences (Hall et al, 2000; Ladd and Petry, 2003).

There is strong evidence that increasing opportunities – availability and accessibility – to gambling does increase the number of regular and problem gamblers in an area (Ben Cave Associates, 2014). Therefore the presence of bookmakers on the high street, and particularly in areas of dense clustering of betting shops, problem gambling is at its highest. Worryingly, Wardle et al (2014) found that gambling machine density was

disproportionately greater in areas of socio-economic deprivation, and also in areas with a younger than average population profile. Individuals with the lowest income are already known to gamble the largest proportion of their income compared to other income groups, and by targeting areas of deprivation, poverty associated with gambling is likely to increase.
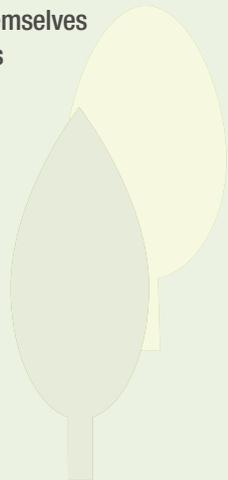
Clustering of betting shops is a problem facing many areas, particularly in London. Newham in East London for example, has more than 80 betting shops – six per square mile (The Guardian, 2013b). Relaxation in planning laws has allowed clustering to occur – shops can currently be converted to bookmakers without needing planning permission (Parliament UK, 2014). Currently, betting shops are classified as type A2 usage 'financial and professional services'. No planning permission is needed for conversion of other A2 usage businesses (including banks and estate agents) into betting shops, neither is planning needed to convert from A3

(restaurants and cafes), A4 (drinking establishments) and A5 (hot food take-aways) to A2 usage (Gov.uk, 2015).

This makes it very difficult for councils to use planning controls to stop betting shops being created from a wide range of other premises on the high street. The use of Article 4 directions has been suggested, which removes the permitted development rights of certain usage classes (Smith, 2015), however it is a very bureaucratic and blunt tool. While Barking and Dagenham and Haringey considered the use of Article 4 directions to remove permitted rights allowing a change of use from restaurants and cafes (A3), public houses (A4) and hot food takeaways (A5) to betting shops. Its use was rejected because it would have limited effect and be too resource intensive.

In terms of young people, a consultation by the Gambling Commission concluded during 2014 that there were "major weaknesses" in the way that betting shops were tackling underage gambling

(Gambling Commission, 2014b). In February 2015, the Gambling Commission published a list of changes to the license conditions for betting shop operators to tackle the issue of underage gambling, including ensuring that the layout of betting shops prevents access to gambling by children and young people. This comes into force in May 2015 (Gambling Commission, 2015a). New provision has also been made to ensure that problem gamblers can self-exclude themselves from using gambling premises (Gambling Commission, 2015a).

FAST FOOD OUTLETS

The fast food industry has seen rapid growth over the past few decades and fast food outlets (FFOs) are an increasingly familiar sight on high streets across the UK. Over half of British adults have experienced an increase in the number of fast food shops on their nearest high street since they began living there (Healthy Places, 2014). **Of particular note is the 'boom' in fried chicken sales, which grew 36% between 2003 and 2008, significantly outstripping growth for the fast food sector as a whole** (The Guardian, 2011). **It is estimated that there is now an average of around one outlet for every 1,280 people in England, and up to one for every 1000 Londoners** (Greater London Authority, 2012a). **Consumption of fast foods has risen in tandem with the upsurge in outlets. Market research suggests that while there has been a decline in the number and value of meals eaten out of the home, fast food is forming an increasing proportion of these out-of-home meals, surpassing 50% in 2011** (Cities Institute, 2013). **This is part of a global trend. Estimates from the World Health Organisation suggest that, by 2008, the average person living in the developed world was making 33 'fast food transactions' per year** (De Vogli et al, 2014).

While many people enjoy the taste and convenience of fast foods, regular consumption may have severe consequences for health. Studies have found increased patronage of FFOs to be associated with high BMI (Fraser et al, 2012a; Government Office for Science, 2007)**, and excess weight gain over time** (Burgoine et al, 2014; Pereira et al, 2005) **as well as insulin resistance** (Pereira et al, 2005). **This is a particular challenge given that obesity is a significant public health concern. Just over a quarter of adults in the UK are obese and 3 in 10 children aged 2-15 are either overweight or obese.**

Typical fast food meals are energy-dense and served in large portion sizes. Some single meals offered in FFOs have calorie levels approaching daily energy intake requirements. Eating foods of this nature can result in 'passive overconsumption' (Pereira et al, 2005) **whereby regular consumers fail to adjust the rest of their diets to account for this high concentration of calories.**

Calorie content aside, high street takeaways in England have been found to offer meals high in salt and low in nutritional value (Government Office for Science, 2007)**, making healthy choices hard** (Caraher et al, 2013). **The link between salt intake and high blood pressure is well established. High blood pressure is one of the primary causes of strokes, heart attacks and heart failure, which together account for around half of all deaths in the UK** (The Guardian, 2011). **In addition, fast food meals are frequently bought with a soft drink, which is high in sugar.**

National consumer surveys in the UK suggest that the accessibility of FFOs is a factor that influences use (NHS London Healthy Urban Development Unit, 2013). **One of the main reasons given by respondents in a Defra-commissioned survey for not adopting a healthy, balanced diet was being 'unable to resist' the**

unhealthy foods on offer. One recent study found that individuals most exposed to FFOs at work consumed the equivalent of half a serving of McDonald's French Fries more takeaway food each week than the least exposed (Burgoine et al, 2014).
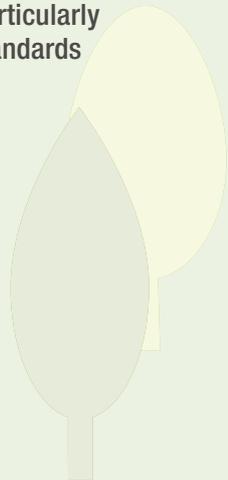
The density of unhealthy food outlets in a neighbourhood has been linked to the prevalence of overweight and obesity in children in England (Black et al, 2014). The number of outlets near a particular school has also been found to significantly affect school obesity rates (Alviola et al, 2014; Currie et al, 2011). This is particularly concerning given consistent evidence that FFOs tend to cluster around schools (Caraher et al, 2013; Austin et al, 2005; Ellaway et al, 2012). Fast food is inexpensive and heavily marketed at children (Freudenberg et al, 2010) who often opt for adult portions (Caraher et al, 2013), when children's meals themselves are

already high in saturated fat, sugar and salt (Wellard et al, 2012). Children who are obese are up to 10 times more likely to become obese adults (Freudenberg et al, 2010), and overweight and obesity at a young age is linked to immediate and long-term physical and mental health risks (Smoyer-Tomic et al, 2008). Addressing childhood obesity is therefore vital.

FFOs also tend to be concentrated in more deprived areas (MacDonald et al, 2007; Cummins et al, 2005; Fraser and Edwards, 2010; Black et al, 2014; Fraser et al, 2012b; NHS London Healthy Urban Development Unit, 2013). This increased presence may be due to increased availability of premises, less resistance to new planning applications by the community and lower rental and purchasing cost as well as greater demand for inexpensive and calorie dense food. Geographical inequalities in fast food provision

also exist, with hotspots in the Northeast, Yorkshire and Humber, the East and West Midlands (Bambra et al, 2012) and a number of London boroughs. Differences in the food environment may therefore exacerbate existing health inequalities.

Concern has also been raised about the food hygiene standards of fast food outlets, with fried chicken outlets appearing to be particularly poor at complying with standards (BBC, 2014).

TANNING SALONS

RICHTER SCALE SCORE **-1**

In 2009, there were an estimated 8,000 tanning salons in the UK (Elliott, 2009). While tanning salons may be licensed in Wales and Scotland, and a couple of regions in England (London and Nottinghamshire), local authorities are not empowered to licence these businesses in other parts of the country, even if they want to. Research suggests that the typical sunbed user is female and aged between 17 and 30 years old. Her diet is generally less healthy than a non-user, and she is more likely to smoke and drink alcohol frequently (Schneider and Kramer, 2010).

Sunbeds produce a tan by emitting UV radiation, primarily UVA (around 95-99% of emissions) and UVB (1-5%) (Mogensen and Jemec, 2010). While both UVA and UVB are emitted by the sun, with all UVA and a fraction of UVB reaching the earth's surface, it has been noted that sunbeds may release levels of UV radiation at levels 10-15 times greater than the midday sun on the Mediterranean sea, creating an environment outside of previous human experience (Boniol et al, 2012). UV emissions cause DNA damage – biochemically, this is the first step both to tanning and skin cancer development (Lim et al, 2010). In response, the skin releases melanin, a dark pigment, to protect itself from further damage. This highlights that tanning can only occur in the presence of DNA damage; there is no safe tan (Lim et al, 2010). While dark-skinned individuals are not immune to sunburn, sun damage tends to be considerably lower than in fair-skinned individuals, and therefore, the former are at lower risk of developing skin cancer (Elliott, 2009).

There are three common forms of skin cancer – basal cell carcinoma (BCC), squamous cell carcinoma (SCC) and malignant melanoma (MacMillan, 2015). There is clear evidence connecting sunbeds to all three of the main types of skin cancer (Boniol et al, 2012). In August 2009, the International Agency for Research on Cancer (IARC), which is part of the World Health Organisation, classified sunbeds as "carcinogenic to humans" (El Ghissassi et al, 2009, p.752). While BCC and SCC are the most common forms of skin cancer (also known as non-melanoma skin cancer), they are also the most treatable. Despite this, in 2012 there were still 638 deaths from non-melanoma skin cancers in the UK (Cancer Research UK, 2014a). Other effects of UV radiation are the induction of cataracts, pterygia and cold sores (Elliott, 2009).

Malignant melanoma is, however, one of the most dangerous types of cancer and rates have increased by 78% among males and 48% among females between 2003 and 2012 (Office for National Statistics, 2012) less common but more serious than BCC and SCC. In 2011, there were 13,348 new cases of malignant melanoma in the UK, of which 49% were in men and 51% in women (Cancer Research UK, 2014b). In 2012, there were 2,148 deaths from malignant melanoma skin cancer (Cancer Research UK, 2014a).

It is estimated that in Europe, 6.9% of malignant melanomas in women can be attributed to sunbed use; 3.7% in men (Boniol et al, 2012).
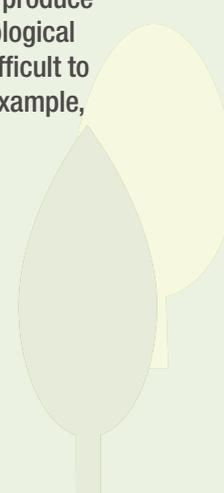
While sunbeds have also been promoted as a means to boost low levels of vitamin D by the sunbed industry, research suggests that vitamin D levels tend to plateau with sunbed use and that there are negative side effects for the majority of individuals using sunbeds for this reason (Elliott, 2009). Low levels of vitamin D could be boosted more safely by securing it from other sources particularly from natural sunlight and increasing dietary intake of fatty fish.

Young people are a key group at risk from sunbed use. It has been illegal since April 2011 for UK tanning salons to allow under-18s to use their sunbeds, however, a survey conducted in Wales in 2012 suggested that around 32% of UK salons were not enforcing this regulation by failing to verify the age of customers using their premises (BBC, 2012). Research suggests that sunbed use in young people was relatively high prior to the ban (Thomson et al, 2010). There have also been incidences of children experiencing severe burns as a result of using sunbeds (for example, The Independent, 2009), with research suggesting that half of all under-18s who have used sunbeds in England have reported signs of burning at least once (University of the West of England, 2014).

Unmanned sunbeds are currently banned in Scotland, Northern Ireland and Wales, but not yet in England. The All Party Parliamentary Group on Skin (APPGS) called for unmanned sunbeds to be banned following their 2014 sunbed review (APPGS, 2014), and Jane Ellison, Parliamentary Under Secretary of State for Public Health responded in December 2014 that a review would be undertaken by Public Health England and other Government officials to consider how this, and the group's other recommendations could be taken forward (Ellison, 2014). Other recommendations put forward by the group include that safety goggles should be made available, all customers should have their skin type analysed and that licensing of sunbed providers should be an option for all local authorities.

There has also been research that suggests the majority (9 out of 10) of sunbeds in England emit ultraviolet radiation levels that exceed current safety limits. Despite a British and European Standard that sets a limit on the UV emission of sunbeds, it is clear that many UK tanning salons are not complying (Tierney et al, 2013). It is therefore not surprising that the APPGS has also recommended that compliance testing for radiant exposure and irradiance limits should be made more consistent across local authorities – Jane Ellison has suggested that non-regulatory approaches to achieving this should be explored (Ellison, 2014).

While it is clear that greater regulation over sunbed use is necessary, there may also need to be greater investment in understanding the reasons behind their use. Knowledge of the risks of using sunbeds is frequently not sufficient to prevent their use (Dennis et al, 2009) and it has been suggested that, while gaining a tan to improve aesthetic appearance is a key reason why sunbeds are used, the relaxation and positive mood effects produced by sunbeds may produce a psychological and physiological dependence that will be difficult to replace by the use of, for example, fake tan (Nolan et al, 2009).

RICHTER SCALE SCORE +6

Healthcare venues are valuable assets on the high street providing medical advice, by signposting to a wide range of health services, including smoking cessation and healthy eating, and to mental health services. The presence of these services on the high street makes them accessible to the wider community. Research has found that distance is the strongest barrier to accessing health centres and surgeries (Goins et al, 2005), meaning that their presence on the high street positively impacts on the health of that community.

GP SURGERIES AND HEALTH CENTRES

GPs remain the first point of contact for members of the community accessing healthcare services. As well as providing direct medical care and advice, surgeries can give advice and signposting for a wide range of health issues, including smoking cessation, mental health and social care services, working closely with health visitors, community nurses and midwifes (NHS Choices, 2015a). Satisfaction with the doctor–patient relationship is often a critical factor in people's decisions to access healthcare services (Goold and Lipkin, 1999). Often, for healthcare advice to be sought or adhered to a patient must have confidence in

the competence of their physician and feel that they can confide in them. This makes doctors' surgeries and health centres a key entity in enabling community members to access health services, both directly and through referral on to other services. It is therefore important for these facilities to have a presence in communities and be easily accessible. While research suggests that only a fifth of GP practices (approximately 300) are still located on the high street (Carmona, 2014) evidence points towards a GP surgery being a feature of a local street as positive for accessing health services in a community. A qualitative study of rural older adults found travel distance to be the strongest barrier to accessing health centres and surgeries. (Goins et al, 2005).

OPTICIANS

In the UK almost 2 million people are living with significant sight loss. Crucially, an estimated 50 per cent of this sight loss is preventable with the early detection and treatment of conditions like glaucoma and diabetic eye disease, and by addressing refractive error through the provision of the correct spectacles (Access Economics, 2009). Although optician services are not usually free to access, the NHS Low Income Scheme means individuals can get financial help with sight tests, glasses and contact lenses based on factors including earnings, student status and retirement status (NHS Business Services Authority, 2015). A study exploring the barriers people face in

accessing primary eye care services has found that, as well as distance, cost was a perceived as a significant barrier to accessing sight tests, and feeling pressurised into buying glasses as services become more commercialised (Jones and Biddyr, 2015). Local high street opticians are seen as less commercial and more 'honest' as they are familiar to the community members, which reinforces the position of opticians on the high street. This is particularly important for people living in areas of high socio-economic deprivation (Jones and Biddyr, 2015; Yip et al, 2015).

DENTISTS

Dentists offer comprehensive oral health services in local community areas, many of which are available through the NHS. As with opticians, the NHS Low Income Scheme also offers financial help with NHS dental services, again based on employment and age status. (NHS Business Services Authority, 2015). Dentists are often promoters and sign posters of other health services, especially those that link to oral health – for example smoking cessation services. Smoking is a major threat to oral health, with nearly 1,900 people dying from oral cancer each year in England – and rates are increasing, especially among younger people. Ease of access to dental services makes for increased use of dental services (Public Health England, 2014a).

COMMUNITY PHARMACIES

Community pharmacies offer an ideal location to reach out to the public and provide much needed health support and advice. Based in high street locations, pharmacies offer greater accessibility than other health care services, with the added convenience of weekend opening times and the lack of an appointment system. It is estimated that 95% of people visit a pharmacy at least once per year and an estimated 99.8% of people from the most deprived areas live within just a 20 minute walk of a community pharmacy (Morrison et al, 2013., Todd et al, 2014).
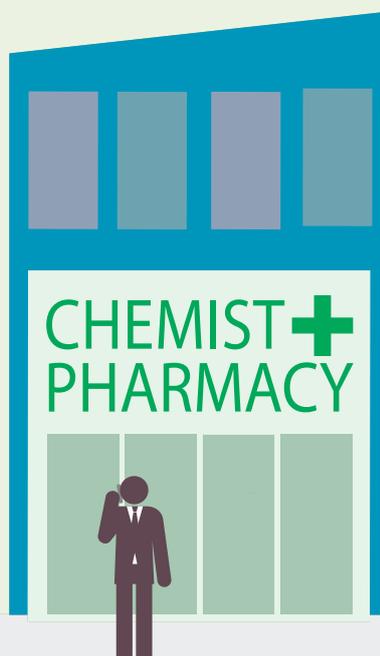
Of the 11,495 community pharmacies in England, many of them are already delivering a wide range of health improvement programmes, including services relating to the management and prevention of chronic disease (e.g. cholesterol and blood pressure reduction programmes), emergency hormonal contraception services and programmes relating to drug abuse, misuse and addiction (e.g. needle exchange services) (Office for National Statistics, 2013). The most frequently delivered service by community pharmacies is the smoking cessation service. An evaluation of healthy living pharmacies (HLPs), one model for pharmacy-based health improvement initiatives, found that, following the introduction of HLPs in Portsmouth, there was a 140% increase in successful 'quits', with individuals entering a HLP being twice as likely to set a successful quit date and achieve a four week non-smoker status than if they had entered a non-HLP (Fajemisin, 2013).

Community pharmacies have real potential to target 'hard to reach' groups and with investment, they have the potential to successfully deliver a wide range of services and reach out to those most in need, reducing the burden on overstretched primary care services.

CLINIC & DOCTORS SURGERY

CHEMIST + PHARMACY

LEISURE CENTRES *HEALTH CLUBS

RICHTER SCALE SCORE **+7 *+5**

Both leisure centres and private health clubs can provide the public with a facility to pursue a range of leisure activities and play an important role in increasing the physical activity levels of local communities by providing a range of exercise options, as well as access to fitness advice from trained professionals.

A physically active lifestyle is associated with a range of beneficial health outcomes, including reducing the risk of developing major chronic diseases (such as coronary heart disease, stroke and type 2 diabetes) by up to 50% (Department of Health, 2004).

The two types of fitness centre differ in two main ways: their community offering and affordability. Many private clubs charge up to £90 a month to use their gym and swimming pools, whereas council-run facilities, or ex-council leisure centres usually charge no more than £30 a month, and offer a range of clubs and social activities in addition to traditional gyms, classes and swimming pool access.
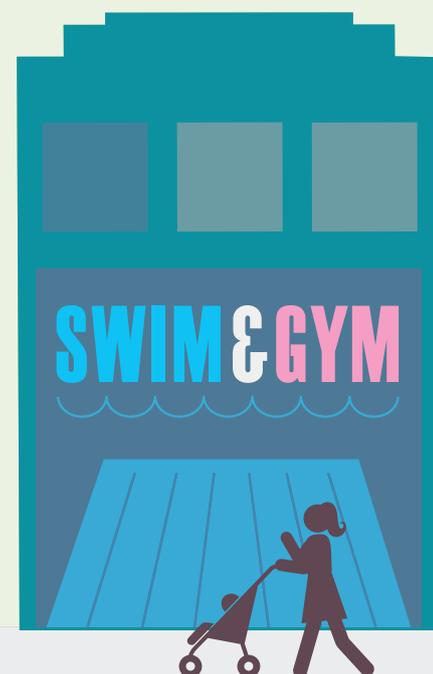
However, both types of fitness facility invoke healthy behaviour outcomes. Fitness centre membership is associated with increased health responsibility and health promoting

behaviours, such as regular participation in exercise programs and visits to a general physician, dentists, athletic therapist, optometrists, or dietician (Ready et al, 2005).

Environmental factors play a major role in healthy behaviours, including physical activity and obesity-related behaviours. Using a database of all indoor exercise facilities in England, a study has shown that the number of physical activity facilities in an area is associated with levels of physical activity (Hillsdon et al, 2007). Further research has shown how reduced access to fitness facilities is associated with decreased physical activity and increased overweight (Gordon-Larsen et al, 2006). This is particularly evident in areas of deprivation, where the availability of local exercise facilities is lower then more affluent areas (Hillsdon et al, 2007; Panter et al, 2008).

A study examining the relationship between the distance to a health fitness centre and an adult's home found that distance to the facility was significantly correlated with uptake and frequency of use (Berke et al, 2006). As a result, local governments may wish to consider access to leisure centre facilities as a priority to meet their targets for improving levels of physical activity and improving health behaviours in a local area (Panter et al, 2008).

Leisure centres are often used as a setting for health promotion campaigns, advice and messages, and often host community groups for mothers and toddlers, school children and the elderly. Local leisure centres often offer free exercise classes/swimming on certain days of the week to encourage healthy behaviours (NHS Choices, 2015b), as well as providing support and guidance across other health behaviours; examples of this include healthy eating advice and giveaways, including offering free fruit (Leicester City Council, 2015) and ideas for healthy alternatives, such as healthy pancake recipes (Payasugym.com, 2015). Many authorities offer free leisure services to under 16s and over 60s, and some have outdoor gyms, basketball hoops, tennis courts and football pitches that you can use free of charge.

SWIM&GYM

LIBRARIES

Public libraries can have a positive impact on health and wellbeing. Libraries are funded predominantly by local authorities and following the move of public health into local authorities libraries have taken the opportunity to work more closely with public health teams, making them a key venue for good quality health information and an access point for health-related services.

Public libraries drive a range of healthy outcomes in communities, building knowledge, access to information, wellbeing (Ingham, 2014), employment and enterprise. They primarily promote literacy, which has a strong link with health outcomes and behaviours – low levels of literacy are associated with a variety of adverse health outcomes (Pignone and DeWalt, 2006). Public libraries are regarded as an institution and an essential element of community life. They are often referred to as 'safe spaces' and 'enabling places', and viewed as more than a building where services are housed (Brewster, 2014), which creates an important community environment that is conducive to wellbeing – an important feature to have on a high street.
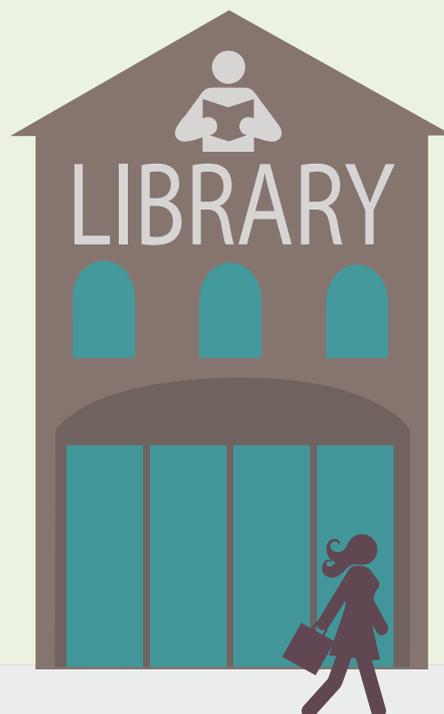
Libraries are a positive setting for delivering health messages, and studies have found libraries are key places to find health information. A study into how public libraries can improve health and wellbeing found that 94% of library users found some or all of the health information they were looking for. The same group were less confident about finding health information online and judging its quality – this shows the importance of being able to access health information in a library (Ingham, 2014). The study also found that many people visited the library to research a condition before visiting a health practitioner. This is an important public health finding, as use of libraries as a first point of call takes pressure off other health services – especially since it was reported that 73% thought the health resources they had accessed through their library had improved their health and wellbeing to some degree (Ingham, 2014).

Libraries contribute significantly to bibliotherapy, defined as the use of books as therapy in mental health treatment, as access to books and reading as a form of self-help leads to substantial long-lasting improvement in people with social anxiety disorder. This in turn releases pressure on other health services, as bibliotherapy is often promoted as an initial intervention before other therapies are offered (Furmark et al, 2009).

Evidence has shown the value of paid staff in libraries, with many feeling that libraries are positive and welcoming places where they are not pressured or judged, and the staff know them and their interests. This familiarity is welcomed, and results in some library users confiding in their local librarian about their mental health status (Brewster, 2014), as attending a public library is not stigmatizing in the way that attending a health clinic could be perceived to be. Trained staff can recommend and pin point to both health resources in the library and local services outside the library, making them a valuable community asset.
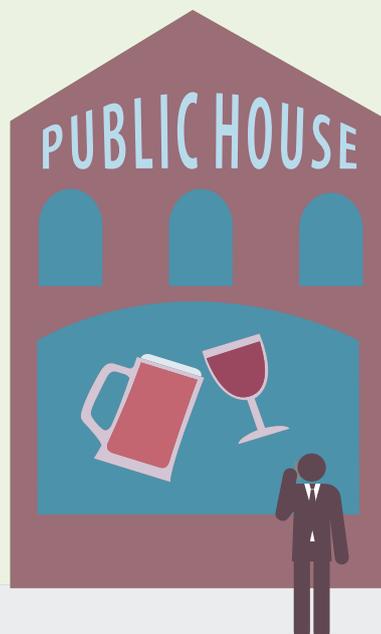
PUBS AND BARS

While prima facie, pubs and bars may seem like they should be classed as a potential hazard to health on the high street, this would be looking at them simply as purveyors of alcohol. They do have other benefits to overall health and wellbeing and therefore in the round we see them as having a more positive contribution to the health of a high street – up to a point.

Pubs and bars can act as hubs for community life, which is important for mental health and wellbeing. They provide a social space and many host a variety of events such as pub quizzes, competitions, sports screenings, live music, parties and have links with local sports teams and charity initiatives. Social isolation is a key trigger for mental health problems (ESRC, 2013), which are experienced by 1 in 4 people in the UK each year, and supportive social relationships improve mental health, health behaviour, physical health and reduce mortality risk (Umberson and Montez, 2010). Furthermore, a Medical Research Council study has noted the positive effects on mental wellbeing of men who felt able to 'open up' and talk about their emotions specifically in the pub context (Emslie et al, 2013).

5. THE RESULTS
UK WIDE DATA

Based on our methodology we have arrived at a ranking of the 70 largest towns and cities across the UK (Figure 1). This ranks places based on the prevalence of businesses that have been identified as either health promoting or potentially harmful to health. Focussing on those towns and cities either at the top or bottom of our rankings there is a marked difference in the diversity of retail in these areas.

Towns and cities which have a 'healthier' retail area provide a greater range of services and businesses, with a higher prevalence of venues such as health clubs, health services and libraries ensuring greater accessibility to such outlets. Those ranked at the top of our league table have a higher concentration of 'unhealthy' high street businesses.

Our league table has found that some towns and cities provide a more limited range of health promoting venues, and are instead being overtaken by venues with potentially negative consequences for health. These findings are especially concerning when examining the health outcomes of these areas. Our 10 unhealthiest retail areas are situated in some of the areas with the worst health outcomes. Looking at the data for district and unitary authorities, the towns and cities which top our league table are in the bottom 40% for premature mortality; 4 of which are in the bottom 5% for premature mortality.

The link with deprivation?

Public Health England collects deprivation data based on the number of people living in the 20% most deprived parts of England. When the 10 towns and cities with the unhealthiest retail area are compared to this deprivation data, we find that on average, 38.65% of the population living in these areas also fall into the category of living in the 20% most deprived parts of England. This is considerably higher than the national average of 20.4% (See Table 3 & 4).

Table 3.

TOWN/CITY	DEPRIVATION
England average	20.40%
Preston	41.90%
Middlesbrough	54.20%
Coventry	32.2%
Blackpool	48.10%
Northampton	21%
Wolverhampton	53.50%
Grimsby (data for North East Lincolnshire)	38.10%
Huddersfield (data for Kirklees)	28.60%
Stoke-on-Trent	52.40%
Eastbourne	16.40%
Bottom 10 average	38.65%

Percentage of population for the unhealthiest retail areas who live in the 20% most deprived part of England

(Public Health England, 2014b).

In comparison, the 10 towns and cities with the healthiest retail area experience far lower rates of deprivation and better health outcomes. The average proportion of the population in these places living in the 20% most deprived areas of England is just 9.3%. It is beyond the scope of this research to identify any causal link, but these statistics certainly highlight the importance of ensuring the retail areas are encouraging healthy lifestyles and ensuring that businesses such as betting shops and payday lenders are unable to cluster in areas of high deprivation.

Whilst these tables highlight considerable differences between the retail areas, at both ends of the tables, concerted efforts are being made by local authorities to improve the health outcomes in these areas. Since 2009, for example, Preston has been designated a healthy city and became the European City of Sport in 2012. Likewise, excellent work is taking place in Blackpool through the Blackpool Wellness Service to improve the health and wellbeing of local people by adopting a holistic approach. To effectively tackle the major public health issues, it is vital that we take a multifaceted approach; this means that wider efforts to improve the health and wellbeing of the local population must extend to the businesses on the high street and retail areas, ensuring that both the types of businesses on the high street and the retail environment does as much as it can to support healthy lifestyle choices.

Table 4.

TOWN/CITY	DEPRIVATION
England average	20.40%
Shrewsbury (data for Shropshire)	2.70%
Ayr	*
Salisbury (data for Wiltshire)	2%
Perth	*
Hereford (data for Herefordshire)	6%
Carlisle	17.90%
Cambridge	2.50%
Cheltenham	10.80%
York	7.10%
Bristol	25.90%
Top 10 average	9.30%

Percentage of population for the healthiest retail areas who live in the 20% most deprived part of England

(Public Health England, 2014b).

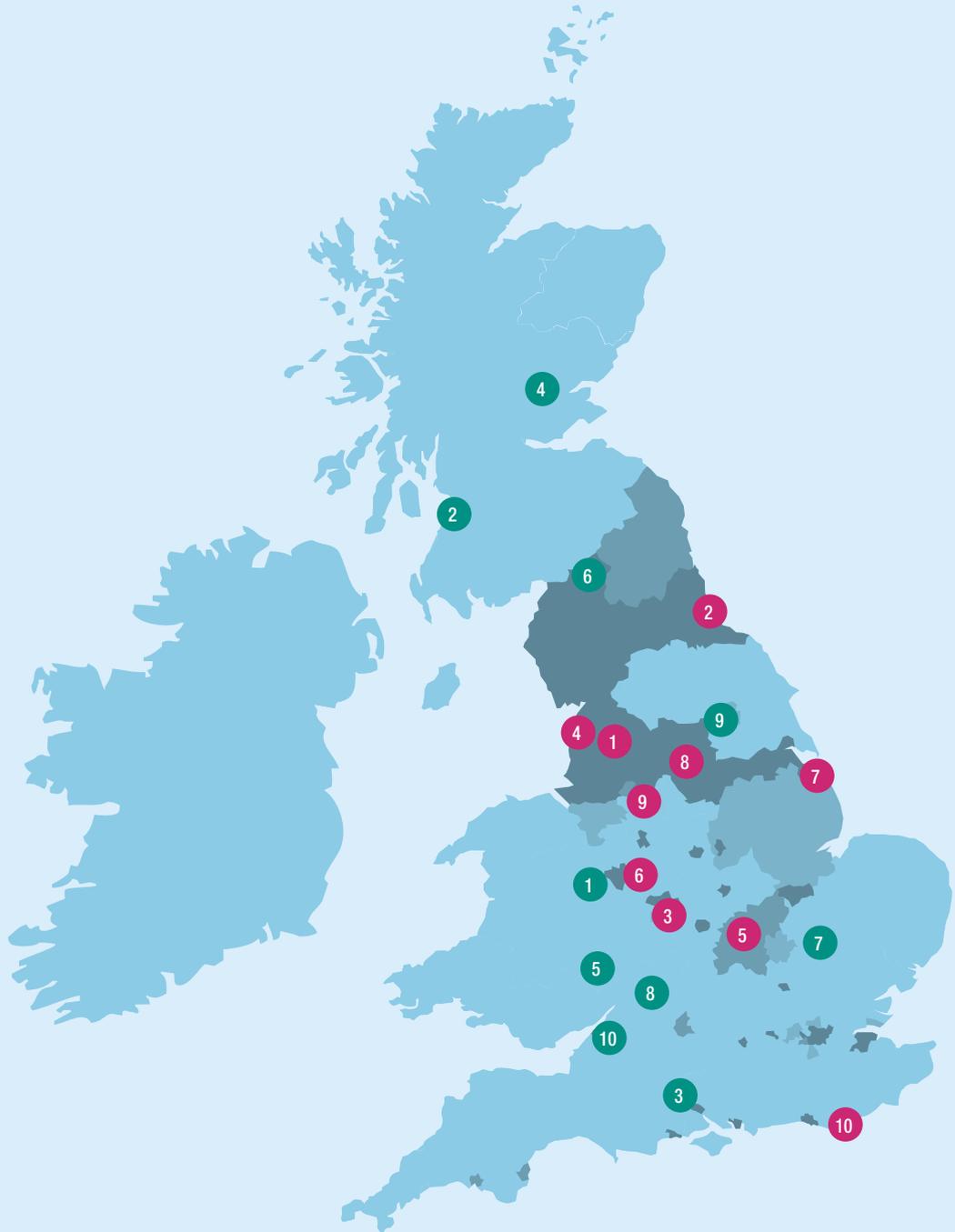*Data not available for Scotland

Figure 1.

The ten unhealthiest UK high streets

RANKING	TOWN/CITY
1	Preston
2	Middlesbrough
3	Coventry
4	Blackpool
5	Northampton
6	Wolverhampton
7	Grimsby
8	Huddersfield
9	Stoke-On-Trent
10	Eastbourne

With the exception of Eastbourne, each of the locations above are sited in areas with 'worst' or 'worse than national average' premature mortality outcomes.

The ten healthiest UK high streets

RANKING	TOWN/CITY
1	Shrewsbury
2	Ayr
3	Salisbury
4	Perth
5	Hereford
6	Carlisle
7	Cambridge
8	Cheltenham
9	York
10	Bristol

The overall score is arrived at by the following calculation:

(Number of unhealthy businesses X their Richter score) + (Number of healthy businesses X their Richter score)

Total outlets on the high street

The league table of London (Figure 2), which ranks 144 individual high streets, identifies stark differences between the high streets at the top and bottom of the table. Not only is there a higher number of unhealthy outlets and a smaller number of health promoting venues in the bottom 10 high streets, there is also a far greater prevalence of clustering. The number of fast food takeaways, for example, surpasses the 5% cluster threshold in 9 of the 10 high streets, surpassing 10% in 4 of them. The high streets in the top 10 do not experience clustering in any category.

As with the towns and cities league table, the unhealthiest high streets are located in areas with the highest deprivation. There is a clear division between the healthiest high streets located largely in the North West and the unhealthiest high streets situated in the East and South of the city. Barnet and Harrow, who are both within the top 10 best UK areas for premature mortality and collectively

have six high streets in the top 10, have just 5.7% and 2% respectively of their population classified as living in the 20% most deprived areas. Comparatively Tower Hamlets and Haringey, who collectively have four high streets in the bottom 10, have 69.7% and 57.3% respectively living in the 20% most deprived areas, considerably higher than the England-wide average of 20.4% (Public Health England, 2014b). These are concerning findings. It is widely established that individuals from the most deprived communities suffer from disproportionately poor health outcomes, it is therefore vital that the high streets in these areas support healthy choices. However, these high streets are instead being overtaken by outlets with potentially damaging consequences for local health and wellbeing.
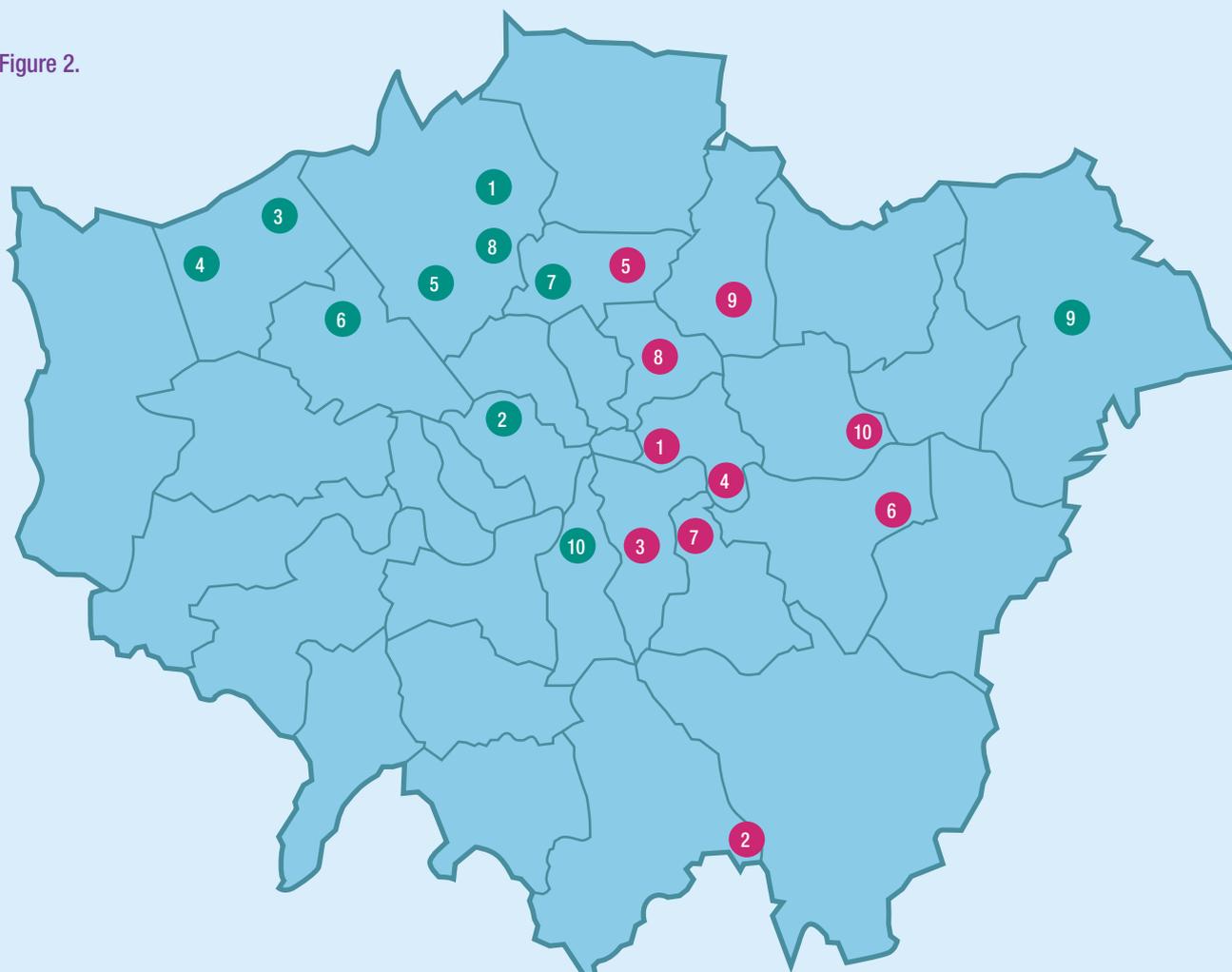
Boroughs with high streets at both ends of the league table are working hard to improve the health and wellbeing of local communities. Tower Hamlets council, for

example, through the Food for Health Awards, is seeking to work with local food outlets to improve the nutritional value of the food they serve. Similarly, Haringey council in collaboration with North Central London NHS is seeking to increase physical activity and improve mental wellbeing in the borough through the Health in Mind 'Walk your Way to Health' programme, which involves local people trained as walk leaders.

The Well London programme is also a clear example of the excellent work taking place at the local level. Well London has projects based in the most deprived boroughs, including Tower Hamlets, Hackney and Southwark, focused on embedding health within communities by training health champions and running a range of classes, events and groups. This work, however, risks being undermined by high streets which promote unhealthy lifestyle choices.

Figure 2.

The ten unhealthiest London high streets

RANKING	HIGH STREET	BOROUGH
1	Whitechapel	Tower Hamlets
2	New Addington	Croydon
3	Camberwell	Southwark/Lambeth
4	Chrisp Street	Tower Hamlets
5	West Green Road/Seven Sisters	Haringey
6	Plumstead	Greenwich
7	New Cross	Lewisham
8	Finsbury Park	Hackney/Islington/Haringey
9	Bakers Arms	Waltham Forest
10	East Beckton	Newham

The ten healthiest London high streets

RANKING	HIGH STREET	BOROUGH
1	Whetstone	Barnet
2	St. Johns Wood	City of Westminster
3	Stanmore	Harrow
4	Pinner	Harrow
5	Temple Fortune	Barnet
6	Kingsbury	Brent/Harrow
7	Muswell Hill	Haringey
8	East Finchley	Barnet
9	Hornchurch	Havering
10	Stockwell	Lambeth

The overall score is arrived at by the following calculation:

(Number of unhealthy businesses X their Richter score) + (Number of healthy businesses X their Richter score)

Total outlets on the high street

LICENSING, PLANNING AND CLUSTERING

a) A limit on the proportion of each type of business on a high street to avoid saturation and provide affordable choice

We believe that action is needed to tackle clustering of businesses. While there is currently no agreed definition of what would constitute an agreed cluster level, we would suggest that this would be when upwards of 5% of outlets on a high street and the surrounding streets contain a particular type of business. While this would still give consumers choice, it would enable greater diversity of provision on high streets. Our research suggests that this is a particularly important issue for fast food outlets.

b) For planning controls to prevent the proliferation of betting shops, payday lenders and fast food outlets

Betting and loan shops and fast food outlets tend to cluster in deprived areas and have a disproportionate impact on those communities and the vulnerable. It is vital that planning controls are put in place to ensure that councils can, in line with their local development plans, reject planning applications for payday loan shops or bookmakers. This could either be achieved by removing payday lenders and bookmakers from the A2 usage class, or, as a Department for Communities and Local Government Technical Consultation on Planning proposes (DCLG, 2014), that betting shops remain in a much smaller A2 use, but with existing permitted development rights to the A2 use class removed. In effect a planning application

would be required for any change of use to a payday loan shop. The Government has yet to respond to the consultation responses.

In relation to fast food outlets, planners should consider granting permission only to hot food takeaways that comply with certain nutritional criteria for the products they sell, although this is yet to be attempted (Greater London Authority, 2012b).

c) Include health as a condition for licensing of all types of businesses

Betting shops require three licenses to be granted in order for them to operate, one of which, the premises license, is granted by the local authority (Gambling Commission, 2015b). Licenses are granted based on a set of very permissive licensing objectives, based on the objectives of the gambling act, and do not provide councils with much scope to decline applications. We call for licensing conditions to be changed to reflect the longer term health impact of establishments and the financial impact that they have on deprived communities, rather than the presumption that as long as short term requirements are being met, that licenses will be granted. Cumulative Impact Policies (CIPs) that assess the impacts arising from a concentration of particular types of premises in a defined area (London Health Inequalities Network, 2013) should be used by councils to determine whether licenses should be granted. CIPs have been primarily used to tackle the problems associated with premises selling alcohol, however, the London Health Inequalities Network (2013) has proposed that betting shop licensing could also benefit from these policies. CIPs can be used during the application process for new premises

licenses, requiring that applicants evidence how they will avoid adding to the cumulative impact and challenges already being experienced in the area. CIPs turn the presumption that a license will be granted to the presumption that it will be denied, unless the applicant can effectively show how that they will not add to the local issues that have been identified. Where it cannot be shown that cumulative impact will not be negatively affected by a new betting shop or payday loan shop it would provide councils with clear criteria for rejecting applications.

d) For tighter controls on the numbers of premises licensed to sell alcohol in already saturated areas

Increasing levels of harmful and hazardous alcohol consumption in parts of the country and the disproportionate impact on some communities are of concern. The proliferation of on and off licenses on some high streets and town centres can reinforce unhealthy levels of drinking as well as lead to increased levels of antisocial behaviour, accidents and violence. This can be particularly noticeable at weekends with higher levels of ambulance call outs and alcohol related attendances at local accident and emergency departments. Cumulative impact policies for alcohol have been introduced in many areas. Health as a licensing objective is called for, so that alcohol harm to health can be taken into consideration in the granting of licenses. Government and local authorities are also asked to toughen how licenses are granted and to ensure that licensed premises do not contribute towards cumulative impacts.

Nudge businesses to adopt health-promoting activities

a) High street businesses to signpost customers to a wide range of support charities

We are calling for staff who work in businesses, including bookmakers and payday loan shops, to receive training in identifying and sensitively signposting customers who may be at risk of physical and mental health problems. The signposted charities would include debt management, mental health, gambling addiction, alcohol and substance abuse and local food banks. Payday lenders and bookmakers should have to demonstrate they have trained staff appropriately and have established links with local charities in order to operate on high streets.

b) Encourage tanning salons to switch from sunbeds to offering spray tans

For some people, tanning and avoiding pale skin is aesthetically important and culturally this does not look set to change. While little research has been done to assess the safety of fake tans, there is a consensus that they are far safer than tanning from UV radiation (Cancer Research UK, 2009). **We call for there to be awareness campaigns encouraging fake tans as a safer alternative and for tanning salons to offer spray tans alongside their sunbeds and to encourage their use over sunbeds.**

c) Fast food outlets encouraged to control portion sizes, adopt healthier cooking methods and improve the health environment they provide

Evidence suggests that the negative impact of fast food consumption on health largely results from the high calorie, salt, sugar and saturated fat content of meals and the large portion sizes they are served in. We call on FFOs to use available information and resources to develop and adopt healthier cooking practices which reduce the energy density, fat and salt content of food, and to assess, monitor and control portion sizes wherever possible. Simple measures can include offering sauces as optional extras for customers; adopting the 'bang, shake and hang' method of frying; and swapping oils that are high in saturated fat, such as palm oil, for oils lower in saturated fat (Greater London Authority, 2012b). Furthermore, portion sizes could be better controlled if market standardised chip cartons and other food packaging were made smaller. Government and local authorities should work with packaging suppliers to encourage the sale of smaller portions (Cities Institute, 2013).

Awards schemes have been set up in a number of areas, for example the healthyliving award in Scotland; the Healthy Options Award in Wales and the Healthy Catering Commitment Scheme which is operating in a number of London Boroughs. In order to obtain these awards, outlets must meet criteria such as offering healthy alternatives, grilling instead of frying wherever possible, or reducing portion sizes. In addition, a number of London Boroughs have run 'healthy frying workshops', which encourage low

cost changes to frying practices which can result in up to 20% reduction in fat content (Cities Institute, 2013). Councils may also consider providing grants or support in securing loans to enable purchase of healthier catering equipment such as grills, which can be prohibitively expensive for some businesses (Cities Institute, 2013).

d) Greater promotion of healthy products within shops

It is estimated that two-thirds of purchases within shops are unplanned; the placement and in-store advertisement of food products is, therefore, critical for influencing the purchasing decisions of customers (Thornton et al, 2013). We call for greater promotion of healthier items within shops, such as in prominent, unavoidable locations within stores like end of aisles displays and through greater use of in-store sampling of healthy food products. Studies have shown that this approach can not only encourage healthy lifestyle choices amongst customers, but can also be beneficial for the business itself. A 12-week study of store in Virginia which introduced a kiosk featuring a range of healthy items and a sampling pod aimed at children found that 58% of customers stated that it encouraged them to buy healthier items with increased sales in healthy items such as bananas, radishes, sunflower seeds and whole-wheat bagels (Holmes et al, 2012).

e) Encourage retailers to change the positioning of unhealthy snack foods, such as sweets and chocolates, away from checkouts and queuing areas

With soaring rates of obesity and related conditions, such as diabetes, we believe that high street stores should create an environment which promotes healthy choices. It is a familiar sight to find checkouts surrounded by sweets and chocolates, enticing customers to make impulse purchases of high fat and sugary products. A survey of the public found that over 90% of people believe that the display of unhealthy products next to checkouts is contributing to increasing levels of overweight and obesity (The Independent, 2013).

This is not only a problem within food shops, but is also a growing issue within non-food shops. A study conducted in 2012 which examined five 'compact food retailers' found that all five stores required customers to queue past junk food displays and four of them displayed unhealthy food on between 21% and 40% of checkouts. Similarly, of the six non-food retailers examined, five of them had unhealthy food displayed on between 6% and 85% of checkouts (Haigh and Durham, 2012). This practice is particularly appealing to children, with brightly coloured displays often at their eye height.

Many studies have demonstrated the impact of children's 'pester power' on the purchasing decisions of their caregivers (Campbell et al, 2012); a public survey found that 73% of people had purchased unhealthy food items when pestered by their children (The Independent, 2013).

Several supermarkets, including Aldi, Lidl and Tesco have already banned the placement of sweets and chocolate from at least some of their checkouts; however, many shops on the high street continue with this practice (The Guardian, 2014). We call on the Government to introduce a ban on the positioning of unhealthy food items next to all checkouts and queuing areas.

f) Encourage shops to move e-cigarettes from next to checkouts

First introduced in 2005, e-cigarettes are an increasing presence on UK high streets, available in a wide range of high streets shops, including specialist 'vaping' stores and cafes. These products have an important role to play in helping smokers to quit or reduce smoking; however, there are concerns that the practice of positioning e-cigarettes next to checkouts may widen their appeal to non-smokers and also, young people and children.

Whilst less harmful than cigarettes, e-cigarettes are not without risk; these products contain nicotine, which is a highly addictive, potentially harmful chemical. Placing these products next to checkouts may normalise their usage and encourage individuals to view them as a lifestyle choice rather than as an aid to quit smoking. To avoid this, these products must instead be placed with other nicotine replacement therapies and medicines. We call on the Government to ban the positioning of e-cigarettes next to all checkouts.

Shove businesses that don't

a) For legislation that allows local councils to set their own differential business rates

Councils currently have no powers to set differential business rates to encourage certain businesses to operate on their high streets, and to discourage others. We call for this power to be made available to local councils so that unhealthy outlets – betting shops, payday loan shops, tanning salons and fast food outlets (among others) can be discouraged and other health promoting businesses be supported financially.

b) Introduction of cigarette-style health warnings

The potential health impacts of gambling, taking out payday loans, using sunbeds and consuming fast food are well documented. We believe that the hazardous impact to health for each of these businesses should be made clear to consumers.

Although the Financial Conduct Authority have made risk warnings compulsory on all high-cost short-term financial products offered by payday loan companies, these tend to consist of a comment that "late repayment can cause you serious money problems". We would like to see these warnings more clearly displayed, and for health to be a key component of them. The association between severe debt and poor mental health is well established. High-interest loans should reflect this

link by informing customers of the potential health risks associated with debt. Similarly, while betting shops display responsible gambling information and highlight the financial risks of gambling, health is not the prominent focus.

c) Bookmakers to halve the maximum stake on fixed odds betting terminals (FOBTs) from £100 to £50

Fixed odds betting terminals have been described as the 'crack cocaine' of the gambling world (Woodhouse, 2015). Harm reduction measures should be taken to decrease the financial impact of these machines by reducing the maximum stake that can be bet to considerably lower than £100 – we suggest that a £50 stake would be a suitable limit.

d) Mandatory food hygiene ratings and calorie and nutrition labelling for fast food outlets
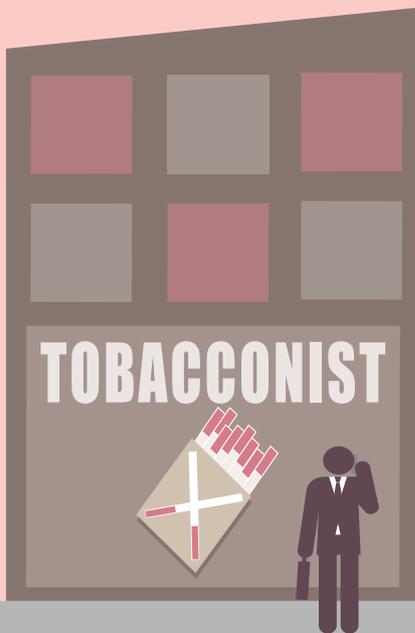
Information on the hygiene standards of the premises from which consumers are purchasing food is voluntary. Research shows that fast food takeaways are generally less compliant with food hygiene regulations than other types of restaurant; in 2013/2014, only 80% of takeaways were 'broadly compliant' (Food Standards Agency, 2014). We are calling for the mandatory display of food hygiene ratings which will enable customers to make informed choices and act as a driving force to encourage greater compliance amongst fast food providers. Research commissioned by the Food Standards Agency found that only 43% of businesses in England were voluntarily displaying their ratings, and just 12% of businesses with a 0 to 2 score (Food Standards Agency, 2012).

Nutritional information is often hard to find in fast food chains, difficult to understand (Allder, 2008) and in independent outlets often absent completely. Sixty percent of consumers claim they would find this information useful in takeaway restaurants and studies have shown that presence of calorie labelling can reduce calorie intake (Morley et al, 2013). We call on Government to make it mandatory for FFOs to provide clear nutritional information for all food sold. After calorie posting became mandatory in New York, customer preferences for lower calorie foods created the incentive for restaurant chains to reduce the calorie content of products by either reducing portion sizes or reformulating recipes (Freudenberg et al, 2010).

e) Unmanned tanning salons to be banned in England and the use of safety goggles enforced for all sunbed users

Unmanned tanning salons and sunbeds prevent controls being enacted over the age of users. While unmanned beds are already banned in Scotland, Northern Ireland and Wales, they are still widely available in England. It is vital that they are banned by Government to ensure that all sunbeds are supervised and therefore prevent young people from using them. Eyes can be badly damaged by sunbed use if they are not protected. We call for legislation to ensure that safety goggle use is made compulsory for sunbed users and that tanning salons provide goggles for their use.

THE
TANNING
SALON

TOBACCONIST

HEADSHOP

PUBLIC HOUSE

GREEN
GROCER

LIBRARY