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To: All Members of the Health and Wellbeing Board

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6 March 2025

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NOTICE OF MEETING - HEALTH AND WELLBEING BOARD 14 MARCH 2025

A meeting of the Health and Wellbeing Board will be held on **Friday, 14 March 2025 at 2.00 pm** in the **Council Chamber, Civic Offices, Bridge Street, Reading RG1 2LU**. The Agenda for the meeting is set out below.

AGENDA Page No

CIVIC OFFICES EMERGENCY EVACUATION: *If an alarm sounds, leave by the nearest fire exit quickly and calmly and assemble on the corner of Bridge Street and Fobney Street. You will be advised when it is safe to re-enter the building.*

A report giving an overview on the implementation of the Berkshire West Health and Wellbeing Strategy 2021-2030 in Reading and, in Appendices A and B, detailed information on performance and progress towards achieving the local goals and actions set out in the both the overarching strategy and the locally agreed implementation plans.

6. BETTER CARE FUND INTEGRATION UPDATE 31 - 48

A report giving an update on the Integration Programme and performance of Reading against the national Better Care Fund (BCF) targets at the end of December 2024 (Quarter 3), and also outlining the spend against the BCF Plan, including the Discharge Fund to support hospital discharges in 2024/25. It also presents the Better Care Fund (BCF) Quarter 3 return for 2024/25, attached at Appendix 1.

7. BOB ICB UPDATE BRIEFING 49 - 58

A report giving an update on matters from the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board.

8. BUILDING BERKSHIRE TOGETHER - ROYAL BERKSHIRE HOSPITAL REDEVELOPMENT UPDATE 59 - 64

A presentation giving an update on the latest situation with the Royal Berkshire Hospital redevelopment programme Building Berkshire Together.

9. HEALTHY WEIGHT NEEDS ASSESSMENT 65 - 406

A report presenting the Reading Healthy Weight Needs Assessment for the development of a whole systems approach to healthy weight and proposing the formation of a task and finish group to oversee the development of a Healthy Weight Strategy and implementation plan.

10. DATES OF FUTURE MEETINGS

Dates for HWB approval:

- 11 July 2025
- 10 October 2025
- 16 January 2026
- 13 March 2026

INFORMATION REPORTS

11. ROYAL BERKSHIRE NHS FOUNDATION TRUST INTEGRATED PERFORMANCE REPORT

This link provides access to the Royal Berkshire NHS Foundation Trust's Integrated Performance Report to December 2024, at page 36.

https://www.royalberkshire.nhs.uk/media/2smkqb4o/public-board-29-january-2025-website-version.pdf

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Present:

Councillor Ruth McEwan (Chair)	Lead Councillor for Education and Public Health, Reading Borough Council (RBC)
Tehmeena Ajmal	Chief Operating Officer, Berkshire Healthcare NHS Foundation Trust (BHFT)
Andy Ciecierski	Clinical Director for Caversham Primary Care Network
Rachael Corser	Chief Nursing Officer, Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB)
Councillor Paul Gittings	Lead Councillor for Adult Social Care, RBC
Councillor Wendy Griffith	Lead Councillor for Children, RBC
Colin Hudson	Reading LPA Commander, Thames Valley Police (TVP)
Alice Kunjappy-Clifton	Lead Officer, Healthwatch Reading
Lara Patel	Executive Director of Children's Services, Brighter Futures for Children (BFfC)
Matt Pearce	Director of Public Health for Reading and West Berkshire
Katie Prichard-Thomas	Chief Nursing Officer, Royal Berkshire NHS Foundation Trust (RBFT)
Councillor Liz Terry	Leader of the Council, RBC
Neil Whiteman	Community Safety Advisor, Reading and West Berkshire, Royal Berkshire Fire & Rescue Service (RBFRS)

Also in attendance:

Niki Cartwright	Director of Improvement and Performance, BOB ICB
Alison Foster	Programme Director, Building Berkshire Together, RBFT
Garyfallia Fountoulaki	Clinical Director for Mental Health Services, BHFT
Lara Fromings	Assistant Director for Transformation, Commissioning and Performance, RBC
Emma Garside	Head of Criminal Justice & Custody, Greater Oxford Area, TVP
David Goosey	Independent Scrutineer and Chair, Berks West Safeguarding Children Partnership
Brian Grady	Director of Education, BFfC
Andrea King	Strategic Lead for Emotional Health and Wellbeing Services, BFfC
Kathryn MacDermott	Director of Strategic Planning, BHFT
Mary Maimo	Public Health & Wellbeing Manager, RBC
Bev Nicholson	Integration Programme Manager, RBC
Theresa Wyles	Divisional Director for Mental Health, BHFT

Apologies:

Steve Leonard	West Hub Group Manager, RBFRS
Gail Muirhead	Prevention Manager, RBFRS
Rachel Spencer	Chief Executive, Reading Voluntary Action
Melissa Wise	Executive Director – Community & Adult Social Care Services, RBC

30. MINUTES

The Minutes of the meeting held on 11 October 2024 were confirmed as a correct record and signed by the Chair.

31. HEALTH AND WELLBEING STRATEGY QUARTERLY IMPLEMENTATION PLAN NARRATIVE AND DASHBOARD REPORT

Mary Maimo presented a report and gave a presentation which gave an overview of the implementation of the Berkshire West Health and Wellbeing Strategy 2021-2030 in Reading and provided detailed information on performance and progress towards achieving the local goals and actions set out in both the overarching strategy and in the locally agreed implementation plans.

The Health and Wellbeing Implementation Plans and Dashboard Update was attached at Appendix A and contained detailed narrative updates on the actions agreed for each of the implementation plans and included the most recent update of key information in each of the following five priority areas:

- Priority 1 - Reduce the differences in health between different groups of people;
- Priority 2 - Support individuals at high risk of bad health outcomes to live healthy lives;
- Priority 3 - Help families and children in early years;
- Priority 4 - Promote good mental health and wellbeing for all children and young people;
- Priority 5 - Promote good mental health and wellbeing for all adults.

Full data for key indicators for each priority was provided in the dashboard report at Appendix B and a copy of the Reading Suicide Prevention Action Plan was attached at Appendix C for the first time.

The development of a children's Emotional & Mental Health (EMH) Triage (an Amber project in Priority 4) was discussed with the Board and Andrea King assured members of the Board that co-design work would extend to voluntary and community sector partners. It was requested that a further update on the design of EMH Triage was reported back to the Board. It was also requested that the timeframes for work to be carried out on amber actions be included in future reports.

Resolved –

(1) That the report be noted;

(2) That an update on the design of a children's EMH Triage be brought back to a future meeting of the Board;

(3) That the timeframes for work to be carried out on amber actions be included in future reports.

32. COMMUNITY WELLNESS OUTREACH PROJECT UPDATE

Further to Minute 39 of the meeting held on 15 March 2024, Bev Nicholson submitted a report and gave a presentation on progress made by the Community Wellness Outreach Project, which encompassed NHS Health Checks as a core service and offered wrap-around support from Voluntary and Community sector partners to provide a holistic support offer to improve community wellness. The pilot project would run until the end of June 2025. There was a target to complete 5,200 NHS Health Checks within the project period, with particular emphasis on identifying those at risk of cardiovascular disease.

The report summarised the progress made up to the end of November 2024 and in the presentation at the meeting, it was reported that there had been 2,402 health checks completed by the end of December 2024. The team was continuing to work with community partners to ensure an appropriate reach. The clinics were now operating on a dual option of drop in or book online model (in some cases venues had a 25% drop in and 75% booked arrangement), and more capacity had been provided by recruiting additional nursing staff delivering the checks at some of the venues, where there was space to do this.

The presentation covered the following areas:

- The Community Outreach delivery method - including focusing on priority groups (aligned with the Core20Plus5 model for addressing inequalities) in areas of deprivation and including other priority groups who might be more at risk of poor health outcomes.
- Data on NHS Health Checks delivered to eligible people - noting that, at the end of Q1 2024/25, and for the first time in any financial year since 2013-14, Reading had performed significantly better than the England average.
- Events and publicity
- Adopting a public health approach
- Ethnic health inequalities
- Progress so far
- Onward referrals
- Data on attendance
- Case studies and feedback
- Outcomes
- Team engagement and partnership working

Bev Nicholson reported that officers were in the process of applying for a Municipal Journal award for the project. The Board noted the success of the project, especially in getting engagement from “hard to reach” individuals and developing trust within communitiest, and congratulated all those involved. It was noted that future funding would be needed to enable the project to continue in the longer term.

Resolved – That the report be noted.

33. SEND STRATEGY 2022-2027 UPDATE

Andrea King and Brian Grady submitted a report on the delivery of the Reading partnership Special Educational Needs and Disabilities (SEND) Strategy 2022-2027. The report had appended a self-evaluation framework (SEF) of the SEND partnership system in Reading.

The report summarised the further progress made in 2024 on the ambitions and actions set out in the strategy. The over-riding key performance indicator for the strategy, as previously reported to Health and Wellbeing Board in October 2023, was that the future local area inspection in Reading, in the complex national context, identified the effectiveness of all partners to improve outcomes for children and young people with SEND and their families. The strategy had ‘gone live’ from January 2022 and work strands had driven priority actions, reporting to the SEND strategy group.

On 17 October 24 a strengthened Reading SEND Strategy Board had been launched, with strengthened senior leadership. The revised SEND Strategy Board was co-chaired

by The Executive Director of Children's Services, Reading Borough Council and Brighter Futures for Children, and the Director of Vulnerable People, Buckinghamshire, Oxfordshire and Berkshire West NHS Integrated Care Board (BOB ICB).

Significant progress had been made in 2024 to review the impact and effectiveness of the SEND strategy and examples of the partnership's impact on outcomes for children were included in the report. In addition, detailed work on the SEF of the SEND partnership system in Reading had been completed, responding in the first instance to the lived experience of children and families, and the SEF was set out in the appendix to the report.

The report also set out the planned next steps to continue to deliver the 2022-2027 strategy through 2024/25 and the key challenges for the year ahead.

In response to a query about how the speed of SEND neurodiverse clinical assessment for children could be improved, Brian Grady explained that work was being carried out with BOB ICB and Berkshire Healthcare Foundation Trust partners on this issue, looking at how to move to a more preventative model, in a co-designed approach with families, schools and other key stakeholders to adopt national evidence-based best practice that enabled preventative neurodiverse screening. It was wanted to start to screen early in communities for neurodivergence and to make adjustments in the community, school and home to be able to respond to children's differences, talents and the things that they struggled with sooner, rather than waiting for clinical assessment, which was obviously a very pressured pathway. Proposals were currently being co-designed as a whole system to address this issue and an update could be provided to the Board later in the year if required.

Alice Kunjappy-Clifton asked about what information and support was available for those with English as a second language to access the services available and about the provision of the information in the SEF in an easy-to-read format. Brian Grady explained what was currently being worked on in this area and said that he would welcome Healthwatch Reading's involvement in co-design and co-production, and that he would take back the point about an easy-to-read SEF.

Resolved –

(1) That the report, progress and key challenges be noted and the next steps be endorsed;

(2) That an update on SEND neurodiverse preventative screening and assessments be brought back to a future meeting of the Board.

34. BERKSHIRE WEST SAFEGUARDING CHILDREN PARTNERSHIP (BWSCP) ANNUAL REPORT 2023/2024

David Goosey submitted a report presenting the Berkshire West Safeguarding Children Partnership (BWSCP) Annual Report for 2023/24, a copy of which was appended to the report. The BWSCP was a multi-agency partnership to promote the safeguarding and wellbeing of children in Reading, West Berkshire and Wokingham, whose role was to co-ordinate the partners' safeguarding services; act as a strategic leadership group in supporting and engaging others; and implement local and national learning including from serious child safeguarding incidents.

The report explained that the BWSCP had entered 2023/24 with the following main priority areas and provided information on the work and progress made on them:

- Creation of a Berkshire West-Wide Neglect Strategy
- Extra-familial Harm: Contextual Safeguarding, Exploitation and Serious Youth Violence
- Establishing a Berkshire West-wide Multi-Agency Safeguarding Hub (MASH) & Front Door Arrangements Leadership Group
- Development of the Partnership Learning and Development Group Training offer
- Continuing Development of the BWSCP Partnership

The report explained that statutory guidance for all safeguarding children partnerships in England "Working Together to Safeguard Children 2023" had been released in December 2023 and gave details of the key topics which partnerships had had to consider, stating that the BWSCP had made arrangements to accommodate all the changes required. It stated that, although not identified Delegated Safeguarding Partners (DSP) or Lead Safeguarding Partners (LSP) as defined in Working Together to Safeguard Children 2023, Public Health Directors across Berkshire West, including Reading's Director of Public Health, were now part of the BWSCP, in terms of named members of the DSP & LSP meeting groups.

The report also stated that the BWSCP had published one Local Child Safeguarding Practice Review in 2023/24 and gave details of the key areas of learning from the case.

Resolved – That the report be noted.

35. BUILDING BERKSHIRE TOGETHER - UPDATE

Alison Foster gave a presentation updating the Board on the Royal Berkshire NHS Foundation Trust's (RBFT) Building Berkshire Together (BBT) project for the redevelopment of the Royal Berkshire Hospital (RBH). A copy of the presentation slides had been circulated with the agenda papers.

The presentation explained that BBT was part of the national New Hospital Programme (NHP), using a common set of designs to save time and money called 'Hospital 2.0', and that construction for the RBH was originally scheduled to begin in 2031, but a review of the NHP was being carried out, with the outcome expected in the new year, and so construction was now expected to be post-2031.

The presentation covered the following areas:

- Options for RBH – focusing on a whole new hospital on a new site, because of the challenges of the current site
- BBT timeline if given the go ahead, with potential construction in 2035 and opening in 2036
- Current position
- Location-Led Integrated Impact Assessment – including an engagement exercise run between May-September 2024 on two sites - Thames Valley Science Park and Thames Valley Park, with over 10,000 responses
- Plans of the two sites
- Key messages from different chapters of the impact assessment
- Locations of Reading Survey respondents
- Reading feedback
- Next steps
    - Await the outcome of the New Hospital Review – expected in the new year
    - Follow the process to lead to formal public and partner consultation

- Options Development - Clinical Model/Travel and Transport Analysis/Environmental/Sustainability/Pre-Consultation Business Case
- Working out which services were needed in the future to determine the right size of hospital
- Engagement opportunities - workshops and focus groups to be part of options development

In response to a question about whether more detailed information was available on the locations of respondents, Alison Foster said that the slides only contained a high-level summary and more detailed information could be provided.

Alice Kunjappy-Clifton asked about what easy-to-read information was available for the public on the latest situation, noting that the public did not understand the process and the pathway. Alison Foster explained that there was a monthly open forum online giving an update on the project, but she could liaise with Healthwatch Reading to work on providing a simple clear message for the public.

Resolved:

(1) That the presentation be noted.

(2) That Alison Foster provide more detailed information on the location of the Reading respondents;

(3) That Alison Foster liaise with Healthwatch Reading to provide easy-to-read, simple and clear information on the latest situation for the public.

36. MENTAL HEALTH INPATIENT TRANSFORMATION PROGRAMME UPDATE

Niki Cartwright submitted a report and gave a presentation on the 3-Year Plan for Adult Mental Health inpatient services, which was part of the national Mental Health, Learning Disability and Autism Quality Transformation Programme (2024-2027). The report had appended a copy of the presentation slides.

The report explained that the NHS England Priorities & Operational Planning Guidance in 23/24 and 24/25 had identified a requirement for Integrated Care Boards to co-produce a strategic plan to localise and realign mental health inpatient services over a 3-year period, to bring all inpatient settings to a national standard. The plan had been recently submitted to NHS England and the presentation gave details of:

- The 3 year timeline and timelines and activities for July – September 20204 and October - December 2024
- A summary of progress so far in Q1, Q2 and Q3 in the following areas:
    - identify baselines and areas of good practice, develop approach
    - co-produce detailed plans and develop detailed data sets
    - roll-out of good practice accelerated
    - learning about restrictive interventions
    - improving environmental standards
    - reducing racial violence and discrimination on wards
- What work was planned in Q4 2025:
    - governance

- culture of care proxy measures
- Key Performance Indicators (KPI) and outcomes
- joint working
- KPI dashboard

Resolved –

(1) That the report be noted;

(2) That an update report be submitted to the Board in a year's time giving details of the progress on and outcomes of the plan.

37. RIGHT CARE, RIGHT PERSON UPDATE

Further to Minute 15 of the meeting held on 6 October 2023, Emma Garside gave a presentation giving an update on the Thames Valley Police (TVP) "Right Care, Right Person" (RCRP) programme, part of a national initiative to ensure an appropriate response from the appropriate agency was given to incidents where there were concerns for welfare linked to mental health, medical or social care issues. The presentation slides had been circulated with the agenda papers.

There was a phased roll out which had started in May 2023; TVP had now gone live with all the six areas of the RCRP model but was not currently applying the model to under 18s in the Thames Valley, and not all phases were fully implemented. Emma Garside explained that TVP had been one of the four forces with which the Home Office had done additional evaluation work pre- and post-implementation and reported that there had not been a significant drop off in the rate of jobs that the police were attending, with the percentages of jobs deployed being around 60% both pre- and post-implementation.

The presentation covered the following areas:

- Progress on the TVP RCRP National Partnership Agreement areas, shown as Red/Amber/Green (RAG) ratings
- RAG ratings in Berkshire, Buckinghamshire, Oxfordshire and Milton Keynes
- The Berkshire local implementation team
- RCRP Phases and progress to date
    - Phase 1 - Concern for Safety reports - Live since May 2023
    - Phase 2 - Walk out from healthcare setting – Live since May 2023
    - Phase 3 - AWOL psychiatric hospital – Live since May 2023
    - Phase 4 - Voluntary attendance policy – Live since September 2024
- Home Office evaluation of Concern for Safety demand.
- RCRP Dashboard data on Concern for Welfare and Mental Health incidents in Berkshire from November 2023 to 31 October 2024
- RCRP Dashboard data on Concern for Welfare and Mental Health incidents in Berkshire in TVP – 12 month review and last month review as at 5 November 2024
- Phase 5 – Use of Section 136 of the Mental Health Act 1983 for detention – target to hand over patient within 1 hour of arriving at a health-based place of safety – Live but not fully implemented
- Phase 6 – Conveyance – Reduce use of police vehicles for transportation of patients – Live but not fully implemented
- Independent Office Police Complaints as at 6 November 2024 – no concerns had been raised about RCRP decision making

- Next Steps, including roll out to Under 18s probably in Spring 2025, following further work with partners

Emma Garside said that she had the December 2024 newsletter from the RCRP coordinator that could be added to the website for information alongside the agenda after the meeting.

Resolved – That the position and presentation be noted and the RCRP newsletter be added to the website alongside the agenda.

38. ONE TEAM – ONE NEW VISION FOR BERKSHIRE'S MENTAL HEALTH

Gary Fountoulaki and Theresa Wyles gave a presentation on the Berkshire Healthcare NHS Foundation Trust's (BHFT) project 'One Team' to develop a new and integrated model of primary and community mental health care for all adults with severe mental illness (SMI).

The project had been established in response to the Long-Term Plan and the Community Mental Health Framework and had the following key objectives:

- Improve access and flow between Community Mental Health Services (CMHTs)
- Reduce boundaries and barriers between primary care/secondary care/voluntary, community & social enterprise (VCSE) groups as well as those between existing secondary care services
- Reduce unwarranted variation across the six CMHTs and Older People's Mental Health Teams within Berkshire Healthcare
- Improve patient and staff experience of using and delivering services

The BHFT had worked extensively with a range of stakeholders, including people with lived experience, patients and families/carers, voluntary and community groups (VCSE), health and social care partners and staff. Following initial workshops, the programme had set out to deliver a new model of care that would:

- Have clear points of entry that reduced multiple access points, referrals, triage and assessments and dissolved the primary and secondary care barriers. ('Easy In')

    - Facilitated through a new single triage form and a "one assessment" form with the process supported and delivered by a fully integrated Multi-Disciplinary Team at place. A single triage and assessment process would reduce waiting lists, duplication and patients having to repeatedly tell their story and better meet the needs of the place.

- Have a consistent offer that was clearly communicated with clear expectations of who would deliver, when and where. ('Offer')

    - This person-centred offer would include core, evidence-based/best practice interventions, and non-clinical provision such as peer and social support.

- Deliver planned end points and supported transitions that would improve patient flow and provide flexible step down with easy re-entry to services when required. ('Easy Out')

    - This would be facilitated through a collaborative inter-agency approach and the use of partner agencies to facilitate discharge.

The presentation gave further details of the model and the changes implemented so far, including:

- Place Teams
- Clear and consistent treatment offer
- Common Point of Entry
- Psychological Network
- Digital enablers and dashboards
- Easy Out
- Let's Connect
- Training and workforce following areas:

It gave examples of feedback from teams on what was going well so far and details of how the changes would transition to business as usual.

Matt Pearce noted that there was a higher percentage of smokers amongst people with SMI and suggested that it would be good to discuss how to encourage those patients to access the smoking cessation services provided by Public Health funds. Theresa Wyles said that she could provide contact details for the appropriate people for further liaison.

Resolved –

(1) That the position and presentation be noted;

(2) That it be noted that Theresa Wyles would provide the relevant contact details to enable further liaison between One Team and the Public Health team to encourage patients with severe mental illness to access smoking cessation services.

39. BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST'S HEALTH INEQUALITIES STRATEGY (INTERIM) 2024-26

Kathryn MacDermott presented the Berkshire Healthcare NHS Foundation Trust's (BHFT) Interim Health Inequalities Strategy 2024-26, including the Trust's commitment to working in partnership to co-produce a health inequalities strategy for 2026 onwards. The Interim Strategy had the following ambition:

> "We will reduce health inequalities by ensuring equitable access to our services and improving health outcomes for our most vulnerable patients and communities. We will address the wider determinants of health by looking at our day-to-day activities to see where we can generate wider social, economic and environmental benefits."

The Interim strategy included the definition of health inequalities to which the Trust was working. It set out data on population health, explaining that there were two significant places of income deprivation in Berkshire – Reading and Slough – but also pockets of deprivation across the county, and how people in areas of deprivation were more likely to live shorter lives and experience less healthy lives, as well as being more likely to encounter poorer outcomes, a poorer experience and barriers to accessing health services. It explained how race and deprivation were also significant drivers of health inequalities.

The strategy contained details of what was already being done by BHFT to address inequalities, including a programme of work on Mental Health Act detentions and the production of a Quality Improvement approach to reducing health inequalities for the following current initiatives:

1. Improving physical health outcomes for people with severe mental illness (SMI)
2. Reducing DNAs ('Did Not Attend's) for physical health services for people from racialised communities
3. Improving access to Talking Therapies for people from culturally and ethnically diverse backgrounds
4. Improving Health Visiting contacts in Reading
5. Reducing suicide for people with autism
6. Improving access to child and adolescent mental health services (CAMHS) early help services for young people in Slough
7. Improving physical health outcomes for people with learning disabilities

The strategy set out how BHFT could address inequality by generating social value in its activities. It gave details of the Trust's commitment to engagement with communities and Voluntary and Community Sector Enterprises to develop a new health inequalities strategy for 2026 onwards through co-production.

BHFT had also developed an Anti-Racism Strategy and it was suggested that this could be brought to a future meeting of the Board.

Kathryn MacDermott reported that Reading ACRE had been commissioned to do community engagement to understand the best areas to focus on to make an impact to reduce health inequalities in Berkshire West, and in Reading in particular, and this work was likely to start in March 2025. She also reported that neighbourhood health guidelines had recently been released, which would provide a good opportunity for community primary care and local authorities to think about how to work together better at neighbourhood level and that health inequalities would be a key priority area in this work.

Matt Pearce said that it would be good for BHFT and Public Health to share data and intelligence on health inequalities, and he would welcome a discussion on how the Public Health team could support BHFT on issues such as data benchmarking and weighting to help inform the new strategy.

Resolved –

(1) That the position and the Interim Strategy be noted;

(2) That Matt Pearce and Kathryn MacDermott liaise on how the Public Health team could support BHFT on data and intelligence sharing in the development of the new strategy;

(3) That the BHFT Anti-Racism Strategy be submitted to a future meeting of the Board.

40. READING PHARMACEUTICAL NEEDS ASSESSMENT

Matt Pearce submitted a report outlining the methodology for developing the Reading Pharmaceutical Needs Assessment (PNA) and seeking approval for the proposed oversight and sign-off arrangements. A draft PNA project timeline was attached at Appendix A.

The report explained the statutory requirement for the Health and Wellbeing Board to assess the need for pharmaceutical services in its area and to publish a statement of its assessment. The current version of the Reading PNA had been adopted in September 2022 and would expire at the end of September 2025 and the report described how the PNA would be updated for 2025-2028.

It set out the following eight key stages to developing the PNA, with details of how it was proposed to progress these in Reading.

- Stage 1 – Governance
- Stage 2 - Gathering of Health and Demographic Data
- Stage 3 - Pharmaceutical Services Information
- Stage 4 - Public and Contractor Engagement
- Stage 5 - Analysis and Drafting
- Stage 6 - Consultation Draft PNA Review and Sign-Off
- Stage 7 - Consultation
- Review, Sign-Off and Publication

It proposed that the Board authorised the Director of Public Health to take overall responsibility for ensuring the PNA met the regulatory requirements and was published in a timely manner. It proposed establishing a Steering Group to support the process, setting out the membership, benefits and responsibilities of the Steering Group, either at Buckinghamshire, Oxfordshire and Berkshire West (BOB) level, or by expanding the separate Task Group which had been set up to oversee the development of the Reading PNA, as Reading and West Berkshire had undertaken a joint procurement exercise and had appointed Healthy Dialogues to progress their PNAs.

The report stated that it was proposed to run public surveys between January and March 2025, to run the survey of pharmaceutical contractors and dispensing doctors in parallel with the public surveys, and to run required consultations with appropriate organisations between May and July 2025. All the timescales were subject to amendment to harmonise with the timescales of the other local authorities and Steering Group meetings if necessary. Once the document was finalised it would need to be signed-off by the Health and Wellbeing Board and published.

Resolved –

(1) That the proposed process for developing the Reading PNA be noted and endorsed;

(2) That the Director of Public Health be authorised to take responsibility for ensuring the document met the regulatory requirements and was published in a timely manner;

(3) That the Director of Public Health be authorised, in consultation with the Steering Group, to approve the consultation draft version of the PNA.

41. BOB ICB UPDATE BRIEFING

Rachael Corser submitted a report presenting a briefing from the BOB Integrated Care Board, as at November 2024.

The report covered the following areas:

- ICB Board meeting – 19 November 2024, including the ICB and system financial position.
- BOB ICB Change Programme – transition to implement the new Operating Model
- BOB System Planning
- Change NHS – the 10 Year Plan
- BOB Primary Care Strategy
- Winter vaccinations
- Same Day Urgent Access Services

Resolved - That the report be noted.

42. READING ARMED FORCES COVENANT AND ACTION PLAN

The Board received an information report on the progress made against the actions listed in the Reading Armed Forces Covenant Action Plan, in particular the health-related actions. A copy of the Reading Armed Forces Covenant Community Action Plan was attached to the report at Appendix A and the report highlighted the progress made against the actions. The report also provided an update on the Armed Forces Covenant Fund Trust.

Resolved: That the report be noted.

43. INTEGRATION PROGRAMME UPDATE

The Board received an information report giving an update on the Integration Programme and the performance of Reading against the national Better Care Fund (BCF) targets to September 2024 (Quarter 2) and outlining the spend against the BCF plan, including the Adult Social Care (ASC) Discharge Fund to support hospital discharges in 2024/25.

The report also covered the Better Care Fund Quarter 2 return for 2024/25, attached at Appendix 1. The Quarter 1 return had been signed off through the delegated authority process and submitted by the deadline of 31 October 2024. One of the National Conditions to be met was that the Council and the Integrated Care Board should have agreed the Section 75 Framework Agreement with the Integrated Care Board, for pooled funding, covering the period 2024/25. This had now been submitted for signing and sealing.

Resolved – That the report be noted**.**

43. DATE OF NEXT MEETING

Resolved – That it be noted that the next meeting of the Health and Wellbeing Board would be held at 2.00pm on 14 March 2025.

(The meeting started at 2.00 pm and closed at 5.28 pm)

READING HEALTH AND WELLBEING BOARD

Date of Meeting	14 March 2025
Title	Health and Wellbeing Strategy Quarterly Implementation Plan Narrative Report
Purpose of the report	To note the report for information
Report author	Mary Maimo
Job title	Public Health and Wellbeing Manager
Organisation	Reading Borough Council
Recommendations	That the Health and Wellbeing Board notes the following updates contained in the report: **Priority 1** – Tasks supporting Actions 1 - 8 within this priority area including partnership working, proposing projects to support provision of a range of services to support people to be healthy, reduce health inequalities. **Priority 2** – Tasks supporting Actions 1 - 6, focusing on identifying health and care needs of individuals at risk of poor outcomes and actions for supporting them. Including engaging with and funding projects that enable people to access information and support at a time and in a way that meets their needs. **Priority 3** – Tasks supporting Actions 1 - 7, have been revised to Actions 1 – 3, focusing on: access to nursery places for disadvantaged 2-year olds, increase and develop the support available for children with SEND needs in early years (at home and when accessing early years provision) and promote availability of information for vulnerable families in reading, including those with no recourse to public funds. **Priority 4** – Tasks supporting Actions 1 - 7 have been updated with a focus on addressing inequalities in mental health, training, the work of the Mental Health Support Teams (MHSTs) and Primary Mental Health Team (PMHT). **Priority 5** – Tasks supporting Actions 1 - 8 have been updated with progress in awareness raising of local mental health support, strengthening a partnership approach to prevention and training, including suicide prevention action planning.

1. Executive Summary

1.1.1 This report presents an overview on the implementation of the Berkshire West Health and Wellbeing Strategy 2021-2030 in Reading and, in Appendices A and B, detailed information on performance and progress towards achieving the local goals and actions set out in the both the overarching strategy and the locally agreed implementation plans.

1.1.2 The Health & Wellbeing Implementation Plans and dashboard report update (Appendix A) contain a detailed update on actions agreed for each implementation plan and the most recent update of key indicators in each priority area. Full data for key indicators for each priority is provided in the full Health & Wellbeing Dashboard Report (Appendix B).

2 Policy Context

2.1 The Health and Social Care Act 2012 sets out the requirement on Health and Wellbeing Boards to use a Joint Strategic Needs Assessment (JSNA) and a Joint Health and Wellbeing Strategy (JHWS) to develop plans which:

- improve the health and wellbeing of the people in their area;
- reduce health inequalities; and
- promote the integration of services.

2.2 In 2021 The Berkshire West Health and Wellbeing Strategy for 2021-2030 was jointly developed and published on behalf of Health and Wellbeing Boards in Reading, West Berkshire and Wokingham. The strategy contains five priority areas:

- Reduce the differences in health between different groups of people
- Support individuals at high risk of bad health outcomes to live healthy lives
- Help families and children in early years
- Promote good mental health and wellbeing for all children and young people
- Promote good mental health and wellbeing for all adults

2.3 In Reading the strategy was supplemented by the development of implementation plans for each priority area. These were presented to the Health and Wellbeing Board and approved in March 2022.

2.4 In 2016 the board had previously agreed to introduce regular performance updates, including a Health and Wellbeing Dashboard Report, at each meeting to ensure that members of the board are kept informed about the Partnership's performance in its priority areas. The current Health and Wellbeing Dashboard Report has been developed to reflect the new priorities set out in the Berkshire West Health and Wellbeing Strategy 2021-2030 and the associated implementation plans.

2.5 The Health and Wellbeing Dashboard provides the latest data available to support the Board to scrutinise and evaluate the performance of the Partnership against the agreed priorities set out in the Health and Wellbeing Strategy. Some of the national data used to measure public health outcomes, particularly for those indicators based on annual national survey and hospital data, goes through a process of checking and validation before publication, which can mean that it is published sometime after it was collected. Other data contained in this report is reported directly from local health service providers, including primary care providers, and, as these data are not validated or processed before publication, there may therefore be some minor discrepancies and corrections between reports.

2.6 At each Health & Wellbeing Board meeting Health & Wellbeing Strategy Priority Leads for Reading Borough Council will provide a narrative update against selected tasks and priority items that have been actioned during that period. Statistical data will be refreshed every six months. The reporting schedule for 2025/26 is therefore as follows:

Health and Wellbeing Board	Narrative updates - selected tasks and priorities	Data refresh
March 2025	✓	✗
July 2025	✓	✓
October 2025	✓	✗
January 2026	✓	✓
March 2026	✓	✗

3 The Proposal

3.1.1 **Overview**

Priority 1 – Reduce the differences in health between different groups of people
The Reading Integration Board (RIB) is leading on this priority as the Board has a programme of projects which are focused on ensuring people get the right care at the right time and in the right place. A Population Health Management approach is used to provide services in areas where there is the greatest need, and to reach out to people in those communities on both a one to one and a group basis. The Programme of work includes a range of projects to support people who may find it more difficult to access services, and as a result there is a difference in their expected health outcomes. Through the Better Care Fund, we commission services to support people who are experiencing Dementia, Young Onset Dementia and Stroke recovery. This is alongside a range of community-based projects that are based within our communities providing services to reduce the impact of difference and support positive outcomes in addressing health and wellbeing needs. Grants provided in 2024/25 covered a range of community-based services to address inequalities, tackle isolation and meet people where they are to engage and support them in achieving improved outcomes *(please note these schemes also contribute towards Priority 5 actions)*:

- **ACRE: Men-2-Men Project** to improve access to health services and promote health and wellbeing among participants and their friends.
- **Berkshire Vision**: Part-fund the Sight Loss Support outreach service supporting visually impaired people in Reading.
- **BOB ICB Autism and Crisis Care**: Project to reduce distress, anxiety and crisis of autistic people requiring paramedic intervention and being taken to hospital by ambulance.
- **Mustard Tree**: Starting Point Navigators provide support to young people aged 11-25 admitted to A&E and wards of the Royal Berkshire Hospital.
- **Parenting Special Children**: Specialist support for families and children with a range of Special Educational Needs and Disabilities, or SEND, including early life trauma by Reading-based charity.
- **RABBLE Theatre**: Programme of activity which is financially and physically accessible and encourages positive mental and physical health supporting a healthy life and building confidence.
- **Reading Gateway Church**, Parish Nurse: Help fund another nurse to combat loneliness and improve health and wellbeing, support those with mental health issues with health advice, and signpost to additional assistance. Establish a new garden wellbeing project.
- **Mencap, Family Health Advisor**: To help clients maintain and improve their physical and mental health by providing information, advice, casework, and practical support.
- **Refugee Support Group**: Mental Health awareness and activities programme to support refugees and asylum seekers in Reading to engage in social and wellbeing activities, build networks and get to know the local area.
- **Torch:** Set up a new service to appoint a new Parish Nurse to focus on areas of need and deprivation in West Reading.

Priority 2 – Support individuals at high risk of bad health outcomes to live healthy lives

Our Community Wellness Outreach project continues and operates on both a drop in and appointment basis. In Reading we had large cohorts of people that had not had an NHS Health Check and who are at higher risk of poor health outcomes. ONS Census (2021) shows that there is a larger proportion of people from an Indian, Pakistani, Asian or African ethnicity in Reading, compared to the ratios for England, and as at the end of January 2025, 55% of people seen are from these ethnically diverse groups, which will enable preventative support to be provided and reduce likelihood of developing more serious conditions. The data as at the end of January shows that there have been 2,537 Health Checks. Of the cohorts seen 68% of people were found to have very high/high body mass index (BMI) scores, 23% had high or very high blood pressure and 25% with high blood glucose levels, a pre-indicator of diabetes and 6% with high cholesterol. The usual age range for the NHS Health checks is from 40 years to 74 years. This project has delivered the

checks to everyone over 18 years of age in Reading to take an early detection and prevention approach. So far 32% of people have been below age 40. The general feedback is that people are happy that this service is being provided in the community with easy access and instant results, along with support and advice to enable them to take a pro-active approach to their health and wellbeing outcomes. The service has received a lot of positive feedback on the impact in communities and these short case studies demonstrate the impact:

- *A young female aged under 25 attended a CWO session with her sister. During her check she spoke to the nurse about her challenges with Mental health and weight management which was followed up with a referral to Sport in Mind. Sport in Mind contacted her regarding the different activities she could attend, and she was supported in a one-to-one translated call with RVA and Language Line to complete the registration form so she can drop into an activity and join in.*
- *A person wanted specific support for surviving bereavement by suicide. They had received counselling from Talking Therapies but felt this has not provided them with the support they needed as they wanted to speak to people who had similar lived experience. They were signposted to a group that met this need and were positive about joining their monthly meetings. They are also to be followed up clinically in a few months due to one of their results during their check.*

Priority 3 – Help families and children in early years

The Early help strategy 2024-2026 is complete and is due for presentation at ACE on 19 March 2025. We are grateful for all the contributions from senior leaders of the One Reading Partnership Board in the co-design and development of this partnership approach. The strategy has received a full endorsement from the partnership and has commenced the more practical focused work in the tactical delivery group. This is a partnership document which sets out the joint approach to integrating services to co-deliver early help services. The strategy focuses on four priorities and to galvanise the partnership in these ways: developing the 'best start for life' plan, a pathway for Early help across early years and parenting support. A safeguarding adolescents programme, a multi-agency approach to making Reading a great and safe place for young people inside and outside of their home. Belonging, improving access to services and breaking down barriers for vulnerable families getting the help they need. And Family hubs, a co-located and integrated approach to local services.

The continued efforts of the Early years team and portage are successfully providing sufficient nursery places for the 2-year-olds (who experience disadvantage) across Reading. There has been a lot of activity to promote the offer and access through various platforms and targeted information sharing. Publicity through Family information Service (FIS) and communication targeted directly to parents and carers. The Early years team are sending information directly to identified vulnerable families and encouraging them to request codes in a timely way. Two-year-old funding leaflets are published in the 12 most spoken languages in Reading which improves access to understanding and entitlement for families. Early years and childcare teams produce quarterly and monthly reports on uptake on 2year old funding to track trends and adapt the approach to maintain the uptake. 41 families have accessed Time for 2's which has been running successfully for 1 year through children's centres in Reading. This support is available for eligible children and families for 2year old funding and supports them while they wait for a place in their desired location. It actively supports their readiness to start in the setting. The commitment to the disadvantaged two-year-old offer is evidenced in the continued expanded childcare entitlement rollout.

There is a commitment across the partnership to increase and develop the support available for children with SEND needs in early years (at home and those accessing early years provision) and the actions agreed are to support emerging needs with a view to meet need, minimise problems escalating and reduce the demand for high-cost interventions as children grow. The work underway

has focussed on supporting practitioners to identify need and offer support early on and to provide families with the spaces, advice, skills and resources that will support children to thrive.

The Holiday and activity fund (HAF) programme has been another highly successful programme this year. For the first time, the programme has introduced specific activities for children with SEND with plans to further expand the offer for 2025.

Focused work has developed the ordinarily available provision (OAP) in early years setting. The focus is on staff being upskilled with improved knowledge and confidence to effectively meet the needs of children with SEND in mainstream PBI settings. Dingley's promise pilot in a local mainstream setting is looking at how to improve a smooth transition of children with SEND into a mainstream class setting (Reception) - Lead by Rebecca Bateman.

The third main strand of priority 3 is a focus on the availability of and access to information for vulnerable families regarding community based, targeted and statutory services. Reading Borough Council is a Council of Sanctuary and information needs to be freely available on what support and services are available for families with young children across all demographic groups and immigration status, including those who have no recourse to public funds (NRPF).

Family information service (FIS) continues to be a highly effective service at maintaining up to date records of available support and resources as well as publicising them to the families who need it most.

Priority 4 - Promote good mental health and wellbeing for all children and young people

Following on from the previous updates to Health and Well-Being Board we offer the following updates:

- The design of a new Emotional and Mental Health Triage for children and young people has commenced. We have had excellent support from our voluntary sector leaders with expertise in this field, who are actively contributing to co-design of the Triage. Following discussion with other regional leaders with good practice in this area, we have drawn on existing good practice as a blueprint for the design for Reading. We very much appreciate the active support from leaders in Berkshire Healthcare Foundation Trust (BHFT), BOB ICB and Public Health in the co-design of these new arrangements. To ensure appropriate safeguarding interface and governance, Andrea King and Jonny Bradish presented the proposals around EMH Triage to Berkshire West Safeguarding Children's Partnership (BWSCP) MASH Steering Group and received full endorsement and support from all statutory partners. Andrea and Jonny have also spent time with colleagues in CSPOA (children's services front door), working with operational managers with oversight of safety, protection and early help partnership resources, to embed the design of EMH Triage in these arrangements, ensuring 'No Wrong Door' for children. We will undertake a similar process with CAMHS CPE (Common Point of Entry). Workstream 3 of the SEND Strategy Board are overseeing the details of these arrangements and have a round table discussion about Triage design on 25th February 25.

- The Primary Mental Health Team (PMHT) have provided a report on their activity and impact on improving outcomes for Reading's children and young people, which was reviewed by the Quarterly Public Health Board on the 17th of February. This report demonstrates the significant demand on emotional and mental health resources in Reading, in line with the national picture. It also demonstrates PMHT's significant impact on improving mental health outcomes for children (using clinical measures i.e., Routine Outcome Measures) i.e., 80% of children had improved outcomes (e.g., RCADS, CORs, Goals, etc). In addition, 24 Schools had been supported with mental health surgery support and the evaluation of these effectiveness of these surgeries demonstrated that 100% of school leaders attending these surgeries described themselves as 'more confident' to respond to the emotional health needs of their students. The relatively small investment in PMHT was noted in the context of significant demand for this support and a 4-5 month waiting list is in place for PMHT support currently; the risks to each child waiting are assessed on a 4-6 weekly basis.

- The H&WBB are asked to note that the MHST (Mental Health Support Team) offer is going through re-tender with BOB ICB. Reading have led a combined Berkshire West tender proposal. We recognise the uncertainty that the tender process generates for systems leaders and particularly for schools who have high confidence in Reading's MHST offer, which performs very favourably in a regional and national context. The outcome of the tender will be known on 1st May and we will keep H&WBB updated.

  Reading has recently been highlighted as an area of national best practice for investment in, and the effectiveness of, coproduction by the government commissioned national review, led by Safe Lives. Reading education leaders will be contributing this good practice to a national webinar in Spring 2025.

Priority 5 – Promote good mental health for all adults

The Reading Mental Health and Wellbeing Network has continued to meet on a quarterly basis now using an agenda model that allows an opportunity to showcase progress on the implementation plan through presentations by each partner organisation. At the most recent meeting in February the group has received presentations from the Ready Friends Befriending Forum, Nature and Health Benefits and the Wellbeing Platform Support Hub.

As reported previously the Closing the Gap 2 procurement process continues to move towards the procurement phase in preparation for October 2025 and the Mental Health and Wellbeing elements of Closing the Gap are main investment of the public health grant in Adult Mental Health and Wellbeing for Reading. A recent further engagement session provided an opportunity to share with the stakeholder partners the proposal to reallocate a greater proportion of this investment towards the establishment of an agreed systematic approach to primary prevention.

The Mental Health Needs Assessment continues to be at the final editing stage in preparation for publication on the Berkshire Observatory website, the home of the Reading Joint Strategic Needs Assessment. This ongoing delay is a consequence of the limited capacity the small Public Health team and publication is now expected to be in May and will be reported at the next board meeting.

The Reading Suicide Prevention Action Planning group has met on a quarterly basis and links with the newly reestablished Pan Berkshire Suicide prevention planning group has strengthened. This allows for collaborative decision making about the recommissioning of the AMPARO bereavement service across the Thames Valley, and development of the specification for a near real time surveillance system for Berkshire. There has also been reporting about the preventative action that is taking place in Reading. This includes reporting of a safeguarding review that ensures the findings from a safeguarding review inform local practice and interagency collaboration to prevent future risk to life, collaboration around a suspected cluster response and the Welcome Platform Support Hub at Reading West.

4 Contribution to Reading's Health and Wellbeing Strategic Aims

4.1 This proposal supports Corporate Plan priorities by ensuring that Health and Wellbeing Board members are kept informed of performance and progress against key indicators, including those that support corporate strategies. It contributes to all the Berkshire West Joint Health & Wellbeing Strategy 2021-30 priorities.

5 Environmental and Climate Implications

5.1 The recommended action will have no impact on the Council's ability to respond to the Climate Emergency.

6 Community Engagement

6.1 A wide range of voluntary and public sector partners and members of the public were encouraged to participate in the development of the Health and Wellbeing Strategy. The indicators included in this report reflect those areas highlighted during the development of the strategy and included in the final version. Key engage will continue to be a part of the process of implementing, reviewing and updating actions within the strategy to ensure it continues to address local need.

7 Equality Implications

7.1 Not applicable - an Equality Impact Assessment is not required in relation to the specific proposal to present an update to the Board in this format.

8 Other Relevant Considerations

8.1 Not applicable.

9 Legal Implications

9.1 Not applicable.

10 Financial Implications

10.1 The proposal to update the board on performance and progress in implementing the Berkshire West Health and Wellbeing Strategy in Reading offers improved efficiency and value for money by ensuring Board members are better able to determine how effort and resources are most likely to be invested beneficially on behalf of the local community.

11 Timetable for Implementation

11.1 The Berkshire West Health and Wellbeing Strategy is a 10-year strategy (2021-2030). Implementation plans are for three years however will continue to be reviewed on an annual basis.

12 Background Papers

12.1 There are none.

Appendices

A. Health & Wellbeing Implementation Plans Narrative Update

B. Key Indicators for each Priority Area

APPENDIX A - HEALTH AND WELLBEING IMPLEMENTATION PLANS NARRATIVE AND DASHBOARD REPORT UPDATE

PRIORITY 1: Reduce the differences in health between different groups of people, Implementation Plan narrative update

Action name	Status	Commentary (100-word max)
1. Take a 'Health in All Policies' approach that embeds health and wellbeing across policies and services.	Green	Ensure Service Policy reviews and proposals for new services and policies undertake Equality Impact Assessments, which also consider the impact of climate change on our residents, e.g. increase in hospital admissions for respiratory conditions due to heatwave/extreme cold weather, as well as the impact of any new services on our climate. Information and advice is provided through our public health teams via alerts and general communications to support a healthy environment.
2. Address the challenge of funding in all areas and ensure that decisions on changing services, to improve outcomes, does not adversely affect people with poorer health.	Green	Ensure Services are delivered as far as possible, close to the communities that they are designed to serve, and are accessible via public transport, and consider the impact on Climate. The Better Care Fund will offer Grants for Community based projects to meet the Health and Wellbeing needs of the localities, taking a Population Health Management (PHM) approach. These are based within communities and community hubs, to ensure they are accessible by the people in those locations.
3. Use information and intelligence to identify the communities and groups who experience poorer outcomes and ensure the right services and support are available to them while measuring the impact of our work.	Green	We use a Population Health Management approach to identify people at risk of poorer outcomes, sharing information with system partners to enable risk stratification and identify service gaps. We continue to use the JOY App and Marketplace for referrals and signposting and use Connected Care and the Berkshire West Inequalities Dashboard to identify groups of people who may be at risk of poor health outcomes, and then provide targeted information, advice and support. The PHM Data shows that there has been improvement in the number of people who have had a health check, and conditions such as hypertension and diabetes are being identified at an earlier stage to improve outcomes.
4. Ensure an effective programme of NHS Health Checks and follow up support services that are designed to meet the needs of all people in the community, ensuring appropriate communication and engagement methods that are culturally sensitive.	Green	The Community Wellness Outreach service is delivering NHS Health Checks in community settings where uptake has been previously low. The focus is on 'place based' support services, where possible, including those offered by RBC, particularly those 'free at the point of use' – green spaces, libraries, some leisure facilities, Reading Green Wellbeing Network programmes. Hospital navigators supporting people into long-term mentoring. Outreach to faith-based organisations to build a network of 'Community Advocates', providing pastoral support to local communities.
5. Continue to develop the ways we work with ethnically diverse community leaders, voluntary sector, unpaid carers, and self-help groups that sit within Local Authorities.	Green	We work closely with Voluntary and Community sector partners in this area such as Association for Cohesion and Racial Equality (ACRE) and Reading Community Learning Centre, as well as Whitley Community Development Association and other community groups based within and reaching into communities to build trust and enable access to appropriate services to meet their needs. We have the Reading Services Guide and the JOY platform, which is used across Reading to enable easy referral to services and to identify gaps in the marketplace that can be highlighted together with the data that identifies a need. Our Place Based Partnerships team, New Directions College and Compass Recovery College also work in partnership with these organisations and communities to provide an integrated and collaborative approach to addressing challenges.

6. Ensure fairer access to services and support for those in most need through effective signposting, targeted health education and promoting digital inclusion, all in a way that empowers communities to take ownership of their own health.	Green	The Social Prescribers, Community Health Champions, Community Connectors, Family Health Advisors and Parish Nurses are key to building relationships with people in our different communities across Reading, and in particular within our ethnically diverse populations. They work in an integrated way to support and enable education about health and wellbeing and to promote screening programmes and health checks that are being delivered locally in communities – providing the information and encouraging engagement in the areas where people are most in need. These health and education programmes, and screening programmes are being well attended and feedback from community members has been very positive as being located within the community has made them more easily accessible. People are encouraged and supported to use the NHS App, and to find information and advice about what they can do to maintain or improve health and fitness. Information can be provided in different languages and mediums to reach different communities based on their needs.
7. Increase the visibility and signposting of existing services and improve access to services for people at higher risk of bad health outcomes, whilst also providing pastoral support through faith-based organisations linked to health and social care services.	Green	There are a number of organisations supported through commissioned contracts, and smaller community grants for faith based and community organisations that specifically support people at higher risk of bad health outcomes. Pastoral support is provided alongside education about health risks and what opportunities there are to reduce risk and improve outcomes. The Parish Nurse project through Reading Gateway Church is a great example of community focused activities and provision of pastoral support. Communicare provide information and advice on benefits and other financial welfare issues, and we work with community leaders in our faith-based settings to ensure there are opportunities for people to access these services in a way that best meets their needs.
8. Monitor and assess how Covid-19 has differentially impacted our local populations, including through the displacement or disruption of usual services. Ensure health inequalities exacerbated by COVID-19 are addressed as we recover and ensure access to services.	Green	People who were at higher risk of poor outcomes due to contracting Covid-19 and leading to Long Covid or other complications are supported through the Long Covid programme being delivered by Primary Care. Our primary care and voluntary and community sector providers continue to be key participants in identifying health inequalities, especially those that were exacerbated by COVID-19, and enable onward referrals to appropriate support services. The JOY App is being used extensively across Primary Care and Social Prescribing services enabling people to access the right activities and information for them alongside a programme of delivering Health Checks in community settings to reach into communities. A risk stratification guidance document has been shared with GP surgeries by the Integrated Care Board, in relation to Chronic Obstructive Pulmonary Disease (COPD), a respiratory condition that has led to the highest number of hospital admissions in Reading.

PRIORITY 2: Support individuals at high risk of bad health outcomes to live healthy lives, Implementation Plan narrative update

Action name	Status	Commentary (100-word max)
1. Identify people at risk of poor health outcomes, using Population Health Management data and local data sources, as well as increase visibility of existing services, and signposting to those services, as well as improving access for people at risk of poor health outcomes.	Green	The Community Wellness Outreach project of delivering NHS Health Checks in ethnically diverse communities, where there are higher levels of deprivation, are a key aspect of the work being undertaken to support people at higher risk. We are working with Primary Care services who sending messages to people in the target groups, who have never had a health check and are in areas of higher deprivation, as we know that if conditions go undetected then there is a higher risk of developing long term conditions such as diabetes and heart disease. When someone attends one of the Community Wellness Outreach sessions, they can also be referred to one of the Social Prescribers for one-to-one support and referred to a range of other services, depending on their needs, to support their wellbeing.
2. To raise awareness and understanding of dementia. Working in partnership with other sectors, we can introduce an integrated programme ensuring the	Green	In Reading 67.5% of those aged 65 or over are estimated to have a coded diagnosis of dementia as of September 2024, which is higher than England (65.5%). The Dementia diagnosis rates have improved year on year since 2021. A Dementia Friendly Reading Steering Group was formed, and a self-assessment was undertaken ahead of applying for Dementia Friendly Community status with the Alzheimer's Society and the data from the self-assessment is currently being processed. Our Community Health Champions are working with our Voluntary and Community Sector partners to build

Dementia Pathway is robust and extended to include pre diagnosis support, and improve early diagnosis rates, rehabilitation and support for people affected by dementia and their unpaid carers.		relationships and confidence with people to know what support and information is available to them, and we fund Young People with Dementia services through the Better Care Fund, to provide activities, advice and information for people with early onset dementia to enable them to remain active and engaged within their communities.
3. Improve identification and support for unpaid carers of all ages. Work with unpaid carers and partner agencies to promote the health and wellbeing of unpaid carers by giving them a break from their caring responsibilities, whilst allowing them to fulfil their caring role.	Green	The Unpaid Carer's Strategy has been implemented and we have funding through the Accelerating Reform Fund to develop pilot projects for Carer's Breaks and Identification of Unpaid Carers. We have a co-production group of people with lived experience and who are currently Carers, and the proposal for the Carer's Breaks service offer is being developed based on the input from the co-production group. The identification of carer's is being undertaken at the BOB Consortium level to take a joint approach across all 5 Local Authority areas.
4. We will work together to reduce the number of rough sleepers and improve their mental and physical health through improved access to local services.	Green	RBC has a dedicated Rough Sleeping Initiatives Team including a Rough Sleeping Initiatives Co-ordinator and Partnerships Officer and who commission all accommodation and support services for people that sleep rough. Services include a rough sleeping outreach service (managed by St Mungo's) and circa 250 supported accommodation units for this cohort (provided by Launchpad, St Mungo's, and The Salvation Army). Launchpad are one of our homelessness charity partners, and there are regular NHS Health Check sessions being provided for the people using their services every month. In Reading there are two other outreach teams working directly and specifically with those sleeping rough / who have formerly slept rough. These are the Health Outreach Liaison Team (HOLT) commissioned by the NHS and the Multiple Disadvantage Outreach Team (MDOT), commissioned by RBC Public Health.
5. Prevent, promote awareness, and provide support to people affected by domestic abuse in line with proposals outlined in the Domestic Abuse Bill.	Green	We continue to work closely with our Voluntary and Community Sector partners, Adult Social Care, Housing and Thames Valley Police to ensure safeguarding concerns are reported to enable action to be taken to support people at risk of domestic abuse, and a Tackling Domestic Abuse Strategy has been developed and implemented. Provision of appropriate safe environments to support people affected by domestic abuse. Local media campaigns to advertise the range of Domestic Abuse support available to both men and women using online resources such as the Reading Services Guide, local newspapers, Reading Borough Council's Facebook and Twitter networks. We provided a grant to Parents and Children Together (PACT) to support more victims of domestic abuse through expanding a pilot project with the Royal Berkshire Hospital (RBH). The pilot began in April 2023 to refer patients from all departments of the Hospital who they believe are experiencing domestic abuse to PACT's trauma-informed Alana House team who come to the hospital to provide in-person support. Quarterly reports are provided to the Reading Integration Board by PACT and since April 2024, the project has supported 32 Reading residents, provided 623 hours of keywork to those referred for support, and of the 16 service users receiving accommodation support: 3 moved to settled accommodation; 6 moved from unsafe to safe accommodation; 4 were supported to sustain their existing accommodation; and 3 went from homelessness to being accommodated.
6. Support people with learning disabilities through working with voluntary organisations in order to concentrate on issues that matter most to them.	Green	Reading is performing better than the England average for supporting people with a Learning Disability into employment. We continue to work closely with our Voluntary and Community Sector partners, some of whom are specialists in supporting people with Learning Disabilities. We have continued to fund a part-time Outreach worker post and have contributed to the Autism Strategy for Berkshire West. We also have the Compass Recovery College which provides free training and information for people with both low-level mental illness and long-term conditions affecting their mental health, including Learning Disabilities.

PRIORITY 3: Help families and children in early years, Implementation Plan narrative update

Action name	Status	Commentary (100-word max)
1. Increase the number of 2-year-olds (who experience disadvantage) accessing nursery places across Reading	Green	Sufficiency of places for children who are 2yrs old is sound and generally where there are families waiting, it is due to waiting for a preferred location rather than a space. There is a quality service offer for children who are waiting which is well used and offers preparatory support to children and their families in readiness for the place available when they accept it. Action – moved to Green.
2. Increase and develop the support available for children with SEND needs in early years (at home and accessing early years provision)	Green	Through the development of new SEND resources for schools' significant guidance on managing social and emotional ill health needs at ordinarily available (OAP at universal level) and in Graduated Responses (GR) to children with more significant needs in partnership between BFfC and ICB leaders. These resources were launched successfully in October 2024 and have been well received. HAF are now offering SEND specific activities for children and their siblings as part of this successful programme.
3. Promote availability of information for vulnerable families in Reading, including those with no recourse to public funds	Amber	There is regular liaison with the Family Information Service to ensure information is shared through FIS/SEND Local Offer and BFfC Comms team; and family help will work with partner agencies and RBC regarding any events where information can be shared further and in a community setting. FIS continues to be a highly effective, proactive service which can adapt its approach to meet the needs of specific cohorts as required. Training needs to be made available to the wider workforce/partnership that provides information on the legal framework, eligibility and support available for families with no recourse by end of 2025. Some of the Brighter Futures for Children workforce have received the training however not all; this is part of the Brighter Futures for Children training programme.

PRIORITY 4: Promote good mental health and wellbeing for all children and young people, Implementation Plan narrative update

Action name	Status	Commentary (100-word max)
1. Provide early intervention for children and young people with the right help and support at the right time	Amber	Our Mental Health Support Teams (MHSTs) and our Primary Mental Health Service, alongside our Educational Psychologists, continue to promote whole school approaches to mental health, and offer a range of training and workshops to nursery, school and college staff. Impact on outcome data and the feedback from children and young people demonstrates a positive experience of these services and improved outcomes for the children. MHST is now subject to a tender process across Berkshire West. Reading (BFfC) have led a shared tender proposal to BOB ICB to maintain and integrate MHST delivery being led by the Local Authorities and expand reach and effectiveness of the offer even further, through integration and economies of scale. We note the anxiety of school leaders about the tender process, recognising that Reading's MHST offer is highly effective in a regional and national context, and there is concern that a move of provider would reduce the effectiveness of the offer. The outcome of the tender will be clear on 1st May 25. We will update H&WBB at this point.
2. Support settings and communities in being trauma informed and using a restorative approach	Green	Through the development of new SEND resources for schools' significant guidance on managing social and emotional ill health needs at ordinarily available (OAP at universal level) and in Graduated Responses (GR) to children with more significant needs in partnership between BFfC and ICB leaders. These resources were launched successfully in October 2024 and have been well received.
3. Coproduction and collaboration with children and young people, families,	Green	Co-production continues to progress, and parents/caregivers and young people have been working closely with BFfC to co-produce the new guidance for schools and the wider system in the OAP and GR resources, which includes emotional health specific guidance for schools' staff, early years settings and the wider partnership. Co-production has included senior leaders for children's services in BFfC sitting alongside children, young people and

	communities and faith groups to shape future mental health services and in delivering transformation of mental health and emotional wellbeing services.		parents/carers to listen to their experiences, an EDI cultural humility approach has been taken to these conversations and associated child level audit activity. Reading has recently been highlighted as an area of national best practice for investment in, and the effectiveness of, coproduction by the government commissioned national review, led by Safe Lives. Reading education leaders will be contributing this good practice to a national webinar in Spring 2025
4.	Develop an easy to navigate local mental health and emotional wellbeing offer for children, young people, parents, carers and professionals/practitioners We will work together to reduce the number of rough sleepers and improve their mental and physical health through improved access to local services.	Amber	There is current early system consideration of whether a partnership emotional health triage system would be of benefit to Reading's children in line with national best practice, early scoping discussions are underway. Following Rapid Review learning there is an urgency to progress this area and additional resource will need to be identified to undertake this work. Design of the interagency EMH Triage arrangements has commenced and we have received good support from the voluntary sector and wider statutory partners in this co-design (see narrative above). Working towards June 2025 for readiness around target.
5.	Identify and provide services for targeted populations i.e. the most vulnerable children and young people to ensure equality of access to support and services	Green	The targeting of BFFC resources is currently subject to review, following the strategic system analysis associated with SEND developments. Proposals for the focussing of Primary Mental Health Team resource and capacity are currently out for consultation.
6.	Recovery after Covid-19/ adolescent mental health	Green	The initial impact of the EBSA team (funded until March 2024) demonstrates that of 39 young people (aged 11-16y) and 36 have returned to education, at an average cost of £6400 per child. MHST and Primary Mental Health Offers and wider Family Help have been updated to respond to post Covid emotional health needs. The children's attendance and mental health continues to be tracked for longitudinal impact. Further consideration is being given to embedding targeted EBSA advice in school surgeries, alongside activity to reduce the likelihood of suspensions and responding promptly to challenges with school attendance, through targeted support of the Educational Psychology Service, in close consultation with the Strategic Leads for Emotional Health & Well-Being and SEND in BFfC. Updates on this will be brought back to H&WBB.
7.	Local transformation plan	Green	In place and embedded in BOB ICB strategic planning

PRIORITY 5: Promote good mental health and wellbeing for all adults, Implementation Plan narrative update

Action name	Status	Commentary (100 word max)
1. Raise mental health awareness and promote wellbeing	Green	This action is now business as usual but there is more to do. The Public Health Communications contract with Blue Lozenge continues to have mental health and wellbeing and suicide prevention in the communication strategy for 2025. An upcoming example in the coming quarter will be Mental Health week in the month of May.
2. Address social factors that create risks to mental health and wellbeing, including social isolation and loneliness	Green	This action has become part of business as usual through the Reading Community Health Champions network and the Mental Health and Wellbeing Network. Further opportunity to establish a primary prevention approach to mental health and wellbeing is included in a proposal for the commissioning specifications for the mental health investment in Closing the Gap 2.
3. Focus targeted support on groups at greater risk of experiencing mental health challenges, loneliness and social isolation and health inequalities in order to support early identification and intervention	Green	This action falls within the scope of the Mental Health and Wellbeing Network's oversight of the implementation of priority 5. It has also become part of business as usual through the Reading Community Health Champions network. The Public Health team are working hard to establish a new operating model that will place the Community Health Champions network on a sustainable footing.
4. Foster more collaborative working across health, care and third sector services to recognise and address mental health support needs	Green	Collaboration is the basis of the Mental Health and Wellbeing Network's oversight function for the implementation of Health and Wellbeing Strategy Priority Area 5. The agenda for the quarterly meetings considers and plan effective collaboration between existing and newer partners.
5. Develop and support peer support initiatives, befriending and volunteer schemes, particularly recognising the impact of Covid-19 on smaller voluntary sector groups	Green	Work with smaller voluntary sector groups continues through the Reading Community Health Champions Network. Befriending and Volunteer schemes from part of the offer from partners across the Mental Health and Wellbeing Network.
6. Build the capacity and capability across the health and social care workforce to prevent mental health problems and promote good mental health	Green	This action is business as usual, progressed through the Mental Health and Wellbeing Network. Opportunities to invite new partners from the Voluntary Community and Social Enterprise sector are continually under discussion following the annual conference and workshop activities. The commissioning of Closing the Gap 2 includes a proposal to reallocate a significant proportion of the investment towards a public mental health approach that achieves a balanced approach between primary prevention and the support for those with mental illness and poor mental health and wellbeing.
7. Support people affected by Covid-19 with their mental wellbeing and associated loneliness and isolation	Green	This action has become part of business as usual through the Reading Community Health Champions network and the Mental Health and Wellbeing Network. Loneliness and isolation have been under consideration by a Mental Health and Wellbeing network task and finish group that has now concluded and will be taking findings to the next meeting of the Mental Health and Wellbeing Network.
8. Develop local metrics to measure progress linked to Reading Mental Health Needs Assessment	Amber	With the recent appointment of a permanent dedicated Senior Public Health Analyst for our small Public Health team in Reading the work to review and develop the Joint Strategic Needs Assessment can start in partnership with our colleagues in West Berkshire. The final draft of the mental health needs assessment is in the final stages of preparation, subject to capacity within the team. It is hoped that support for the new public health and wellbeing team operating model will be agreed in Q1 or Q2 of 2025/26.

APPENDIX B - KEY INDICATORS FOR EACH PRIORITY AREA

WHB Strategy 2021/30 Priority Name	Indicator Name (with link to the datasheet)	Data Source	Link to the data	Update frequency	Time periods
PRIORITY 1: Reduce the differences in health between different groups of people	1.1 Disease prevalence in all registered population, compared with prevalence in registered population in the most deprived areas (quintiles 1&2)	Frimley Local Insights (Connected Care)	Connected Care System Insights - Power BI	Monthly	December 2022, June 2023, October 2023
	1.2 Proportion of all registered patients who have had a health check, compared with the proportion of those who have had a health check in the most deprived areas (quintiles 1&2)	Frimley Local Insights (Connected Care)	Connected Care System Insights - Power BI	Quarterly	2022/23
	1.3 Proportion of current smokers in all population and in the most deprived (quintiles 1& 2)	Frimley Local Insights (Connected Care)	Connected Care System Insights - Power BI	Monthly	Oct-23
	1.4 Proportion of overweight and obese population in all areas and in the most deprived (quintiles 1 & 2)	Frimley Local Insights (Connected Care)	Connected Care System Insights - Power BI	Monthly	Oct-23
PRIORITY 2: Support individuals at high risk of bad health outcomes to live healthy lives	2.1 Inequality in life expectancy at birth by gender - Slope Index of Inequality (years)	OHID - Public Health Outcomes Framework	Public Health Outcomes Framework - OHID (phe.org.uk)	Annually	2010/12 to 2018/2020
	2.3 Dementia diagnosis rate in people aged 65+ as a percentage of those estimated to have dementia (%)	NHS Digital and OHID Fingertips	Primary Care Dementia Data - NHS Digital	Monthly	May 2021 to July 2023
	2.4 Number and rate of people sleeping rough (annual snapshot)	Department for Levelling Up, Housing and Communities	Tables on rough sleeping - GOV.UK (www.gov.uk)	Annually	2010 to 2022
	2.5 Proportion of supported working-age adults with learning disabilities in paid employment (%)	OHID Fingertips - Learning Disability Profiles	Learning Disability Profiles - Data - OHID (phe.org.uk)	Annually	2014/15 to 2019/2020
PRIORITY 3: Help families and children in early years	3.1 School readiness	Department for Education	https://explore-education-statistics.service.gov.uk/find-statistics/early-years-foundation-stage-profile-results/2021-22	Annually	2012/13 to 2021/22
	3.2 Hospital admissions caused by unintentional and deliberate injuries in children (0-4 years)	OHID - Child and Maternal Health	Public health profiles - OHID (phe.org.uk)	Annually	2021/22
	3.3 Proportion of children aged 2-2 1/2 yrs receiving ASQ-3 as part of the Healthy Child Programme or integrated review	OHID - Public Health Profiles	Public health profiles - OHID (phe.org.uk)	Annually	2015/16 to 2020/21
	3.4 Percentage of 2-year-olds achieving at least 'expected' in communication and language in the Early Years Foundation Stage Profile	Department for Education	Early years foundation stage profile results: 2018 to 2019 - GOV.UK (www.gov.uk)	Annually	2012 to 2022
	3.5 Proportion of take up of targeted 2 year old funding for eligible children	Early Years Team	The data can be requested from Rebecca Gisson (rebecca.gibson@brighterfuturesforchildren.org) or Lorna McGifford (Lorna.McGifford@brighterfuturesforchildren.org)	Term	Summer term 2019 to Summer term 2023
	3.6 Health Visiting (Antenatal numbers seen, New birth visits within 14 days, 6-8 weeks review uptake % with 8 weeks, 6-8 weeks breastfeeding % recorded, 6-8 weeks breastfeeding % at all, 1 year review uptake %, 15 months review uptake %, 2.5 years review uptake %)	Health Visitors	Berkshire West PH Hub - Home (sharepoint.com)	Quarterly	Q1 2020 to Q1 2023
PRIORITY 4: Promote good mental health and wellbeing for all children and young people	4.1 School pupils with social, emotional, and mental health needs	OHID - Public Health Profiles	Public health profiles - OHID (phe.org.uk)	Annually	2014 to 2021
	4.2 Children in care	OHID - Public Health Profiles	Public health profiles - OHID (phe.org.uk)	Annually	2011 to 2021
	4.3 Looked after children whose emotional well-being is a cause for concern	OHID - Public Health Profiles	Public health profiles - OHID (phe.org.uk)	Annually	2014-21
	4.4 Number of referrals to the Mental Health Service Team (MHST)	Brighter Futures for Children	The contacts for this data are: ross.locke@brighterfuturesforchildren.org or deborah.hunter@brighterfuturesforchildren.org	Quarterly	FY 2022/23 and Q1&4 2023/24
	4.5 Children and young people engaged with MHST who have moved toward their goals	Brighter Futures for Children	The contacts for this data are: ross.locke@brighterfuturesforchildren.org or deborah.hunter@brighterfuturesforchildren.org	Quarterly	FY 2022/23 and Q1&4 2023/24
	4.6 Percentage of children and young people working with the Primary Mental Health Team who have moved towards their goals	Brighter Futures for Children	The contacts for this data are: ross.locke@brighterfuturesforchildren.org or deborah.hunter@brighterfuturesforchildren.org	Quarterly	FY 2022/23 and Q1&4 2023/24
PRIORITY 5: Promote good mental health and wellbeing for all adults	5.1 Number of people diagnosed with SMI	Frimley Local Insights (Connected Care)	Connected Care System Insights - Power BI	Monthly*	2022/23
	5.2 Number of people diagnosed with depression	Frimley Local Insights (Connected Care)	Connected Care System Insights - Power BI	Monthly*	2022/23
	5.3 Number of drug and alcohol outreach support to the street homeless population	Intensive and Engaging Rough Sleeper Service (IAE)	The contact for this data is Sally Andersen (sally.andersen@reading.gov.uk)	Quarterly	Q1-Q4 2022/23
	5.4 Self-reported well-being (happiness/anxiety/satisfaction/worthwhile)	OHID - Common Mental Health Disorders	Common Mental Health Disorders - OHID (phe.org.uk)	Annually	2011 to 2022
	5.5 Loneliness: percentage of people who feel lonely often, always, or some of the time	OHID - Public Health Profiles	Public health profiles - OHID (phe.org.uk)	Annually	2019/20
	5.6 Gap in employment rate between those with a physical or mental health long-term condition (aged 16-64) and the overall employment rate Gap 2021/22 - percentage points	OHID - Public Health Profiles	Public health profiles - OHID (phe.org.uk)	Annually	2013/14 to 2021/22
	5.7 Fuel poverty (low-income low energy efficiency methodology)	OHID - Public Health Profiles	Public health profiles - OHID (phe.org.uk)	Annually	2019 to 2021
	5.8 Unemployment rate (% of working age population claiming out of work benefits)	OHID - Public Health Profiles	Public health profiles - OHID (phe.org.uk)	Annually	2021/22
	5.9 Adults in contact with secondary mental health services who live in stable and app	OHID - Public Health Profiles	Public health profiles - OHID (phe.org.uk)	Annually	2021/22

READING HEALTH AND WELLBEING BOARD

Date of Meeting	14 March 2025
Title	BCF Integration Update
Purpose of the report	To note the report for information
Report author	Beverley Nicholson
Job title	Integration Programme Manager
Organisation	RBC – Adult Social Care / BOB Integrated Care Board
Recommendations	1. That the performance in Quarter 3 against BCF Metrics 2024/25 is noted. 2. That the Health and Wellbeing Board note the BCF Quarter 3 return (2024/25) was formally submitted by the due date of 14th February 2025, following the Delegated Authority procedure.

1. Executive Summary

1.1 The purpose of this report is to provide an update on the Integration Programme and performance of Reading against the national Better Care Fund (BCF) targets. This report will show the position as at the end of December 2024 (Quarter 3), and also outline the spend against the BCF Plan, including the Discharge Fund to support hospital discharges in 2024/25.

1.2 The BCF metrics were agreed with system partners during the BCF Refresh Planning process for 2024-25.

a) The number of avoidable admissions (unplanned hospitalisation for chronic ambulatory care) The target for Q3 was no more than 176, per 100,000 population, **Met**
b) The number of emergency hospital admissions due to falls in people aged 65 and over, per 100,000 population. The target for Q3 was no more than 456, **Met**
c) An increase in the proportion of people discharged home using data on discharge to their usual place of residence. The target for Q3 was not less than 92.2% **Met** *(Note: this was met for the Quarter but not on track for the year. The current forecast is 91.9%)*
d) The number of older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population. The target for Q3 was no more than 140. **Not Met**

Details against each of these targets are outlined in Section 3 of this report along with examples of the collaborative work with system partners.

The report also covers the Better Care Fund (BCF) Quarter 3 return for 2024/25, attached at Appendix 1. The Quarter 3 return was signed off through the Delegated Authority process in advance of submission by the due date of 14th February 2025.

2. Policy Context

2.1. The Better Care Fund Policy Framework[1] and the Addendum to this policy for refreshed plans in 2024/25[2] set out the principles for the pooling of funds to support integrated working across health and social care, to ensure the right care is available to people at the right time. The Reading Integration Board (RIB) is responsible for leading and overseeing system working with Local Authority Adult Social Care and Housing, Acute and Community health providers, Primary Care, Integrated Care Board (ICB) Commissioners, Voluntary and Community Sector partners and Healthwatch, across Reading. The aim of the board is to facilitate partners and other interested stakeholders to agree and deliver a programme of work that promotes integrated working to achieve the national Better Care Fund (BCF) performance targets, as set out in sections 1.2 and 3.0 of this paper.

3. Performance Update for Better Care Fund and the Integration Programme

3.1. Performance as at the end of Quarter 3, 2024/25

3.1.1 Admission Avoidance

This measure aims to show a reduction in avoidable admissions (unplanned hospitalisation for chronic ambulatory care sensitive conditions). This measures how many people with specific long-term conditions, which should not normally require hospitalisation if their conditions were well managed, were admitted to hospital in an emergency. These conditions include, for example, diabetes, epilepsy and hypertension.

Our target for 2024/25 is to have no more than 753 admissions, per 100,000 population, for the year. The target for Q3 was no more than 176, per 100,000 population. The actual performance was 156.9 Targets for 2024/25 were set by reviewing the performance in 2023/24, when we met the target for that year by a small margin and our Urgent and Emergency Care Board, in their health capacity and demand planning, predicted a 2.3% increase in non-elective admissions for 2024/25 which we applied to our actuals from last year. We then applied a 1% reduction to set this target, as the BCF Planning Guidance requires a “stretching target” for plans to be agreed. We believe this is a stretching target given the increasing complexity we are seeing in hospital discharges.

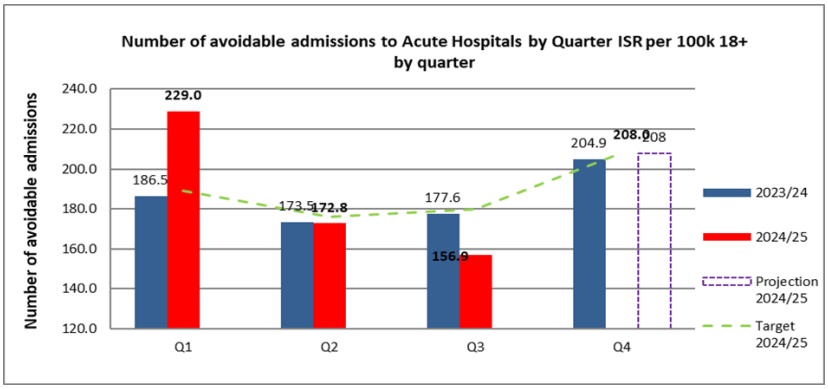
Analysis of the reported data shows that the top three conditions that people are admitted for are Chronic Obstructive Pulmonary Disease (COPD), Asthma and Heart Failure. We have a working group actively reviewing communications over the Winter period to ensure people are reminded to have their annual reviews with their GP and know what to look for in the early stages of their condition worsening, and take early action. The ICB have also issued risk stratification guidelines to GPs to enable early identification of any worsening COPD symptoms.

We continue to work with our public health, system partners and operational teams to reduce the number of admissions, and have the Community Wellness Outreach project running which provides Health Checks, with a particular focus on people who are at risk of poor health outcomes, and ensuring follow up with GPs where there are particular concerns raised during the check, that need to be addressed urgently.

[1] https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025

[2] Addendum to the 2023 to 2025 Better Care Fund policy framework and planning requirements - GOV.UK (www.gov.uk)

Number of Unplanned hospitalisations for chronic ambulatory care sensitive conditions per 100,000 population - 18+, Acute hospitals	
Annual Target for 2024/25 (no more than)	753
Target performance for Quarter 3 (2024/25) (no more than)	176
Actual performance in Quarter 3 (2024/25)	156.9
Actual annual performance to date (2024/25)	559
Status	Green



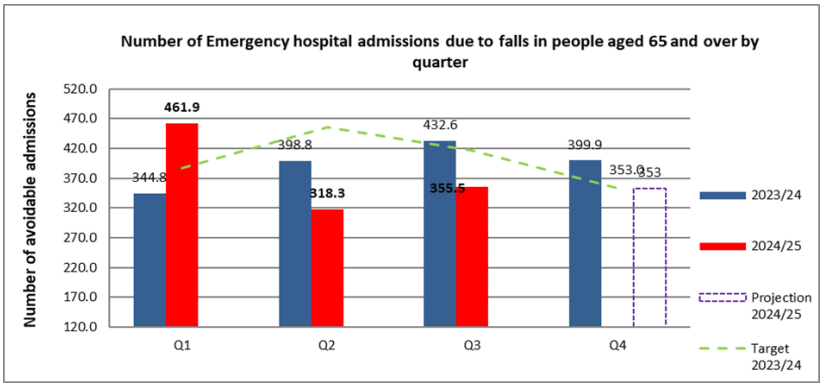
Note: *As data is refreshed retrospectively, i.e. reported admissions are flagged at discharge date, the position reported here may change as some people are admitted but not discharged within the quarter, and for this reason we are using data one month after the end of the quarter to calculate the position for the risk share claims from the BCF.*

3.1.2 Falls

This metric is in relation to emergency hospital admissions due to falls in people aged 65 and over. The target for 2024/25 is to have no more than 1,612 per 100,000. The performance as at the end of December 2024 was 1,136, and this is still significantly lower than performance in the same period in the previous year. We performed well against this target in 2023/24, and significantly below the average 3 year maximum that had been set. It was noted that the 65+ population figure being used on the planning template was not using ONS datasets and had been static since 2021/22 and yet our 65+ population has been increasing, so we changed the population figure to match the 65+ population used for Long Term Admissions to Residential/Nursing care which also focuses on this group. This change showed a 4% increase in the population of 65+ from the original figure that had been used as a denominator (i.e., 21,100). The target equates to a 2% reduction on actual performance in 2023/24 accounting for the adjustment in population figures.

We continue to provide Technology Enabled Care equipment that could be installed/worn to build confidence and ensure early alerts for people who are frail or at risk of falls. A diagnostic review of falls was undertaken and the findings presented to the Reading Integration Board in November to inform further development of the falls service in Reading. An addendum will be included in the report for Health and Wellbeing Board in March to share the highlights of the review.

Number of Emergency hospital admissions due to falls in people aged 65+ per 100,000 population. Directly Standardised Rate (DSR)	
Annual Target for 2024/25 (no more than)	1,612
Target performance quarter 3 (no more than)	456
Actual performance in Quarter 3 (2024/25)	356
Actual annual performance to date (2024/25)	1,136
Status	Green



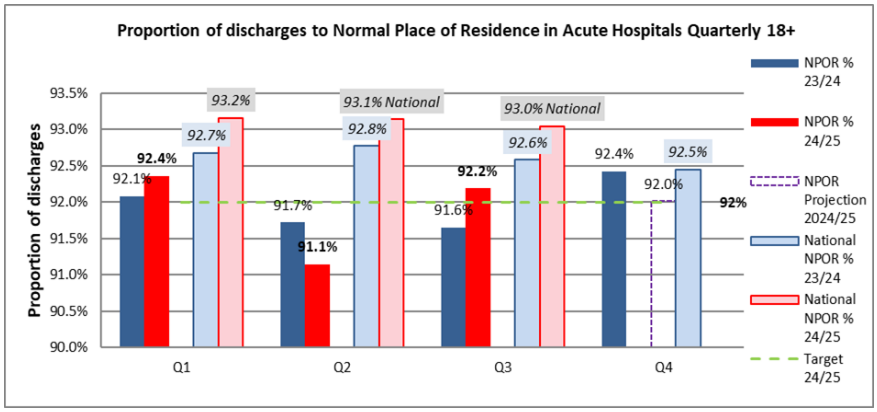
***Note**: This data is subject to change because updates are made to the dataset retrospectively when people are discharged from hospital, not on admission and this can span over two quarters.*

3.1.3 Discharge to Normal Place of Residence

This aims to increase the proportion of people who are discharged directly home, from acute hospitals with a target of not less than 92.2% per quarter. This is based on hospital data for people "discharged to their normal place of residence". Performance in Quarter 3 has improved, with the quarterly target being met but the annual performance to date is slightly below the annual target and remains below the national average by 0.8% for this metric. The target for this metric was maintained at the same rate as last year, as we did not meet the target in 2023/24 missing it by just 0.2%. Given the increasing complexities we have seen in hospital discharges it was agreed that we should maintain this target at the same level as in the original 2023/25 plan, which would constitute a stretching target.

There is an impact on this metric of the numbers of people being admitted to residential/nursing homes (see 3.1.4) for their long term care. We continue to work with the multi-disciplinary team and the hospital discharge hub, to follow the ethos of "Home First", in line with the Hospital Discharge Policy with support from domiciliary care and, if needed, through the use of TEC / equipment that can be installed to support independent living, and reablement.

Proportion of discharges to Normal Place of Residence in Acute Hospitals 18+, per month	
Annual Target for 2024/25 (no less than)	92.2%
Target performance per quarter (not less than)	92.2%
Actual performance in Quarter 3 (2024/25)	92.2%
Actual annual performance to date (2024/25)	91.9%
Status	Green



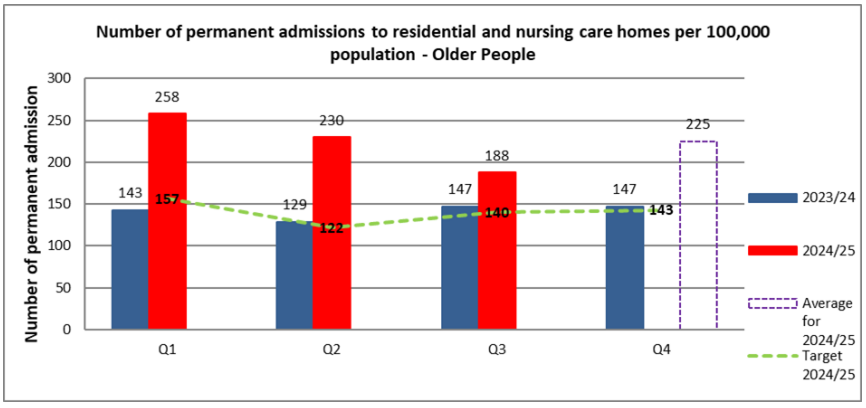
3.1.4 Permanent Admissions to Residential/Care Homes

This aims to reduce the number of older adults (65+) whose long-term care needs are met by admission to residential or nursing care per 100,000 population with a maximum target of 562 admissions for the year. We had a 31% increase in permanent admissions in 2023/24, compared to the plan with over 66% of those admissions being into Dementia Care beds. We have taken our actuals for 2023/24, applied the population increase from 2023/24 to 2024/25, and then applied a 1% reduction to reach the target for 2024/25, which was a challenging target, given the rising population of over 65s with increasing complexity of needs.

The target for quarter 3 was no more than 140 people per 100,000 and the actual rate for the quarter was 188, 34% higher than the target for the quarter.

We know that 49% of admissions were primarily for dementia beds, which is significantly lower than in 2023/24 (66%). We continue to work with our system partners to identify appropriate care for people to meet their needs and are aware of the work being undertaken by Buckinghamshire, Oxfordshire, Berkshire West (BOB) to develop a Dementia Strategy, which will also inform our specialist discharge pathways. We have a multi-disciplinary working group looking at the admissions to care homes and identifying any actions that can be taken to improve outcomes.

Quarterly Number of permanent admissions to residential and nursing care homes per 100,000 population - Older People	
Annual Target for 2024/25 (no more than)	562
Quarterly Target for Quarter 3 (not more than)	140
Actual performance in Quarter 3 (2024/25)	188
Actual annual performance to date (2024/25)	675
Status	Red



4. Contribution to Reading's Health and Wellbeing Strategic Aims

4.1. Our contribution to the overall direction of the Berkshire West Joint Health & Wellbeing Strategy 2021-30. Priority areas:

1. Reduce the differences in health between different groups of people
2. Support individuals at high risk of bad health outcomes to live healthy lives
3. Help children and families in early years
4. Promote good mental health and wellbeing for all children and young people
5. Promote good mental health and wellbeing for all adults

4.2. Reading Integration Board (RIB) are leading on delivery against priorities 1 and 2 for Reading. Action plans have been developed in collaboration with the members of RIB,

which includes representation from system partners, including Acute Hospital, Primary Care and Voluntary and Community Sector. Delivery against the action plans involves a collaborative approach, supported by the membership of the Integration Board. The action plans were reviewed by the RIB membership in June 2024/25, against the 10-year strategy and have been updated, reflecting the positive progress to date in reducing difference in health and supporting people at risk of poor health outcomes.

4.3. In working to address priorities 1 and 2, grant funding is provided through the Better Care Fund to Voluntary and Community sector organisations for projects that support us in addressing these priorities. We are spotlighting the projects at each RIB meeting and have seen some great outcomes. One of the projects presented to RIB for Quarter 3 was the Parish Nurse Project with Reading Gateway Church, a service which combats loneliness, improving the health and wellbeing of individuals, supporting those with mental health issues by providing health advice, signposting to additional assistance and combatting hoarding. The demand for this service has been increasing, and referrals to the Parish Nurse Service have a two week wait for the first contact at this time.The team shared these case studies showing the difference made by having this support.

4.3.1 **Case Study 1:**

X is a gentleman, who lives alone . He has support from his family. X was referred through a family friend. X was very poorly on initial assessment he didn't like to bother his GP or any services . He was having constant falls and was suffering from other un-diagnosed ailments. On initial assessment X was very suspicious and unwilling to engage. With further follow up visits and being able to build up trust we were able to put measures in place to help X remain in his own home. A personal alarm was fitted , joint visits with the OT were undertaken and referrals were made to his GP and conditions treated. The welfare unit at the fire service were also contacted to arrange a welfare and fire assessment visit. Support was given to the family with advice and choices made available . Ongoing support continues with this gentleman, and he has been able to remain in his own home with the appropriate support in place.

4.3.2 **Case Study 2:**

K is an elderly gentleman who lives on his own and was referred to us from the social prescribing team . K has multiple physical problems and was attending his GP on numerous occasions. At an Initial home visit K was a wary and wasn't too keen . With further follow ups we began to establish a relationship and trust was formed . K was very lonely but had social anxiety so found it very difficult to access any groups or social events. We were able to encourage him to attend the coffee morning initially as it was quiet, and I met him at the door making him feel welcome . K then expressed an interest in our therapy garden and came along to do a bit of weeding! He enjoyed the company of other males and the provision of a hot free lunch . We continue to support K.

4.3.3 **Case Study 3:**

Z Was referred to our services from RBC Social workers. This lady lived alone in assisted living accommodation . She had a terminal illness and her daughter thought that she needed support and wasn't happy with the current engagement . On initial visit the lady was very sceptical of us and didn't want to engage . During the visit we were able to break down the barriers and the stigma of health services and the church. We were able to ascertain that she needed spiritual health intervention as well as physical and emotional help. She was referred for a home visit to the GP and we were able to pray with this lady and her daughter. Both were extremely grateful and felt they were being listened to and cared for in a holistic way. On subsequent visits with a PN assistant I was able to support the patient whilst the assistant was able to take the daughter/ carer for a coffee and spend time with her, offering support and a chance to chat .We continued to support these 2 lovely ladies until sadly Z passed away . On Her final days she was able to say how the peace she had received from our visits had enabled her to enjoy the last few weeks and she was no longer in turmoil . We still continue to support the daughter.

4.4. We are also delivering against Priority 2: identifying people at risk of poor health outcomes, through our Community Wellness Outreach project, which is reaching into communities where there are higher levels of deprivation, and where there are larger numbers of people from ethnically diverse backgrounds that are more at risk of developing conditions that can lead to cardiovascular disease, such as hypertension and diabetes. The project is funded from the Integrated Care Board (ICB) Inequalities Fund, which has been pooled into our Section 75 Framework Agreement for the Better Care Fund, and is funded to the end of June 2025. The service is being delivered by the Meet PEET Nurses from the Royal Berkshire hospital and supported by Reading Voluntary Action to co-ordinate venues, enable appointments to be booked and provide social prescribing services. A separate presentation on outcomes from these checks to date has been provided for the Board.

4.5. The Reading Integration Board (RIB) Programme Plan objectives are mapped to both the Health and Wellbeing Board strategic priorities, as listed in 4.1 above. Links with the strategic priorities of the Berkshire West Health and Care Partnership are also identified and a number of joint programmes of work are underway. The ICB provides a monthly update report including information on partnership priorities which are currently as follows:

- Future models of care (with links to RBFT New Hospital Programme)
- Integrated neighbourhood team development
- Same day access
- Community wellness outreach programme
- SEND
- Therapies Review
- Children and Young People's Mental Health – Mental Health Support Teams in schools

5. Environmental and Climate Implications

5.1. The Council declared a Climate Emergency at its meeting on 26 February 2019 (Minute 48 refers).

5.2. No new services are being proposed or implemented that would impact the climate or environment, however, climate implications are being considered in relation to the wider context of the Health and Wellbeing Board Strategic Priority Action Plans, and the potential impact on avoidable admissions, particularly those related to respiratory conditions as we move into the Winter period.

6. Community Engagement

6.1. Engagement in relation to specific services takes place, such as feedback on customer satisfaction for services such as Reablement. Stakeholder engagement continues to be a key factor in effective integrated models of care, and engagement with all system partners is important to the Reading Integration Board. The Service User feedback forms submitted by people using the Community Reablement Team, indicate 100% satisfaction rates with the service. We have also held co-production sessions with Carer's to support us in shaping a Carer's breaks and respite service, funded through the Accelerating Reform Fund, and feedback from people engaged has been very positive.

6.2. Reading Adult Social Care have recruited a co-production lead and setup a Working Together Group of service users, carers and self-funders. This will help ensure that services are co-designed with service users, carers and families as much as possible, and feedback on user experiences will be gathered.

7. Equality Implications

7.1. Under the Equality Act 2010, Section 149, a public authority must, in the exercise of its functions, have due regard to the need to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

7.2. There are no new proposals or services recommended in this report that would impact negatively on anyone with protected characteristics. We continue to monitor equality data to ensure people are not adversely affected.

8. Other Relevant Considerations

8.1. The Better Care Fund Planning and Performance reporting included in this report requires us to adhere to the Better Care Fund Framework 2023/25 four National Conditions and the Better Care Fund Objectives:

- National Condition 1: Plans to be jointly agreed.
- National Condition 2: Enabling people to stay well, safe and independent at home for longer.
- National condition 3: Provide the right care in the right place at the right time.
- National Condition 4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services.

BCF Objective 1: Enabling people to stay well, safe and independent at home for longer.
BCF Objective 2: Provide the right care in the right place at the right time.

8.2. Confirmation was received from the National Better Care Fund Team on 21st August 2024, that our refreshed BCF Plan for 2024/25 was accepted.

9. Legal Implications

9.1. Compliance with the Better Care Fund (BCF) 2023/25 National Conditions has been confirmed in the BCF Quarter 3 return.

10. Financial Implications

10.1. **BCF 2024/25 Expenditure to date against the Plan**
Budgets are aligned to the refreshed Better Care Fund plan for 2024/25. Whilst there is an underspend currently showing against 2024/25, this funding has been committed to projects that are continuing into 2025/26. The budgets are reviewed on a monthly basis at the Reading Integration Board, to ensure we report any slippage in schemes. **Note:** The budget sheet as at end December reported spend as £15,628,509 *(see table below)* 76%, with projects that will be running in 2025/26 carrying forward funding as agreed with the ICB at the Reading Integration Board.

RIB Summary Report at P9	Original Budget £k	YTD Budget as at 31/12 £k	YTD as at 31/12 (Actuals) £k	Forecast to 31/03/25 £k	Variance £k
Reading Borough Council Hosted Schemes	12,177,724	9,133,293	9,031,928	12,077,503	-100,221
BOB Integrated Care Board	1,795,924	1,346,943	1,346,943	1,795,924	0
Cross BOB ICB Hosted Schemes	3,483,173	2,612,380	2,612,380	3,483,174	0
ICB Portion of Adult Social Care Discharge Fund passported to Reading (Qtr3 data)	629,170	314,585	490,336	629,170	0
LA Adult Social Care Discharge Fund (Qtr3 data)	1,473,618	736,809	1,313,063	1,473,618	0
23/24 Under Spend	1,572,812		833,859	1,111,812	-461,000
Total	**21,132,421**	**14,144,010**	**15,628,509**	**20,571,201**	**-561,221**

10.2. **BCF Return Q3 - Expenditure**
2024/25 is the second year of a two-year Better Care Fund (BCF) plan and expenditure in is as per our original submission with minor adjustments to increase the allocation in areas of greatest need and reduce in other areas based on actual spend in the previous year. The Quarter 3 BCF return (Appendix 1) shows expenditure as at the end of December 2024.

10.3. **Section 75 Framework Agreement**
The Section 75 Framework Agreement, covering the BCF planned expenditure from the Integrated Care Board (ICB) and Reading Borough Council, was signed and sealed on 8th January 2025.

11. Timetable for BCF Reporting

11.1. The Quarter 3 BCF return, covering the period from 1st October 2024 to 31st December 2024, was submitted on 14th February 2025, following the Delegated Authority procedure and ICB agreement. The final End of Year (EOY) return will be prepared for submission in line with the updated BCF reporting schedule:

Task/Activity/Milestone description	Start Date	End Date	Submission Dates
Q1 Report Template completion period	29/07/24	29/08/24	
Q1 Report Submission			**29/08/24**
Q1 National and Regional Assurance Period	01/09/24	30/09/24	
Q2 Reporting Template Completion Period	16/09/24	31/10/24	
Q2 Report Submission			**31/10/24**
Q2 National and Regional Assurance Period	01/11/24	30/11/24	
Q3 Reporting Template Completion Period	16/12/24	14/02/25	
Q3 Report Submission			**14/02/25**
Q3 National and Regional Assurance Period	01/02/25	28/02/25	
Q4 EOY Return Completion Period	04/04/25	30/05/25	
Q4 EOY Submission			**30/05/25**

Background Papers

The BCF performance data included in this report is drawn from the Reading Integration Board Dashboard – January 2025 *(Reporting up to 31st December 2024).*

Appendices

1. Reading BCF Quarter 3 Return (2024/25)

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Appendix 1

HM Government

NHS England

Better Care Fund 2024-25 Q3 Reporting Template

2. Cover

Version 1.0

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will be published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Reading
Completed by:	Beverley Nicholson
E-mail:	beverley.nicholson@reading.gov.uk
Contact number:	0118 937 3643
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes
If no, please indicate when the report is expected to be signed off:	

Checklist

Complete:
Yes
Yes
Yes
Yes
Yes
Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'.

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5.1 C&D Guidance & Assumptions	Yes
5.2 C&D H1 Actual Activity	Yes
6b. Expenditure	Yes

For further guidance on requirements please refer back to guidance sheet - tab 1.

<< Link to the Guidance sheet

Better Care Fund 2024-25 Q3 Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Reading

		Checklist Complete:
Has the section 75 agreement for your BCF plan been finalised and signed off?	Yes	Yes
If it has not been signed off, please provide the date section 75 agreement expected to be signed off		Yes
If a section 75 agreement has not been agreed please outline outstanding actions in agreeing this.		Yes

Confirmation of Nation Conditions

National Condition	Confirmation	If the answer is "No" please provide an explanation as to why the condition was not met in the quarter and mitigating actions underway to support compliance with the condition:	
1) Jointly agreed plan	Yes		Yes
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes		Yes
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes		Yes
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes		Yes

Better Care Fund 2024-25 Q3 Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Reading

National data may be unavailable at the time of reporting. As such, please utilise data that may only be available system-wide and other local intelligence.

Metric	Definition	For information - Your planned performance as reported in 2024-25 planning				For information - actual performance for Q2 (For Q3 data,please refer to data pack on BCX)	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs *Please: - describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans - **ensure that if you have selected 'data not available to assess progress' that this is addressed in this section of your plan***	Achievements - including where BCF funding is supporting improvements. *Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics*	Variance from plan *Please ensure that this section is completed where you have indicated that this metric is not on track to meet target outlining the reason for variance from plan*	Mitigation for recovery *Please ensure that this section is completed where a) Data is not available to assess progress b) Not on track to meet target with actions to recovery position against plan*	
		Q1	Q2	Q3	Q4							
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	189.0	176.0	180.0	208.0	172.1	On track to meet target	The prevalence of the conditions that lead to hospitalisation and ensuring communications are targeted at the right people to reduce likelihood of admission. The Community Health Champions programme is coming to an end as it was funded through Covid recovery funding and there is no additional funding to sustain this service.	We have had 559 admissions per 100,000 population as at the end of December 2024, and our current projections to the end of March 2025 are 745 against a maximum of 753. We have shared the more detailed information about the top 3 conditions with our Integration Board members, including Public Health and have noted the Public Health announcements on commercial radio stations with regard to increased risk (2 x more likely to be admitted to hospital) for these conditions, in particular Asthma and Chronic Obstructive Pulmonary Disease (COPD) and how to manage these to avoid admission.	Not Applicable	Not Applicable	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	92.6%	92.1%	92.2%	92.0%	91.2%	Not on track to meet target	Our Hospital Discharge Teams and the Discharge Hub look to achieve a "Home First" approach but there has been a significant and continued increase in the number of admissions to Long Term Nursing or Residential Care, which has impacted on this target.	We work closely with care providers and the voluntary and community sector to enable a discharge home wherever possible.	Our performance for the year as at the end of December was 91.9%, which puts us just below the minimum target of 92.2% for the year.	Not Applicable	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				1,612.2	318.6	On track to meet target	Funding falls prevention services e.g. Reconditioning Programme, in the interim whilst the Falls Prevention Lead is recruited. Funding via Public Health Grant for these services has ended and we are looking at options to partially fund through the Falls project funding allocation from the BCF, which will require senior level sign off.	As at the end of December 2025, there had been 1,136 admissions due to falls, per 100,000 population (65+), against a maximum target of 1,612, and a projection of 1,514 to the end of the year. We completed a Falls Diagnostic piece of work, which was presented to the Reading Integration Board in November and are now moving onto Phase 2 of the Falls project, to recruite a Falls Prevention Lead, which we expect to be completed in Quarter 4.	Not Applicable	Not Applicable	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				562	not applicable	Not on track to meet target	Our admissions to Nursing/Residential homes for Long Term Care needs to be met have exceeded our maximum target for the year as at the end of December, with 675 admissions per 100,00 population (65+) against a maximum target of 562, and our current projecttions to year end are 900, almost twice the target set.	Our hospital discharge team are ensuring effective triage on discharges where the hospital discharge hub have advised a Pathway 3 discharge is required. Our local hospital have also started a project to review the potential "overprescription" of care on discharge.	The average age of admissions is 80+, and cases are now very complex with extensive needs to be met. We currently have no opportunity to compare these increases with other areas to know if we are an outlier or if this level of demand is also increasing in other areas. Whilst we have received anecdotal confirmation that there are these same pressures in other areas in our region, we do not have the data to compare at this stage.	Not Applicable	Yes

Better Care Fund 2024-25 Q3 Reporting Template

5. Capacity & Demand

Selected Health and Wellbeing Board: Reading

5.1 Assumptions

	Checklist
1. How have your estimates for capacity and demand changed since the last reporting period? Please describe how you are building on your learning across the year where any changes were needed.	
We have noticed longer waits for discharge on Pathway 0 and have recommissioned a Hospital to Home service from the Voluntary and Community Sector to support people who may be vulnerable but do not have care needs, to support their discharge, checking that they have food, prescriptions, heating etc., alongside advice and signposting to other support if needed. The new service is starting from 1st February 2025. Pathway 1 discharge average waits have also increased from 1.6 days in Q2 to 2.7 days. The recent community bed audit actions are ongoing to maximise utilisation of community beds to support a reduction in the length of wait on Discharge Ready lists through the winter period.	Yes
2. Do you have any capacity concerns for Q4? Please consider both your community capacity and hospital discharge capacity.	
Gaps in Urgent Community Response (UCR) capacity vs demand and the continued impact of this continues to be flagged to Executive Board and next steps are being considered as part of the Buckinghamshire, Oxfordshire, Berkshire West (BOB) Integrated Care Board's (ICB) financial planning process. As a result of changes to BCF funding streams, an interim mitigation was agreed by the Urgent and Emergency Care (UEC) Place Director to reprioritise some of the UEC funding that Berkshire Health Foundation Trust (BHFT) receive to cover medical/therapy weekend provision at community hospitals, to cover the gap in UCR for the remainder of this financial year. Whilst demand for UCR does still exceed capacity, effective triaging is in place to enable redirection where required. Community and acute colleagues continue to work closely with the South Central Ambulance Services (SCAS) and GP partners to maximise use of all Single Point of Access pathways so as to ensure all alternative pathways to admission are being used. A system meeting is being arranged to explore ongoing use of UEC funding or other options to mitigate the gap and avoid a reduction in capacity with wider risks for the system.	Yes
3. Where actual demand exceeds capacity, what is your approach to ensuring that people are supported to avoid admission or to enable discharge? Please describe how this improves on your approach for the last reporting period.	
Focus in Q3 has predominantly been on gearing up for winter pressures and ensuring maximised use of admission avoidance services to support system resilience. This included launching our Same Day Urgent Access pilot on 1 Oct, supporting utilisation and growth of Single Point of Access routes and bolstering OOH and discharge staffing capacity to mitigate the increased volumes over winter. Key programme updates this quarter: 5.3.1. Same Day Urgent Access – pilot GP streaming service co-located on acute hospital site began on 1 Oct triaging minor illness patients from Emergency Department (ED) front door. This aims to reduce Type 1 ED attendances, reduce overcrowding in ED and ensure more patients are being seen appropriately. Service volume has increased by 20% since the service began and as it becomes more established. Discussions are ongoing for next steps from April 2025 in terms of extension and expansion of the pilot. 5.3.2. Admission avoidance workshop - plans for a Berkshire West Urgent and Emergency Care (UEC) workshop at the end of Feb-25 are in progress. Workshop will focus on reviewing current admission avoidance services available across Berkshire West and identifying gaps/ areas to prioritise and refresh as we head into 2025-26. Outputs from the workshop will form the basis of the UEC Programme Board's work programme for 2025-26.	Yes
4. Do you have any specific support needs to raise for Q4? Please consider any priorities for planning readiness for 25/26.	
The impact of Better Care Funding remaining the same in 2025/26 is a concern given the rising costs of care in the community and impact on resourcing, as outlined under section 2 on this page. Complexity of needs has continued to rise with admissions to nursing/residential for long term care having exceeded our annual target by December. The targets were set based on actual admissions in 2023/24 and the demand has been significantly exceeded. We need to be able to compare with other LA areas to see if we are an outlier or if this is an increasing trend. The average age of people being admitted for Long Term care is 80+	Yes

Better Care Fund 2024-25 Q3 Reporting Template

5. Capacity & Demand

Selected Health and Wellbeing Board: Reading

Actual activity - Hospital Discharge		Prepopulated demand from 2024-25 plan			Actual activity (not including spot purchased capacity)			Actual activity through only spot purchasing (doesn't apply to time to service)			
Service Area	**Metric**	**Oct-24**	**Nov-24**	**Dec-24**	**Oct-24**	**Nov-24**	**Dec-24**	**Oct-24**	**Nov-24**	**Dec-24**	
Reablement & Rehabilitation at home (pathway 1)	Monthly activity. Number of new clients	127	121	107	42	55	59	0	0	0	Yes
Reablement & Rehabilitation at home (pathway 1)	Actual average time from referral to commencement of service (days). All	4.7	2.6	2.6	2.3	1.9	4				Yes
Short term domiciliary care (pathway 1)	Monthly activity. Number of new clients	31	20	24	24	26	28	0	0	0	Yes
Short term domiciliary care (pathway 1)	Actual average time from referral to commencement of service (days) All	2	2	2	4.6	3.7	3				Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly activity. Number of new clients	33	26	29	34	35	26	0	0	0	Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Actual average time from referral to commencement of service (days) All	1.4	2.2	1.7	1	2	4				Yes
Other short term bedded care (pathway 2)	Monthly activity. Number of new clients.	6	4	5	0	0	0	0	0	0	Yes
Other short term bedded care (pathway 2)	Actual average time from referral to commencement of service (days) All	1.4	2.2	1.7	0	0	0				Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly activity. Number of new clients	16	15	15	6	10	5	0	0	0	Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	29.3	15.9	19.9	10	21	16				Yes

Actual activity - Community		Prepopulated demand from 2024-25 plan			Actual activity:			
Service Area	**Metric**	**Oct-24**	**Nov-24**	**Dec-24**	**Oct-24**	**Nov-24**	**Dec-24**	
Social support (including VCS)	Monthly activity. Number of new clients.	15	16	12	0	0	0	Yes
Urgent Community Response	Monthly activity. Number of new clients.	157	152	179	122	138	140	Yes
Reablement & Rehabilitation at home	Monthly activity. Number of new clients.	140	163	142	90	68	66	Yes
Reablement & Rehabilitation in a bedded setting	Monthly activity. Number of new clients.	41	38	43	41	36	26	Yes
Other short-term social care	Monthly activity. Number of new clients.	3	4	5	1	1	2	Yes

Better Care Fund 2024-25 Q3 Reporting Template

To Add New Schemes

6. Expenditure

Selected Health and Wellbeing Board: Reading

Running Balances	2024-25 Income	Expenditure to date	Percentage spent	Balance
DFG	£1,306,000	£979,500	75.00%	£326,500
Minimum NHS Contribution	£13,153,195	£9,662,898	73.46%	£3,490,297
iBCF	£2,692,624	£2,019,468	75.00%	£673,156
Additional LA Contribution	£1,468,920	£1,145,686	78.00%	£323,234
Additional NHS Contribution	£0	£0		£0
Local Authority Discharge Funding	£629,170	£490,336	77.93%	£138,834
ICB Discharge Funding	£1,473,618	£1,313,063	89.10%	£160,555
Total	**£20,723,527**	**£15,610,951**	**75.33%**	**£5,112,576**

Comments if income changed
Update to LA Contribution based on adjustments of c/fwd funding, as set out in S75 Schedule 1. £1,572,812, after final Year End adjustments, so total income adjusted to £21,132,421.

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2024-25 Minimum Required Spend	Expenditure to date	Balance
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£3,468,488	£3,893,759	£0
Adult Social Care services spend from the minimum ICB allocations	£6,624,884	£5,496,200	£1,128,684

Checklist Column complete: Yes Yes

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Planned Outputs for 2024-25**	Outputs delivered to date (Number or NA if no plan)	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	New/ Existing Scheme	Previously entered Expenditure for 2024-25 (£)	Expenditure to date (£)	Comments
1	Short Term / Hospital Discharge Team	Local Authority Social Work and Occupational Therapy	Care Act Implementation Related Duties	Other	Hospital Discharge Support Team	1441	1,080.75		Social Care	0	LA			Local Authority	Minimum NHS Contribution	Social Care	£ 2,030,421	£1,519,725	Updated planned expenditure £2,026,300
2	Reablement	Reablement & Rehabilitation Services	Home-based intermediate care services	Reablement at home (to support discharge)		800	619	Packages	Social Care	0	LA			Local Authority	Minimum NHS Contribution	Social Care	£ 2,081,500	£1,561,125	
3	Step Down Beds - Discharge to Assess	Step Down Beds - Discharge to Assess	Bed based intermediate Care Services (Reablement, rehabilitation, wider short term services	Bed-based intermediate care with rehabilitation (to support discharge)		24	5	Number of placements	Social Care	0	LA			Local Authority	Minimum NHS Contribution	Social Care	£ 301,872	£255,750	Updated planned expenditure £341,000. Longer lengths of stay, average 50.8 weeks due to complex issues to move on to accommodate long term needs.
4	Step Down Beds - Discharge to Assess	Step Down Beds - Discharge to Assess	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		8	6	Number of placements	Social Care	0	LA			Local Authority	Minimum NHS Contribution	Social Care	£ 87,428	£65,475	Updated planned expenditure £87,300
5	Care Packages - Mental Health	Personalised Care at Home	Personalised Care at Home	Mental health /wellbeing		200	150		Social Care	0	LA			Private Sector	Minimum NHS Contribution	Social Care	£ 139,800	£104,850	
6	Care Packages - Physical Support	Personalised Care at Home	Personalised Care at Home	Physical health/wellbeing		589	442		Social Care	0	LA			Private Sector	Minimum NHS Contribution	Social Care	£ 854,100	£640,575	
7	Care Packages - Memory and Cognition	Personalised Care at Home	Personalised Care at Home	Other	Memory and Cognition	222	167		Social Care	0	LA			Private Sector	Minimum NHS Contribution	Social Care	£ 538,100	£403,575	
8	TEC Equipment	TEC equipment	Assistive Technologies and Equipment	Assistive technologies including telecare		1200	900	Number of beneficiaries	Community Health	0	LA			Private Sector	Minimum NHS Contribution	Community Health	£ 214,500	£160,875	
9	Carers Funding - Grants, Voluntary	Carers Services	Carers Services	Respite services		60	45	Beneficiaries	Social Care	0	LA			Charity / Voluntary Sector	Minimum NHS Contribution	Social Care	£ 202,000	£151,500	
10	Carers Funding - Grants, Voluntary	Carers Services	Carers Services	Respite services		200	150	Beneficiaries	Social Care	0	LA			Charity / Voluntary Sector	Additional LA Contribution	Social Care	£ 305,000	£228,750	

Checklist		Column complete:					Yes											Yes	
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Planned Outputs for 2024-25**	Outputs delivered to date (Number or NA if no plan)	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	New/ Existing Scheme	Previously entered Expenditure for 2024-25 (£)	Expenditure to date (£)	Comments
11	Care Act Funding	Care Act Implementation Related Duties	Care Act Implementation Related Duties	Other	Carer advice and support	0	0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	Social Care	£ 408,700	£306,525	
12	LA Discharge & Admission Avoidance	LA Discharge & Admission avoidance projects	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess			0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	Social Care	£ 459,621	£329,850	Updated planned expenditure £439,800
13	IMHA	Prevention / Early Intervention	Care Act Implementation Related Duties	Independent Mental Health Advocacy		0	0		Social Care	0	LA			Charity / Voluntary Sector	Minimum NHS Contribution	Social Care	£ 35,000	£26,250	
14	BCF Local Project Management	BCF Local Project Management	Enablers for Integration	Programme management		3.5	3.6		Social Care	0	LA			Local Authority	Minimum NHS Contribution	Social Care	£ 168,000	£126,000	
15	Hospital to Home - Extended Settling In Services (Red	Post Hospital Discharge - Home from Hospital	Prevention / Early Intervention	Social Prescribing		81	20		Social Care	0	LA			Charity / Voluntary Sector	Minimum NHS Contribution	Social Care	£ 10,000	£5,000	New Service commissioned to commence in February 2025.
16	Care Home Selection (CHS) - Project in RBH	Care Home Selection (CHS) - Project in RBH	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes		1	1		Community Health	0	LA			NHS Community Provider	Minimum NHS Contribution	Community Health	£ 62,000	£46,500	
17	Out Of Hospital Speech & Language Therapy	Eating & drinking referral service	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess			0		Community Health	0	NHS			NHS Community Provider	Minimum NHS Contribution	Community Health	£ 63,673	£47,755	
18	Out of Hospital Care Home in-reach	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes			0		Community Health	0	NHS			NHS Community Provider	Minimum NHS Contribution	Community Health	£ 124,636	£93,477	
19	Out Of Hospital - Community Geriatrician	Provide Community Geriatrician Service - urgent referrals seen within 2 days.	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		1300	975	Number of placements	Community Health	0	NHS			NHS Community Provider	Minimum NHS Contribution	Community Health	£ 131,408	£98,556	
20	Out Of Hospital - Intermediate Care (including	Rapid response services delivered for patients discharged from A&E or	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation accepting step up and step		800	600	Number of placements	Community Health	0	NHS			NHS Community Provider	Minimum NHS Contribution	Community Health	£ 1,060,748	£795,561	
21	Out Of Hospital Health Hub	Acute Single Point of Access to Community Health Services.	Integrated Care Planning and Navigation	Assessment teams/joint assessment			0		Community Health	0	NHS			NHS Community Provider	Minimum NHS Contribution	Community Health	£ 487,700	£365,775	
22	Out Of Hospital - Intermediate Care night sitting, rapid	Rapid response services delivered to patients in their own homes, avoiding	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		1680	1,557	Number of placements	Community Health	0	NHS			NHS Community Provider	Minimum NHS Contribution	Community Health	£ 349,518	£262,139	
23	Connected Care	Connected Care	Other				0		Other	0	NHS			Private Sector	Minimum NHS Contribution	Other	£ 316,980	£237,735	
24	Carers Funding ICB	Support for Young People with Dementia (YPWD), Alzheimers	Carers Services	Other	Support Young People with Dementia /	80	78	Beneficiaries	Community Health	0	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Community Health	£ 119,420	£89,565	
25	Street Triage	Street Triage service supporting Reading Rough sleepers	Integrated Care Planning and Navigation	Assessment teams/joint assessment			0		Mental Health	0	NHS			NHS Community Provider	Minimum NHS Contribution	Mental Health	£ 173,404	£130,053	
26	Falls Service & Frailty	Falls service to reduce Admissions due to falls	Community Based Schemes	Integrated neighbourhood services			0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	Social Care	£ 281,056	£0	Updated planned expenditure £266,000. Expected spend is pending the outcome of Diagnostic Review to inform Falls service development.
27	Care Homes / RRaT	Intermediate Care Services	Home-based intermediate care services	Rehabilitation at home (accepting step up and step down users)		1730	1,298	Packages	Community Health	0	NHS			NHS Community Provider	Minimum NHS Contribution	Community Health	£ 655,686	£491,765	
28	Discharge to Assess Beds	Hospital Discharge	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		40	19	Number of placements	Social Care	0	LA			Local Authority	Local Authority Discharge	Social Care	£ 421,200	£315,900	Commissioned block of beds.
29	Hospital to Home Service (Extended)	Hospital to Home Service British Red Cross	Personalised Care at Home	Physical health/wellbeing		181	48		Social Care	0	LA			Charity / Voluntary Sector	Local Authority Discharge Funding	Social Care	£ 40,000	£10,000	Contract finished in July, allocated one quarter of funding. Actual spend was £13,124. New Hospital to Home contract will commence in February 2025.
30	TEC Hospital Discharge	TEC Hospital Discharge Pilot	Assistive Technologies and Equipment	Assistive technologies including telecare		800	600	Number of beneficiaries	Social Care	0	LA			Local Authority	ICB Discharge Funding	Social Care	£ 99,547	£75,000	
31	Home Care Hours to support Discharge	Home Care Hours to support Discharge	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess		11132	8349	Hours of care (Unless short-term in which case it is packages)	Social Care	0	LA			Private Sector	ICB Discharge Funding	Social Care	£ 242,000	£181,500	

Checklist		Column complete:					Yes											Yes	
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Planned Outputs for 2024-25**	Outputs delivered to date (Number or NA if no plan)	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	New/ Existing Scheme	Previously entered Expenditure for 2024-25 (£)	Expenditure to date (£)	Comments
32	Bed & Breakfast (Rough Sleepers/No	Bed & Breakfast (Rough Sleepers/No recourse to public funds)	Housing Related Schemes			52	52		Social Care	0	LA			Local Authority	Local Authority Discharge	Social Care	£ 37,517	£37,517	All of this allocation has now been spent. The actual spend for this service is 116,429, supported through Adult Social
34	Social Worker/OT posts within Hospital	Social Worker/OT posts within Hospital Discharge	Integrated Care Planning and Navigation	Support for implementation of anticipatory care		4	4		Social Care	0	LA			Local Authority	ICB Discharge Funding	Social Care	£ 360,000	£296,889	Fixed Term posts in place.
35	Hospital / CRT Delivering extended hours / Bank holidays	Hospital / CRT Delivering extended hours / Bank holidays	Home-based intermediate care services	Rehabilitation at home (to support discharge)		21	21	Packages	Social Care	0	LA			Local Authority	Local Authority Discharge Funding	Social Care	£ 30,000	£30,000	100% of allocation spent. Actual spend is 52,645 as at end of Q3. Additional hours hospital discharge team and CRT to support discharge. Original plan showed output as packages but should have been hours, unable to amend in the template.
36	Complex cases - High Cost Placement	Complex cases - High Cost Placement (including MH)	Residential Placements	Care home		100	100	Number of beds	Social Care	0	LA			Local Authority	ICB Discharge Funding	Social Care	£ 732,071	£732,071	100% of allocation is spent at the end of Q3. Actual spend to date is 1,124,272, supported through Adult Social Care.
37	Brokerage staff	Brokerage staff	Integrated Care Planning and Navigation	Support for implementation of anticipatory care		2	2		Social Care	0	LA			Local Authority	ICB Discharge Funding	Social Care	£ 40,000	£27,603	
40	ICB PMO (BoB)	Share of Cross Berkshire West Programme	Enablers for Integration	Programme management			0		Other	0	LA			Local Authority	Minimum NHS Contribution	Other	£ 87,418	£65,564	
41	iBCF	Community Reablement Services	Home-based intermediate care services	Reablement at home (to support discharge)		800	600	Packages	Social Care	0	LA			Private Sector	iBCF	Social Care	£ 2,692,624	£2,019,468	
42	DFG	Supporting people with disability	DFG Related Schemes	Adaptations, including statutory DFG grants		80	64	Number of adaptations funded/people	Social Care	0	LA			Private Sector	DFG	Social Care	£ 1,306,000	£979,500	
43	Risk Share-LA	Other	Integrated Care Planning and Navigation	Other	Risk Share		0		Other	0	NHS			NHS	Minimum NHS Contribution	Other	£ 583,243	£437,432	£134,000 claimed up to Q2 and balance retained by the ICB. Q3 figures have not yet been agreed.
44	BHFT Re-ablement Contract	Reablement & Rehabilitation Services	Home-based intermediate care services	Joint reablement and rehabilitation service (to support discharge)		1809	1480	Packages	Community Health	0	NHS			NHS Community Provider	Minimum NHS Contribution	Community Health	£ 1,114,937	£836,203	
45	ICB Contingency	ICB Contingency	Other				0		Community Health	0	NHS			NHS Community Provider	Minimum NHS Contribution	Community Health	£ 10,326	£7,744	
46	Other	LA Care Act Implementation	Care Act Implementation Related Duties	Other	Care Act	0	0		Social Care	0	LA			Local Authority	Additional LA Contribution	Social Care	£ 1,163,920	£916,936	Adjusted to £1,572,812 following year end adjustments from 2023/24.
33b	Minor Works required to support people to	Minor Works required to support people to be discharged from Hospital	Housing Related Schemes	0	0	80	60		Social Care	0	LA	0		Local Authority	Local Authority Discharge	Social Care	£ 50,000	£37,500	Contribution towards full spend -Minor Works
38b	Self-Neglect - Blitz Cleans	Self-Neglect - Blitz Cleans	Housing Related Schemes	0	0	20	30		Social Care	0	LA	0		Local Authority	Local Authority Discharge Funding	Social Care	£ 30,453	£44,419	Spend has exceeded the allocation here and has been offset against lower spend in other areas of the discharge fund allocations.
39b	Social Care Workforce Development	Social Care Workforce Development and Retention	Workforce recruitment and retention	0	0	0.5	10	WTE's gained	Social Care	0	LA	0		Local Authority	Local Authority Discharge	Social Care	£ 20,000	£15,000	Outputs are not WTEs but number of Domiciliary Care staff trained in Reablement to increase capacity.

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

READING HEALTH AND WELLBEING BOARD

Date of Meeting	14 March 2025
Title	BOB ICB Update Briefing
Purpose of the report	To note the report for information
Report author	Caroline Tack and Sarah Adair
Job title	Associate Director of Transformation and Improvement, and Associate Director of Communications and Engagement
Organisation	Buckinghamshire, Oxfordshire and Berkshire West ICB
Recommendations	The purpose of this paper is to provide an ICB update and detail on our planning activities across BOB. The paper will specifically cover: 1. BOB ICB Board meetings 2. Community Wellness Outreach Programme 3. BOB ICB Operating Model – next steps 4. Working with local people and communities 5. 10-Year Health plan for the NHS 6. New provider for BOB non-emergency patient transport services 7. BOB ICB financial position within 2024/25 8. NHS Operational Planning for 2025/26 and associated national priorities 8.1Priorities and operational planning guidance 2024/25 8.2 Development of a medium-term plan for transformation and improvement 9. Joint Forward Plan refresh – timescales and engagement The above activities are a key part of BOB ICBs responsibility to plan and arrange health and care services to meet the needs of our population, working to improve their health and lives. This will require joint working with our partners to ensure we prioritise our resources effectively, based on evidence, to achieve the best outcomes for our residents and communities. The Board Members are asked to note the content of this report and provide views or feedback on the ongoing planning process and development of the medium-term strategy.

ICB Update and System Priorities

1. BOB ICB Board meetings

The most recent BOB ICB Board meeting took place on 14 January 2025. The papers can be found on the BOB ICB website. The next meeting will take place on 11 March 2025. Please see the website for papers which are published seven days before the meeting date.

2. Community Wellness Outreach Programme

An initial review of the community outreach work has been completed, with the programme currently running to end of June 2025. The recommendation from the review and the subsequent workshop is that the pilot should be extended and this is now being considered as part of the wider planning process described above.

3. BOB ICB Operating Model – next steps

We have now transitioned to our new **Operating Model** and associated structure.
Our operating model was developed through consultation, collaboration and engagement with both our staff and partner organisations. The work we have done will allow the ICB to:

- Focus on what we are uniquely placed to do as a system leadership organisation
- Deliver our core functions effectively and efficiently
- Build the right culture and behaviours to work well across our teams and in collaboration with our partners.

Our commitment to strongly support Place development and Place partnerships is reflected in our new operating model, with an ICB senior executive sponsor for each Place. Rachael Corser, Chief Nursing Officer, is the executive sponsor for Buckinghamshire, Matthew Tait, Chief Delivery Officer, for Oxfordshire, and Dr Ben Riley, Chief Medical Officer, will be the sponsor for Berkshire West. The Berkshire West model will be supported by the wider executive and clinical leadership team to ensure effective engagement across all three of its local authority areas. Dr Abid Irfan as Interim CMO will be the executive sponsor for Berkshire West until Ben joins the ICB later in March.

The executive sponsors will work closely with **Dan Leveson, Director of Place and Communities** and through the place-based partnerships to enhance integration and efficiency by supporting the alignment of the NHS, local authorities, and voluntary organisations. This partnership working is crucial to support proactive and preventative care at a local level to help address health inequalities and improve overall population health.

The executive sponsors will join key discussions with partners at local meetings including Health and Wellbeing Boards, Health Overview and Scrutiny Committee and Place based partnership meetings to ensure an effective senior connection with the ICB's executive team and Board and raising the profile of Place and its long-term development.

4. Working with local people and communities

As we implement our new operating model, we are strengthening and improving our approach to working with our local people and communities, putting more dedicated resource and focus to support this aim.

BOB ICB wants to ensure we are embedding a public involvement approach across the organisation and drawing insights from our partners and communities to inform our work as we commission services for our population.

We aim to create more meaningful and inclusive opportunities for public involvement, ensuring that our residents' voices are heard and valued in our decision-making processes.

5. 10-Year Health plan for the NHS

In October 2024, the Government launched a public engagement initiative to shape the 10-Year Health Plan for the NHS, which aims to address the challenges facing the NHS and ensure it is fit for the future. The final plan, expected in Spring 2025, will respond to the findings of the Darzi review and aims to deliver three main shifts:

- Hospital to community: Moving more care from hospitals to communities
- Analogue to digital: Making better use of technology in health and care
- Treatment to prevention: Focusing on preventing sickness, not just treating it

The Government introduced an online platform, Change NHS, where the public, NHS staff, NHS partners and stakeholders can share their experiences, views and ideas on these proposed shifts. The online engagement platform will be live until the end of February. A series of regional engagement events are also taking place, led by the NHS national and regional teams, to facilitate in-depth discussions with the public and NHS staff. A public deliberative event was held in Folkestone earlier in December for the south east region and an NHS staff event for the south east region was held on 25 February 2025 in Reading.

All ICBs have been asked to support the national engagement at a local level. For BOB, we have taken the following approach:

- **Summarising existing insights** – in BOB we already have a lot of insight from local people so, we will summarise existing insight from our engagement work including focus groups with refugees, people experiencing homelessness, asylum seekers, young people and people experiencing alcohol or drug problems.
- **Working with our partners** – we are working with BOB Voluntary, Community and Social Enterprise Health Alliance (BOB VCSE) to facilitate workshops with voluntary organisations and community groups. We have engaged with our Healthwatch partners to spread awareness of the engagement and have offered to facilitate workshops with their members.
- **Delivering workshops / focus group** – identifying and delivering workshop sessions across the BOB geography. We are running 10 workshops sessions with different community groups including young people with SEND, people experiencing homelessness, people with ADHD, 70+ women living in rural communities, people who are using community larders / food banks and with community champions in areas of deprivation across BOB.
- **Staff workshops / events** - we have run three sessions for ICB staff and NHS Trust colleagues are also running staff sessions across their organisations.

6. New provider for BOB non-emergency patient transport services

NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board has appointed EMED Group to provide NHS non-emergency patient transport services after a thorough and competitive procurement process, with the new service starting on 1 April 2025.

EMED is working with South Central Ambulance Service NHS FT and other subcontracted providers to ensure affected staff are transferred to EMED in accordance with Transfer of

Undertakings (Protection of Employment) Regulations 2006. There are no redundancies resulting from this change.

The contract has been awarded for an initial five-year period with the option to extend for a further five years – 10 years in total. A range of quality indicators are detailed in the contract, linked to delivery of the service specification which will be reviewed and managed through regular contract management meetings. Non delivery of the quality/performance indicators will be managed via this mechanism and in accordance with the NHS National Standard Contract as necessary.

More information is available on the Buckinghamshire, Oxfordshire, Berkshire West and Frimley - EMED Group website and will be updated regularly as the launch date approaches.

7. BOB ICB financial position within 2024/25

Recognising that there is a delay in finalising monthly financial figures and using the most recent ICB board meeting as an in-year point, the ICB's financial position is set out in board papers and can be found here. The ICB will continue to work on improving its financial position, aiming to deliver a break-even (or small surplus) against plan by year end.

8. BOB planning process update

8.1 Priorities and operational planning guidance 2024/25

Each year, the ICB and NHS Trusts go through an annual planning cycle, which involves the process of setting budgets and planning and prioritising our activities and investments, as we seek to meet national standards and priorities across our organisations.

To support this, the ICB and NHS Trusts are required to submit specific operational and financial information to NHS England as part of the nationally co-ordinated NHS planning process. This process is informed by the publication of national annual planning guidance, which for 2025/26 was published at the end of January 2025.

This year there are fewer national priorities – 18 headline targets (**Appendix 1**), which is a reduction from 31 last year and 133 as recently as 2022/23. Operational priorities include:

- Reducing the time people wait for Elective Care
- Improving patients access to General Practice and urgent dental care
- Improving A&E waiting times and Ambulance response times
- Improving patient flow through mental health crisis and acute pathways
- Improving access to children and young people's (CYP) mental health services

The financial ask of systems in challenging. All systems are required to submit a first draft plan that is breakeven with a plan for all partners to live within that envelope. Planning guidance is clear on the ask of all systems:

- Systems have **greater financial flexibility** to manage constrained budgets
- Providers will need to **reduce their cost base** by at least 1% and achieve 4% improvement in productivity to deal with demand growth
- **All parts of the NHS must now live within their means.**
- **Difficult decisions will be needed** – the NHS will need to reduce or stop spending on some services and functions, reduce waste and tackle unwarranted variation.

The ICB has been co-ordinating the discussions on how we achieve this with our NHS partners. Our final plan for 2025/26 will be submitted to NHSE on 27 March.

8.2 Developing our medium-term plan

In addition to the work ongoing to meet our statutory requirement to develop a joint plan across NHS partners in BOB for 2025/26, we have also recognised the need for our system to have a clearer strategy to ensure we have a collective plan towards system sustainability, transformation and improvement. This is supported by the findings of multiple recent system diagnostic reviews, which have identified the need for unified strategic framework to align financial and clinical priorities across BOB, address commissioning variation and support alignment about how we use our collective resources. The medium-term plan responds to the challenges presented by our forecasts if we were to take no action.

Our approach to this plan has started with development of a new analytical baseline for the system, which seeks to align partners around a common understanding of the most significant health challenges affecting our population and the key opportunities to work together to make improvements. It focuses on:

- **An analysis of our population's needs** – building an analytical baseline of our population health needs and how our services are accessed to inform prioritisation of focus and resource.

- **Agreeing a clear medium term system plan** – developing a clear medium-term plan for sustainability, transformation and improvement, based on a shared understanding of our population.

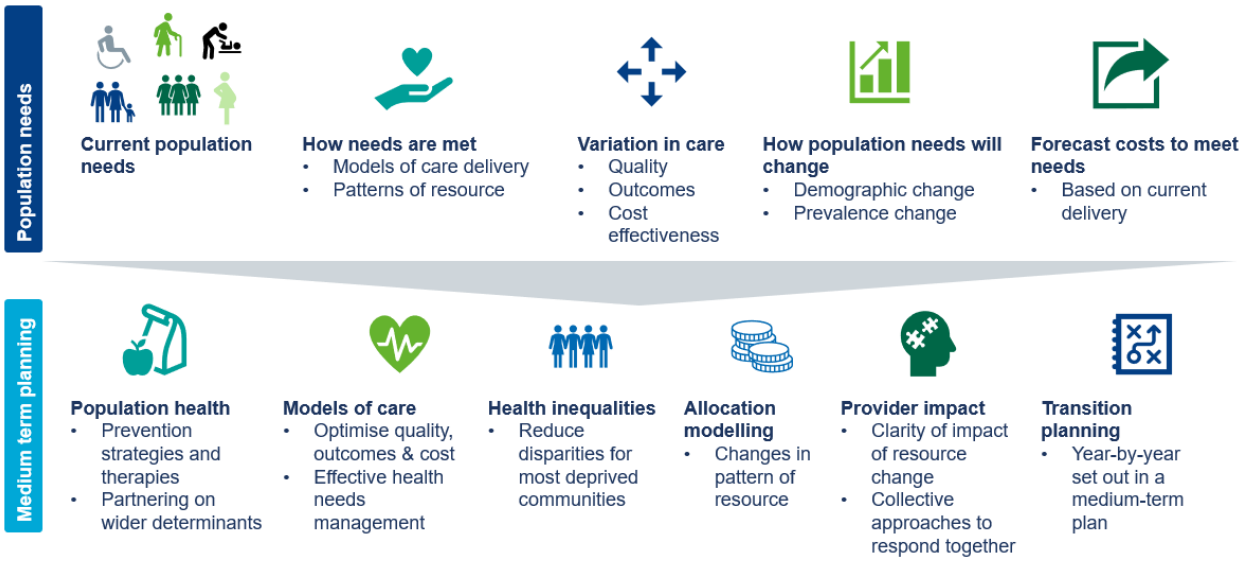


Figure 1: Our approach to developing the medium-term plan

To understand population needs and how they will change over time, we have looked at a number of sources of data.

The initial analysis shows some of the specific challenges facing our population now.

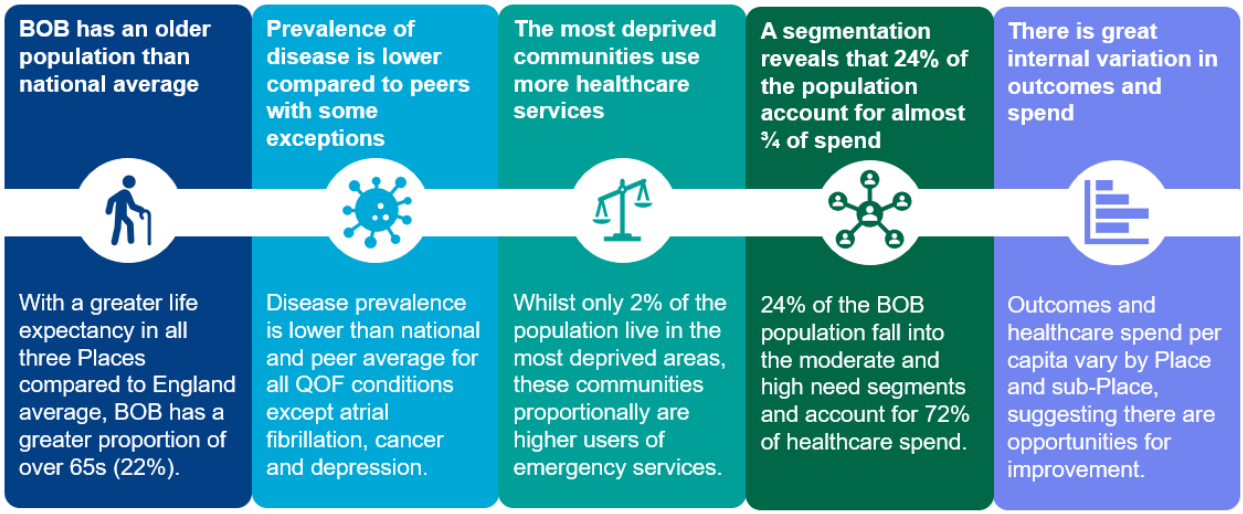


Figure 2: A high-level summary of BOB population and opportunities for improvement

A "do-nothing" scenario has been developed to reflect the expected change in the health requirements of the population if there is no major transformation. To support this analysis, the population has been categorised into different segments, according to age and acuity of health need.

Findings from this work indicate that:

- In 2023/24, 24% of the population of BOB fell into moderate and high need segments but account for 72% of the overall healthcare costs. This is set to grow to 80% by 2029/30 if no major transformation is delivered.

- People in this 72% have higher rates of chronic conditions and experience deteriorating health, resulting in higher ongoing usage of primary care to manage conditions and emergency resources when experiencing crisis.

- People with more significant health needs use considerably more resource than the low needs groups, equal to up to 20-times more A&E attendances and 72-times more primary care contacts per year. Activity pressure is expected to increase by 18% for both these areas by 2029/30, placing greater strain on the providers across the system, in terms of operational deliverability and financial sustainability in the do-nothing scenario

- The population segment relating to people with dominant psychiatric conditions is the only segment that is projected to grow across all age bands, which means that community and mental health providers in BOB are also projected to see their positions worsen given the increased need for out of hospital care for this group.

- The system (NHS organisations only) deficit is projected to grow to £722m by 2029/30 if no action is taken. This is driven by increasing costs of care, the number of people requiring care and support and the complexity of the population need increasing.

The emerging medium-term plan will respond to the challenges presented by the do-nothing scenario, from a quality perspective, aiming to keep people in health for longer, and a financial perspective that drives the system towards a more sustainable position. Opportunities to address the challenges in the 'do-nothing' scenario are derived from multiple sources and the impact will be refined and tested with stakeholders, which includes:

- Benchmarking to peers and against identified internal variation – to understand potential opportunity size

- Best practice case study impact analysis – to understand and quantify the potential impact of specific interventions on activity
- Return on investment analysis – to understand potential investment dependencies and requirements

Four opportunity areas have been identified for transformation in BOB:

Opportunity 1: Reducing the growth in progression of ill health

This focuses on keeping people in good health and enabling people to manage long term conditions more effectively, which makes the shift from reactive to proactive care. The opportunities identified are based on the extent of prevalence, expected growth, and pathways where innovation can significantly change disease progression. In BOB, it is recommended that four areas should be considered include **cardiovascular disease, diabetes, obesity and dementia** for primary and secondary prevention initiatives.

Opportunity 2: Transforming models of care

This focusses on making the shift from acute to community and analogue to digital care, to deliver more consistent proactive care to support effective population health management. Priority segments and interventions in BOB for care model transformation are **frailty, multi-morbidity high complexity, lower complexity segments and dominant psychiatric conditions**. The opportunity is broadly realised and set by national expectations of a Neighbourhood Health model, which will provide the building blocks for a more proactive and anticipatory model of care that delivers improvements in quality and outcomes.

Opportunity 3: Improving care for the most disadvantaged communities

In BOB, a small proportion of people live in the Core20, but they experience disproportional inequalities especially with respect to life expectancy. Per capita costs for the Core20 cohort are consistently higher than the non-Core20 populations. This is driven by Core20 communities using health care resources at a higher rate – this is particularly evident for acute emergency, community and mental health services. Opportunities to improve outcomes and health inequalities involve **mobilising assets within local communities to increase participation and improve outcomes**.

Opportunity 4: Optimising the efficiency of care delivery

This opportunity considers the impact of provider productivity gains and making better use of existing resources as well as opportunities for providers in BOB to work together. These opportunities cover **clinical and non-clinical areas for all points of delivery** where data quality allowed for data analysis to be undertaken.

Refining the opportunities and system involvement

We will now work with system stakeholders to support the development of opportunities, prioritise high impact actions and start to set out the medium-term plan for the system for the next 3-5 years. Work is now required to:

- Stocktake existing programmes: for example Long Term Conditions, against identified opportunities areas
- Align existing programmes behind opportunities and initiatives identified
- Develop implementation plans for programmes where plans do not already exist

9. Joint Forward Plan Refresh 2025/26

ICBs and their partner trusts have a duty to prepare a plan setting out how they propose to exercise their functions in the next five years (the 'Joint Forward Plan' (JFP)). JFPs should set out how the ICB will meet its population's health needs. As a minimum, it should describe how the ICB and its partner trusts intend to arrange and/or provide NHS services to meet the physical and mental health needs of their population.

In 2025/26 it is expected that ICBs and trusts will undertake a limited refresh of existing plans before the beginning of the new financial year given the anticipated publication of the 10 Year Health Plan in Spring 2025 and a multi-year financial settlement for the public sector as part of the Spending Review 2025. NHSE is planning to work with systems to develop a shared set of expectations and a timetable for more extensive revision of JFPs. al This will include a shift from single to multi-year operational and financial planning.

The analytical work, described above, and the operational planning priorities will form a part of the 2025/26 refresh of the JFP, alongside triangulation with local strategies and engagement with system stakeholders, including Health and Wellbeing Boards. An engagement plan will be developed as part of the refresh which will be shared with partner organisations. Further information on our proposed approach to engagement will be provided following the release of national expectations on the development of a revised plan.

Asks of the Board or of members present

The Board is asked to note the update and provide any views or feedback into the ongoing planning process and development of the medium-term plan.

Appendix 1: National Guidance - Operational Planning priorities 2025/26

Priority	Success measure
Reduce the time people wait for elective care	Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% improvement
	Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% improvement
	Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026
	Improve performance against the headline 62-day cancer standard to 75% by March 2026
	Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026
Improve A&E waiting times and ambulance response times	Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25
	Improve Category 2 ambulance response times to an average of 30 minutes across 2025/26
Improve access to general practice and urgent dental care	Improve patient experience of access to general practice as measured by the ONS Health Insights Survey
	Increase the number of urgent dental appointments in line with the national ambition to provide 700,000 more
Improve mental health and learning disability care	Reduce average length of stay in adult acute mental health beds
	Increase the number of CYP accessing services to achieve the national ambition for 345,000 additional CYP aged 0–25 compared to 2019

	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, delivering a minimum 10% reduction
Live within the budget allocated, reducing waste and improving productivity	Deliver a balanced net system financial position for 2025/26
	Reduce agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems
	Close the activity/ WTE gap against pre-Covid levels (adjusted for case mix)
Maintain our collective focus on the overall quality and safety of our services	Improve safety in maternity and neonatal services, delivering the key actions of the of the 'Three-year delivery plan'
Address inequalities and shift towards prevention	Reduce inequalities in line with the Core20PLUS5 approach for adults and children and young people
	Increase the % of patients with hypertension treated according to NICE guidance, and the % of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidance

NHS
Royal Berkshire
NHS Foundation Trust

Building Berkshire Together

Reading Health and Wellbeing Board

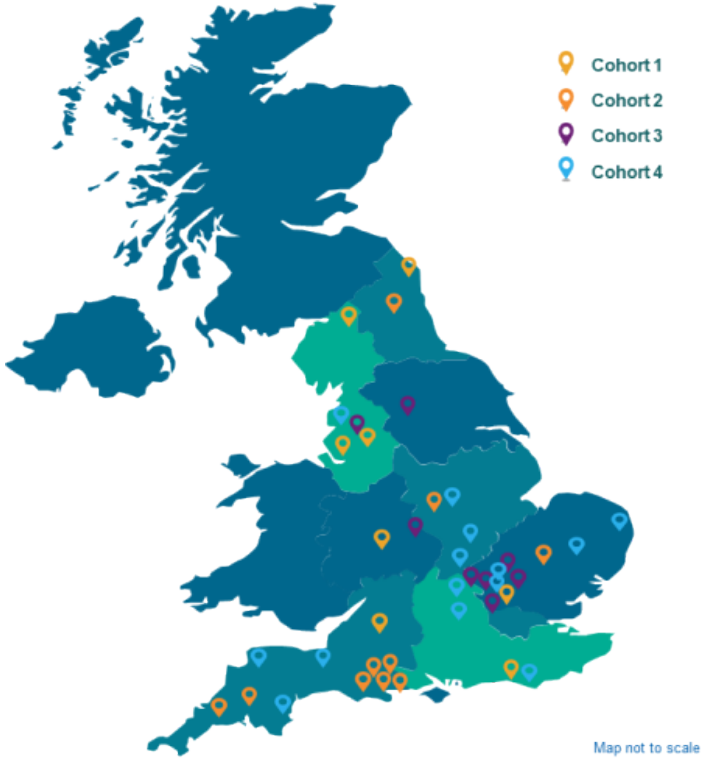
14 March 2025

BUILDING BERKSHIRE Together
OUR NEW HOSPITAL PROGRAMME

@building_berkshire_together @buildingberkshiretogether @BuildingRBH

New Hospital Programme

- Major Government programme investing in hospitals across England
- Centralised programme which will use a common set of designs to save money and time – this is called Hospital 2.0
- Royal Berkshire Hospital was one of the original hospitals on the programme in 2019 and due to be built before 2030 – this was then delayed to start construction in 2031 with the introduction of RAAC hospitals.
- The outcome of a further government review was announced on 20 January 2025



Royal Berkshire Hospital

NHS
Royal Berkshire
NHS Foundation Trust

- Following the review, our programme has been delayed further and construction will now start between 2037-39
- Funding of £2 billion or more has been allocated, indicating support for a whole new hospital on a new site
- Funding for the programme will resume after 2030
- The Trust are standing the programme team down

Challenges

- Maintaining the current estate
- Meeting increasing population demands
- Land availability for future new hospital
- Meeting NHS Net Zero targets

Next steps

- Secure funding for business case for land purchase
- Master planning for the next 15 years
- Accelerate system transformation

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READING HEALTH AND WELLBEING BOARD

Date of Meeting	14 March 2025
Title	Healthy Weight Needs Assessment for Adults in Reading
Purpose of the report	To make a decision
Report author	Nina Crispin
Job title	Public Health Programme Officer
Organisation	Reading Borough Council
Recommendations	1. That the Health and Wellbeing Board notes the publication of the Healthy Weight Needs Assessment for Adults in Reading 2. That the Health and Wellbeing Board endorses a whole systems approach to healthy weight for Reading and the formation of a task and finish group to oversee the development of a strategy with an implementation plan 3. That by adopting a whole systems approach to healthy weight, all partners and professional disciplines in the system play their part and commit to systems changes 4. That the Health and Wellbeing Board partners commit to the development of the whole systems approach to healthy weight strategy by nominating representative(s) to join the task and finish group

1. Executive Summary

1.1. Overweight and obesity are defined by the World Health Organisation (WHO) as abnormal or excessive fat accumulation that may impair health. Obesity is one side of the double burden of malnutrition. Health risks related to obesity are many and well known with the WHO highlighting that overweight and obesity (and poor diet) are major risk factors for many chronic diseases, including type 2 diabetes, cardiovascular disease (which is the main cause of premature death in the UK) and some cancers, in addition to joint and mobility issues, depression, low mood and fertility issues.

1.2. Evidence suggests that a Whole Systems Approach to Healthy Weight is needed to influence changes at systems levels and policies in the areas that have an impact on the population's health. These areas of influence include social and economic conditions, food production, agriculture, environment and planning, tax and levies, education and schools, industry practice and innovation, media and advertising (Office for Health Improvement and Disparities OHID)

1.3. A Healthy Weight Needs Assessment was undertaken in 2023 to better understand the needs of Reading's population regarding effective provision that promotes healthy weight. The needs assessment interrogated the evidence-base around nutrition, physical activity, and weight to better understand the health inequalities

around excess weight, including wider and commercial determinants that impact people's weight. The focus of this Healthy Weight Needs Assessment is on excess weight and reaching and maintaining a healthy weight, and the ability of the Local Authority and partners to drive and influence change.

1.4. It needs to be acknowledged that working on the recommendations from the needs assessment will require prioritisation as we won't be able to address them all at once. The prioritisation work will need to be driven by local needs and Council priorities.

2. Policy Context

2.1. To address the issue of obesity across the population, national and local action is required by many organisations and stakeholders. In Reading, a long-term, system-wide approach is needed that makes healthy weight everybody's business. This approach needs to be tailored to local needs and works across the life course. It is not just for public health professionals to act; all Council departments, the NHS, the wider public sector, the third sector and businesses all have an important role to play, working together and with their communities.

2.2. In Reading, there are over 85,000 adults who are overweight. In 2022/2023, 28.2% of adults 18 and over were obese (England 26.2%), whilst 61.2% were overweight or obese (England 64%). Levels of obesity and excess weight in Reading were (statistically) similar to England. The prevalence of obesity and excess weight (overweight and obese) continues to increase nationally.

2.3. Children are heavily exposed to television advertising for food and drinks high in salt, fat or sugar; fast food shops are a growing presence on high streets and increasingly cluster around schools. The government has pledged to halve childhood obesity and significantly reduce the gap in obesity between children from the most and least deprived areas by 2030[1].

2.4. The Advertising (Less Healthy Food Definitions and Exemptions) Regulations 2024 were laid before Parliament on 3 December 2024 and will come into force UK-wide on 1 October 2025.

2.5. Core20Plus5 is an NHS England approach to reduce health inequalities of adults, children and young people of the most deprived 20% of the population across the UK, in 5 focus areas. For children and young people, the 5 focus areas are asthma, diabetes, epilepsy, oral health and mental health – mental health is a co-morbidity linked to obesity. For adults, the 5 focus areas are maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis, hypertension / lipid optimal management – which can all be linked as co-morbidities to obesity.

2.6. In the NHS Long Term Plan (2019), obesity is one of the focus areas for 'targeted support offer and access to weight management services' in order to generate 'a significant impact on improving health, reducing health inequalities and reducing costs'[1].

2.7. The Office for Health Improvement and Disparities (OHID) (updated 2022) makes 'anti-obesity drive' a focus of its health prevention and improvement agenda[2].

[1] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf
[2] https://researchbriefings.files.parliament.uk/documents/CDP-2022-0015/CDP-2022-0015.pdf

2.8. The Childhood Obesity Action Plan (2016)[3] sets out a number of key initiatives across the system to alleviate obesity levels in children and young people, such as introducing a soft drinks industry levy, taking out 20% of sugar in products, supporting innovation to help businesses to make their products healthier, helping all children to enjoy an hour of physical activity every day.

2.9. The National Institute for Health and Care and Excellence (NICE) [NG246] (updated 2025) reviewed their guidelines on the prevention and management of overweight, obesity and central adiposity in children, young people and adults[4].

3. The Proposal

3.1. An effective way to addressing the complex issue of healthy weight is to consider a whole systems multi-level approach through a Health in All Policies lens. This ranges from upstream efforts to build health-promoting environments to the provision of services for those who need support to manage their weight. It will also consider all available policy levers across the system: legislation, regulation, fiscal measures, environmental and planning, communications and marketing and service provision.

3.2. The Healthy Weight Needs Assessment has identified recommendations to support systems-wide change in Reading for addressing healthy weight issues (See Executive Summary – Appendix 1)

3.3. It is proposed that the recommendations from the Healthy Weight Needs Assessment informs the development of a Whole Systems Approach to Healthy Weight in Reading, covering the life course of an individual.

3.4. It is also proposed that a Whole Systems Approach Task and Finish Group is set up to oversee the development of a Whole Systems Approach to Healthy Weight Strategy for Reading. The task and finish group membership would include representatives from the Integrated Care Board, the NHS, Transport and Planning Department, Voluntary Sector partners, Active Reading colleagues, Advertising Team, and colleagues from Children and Young People's services.

3.5. Due the very low response received from the needs assessment survey targeted at educational settings (children and young people), a separate needs assessment will need to be conducted to gather insights on the pathways available to children and young people in Reading who are obese or overweight and identify recommendations to address the issue.

[3] file:///C:/Users/crisnin/OneDrive%20-%20reading.gov.uk/WSA/Childhood_obesity_2016__2__acc.pdf

[4] https://www.nice.org.uk/guidance/ng246

4. Contribution to Reading's Health and Wellbeing Strategic Aims

4.1. The proposals in this report are in line with the overall direction of the Berkshire West Joint Health & Wellbeing Strategy 2021-30 by contributing to all of the Strategy's five priorities;

1. Reduce the differences in health between different groups of people
2. Support individuals at high risk of bad health outcomes to live healthy lives
3. Help children and families in early years
4. Promote good mental health and wellbeing for all children and young people
5. Promote good mental health and wellbeing for all adults

4.2. In addition, the proposals support the Reading Borough Council Corporate Plan's vision for Thriving communities:

> We will support families and ensure that vulnerable children in Reading are protected and supported to be well and healthy.

5. Environmental and Climate Implications

5.1. The Council declared a Climate Emergency at its meeting on 26 February 2019 (Minute 48 refers).

5.2. There are no environmental or climate implications arising from the decision

6. Community Engagement

6.1. The healthy weight needs assessment was conducted between 5th May 2023 to 16th June 2023. Extensive engagement with local communities and partners was conducted during the consultation period of 5th May 2023 to 16th June 2023. A multiple-pronged approach was taken, firstly with three surveys – Public facing aimed at parents, carers and general public who lived in Reading, Healthcare professionals including those within the community voluntary sector and with those in educational settings – ranging from early years to further education (18 years and under).

6.2. The survey targeted at adults aged 18+ and families contained 33 questions and the total number of people who responded was 208.

6.3. The survey that targeted professionals working with people who may experience excess weight contained 19 questions and received 77 responses.

6.4. Due to the very low level of response on the survey that targeted educational settings (only 7), it was not possible to incorporate the results and finding in the Healthy Weight Needs Assessment report.

6.5. In addition to the three surveys, 12 focus groups / professional interviews were conducted, using a range of media including online forums, TEAMs meetings and in person interviews/ discussions. Interview followed the same theme as the questionnaires; however, they were more fluid in approach to navigating, leading with the area of most concern/pressing for the audience

6.6. For a full consultation report, see the full Healthy Weight Needs Assessment Full Report December 2024 (Appendix 2)

7. Equality Implications

7.1. Under the Equality Act 2010, Section 149, a public authority must, in the exercise of its functions, have due regard to the need to—

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

7.2. An Equality Impact Assessment (EqIA) is not applicable to this decision.

8. Other Relevant Considerations

8.1. Not applicable

9. Legal Implications

9.1. Not applicable.

10. Financial Implications

10.1. Not applicable.

11. Timetable for Implementation

11.1 The timeline for the development of the strategy is as follows:

Activity	Expected Timeline
Set up a core task and finish group to oversee the development of a whole systems approach to healthy weight strategy	May 2025
Whole systems approach to healthy weight strategy development with partners	May 2025 – October 2025
First draft of strategy ready	November 2025

12. Background Papers

12.1. There are none.

Appendices –

1. Healthy Weight Needs Assessment Executive Summary Report (March 2025)

2. Healthy Weight Needs Assessment Full Report (March 2025)

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Reading Borough Council
Working better with you

HEALTHY WEIGHT NEEDS ASSESSMENT

PROMOTING HEALTHY WEIGHT FOR ADULTS IN READING

EXECUTIVE SUMMARY

March 2025

Table of Contents

1. Purpose and aims

The purpose of this health needs assessment is to better understand the needs in terms of healthy weight for adults in Reading's population and to review the available evidence to meet those needs.

The aims of this health needs assessment are to summarise the evidence-base for nutrition, physical activity, and healthy weight; to better understand how health inequality is connected to excess weight and to examine the wider and commercial determinants of healthy weight.

It should be noted that further community engagement with children and young people in Reading is needed to understand their needs. This will be conducted at a later date.

1.1 Objectives

The objectives of this needs assessments are to:

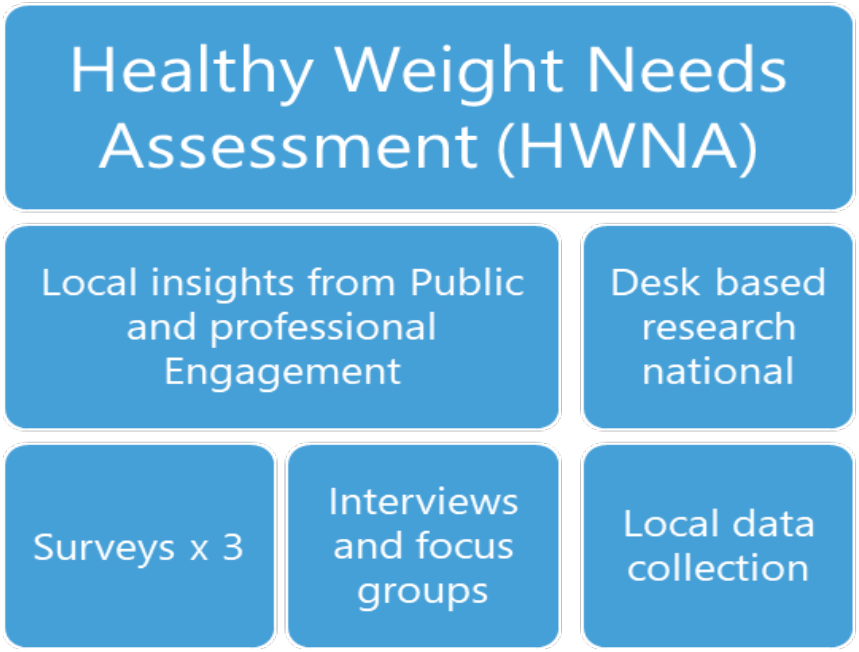
- Define who is impacted by excess weight.
- Understand the factors that contribute to excess weight both nationally and locally.
- To review existing services and local assets.
- Compare activity in Reading with evidence based best practice.
- Understand how best to support people to overcome some of the barriers identified in achieving a healthy weight.
- Identify gaps in local service provision, policy and action.
- Form evidence-based recommendations to reduce the prevalence of excess weight locally.
- Inform future commissioning intentions.
- Provide direction and influence resource allocation that prioritises the reduction of excess weight in Reading.

1.2 Scope

The scope of this needs assessment is to understand how to prevent overweight and obesity amongst the adult population of Reading and to effectively promote the achievement and maintenance of a healthy weight. Healthy Weight is the primary aim and while being underweight is a problem for some groups, excess weight impacts a bigger proportion of the local population and the increasing trend is of concern. Local Authorities are well placed to respond and to influence the determinants at a local level. This needs assessment provides recommendations about how Reading Borough Council with its system partners can influence local services and activities that promote the maintenance of a healthy weight for the Reading population.

1.3 Methodology

To address the aims and objectives set out above a mixed-method research approach was undertaken. This is set out in the chart below. The research was undertaken by a working group drawn from the core Public Health Team with experience and expertise in the field of healthy weight.



1.3.1 Data Review

Desk-based research was undertaken to understand the current local and national evidence base. A range of sources were used including the Office for Health Improvement and Disparities (OHID), Sports England, NHS Digital, The Kings Fund, GOV.UK and the National Institute for Health and Care Excellence (NICE).
In addition, local evidence sources were used that included the evaluation of local provision.

1.3.2 Engagement

Local communities and partners were engaged in the needs assessment process during the consultation period of 5th May 2023 to 16th June 2023. A multiple-pronged approach was taken to the consultation.

There were three surveys:

1. A public facing survey aimed at parents, carers and the public who live in Reading

2. A survey to healthcare professionals including those within the voluntary community sector

3. A survey to educational settings, ranging from early years to further education 18 years and under

A series of 12 focus groups and professional interviews were carried out using a range of media including online platforms and in person interviews or discussions. The interviews followed the same theme as the questionnaires and were more fluid in their approach to navigating or leading areas that were of most concern and pressing for the audience.

In all survey areas in which engagement activities were held online, support was provided to ensure that attendees were able to use online platforms such as MS Teams or Zoom or could join the meeting via a telephone line. When the engagement activities were held face to face, additional care was taken to ensure that those people taking part were in a safe and accessible environment.

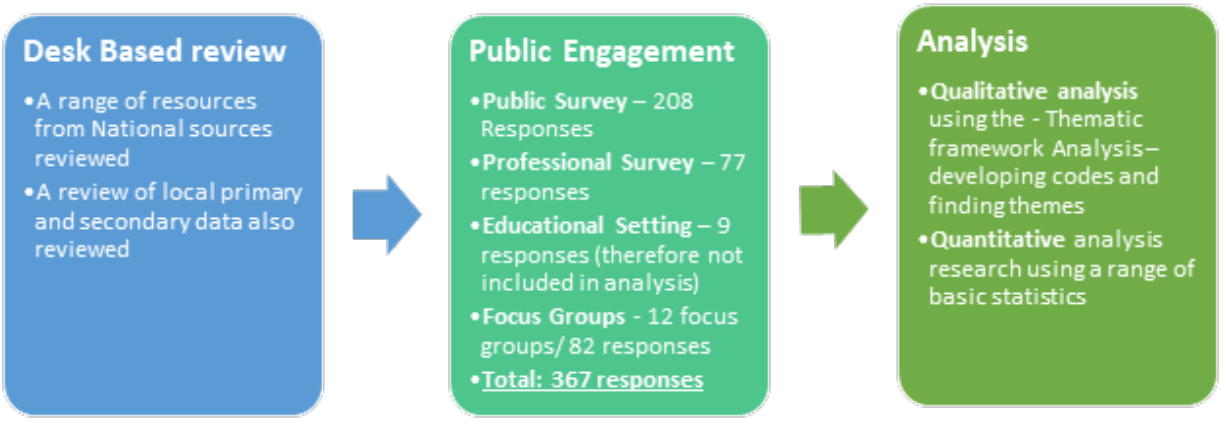
1.3.3 Analysis

Figure 1.1 below summarises the steps in the engagement and analysis of data. Qualitative data from the focus groups and free text from the consultation were analysed using a thematic analysis approach using MS Excel and MS Word. Both were available and an integral part in the analysis.

The quantitative data was taken from the consultation feedback. The analysis of the quantitative data included detailed analysis of responses to some of the questions received from a range of ethnic minority groups.

A total of 367 people engaged with the consultation to capture their views and experience around weight. The response rate to the survey was not high with only 9 responses received from educational settings. Further steps will need to be taken to engage with young people and professionals who influence children and young people.

Figure 1.1 - summary of steps undertaken and engagement outputs.



2. What is excess weight and why does it matter?

Overweight and obesity are defined by the World Health Organisation (WHO), as abnormal or excessive fat accumulation that may impair health. Obesity is one side of the double burden of malnutrition. Worldwide obesity has nearly tripled since 1975, with over 650 million adults being classified as obese in 2016. The focus of this Healthy Weight Needs Assessment for adults is Excess Weight and reaching and maintaining a healthy weight, and how a Local Authority might drive and influence change.

Body mass index (BMI) is a simple index of weight-for-height and is commonly used to classify overweight and obesity in adults. It is defined as a person's weight in kilograms divided by the square of their height in meters (kg/m^2). Age also needs to be considered when defining overweight and obesity in children.

Another measure of healthy weight is the waist-to-height ratio. This is a good indicator of excess tummy fat. A person can have a healthy BMI and still have tummy fat. The waist-to-height ratio is calculated by dividing the waist measurement by height. A waist-to-height ratio of 0.5 or higher indicates that there may be an increased risk of heart disease, type 2 diabetes, and stroke.

This follows recommendations from the National institute for Health and Care Excellence (NICE) about identifying and assessing overweight and obesity in adults[1]. BMI is a good measure at the population level, but not at the clinical level and is best when used in combination with the waist to height ratio.

[1] https://www.nice.org.uk/guidance/ng246/chapter/Identifying-and-assessing-overweight-obesity-and-central-adiposity

2.1 Who is affected?

2.1.1 Maternity

Additional weight before pregnancy and excessive gestational weight gain are major determinants of risk for pregnancy loss, gestational diabetes, hypertensive conditions, labour complications and significant threat to the lives of both mothers and babies. Excess weight also poses additional challenges with conception. Excessive weight gain in pregnancy and post-partum weight retention may compromise future fertility and increase risk for future pregnancies[2].

A recently published report on maternal deaths noted that of the 275 pregnant women who died from 2020 to 2022, 64% of them were obese[3].

Healthy weight before and between pregnancy was one of 6 priority areas previously identified by Public Health England (PHE) publication 'Maternity High impact areas'.

The maternity high impact areas listed and addressed in this publication are:

- improving planning and preparation for pregnancy
- supporting parental mental health
- supporting healthy weight before and between pregnancy
- reducing the incidence of harms caused by alcohol in pregnancy.
- supporting parents to have a smokefree pregnancy.
- reducing the inequality of outcomes for women from Black, Asian and Minority Ethnic (BAME) communities and their babies

2.1.2 Children

Table 1a below shows that in 2023/24, 21.9% of Reception pupils in Reading were overweight or obese, that is 1 in 5 of 400 pupils. This prevalence was similar to England at 22.1%. The prevalence of underweight Reception pupils in Reading was 1.9%, significantly higher than England at 1.2%. 37% of Year 6 pupils in Reading were overweight or obese, which was similar to England at 35.8%. Table 1b shows that locally, 700 Year 6 pupils were overweight or obese.

It should be noted that this needs assessment is focused on adults. We know that children obesity persists into adulthood, therefore early preventative measures to address obesity risks in children and young people will need to be considered in future assessments.

[2] Langley-Evans et al. Overweight, obesity and excessive weight gain in pregnancy as risk factors for adverse pregnancy outcomes: A narrative review. Journal of Human Nutrition and Dietetics. 2022. Vol 35, no 2., page 250 - 265. https://doi.org/10.1111/jhn.12999

[3] https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2024/MBRRACE-UK_Maternal_FULL_Compiled_Report_2024_V1.1.pdf

Tables 1a and 1b: Weight among Reception and Year 6 pupils in Reading (2023/24)

Figure 1a Reception

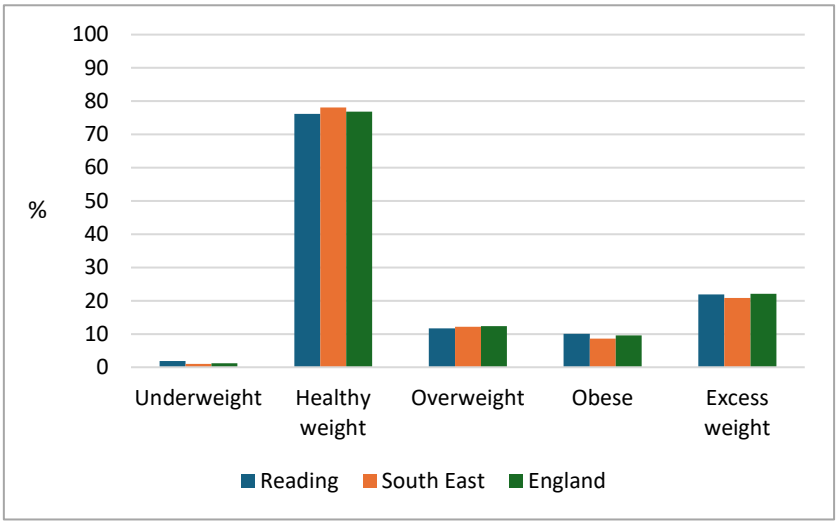
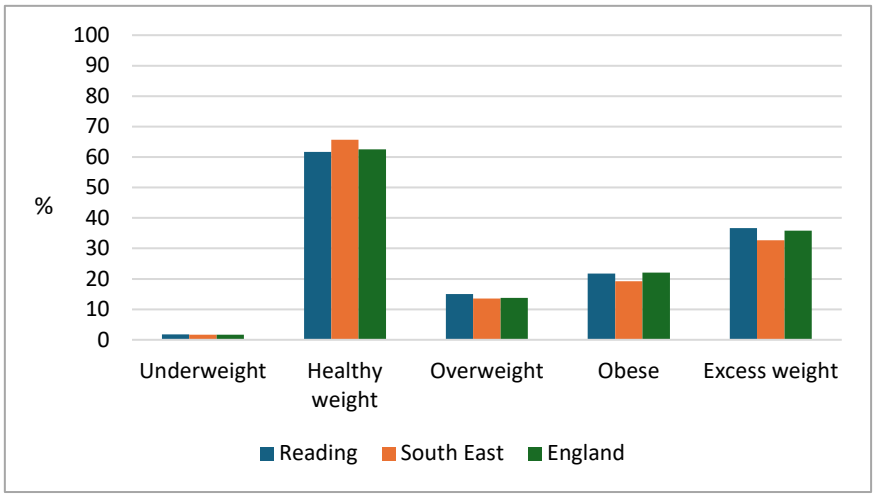


Figure 1b Year 6



Source: Department of Health and Social Care (Obesity Profile)

* Excess weight = overweight or obese

Between 2007/08 and 2023/24, the prevalence of Reception pupils overweight or obese (excess weight) in Reading increased slightly from 20.8% to 21.9%; 2020/21 data for Reception and Year 6 pupils in Reading is not available due to the covid pandemic.

During this time, the numbers of Reception pupils with excess weight increased from 270 to 400 locally. In England, the prevalence fell during this time from 22.6% to 22.1%.

Among Year 6 pupils, the prevalence of excess weight increased in Reading from 33.7% to 36.7% between 2007/08 and 2023/24. The numbers of Year 6 pupils with excess weight increased during this time from 430 to 700. In England, the prevalence of excess weight increased from 32.6% to 35.8% during this period.

2.1.3 Adults

For adults, the WHO defines overweight, and obesity as follows:

- overweight is a BMI greater than or equal to 25; and
- obesity is a BMI greater than or equal to 30.

BMI provides the most useful population-level measure of overweight and obesity as it is the same for both sexes and all ages of adults. However, it should be considered a rough guide because it may not correspond to the same degree of fatness in different individuals.

The prevalence of obesity and excess weight (overweight and obese) continues to increase nationally. In 2022/2023, 26.2% of adults aged 18 and over in England were obese, while 64% were overweight or obese[4].

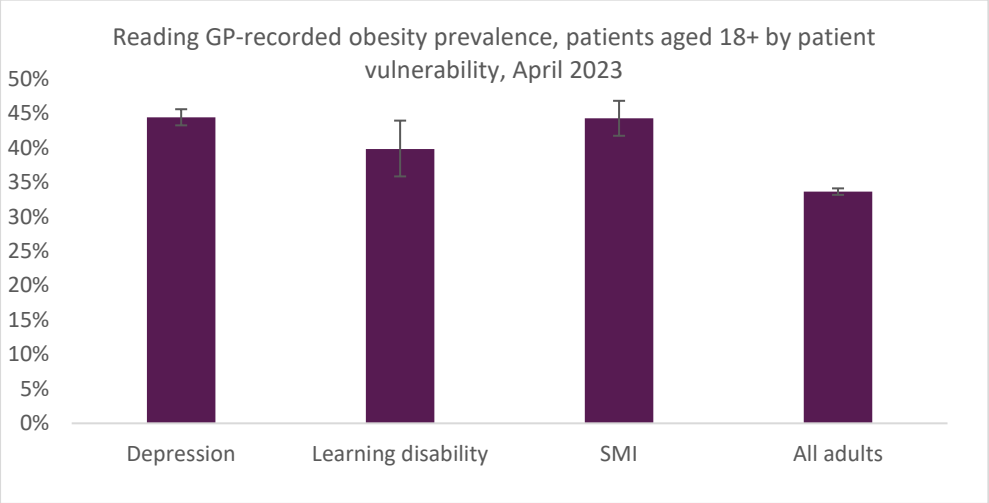
Locally, in 2022/2023, 28.2% of adults 18 and over were obese (England 26.2%), whilst 61.2% were overweight or obese (England 64%). Levels of obesity and excess weight in Reading were (statistically) similar to England.

2.1.4 High-risk groups

Figure 2.1 below shows the prevalence of obesity amongst adults in Reading who are recorded on GP records as having depression, a learning disability, or a serious mental illness (SMI). Data only includes those who have had their BMI recorded in the past 12 months. Obesity prevalence is higher amongst adults with these conditions than it is on average for all adults.

[4] https://www.gov.uk/government/statistics/update-to-the-obesity-profile-on-fingertips/obesity-profile-short-statistical-commentary-may-2024

Figure 2.1: Reading GP data – obesity prevalence, patients 18+ - by patient vulnerability



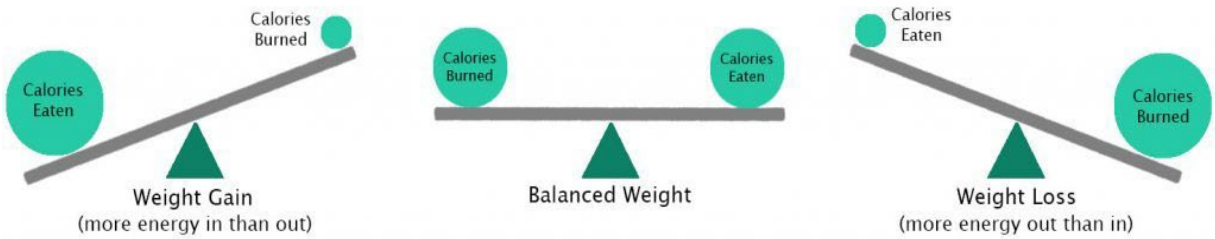
(Frimley Integrated Care System, 2023) [accessed April 2023]

2.2 Causes of excess weight and whole systems approach to obesity

Obesity and overweight issues arise from a complex interplay of influences as described below:

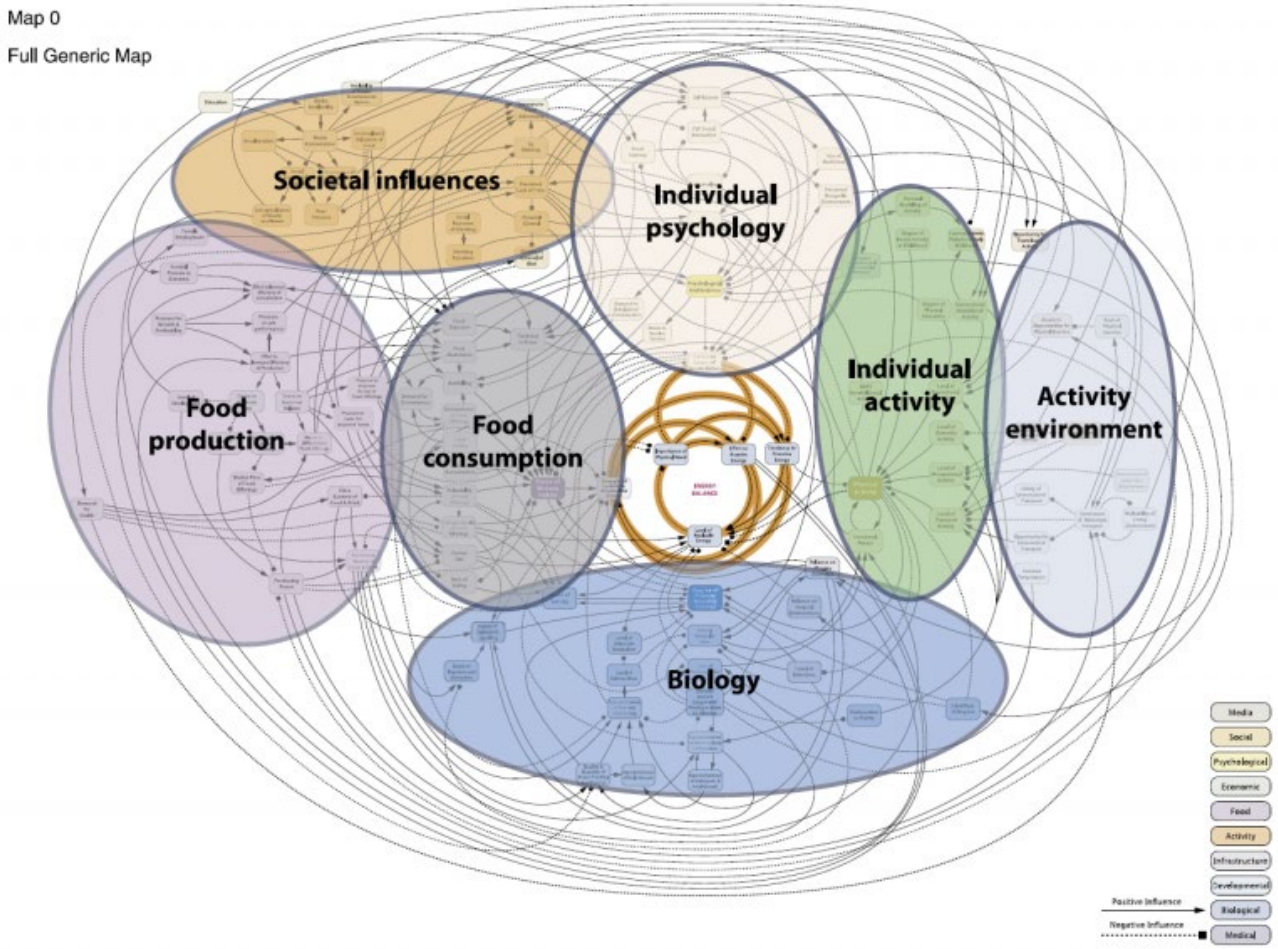
- an increased intake of energy-dense foods that are high in fat and sugars; and/or
- an increase in physical inactivity due to the increasingly sedentary nature of many forms of work, changing modes of transportation, and increasing urbanisation
- lasting impacts of the COVID 19 pandemic with new lifestyle, societal, and environmental norms

Figure 2.2: Energy balance vs energy imbalance



Changes in dietary and physical activity patterns are the result of a complex mix of interactions that can be grouped into environmental, commercial, and societal influences as depicted in the Obesity System Map below (Figure 2.3).

Figure 2.3: The full obesity system map with thematic clusters, from the Tackling Obesities: Future Choices report



Biological influences such as pre-existing inherited susceptibility, co-existing illness, or medications all play an important role.

It should be noted how dietary intake and expenditure are potentially influenced by wider and commercial determinants. The legacy of the COVID 19 pandemic has impacted on people's life, and the cost-of-living crisis is an additional influence on behaviours connected with eating, drinking, and moving and so will fall within the scope of this healthy weight needs assessment.

The complex interaction of factors that lead to individual vulnerability and exposure to risk factors for overweight and obesity as described in the Foresight report (HM Government, 2007) suggests that everyone is at risk of overweight and obesity, with poor diet and sedentary lifestyles causes of obesity at an individual level.

Over 100 wider determinants of obesity were identified by the Foresight report. These encompassed individual and family eating habits; physical activity habits; the food and physical activity environments in which people live, work and play; societal influences such as income; education; occupation as well as individual psychology including mental health and wellbeing.

The Foresight and the McKinsey Global Institute (2014) report stated that no single solution will be sufficient for reversing obesity, emphasising the need for a comprehensive, systematic approach[5].

2.3 Protective factors

There are two main protective factors: diet and physical activity. Both influence the energy balance and are explored in some detail in the needs assessment.

2.4 Health impacts of excess weight

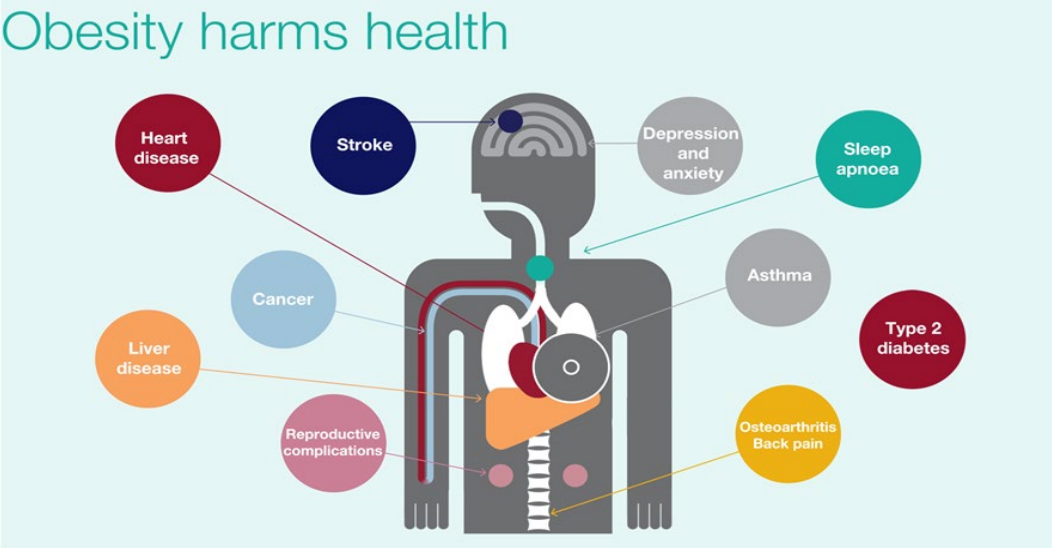
IN 2022 the Office for Health Improvements and Disparities reported that the impacts of excess weight are individual, societal and economic.

Being overweight and obese can have a detrimental impact on physical and mental health. Excess weight is linked to a wide range of diseases, including type 2 diabetes, hypertension, some cancers, heart disease, stroke, and liver disease. Excess weight is also linked to psychological and emotional health issues and sleep disorders.

[5] Public Health England. Whole systems approach to obesity: A guide to support local approaches to promoting a healthy weight. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/820783/Whole_systems_approach_to_obesity_guide.pdf

Figure 2.4 below illustrates some of the main health issues that can be caused by excess weight. Obesity reduces a person's life expectancy by an average of 3 years and severe obesity reduces it by 8-10

Figure 2.4: Office for Health Improvement & Disparities



2.5 Economic impacts of excess weight

The current annual social costs of obesity in the UK are estimated to be around £58 billion, equivalent to 3% of GDP for the UK in 2020. This includes direct costs such as the cost of obesity-related diseases on the health system, including COVID-19 and mental health issues and the loss of quality adjusted life years for individuals. It also includes the wider costs to society such as loss of productivity and cost of social care (Frontier Economics[6])

Other findings include[6]:

- The estimated annual NHS spend on obesity related diseases is £6.5 billion[7] per year.
- The estimated cost of obesity-related risks of Covid-19 is £4 billion.
- Costs tied to loss of productivity and increased social care are estimated to be up to £7.5 billion.
- A 10% reduction in obesity prevalence could lead to significant cost savings, not only to the NHS but also in terms of improved quality of life and workplace productivity. This social gain could be equivalent to almost £6 billion per year.

[6] https://www.frontier-economics.com/media/hgwd4e4a/the-full-cost-of-obesity-in-the-uk.pdf
[7] https://healthmedia.blog.gov.uk/2023/06/07/government-plans-to-tackle-obesity-in-england/

3. Local weight management services

Reading offers a range of services, interventions and activities that contribute to helping people keep active and manage their weight. However, there is a need to ensure that these are systematic, coordinated and integrated to increase their visibility and effectiveness.

Reading Borough Council commissions the delivery of lifestyle and behavioural weight management services for children, families, and adults. Currently, there are four main services that deliver weight management support:

1. Free Swims
2. Physical Activity Referral Scheme (PARS)
3. Adult Weight Management (AWM)
4. Cardiac, which is a PARS version for those who have had a cardiac episode.

PARS, AWM, and Cardiac are delivered under a contract with Greenwich Leisure Ltd (GLL). See Appendix 10.3 for a full report on Healthy Weight Needs Assessment from the Healthwise programme report 2023

The 'Free Swims' service delivers free swims for senior residents of Reading at Reading Sport & Leisure Sites who qualify through the 'Your Reading Passport' card. The primary purpose of the service is to help secure an increase in physical activity and to promote healthy lifestyle choices by removing barriers to sport and physical activity, especially for those currently inactive and from the most deprived areas of the Borough. The 'Free Swims' offer is also offered to young people accessing the holiday programmes.

Reading has several walks in and around the borough to promote physical activity and connection with nature and community in groups. More information about weight management and physical activity can be found at RBC Walks webpage and the Reading Service Guide.

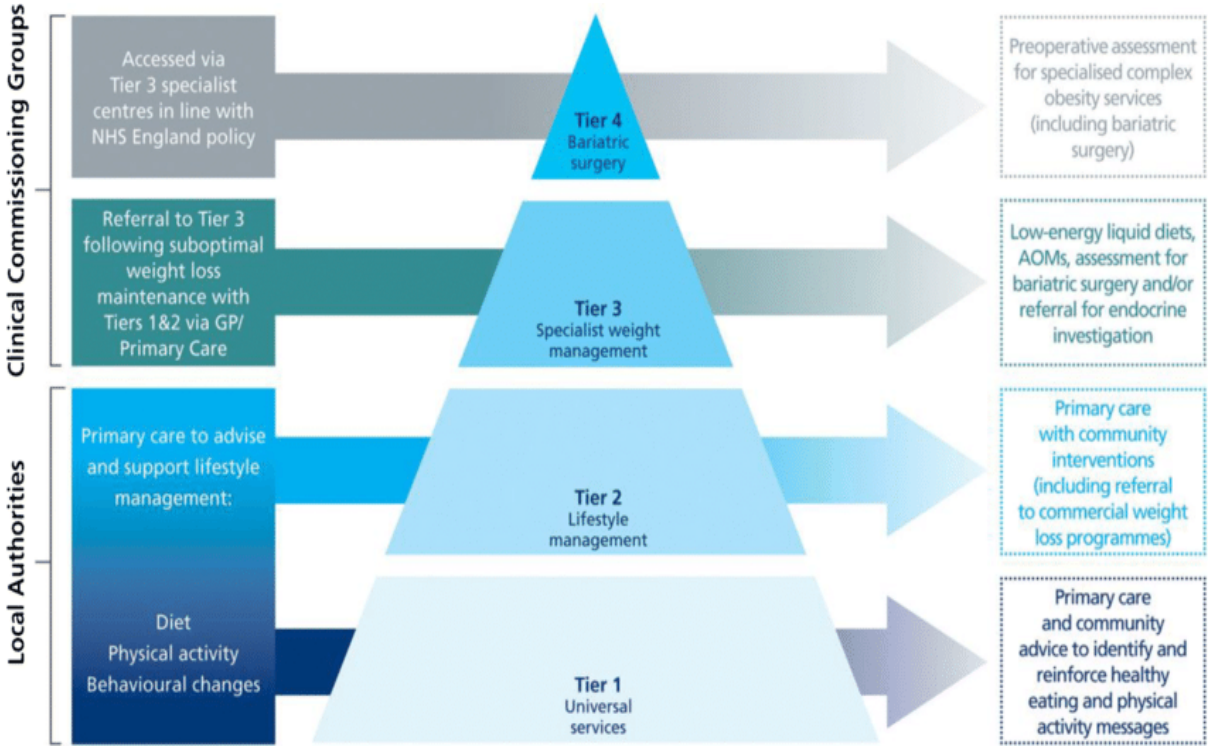
Gamification can be a method for increasing active travel and physical activity. Intelligent Health ran their Beat the Street programme between 25 September to 6 November 2024 in South and East Reading. This involved children, families and community members walking to boxes around schools, parks and pre-determined areas to collect virtual points.

School age children can access school meals that offer a balanced diet. In Reading, current provision to support school meals include the Free School Meals Programme and the Healthy Start Voucher scheme. Alongside this, most primary schools offer a Wraparound Childcare provision which might include a breakfast club and an after-school club. These clubs can include some food provision and physical activities.

The Community Wellness Outreach programme is being delivered by the Royal Berkshire Hospital's Meet PEET in Reading to provide NHS Health Checks in local community settings and identify people who may be at risk of high blood pressure, diabetes or cardio-vascular disease.

In addition, Reading Voluntary Action, through the Community Wellness Outreach project, has funded 10 "Give it a Go" memberships (£30 per membership) delivered by GLL. The six-week programme allows individuals to try different activities within the leisure centres. GLL added a "Week 0" as an introductory session that includes a tour of the leisure centre, tea & coffee, a Q&A session (covering topics such as what to wear and what to bring), and assistance with membership applications. This is not a Healthwise product or programme and is not monitored for any related outcomes.

Currently in the United Kingdom, weight management services are classified into four 'tiers'. Tiers 1 and 2 are currently commissioned by Local Authorities and Tiers 3 and 4 by Integrated Care boards (or ICBs), formally Clinical Commissioning Groups. Figure 3.1 below shows the pathways in England.

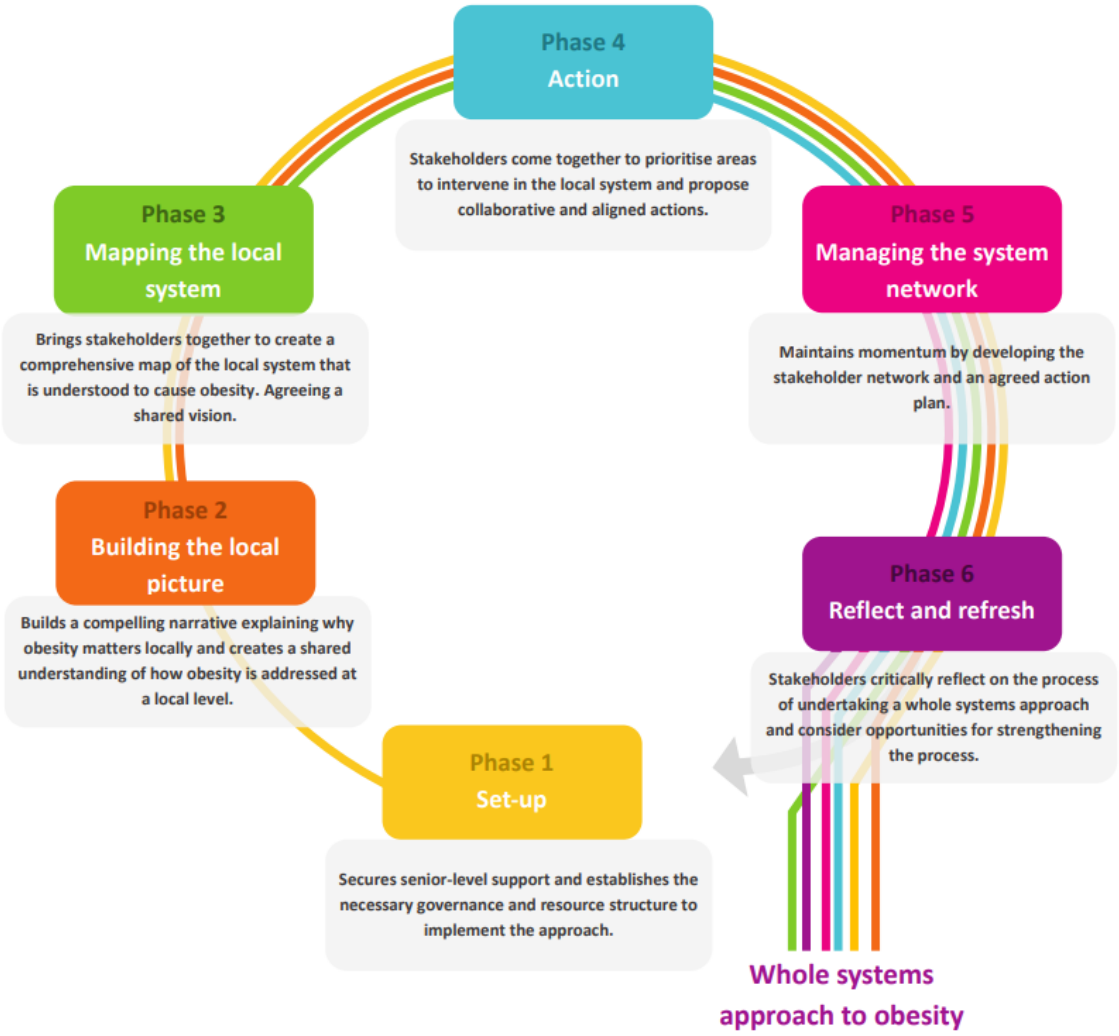


Across the Buckinghamshire, Oxforshire and Berkshire (BOB) Integrated Care Board (ICB) patients can access a Tier 3 pathway that includes weight the loss medications Semaglutide and liraglutide. The consultant led service is available to patients under the Right to Choose Framework.

A Tier 4 service is provided at the Royal Berkshire Hospital (RBH) and receives 550 referrals each year. The entry route is through the Endocrinology service. The expectation is that clients will progress to surgery and the waiting time from referral to surgery is around 3 years. The Acute Provider Collaborative Group have recently commissioned a deep dive into Bariatric Surgery.

4. Whole Systems Approach to obesity

The whole systems approach to obesity is an essential guide for local authorities about the implementation of a Whole Systems Approach to Obesity (WSAO)[8]:



Reading Borough Council Public Health Team is in the early stages of promoting and planning the implementation of a Whole Systems Approach to Obesity. This takes account of a complex geographical area and complicated health economy. The planning of each phase will be in collaboration withs system partner organisations from all sectors; working together to take a multi-agency approach to reducing obesity across the population in Reading.

[8] https://assets.publishing.service.gov.uk/media/5d396e7140f0b604de59fde9/Whole_systems_approach_to_obesity_guide.pdf

4.1 Whole Systems Approach, Health inequalities and Wider determinants of health

A whole systems approach to obesity is a good example of a 'Health in All Policies' approach. It draws on a local authority's potential to engage local communities and local assets with the sustained, visible and active support of elected members, the chief executive and senior leaders to send a clear signal that tackling obesity is a priority for the whole local authority, not just the public health team. The wider determinants of health, social and health inequalities, poverty, and social isolation can be positively influenced at a local level by a WSAO to help mitigate the exposure to risk factors and remove barriers so that everyone can lead a healthy life.

This can be achieved by:

1. **Addressing the social determinants of health**: Poverty, unemployment, and social exclusion, play a crucial role in obesity. A Whole Systems Approach to Obesity can help to promote equity and reduce health inequalities.

2. **By engaging stakeholders across multiple sectors:** to address the social determinants for example by addressing food insecurity, a significant factor in obesity. This could be working with local food producers and suppliers to provide affordable, healthy food, and reduce the risk of obesity.

3. **Creating a supportive environment that fosters healthy lifestyles**: Implementing changes to local policies, infrastructure, and programs. For example, by providing more access to local healthy food options, increasing local opportunities for physical activity, creating safe walking and cycling routes. This could make the healthy choice the easiest choice and mitigate the impact of socio-economic factors on health outcomes.

4. **Collaboration with high-risk populations**: High-risk populations, such as children, low-income groups, and ethnic minorities can be supported in the coproduction of appropriately tailored interventions whilst ensuring delivery of universal services at a scale and intensity proportionate to the degree of need.

It is clear from the available evidence that obesity is linked to wider social and economic inequalities and is not just a health issue. People living in areas with poor access to healthy food options, to safe places to exercise and experiencing higher levels of deprivation are more likely to be obese. A WSAO can help to make changes that mitigate the impact of the socioeconomic environment and reduce the risk of obesity.

NICE guidelines state "It is unlikely that the problem of obesity can be addressed through primary care management alone. More than half of the adult population are overweight or obese and a large proportion will need help with weight management. Although there is no simple solution, the most effective strategies for prevention and management share similar approaches. The clinical

management of obesity cannot be viewed in isolation from the environment in which people live."

Summary

- There is an overarching national 'Call to Action' on obesity with published policy aims for population weight loss.
- Local authorities are encouraged to implement the Whole Systems Approach to Obesity (WSAO) to collaborate and align their efforts with other public services and organisations such as planning, regulation, sport and green spaces all to be mobilised to tackle obesity and improve the health in their local area.
- Guidance on a Whole Systems Approach to Obesity provides an opportunity to move away from relatively short-term interventions towards a long-term approach that rebalances individual behaviour change with a systematic structural approach that engages the full range of partners across the local system in Reading.
- Local authorities are encouraged to use their local regulatory powers to curb fast-food outlets and to promote active travel and physical activity.

5. Recommendations

Theme	Description of action
Wider Determinants and Commercial Determinants	**Reframe the narrative** So that upstream prevention is at the heart of what public health are about and the impact this has specifically to reversing the tide of excess weight.
	Work toward becoming a public health council Consider developing a Health in all Policy approach that delivers prevention and sustainable outcomes at every opportunity.
	Adopting a healthier advertising policy in Reading Improving the food environment and increasing the opportunity for advertisement for profitable sectors (non-food related ads) as successfully seen in other areas who have already adopted such an approach, i.e. reducing fast food advertising
Training	**Upskilling workforce** Including adult social care about eating well, signposting and Making Every Contact Count or similar programs.
	Develop a mechanism To capture and evaluate the impact of raising the issue of weight to residents and patients through the VCSE Joy app.
	Public facing support/training for unpaid and paid carers To support themselves and support the person they are caring for, in terms of food, nutrition and others. This should include practical cooking sessions and guidance with training for paid carers supporting those living in shelter/supported living accommodation.
	Raise the profile of the Whole Systems Approach to obesity To support policy makers and key stakeholders across Reading Borough Council to recognise their role in reducing the prevalence of excess weight.
Physical Activity	**Promote physical activity in daily life** Encourage integrating physical activities like walking, cycling, and using stairs into everyday routines. Employers and local authorities should create environments that support these choices.
	Tailor interventions for seldomly heard groups Develop and implement weight management physical activity programs tailored to the diverse needs of the community, considering different age groups, cultural backgrounds, and physical abilities. E.g., for men, use strategies like male-friendly language, men-only groups, and activities linked to sports clubs. Include behaviour modification and motivational strategies for increased participation and effectiveness.
	Leverage technology and gamification Utilise interactive, web-based platforms and incorporate gamification elements in fitness programs to increase motivation, enjoyment, and adherence to physical activity, especially among

	younger and digitally inclined individuals. Ensure that they suit individual preferences and cultural contexts for maximum effectiveness.
Eating Well and our Food Environment	**Build healthier communities** By connecting communities to support better food choices, helping people to make better food decisions for better health and wellbeing. A whole system approach, sharing information and resources.
	Tackle food poverty Improve access to nutritious food for all, provide support to groups that provide a safe space to residents, food and beverages. Explore opportunities for increasing training and skills. Improve access to cooking and budgeting courses.
	Create healthier environment Develop an environment that promotes healthy eating and physical activity as part of daily life e.g. a sustainable transport network that makes walking and cycling the default form of travel around our communities; reducing the number of licensing authorisation for fast food outlets.
	Reduce fast food advertising Particularly near places where children congregate schools and nursery schools and promote messages about healthy eating.
	Support and incentivise local food outlets to provide a healthier food offer.
	Create a minimum standard of food/drink offered across all public sector facilities Ensure Government Buying Standard-based criteria are used in the procurement of food and catering services by public sector facilities.
	Ensure Healthy Start is well promoted across Reading By a range of professionals: healthcare, community voluntary sector and council and that there are clear pathways to support a wide range of eligible people and families to sign up to the scheme and to be able to access fresh fruit & vegetables, milk and supplements.
	Schools Increase free school meal uptake, this is better value for schools and ensure that children have access to at least one hot, nutritious meal during the day.
Weight Management Provision	**Develop holistic and compassionate services** To provide a variety of options including non-traditional weight management services including: - Exercise only groups (Tier 1) - Smaller groups - Age/life-course /gender course appropriate - Longer term support - Targeted specific cohort such as Learning Disability - Emotional/mental health links with food and behaviour change insights - Other outcomes such as Physical activity, Blood pressure and wellbeing taken into consideration – not just weight.

	Weight management provision should be inclusive For neurodiversity, mental health, cultural heritage, physical disability, limited mobility and ethnicity. This is particularly important for people who live in economically deprived areas with respect to physical activity and access for all to green spaces and parks.
Referral Pathway	**Clear Summary of pathway made available from Tier 1 to Tier 4.** This would aid referrals and those who signpost to understand what services are available and to whom.
	Continue the collaborative working group between Public Health, integrated care board (ICB) To review care pathways, explore what can be done to minimise some of the gaps and to consider the value of inviting a Dietitian to this group.
	Work with service providers to maintain free, acceptable waiting times and improve referral quality within Tier 2 adult weight management at Healthwise. This will include doing engagement work and training with referral, especially health care professionals.
Marketing and Communication	**Explore ways to raise the profile of physical activity pathways to service providers** Including the Voluntary, Community, Social Enterprise sector, Healthcare Professionals and residents. Improve awareness of and use of weight centric and physical activity pathways in Reading for service providers through the JOY app for example.
	Develop a local social marketing strategy for maintaining a healthy weight through eating well and moving more There will need a universal offer and a culturally appropriate offer for targeted audiences whose specific needs not met via the universal communications strategy. This should be informed by insights work and collaboration with existing networks such as community health champions, Healthwatch Reading and the Voluntary Community Social Enterprise sector.
	Social Marketing To support the Reading Food Partnership.

6. Summary of identified gaps

The needs assessment provided an opportunity to scan the local systems and identify gaps in service provision. See a list below:

Chapter	Identified Gap(s)
Local Assets Mapping	❖ The findings of local assets mapping workshops are that the most impactful area local government can focus efforts on is Living and Working Conditions. However, these are the areas where there are the fewest interventions and actions based on the information collected to date. ❖ Although there are gaps in attendance, this picture is reflective of activity across the system, as seen across England with efforts tending to focus on lifestyle change in recent years.
Food and our environment	❖ There are no specific restrictions on advertising content beyond those provided by the Advertising Standards Authority. ❖ As Reading's advertising licence for bus shelters and free-standing units expires in May 2025, there is now an opportunity to review the local advertising policy to explore if it is possible to reduce exposure to fast-food advertising, noting the revenue implications.
Local weight management pathways	❖ Tier 3 provision ❖ Lack of choice for Tier 2 Adult Weight Management programmes, reliant on Healthwise as Healthwise is the sole current provider in Reading. ❖ The current pathway for children needs to be mapped. There is not a Tier 2 pathway, which is the responsibility of the Local authority to provide.

7. Glossary

Needs Assessment

A systematic process that identifies needs within a specific group or geography. It enables policy makers to make decisions according to current gaps, allocating resources and developing interventions based on findings.

Compassionate approach to healthy weight

An approach that shifts blame away from individuals, implements measures towards healthier environment and recognises the unequal impacts of poverty and inequality on people.

Healthy Weight, Overweight and obesity

Definitions of underweight, desirable weight, overweight and obesity among adults and children are defined using the body mass index (BMI) which is a measure of the weight to height ratio. BMI is a calculation that takes a person's weight in kilograms and divides it by the square of height in metre.

In adults, underweight is defined as having a BMI of either less than 18.5 or less than 20; overweight is defined as having a BMI of 25 or more; obese is defined as having a BMI of 30 or more, and morbidly obese is defined as having a BMI of 40 or more.

Please note that the term 'obese' and 'very overweight' are used interchangeably throughout this document.

Body Mass Index

BMI is a simple index of weight-for-height and is calculated by dividing a person's weight in kilograms by the square of their height in metres (kg/m2). BMI is a widely used indicator that does not distinguish between muscle and fat therefore may not accurately reflect health risks at individual level.

Indices of Multiple Deprivation - measures relative deprivation across a range of parameters experienced by people living in small areas called Lower-level Super Output Areas (LSOAs) in England.

Inequalities - Inequities in health are caused by the unequal distribution in the determinants of health, including power, income, goods and services, poor and unequal living conditions, and the differences in health-damaging behaviours that these wider determinants produce. Large socioeconomic, gender and ethnic inequities exist in terms of obesity[9].

[9] WHO (2013) Obesity and inequities Guidance for addressing inequities in overweight and obesity

Inductive coding thematic approach

A qualitative data analysis method that is employed to identify common themes and patterns in mostly textual data, usually from interview transcripts, field notes or open-ended survey responses. The opposite of inductive coding is deductive coding with pre-established categories prior to data analysis. Inductive coding allows themes to emerge from the data until the researcher reaches saturation whereby no new theme is identified.

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Obesogenic environment - The term 'obesogenic environment' refers to the role environmental factors may play in determining both nutrition and physical activity. It has been defined an environment that promotes gaining weight and one that is not conducive to weight loss" within the home or workplace (Swinburn, et al., 1999).

Whole Systems Approach (WSA)

A method for addressing complex problems by considering varying components of the system and its context. It calls for a holistic approach and collaboration to tackle its multifaceted components.

8. Acknowledgment

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Reading Borough Council
Working better with you

HEALTHY WEIGHT NEEDS ASSESSMENT

PROMOTING HEALTHY WEIGHT FOR ADULTS IN READING

Fast Food outlets per 100,000 population (2024/OHID)

Prepared by: Yasmine Illsley, Amanda Nyeke, Sabine Mayeux, Chrystanthi Tsiarigkli, Nina Crispin, Joshua Rencher

Full report: March 2025

Table of Contents

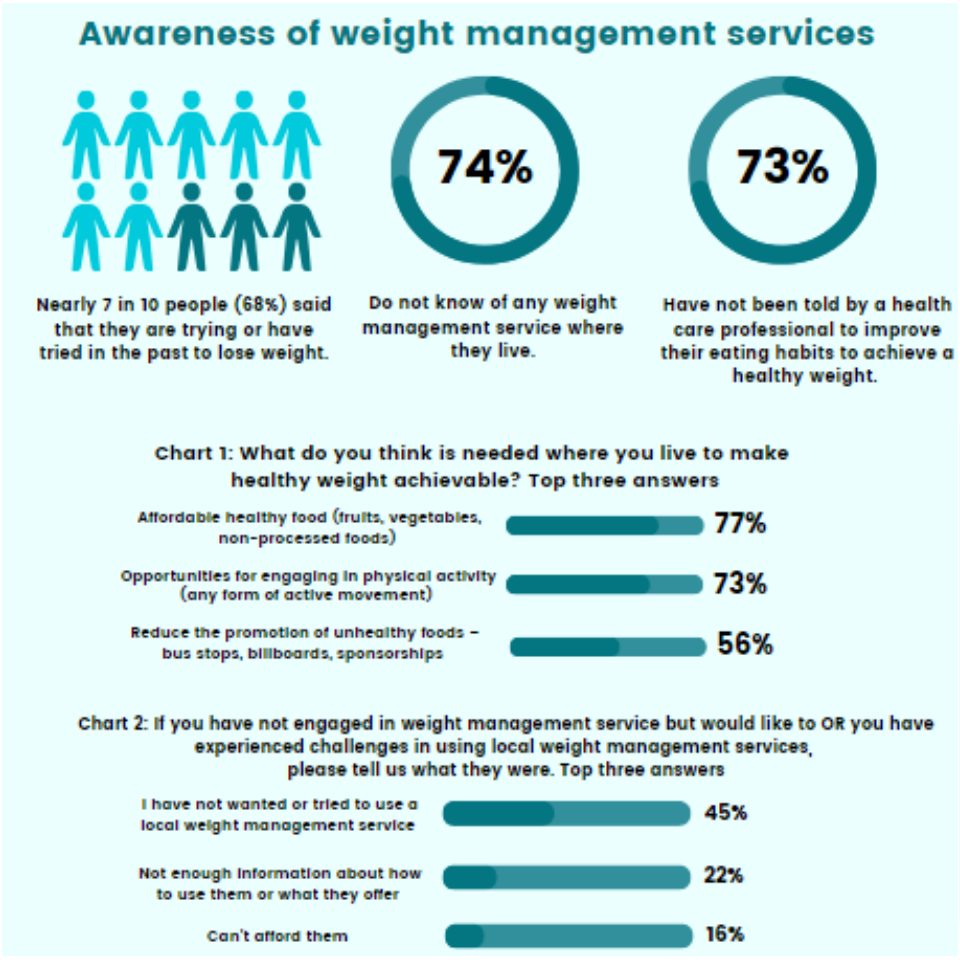
1. Executive summary and Recommendations

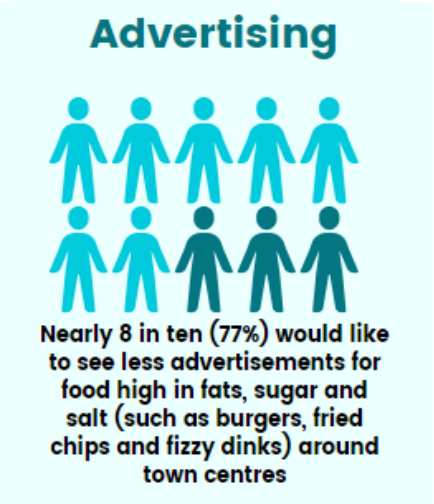
1.1 Executive summary

The purpose of this needs assessment is to provide local and national quantitative and qualitative evidence to inform a strategic and whole systems approach to reducing obesity in Reading.

This document is not static and will continue to be informed by contributions from local stakeholders who have an agenda in enabling the reduction of obesity for local residents.

The infographics below highlight the local context and responses to the survey that was shared with members of the public and professionals (Healthy weight needs assessment survey run from 5th May 2023 to 16th June 2023)





On food insecurity, some people said:

"Bought less food and stuff on sale, prioritising value over health"

"Increased prices have led to credit card debt"

"We are a product of our environment - quote form member of ethnic minority"

1.2 Recommendations

Theme	Description of action
Wider Determinants and Commercial Determinants	**Reframe the narrative** So that upstream prevention is at the heart of what public health are about and the impact this has specifically to reversing the tide of excess weight.
	Work toward becoming a public health council Consider developing a Health in all Policy approach that delivers prevention and sustainable outcomes at every opportunity.
	Adopting a healthier advertising policy in Reading Improving the food environment and increasing the opportunity for advertisement for profitable sectors (non-food related ads) as successfully seen in other areas who have already adopted such an approach, i.e. reducing fast food advertising.
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7.3 – Food and our environment	There are no specific restrictions on advertising content beyond those provided by the Advertising Standards Authority. As Reading's advertising licence for bus shelters and free-standing units expires in May 2025, there is now an opportunity to review the local advertising policy to explore if it is possible to reduce exposure to fast-food advertising, noting the revenue implications.
8.3 Local weight management pathways	Tier 3 provision Lack of choice for Tier 2 Adult Weight Management programmes, reliant on Healthwise as Healthwise is the sole current provider in Reading. The current pathway for children needs to be mapped – no tier 2 which is the responsibility of the Local authority responsibility to provide.

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2. Introduction

2.1 What is excess weight and why does it matter?

Overweight and obesity are defined by the World Health Organisation (WHO), as abnormal or excessive fat accumulation that may impair health.

Obesity is one side of the double burden of malnutrition. For this Healthy Weight Needs Assessment, the focus is on Excess Weight and reaching and maintaining a healthy weight, and the ability of the Local Authority to drive and influence change. Worldwide obesity has nearly tripled since 1975, with over 650 million adults being classified as obese in 2016.

Body mass index (BMI) is a simple index of weight-for-height that is commonly used to classify overweight and obesity in adults. It is defined as a person's weight in kilograms divided by the square of his height in meters (kg/m^2).

2.1.1 Adults

For adults, the WHO defines overweight, and obesity as follows:

- overweight is a BMI greater than or equal to 25; and
- obesity is a BMI greater than or equal to 30.

BMI provides the most useful population-level measure of overweight and obesity as it is the same for both sexes and all ages of adults. However, it should be considered a rough guide because it may not correspond to the same degree of fatness in different individuals.

For children, age needs to be considered when defining overweight and obesity.

2.1.2 Children under 5 years of age

For children under 5 years of age:

- overweight is weight-for-height greater than 2 standard deviations above WHO Child Growth Standards median; and
- obesity is weight-for-height greater than 3 standard deviations above the WHO Child Growth Standards median.

2.1.3 Waist-to-height ratio

Another measure of healthy weight is the waist-to-height ratio, which is a good indicator of excess tummy fat. A person can have a healthy BMI and still have tummy fat. The waist-to-height ratio is calculated by dividing the waist measurement by height. A waist-to-height ratio of 0.5 or higher means you may have increased health risks such as heart disease, type 2 diabetes, and stroke. (Source: National Health Service (NHS), 2023)

2.2 Who is impacted?

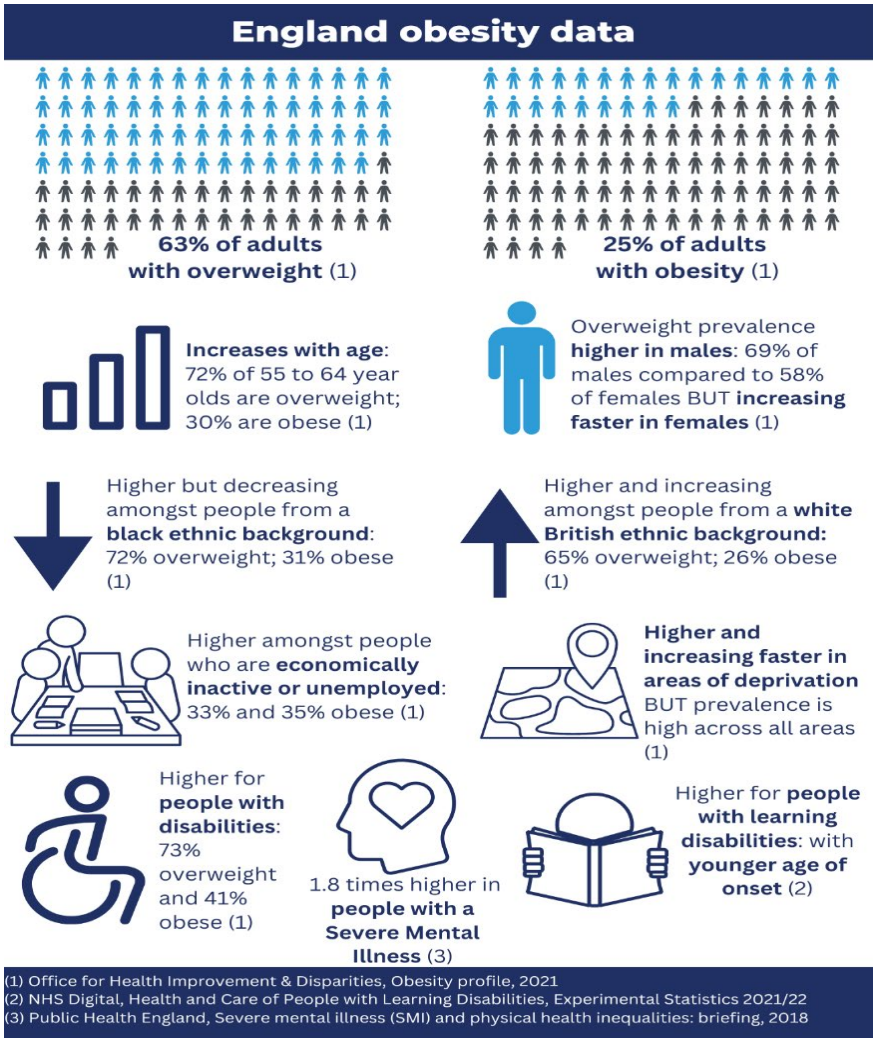
The prevalence of obesity and excess weight (overweight and obese) continues to increase nationally. In 2022/2023, 26.2% of adults aged 18 and over in England were obese, while 64% were overweight or obese[2]

The complex interaction of factors that lead to individual vulnerability to overweight and obesity as described in the Foresight report (HM Government, 2007) means that everyone is at risk of overweight and obesity.

This is further attested to in the overall prevalence rates seen in England and across other areas of the world.

However, there are trends seen in the data that indicate that the prevalence of overweight and obesity is elevated above average amongst some broad groups of people. These are summarised in Figure 2.1 and described in further detail below.

Figure 2.1 England Obesity Data



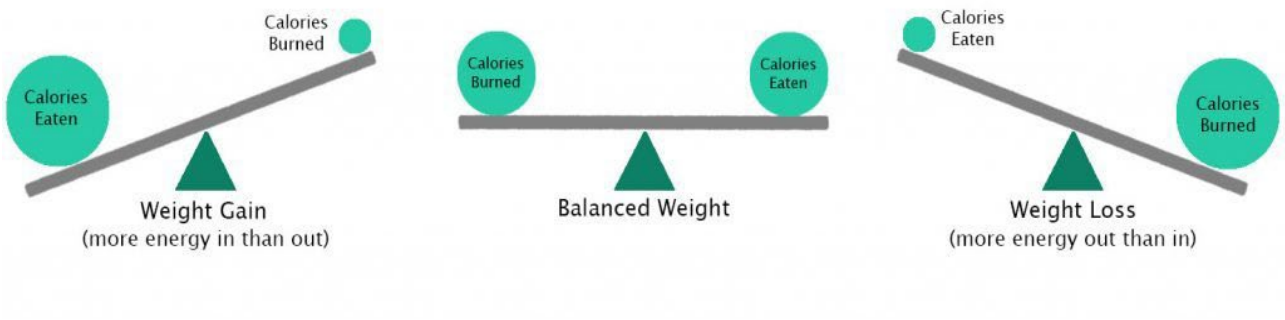
[2] https://www.gov.uk/government/statistics/update-to-the-obesity-profile-on-fingertips/obesity-profile-short-statistical-commentary-may-2024

2.3 Causes of excess weight and whole systems approach to obesity

Obesity and overweight issues arise from a complex interplay of influences as described below:

- an increased intake of energy-dense foods that are high in fat and sugars; and/or
- an increase in physical inactivity due to the increasingly sedentary nature of many forms of work, changing modes of transportation, and increasing urbanisation, and most recently lasting impacts of the pandemic on new lifestyle, societal, and environmental norms.

Figure 2.2: Energy balance vs energy imbalance

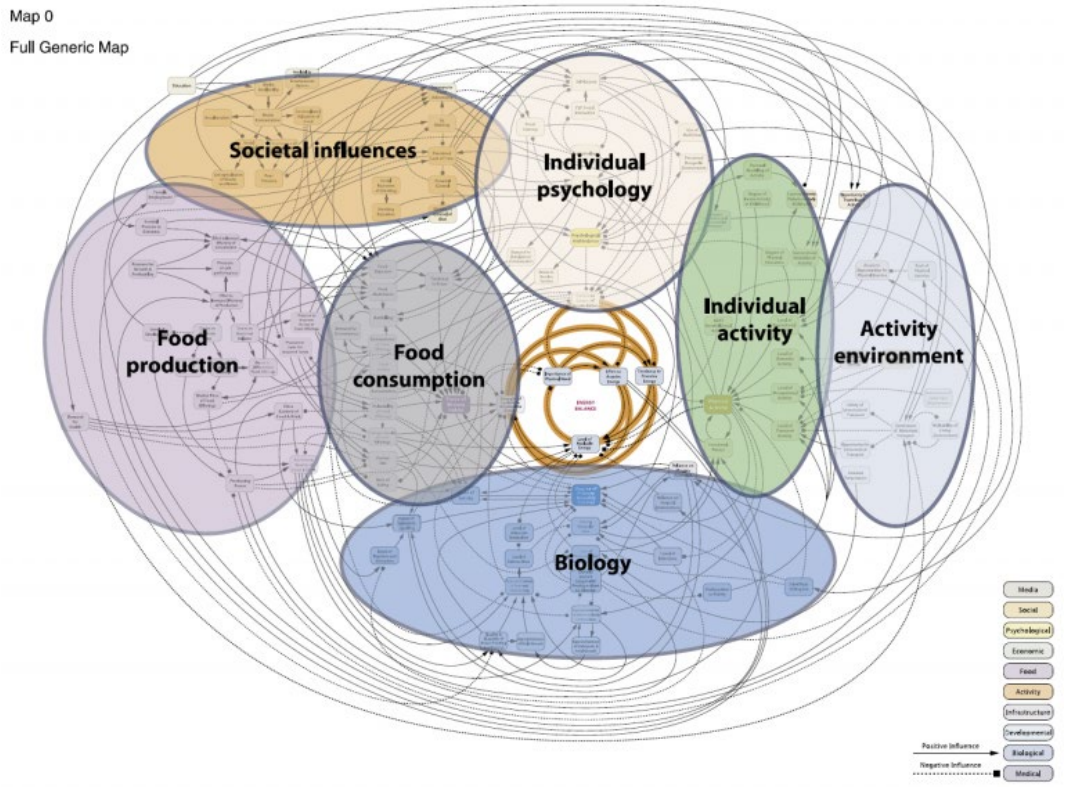


However, in reality, changes in dietary and physical activity patterns are the result of a complex mix of interactions that can be grouped into environmental, commercial, and societal influences as depicted in the Obesity System Map below (Figure 2.3).

Biological influences also play a key role, e.g. pre-existing inherited susceptibility, co-existing illness, or medications.

Thus, it is key to understand how dietary intake and expenditure have been impacted by some of these wider and commercial determinates. The pandemic has undoubtedly had a lasting impact on people's life, and the ongoing cost of living is also influencing people's behaviour around eating, and drinking, and moving. Thus, will be a focus of this healthy weight needs assessment.

Figure 2.3: The full obesity system map with thematic clusters, from the Tackling Obesities: Future Choices report



Other causes to note include hormonal issues (i.e., hypothyroidism, Cushing's syndrome), genetics, certain medicines (i.e., some steroids, medications for diabetes and mental illness, etc.), long-term medical conditions, and lack of physical activity. In addition, smoking, heavy alcohol consumption, oral hygiene, and having a diet low in fruit and vegetables are risk factors for excess weight and obesity. Stop smoking may also lead to gaining excess weight, however, following a healthy diet and being physically active can mitigate the risk of gaining excess weight when someone quits tobacco.

The Obesity System Map categorised various variables into 7 cross-cutting predominant themes:

- **Biology:** an individual's starting point - the influence of genetics and ill health.
- **Activity environment:** the influence of the environment on an individual's activity behaviour, for example, a decision to cycle to work may be influenced by road safety, air pollution, or provision of a cycle shelter and showers.
- **Individual Activity**: the type, frequency, and intensity of activities an individual carries out, such as cycling vigorously to work every day.
- **Societal influences**: the impact of society, for example, the influence of the media, education, peer pressure, or culture.

- **Individual psychology**: for example, a person's psychological drive for particular foods and consumption patterns, or physical activity patterns or preferences.
- **Food production**: the influence of the food production or environment on an individual's food choices, for example, a decision to eat more fruit and vegetables or takeaways may be influenced by the availability and quality of this food near home or work;
- **Food consumption**: the quality, quantity (portion sizes), and frequency (snacking patterns) of an individual's diet

2.4 Protective factors

There are two key protective factors - Diet and physical activity, which influence the energy balance, and thus will be explored in more detail later in this needs assessment.

3. Purpose, objectives, scope and methodology

3.1 Purpose and aims

The purpose of this health needs assessment is to better understand the needs of Reading's population regarding effective provision that promotes healthy weight. Nationally and indeed locally the number of people experiencing excess weight, and the associated negative consequence to health, is increasing. Since the last needs assessment was undertaken in 2019/20, there has been a global pandemic in 2020-2022 and people continue to experience the increasing impacts of austerity, with a '*cost of living crisis*' being declared in 2022. These will undoubtedly have impacted the way people live their lives including their choices around food and physical activity, but it is also important to note the impact these major events will have had on wider and commercial determinants of health. Moreover, the former needs assessment focused almost entirely on weight at an individual level, i.e., management services. The need to explore the wider environmental and societal impacts was evident.

The aims of this health needs assessment are to interrogate the evidence-base around nutrition, physical activity, and weight to better understand the health inequalities around excess weight, including wider and commercial determinants that impact people's weight. This needs assessment created an opportunity to engage with residents with lived experience and apply all sources of intelligence to form recommendations to reduce these health inequalities in order to reverse the trend of excess weight locally in Reading. The aim is also to find what the weight landscape looks like for Reading population and compare these to other similar regions, as well as Berkshire West and the South East.

The initial aim was to understand the needs of children and adults, however, due to challenges outlined in the methodology, further community engagement with children and young people is needed to understand their needs and will be conducted at a later date.

3.2 Objectives

- Define who is impacted by excess weight.
- What factors contribute to excess weight nationally and locally.
- Review existing services/assets.
- Find out how Reading compares against evidence of best practice.
- Understand how best to support people – adults and children in overcoming some of these barriers identified in achieving healthy weight.
- Identify gaps in service provision, policy and or local action.
- Form evidence-based recommendations to address excess weight locally.
- Inform commissioning intentions going forward.

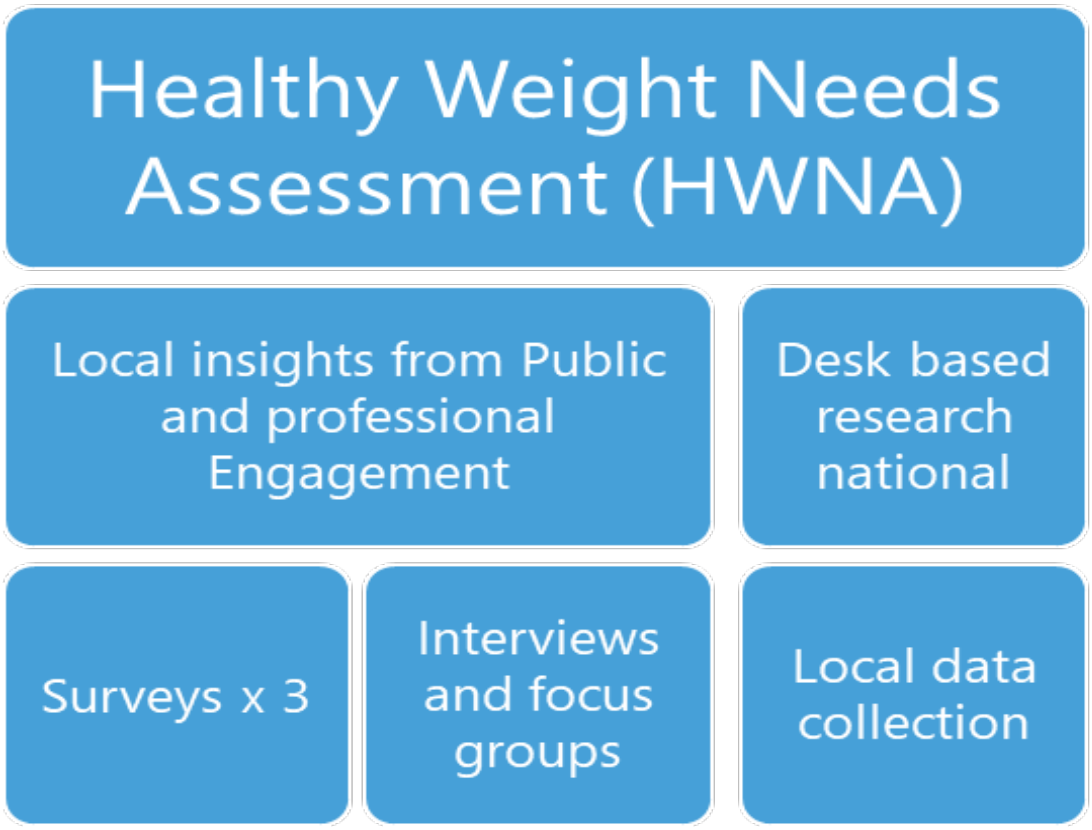
- Give clear direction of what to prioritise in Reading to address excess weight and influence resource allocation to support this.

3.3 Scope

The focus of this needs assessment is to understand how to prevent overweight and obesity and promote healthy weight more effectively for the adult population of Reading. Healthy Weight is the primary aim and although underweight is a concern, excess weight impacts a bigger proportion of people, and its increasing trend is of concern for public health. Local Authorities are best placed to respond to the distinct local factors that influence weight. This needs assessment provides recommendations on how Reading Borough Council can influence services and local activities that promote and maintain healthy weight for the Reading population.

3.4 Methodology

To address the aims and objectives of this needs assessment and to understand the issues in Reading in relation to weight, a mixed-method research approach was undertaken, which is detailed below. The research was undertaken by a core public health working group with experience and expertise in healthy weight agenda.



3.4.1 Data Review

Desk-based research was undertaken to understand the current evidence base, both locally and nationally. A range of sources were included, including the Office for Health Improvement and Disparities (OHID), Sports England, NHS Digital, The Kings Fund, GOV.UK and NICE, as well as local evidence bases such as evaluation of local provisions.

3.4.2 Engagement

Another key aspect of understanding the needs of Reading in relation to weight included conducting an extensive piece of community engagement. For this aspect of the review, a multiple-pronged approach was taken. Firstly, three surveys were developed:

1. A public facing survey aimed at parents, carers and the public who live in Reading

2. A survey to healthcare professionals including those within the voluntary community sector

3. A survey to educational settings, ranging from early years to further education 18 years and under

A range of questions were included such as multiple-choice questions, Likert scale questions, and some open-ended questions in almost all sections for comments, so capture any additional experiences/beliefs not reflected in the options. Please see Appendix 10.1 and 10.2 for the results of the surveys.

The surveys were shared via email and signposted via various newsletters to a number of key stakeholders, partners, and community groups; including Berkshire Health Foundation Trust, Brighter Futures for Children, Public health commissioned services, and colleagues across Reading Borough Council (RBC) - adult social care, housing, transport, planning, licensing to name a few, along with the Community and voluntary sector.

The surveys were hosted online (Reading Consultation and Engagement Hub), with an option of paper copies being requested to increase accessibility and inclusivity.

A5 Flyers were also produced with QR codes signposting the general public to take part in the survey. Social media was also used to help disseminate the survey link, which was hosted via Reading Engagement Hub.

In addition to the three surveys, 12 focus groups/ professional interviews were conducted, using a range of media including online forums, TEAMs meetings and in person interviews/ discussions. Interview followed the same theme as the

questionnaires; however, they were more fluid in approach to navigating, leading with the area of most concern/pressing for the audience.

In all survey areas in which engagement activities were held online, support was provided to ensure attendees were able to use online platforms (such as TEAMS or Zoom) or could join the meeting via a telephone line. Where engagement activities were held face to face, additional care was taken to ensure people taking part were in a safe and accessible environment.

3.4.3 Analysis

Qualitative data from the focus groups and free text from the consultation were analysed using thematic analysis. This was the best approach based on the research questions and aims. Tools used included: Excel and Word, which were readily available to use and were an influential part in the analysis methodology.

Summary table below shows the steps taken to create the thematic analysis:

Table 1 summarise qualitative analysis steps taken

Phase	Process
Step 1	Read (and re-read) data to become familiar with what the data entails, paying specific attention to patterns that occur.
Step 2	Codes generated by documenting where and how patterns occur. This happened through data reduction where the researcher collapses data into labels in order to create categories for more efficient analysis.
Step 3	Combine codes into overarching themes that accurately depict the data. The researcher should also describe what is missing from the analysis.
Step 4	As a collective working group, we explored how the themes support the data and the overarching theoretical perspective. If the analysis seems incomplete, the researcher needs to go back and find what is missing.
Step 5	Write the report! Decide which themes make meaningful contributions to understanding what is going on within the data. Note that the frequency of themes doesn't always mean more frequent – but common perspective. Something might only be articulated once but can have equal importance – might be the glue/perspective that others are aware of/ did think to articulate.

The quantitative data was taken raw from the consultation feedback. Analysis of the quantitative data was conducted – with further analysis which looked at some of the responses to questions 1, 5 and 18 from those who identified from a range of ethnic minority groups.

There was not a very high response to the survey, with only 9 responses received from the educational setting. Thus, a total of 367 people engaged with the process to capture their views and experience around weight.

Further steps will need to be taken to engage with young people and professionals who influence children and young people.

Figure 3.1 - summary of steps undertaken and engagement outputs.

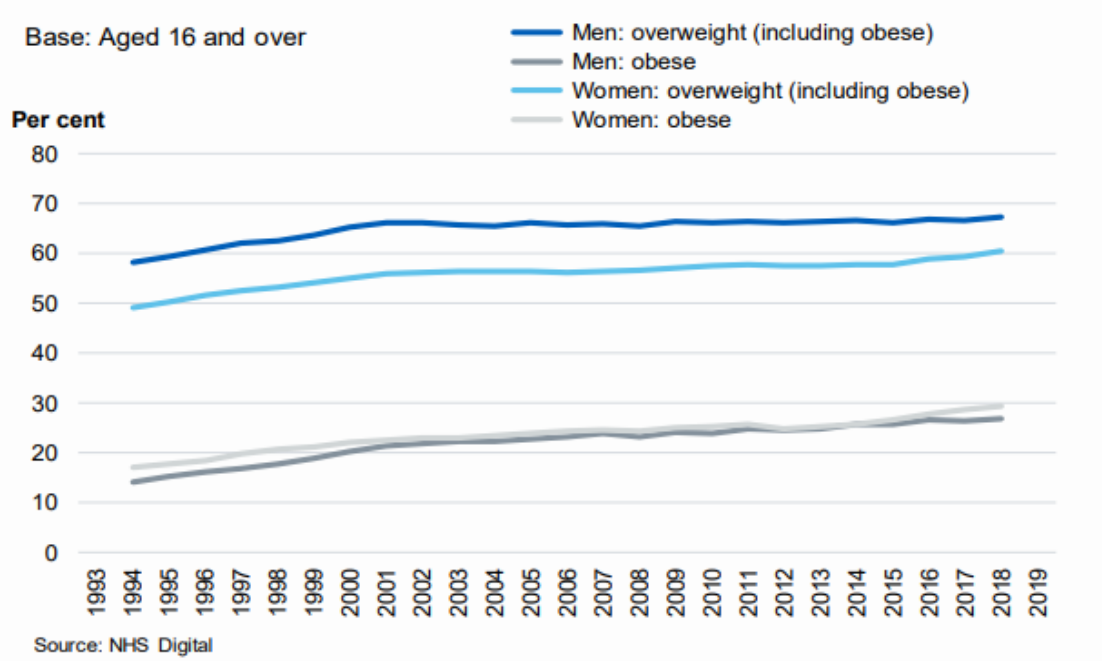
4. The scale of the issue - Adults

4.1 National Picture

The percentage of adults (aged 18+) classified as overweight or obese is measured as part of the Public Health Outcomes Framework (Public Health England, 2019). Calculations are based on survey data recorded as part of the Active Lives Adult Survey (Sport England, 2022). Data are directly age standardise rates per 100 people expressed as a percentage.

Nationally, excess weight in adults (16+) has been increasing over time, while more men are carrying excess weight than women. Obesity, rates are higher in women.

Figure 4.2: Prevalence of overweight and obesity in adults in England, by sex: 1993-2019 (three-year rolling averages)

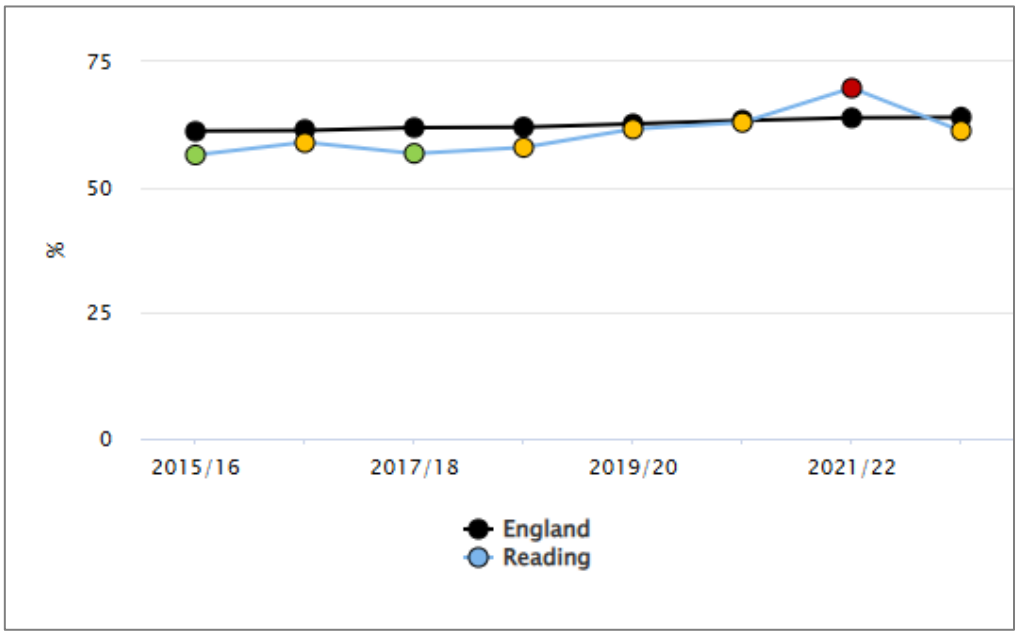


Obesity data for adults in England and Reading is available from the Department of Health and Social Care Fingertips website (Fingertips). Whilst data is available at a local authority level on the site, data for electoral wards or by levels of deprivation for local authorities is not available. Data on the Fingertips site is sourced from the Sport England Active Lives Survey (Sport England ALS), however, ward/deprivation data is currently not available.

4.2 Local picture

Locally, in 2022/2023 28.2% of adults 18 and over were obese (England 26.2%), whilst 61.2% were overweight or obese (England 64%). Levels of obesity and excess weight in Reading were (statistically) similar to England.

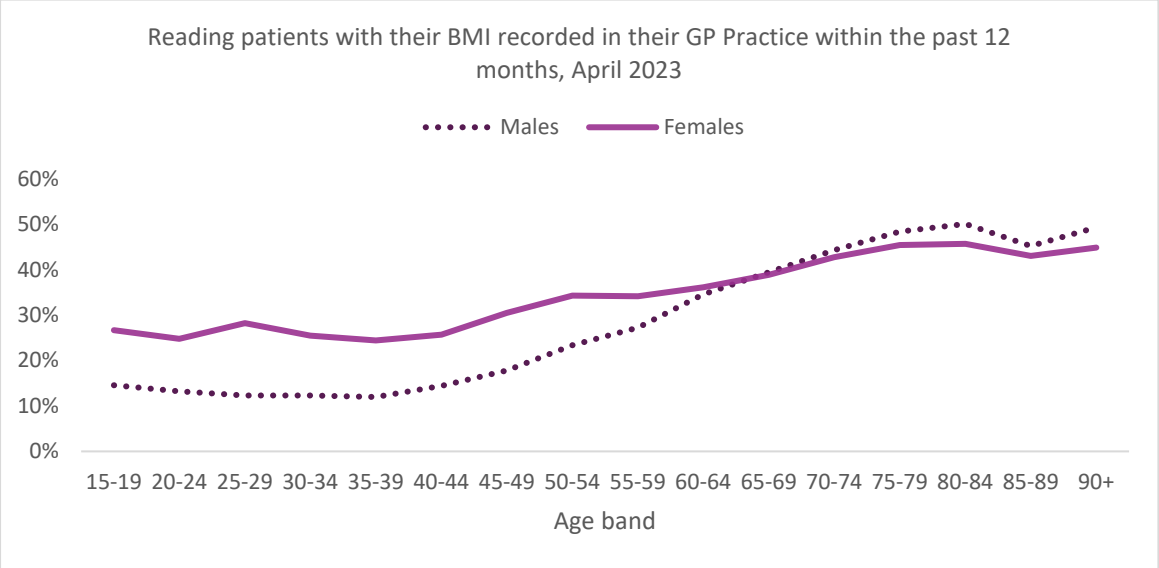
Figure 4.2: Percentage of adults (18+) classified as overweight or obese in Reading compared to England



The local authorities across Berkshire benefit from a system called Connected Care which provides health and social care professionals with a shared care record of their patients. A secondary benefit of this system is the ability to utilise this data to provide insights into the health and well-being of the local population and the ability to target the provision of health services in a way that best suits population needs (Frimley Integrated Care System, 2023).

25% of adults aged 18 and over living in Reading have had their BMI recorded by their GP in the past 12 months. Females (31%) are more likely to have had the BMI recorded than males (20%) and recording coverage increases with age which is driven by a difference in recording between males and females in young age groups (Figure 4.3). This is potentially driven by targeted recording in females due to the prescribing of hormonal contraception at the time of pregnancy.

Figure 4.3: BMI recording uptake in primary care

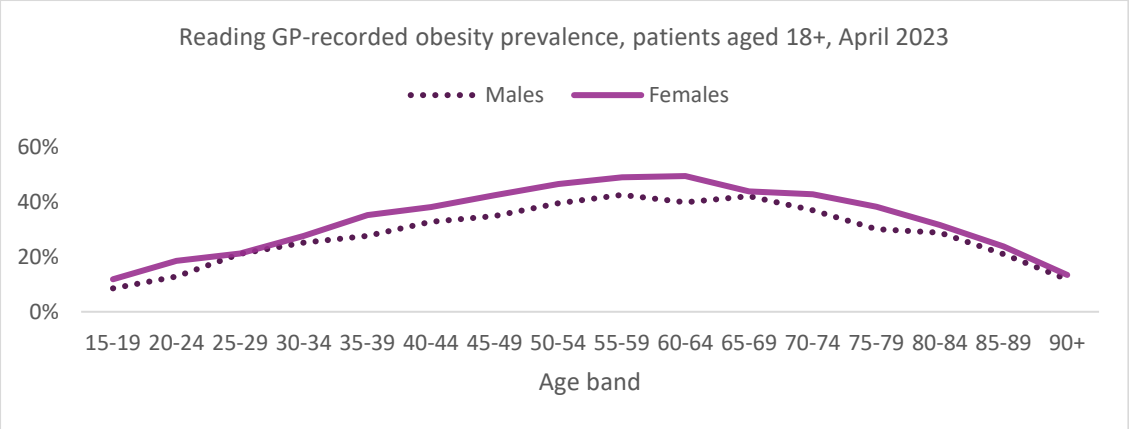


(Frimley Integrated Care System, 2023) [accessed April 2023]

There is no variation in BMI recording coverage associated with deprivation. People from 'other' ethnic groups are slightly less likely to have their BMI recorded in the past 12 months (23% compared to an average of 25%).

34% of people living in Reading who have had their BMI measured in the past 12 months, are recorded as being obese. The prevalence of obesity is slightly higher in females (35%) compared to males (32%) and peaks around the age of 60 (Figure 4.4).

Figure 4.4: Reading GP data - obesity prevalence, patients aged 18+ by Gender

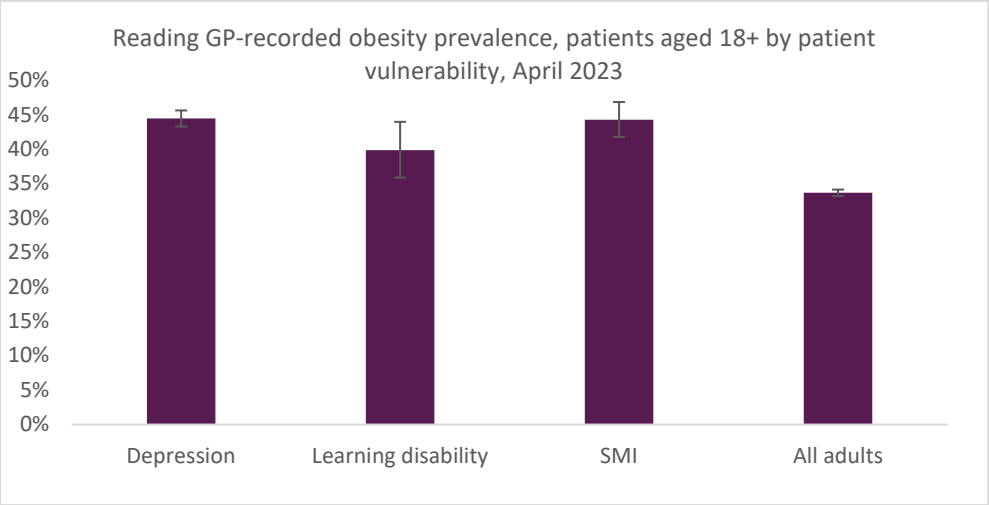


(Frimley Integrated Care System, 2023) [accessed April 2023]

4.3 High-risk groups

Figure 4.5 shows obesity prevalence amongst Reading adults who are recorded on GP records as having depression, a learning disability, or a serious mental illness (SMI). Data only includes those who have had their BMI recorded in the past 12 months. Obesity prevalence is higher amongst adults with these conditions than it is on average for all adults.

Figure 4.5: Reading GP data – obesity prevalence, patients 18+ - by patient vulnerability



(Frimley Integrated Care System, 2023) [accessed April 2023]

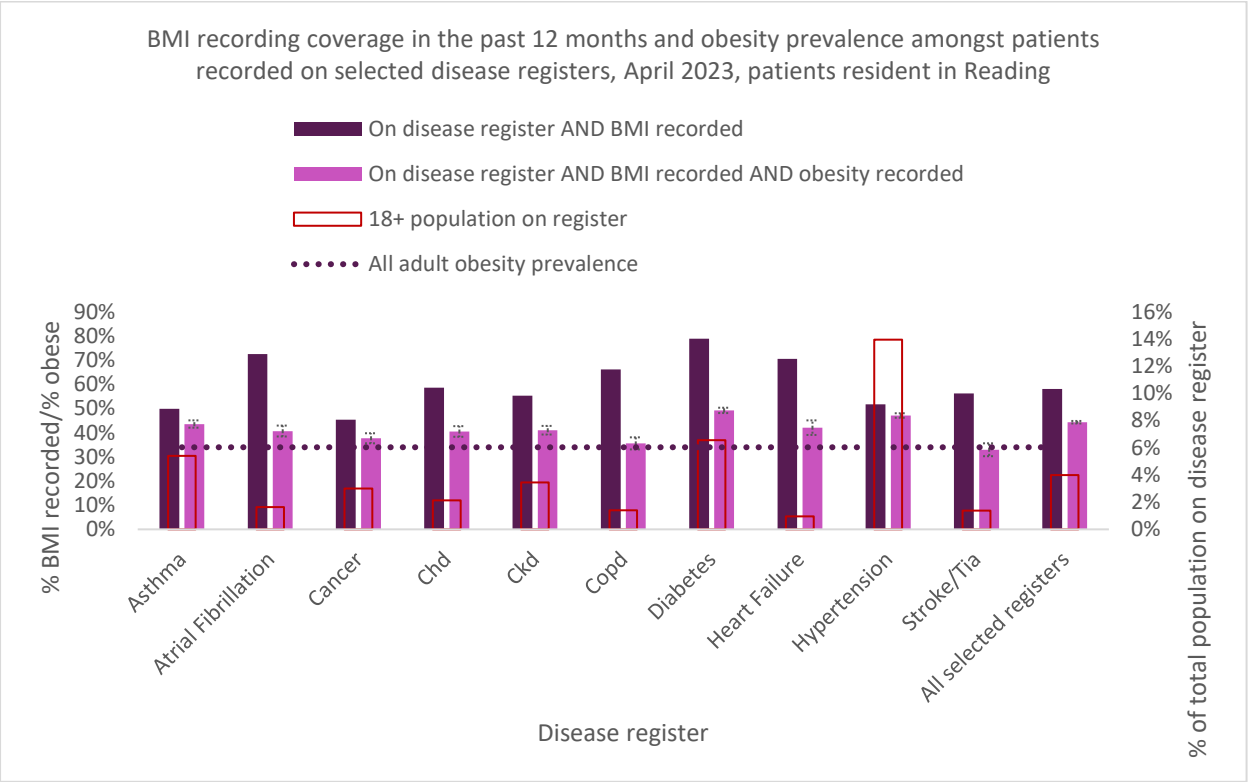
Figure 4.6 below shows

1. The percentage of the adult population living in Reading who are recorded as having selected conditions (e.g., diabetes) on GP registers and
2. the percentage who have had their BMI recorded in the past 12 months and
3. the percentage who are recorded on GP registers as having obesity

Earlier in this report, it was mentioned that 25% of the total adult population living in Reading have had their BMI recorded in the past 12 months. On average, 58% of those with the selected conditions (Figure 4.6) have had their BMI recorded in the past 12 months. This ranges from 45% of those on the cancer register to 79% of those on the diabetes register.

It was also mentioned in earlier in this report that 34% of all adults living in Reading have had their BMI measured in the past 12 months and are recorded as being obese. This increases to an average of 44% for those who are on the selected disease registers and ranges from 36% of people who are on the chronic obstructive pulmonary disease (COPD) register to 49% of people who are on the diabetes register. Obesity prevalence is higher than average amongst people included on all the selected registers with the exception of the COPD and the stroke/ Transient ischaemic attack (TIA) register.

Figure 4.6: BMI recording coverage over past 12 months in relation to disease register



(Frimley Integrated Care System, 2023) [accessed April 2023]

4.4 Forecast of overweight and obesity locally

Drawing on reliable sources of annual trend data on excess weight and obesity from the National Child Measurement Programme (NCMP) and Active Lives Adult Survey and using the Excel forecast function, crude estimates of future prevalence of excess weight, obesity and overweight are provided up to the year 2038.

The adult (18+) weight forecasts are derived from two sets of data: one excludes the years 2020/21 and 2021/22 (height of the Covid-19 pandemic), while the other includes those years to account for the potential impact of the pandemic on weight-related trends.

The forecasts show that by 2038, 75% (excluding Covid-19 years) of adults aged 18+ could be overweight or obese, or 96% (128,177 adults) if including Covid-19 pandemic years and their impact, if no change is made. The forecasts also show that 14% (68,662 adults) of adults aged 18+ to be obese and 61% to be overweight by 2038.

Adults forecast

Prevalence excluding Covid-19 years (2015/16 - 2019/20):

- The prevalence of excess weight in adults starts at 56.4% in 2015/16 and fluctuates around that level until 2019/20.
- There is a slight increase from 2016/17 to 2018/19, followed by a more significant increase to 61.6% in 2019/20.

Prevalence including Covid-19 years (2015/16 - 2021/22):

- In the years during the Covid-19 pandemic (2020/21 and 2021/22), there is a notable increase in overweight and obesity, with rates rising to 62.9% and 69.7%, respectively.

Projection/forecast period (2022/23 - 2037/38):

- The forecasted prevalence of excess weight continues to rise steadily, irrespective of whether Covid-19 years are included or not. The values range from 61.1% in 2022/23 to 75.1% (three quarters of the Reading adults) in 2037/38 (excluding COVID years) and from 68.1% in 2022/23 to 96.2% in 2037/38 (including COVID years). The forecasts suggest obesity will overtake overweight which means more complex challenges may arise due to the complex nature of obesity.

The forecasts reveal a continuous upward trajectory of excess weight prevalence over the coming years, with a steeper increase if the pandemic's impact is taken into account. The pronounced increase in excess weight will have a significant impact on key areas in Reading including the economy, if action is not taken.

Figure 4.7: Forecasted percentage of adults (18+) classified as overweight, obese or with excess weight (excluding COVID years 2020/21), projection until 2038, Reading

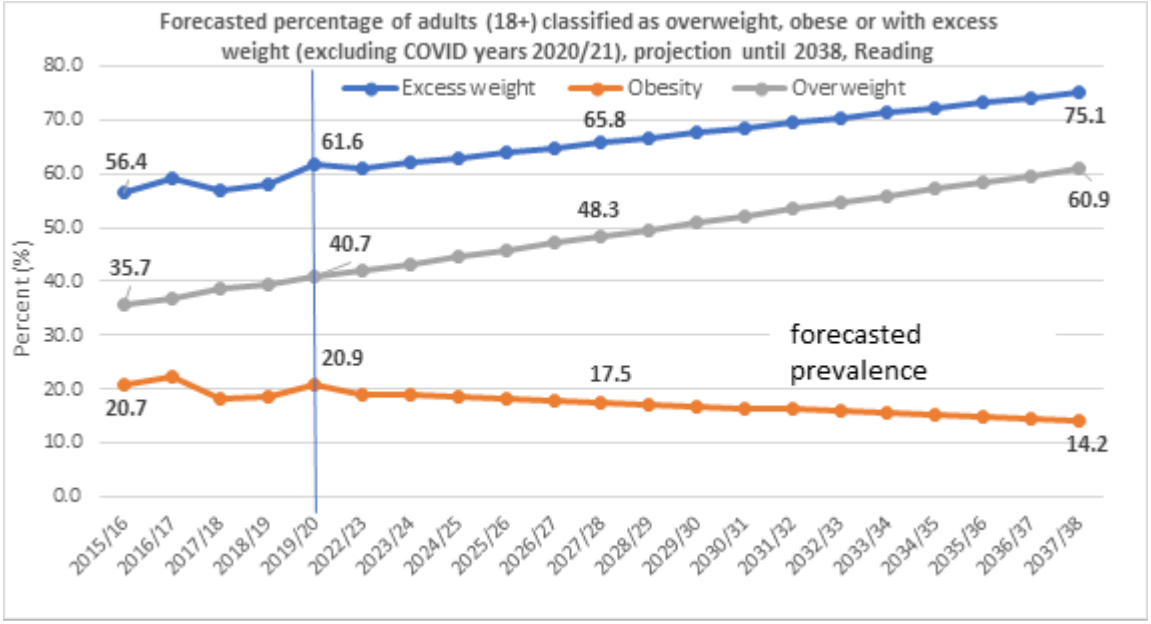
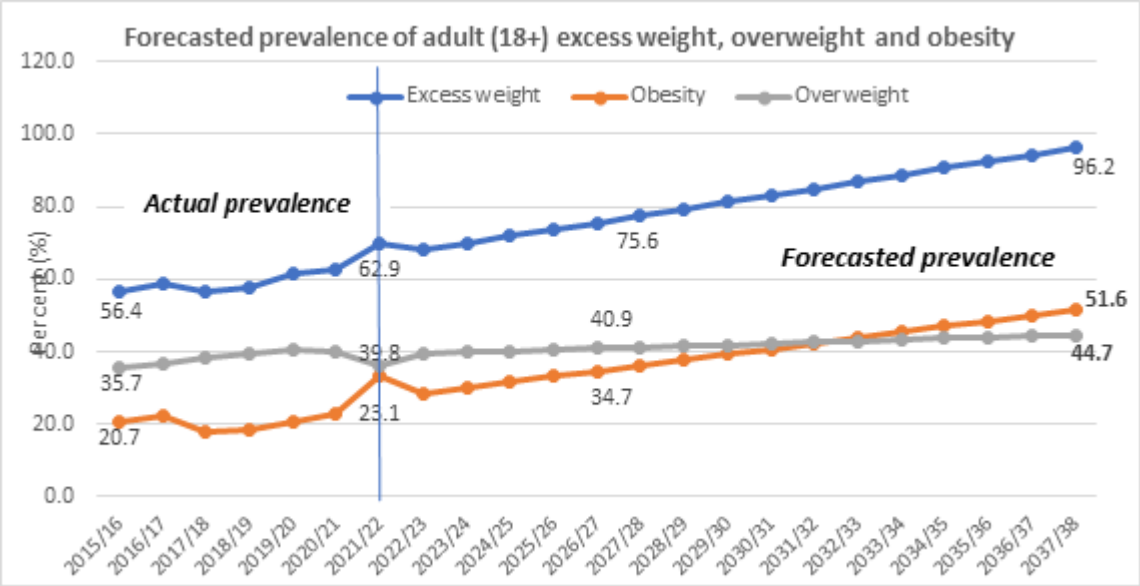


Figure 4.8: Forecasted percentage of adults (18+) classified as overweight, obese or with excess weight (including COVID years 2020/21), projection until 2038, Reading



Limitations with predictive approach

- The aforementioned projection is based on the Public Health Outcomes Framework figures, which draws on Sports England's annual Active Lives Adult Survey. It is therefore based on self-reporting rather than direct measurement of weight, which introduces the possibility of bias in the data.

- While giving a crude future projection of the levels of obesity in Reading, this does not account for policy changes, development of new therapeutic techniques, or unforeseen events, all of which could influence the change in overweight and obesity levels in the future.

- Exclusion or inclusion of Covid-19 years introduces a level of uncertainty, as the pandemic has had various impacts on people's health, lifestyle, and access to resources.

- It's essential to consider the data as an indication of potential future trends rather than definitive predictions, and further research and analysis would be necessary to fully understand the dynamics of excess weight prevalence.

5. Scale of the Issue - Children

5.1 National Picture

Nationally, the picture is similar for children as for adults. There is a continued increase in weight from when children start school aged 4-5 in Reception to when they leave primary school in Year 6 aged 10-11. The Government's National Child Measurement Programme (NCMP) provides robust surveillance to monitor estimates of excess weight in primary school children across the country and is a mandated activity for Local Government.

The latest data for school year 2023/24 shows that 22.1% of Reception pupils were overweight or obese (excess weight), whilst in Year 6, it was 35.8%. Overall, 76.8% of Reception pupils had a healthy weight, and in Year 6, it was 62.5%.

Key facts:

- The prevalence (percentage) of excess weight in Reception has fallen from 27.7% in 2020/21 to 22.1% in 2023/24, similar to the levels seen before the COVID-19 pandemic.
- The prevalence of excess weight in Year 6 fell from 40.9% in 2020/21 to 35.8% in 2023/24, following a similar pattern to Reception pupils.
- Between 2020/21 and 2023/24, the prevalence of healthy weight among Reception pupils increased from 71.3% to 76.8%.
- During this same period, the prevalence of Year 6 pupils with a healthy weight increased from 57.8% to 62.5%.
- Between 2020/21 and 2023/24, the prevalence of Receptions pupils who were underweight increased from 0.9% to 1.2%.
- Among Year 6 pupils, the prevalence of underweight increased from 1.2% to 1.7% during this same period.
- Following the COVID-19 pandemic, the majority of weight indicators for Reception and Year 6 pupils have returned to their pre-pandemic levels.

Inequalities:

- **Gender**: In 2023/24, the prevalence of excess weight in Reception pupils was higher among boys (22.2%) compared with girls (21.9%); in Year 6, this difference was greater (38.1% for boys compared with 33.5% for girls).

- **Ethnicity**: The prevalence of excess weight in Reception was highest among Black ethnic minority pupils, pupils whose ethnicity was Mixed (White/Black) and White Irish pupils in 2023/24. The prevalence of underweight children in Reception was highest among Asian pupils, especially Indian children. In Year 6, patterns of excess weight were similar to Reception (excluding White Irish pupils but including Bangladeshi pupils), whilst for underweight pupils, patterns mirrored those seen among Reception pupils.

- **Deprivation**: In 2023/24, 26.1% of Reception pupils living in the most deprived areas were overweight or obese compared with 17.0% in the least deprived; the prevalence of underweight children was also higher among those living in more deprived areas. In Year 6, 43.3% of children living in the most deprived areas were overweight or obese compared with 25.2% in the least deprived areas; 1.7% of children living in the most deprived areas were underweight compared with 1.9% in the least deprived areas.

5.2 Local Picture

In 2023/24, over 1 in 5 Reception pupils (21.9%) were overweight or obese in Reading, which is 400 pupils (Table 1a). This prevalence was similar to England (22.1%). The prevalence of Reception pupils underweight in Reading (1.9%) was significantly higher than England (1.2%). Among Year 6 pupils, over one-third (36.7%) in Reading were overweight or obese, similar to England (35.8%). This means that, locally, 700 Year 6 pupils were overweight or obese (Table 1b).

Tables 1a and 1b: Weight among Reception and Year 6 pupils in Reading (2023/24)

Table 1a Reception

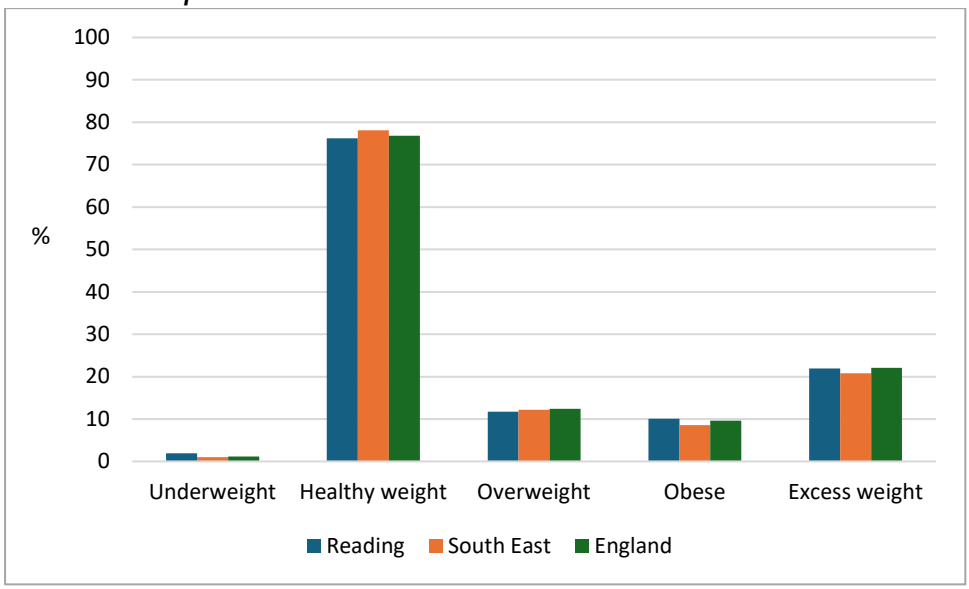
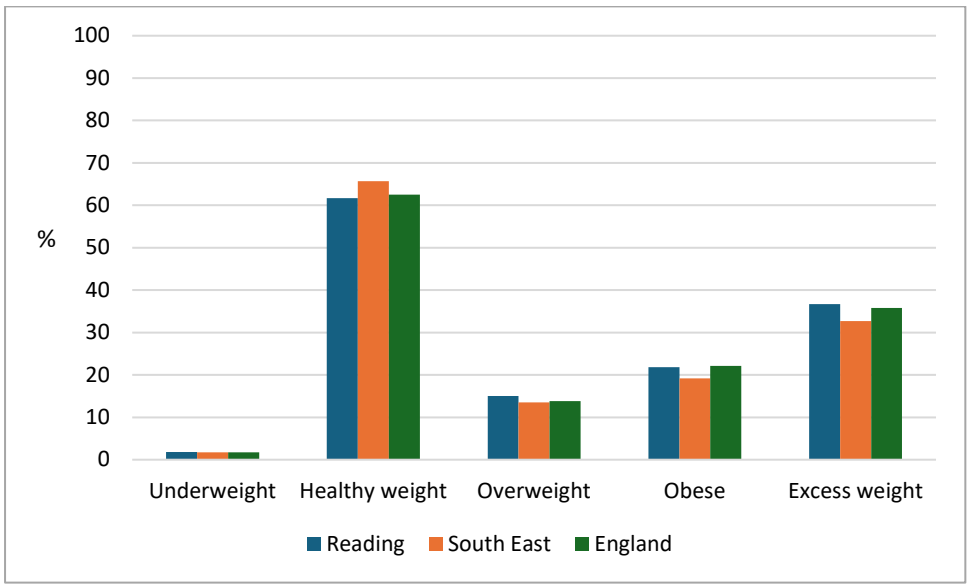


Table 1b Year 6



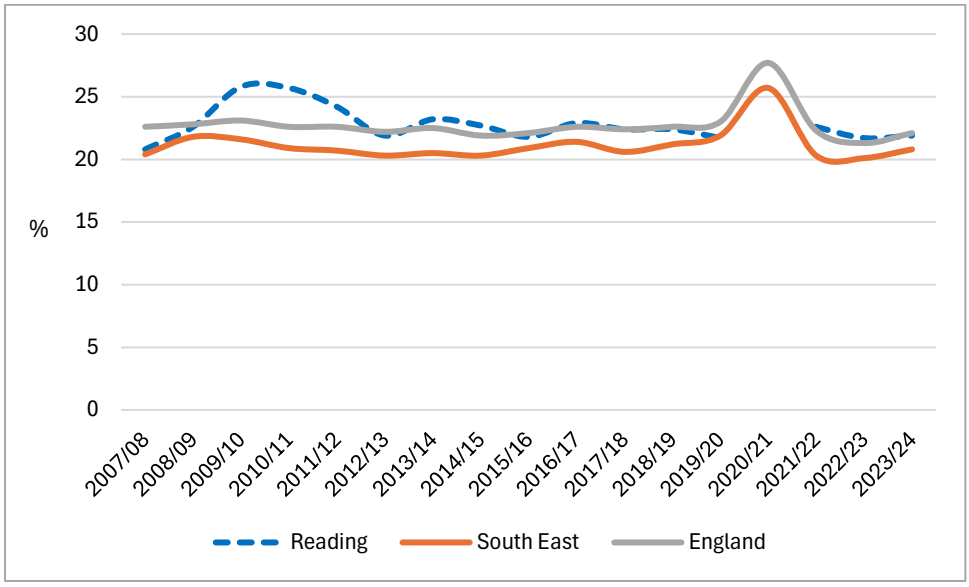
Source: Department of Health and Social Care (Obesity Profile)

* Excess weight = overweight or obese

Between 2007/08 and 2023/24, the prevalence of Reception pupils overweight or obese (excess weight) in Reading increased slightly from 20.8% to 21.9% (Figure 5.1; 2020/21 data for Reception and Year 6 pupils in Reading is not available). During this time, the numbers of Reception pupils with excess weight increased from 270 to 400 locally. In England, the prevalence fell during this time from 22.6% to 22.1%.

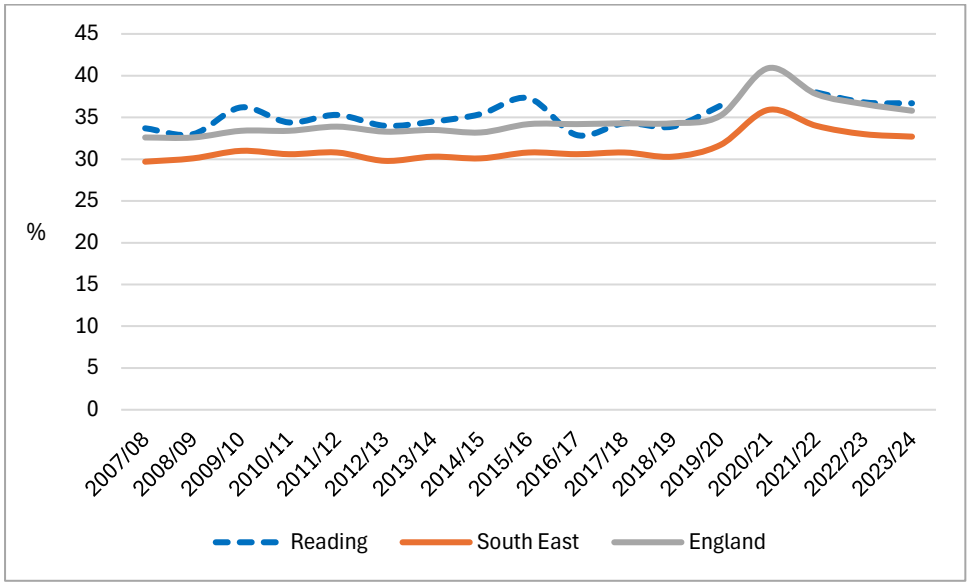
Among Year 6 pupils, the prevalence of excess weight increased in Reading from 33.7% to 36.7% between 2007/08 and 2023/24 (Figure 5.2). The numbers of Year 6 pupils with excess weight increased during this time from 430 to 700. In England, the prevalence of excess weight increased from 32.6% to 35.8% during this period.

Figure 5.1 Percentage of Reception pupils overweight or obese in Reading (2007/08-2023/24)



Source: Department of Health and Social Care (Obesity Profile)

Figure 5.2 Percentage of Year 6 pupils overweight or obese in Reading (2007/08-2023/24)

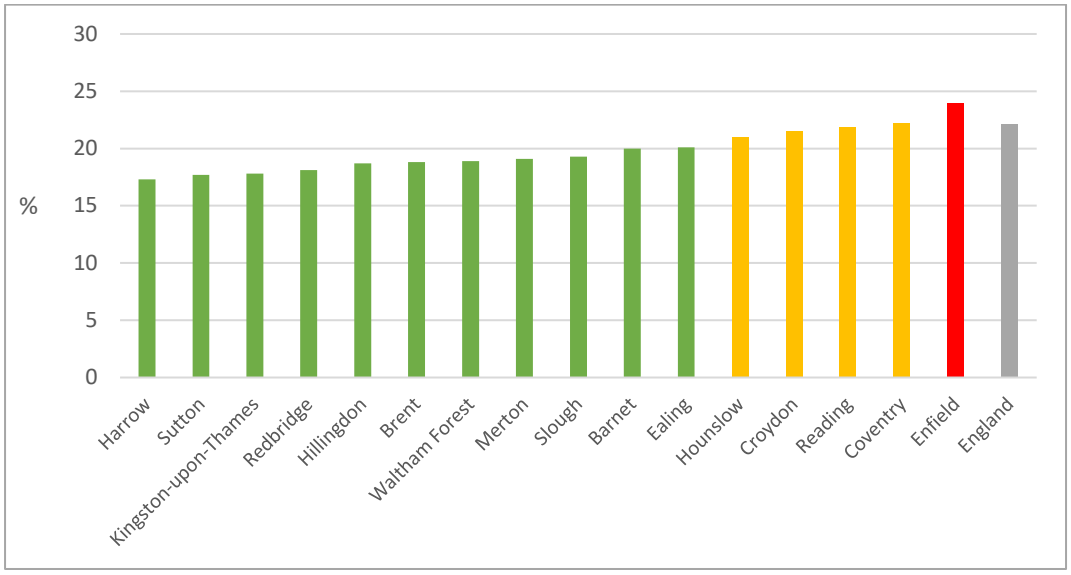


Source: Department of Health and Social Care (Obesity Profile)

5.3 How does Reading compare with statistical neighbours

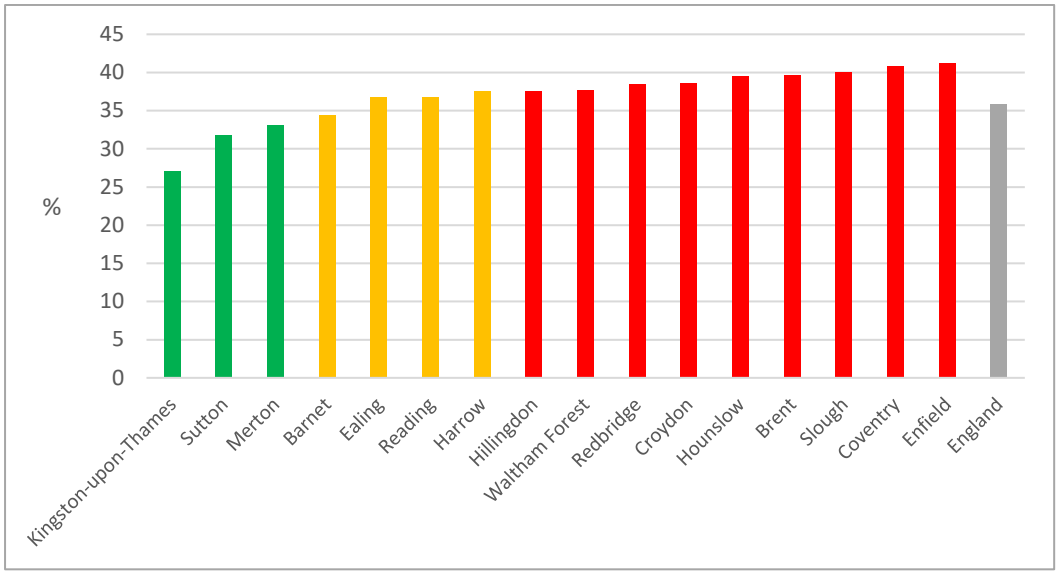
The prevalence of excess weight among Reception and Year 6 pupils in Reading has been compared with it nearest statistical neighbours (based on NHS England). Statistical neighbours, or peers, are those areas that are similar across a range of indicators such as population demographics, ethnicity, socio-economic characteristics and so on. Compared with its statistical neighbours, Reading had the third highest prevalence of excess weight among Reception pupils and the eleventh highest for Year 6 pupils in 2023/24 (Figures 5.3-5.4).

Figure 5.3 *Percentage of Reception pupils overweight or obese in Reading and its statistical neighbours (2023/24)*



Source: Department of Health and Social Care (Obesity Profile)

Figure 5.4 *Percentage of Year 6 pupils overweight or obese in Reading and its statistical neighbours (2023/24)*



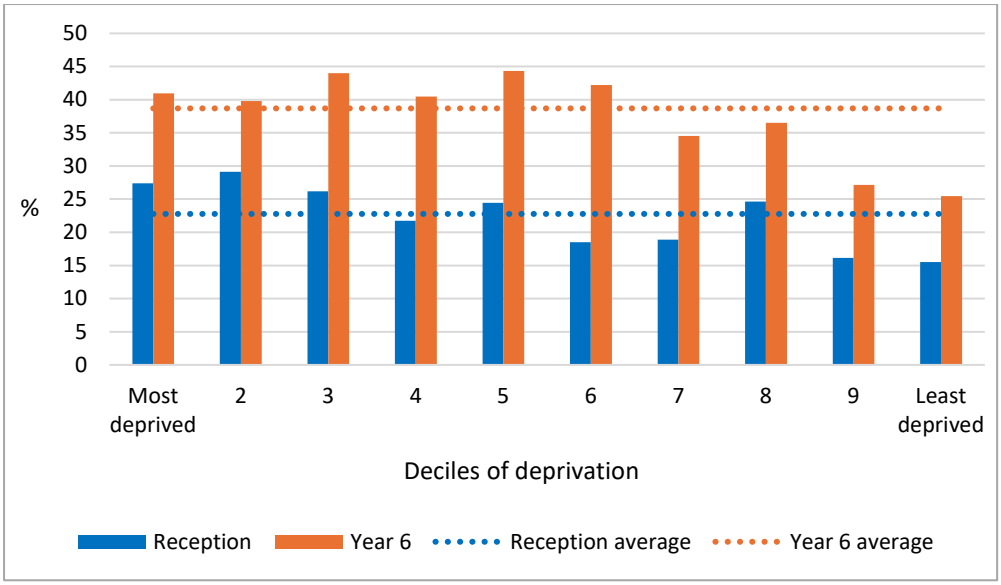
Source: Department of Health and Social Care (Obesity Profile)

5.4 Inequalities in Children health in Reading

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them. Health inequalities exist between people living in areas of affluence and deprivation, between different ethnic groups, ages, gender, sexuality, and are seen among a host of people including vulnerable migrants and asylum seekers, victims of modern slavery, the homeless, sex workers and so on.

The prevalence of Reception and Year 6 pupils who were overweight or obese (excess weight) was higher among the more deprived areas of Reading in 2021/22-2022/23 (Figure 5.5). In Reception, for instance, 27.4% of pupils living in the most deprived areas of Reading (see Figure 8) were overweight or obese compared with 15.5% living in the least deprived areas (Reading average = 22.8%); among Year 6 pupils, the respective figures were 41.0% compared with 25.4% (average = 38.7%).

Figure 5.5 *Percentage of Reception and Year 6 pupils overweight or obese by deprivation deciles in Reading (2021/22-2022/23)*

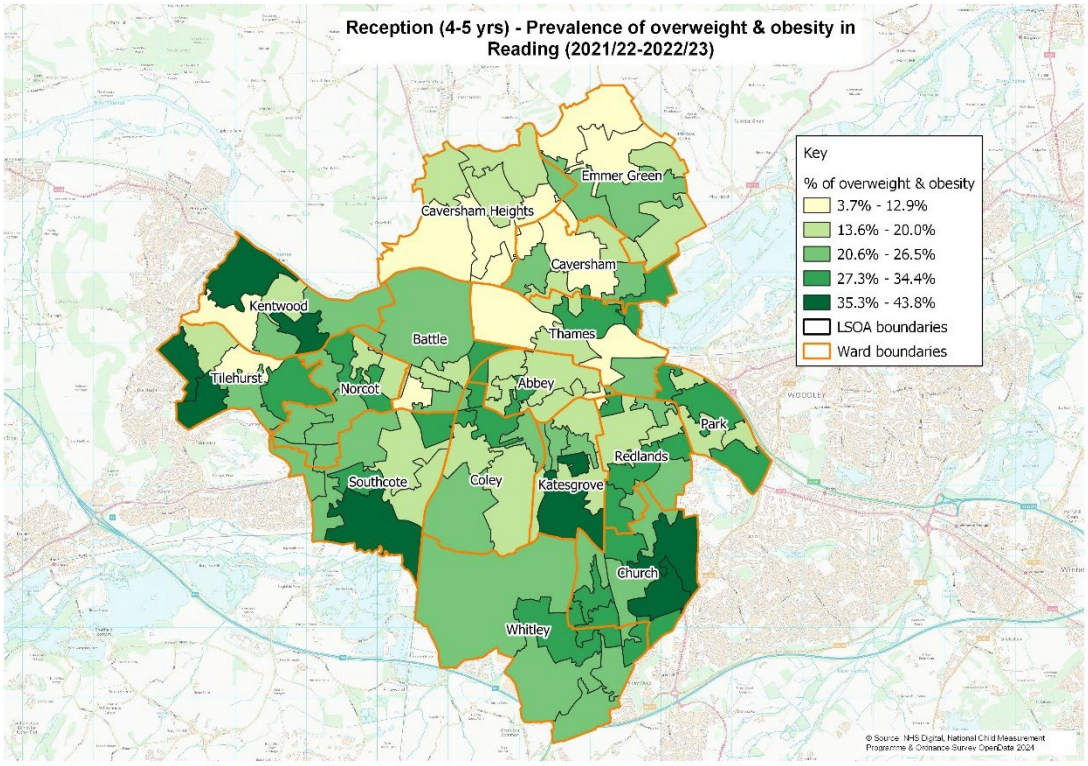


Source: Reading Public Health Intelligence Team

Figures 5.6 and 5.7 offer a visual mapping of the prevalence of overweight and obesity for Reception year and Year 6 during 2021-2023.

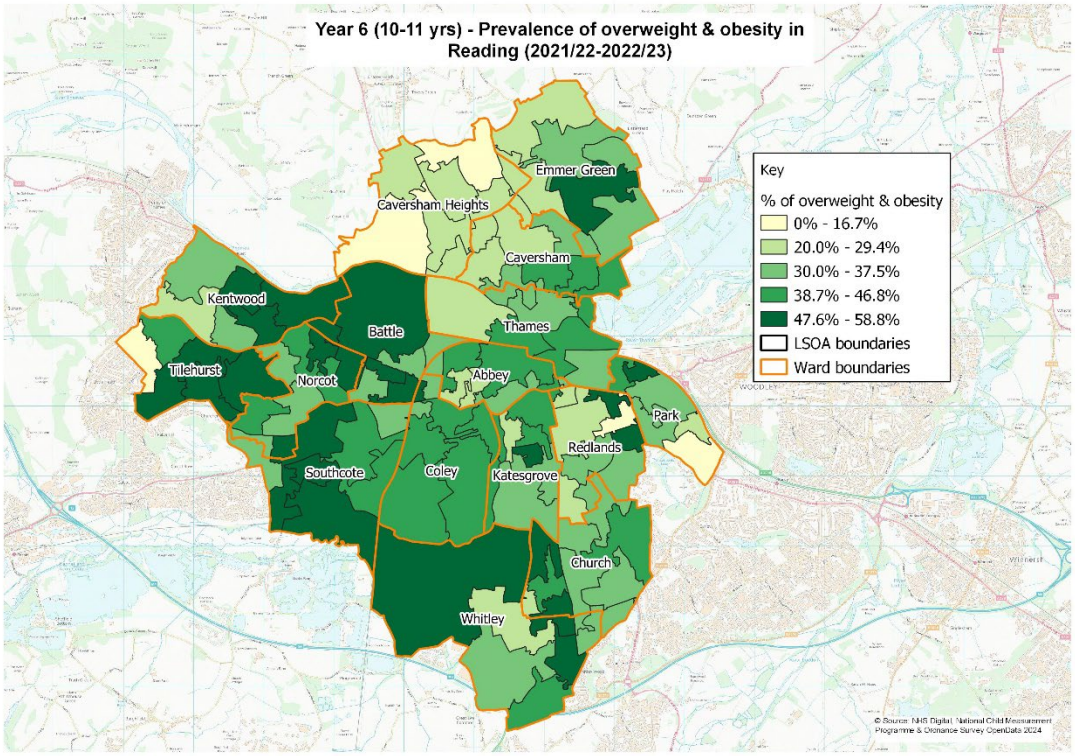
Figure 5.8 shows the Index of Multiple Deprivation in Reading in 2019, identifying Church, Norcot and Southcote Wards as the most deprived 20% of the Lower layer Super Output Areas (LSOAs). LSOAs comprise between 400 and 1,200 households and have a usually resident population between 1,000 and 3,000 persons.

Figure 5.6 Prevalence of overweight & obesity in Reading 2021-2023 - Reception



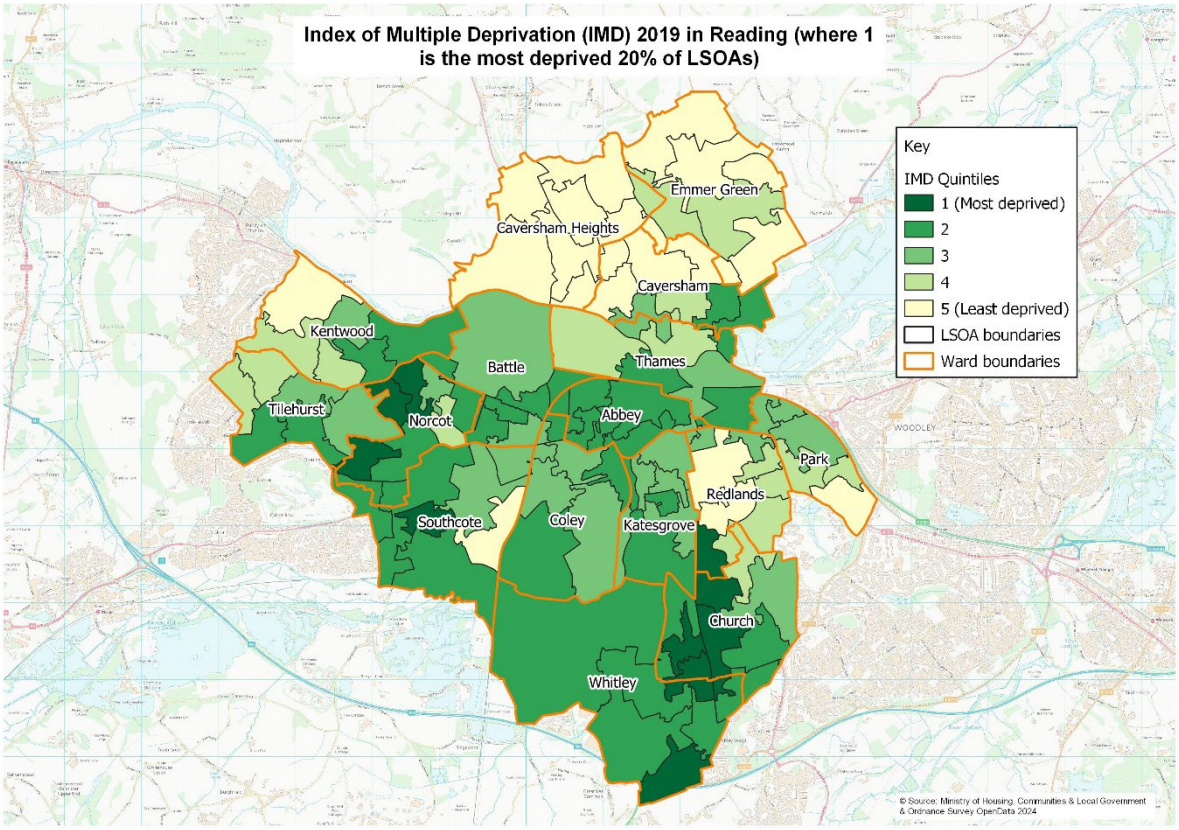
Source: Reading Public Health Intelligence Team

Figure 5.7 Prevalence of overweight & obesity in Reading 2021-2023 – Year 6



Source: Reading Public Health Intelligence Team

Figure 5.8 Index of Multiple Deprivation (IMD) 2019 in Reading



Source: Reading Public Health Intelligence Team

6. Impact of living with excess weight

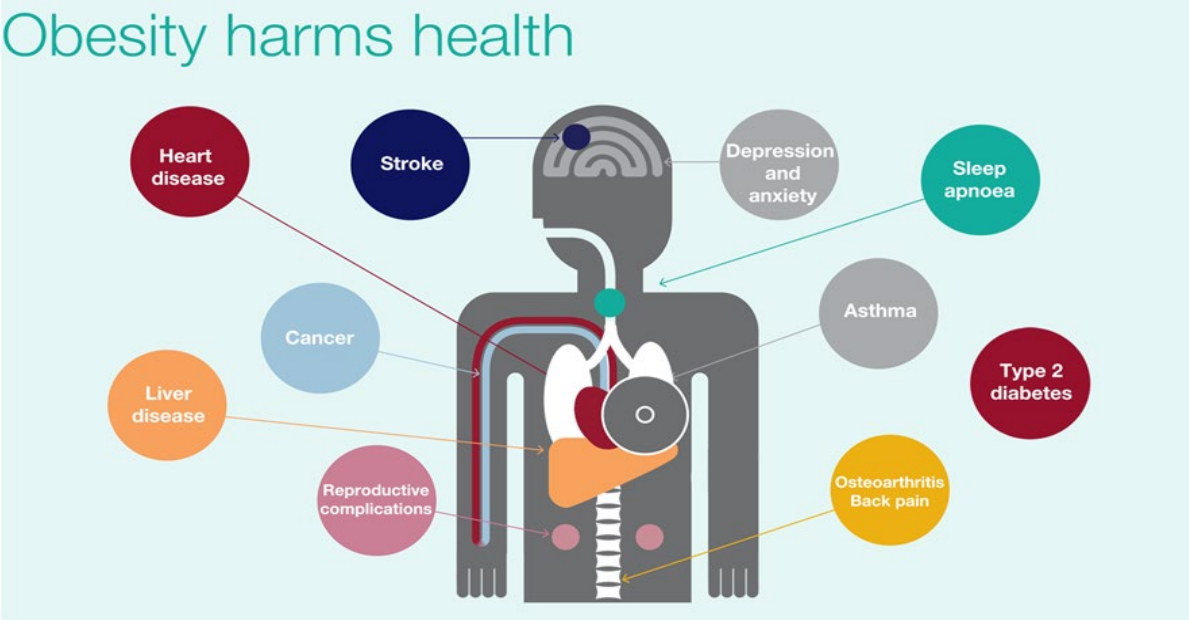
6.1 Health impacts of excess weight

The impacts of weight are varied, ranging from individual to society and economic.

Being overweight and obese can have a detrimental impact on physical and mental health. Excess weight is linked to a wide range of diseases, such as type 2 diabetes, hypertension, some cancers, heart disease, stroke, and liver disease. Excess weight is also linked to psychological and emotional health issues and sleep disorders (Office for Health Improvement and Disparities (OHID), 2022). The figure below illustrates some of main the health issues that can be caused by excess weight.

Obesity reduces a person's life expectancy by an average of 3 years and severe obesity reduces it by 8-10 (Office for Health Improvement & Disparities, 2022).

Figure 6.3: PHE/OHID Obesity Harms



The Global Burden of Disease project (The Institute for Health Metrics and Evaluation, 2019) represents a systematic scientific effort to quantify the comparative magnitude of health loss due to disease, injury and risk factors by age, sex, and geography for specific points of time. It uses a summary measure referred to as Disability Adjusted Life Years (DALYS). DALYS are a time-based measure that combines years of life lost (YLLs) due to premature mortality and years lived with a disability (YLDs).

The 2019 attributed 10% of non-communicable disease DALYs to high BMI. In the case of diabetes and chronic kidney disease (CKD), 54% of DALYs due to these conditions were attributed to high BMI. 22% of DALYs due to cardiovascular disease were attributed to high BMI.

Table 1: Percentage of DALYs attributed to high BMI by cause, England 2019

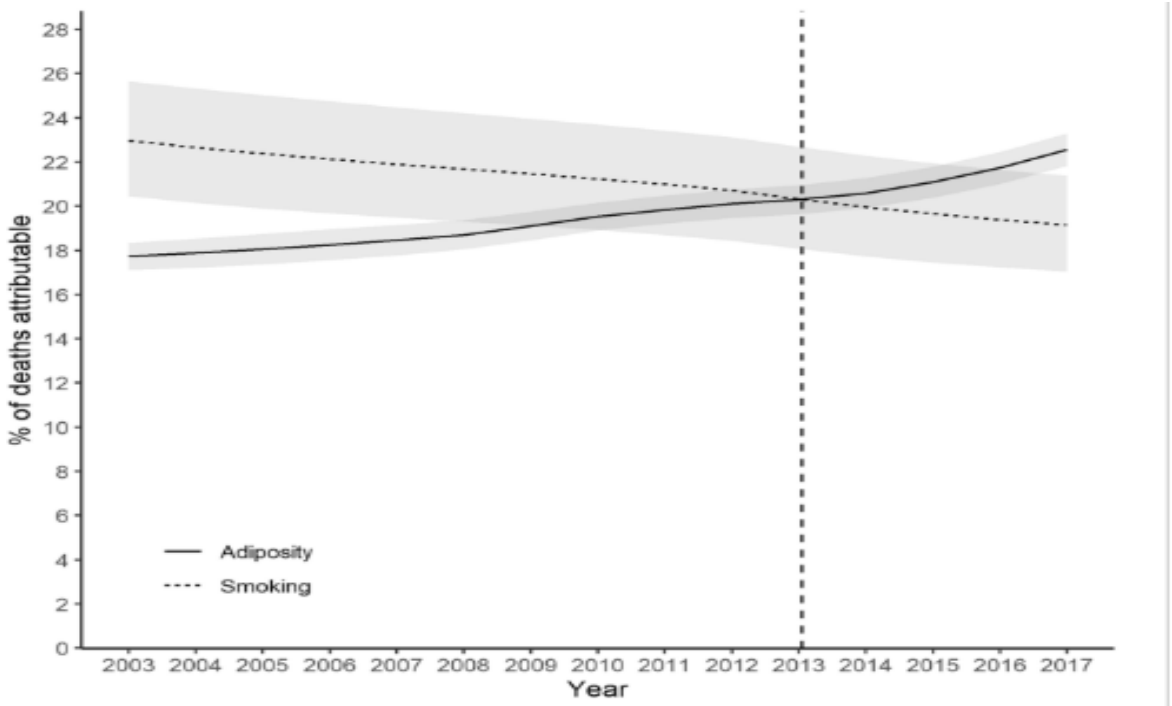
Cause	Cause % contribution to total DALYs	High BMI % attribution
Cardiovascular	15%	22%
Cancer	19%	7%
Musculoskeletal	11%	7%
Diabetes and Chronic Kidney Disease	4%	54%
Chronic respiratory	7%	6%
Neurological	7%	6%
Digestive	5%	9%
All non-communicable	88%	10%

(Institute for Health Metrics and Evaluation, 2019)

A recent study found that obesity now accounts for more deaths in England and Scotland than smoking among middle- and old-age people[3] (Ho 2021). Between 2003 and 2017, there was a decline in smoking prevalence decline, and an increase in obesity prevalence. Combining data sets on smoking and obesity, they estimated smoking contributed to 23% of all deaths in 2003, and that number decreased to 19% in 2017 (Figure 6.2). Meanwhile, obesity contributed to 18% of deaths in 2003 and that number increased to 23% in 2017. The contribution of obesity exceeded that of smoking in 2013. This is believed to be true for those over 45 years (for those younger than 45 years, smoking remains the largest contributor of mortality. As with all research, there are limitations, – in this case, the impact of passive smoking and the legacy of vaping with vapes and e-cigarettes. Further research may be needed to be certain of such claims, what is widely agreed is that Tobacco, alcohol, and unhealthy foods are the three leading causes of preventable death and ill health in England and key drivers of health inequalities (The Health Foundation, 2023). The tide of excess weight continues to rise and negative impacts on both absolute and quality of life is huge.

[3] [1] Ho, F.K., et al. Changes over 15 years in the contribution of adiposity and smoking to deaths in England and Scotland. BMC Public Health 21, 169 (2021) https://doi.org/10.1186/s12889-021-10167-3

Figure 6.4: Largest Contributor to Death - Smoking Vs obesity



Percentage of all-cause deaths attributable to adiposity and smoking. Shaded areas are 95% confidence bands. Vertical dashed line indicates cross-over

6.2 Hospital Admission and Adult Social Care

In England during 2019/20, there were 10,780 hospital admissions that were directly attributable to obesity and just over 1 million where obesity was a factor (NHS Digital, 2021). The leading primary diagnosis related to admissions where obesity was a factor was maternal care followed by knee joint issues, gallstones, heart disease, and hip issues. There were 294 thousand items prescribed for the treatment of obesity in 2020[4] (Orlistat).

6.2.1 The cost associated with excess weight

Findings show that the current social annual cost of obesity in the UK is at around £58 billion, equivalent to around 3% of the 2020 UK GDP. This includes direct costs such as the cost of obesity-related diseases on the health system (including COVID-19 and mental health issues) and the loss of quality adjusted life years for individuals. In addition, it includes the wider costs to society such as loss of productivity and cost of social care (Frontier Economics)

[4] Digital NHS UK Data and Information

Other key findings include[5]:

- The estimated annual NHS spend on obesity related diseases is £6.5 billion.
- The estimated cost of obesity-related risks of Covid-19 is £4 billion.
- Costs tied to loss of productivity and increased social care are estimated to be up to £7.5 billion.
- A 10% reduction in obesity prevalence could lead to significant cost savings, not only to the NHS but also in terms of improved quality of life and workplace productivity. This social gain could be equivalent to almost £6 billion per year.

6.2.2 Impact on adult social care

The diagram below depicts varying degree of excess weight and impact of care packages required.

Figure 6.5: Adult social care costs

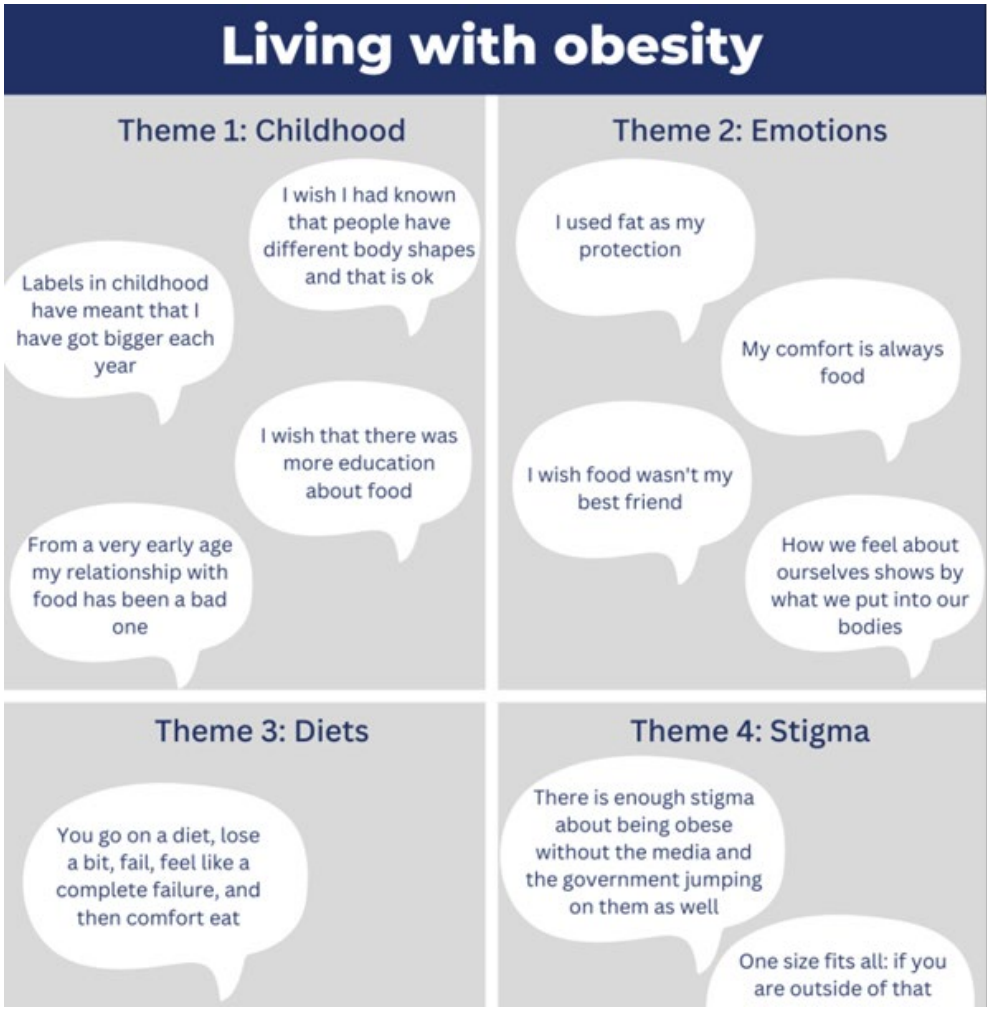
[5] https://www.frontier-economics.com/media/hgwd4e4a/the-full-cost-of-obesity-in-the-uk.pdf

6.3 Living with excess weight and Stigma

An area often forgotten or overlooked is the lived experience of excess weight.

Figure 6.4 shows a summary of themes that people who are living with obesity discussed during a recent recording for Obesity UK around their personal experiences. The five people (3 females and 2 males) shared experiences around their childhood including what they wished would have been different for them. Judgment around their size and what they were eating was apparent from a very young age. Eating what was affordable was also discussed by one participant. Participants wished that they had understood that balance between diet and exercise was key and wished that there had been more education about food and different body shapes. Emotions as both triggers and maintaining factors for weight gain were prominent themes. Some of the participants had gone on to have weight-loss surgery and one discussed her struggle with diets. Two of the female participants had been dieting since childhood. Perhaps the strongest theme was stigma: all participants felt judged for their size. The inclusion of obesity as a priority criterion for COVID-19 was seen as a positive step forward to viewing obesity alongside any other physical health condition.

Figure 6.6: Personal Experience of living with obesity shared with Obesity UK



People with obesity suffer with weight-related stigma, which can damage their self-esteem and employment prospects and lead to mental ill health, such as anxiety and depression. People with severe obesity who are also disabled, may as a result suffer even worse social stigma, as the stigma associated with disability can be compounded by obesity

Social care report - Social care and obesity (local.gov.uk)

Nearly 4/10 people the residents who responded to the needs assessment survey had experienced or were aware of the stigma people experience, especially when considering access to a weight management service.

7. Local Assets

7.1 Previous Asset mapping work

In the previous Healthy Weight Needs Assessment for Berkshire West 2020, a mapping exercise was undertaken to identify the interventions across a life course approach to managing and preventing excess weight. The information can be found on pages 64 – 128 of the needs assessment – (https://reading.berkshireobservatory.co.uk/wp-content/uploads/2022/02/Berkshire-West-Healthy-Weight-Needs-Assessment-Publication.pdf)

This was very much a live document which was still being added to, however the arrival of the Covid-19 pandemic in February/March 2020,a month after the publication was published and a subsequent shift in priority and workforce capacity, this work mapping exercise has ceased.

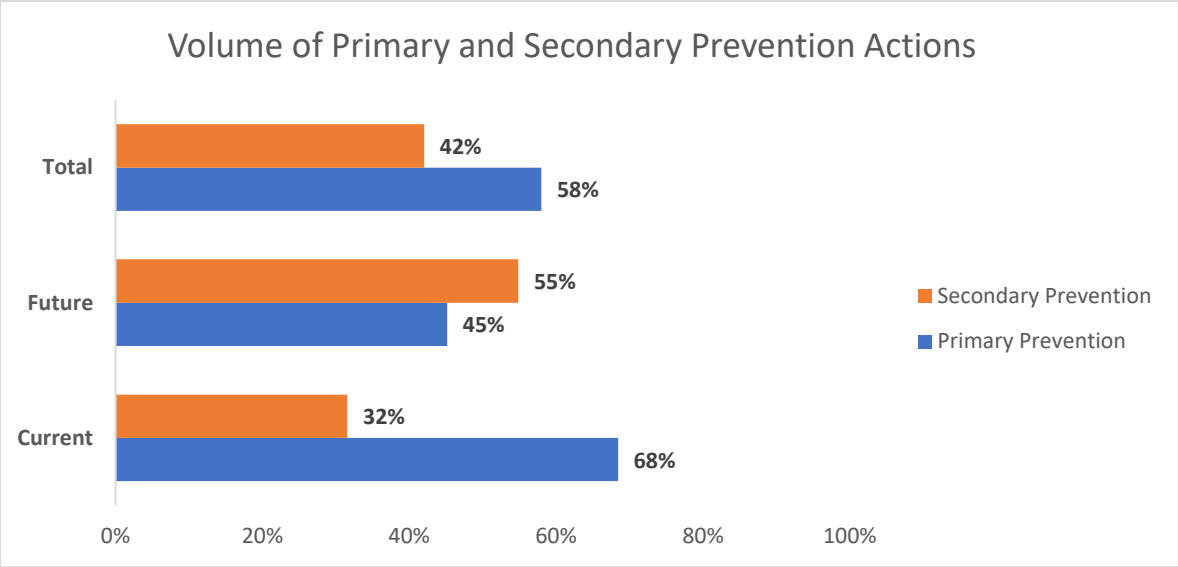
7.2 Recent Asset Mapping

As a way of sense checking activity to date, post the pandemic, Reading hosted two online mapping workshops in November 2023.

The results are summarised below:

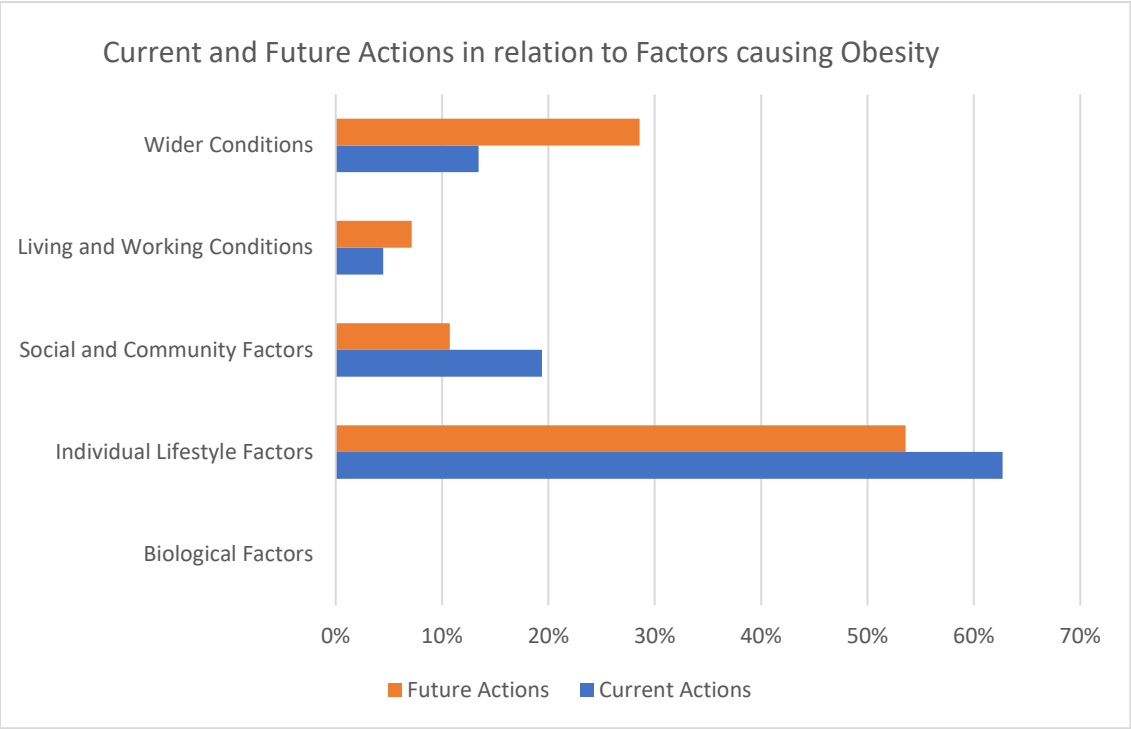
- Two online workshops were held, where over 60 people attended from a range of organisation including, across Reading Borough Council, Integrated Care Board and community voluntary sector to explore current activity, projects, services and local asset that support the food, physical activity and healthy weight agenda.
- Using PHE whole systems approach to weight resources it enabled us to
    - A) understand the level of prevention i.e. primary or secondary prevention.
    - B) explore which level of Whitehead and Dahlgren's model of wider determinants were being addressed as part of this intervention.
- Results indicated that currently most activity in Reading is supportive of primary prevention (Chart 7.1). However, it should be noted that this is likely to be reflective of who was in the room for both workshops. There was a notable lack of front-line clinicians in Health as well as those from planning and licencing for example.
- When future/planned activity was also taken into account, there was a more even balance between levels of prevention, with a small majority primary over secondary prevention.

Chart 7.1: Volume of Primary and Secondary Prevention Actions – from asset mapping exercise (November 2023)



In Chart 7.2 below, when considering current actions, 63% (42) of them were at an individual lifestyle level, which is the 3rd leading cause of excess weight, whereas most causes of obesity are derived from living and working condition (33% of causes); yet just 4% of local actions focus on this level of the Whitehead and Dalhgren model. The same picture was seen when future planned activities were considered.

Chart 7.2: Current and Future Actions in relation to factors contributing to obesity – from asset mapping exercise (November 2023)



In Figures 7.1 and 7.2, show on the left side Whitehead and Dahlgren's model of wider determinants. The red bars represent causes of obesity, of which there were 226 in total. This is then mapped against Reading's local actions (green) and the layers of the wider determinants in which they were influencing. Firstly, current action was mapped (Figure 7.1) followed by Current and future planned activity (Figure 7.2).

Figure 7.1: Current Actions

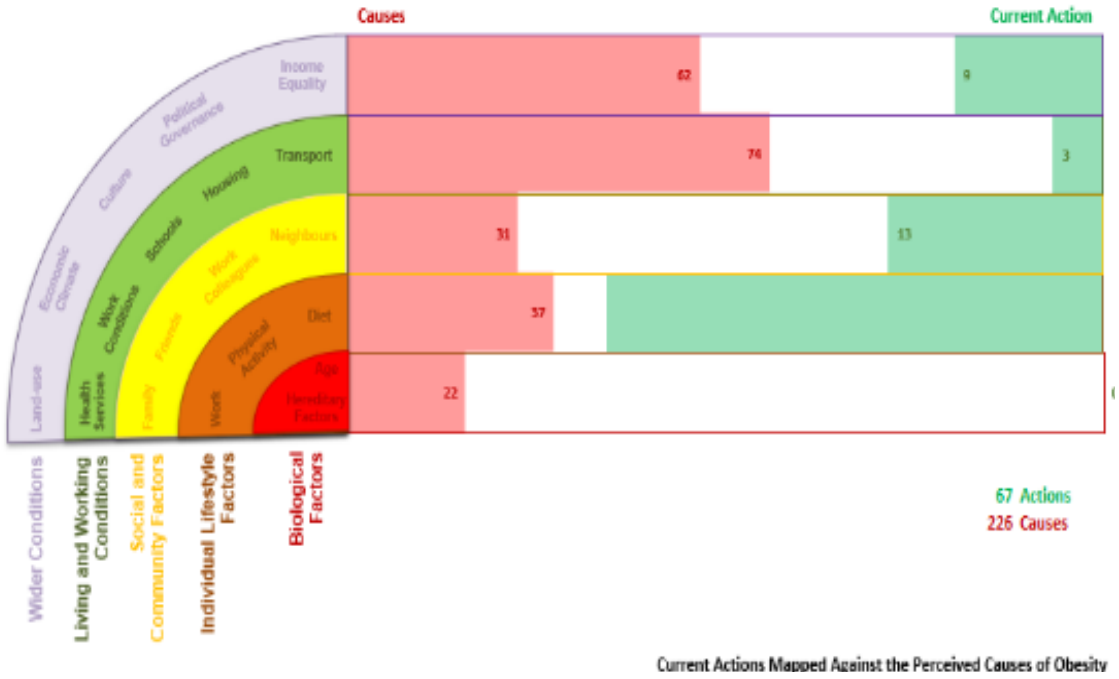
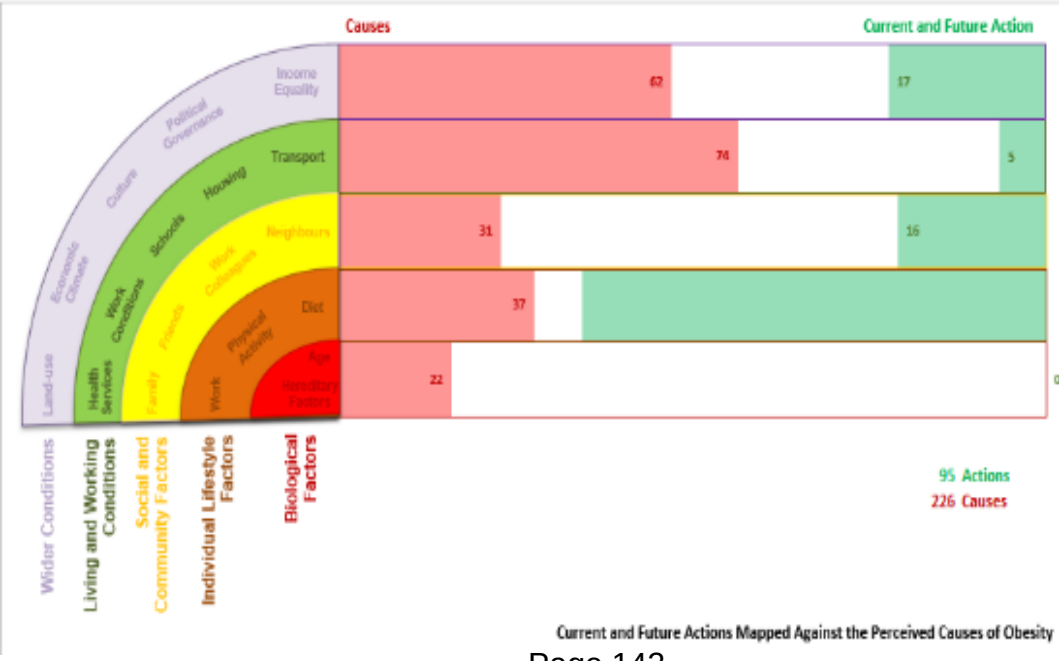


Figure 7.2: Current and Future Action combined



To note:

- **Physical Activity mapping exercise** is currently underway to help the council better understand what provision is currently available, how well utilised this is with the vision with leisure and public health exploring collaboratively on ways to increase the engagement by increasing diversity – resulting in more uptake/increase opportunities for people to participate in a form of physical activity.

7.3 Gaps

- The findings of local assets mapping workshops are that the most impactful area local government can focus efforts on is Living and Working Conditions. However, these are the areas where there are the fewest interventions/actions based on the information collected to date. Although there are gaps in attendance, this picture is reflective of activity across the system, as seen across England with efforts tending to focus on lifestyle change in recent years.

7.4 Recommendations

- Whole Systems Approach to bring partners together and develop a Whole Systems Approach Healthy Weight Strategy for Reading
- Increase delivery of system wide intervention such advertisement, planning, licensing over more individual level actions.
- Ongoing mapping to ensure there is information available to support signposting and explore how best to improve access to current provision to maximise efforts already underway.

8. Physical Activity

Poor diet and sedentary lifestyles are key causes of obesity at an individual level, however, over 100 "wider determinants" of obesity were identified by the Foresight report in 2007 encompassing individual, and family eating and physical activity habits, the food and physical activity environments in which people live, work and play; societal influences such as income; education; occupation as well as individual psychology including mental health and wellbeing.

Society has become characterised by environments that provide an abundance of energy dense, flavour enhanced food and drink, and lifestyles that promote sedentary behaviour through use of labour-saving technology, therefore, encouraging a normalisation of excess weight gain whereby obesity is a 'normal' and passive response to the obesogenic environment[6].

According to The UK analysis of the Global Burden of Diseases, Injuries and Risk Factors Study, low physical activity including physical inactivity is the fourth leading risk factor contributing to deaths and the burden of disease worldwide[7]. It ranks in front of overweight or obesity. In contrast, regular physical activity is known to be advantageous for cardiovascular health, mental wellbeing and decreasing the risk of depression. Among older people, physical activity is also associated with improved health, better cognitive function, and a reduction in the risk of falls in those with mobility issues.

8.1 National Picture – Physical Activity

Figure 8.1: Physical Activity for adults and older people summary 2019

There is well documented evidence regarding the health benefits of a physically active lifestyle which also suggests that regular activity is related to reduced incidence of many chronic conditions. Whether weight loss is achieved or not, a variety of health benefits and improvement in health outcomes are attributable to regular physical activity[7].

[6] Obesogenic environment: the influences that the surroundings, opportunities or conditions of life have on promoting obesity in individuals and populations
[7] NHS Digital. Health Survey for England 2021 part 2: Adult physical activity. May 2023

The Chief Medical Officers of the UK published guidelines in 2019 on the amount of activity recommended for adults for health, stating that:

> *Adults (aged 19 and over) should aim to be active at least 150 minutes of moderate intensity weekly (increased breathing and able to talk), or 75 minutes of vigorous intensity activity per week (breathing fast and difficulty talking), or a combination of both. To keep muscles, bones and joints strong, build strength on at least 2 days a week. Minimise sedentary time by breaking up periods of inactivity and for older adults, to reduce the chance of frailty and falls, improve balance 2 days a week*[8]

Figure 8.2: Summary of Physical Activity Recommendation across the life course, CMO 2019

Figure 8.3: Physical Activity Guidelines for disabled Adults, 2019

Chief Medical Officer: "some are good, more is better"

National Rates: 66% of adults in England aged 19 and over report doing at least 150 minutes of moderate-intensity physical activity per week. 23% report doing less than 30 minutes per week. The following groups are more likely to report doing at least 150 minutes of moderate-intensity physical activity per week:

[8] Department of Health and Social Care. Physical activity guidelines: adults and older adults. Sept 2019.

- People in less deprived areas.
- People from white British, white other, or mixed ethnic backgrounds.
- People who are in employment.
- People without disability.
- People educated to level 3 or level 4 and above.
- People aged between 19 and 74.
- Males

46% of children in England aged 5 to 16 take part in an average of at least 60 minutes of moderate-intensity activity per day. The following are more likely to take part in this level of activity:

- Children from white British and white other ethnic backgrounds
- Children in younger year groups (school years 1 and 2)

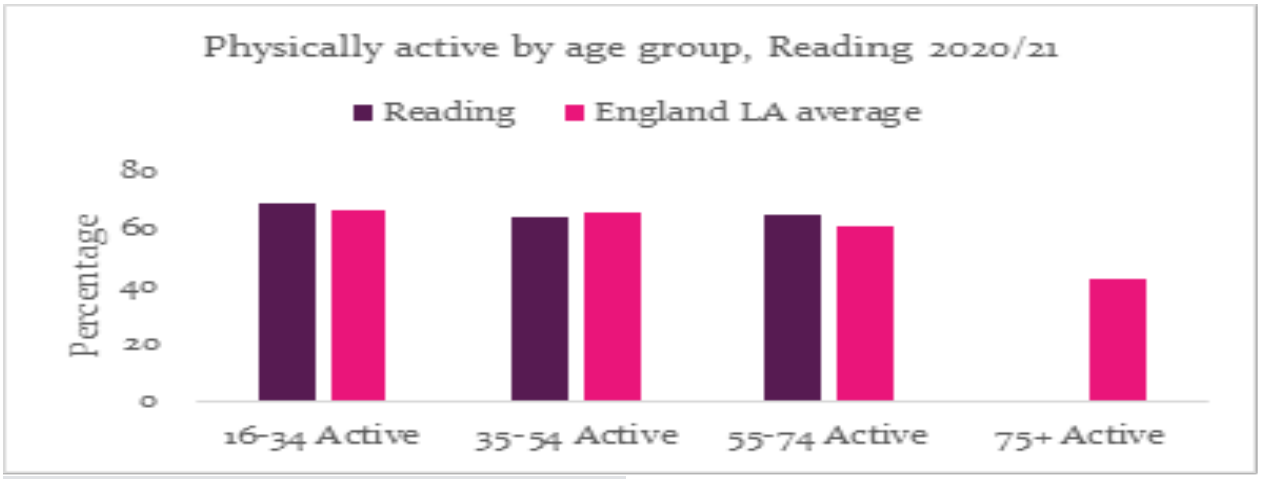
8.2 The Local Picture: Reading Physical Activity

The Public Health Outcomes Framework includes an indicator for self-reported physical activity in those aged 19 and over, derived from the Sport England Active Lives Survey. The Active Lives Survey is a national survey which has been running for a number of years. However, sample sizes for local areas do vary at times, and can be quite small. Therefore, results from the Survey need to be treated with caution at times.

In Reading in 2022/23, 21.7% of adults aged 19 and over were physically inactive (less than 30 minutes of physical activity a week), similar in comparison to 22.3% in England. While 69.1% are physically active in Reading

Physical activity declines with age. Both 16- to 34-year-olds and 55- to 74-year-olds living in Reading are slightly more likely than the England average to report being physically active (Figure 8.4). Survey sample numbers are too small to calculate percentages for the 75+ age group in Reading.

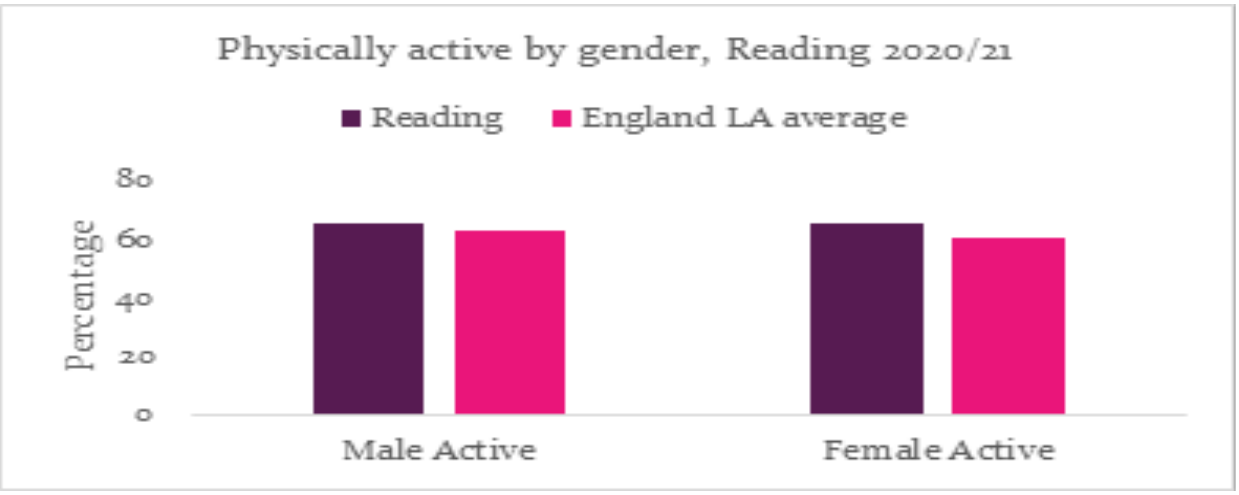
Figure 8.4: National vs Local Physical Activity by age group



(Office for Health Improvement & Disparities, 2023)

There is less evidence of the gender gap between women and men in Reading.

Figure 8.5: Physical activity by gender in Reading vs Nationally



8.3 Evidence of what works

The role of physical activity in achieving healthy weight is evident. The National Institute for Health and Care Excellence (NICE) recommends multicomponent weight management services that combine diet, **physical activity**, and behaviour change strategies. These interventions should be personalised, with provision of on-going monitoring, support and care including motivational interviewing. *The physical activity element of interventions should focus on activities that fit easily into people's everyday lives and should aim to improve people's belief in their ability to change and facilitate a reduction in sedentary behaviour*.

Well designed and evidence-based interventions are likely to be appropriate to most population groups. However, evidence indicates that special attention should be given to tailoring interventions for specific groups like individuals with disabilities, women during and after pregnancy, men and low-income groups. [9]

Interactive computer-based interventions have shown effectiveness in weight loss and maintenance in people living with excess weight, compared to no intervention or minimal interventions (leaflets or usual care)[10]. The amount of additional weight loss, however, is relatively small and of brief duration, making the clinical significance of these differences unclear. This was later supported by a study in 2017, adding that more encouraging weight loss results were achieved when web-based interventions were enhanced (i.e., more interactive and tailored) than when they were basic (i.e., information website only)[11]. Reported effect sizes were small; for example, weight loss of 1 to 2 kg may not by clinically significant, irrespective of significance level.

[9] NICE. Key priorities for implementation. Obesity prevention. Guidance. (2006, December 13). https://www.nice.org.uk/guidance/cg43/chapter/key-priorities-for-implementation

[10] Wieland LS, Falzon L, Sciamanna CN, Trudeau KJ, Folse SB, Schwartz JE, Davidson KW. Interactive computer-based interventions for weight loss or weight maintenance in overweight or obese people. Cochrane Database of Systematic Reviews. 2012(8).

[11] Sorgente A, Pietrabissa G, Manzoni GM, Re F, Simpson S, Perona S, Rossi A, Cattivelli R, Innamorati M, Jackson JB, Castelnuovo G. Web-based interventions for weight loss or weight loss maintenance in overweight and obese people: a systematic review of systematic reviews. Journal of Medical Internet Research. 2017;19(6):e229.

However, the Foresight and the McKinsey Global Institute (2014) report states that no single solution is sufficient for reversing obesity, emphasising the need for a comprehensive, systematic approach[12].

NICE recommends that local authorities work with local partners, such as voluntary organisations and industry, to design, produce and manage more safe spaces that encourage physical activity, both incidental and planned, which address any concerns about crime, safety and inclusion, as a priority. Local authorities must offer schemes and facilities such as walking and cycling routes, cycle parking, safe play areas along with area maps while making streets safer and cleaner, through methods including pedestrian crossings, lighting and walking schemes, congestion charging and traffic calming.

8.4 Physical Activity and the Built Environment

The **built environment**, particularly walkability and cycling infrastructure, plays a significant role in facilitating physical activity. Studies suggest that improved pedestrian and cycling routes can increase physical activity and accessibility.[13]

Walkability and Cycling infrastructure

Reading is considered to have good walkability, suggesting that residents can easily access amenities and services by foot, which encourages physical activity and supports a healthy weight. However, where some areas may lack adequate pedestrian infrastructure, such as pavements, crossings, and lighting, it is recommended that the council should prioritise improvements in these areas to promote walking and contribute to reducing excess weight.[14]

According to the Department for Transport, Reading had 11.6 miles of dedicated cycle routes in 2019, which is an increase from 9.2 miles in 2018. However, currently cycle routes in Reading do not always connect with each other. They can also be of low quality making it particularly hard for cyclists with adapted bikes to use. The Reading Transport Strategy 2024 has committed to investment in walking and cycling infrastructure to improve access, increased levels of walking and cycling, reduce conflict between pedestrians and cyclists and in increased levels of physical activity, leading to improvements in health.[15]

Sports and leisure service provision

Engaging in leisure activities, like sports, dance, or other physical activities can help maintain a healthy weight. It can also provide social support and a sense of community, which can improve mental health and wellbeing.

Expanding access to public sports and leisure services (leisure centres, swimming pools, sports clubs, outdoor activities, and exercise classes) is crucial. National Institute for Health Research (NIHR) research highlights the benefits of free access to such facilities

[12] Public Health England. Whole systems approach to obesity: A guide to support local approaches to promoting a healthy weight. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/820783/Whole_systems_approach_to_obesity_guide.pdf
[13] Malacarne D, Handakas E, Robinson O, Pineda E, Saez M, Chatzi L, et al. The built environment as determinant of childhood obesity: A systematic literature review. Obes Rev. 2022;23(S1):e13385.
[14] Ortegon-Sanchez A, McEachan RRC, Albert A, Cartwright C, Christie N, Dhanani A, et al. Measuring the Built Environment in Studies of Child Health—A Meta-Narrative Review of Associations. Int J Environ Res Public Health. 2021 Jan;18(20):10741.
[15] Reading.go.uk (Oct, 2023) Strategic and town centre cycle routes. https://www.reading.gov.uk/vehicles-roads-and-transport/transport-strategy/reading-transport-strategy-2040/walking-and-cycling/schemes-and-initiatives/strategic-and-town-centre-cycle-routes/.

in increasing involvement in physical activity and effective walking programs, including gym activities and swimming[16] [17] due to the removal of barriers related to cost and provision of incentives to encourage facility use[18]. However, the long-term effectiveness of community exercise programs remains uncertain. Evidence is less clear in relation to those most in need.

Free physical activity offers have been evidenced to increase engagement among disadvantaged groups e.g., increased take up of swimming in deprived areas has been shown resulting from free holiday swims, contributing to reducing inequalities in physical activity.[19] However, other research showed that this was not sufficient to encourage inactive adults in disadvantages areas to engage in regular exercise.[17]

Walking programs

Evidence also suggests the cost-effectiveness of walking programs in increasing physical activity in those aged 45-75, with positive changes sustained at three years. The programmes included tips on behaviour change, walking plans, a pedometer, and support via nurse consultations although the group without nurse consultation was best value for money.[20]

Community Programmes

There is mixed evidence relating to community physical activity programs, with one study showing at 12 months, classes held in the community centre being more effective than home exercise classes for people aged 65+ in addition to encouraging walking.[21]
Other studies showed minimal effect of community programs.
Some identified barriers and facilitators of community programs including poor awareness of community-based programs in people over 55. While facilitators included social support, enjoyment and tailored programs in people aged 40 – 64, and affordability as a facilitator in those living in areas experiencing deprivation.[22] [23]

Access to assets like bikes or gym equipment, can promote physical activity and reduce sedentary behaviours. Having access to these assets can also provide opportunities for physical activity outside of formal leisure activities and can be particularly important for those with limited access to leisure facilities or opportunities.

There are real achievable population health gains through more people becoming more active throughout the life course. Planning and development which seeks to reduce obesity and increase physical activity levels in Reading should invest the available resources in a way which seeks to achieve proportionately higher uptake levels across the deprivation gradient. This will ensure that any development or service does not increase but reduces health inequalities.

[16] Higgerson J, Halliday E, Ortiz-Nunez A, Brown R, Barr B. Impact of free access to leisure facilities and community outreach on inequalities in physical activity: a quasi-experimental study. J Epidemiol Community Health. 2018 Mar;72(3):252–8.
[17] Candio P, Meads D, Hill AJ, Bojke L. Does providing everyone with free-of-charge organised exercise opportunities work in public health? Health Policy. 2022 Feb 1;126(2):129–42.
[18] Ward F, Halliday EC, Barr B, Higgerson J, Holt V. Leisure centre entrance charges and physical activity participation in England. Health Promot Int. 2019 Jun 1;34(3):379–88.
[19] Higgerson J, Halliday E, Ortiz-Nunez A, Barr B. The impact of free access to swimming pools on children's participation in swimming. A comparative regression discontinuity study. J Public Health Oxf Engl. 2019 Jun 1;41(2):214–21.
[20] Harris T, Kerry S, Victor C, Iliffe S, Ussher M, Fox-Rushby J, et al. A pedometer-based walking intervention in 45- to 75-year-olds, with and without practice nurse support: the PACE-UP three-arm cluster RCT. Health Technol Assess. 2018 Jul 2;22(37):1–274.
[21] Iliffe S, Kendrick D, Morris R, Masud T, Gage H, Skelton D, et al. Multi-centre cluster randomised trial comparing a community group exercise programme with home-based exercise with usual care for people aged 65 and over in primary care. Health Technol Assess. 2014 Aug 7;18(49):1–106.
[22] Olanrewaju O, Kelly S, Cowan A, Brayne C, Lafortune L. Physical Activity in Community Dwelling Older People: A Systematic Review of Reviews of Interventions and Context. PLOS ONE. 2016 Dec 20;11(12):e0168614
[23] Kelly S, Martin S, Kuhn I, Cowan A, Brayne C, Lafortune L. Barriers and Facilitators to the Uptake and Maintenance of Healthy Behaviours by People at Mid-Life: A Rapid Systematic Review. PLOS ONE. 2016 Jan 27;11(1):e0145074.

Promoting active workplaces

Workplace interventions to reduce sedentary behaviour and promote physical activity and active travel, although having limited evidence for their effectiveness, are essential components of a healthy work environment.

Local authorities play a key role in obesity prevention and management, due to their influence on employee health and industry costs.[24]. Local authorities should promote healthy food and drink by offering nutritious options in their catering services and encourage physical activity through facilities like showers, secure bicycle parking, and attractive staircases. Employees living with excess weight often take more sick leave due to related health issues. Factors like shift work, extended working hours, and sedentary jobs can contribute to weight gain. The Department of Health and Social Care[25] recommends minimizing sedentary time for better health. The shift to hybrid work models, accelerated by the COVID-19 pandemic, presents challenges and new opportunities for creating healthier workplaces.

NIHR studies have shown mixed results for interventions aimed at reducing sedentary behaviour at work. While height-adjustable desks reduced sitting time in one study and promoted positive psychological health[26], a broader review suggests their effectiveness diminishes over time. [27] Strategies like step competitions and regular breaks have not consistently reduced sitting time.[26] [27] [28] Financial incentives for increasing physical activity in public sector workplaces have not been cost-effective.[29]

Challenges in reducing sedentary workplace practices include high workloads, competing priorities, social norms, and unclear responsibility for behavioural change.[27] [28] Raising awareness on the health risks of prolonged sitting,[30] positive attitudes to height-adjustable desks, feedback and ongoing support regarding sitting time can help in modifying behaviours.[31]

Relaxing parking policies at work tends to increase car usage and decrease active travel[32], while efforts to encourage walking to work, such as co-worker-led initiatives, have not significantly increased moderate to vigorous physical activity.[33]

[24] Recommendations | Obesity prevention | Guidance | NICE
[25] https://www.gov.uk/government/publications/physical-activity-guidelines-uk-chief-medical-officers-report
[26] Edwardson CL, Yates T, Biddle SJH, Davies MJ, Dunstan DW, Esliger DW, et al. Effectiveness of the Stand More AT (SMArT) Work intervention: cluster randomised controlled trial. The BMJ. 2018 Oct 10;363:k3870.
[27] Shrestha N, Kukkonen-Harjula KT, Verbeek JH, Ijaz S, Hermans V, Pedisic Z. Workplace interventions for reducing sitting at work. Cochrane Database Syst Rev. 2018 Jun 20;6(6)CD010912.
[28] Mackenzie K, Such E, Norman P, Goyder E. Understanding the Implementation of "Sit Less at Work" Interventions in Three Organisations: A Mixed Methods Process Evaluation. Int J Environ Res Public Health. 2021 Jul 9;18(14):7361.
[29] Hunter RF, Gough A, Murray JM, Tang J, Brennan SF, Chrzanowski-Smith OJ, et al. A loyalty scheme to encourage physical activity in office workers: a cluster RCT. Public Health Res. 2019 Sep 3;7(15):1–114.
[30] Mackenzie K, Such E, Norman P, Goyder E. Development, implementation, and evaluation of Sit Less at Work interventions in diverse organisations: a mixed-methods study. The Lancet. 2021 Nov 1;398:S63.
[31] Biddle SJH, O'Connell SE, Davies MJ, Dunstan D, Edwardson CL, Esliger DW, et al. Reducing sitting at work: process evaluation of the SMArT Work (Stand More At Work) intervention. Trials. 2020 May 13;21(1):403.
[32] Knott CS, Sharp SJ, Mytton OT, Ogilvie D, Panter J. Changes in workplace car parking and commute mode: a natural experimental study. J Epidemiol Community Health. 2019 Jan 1;73(1):42–
[33] Audrey S, Fisher H, Cooper A, Gaunt D, Metcalfe C, Garfield K, et al. A workplace-based intervention to increase levels of daily physical activity: the Travel to Work cluster RCT. Public Health Res. 2019 Jun 5;7(11):1–128.

Active travel, physical activity and maintaining a healthy weight

Active travel involves using physically active modes of transport like walking or cycling instead of motorised vehicles (cars, motorbikes).[34] Public transport also supports active travel as it often requires walking or cycling to access. Active travel can promote physical activity and reduce reliance on cars or other motorized transport. Encouraging active travel can also help reduce air pollution and congestion, which can contribute to poor health outcomes. Providing infrastructure and facilities to support active travel, such as bike lanes or safe pedestrian routes, can help support healthy weight. The effectiveness of interventions in this area varies, with factors like safety, accessibility, and connectivity playing crucial roles.

Increases in road transport contributes to reduced physical activity and rising excess weight. Opting for more active travel can enhance health, quality of life, environmental conditions, local productivity, while also reducing public expenditure. In the UK, many are not meeting physical activity guidelines, especially in deprived areas.[35] Integrating walking or cycling into daily routines is highly effective for increasing physical activity.[36]

The COVID-19 pandemic has been a catalyst for change, promoting cycling and walking[37], with 2020 witnessing the highest number of cyclists on public roads since the 1960s.[38] This shift, along with new hybrid working patterns, offers unique opportunities and challenges for active travel. However, a statistical release from the Department of Transport (August 2024) commented that "whilst cycling trips ... increased over the pandemic during 2020, the average number of trips and stages have returned to similar levels seen in 2019"[39]

According to NIHR research findings:

A study tracking over 8,000 schoolchildren (7-14) showed that those who **walked or cycled to school** had healthier body weights compared to those who travelled by car, especially in deprived areas.[40]

Cycle training in primary schools hasn't significantly increased cycling among adolescents. Cycling is more prevalent among teenage boys, in rural areas, and regions with high adult cycling rates.[41]

Enhancing the quality and connectivity of walking and cycling paths boosts active travel and helps more people meet physical activity guidelines. The most significant increases in active travel, (which also reduced health inequalities) occurred along routes connected to public transport hubs, in areas with low walking and cycling usage,

[34] https://www.gov.uk/government/publications/active-travel-a-briefing-for-local-authorities
[35] https://evidence.nihr.ac.uk/how-local-authorities-can-reduce-obesity/#iLightbox[d7179ca2496f8f4c30f]/0
[36] https://www.gov.uk/government/publications/active-travel-a-briefing-for-local-authorities
[37] https://www.gov.uk/government/publications/increasing-uptake-of-cycling-following-covid-19-travel-disruption
[38] https://www.gov.uk/government/publications/active-travel-schemes-supported-by-government-funding
[39] https://www.gov.uk/government/statistics/walking-and-cycling-statistics-england-2023/walking-and-cycling-statistics-england-introduction-and-main-findings-national-travel-survey#total-stages-cycled
[40] Laverty AA, Hone T, Goodman A, Kelly Y, Millett C. Associations of active travel with adiposity among children and socioeconomic differentials: a longitudinal study. BMJ Open. 2021 Jan 1;11(1):e036041.
[41] McKay A, Goodman A, van Sluijs E, Millett C, Laverty AA. Cycle training and factors associated with cycling among adolescents in England. J Transp Health. 2020 Mar;16:100815.

high population density, and deprivation, also considering accessibility and convenience[42] [43] [44]

Effective walking and cycling programs focus on **traffic and personal safety and improving the overall experience**.[44] Infrastructure improvements like bridges or tunnels can increase the use of these paths, though they may not appeal to all users, such as women who may have safety concerns.[43]

Using **public transport** is linked to lower BMI in adults.[45]. Free bus passes for the elderly[46] and minority ethnic groups[47] can encourage active travel, and where physical activity is not significantly increased, other social benefits arise.[48]

A multifaceted approach involving personalised interventions, enhanced public facilities, workplace initiatives, and improved urban infrastructure is vital in promoting physical activity for maintaining a healthy weight.

Gamification

The application of game-design elements in non-game contexts has a place in encouraging physical activity. The concept leverages the human psychological response to gaming, such as point scoring, competition, and rules of play, to make physical activity more engaging and motivating. Evidence of effectiveness includes:

- Gamification elements like rewards, challenges, and leaderboards can significantly **increase motivation and engagement** in physical activities. One study[49] found that gamification positively affects exercise motivation and physical activity levels.
- Gamification can **enhance adherence to physical activity routines**. A systematic review indicated that gamified interventions were effective in increasing physical activity, particularly when they included elements like social competition and support.[50]
- Incorporating game elements into exercise programs can make the experience **more enjoyable** and **less monotonous**. One study showed that gamified physical activity interventions could increase enjoyment, a critical factor in long-term exercise adherence.[51]
- Gamification has been found effective in **engaging specific groups** who might be less inclined to participate in traditional exercise programs, like younger individuals or those who are more digitally inclined.

[42] Panter J, Ogilvie D. Can environmental improvement change the population distribution of walking? J Epidemiol Community Health. 2017 Jun 1;71(6):528–35.
[43] Le Gouais A, Panter JR, Cope A, Powell JE, Bird EL, Woodcock J, et al. A natural experimental study of new walking and cycling infrastructure across the United Kingdom: The Connect2 programme. J Transp Health. 2021 Mar 1;20:100968.
[44] Panter J, Guell C, Humphreys D, Ogilvie D. Can changing the physical environment promote walking and cycling? A systematic review of what works and how. Health Place. 2019 Jul 1;58:102161.
[45] Patterson R, Webb E, Hone T, Millett C, Laverty AA. Associations of Public Transportation Use With Cardiometabolic Health: A Systematic Review and Meta-Analysis. Am J Epidemiol. 2019 Apr;188(4):785–95.
[46] Laverty AA, Webb E, Vamos EP, Millett C. Associations of increases in public transport use with physical activity and adiposity in older adults. Int J Behav Nutr Phys Act. 2018 Apr 2;15:31.
[47] Patterson R, Webb E, Mindell JS, Millett C, Laverty AA. Ethnic group differences in impacts of free bus passes in England: A national study. J Transp Health. 2018 Dec;11:1–14.
[48] Green J, Steinbach R, Jones A, Edwards P, Kelly C, Nellthorp J, et al. On the Buses: A mixed method evaluation of the impact of free bus travel for young people on the public health. Public Health Res. 2014 Feb 18;2(1):1–206.
[49] Hamari, J., & Koivisto, J. (2015). "Measuring flow in gamification: Dispositional Flow Scale-2." Computers in Human Behavior, 40, 133-143.
[50] Patel, M. S., et al. (2019). "A Randomized Trial of Social Comparison Feedback and Financial Incentives to Increase Physical Activity." Journal of the American Heart Association, 8(13).
[51] Lister, C., et al. (2013). "Just a Fad? Gamification in Health and Fitness Apps." JMIR Serious Games, 1(1), e9.

- Many **fitness and health apps** now incorporate gamification to encourage users to achieve their fitness goals. These apps use points, badges, progress tracking and social sharing to motivate users.[52]

Physical Activity Framework

This is a broad term to describe the processes that help people who would benefit from being more active to receive behaviour change support and access to a range of structured opportunities to be more active.

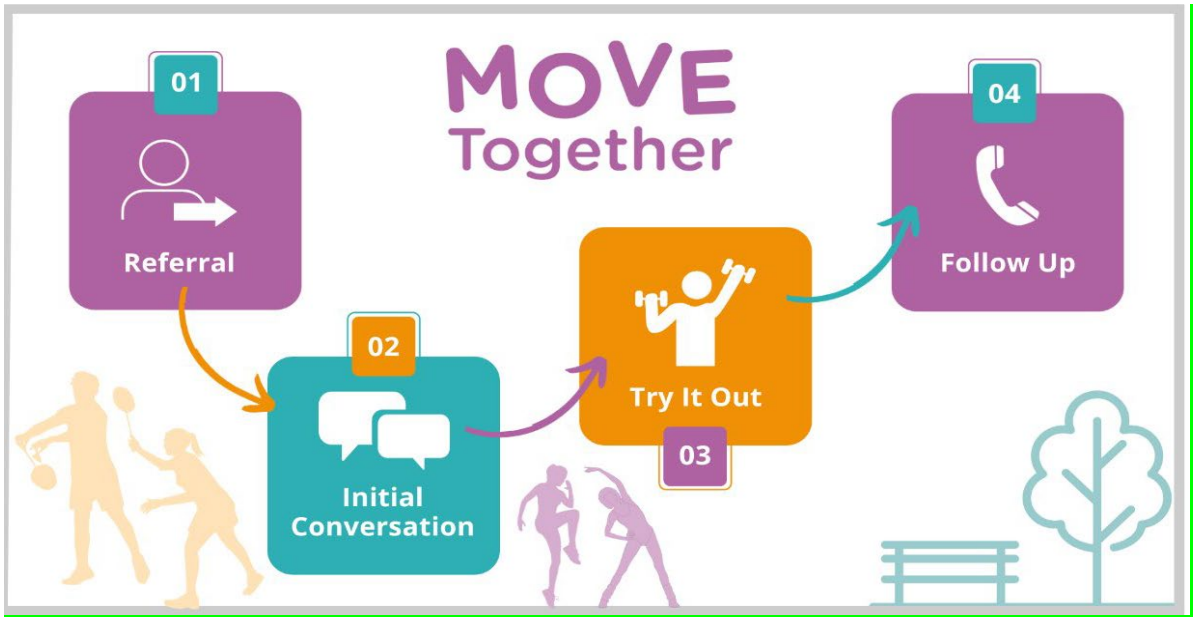
It has both a strategic (blue) focus and an operational (green) focus (Figure 8.6)

Figure 8.6: Physical Activity Framework Model Summary

A local example of a well-established pilot case study includes Move Together by Oxfordshire County Council, funded by public health and BOB ICB. Its outcomes are summarised below in Figure 8.7.

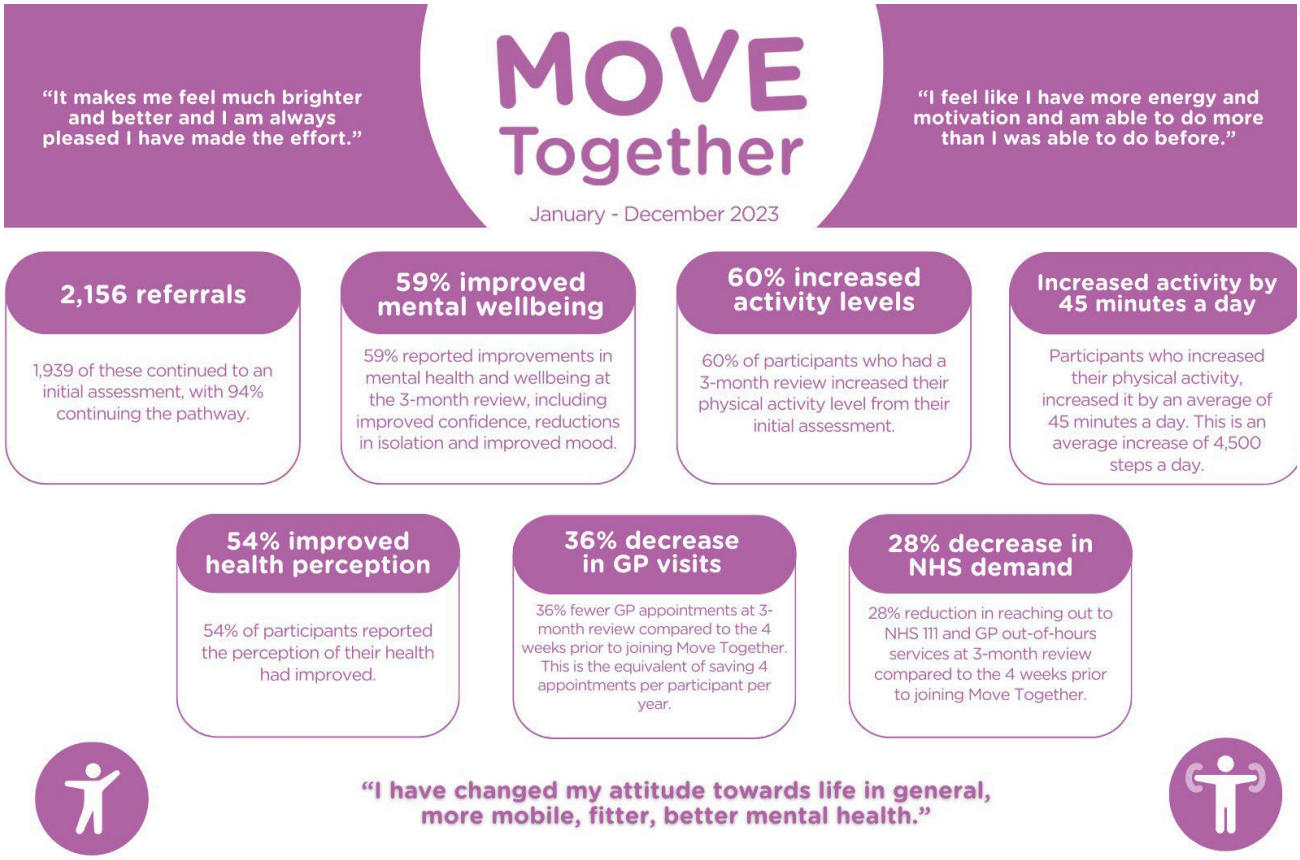
[52] Middelweerd, A., et al. (2015). "Apps to Promote Physical Activity Among Adults: A Review and Content Analysis." International Journal of Behavioral Nutrition and Physical Activity, 12, 97.

Figure 8.7: Move together pathway, a case study



Taken from Move together outcomes Report, 2024.

Figure 8.8: Move together infographics summary of outcomes (taken from outcome report)



8.5 Recommendations

1. **Increase accessibility to active travel options -** Develop and improve infrastructure for walking and cycling in Reading, focusing on enhancing connectivity and safety to encourage more residents to engage in active travel. Public Health England published a guide of practical actions for local authorities to promote active travel.
2. **Develop innovative community solutions -** Implement new and effective strategies to maximise community engagement with leisure facilities and services, enhancing long-term health and activity levels. Move More pathways is a good example of this.
3. **Enhance sports and leisure service provision -** Expand access to public sports and leisure services and consider offering free or subsidized access to these facilities, especially for disadvantaged groups.
4. **Utilise Sport England's tested methods** for using sports and physical activity to combat obesity. Adapt their resources, models, and tools to meet local community needs.
5. Work with local partners to **create safe spaces** that encourage physical activity. This includes managing traffic, improving lighting, and providing amenities like cycle parking and play areas to make streets safer and more conducive to physical activity.
6. **Appoint senior physical activity champions** to promote and co-develop community-based physical activity initiatives, as recommended by NICE. Follow NICE guidance for employers, including local authorities, on promoting physical activity in the workplace.
7. **Promote physical activity in daily life -** Encourage integrating physical activities like walking, cycling, and using stairs into everyday routines. Employers and local authorities should create environments that support these choices.
8. **Tailor interventions for seldomly heard community groups -** Develop and implement weight management physical activity programs tailored to the diverse needs of the community, considering different age groups, cultural backgrounds, and physical abilities. E.g., for men, use strategies like male-friendly language, men-only groups, and activities linked to sports clubs. Include behaviour modification and motivational strategies for increased participation and effectiveness.
9. **Leverage technology and gamification -** Utilise interactive, web-based platforms and incorporate gamification elements in fitness programs to increase motivation, enjoyment, and adherence to physical activity, especially among younger and digitally inclined individuals. Making them suit individual preferences and cultural contexts for maximum effectiveness.

9. Food and our environment and health

9.1 Food and our environment

Influencing what people buy and eat	Encouraging healthy schools	Expanding access to public sports and leisure services
Promoting active workplaces	Providing weight management programmes	Designing built and natural environments
Enabling active travel and public transport	Preventing obesity in children and families	Embracing system-wide approaches

Figure 9.1: The Interplay of various factors in managing healthy weight, action plan for local authorities[53]

9.1.1 Food availability

The grocery landscape in Reading is dominated by major supermarket chains that have branches in the centre of the town and its surrounding wards: Waitrose (3), Tesco Express (11), Tesco Extra (2), Marks and Spencer Simply Food (1), Morrisons (1), Sainsbury's (2), Co-op (5), Aldi (4), Lidl (3). Local and independent grocery stores are found mainly along Oxford Road, in the west part of Reading, and near Cemetery junction, in the east. Reading Buses provide good transport links across the town to major supermarkets and local grocery stores.

[53] NIHR (2022) How can local authorities reduce obesity? Insights from NIHR research. https://evidence.nihr.ac.uk/how-local-authorities-can-reduce-obesity/

In the public survey, which was conducted in 2023, over nine in ten respondents said that they eat home-cooked meals most of the time. One in five said they also eat takeaways or ready meals at home, and just over one in ten (11.5%) responded that also eat in restaurants, pubs, or cafes. The majority (7%) of those who do not eat at home most regularly do so because of work patterns (Figure 9.2).

Figure 9.2: Response to the question 'what are your meals made of?' Residents' survey

Affordability of food since the Covid-19 pandemic and the cost of living

Just over half of respondents (54%) reported that their eating and drinking habits have not changed since the pandemic. Of those who said that their eating and drinking habits had changed since the pandemic, 22% answered that their eating and drinking habits had improved, and 24% that they had worsened. Of those who reported that their eating habits had changed, 29% said they now cooked more at home from scratch, 22% that they are more careful about how much they spend on food; 20% reported relying on food for comfort and 20% that they snacked more often, as shown in Chart 3 below.

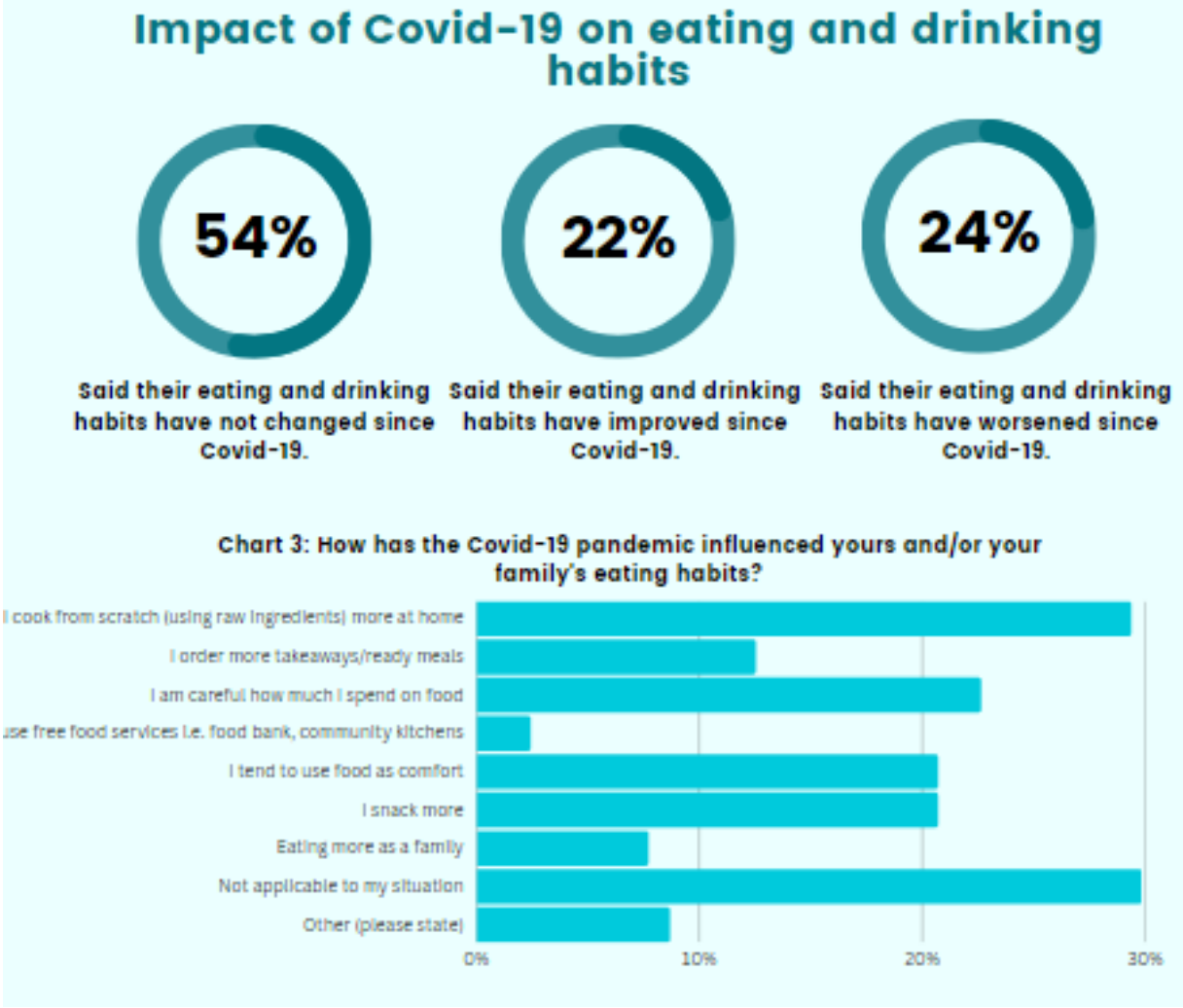


Chart 3: Answer to the question: 'what has been the impact of Covid on your eating habits'?

Focus groups, which were held in 2023, confirmed similar findings as they pointed to the adverse impact of the pandemic and the cost-of-living crisis on residents' food shopping:

"I am fortunate in that I can afford to buy food at current prices. I certainly check prices much more carefully than previously and plan menus with greater care, bulk buy and freeze food etc to save money"

"Bought less food and stuff on sale, prioritising value over health"

"Food is a priority for buying other things - Holidays, new (unnecessary) clothes, entertainment- are luxuries. I spend appropriately and cut back where necessary"

"I have seen my weekly food bill increase by 50% since last year. Absolute disgrace that as someone that works full time and with no longer children at home that I have to watch every penny until my next payday"

"I'm learning where to buy cheaper food, and I often decide to not buy fancy food, but just basics"

"I am most definitely buying less meat / fresh food because of the increase in costs"

"Have to opt for low-cost options like frozen food or price reduced items".

"I am more careful what I buy and ensure that there is no waste in food at home."

"We budget very carefully and live a frugal lifestyle anyway. As a result, we are not happy with the food price rises, but have thus far coped OK".

"Adopting a sustainable diet need not be perceived as difficult or expensive. Parking is an issue at RISC but it's worth the effort, pulses, nuts, and dried fruit is actually affordable. We bring our own containers and it's better in many ways, for us, the environment and producers, too".

Refill Centre at the Global Café, Reading International Solidarity Centre (RISC)

Meet Global Refills: the newest addition to the RISC Family. Inspired by the growing zero-waste movement, the Refill Café has brought bulk foods to central Reading. The goal is to help empower the local community to reduce packaging waste and single-use plastics. The drive has come from the images of plastic accumulating on beaches, filling the oceans and piling up in landfills in mostly majority world countries.

risc.org.uk - global refills

Reflections on changing the food culture in Reading

During the survey that was conducted in 2023, people expressed their thoughts and concerns:

"It's also easy not to keep going to fast food places which is just being lazy. On the rare occasions I go to somewhere like McDonald's I am astounded by the number of people there, especially obese children".

"When there are money and time pressures, people will go for the cheap, carb-rich, option that quickly fills you up (fast-food) and the option that is available to them easily due to location".

"Fed up of being judged by very thin women who think that all you have to do is stop eating cakes"

"It's a cultural issue: children are losing out on cooking traditional meal as cheaper/easier option is to get a burger/take away. Cooking skills being lost. Preference for fast food over family foods"

Community food growing and allotments

All local authorities have a mandatory obligation to provide allotment provision under Section 23 of the 1908 Small Holdings and Allotments Act but there is no time scale attached to this piece of legislation. Sites can also be provided by the National Trust and private landlords including organizations such as the Church of England. The National Allotment Society provides information about allotments for anyone with an interest in allotment gardening[54]. In Reading, there are 20 allotment sites across the brough with waiting lists ranging from one year (in Coley Park) to twelve years (in Caversham with an average waiting time of four years [55]. Findings from the survey and focus groups, conducted in 2023, have revealed an interest in food growing and allotment gardening:

"Food growing places provide opportunities for informal 'multi- and inter-generational teaching & learning"

"Community garden would be helpful where people could grow and pick veg and fruit and interact with the community"

"I have found that since I've taken on an allotment, I am more active and I'm making better food choices. As a result, I'm starting to lose weight. I also feel happier, which in turn also allows me to avoid comfort eating"

"Allotments where the Civic Centre used to be a great addition of green space to a part of the town with little easily accessible green space!"

"Caversham primary school used to have an allotment where children learnt about growing their own food, but they no longer do so"

"More gardening for everyone, combine exercise with growing food for healthier eating. More environmental conservation - combine exercise with increasing biodiversity"

Suggestions from Community Food Growing (CFG) groups (Incredible Edible Reading, Food for families) include:

"Sourcing core funding to support CFG growing from re-thought council strategies to tackle climate change, health & wellbeing, waste management, biodiversity, cost-of-living and community cohesion. 'Joined-up' thinking in policy is needed as councils could get more for their limited funding if they could focus on targeted community-led food growing initiatives that deliver so many benefits on so many fronts. CFG lies at the intersection of all the objectives of RFP: raising awareness, health & wellbeing, climate resilience, reducing inequality"

"Access to land could be articulated clearly in terms of the 'Right to Grow' campaign: mapping existing council owned land suitable for community food

[54] About Us – The National Allotment Society – National Society of Allotment and Leisure Gardeners Ltd (nsalg.org.uk)
[55] Allotments Reading Borough Council https://www.reading.gov.uk/leisure/outdoors/allotments/

growing; reducing bureaucracy so that no-cost leases could be readily provided to community groups; and then supporting community food-growing initiatives with resourcing especially for CFG coordinators. Right To Grow policy would support groups who want to grow food & facilitates access to land (temporary or permanent); hopefully this would streamline the leasing process with RBC-owned land. F4F has had a challenging experience trying to agree leases - the terms simply do not reflect the types of activities in community food growing gardens. We need a template that is fit for purpose & can be adapted for specific sites"

"Get Local Authorities to support partnerships with business through the planning process (making sure that development plans have inbuilt CFG spaces) and from subsequent Community Infrastructure Levies to pay for CFG. Also, businesses to contribute existing spaces to CFG + sponsorship. All departments in Reading Borough Council need to recognise that value of CFG. At present we have good collaborative working relationships with some officers but some, e.g., Directorate of Economic Growth, do not respond to requests to discuss CFG in the long-term infrastructure plan as part of public realm"

"Coordination between groups directly involved in food growing e.g. F4F, Freely Fruity. Needs long term core funding rather than insecure bids to Small Grants or BCF which are very competitive. Incredible Edible Reading could perform this function with a coordinator & team of freelance tutors, garden designers"

"Specialist team for working with schools coordinated by RISC's educational team would support schools to create their own gardens & provide training for teachers to maximise the educational benefits of outdoor classroom, especially bringing food issues into the whole curriculum".

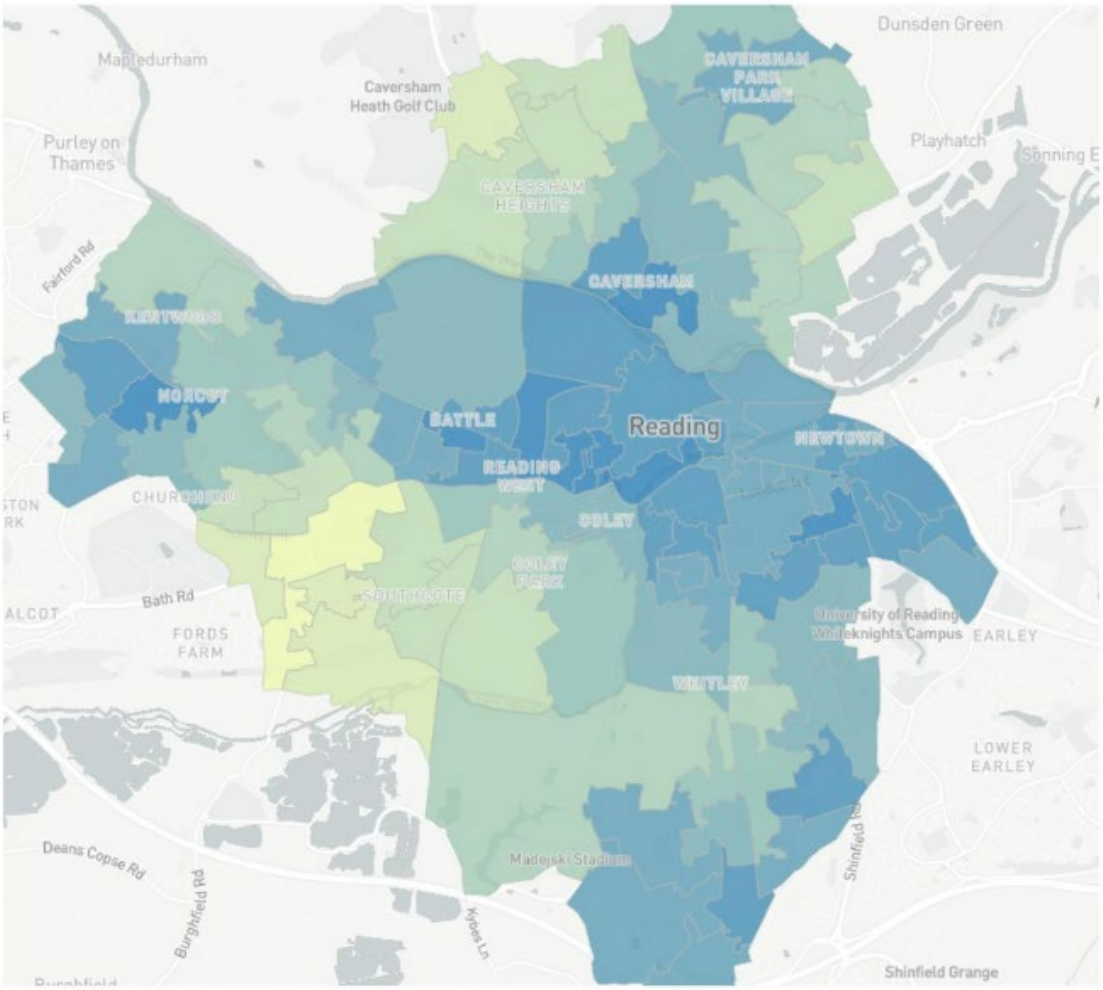
9.1.2 Fast Food Outlets

The increasing number of fast-food outlets that provide relatively cheap and readily available meals throughout the day contribute to rising levels of obesity. Guidance from Public Health England (PHE) estimated over 50,000 fast food and takeaway outlets (from 2014 data set), fast food delivery services, and fish and chip shops in England[56]. Findings suggest that over a quarter of adults and a fifth of children rely on food outlets for at least one of their meals once a week, meals that are associated with high calory intake, low levels of micronutrients and high levels of fat, sugar, and salt. Evidence links the availability of fast-food outlets and level of area deprivation, as confirmed by 2017 data from the Food Standards Agency Food Hygiene Rating Scheme used to map the density of fast-food outlets in local authorities across England[57]. In its analysis, PHE uses the term 'fast food' to designate energy dense food that is available quickly at outlets that include but are not limited to burger, kebab, fish and chip shops, and pizza outlets. Most are

[56] Health matters: obesity and the food environment - GOV.UK (www.gov.uk) https://www.gov.uk/government/publications/health-matters-obesity-and-the-food-environment/health-matters-obesity-and-the-food-environment--2

[57] Obesity and the environment - Density of fast-food outlets at 31/12/2017 (publishing.service.gov.uk)

independent companies with one or two shops, and the rest are part of food chain retailers with numerous outlets operating as multi-functional outlets, offering eat in and sit-down meals as well as takeaway and home delivery[58]. Fast food outlets in local authorities range from 26 to 232 per 100,000 residents in any local authority and Reading is among the local authorities with the highest number of fast-food outlets per residents, that is, a count of 197 outlets or 121.1 per 100,000 residents.



(Consumer Data Research Centre, 2022) [accessed via Berkshire West Public Health Inequalities report April 2023]

Figure 9.3: Access to Health Assets and Hazards Index. Fast food sub-domain where darker shaded areas indicate easier access to fast food shops

Figure 9.3 is taken from the Access to Health Assets and Hazards Index (AHAH) but this time focussing on the fast-food sub-domain. This is calculated using the mean distance to a fast-food retail store based on the calculated road network distance. Areas ranking worse on this sub-domain of the index are mainly across the centre

[58] Fast food outlets: density by local authority in England - GOV.UK (www.gov.uk)

of the Borough from Norcot in the West over to Park in the East. Areas of Whitley and Church in the South and Peppard in the North also rank worse on the index

Residents reported having had to cut back on eating out, bring packed lunch to work or batch cook to save money since the pandemic. They highlighted eating less outside of the home and relying less on takeaway meals:

"'Food shopping is very expensive and as a result of this we can hardly ever eat out or have takeaways'"

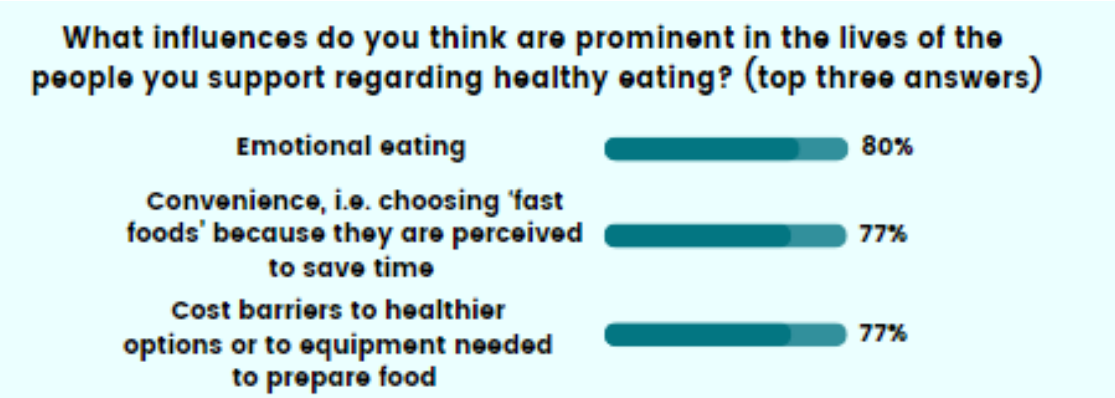
"More conscious about spending but thankfully have not been prevented from buying food, we are still able to do so but there has been an evident increase in awareness of cost leading to more careful shopping and less eating out"

"I know what to do but I am too tired when I come back from work. I have less money to buy healthy food"

A recurrent phrase is 'time poor' especially among families and professionals. Ordering a takeaway or purchasing ready meals allows parents to 'cope' especially when they look after children with mental health challenges and learning difficulties. While eating out can be stressful for parents whose children are 'fussy eaters' because they feel 'watched' and 'judged' for their food choices and children's behaviour in public, according to a group of parents, ordering food from fast food outlets or purchasing ready meals from supermarkets helps prevent food waste. Supporting community groups where children eat together offers 'a breathing space' for parents and furthermore, it appears that children are less 'picky' and more communicative about their food when surrounded by other children.

Among professionals, as shown in Chart 4, eight in ten respondents said that emotional eating was the most prominent influence of unhealthy weight in the people they support. The other two most dominant responses were convenience (77%) and cost barriers to healthier options or to the equipment needed to prepare food (77%).

Chart 4: Response to Public Survey Question: 'What influences do you think are prominent in the lives of the people you support regarding healthy eating



Charts 5 and 6 highlight interventions that people think might help children eat better: positive adverts and healthy messages in the media, early years education, supporting new mothers with breastfeeding, banning junk food from schools and fun games around healthy eating in schools.

Chart 5: Are there any broader actions outside of the home that might encourage children and young people to eat well?

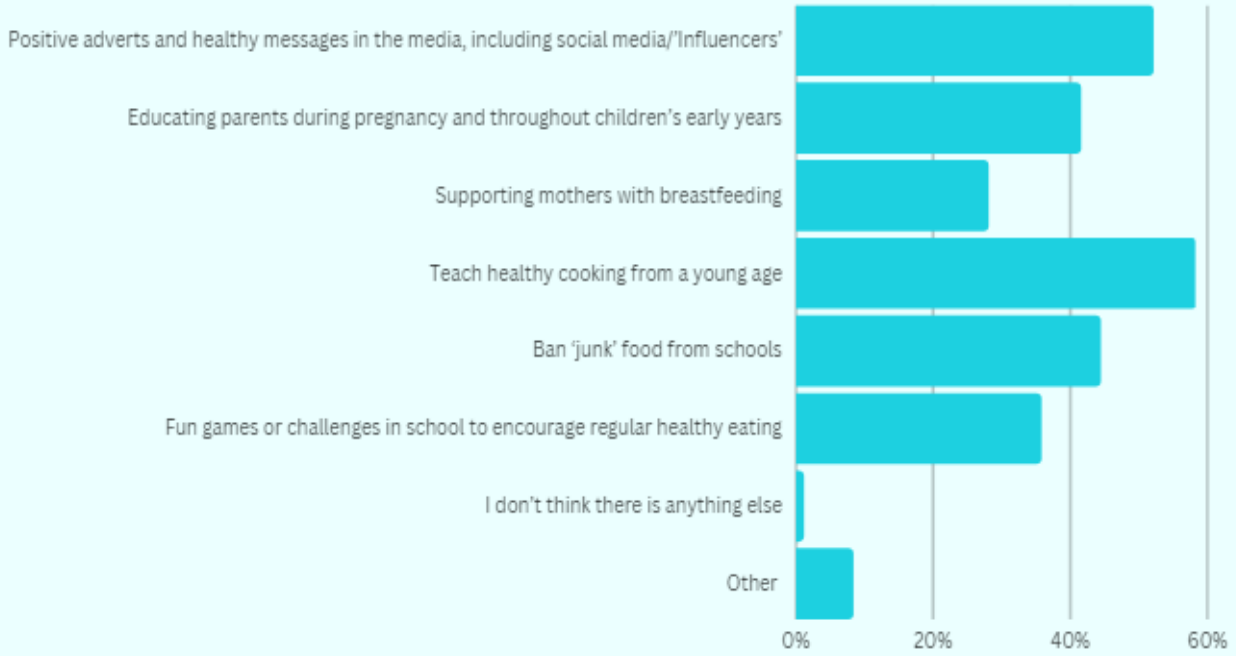
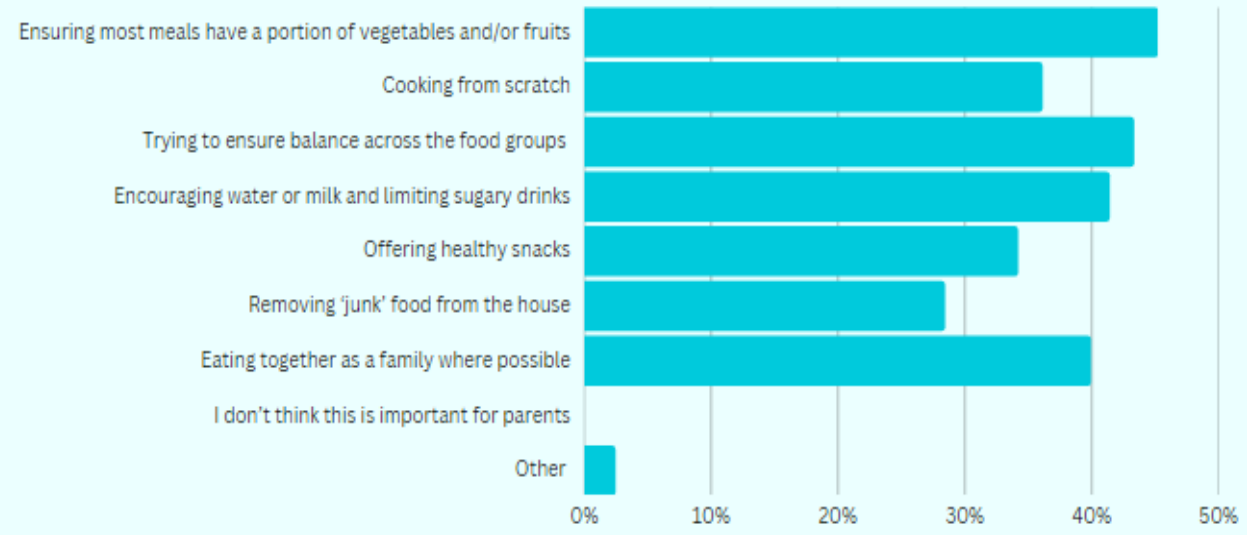


Chart 6: What do you think is important/helpful in encouraging children to eat well at home?



9.1.3 Food promotion and advertising

Advertising for unhealthy foods and drinks has long been associated with poor public health; in particular, child obesity and health inequalities.

Exposure to advertising is an important contributing factor influencing awareness, attitudes and preferences, purchase intent, purchase requests, purchase, and consumption, including advertising targeted at children. Outdoor advertisement spaces including bus stops, billboards and transport facilities are highly visible locations for advertisement and an integral part of the total exposure for residents. In 2021, the UK outdoor advertising industry generated more than £900 million in revenue. Data from Scotland suggest that HFSS [foods high in fat, salt, and sugar] products totalled about 33% of all "out-of-home" advertisements, 4% on alcohol and 0.4% on gambling. Outdoor advertising is thought to reach 98% of the UK population at least once a week, with 85% reporting exposure to HFSS product advertising specifically in the past 7 days with those from lower socio-economic groups have higher exposure to such adverts. Evidence suggests that unhealthy commodity advertising has cumulative effects, such that attitudes and consumption behaviours correlate with the frequency of exposure to marketing messages in the case of HFSS products, it has been shown that such advertisement exposure directly impacts on acute and longer-term consumption, particularly in children and adolescents.

As a results, The Association of Directors of Public Health clearly states its position on advertising:

Marketing for HFSS food and drink products should be banned on all media devices before the 21:00 watershed and sponsorship by HFSS brands should be restricted

Healthier Advertising Policy

Evidence from the London School of Hygiene and Tropical Medicine's evaluation of the Transport for London policy has shown that the restrictions led to a 20% reduction in purchases of sugary products[59], and a 1000 calorie decrease per week per household from unhealthy foods and drinks. Further modelling research from the University of Sheffield has estimated that across London, the restriction will lead to 95,000 fewer cases of obesity, 3000 fewer cases of diabetes and 2000 fewer cases of heart disease and save the NHS £218million over the lifetime of the current population.

Moreover, Transport for London also announced that their **advertising revenues have been unaffected** by the restrictions since implementation in 2019. In the first year of the policy, revenues went up by £2.3 million, and in the second year (2020-21), despite financial losses due to Covid lockdowns at the time, the restrictions enabled the advertising figures to be maintained.

[59]https://www.london.gov.uk/press-releases/mayoral/households-buying-1000-fewer-calories-per-week#:~:text=It%20found%20households%20purchased%201%2C000,a%2020%20per%20cent%20reduction.

Granted, transportation in London is unique, with a heavy reliance on the underground and buses for day to day living in the large, sprawling, highly populated city. Reading is similar in many respects, being a large urban town. It has a strong bus network covering most (not all) of Reading Borough Council, though it does have a separate rail network and providers Car ownership in Reading declines significantly with increased levels of deprivation [national reference needed – don't have this data locally].

To date 13 local authorised have successful brought in such a ban, 6 in London and 7 outside of London, with over 150 local authorities (40% of Local Authorities) seeking support of Sustain* for support with developing their own policy, demonstrating this model works in urban areas outside of London, not to dissimilar to Reading and there is a growing appetite for change.

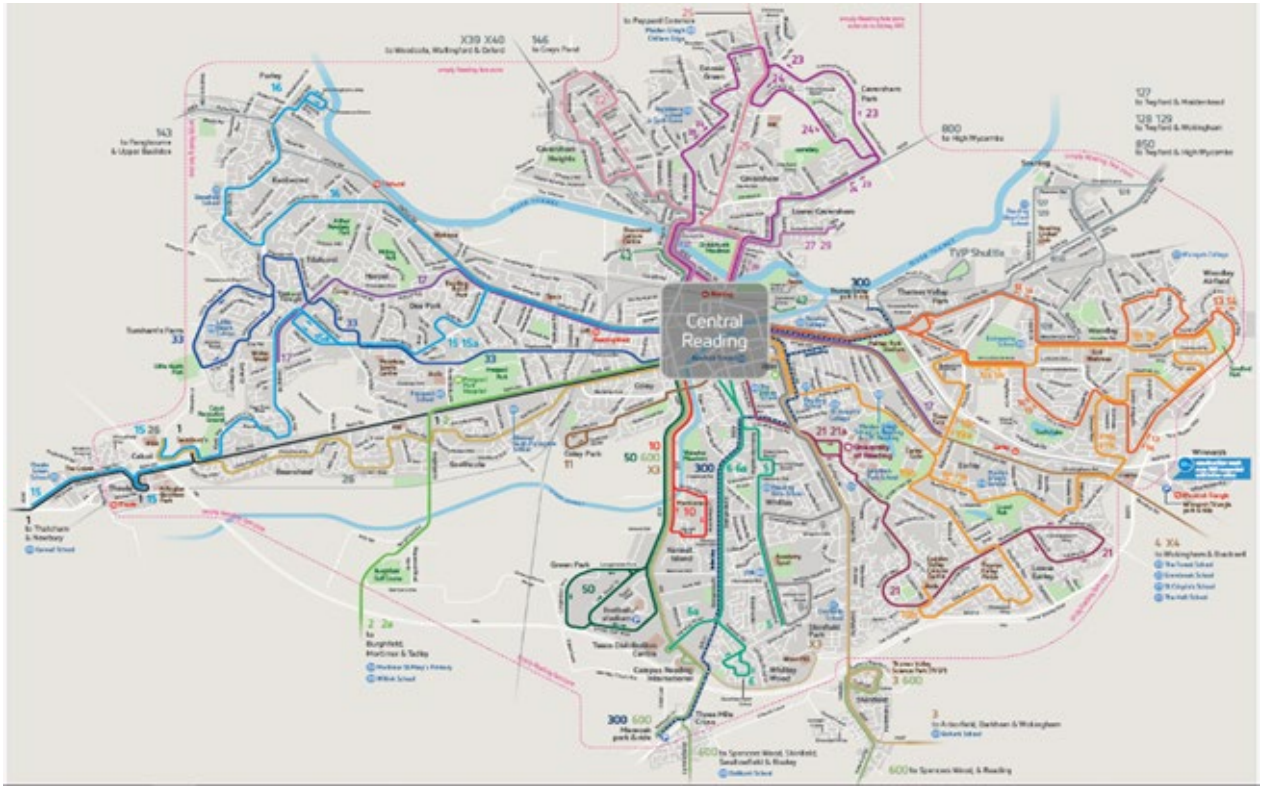


Figure 9.4: Mapping of Bus Routes in Reading

Local picture

Many Reading bus stops have bus shelters around 250 in total. Reading has a contract with JC Decaux assets, covering approximately 165 bus shelters, of which 110 are advertising shelters, of which 6 are digital; the others are RBC owned. There is currently no adverting space on the council's own shelters. Waiting lists for advertising are several months long. However, to date, there are no specific restrictions on advertising content beyond those provided by the Advertising Standards Authority.

As Reading's advertising licence for bus shelters and free-standing units expires in May 2025, there is now an opportunity to review the local advertising policy to explore if it is possible to reduce exposure to fast-food advertising, noting the revenue implications.

The resident's survey revealed that nearly 8 in 10 respondents would like to see less advertising for food high in fats, sugar, and salt (such as burgers, fried chips, and fizzy drinks) around town centers (18).

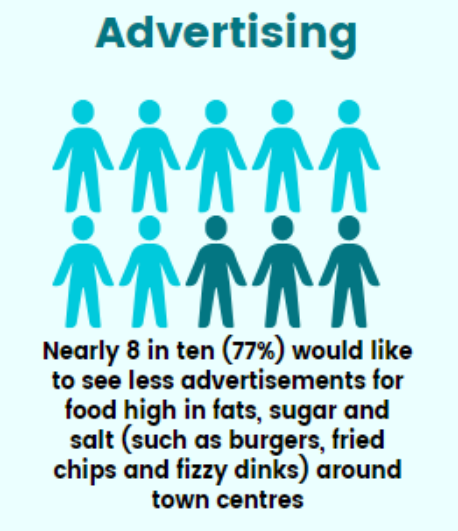


Figure 9.5: Residents' responses to the question about food advertising

Residents responded favourably to limiting advertising and encouraging messages about healthy behaviour in public spaces and in schools:

The promotion and enablement of healthy eating/exercise as a joyful thing rather than the policy of disapproval and negative attitudes towards 'unhealthy' eating/ habits.

Create marketing campaigns for healthy lifestyles to promote healthier behaviour.

Diets do not work and can lead to lifelong issues with disordered eating and altered metabolism. We should not be promoting dieting, but should be promoting gentle, daily activity that is sustainable. The cost of quality fruit/veg/meat is also an issue

The promotion and enablement of healthy eating/exercise as a joyful thing rather than the policy of disapproval and negative attitudes towards 'unhealthy' eating/ habits.

Our media constantly promotes unhealthy food. Most of the ads on TV and Internet are for unhealthy food, which is widely promoted and make readily available. Adults and kids are often influenced by this. Healthy foods need to be promoted similarly and should be made readily available.

Have you ever seen a billboard with parsnips? Or salad without a burger? It's just sugar. And crap food. Burgers, KFC, Greggs. That's what we eat. What's the council doing? Nothing because they want the money from the poison they promote.

9.2.1 Key Determinants of Healthy Weight

Diet is the biggest determinant of healthy weight. However, many factors are at play which impact the foods we consume. As outlined above, it is not simply a case of individual choice. As is the case with lifestyle behaviour, including physical activity, health inequalities are at play.

In 2021, the households amongst the poorest 5th of all households in England would have to spend 40% of their disposable income on food to meet Eatwell Guide costs compared to 7% of the richest 5th of all households (The Food Foundation, 2021). This is clearly going to impact on one's ability to eat well.

9.2.1.1 Healthy eating and dietary risk factors

Energy intake from food contributes to maintaining energy balance and a healthy weight; beyond calories, the nutritional content of various food types contributes to the maintenance of good health.

The Global Burden of Disease study[60] found that increased Body Mass Index (BMI) is associated with physical inactivity, excessive caloric intake, and diet quality. While establishing the impact of dietary components on health, including appetite, absorption and weight is complex, it is important to support individual action by tackling diet quality and excess energy intake through public policies such as national subsidies, taxes and local information campaigns and improving accessibility locally. Addressing dietary risk factors would reduce global risks for cardiovascular disease, cancers, diabetes, and kidney-related diseases. Dietary factors include the under-consumption of dietary fibres, fruit, nuts, seeds, and vegetables, and the over-consumption of processed meat, foods high in energy, fat, simple sugars, and sodium.

The World Health Organisation (WHO) recommends consuming a healthy diet throughout the life-course to prevent noncommunicable diseases and malnutrition of various kinds across the life course[61]. Dietary patterns have shifted in recent years due to increased consumption of processed foods, rapid urbanisation and changing lifestyles notably with work that is more sedentary. Individual characteristics such as age, gender or occupation play a role in defining what a healthy diet should be at individual level, however, basic principles apply to the population. Studies of dietary trajectories across the life course[62] point to the establishment of dietary patterns before the age of three and to important

[60] Murray et al. (2020) Global burden of 87 risk factors in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019 https://www.healthdata.org/research-analysis/library/global-burden-87-risk-factors-204-countries-and-territories-1990-2019

[61] WHO https://www.who.int/news-room/fact-sheets/detail/healthy-diet

[62] https://www.cambridge.org/core/journals/british-journal-of-nutrition/article/dietary-trajectories-through-the-life-course-opportunities-and-challenges/1EE5008166B0647488E35B1FF508DAB5

'windows of change' in the life-course; for example, during teenage years and early adulthood. The transition from adolescence to young adulthood is a critical period for interventions aimed at reducing chronic risk and preventing a transgenerational cycle of obesity and associated diseases. Evidence suggests this critical period is high risk for excess weight gain as young adults adopt poor dietary habits and lifestyle behaviours that are linked with the early onset of obesity and chronic disease risk factors.

The Eatwell Guide

National advice on eating healthily is depicted in Public Health England Eating Well guide, with the following nutritional standards and targets, see Figure 9.6[63]:

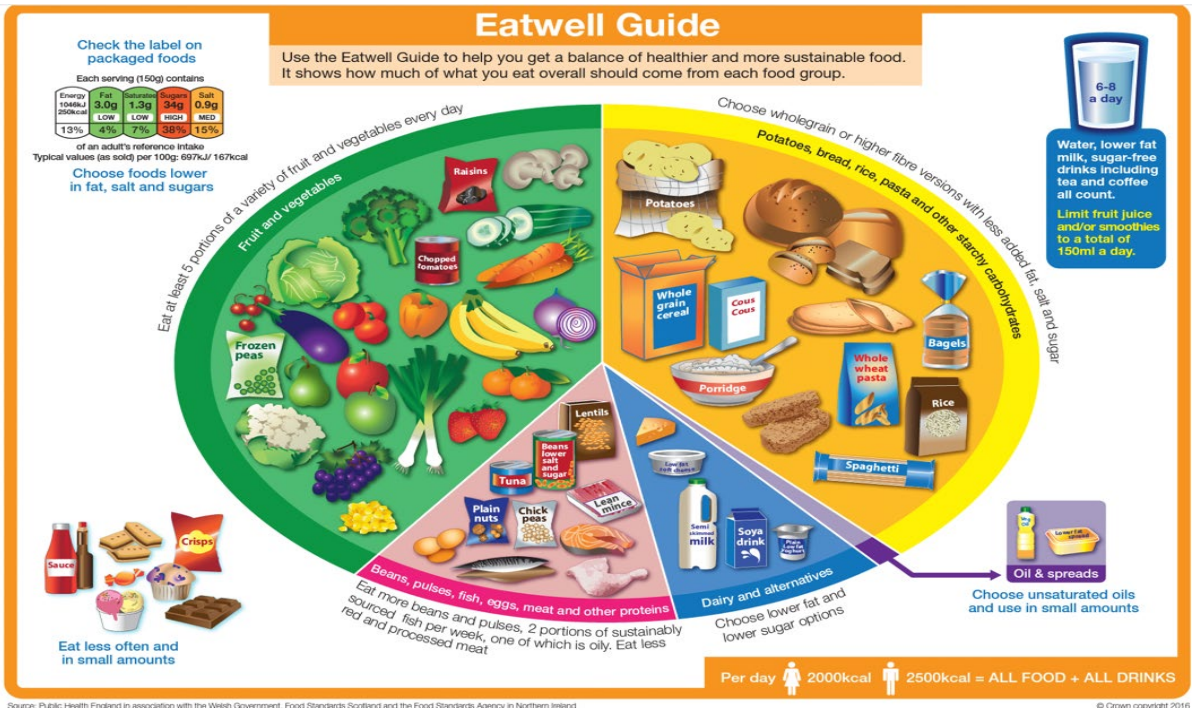


Figure 9.6. The Eatwell Guide

A high BMI is one resulting factor of a poor diet. It is possible to have a normal BMI but not consume an optimum diet that supports good health and well-being. A diet that is high in fruits, vegetables, legumes, whole grains, nuts and seeds, fibre, and calcium and low in red and processed meat, sugar, trans fats, and sodium will contribute to good health and a healthy BMI.

[63] NHS (2018) The Eatwell Guide https://www.nhs.uk/live-well/eat-well/food-guidelines-and-food-labels/the-eatwell-guide/

Recommended calory intake

The energy value of food is measured in units called calories. Calorie intake varies depending on age, metabolism, and levels of physical activity, among other things. The average physically active man needs about 2,500 calories a day to maintain a healthy weight, and the average physically active woman needs about 2,000 calories a day[64].

Consumption of fruits and vegetables

The measure widely used to assess the quality of a population's diet at a local as well as national level is the proportion of the population who, when surveyed, reported that they had eaten the recommended 5 portions of fruit and vegetables on a usual day. Data on fruit and vegetable consumption in children are available at the national level, based on the National Diet and Nutrition Survey[65] (NDNS, from 2016-2017 and 2018-2019). Latest estimates indicate that 12% of 11- to 18-year-olds meet the the 5 A Day recommendation with 2.9 portions a day; 33% of adults aged 19 to 64 years and 40% older adults aged 65 to 74 years met the recommendations with an average of 4.3 to 4.5 portions per day. 27% of older adults aged 75 years and above ate 5 a day with over 3.9 daily portions.

Most recent findings from the Health Survey for England 2022, released in 2024, reported that 29% of adults ate the recommended daily portions of fruits and vegetables whereas 7% ate none[66].

Based on the results of the 2019/20 Active Lives Survey[67], 55% of the population aged 16 and over were eating the recommended 5-a-day. The following groups were more likely to be meeting the recommended 5-a-day: those living in less deprived areas, people from white British backgrounds, who were economically inactive, without disability, educated to level 4 or above, aged 55 to 84, and women.

In Reading, 57% of people aged 16 and over reported eating the recommended 5-a-day in 2019/20. This is higher than the England average and similar to the average for the South East region (58%) Figure 9.7 contains the proportion of adults meeting the recommended '5-a-day' in Berkshire local authorities, in the South East region, and in England. Reading has a slightly lower percentage of adults meeting the recommended '5-a-day' (57% vs. 58%) compared to the South East region.

[64] What should my daily intake of calories be? - NHS (www.nhs.uk)
[65] https://www.gov.uk/government/statistics/ndns-results-from-years-9-to-11-2016-to-2017-and-2018-to-2019/ndns-results-from-years-9-to-11-combined-statistical-summary
[66] https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2022-part-1
[67] Office for Health Improvement & Disparities. (2020). Fingertips: public health data. Retrieved from Public health outcomes framework: https://fingertips.phe.org.uk/search/fruit#page/0/gid/1/pat/6/par/E12000008/ati/402/are/E06000037/iid/93077/age/164/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0

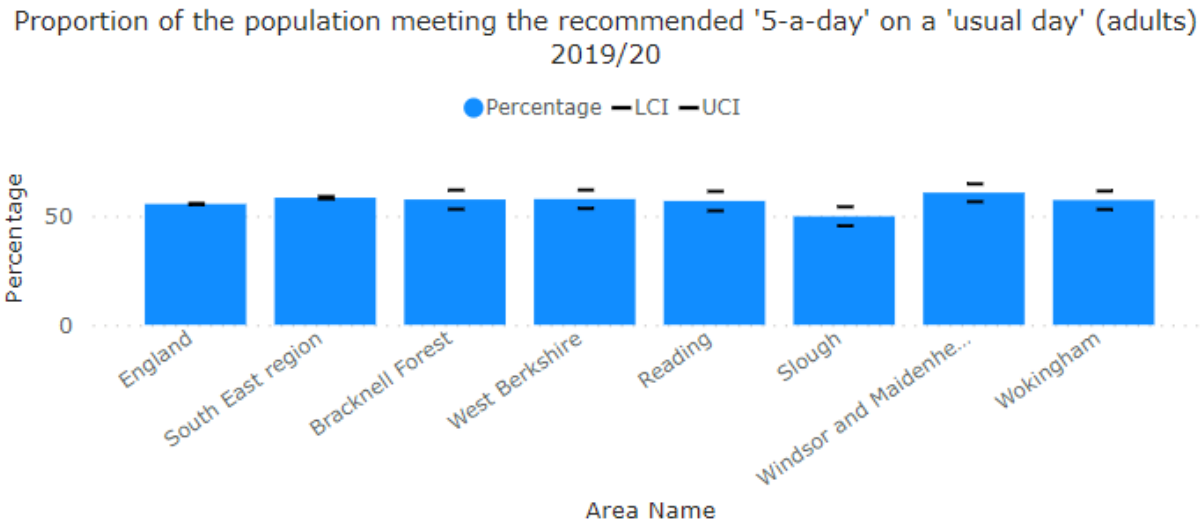


Figure 9.7 - Proportion of population eating the recommended '5-a-day'. Source: 2021 Annual Report Berkshire Food Facts - Power BI

Dental health and soft drinks

Dental health in childhood is an important consideration as children who are overweight are found to have worse oral health than children who fall within the healthy weight range[68]. UK Public Health guidance updated in 2021 shows that children who are overweight are more likely to have dental caries than children of healthy weight (PHE, 2021)[69]. The consumption of food and beverages containing high levels of sugar is an important factor in poor oral health and excess weight, both of which are exacerbated by factors such as deprivation and lifestyle. It is estimated that the amount spent on overweight and obesity-related ill-health in 2014-2015 exceeded the national spend on the police, fire service and judicial system combined[70]. Still according to 2021 public health guidance[71], children from low-income backgrounds are most affected by high obesity rates, with children aged five living in most deprived areas twice as likely to be obese compared to those in least deprived areas.

Reducing the amount of sugar consumed by children is central to the 2016 Childhood Obesity plan given that children were found to consume up to three times more sugar than recommended[72]. The Soft Drinks Industry Levy (SDIL) led to a reduction in the sugar contained in soft drinks by 11%. The sugar reduction

[68] Panagiotou et al. (2021) https://link.springer.com/article/10.1007/s40368-021-00643-0
[69] PHE (2021) School-aged years high impact area 3: Supporting healthy lifestyles https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children/school-aged-years-high-impact-area-3-supporting-healthy-lifestyles
[70] The economic burden of ill health due to diet, physical inactivity, smoking, alcohol and obesity in the UK: an update to 2006-07 NHS costs https://pubmed.ncbi.nlm.nih.gov/21562029/
[71] PHE (2021) School-aged years high impact area 3: Supporting healthy lifestyles https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children/school-aged-years-high-impact-area-3-supporting-healthy-lifestyles
[72] PHSE (2018) Childhood Obesity Plan. https://www.gov.uk/government/publications/childhood-obesity-a-plan-for-action-chapter-2

programme challenged all sectors of the food and drink industry, including retailers, manufacturers, and the out-off-home food sector to reduce the amount of sugar in the foods most eaten by children by 20% by 2020. As shown in Figure 9.8, the largest contributors of sugar in children's diets are soft drinks, fruit drinks and smoothies, cakes, and morning goods. The food and drinks industries are encouraged to reformulate foods to reduce sugar levels, provide smaller portions or promote lower- to-no sugar products.

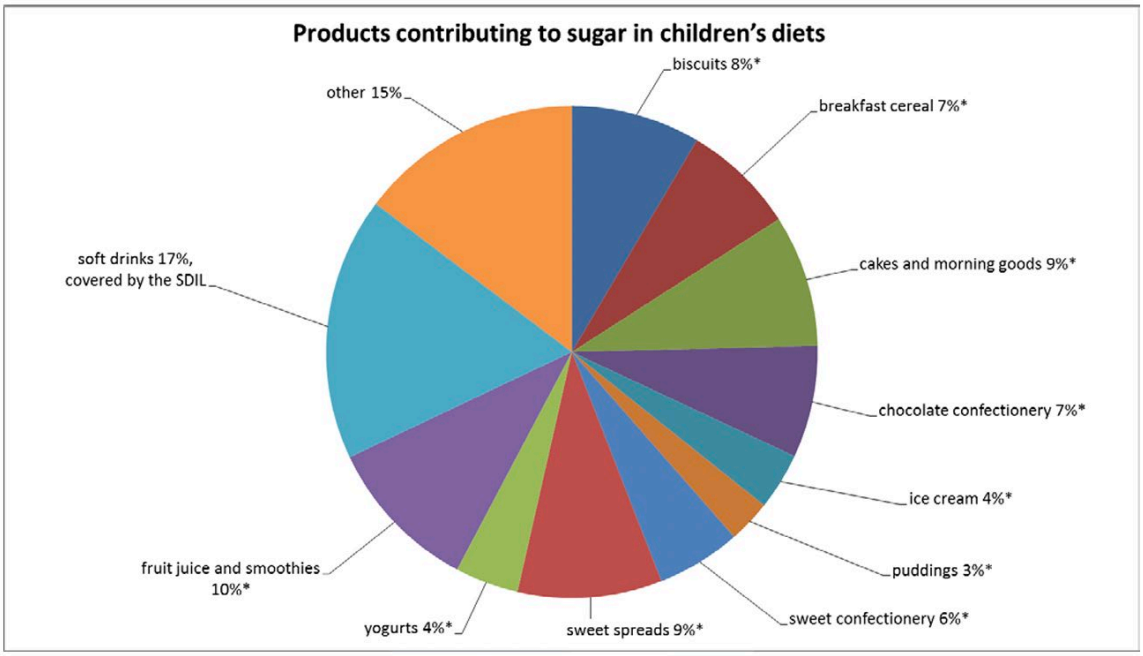


Figure 9.8. Largest contributors of sugar in children's diets (PHSE, 2018). Source: National Diet and Nutrition Survey (NDNS), years 7 and 8 (2014/15 - 2015/16).

Alcohol and healthy weight

Alcohol is highly calorific and adds to energy intake contributing 8.4% in under 65s and 6.4% in over 65s of total calories consumed by those who drink alcohol[73]. Not only is alcohol the highest calorie substance at 7 kcal/g, but evidence also suggests that excessive alcohol consumption, defined as more than two drinks per day, is a risk factor for obesity[74]. Light to moderate alcohol consumption is not as consistently linked with obesity but alcoholic drinks nevertheless constitute an additional day's worth of calories each year for 3.4 million adults.[75] A 2015 Ipsos Mori report for Drinkaware found that only 11% of the UK population reported abstaining from drinking alcohol with 60% of adults drinking at least once a week, and 20% more than four times.[76] Despite this frequency and associated links with obesity and other health concerns, alcoholic drinks in the UK are not required to provide any caloric information, only number of units contained in their beverage

[73] Main heading (publishing.service.gov.uk)
[74] Obesity in adults - Symptoms, diagnosis and treatment | BMJ Best Practice
[75] Drinkaware Monitor 2014: Adults' drinking behaviour and attitudes in the UK (ipsos.com)
[76] Drinkaware Monitor 2014: Adults' drinking behaviour and attitudes in the UK (ipsos.com)

and the maximum number of weekly units recommended by the UK Chief Medical Officer. The latter is evidently inadequate at regulating consumption given that that only 18% of UK adults correctly identified that the recommended maximum number of weekly units is 14 according to a 2022 Ipsos Mori-Drinkaware report which also found that a quarter of UK adults exceed the recommended limit[77]. Among high-risk drinkers, 28% people report doing so to cope with depression or their problems. To support healthier choices, the Department of Health and Social Care issued a call to action for the provision of calorie labelling on all pre-packaged alcohol sold [78]. Calorie labelling on alcoholic drinks would empower consumer to make healthier choices and encourage lifestyle factors that contribute to healthy weight, including diet, exercise, and alcohol moderation.

Diet and stigma

Figure 9.9 shows a summary of themes that people who are living with obesity discussed during a recent recording for Obesity UK about their personal experiences. The five people (3 females and 2 males) shared experiences from their childhood including what they wished would have been different for them. Judgement around their size and what they were eating was apparent from a very young age. Eating what was affordable was also discussed by one participant. Participants wished that they had understood that balance between diet and exercise was key and wished that there had been more education about food and different body shapes. Emotions as both triggers and maintaining factors for weight gain were prominent themes. Some of the participants had gone on to have weight-loss surgery and one discussed her struggle with diets. Two of the female participants had been dieting since childhood. Perhaps the strongest theme was stigma: all participants felt judged for their size. The inclusion of obesity as a priority criterion for COVID-19 was seen as a positive step forward to viewing obesity alongside any other physical health condition.

[77] Drinkaware Monitor 2022: Impact of alcohol beyond the drinker | Drinkaware
[78] Tackling obesity: empowering adults and children to live healthier lives - GOV.UK (www.gov.uk)

Figure 9.9: Perceptions of living with obesity. Source: Obesity, UK. The Reality of Obesity podcast series, March 2021

Determinants of dietary choices: perceived barriers and health behaviour

Some evidence shows that the social environment may have a greater impact on dietary choices than the physical environment[79]. Socioeconomic factors that are associated with healthy diet include income and education whereas physical inactivity and alcohol consumption are adversely associated with a healthy diet[80]. Theoretical models applied to food explain the important role of perception in dietary choices – the Health Belief Model (Figure 9.10) in particular can explain why individuals do not adopt preventative health measures[81] of which perceived barriers and benefits are the strongest predictors[82]. Awareness of what constitutes a healthy diet does not result in dietary intakes that reflect this knowledge[83] which can be explained by perceived barriers, the most common being cost, time constraints, irregular working hours, taste preferences and poor cooking skills. A study by Morrow et al. 2017 grouped key perceived barriers to healthy eating (Table 1) to investigate their relationship with fruit and vegetable consumption in a general adult population from the 2008 Scottish Health Survey[84].

Findings showed that price, a commonly perceived barrier to healthy eating, was not significantly associated with fruit and vegetable intake; conversely, factors such as a lack of cooking skills, preparation time and willpower were significant among women. Not liking the taste of healthy foods or finding them too boring were common barriers for women and men. Studies that use this model can help shape interventions aimed at improving dietary choices because these factors appear more if not as important as commonly perceived barriers to healthy eating. Considering various factors can yield better results, for example, changing the obesogenic environment might not be as effective in populations that reported not liking fruit. Another example pertains to lack of skills as a greater barrier to the consumption of vegetables rather than preparation time or lack of willpower. In some cases, nutritional policies aimed at increasing cooking skills might result in improvement in dietary intakes and where cost is a perceived barrier, interventions such as fruit and vegetable vouchers or subsidies might have a larger effect on the probability of adopting a healthy diet. This model can add to interventions aimed at shaping the environment to promote healthier behaviour by considering individual motivations and abilities. Sociocultural, physical, and economical environmental factors shape perceived benefits and barriers to health promoting action[20]; therefore, the Health Belief Model can help identify where to act in the interplay between individual-level and environmental factors that determine food choices and eating habits. In addition, it can empower individuals

[79] Brug J. 2008. Determinants of healthy eating: motivation, abilities and environmental opportunities. Fam Pract 25(1): 50–5.
[80] Thiele S, Mensink G, Beitz R. Determinants of diet quality. Public Health Nutr 2004;7 (1):29–37.
[81] Rosenstock IM. Historical origins of the health belief model. Health Educ Behav 1974;2 4:328–35.
[82] Carpenter CJ. A meta-analysis of the effectiveness of health belief model variables in predicting behaviour. Health Commun 2010;25 (8):661–9.
[83] Bates B, Lennox A, Prentice A et al. National Diet and Nutrition Survey: Results from Years 1–4 (combined) of the Rolling Programme (2008/2009–2011/12). Public Health England, and Food Standards Agency: London, 2014.
[84] L. Mc Morrow, A. Ludbrook, J.I. Macdiarmid, D. Olajide. Journal of Public Health, Volume 39, Issue 2, June 2017, Pages 330–338, https://doi.org/10.1093/pubmed/fdw038

by promoting proactive strategies for them to adopt healthier behaviour and counter perceptions that hinder cues to action.

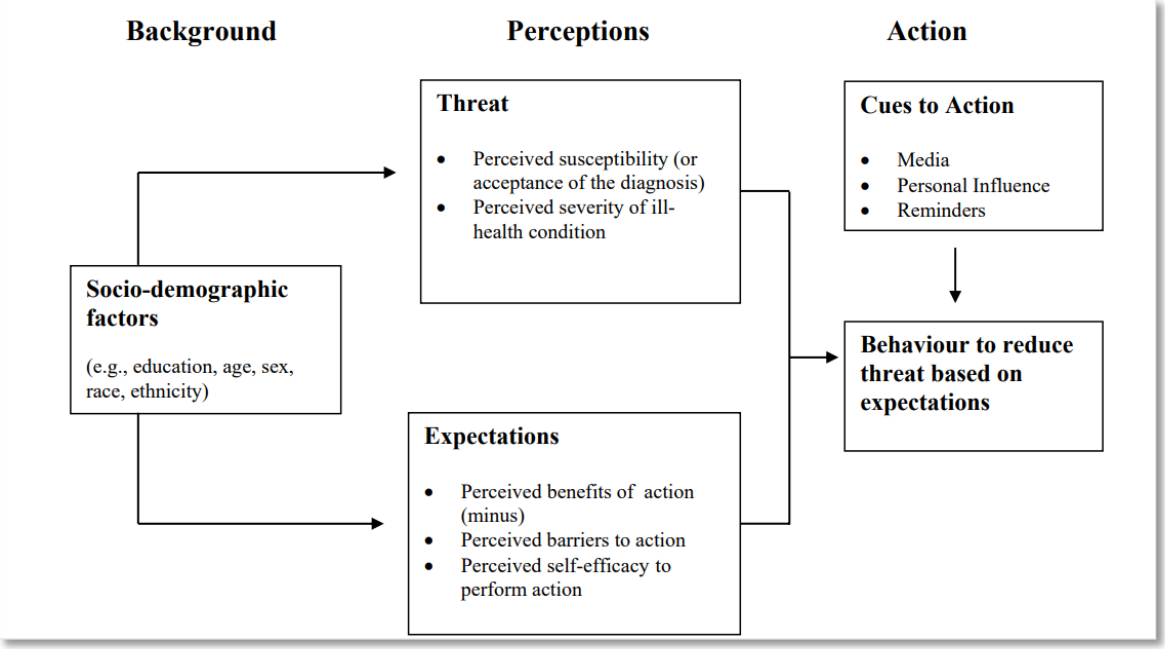


Figure 9.10. The Health Belief Model. Source: Rosenstock et al. 1994[85]

Table 2. Perceived barriers to healthy eating in the knowledge, attitudes and motivations module taken from Morrow et al. 2017.

Common perceived barriers
Family discouraging or unsupportive
Friends discouraging or unsupportive
People at work discouraging or unsupportive
Not knowing what changes to make
Not knowing how to cook more healthy foods
Lack of choice of healthy foods in canteens and restaurants
Lack of choice of healthy foods in places where you do your main shop
Healthy foods are too expensive
Healthy foods take too long to prepare
Healthy foods too boring
Don't like the taste/don't enjoy healthy foods
Lack of willpower
Other (e.g. shift work and lack of time)
None of these—nothing prevents me from eating more healthily

[85] Rosenstock, I. M., Strecher, V. J., & Becker, M. H. 1994, "The health belief model and HIV risk behavior change," in Preventing AIDS: Theories and Methods of Behavioral Interventions, R. J. DiClemente, ed., pp. 5-24.

Food standards for catering services

The Government Buying Standard for food and catering services (GBSF)[86] and the School Food Standards[87] set out minimum mandatory conditions and recommended guidelines for food and catering services in the public sector and schools, respectively. These standards ensure food procurement is in line with evidence-based dietary recommendations and they reward good practice such as actions taken to minimise waste and ethical trading. Post Brexit, the EAT-Lancet Commission on healthy diets from sustainable food systems recommends that diets and food systems in high income countries must drastically change so they nurture human health and support environmental sustainability (Willett et al., 2019)[88]. The Department for Environment, Food and Rural Affairs (DEFRA) Policy paper (2014) DEFRA 'A plan for public procurement: food and catering' presented voluntary standards to the public sector and suppliers when buying food and catering services[89]. The plan proposed a toolkit to improve food procurement in the public sector, and particularly encouraged opportunities for using British grown produce and food within the public procurement market through stronger ties with industry, procurers, researchers, and farmers.

The 'Eat Better, Start Better' guidance[90] reflects the government's dietary recommendations for children aged 6 months to 5 years and sets out the food and drink guidelines for early years settings in England. Supporting materials have been developed in partnership with the Department of Education to help early years providers and practitioners to meet the Early Years Foundation Stage welfare requirement for the provision of healthy, balanced, and nutritious food and drink[91]. The Children's Food Trust for Public Health England, with input from the Department for Education and the Department of Health published example menus to assist early years professionals plan healthy meals for infants and children aged 6 months to 4 years in their care[92]. The information is aimed at early years settings, showing how welfare requirements[93] can be met to provide healthy, balanced, and nutritious meals for children.

[86] DEFRA (2021) Government Buying Standard https://www.gov.uk/government/publications/sustainable-procurement-the-gbs-for-food-and-catering-services/government-buying-standard-for-food-and-catering-services

[87] DEFRA (2023) School Food Standards https://www.gov.uk/government/publications/school-food-standards-resources-for-schools/school-food-standards-practical-guide

[88] Willett et al. (2019) https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31788-4/fulltext

[89] DEFRA (2014) A plan for public food procurement. https://www.gov.uk/government/publications/a-plan-for-public-procurement-food-and-catering

[90] https://www.foundationyears.org.uk/files/2017/11/Eat-Better-Start-Better1.pdf

[91] Eat Better, Start Better - Foundation Years

[92] Example menus for early years settings in England - GOV.UK (www.gov.uk)

[93] Early years foundation stage (EYFS) statutory framework - GOV.UK (www.gov.uk)

Food Production and Climate Change

While global food production is rising with population growth, 820 million people are estimated to lack access to sufficient calories. Furthermore, a large, unknown number of people are malnourished in that they consume poor quality diets that lead to micronutrient deficiencies along with diet-related non-communicable diseases and obesity.

The 2021 National Food Strategy estimates that the food system is responsible for at least a fifth of greenhouse gas emissions in the UK, the largest contributor being agriculture with methane production from livestock[94]. Findings match that of EAT Lancet Commission who call for a global transformation of the food system to address issues that overlap i.e., inadequately nourished populations and unsustainable global food production.[95]

The 2021/22 Berkshire Public Health Annual Report, a joint publication by the Directors of Public Health of Berkshire East and Berkshire West, Stuart Lines and Tracy Daszkiewicz respectively, had a broad focus on food from production to consumption, and its impact on health and wellbeing as well as the environment[96]. The report considered our interconnectedness and impact on the environment, highlighting the potential of collective efforts towards changing food production and eating habits at global, national, community and individual levels.

[94] https://www.nationalfoodstrategy.org

[95] Willett et al (2019) Food in the Anthropocene: the EAT–*Lancet* Commission on healthy diets from sustainable food systems. The Lancet. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31788-4/fulltext

[96] Lines, S. and Daszkiewicz, T. 2022. Helping tackle climate change one meal at a time. Available at: Berks APHR Website_PDF.pdf (reading.gov.uk) Accessed 29/05/24

9.2.2 Food security

National picture

The Government Food Strategy (GFS)[97] was published in June 2022, following the publication of the final report of the National Food Strategy (NFS) independent review in July 2021[98]. Because food policy is devolved, both only covered England; Chapter 16 of the National Food Strategy presented 14 recommendations spilt in four main categories, three of which are relevant to this report:

Escape the junk food cycle and protect the NHS Recommendation by 1) introducing a Sugar and Salt Reformulation Tax. Use some of the revenue to help get fresh fruit and vegetables to low-income families; 2) introducing mandatory reporting for large food companies; 3) launching a new "Eat and Learn" initiative for schools.

Reducing diet-related inequalities by 1) extending eligibility for free school meals; 2) funding the Holiday Activities and Food programme for the next three years; 3) expanding the Healthy Start Scheme; 4) trialling a "Community Eatwell" Programme, supporting those on low incomes to improve their diets.

Creating a long-term shift in our food culture by 1) investing £1 billion in innovation to create a better food system; 2) creating a National Food System Data programme; 3) strengthening Government procurement rules to ensure that taxpayer money is spent on healthy and sustainable food; 4) setting clear targets and bringing in legislation for long-term change.

While food security was a key concern in the NFS, the Government Food Strategy only considered maintaining the current rate of self-sufficiency of commodities produced in the UK, mostly ignoring food imports on which the UK food sector is dependant[99]. In addition, the GFS disregarded the implementation of a sugar and salt reformulation tax which would provide revenue to support low-income households. Food security has been affected by food inflation currently at rates that are in sharp contrast with previous decades which were marked by stable prices and deflation as shown in Figure 9.11. Global political events since the 2022 invasion of Ukraine and the rise in energy costs have adversely impacted food prices: the rate of annual food price inflation at 12.1% exceeds that of the general Consumer Prices Index (CPI) of annual inflation at 6.7% in September 2023[100].

[97] https://www.nationalfoodstrategy.org
[98] DEFRA (2019) Developing a National Food Strategy https://www.gov.uk/government/publications/developing-a-national-food-strategy-independent-review-2019
[99] DEFRA (2023) Food Poverty. Seventh Report of Session 2022–23 https://publications.parliament.uk/pa/cm5803/cmselect/cmenvfru/622/report.html#heading-8
[100] ONS, 2023. Consumer price inflation, UK: September 2023 Consumer price inflation, UK - Office for National Statistics

Figure 9.11: Food and Drink price inflation rising since mid-2021. Source: Office for National Statistics[101]

Sustained rates of food price inflation are affecting households across all socio-economic groups, but their impact is more prominent among low-income households who report foregoing meals to save money. The latest release of the Family Resources Survey for the financial year 2021 - 2022 reported food insecurity among 12% of households in the last 30 days; 3% of all households reported using a food bank in the last 12 months and 7% of households with gross weekly incomes of less than £200 per week relied on a food bank once in the last year[102]. The National network of food banks managed by the Trussell Trust publish yearly statistics that provide a valuable picture of the current food aid in the UK even though Trussell Trust foodbanks are only one of many forms of food aid support. Most recent data show that the Trussell Trust distributed the highest number of parcels over a twelve-month period from April 2022 to March 2023 with three million emergency food parcels, a 37% increase from the previous financial year 2021/22.[103]

Further food insecurity data has been collected by the Food Foundation since the outbreak of the covid pandemic in March 2020 to track and report on the experiences of food insecurity nationally[104]. Findings point to nearly one in four households with children reporting food insecurity in the month prior to being asked about their access to food (Figure 9.12).

[101] Food Security - Environment, Food and Rural Affairs Committee (parliament.uk)
[102] Family Resources Survey: financial year 2021 to 2022 - GOV.UK (www.gov.uk)
[103] The Trussell Trust, 2023. Microsoft Word - EYS UK Factsheet 2022-23_FINAL (trusselltrust.org)
[104] Food Insecurity Tracking | Food Foundation

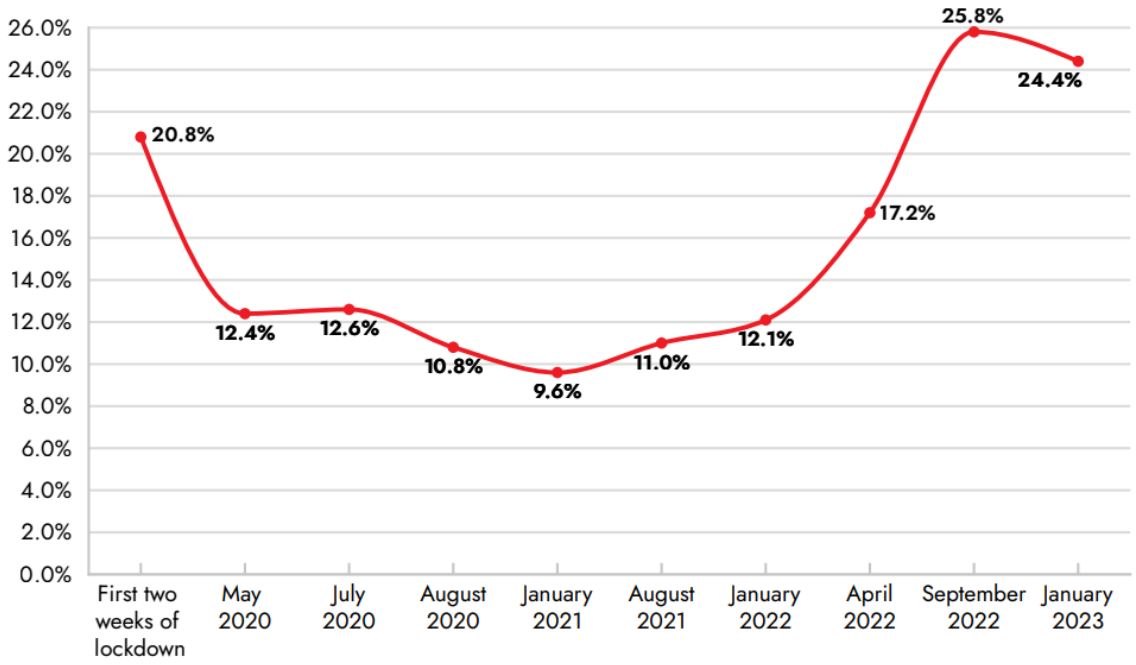


Figure 9.12. Food insecurity tracker. Source: Food Foundation, 2023.

Importantly, Food Foundation data points to a change in the diet quality due to the cost of living: 37% of all households and 53% of households in lower income groups i.e., with annual income of less than £20k, cannot buy healthy food.

Affordability of healthy food is an important driver of inequalities in diet quality and health outcomes. Low income, food insecure families tend to rely on less healthy food (such as high fat, high sugar and salt and ultra-processed food) that is less expensive calorie for calorie than healthier food such as fruits, vegetables, fish and high fibre foods. Figure 9.13 shows that the price of healthier foods such as cheddar cheese, carrots and bananas has seen a sharper increase compared to that of unhealthier foods such as crisps, cooked ham, or milk chocolate bars.

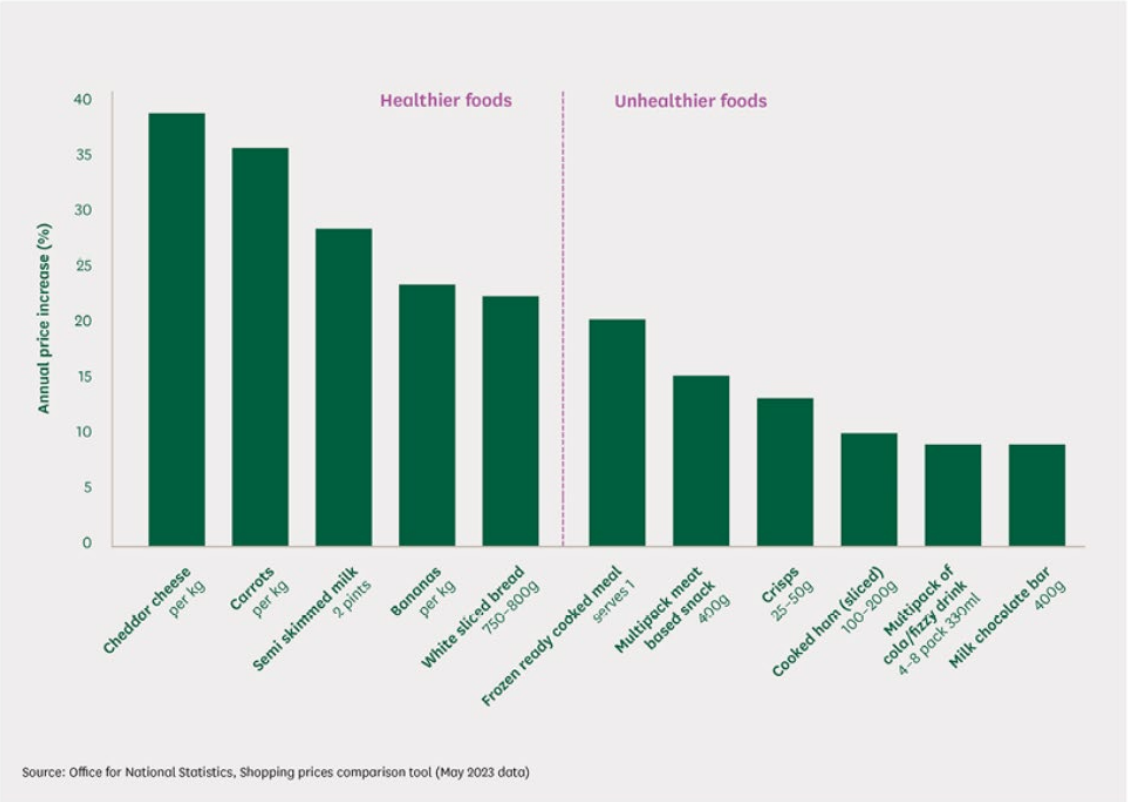


Figure 9.13: Annual Price Increase in food items to May 2023. Source: ONS. Shopping prices comparison tool (May 2023 data).

Since residents' views were collected in the summer of 2023, latest data from the Office of National Statistics indicate an increase of overall inflation to 2.2% in the 12 months to July 2024 (CPI), whereas food inflation has remained stable at 1.5% (CPIH) as shown in Figure 9.14[105]. Accordingly, the highest level of overall inflation in forty years reached a peak of 11.1% in October 2022, with inflation for food and non-alcoholic beverages peaking at 19.2%. The UK currently holds the highest core inflation and highest food inflation rate among the G7 countries, when overall inflation peaked at 9.1% in the United States, 8.7% in Germany, and 6.9% in France.

[105] https://foodfoundation.org.uk/news/food-prices-tracker-august-2024

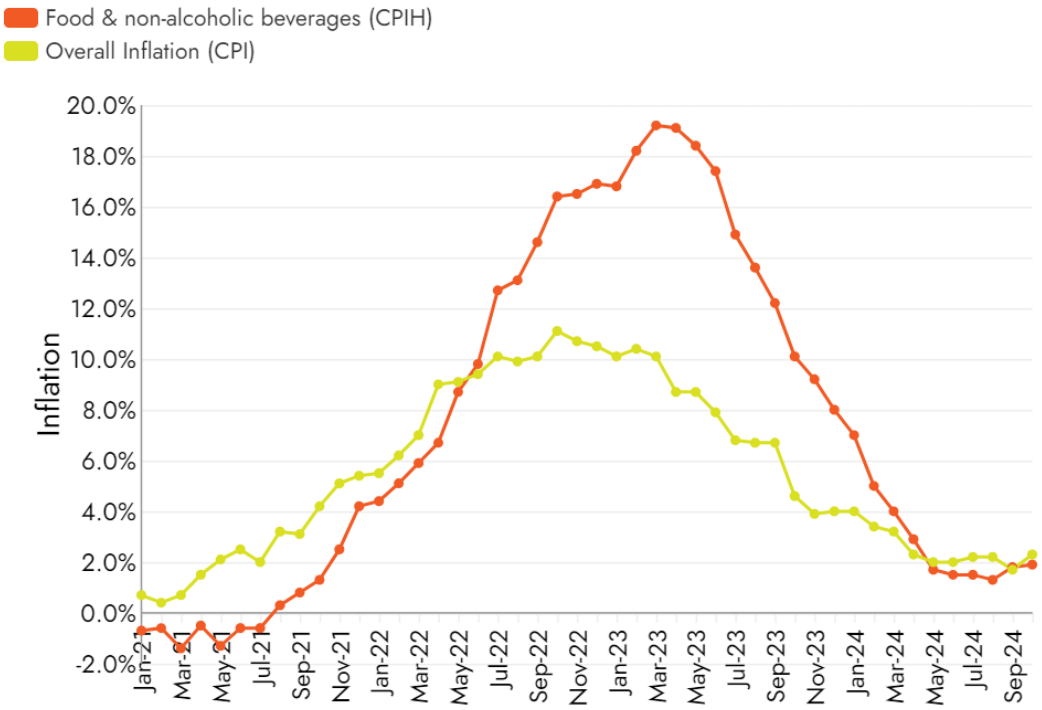


Figure 7.14: Overall inflation v food inflation. Source: ONS, Consumer price inflation tables[106]

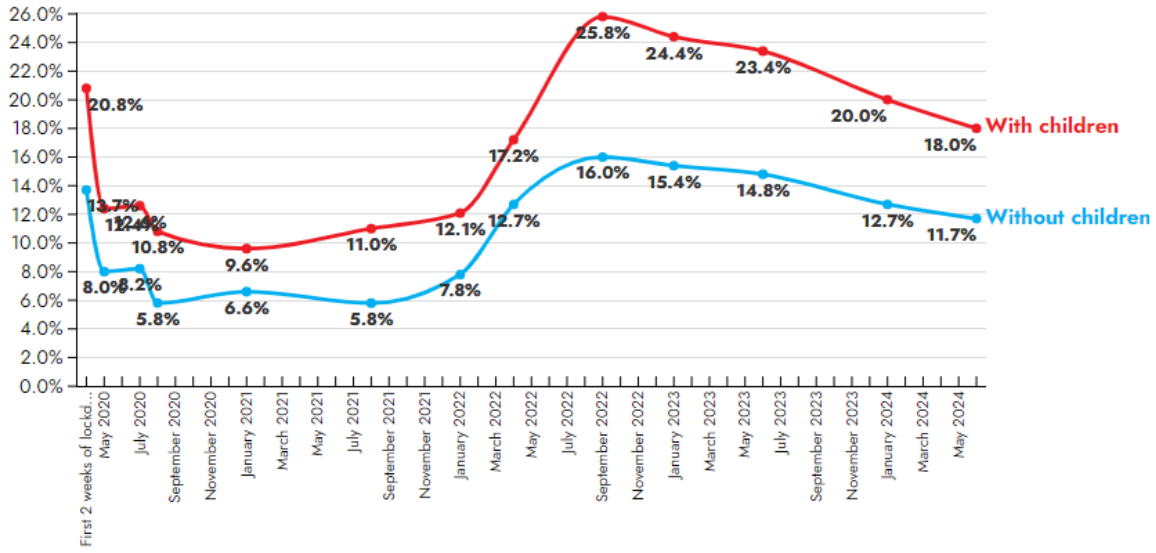


Figure 9.15: Percentage of households experiencing food insecurity[107]

[106] https://www.ons.gov.uk/economy/inflationandpriceindices/datasets/consumerpriceinflation
[107] https://foodfoundation.org.uk/initiatives/food-insecurity-tracking#tabs/Round-15

Further recent data collected by the Food Foundation show that households with children are more likely to experience food insecurity than those without children (18% and 12% respectively in 2024, as shown in Figure 9.15). There has been a decline in food insecurity prevalence from its peak in September 2022 when it reached 26% and 16% respectively. The evidence suggests that food poverty and unhealthy diets are contributing to a decrease in life expectancy, poor health outcomes and a worrying rising obesity in children[108]. When considering factors that support a healthy BMI, it is essential to acknowledge that they are not available to all in equal measure. It is not simply the case that people from different population groups choose to behave differently when it comes to diet and physical activity: behaviours are shaped by the social and economic environments in which people live. For example, whether a person eats a healthy diet is not only dependent on choice but also on what type of food is accessible to them and how affordable it is. Affordability is relative but nevertheless dependent on agricultural policy, taxation, and the regulation of the content of processed food and drink (Dahlgren & Whitehead, 2021). In 2021, the households amongst the poorest 5th of all households in England would have to spend 40% of their disposable income on food to meet Eatwell Guide costs compared to 7% of the richest 5th of all households[109] .

School meal provision

Current provisions to support school meals include the Free School Meal Programme, the National School Breakfast Programme, and the Healthy Start Voucher scheme. Alongside this, the majority of primary schools offer a Wraparound Childcare provision which could consist of a breakfast club and/or after school club. These clubs would include some food provision and physical activities. A report published by Good Food for Children Working Group members, led by the Faculty of Public Health identified gaps in the current provision of school meals[110]. Childhood food insecurity is associated with greater risks of health concerns in adulthood, lower educational attainment, and poor lifetime health. Recommendations include providing universal access to Free School Meals and expanding access to existing programmes, all of which are in line with other policy recommendations, for example, recommendations by the Academy of Medical Royal Colleges[111]. The 2023 report 'Securing our Healthy Future' recognises that children in low-income households are more likely to have diets which are high in sugar, saturated fat, and salt, and low in fruits and vegetables, and that areas of greater deprivation tend have more fast-food outlets and fewer green spaces. These act as barriers to accessing healthy food and undertaking physical activity; therefore, an intervention might be to extend the Free School Meals scheme to all

[108] https://www.nuffieldfoundation.org/project/changing-the-story-of-dietary-inequality
[109] The Food Foundation. (2021). The Broken Plate Report, 2021. Retrieved from The Food foundation: https://foodfoundation.org.uk/sites/default/files/2021-10/FF_Broken_Plate_Report-2021_Overview.pdf
[110] FPH and partners launch new report on Good Food in Childhood - Faculty of Public Health https://www.fph.org.uk/news/good-food-for-children/
[111] Securing_our_healthy_future_0923.pdf (aomrc.org.uk) p. 8

children in primary schools so they can all be provided with a nutritious meal[112]. Costs associated with the universal provision of school meals would be met by new targeted levies on unhealthy food and drink, such as the salt and sugar levies as outlined in the National Food Strategy[113] . Latest Healthy Start data for Reading suggests that more needs to be done to raise awareness of the scheme amongst low-income families. Uptake of the Programme as of March 2024 (see textbox) was relatively low at 66%, which represents 935 out of 1420 families who meet the criteria according to the Department of Works and Pension. An issue with the data feed at DWP led to an incorrect number of eligible Healthy Start beneficiaries being reported between July 2023 and February 2024. Therefore, the previously calculated uptake percentages across local authorities were overstated. Individual applicants, existing beneficiaries or payments were not affected but as a result historical data cannot be retrieved to identify trends. It is suggested that the current low uptake may be positively associated with a recent change in service provision (electronic application/prepaid card) for the Healthy Start Scheme.

Healthy Start

Healthy Start is a national programme that provides financial support to eligible young families and pregnant women for fruit, veg, and milk, as well as providing free vitamins.

Anyone who is pregnant or families with children under 4 and in receipt of qualifying benefits may be entitled to get help to buy some basic foods and milk.

Beneficiaries of the scheme will get:

- £4.25 each week of their pregnancy (from the 10th week of pregnancy)
- £8.50 each week for children from birth to 1 year old
- £4.25 each week for children between 1 and 4 years old

The payments will stop on the child's 4th birthday or if they no longer receive the qualifying benefits.

They can also get free Healthy Start vitamins.

Current Uptake of the Healthy Start Scheme by Local Authorities as of March 2024. Source: DWP.

Local Authority	People on Digital Scheme	Eligible Beneficiaries	Uptake (%)
Reading	**935**	**1,420**	**66**
West Berkshire	**546**	**878**	**62**
Wokingham	**457**	**696**	**66**

Are children in your area getting a Healthy Start? (foodjusticefinder.com)

NHS Business Services News (nhsbsa.nhs.uk)

[112] Securing_our_healthy_future_0923.pdf (aomrc.org.uk)
[113] https://www.nationalfoodstrategy.org/

Food insecurity in Reading

The town of Reading features a wide range of food support services led by the voluntary sector, some of which receive funding or are commissioned by Reading Borough Council (RBC).

Readifood and Churches in Reading Drop-in Centre (CIRDIC) are two such services that provide food to individuals experiencing acute forms of hardship. ReadiFood operates via referral only, whereas CIRDIC is a drop-in open to anyone who is homelessness or at risk of homelessness. An increase in attendance is common across all food service providers with, in some instance, a twofold increase in the number of service users requiring emergency food support now compared to pre-pandemic times. The cost-of-living crisis with higher rents and utility bills has adversely affected service providers as illustrated by the CIRDIC centre that momentarily risked closure due to increased running costs but not lack of food donations.

Established local, public-led charitable initiatives such as New Beginnings, The Way Ministry, Sikh Welfare & Awareness Team (SWAT), Sadaka, and Providence Chapel have experienced a steady increase in the number of service users from wider socio-economic backgrounds and with complex needs requiring help with emergency food alongside other necessities such as toiletries and clothing. Such growing need is reflected in the ever-growing network of food and support providers in the town of Reading that operate as ”warm spaces“ to address not only the cost-of-living crisis but also social isolation. In that respect, ‘warm banks’, ‘warm spaces’ or ‘cafes’ are relatively new additions to the food landscape given that they did not exist a couple of years ago. While organisations provided sit-down meals (e.g., Sadaka, Cirdic, New Beginnings, The Way Ministry) and community cafes offered low-cost food (e.g., WCDA, Dee Caf) for anyone but especially the most marginalised, providers are now setting up safe, wellbeing spaces for everyone. These spaces provide snacks and warm beverages as well as activities such as crafts and language classes (e.g., Abbey Renew Wellbeing Café, Coffee and Craft at Wycliffe Church, wellbeing sessions and English conversation classes at Sadaka). Some charitable food initiatives do not keep track of numbers unlike commissioned services such as CIRDIC and ReadiFood, as shown in Table 2.

From February to April 2023 (Q2), CIRDIC provided 2124 food parcels to people who were most disadvantaged, an increase of 5.5% on Q1 with 2013 parcels given out from November 2022 to January 2023. The independent food bank ReadiFood delivered 2743 parcels in Q2, an increase of 13.2% on Q1 with 2424 parcels given out from November 2022 to January 2023

Table 3. Parcels given out by CIRDIC and READIFOOD Q1 and Q2 2023

Number of warm meals	**Previous performance /baseline (per month)**	**February**	**March**	**April**	**Q2 total**	**Q1 total**
CIRDIC	600	624	700	800	**2124**	2013
ReadiFood	480	805	1,127	809	**2,743**	2424

Only half of respondents to the public survey reported having their food purchases affected by inflation (See Appendix xxx for a full report of responses to the survey). In response to the question 'With the recent increase in food prices in the last 12 months, have you experienced any of the following?' 41% said that the increase in prices has not affected them much or at all. The next two most prevalent answers were prioritizing paying bills or rent over food shopping (13.5%) and having to skip meals (7%). Over nine in ten responded never having used free food services (i.e., community kitchens, pantries, food parcels). The majority of those who do use free food services reported relying on them very rarely or no more than once a fortnight.

In contrast, residents reported having had to cut back on food shopping or eating out in the last few months. They also reported being more aware of their shopping habits, adjusting their budgets and buying less of certain types of food such as meat or fish:

"More conscious about spending but thankfully have not been prevented from buying food, we are still able to do so but there has been an evident increase in awareness of cost leading to more careful shopping"

"Altered family budget - more on food, less travel"

"Trying to get by in a smart way with discounts"

People also reported buying less food and 'stuff' on sale, , prioritising value over health

"Food is a priority for buying other things - Holidays, new (unnecessary) clothes, entertainment- are luxuries. I spend appropriately and cut back where necessary."

"I have seen my weekly food bill increase by 50% since last year. Absolute disgrace that as someone that works full time and with no longer children at home that I have to watch every penny until my next payday."

"I'm learning where to buy cheaper food, and I often decide to not buy fancy food, but just basics."

"I am most definitely buying less meat / fresh food because of the increase in costs."

"Have adjusted what products I buy to save some money and reduced food waste by labelling foods in the fridge etc."

"I am now vegan, it saves money"

"I don't buy the occasional treat like salmon. I stopped eating out and I bring packed lunches to work."

Free food services

Volunteers who operate free food services reported needing better facilities to prepare wholesome meals and to store non-perishable food and crockery. Service users who responded to our questions talked about an ongoing crisis, which meant that the recent increase in the cost of living contributed to existing hardship. Overall, an increased number of people rely on food services, and while no official records are kept, an estimated 20% increase was common for most free food places. Since the covid pandemic, more families and people in work found themselves needing support with food, and increasingly, asylum seekers and refugees visit food services on a regular basis. At times, meals served at hotels were found to be either insufficient, of poor quality or culturally inappropriate, for instance, for individuals who follow a strict vegan diet.

"We see more people with young children who can't pay their bills. More children with parents who are asylum seekers and refugees. Some Ukrainians but they don't feel comfortable with other SUs. More people overall, at least 10% increase on previous years. People can't eat, can't pay afford to live in Reading, I myself donate and volunteer less because I have had to take another job to pay my own rent. I do feel sorry for people we try to help."

"I get £60 per week from my benefits. I can't afford food. Free food saves me, and maybe one day I will give back. Some people wouldn't eat without these places that save lives."

"Food poverty? I am just poor. No money. I live in a tent, St Mungo's was going to help but I am waiting. I survive because of food places. In summer it's alright but I am afraid to spend winter in the cold again. I work but my girlfriend doesn't, I worry about her when I am gone. I can't afford a place. No money, no address, just a tent."

"I am not healthy. I know it but I look around me and people I see are not healthy, they are not in the streets, but they are not healthy. It's the system. We need quiet places to have a coffee and a rest when we are in the streets, maybe the council leisure centres could let us have free coffee at their cafes, I don't know."

''When you are homeless these things are not important because everything is impossible. If you are very sick maybe you can go to A&E but right now I am a nobody."

"Austerity, Covid, Energy Crisis, cost of living crisis. It's just an ongoing crisis. Can't afford food, rent, things, for us it's more of the same. Just getting worse. Maybe emergencies are not emergencies after all."

9.3 Recommendations

- Adopt a Borough wide advertising policy which would reduce exposure to high fat, high sugar (HFSS) food in drink in Reading, particularly safeguarding for children and young people and those already experiencing health inequalities living in areas of high socio-economic disadvantage.
- Connecting communities to support better food choices, helping people to make better food decisions for better health and wellbeing.
- Tackle food insecurity. Improve access to nutritious food for all, provide support to groups that provide meals to residents.
- Healthy environments. Enable healthy weight by building healthy places and environments, incentivising local food outlets to provide a healthier food offer.
- Support local food growing by allocating land to growing projects, allowing public spaces to be used for food growing, and providing support to current projects.
- Minimise fast food advertising and promote messages about healthy eating.
- Ensure Government Buying Standard-based criteria are used in the procurement of food and catering services by public sector facilities.

10. Evidence Based Solution

10.1 Strategies and Policy to Promote Healthy Weight

NICE guidelines (see Table 1) recommend local authorities work with local partners, such as voluntary organisations and industry, to design, produce and manage more safe spaces that encourage physical activity, both incidental and planned, and address any concerns about crime, safety, and inclusion. Table 1 indicates a range of guidelines that have been published in this area. Local authorities must offer schemes and facilities such as walking and cycling routes, cycle parking, and safe play areas along with area maps . They should make streets safer and cleaner, through methods including pedestrian crossings, lighting, and walking schemes, congestion charging, and traffic calming.

The Royal College of Physicians reviewed the cost-effectiveness of a range of interventions and concluded that prevention of overweight and obesity can be cost-effective, but interventions that modified a target population's environment, i.e., financial and regulatory measures, reported the most favourable cost effectiveness(see Table 1) The report emphasised the requirement for an increase in the number of multidisciplinary teams within the UK, to provide a comprehensive rather than inconsistent service offering. The District Council Network proposed a District Offer to embed health interventions more strongly into the work of councils. The Local Government Association[5]allied to Integrated Care Systems calls for health in all policies approach. The implications for work on obesity include more collaborative work on:

- Travel and transport (e.g., active travel plans)
- Food procurement (e.g., school meals and catering in residential settings)
- Planning and licensing (e.g., influencing the design of new builds to include green spaces, planning permission for food outlets)
- Trading Standards (e.g., regulation of food establishments and opportunities for awards for healthier options)
- Environmental health (e.g., public food safety, air quality)
- Opportunities for physical activity (e.g., leisure centres, local authority health programmes, adult education)
- Sustainability (e.g., reducing vehicle emissions, recycling)
- Food security (e.g., supporting Kent producers, food banks, cookery classes)
- Education (e.g., integrating the Child Measurement Programme more strategically).

NHS England Five Year Forward Plan and the Next steps on the NHS Five Year Forward View for the NHS puts prevention high on the agenda. It required providers and commissioners to work together to dissolve the artificial barriers between prevention and treatment, physical health and mental health. It has developed and taken forward actions and investments to enable a greater focus for integrated working across primary, community, social care and acute care(see Table 1).

The focus on prevention, along with the **NHS Long-Term Plan**, is a unique opportunity to bring about positive and genuine improvement in health and social care delivery over the next 5 years.

Taking a life course approach, the table below summarises key national policies to promote healthy weight.

Table 4:Policy, strategy, and guidance summary table

Life course	Policy, guidance, and strategy
Whole Systems Approach	• Whole Systems Approach to healthy weight • LGAs Making obesity Everybody's Business • ADPH - Healthy Weight position statement (Nov 2023)- recommendation of overarching action to address weight, diet and physical activity at local government level • Sector Lead Improvement, Healthy Weight – benchmarking/evaluation tool on key action to promote/enable healthy weight
Maternity	• Weight management before, during and after pregnancy (PH27) • Physical activity for pregnant women (publishing.service.gov.uk)
Infants	**From Birth** • Feeding in the first year of life – SCAN Report 2018 • UNICEF Breast friendly settings/scheme • Good practice Case Study – *Be a star* programme **Around 6 months** • Introducing Solid Foods • Eat Better Start Better - Portion Sizes and menu ideas • Chief Medical Officer Physical Activity
Early Years	• Eat Better Start Better - Portion Sizes, menu ideas, tooth friendly drinks • Chief Medical Officer Physical Activity • Whole setting approach – food for life
School aged children	Primary Prevention • Whole School Approach • The Daily Mile • Healthy Schools Programmes Secondary Prevention • Weight management: lifestyle services for overweight or obese children and young people (PH47)
Adulthood	Primary prevention Physical activity guidelines, maternity, adults, including disabilities and Preventing excess weight gain (NG7)

	Secondary Prevention: NHS Long term Plan Coreplus20 NICE guidelines: • Weight management: lifestyle services for overweight or obese adults (PH53) • Obesity prevention (CG43) • Obesity: identification, assessment and management (CG189) • Obesity: working with local communities (PH42) • BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups (PH46) • Semaglutide for managing overweight and obesity (nice.org.uk)
Workplace	Workplace health, apply all our health **Locally** - Annual Public Health Report 201/20 – A good place to work
Food Environment /Physical Landscape	**Planning** • Healthy and safe communities -GOV.UK (www.gov.uk) • Using the planning system to promote healthy weight environments (publishing.service.gov.uk) • Addendum: Hot food takeaways use in the new Use Class Order -GOV.UK (www.gov.uk) • Hot food takeaway Supplementary Planning Document - Gateshead Council **Physical Landscape/ High Streets** • Healthy Streets Approach (London) • Healthier Food Advertising Policy Toolkit | Sustain (sustainweb.org)
Workforce	Making Every Contact Count Personal Centre Care Training - ICB

10.2 Spotlight on Whole Systems approach

The report Making Obesity Everyone's Business – A Whole Systems Approach to Obesity (see Table 1) emphasised the importance of the adoption of a Whole Systems Approach to Obesity (WSAO) to tackling obesity by local authorities. Referring to the Obesity Systems Map, the report argues that the complexity of the obesity problem makes it **difficult to tackle one component at a time**. This was followed by the publication of guidance for the Whole Systems Approach to Obesity by partners from Public Health England (now Office for Health Improvement and Disparities) and Leeds Beckett University in 2019(see Table 1). The guidance provides an opportunity to move away from the relatively short-term interventions taken by individual organisations to a longer-term approach which engages the full range of partners across local systems.

The whole systems approach to obesity (WSAO) is a framework that recognizes the interconnectedness of various factors contributing to obesity and the need for a comprehensive and coordinated effort across different sectors that goes beyond individual behaviour change, to create a supportive environment that enables healthy choices. This can include access to affordable healthy foods, safe and accessible places to exercise, and healthy lifestyle education. It involves engaging stakeholders across multiple sectors, including health, education, transportation, planning, food production and distribution among others.

A WSAO "*enables local stakeholders, including communities, to come together, share an understanding of the reality of the challenge, consider how the local system is operating and where there are the greatest opportunities for change. Stakeholders agree actions and decide as a network how to work together in an integrated way to bring about sustainable systems change.*' (see Table 1). It can create a more integrated and coordinated response that addresses the underlying systemic and social factors that contribute to obesity (see Table 1).

Partnership working between sectors to address the root causes of obesity through a WSAO, enables shared resources, expertise, and knowledge to design interventions that are more effective, sustainable, and that can improve the health of Reading residents.

10.3 Phases of the Whole Systems Approach

The whole systems approach to obesity guide (see Table 1) is a useful guide for local authorities to implement a whole systems approach to obesity:

Reading is in the early stages of implementing of a Whole Systems Approach to obesity, while considering the complex geographical area and complicated health economy. However, it is planned that each phase of the WSAO will be implemented as appropriate, to embed this throughout Reading, in collaboration with partner organisations from various sectors; working together to take a multi-agency approach to reducing obesity across the population.

10.4 Whole Systems Approach, Health inequalities and Wider determinants of health

Wider determinants of health, social and health inequalities, poverty, and social isolation can be positively influenced by a WSAO to help create a more equitable society where everyone can lead a healthy life. This can be done through:

1. **Addressing the social determinants of health**: Poverty, unemployment, and social exclusion, play a crucial role in obesity. By engaging stakeholders across multiple sectors and addressing these social determinants, a WSAO can help promote equality and reduce health inequalities.

   e.g., WSAO can address food insecurity, a significant factor in obesity. By working with local food producers and suppliers to provide affordable,

healthy food, a WSAO can improve access to healthy food and reduce the risk of obesity.

2. **Creating a supportive environment that fosters healthy lifestyles**: Implementing changes to local policies, infrastructure, and programs.

   e.g., Providing more access to healthy food options, increasing opportunities for physical activity, creating safe walking and cycling routes, and providing access to healthy food options.
   This would make it easier for people to make healthy choices, contribute to addressing health inequalities and reduce the impact of socio-economic factors on health outcomes.

3. **Interventions to high-risk populations**: High-risk populations, such as children, low-income groups, and ethnic minorities can be supported with provision of tailored interventions as appropriate, whilst ensuring delivery of universal services at a scale and intensity proportionate to the degree of need. This can help to address health inequalities and improve health outcomes.

Obesity is not simply a health issue but is linked to wider social and economic inequalities. People living in areas with poor access to healthy food options, to safe places to exercise and experiencing higher levels of deprivation are more likely to be obese. Addressing wider determinants of health works towards reducing health inequalities.

NICE guidelines(see Table 1) state "It *is unlikely that the problem of obesity can be addressed through primary care management alone*. More than half of the adult population are overweight or obese and a large proportion will need help with weight management. Although there is no simple solution, the most effective strategies for prevention and management share similar approaches. The clinical management of obesity cannot be viewed in isolation from the environment in which people live." A WSAO can help to change the environment and reduce the risk of obesity.

Summary

- There is an overarching national 'Call to Action' on obesity with published ambitions for population weight loss.
- Local authorities are strongly encouraged to implement the Whole Systems Approach to Obesity (WSAO) and align efforts of other public services and organisations, e.g., planning, sport and green spaces to be mobilised to tackle obesity and improve the health in their local area in a collaborative way.
- Guidance on a WSAO provides an opportunity to move away from the relatively short-term interventions to a long-term approach which engages the full range of partners across the system in Reading.
- Local authorities are encouraged to use their powers to curb fast-food outlets along with promoting active travel and exercise.

10.5 Weight Management Pathways – National

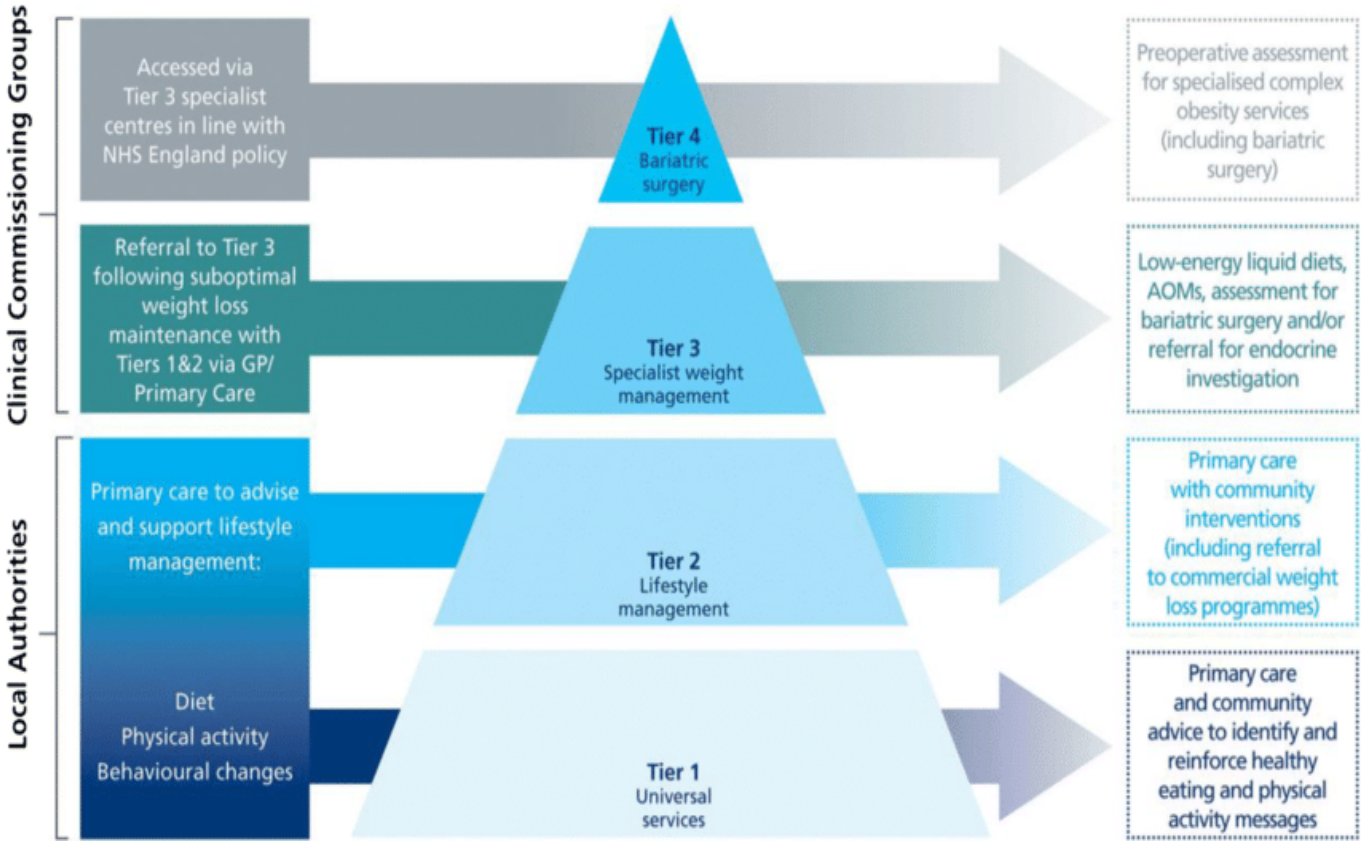
10.5.1 Adults

Weight management services have been considered an important part of addressing obesity. However, a shift away from the individual and a focus on the wider determinants of health is now considered the best way forward.

Nonetheless, there is still a need to support those individuals who are ready and keen to seek support to reduce their weight, in addition to promoting physical activity and providing universal information on a healthy diet

Currently in the United Kingdom, weight management services are classified into four 'tiers'. Tiers 1 and 2 are currently commissioned by Local Authorities and Tiers 3 and 4 by Integrated Care boards (or ICBs), formally Clinical Commissioning Groups.

Figure 10.1 below shows the pathways in England.



Source: Hazlehurst, et al, 2020. Adapted from Wilding 2018[12]

Table 2: Tier 1 – 4 Weight Management services

Tier	Description	Local picture at high level
Tier 1	Tier 1 services are provided by local and regional public health teams, together with the identification and advice, often carried out in a primary care setting, by healthcare professionals such as GPs, nurses, health visitors, school nurses, etc., but are also supported from pharmacists, local leisure providers, and allied organizations.	Some activity, but it is fragmented
Tier 2	Tier 2 services are delivered by local community weight management services, which provide a multi component programme based on NICE guidelines - Community-based diet, nutrition, physical activity, and behaviour change advice, normally in a group environment. Access to these services is usually for a limited time, often only 12 weeks.	One programme Provided via leisure providers since March 2022.
Tier 3	Tier 3 services are the specialist weight management clinics that provide non-surgical intensive medical management with a Multi-disciplinary Team (MDT) approach that consists of a doctor with a special interest in obesity (physician or GP), specialist nurses, specialist dietitians, psychological support, and specialist exercise therapists/physiotherapists.	No current provision in Reading
Tier 4	Tier 4 services are performed in secondary care with pre-operative assessment and post-operative care and support. Bariatric Support.	Royal Berkshire NHS Foundation Trust

See also - Community Services Data Set Tier 2 and Tier 3 weight management service guidance - NHS Digital

10.5.2 Maternity

Women carrying additional weight before pregnancy and excessive gestational weight gain are major determinants of risk for pregnancy loss, gestational diabetes, hypertensive conditions, labour complications and significant threat to the lives of mothers and babies. Excess weight poses additional challenges with conception in the first instance. Moreover, excessive weight gain in pregnancy and post-partum weight retention compromise future fertility and increase risk for future pregnancies[114].

[114] Langley-Evans et al. Overweight, obesity and excessive weight gain in pregnancy as risk factors for adverse pregnancy outcomes: A narrative review. Journal of Human Nutrition and Dietetics. 2022. Vol 35, no 2., pg 250 - 265. https://doi.org/10.1111/jhn.12999

The recently published three-yearly MBBRACE report on maternal deaths noted that of the 275 pregnant women who died in 2020 - 2022, 64% of them were obese[115]

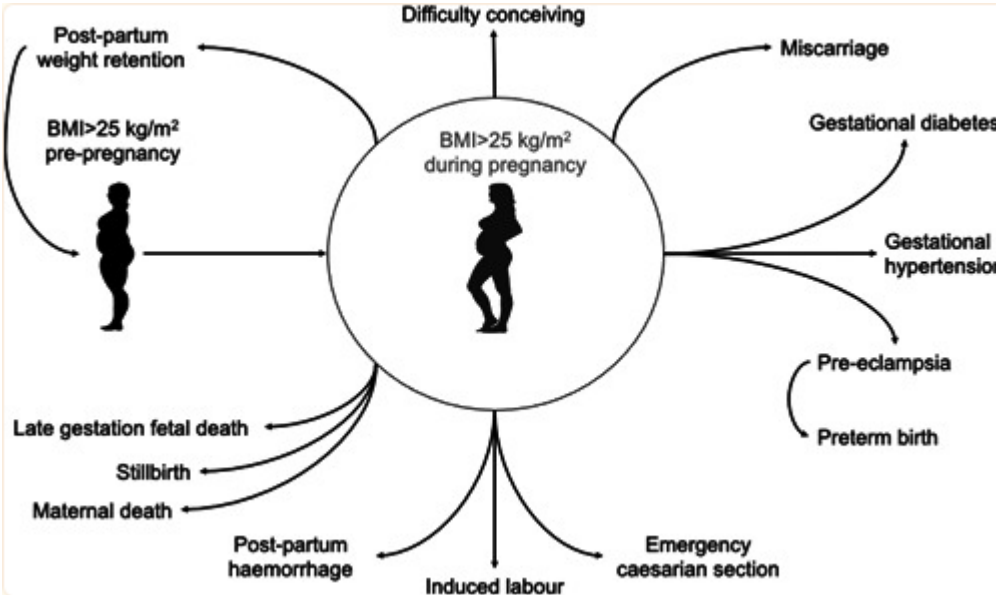


Figure 10.2: Obesity in pregnancy is a risk factor for adverse outcomes. BMI, body mass index. Source Langley Evans 2022

Yet pregnancy is a stage of life when women have greater openness to messages about their lifestyle and health. It is also a time when they come into greater contact with health professionals. Thus, pregnancy is regarded as a teachable moment when women are at their most receptive to messages about their health. However, unclear guidance on diet and physical activity, weight stigma from health professionals, , reluctance among professionals about raising issues about weight, and stretched resources are barriers to interventions that we identified in the needs assessment surveys of the public and of health professionals.

Currently management of pregnancy weight gain and the impact of overweight tends to be poor (Langley Evans et al, 2022). There is still no formal, evidence-based guidelines from the UK government or professional bodies on what constitutes appropriate weight gain during pregnancy. The amount of weight a woman may gain in pregnancy can vary a great deal. Only some of it is due to increased body fat – the unborn child, placenta, amniotic fluid and increases in maternal blood and fluid volume all contribute.

[115] https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2024/MBRRACE-UK_Maternal_FULL_Compiled_Report_2024_V1.1.pdf

However, one possible guide is provided by the US Institute of Medicine guidelines[116]): obese women are expected to gain 5-9 kg (11-20 pounds) in pregnancy, overweight women slightly more at 7 – 11.5Kg (15-25lbs) and healthy weight women more still between 11.5 and 16kg (25-35kg). See summary table below.

Table 35: Weight gain in pregnancy US guide

BMI	Total Weight Gain	
	Range in kg	Range in lbs
Underweight (< 18.5 kg/m^2)	12.5-18	28-40
Normal weight (18.5-24.9 kg/m^2)	11.5-16	25-35
Overweight (25.0-29.9 kg/m^2)	7-11.5	15-25
Obese (≥ 30.0 kg/m^2)	5-9	11-20

Maternity Pathway

The focus is generally on supporting women to manage their weight before pregnancy, not through advocating weight loss but by providing support to minimise excessive gestational weight gain). "Dieting during pregnancy is not recommended as it may harm the health of the unborn child"[117].

NICE Guideline (PH27) 2010 clinicians aim to provide patient-centred assessments and care plans to ensure that the following points are addressed:

- Why someone might find it difficult to lose weight.
- Support is tailored to individual needs and choices.
- Clinicians are sensitive to the service-users weight concerns.
- Clinicians help to identify and address barriers to change.

The Specialist Weight Management Service (SWMS) Maternity Service - Happy Mum, Healthy Bump was a pilot programme set up in 2012 in Wigan (Aintree University Hospital NHS Foundation trust). It was built on guidance at the time and looked specifically at supporting obese women. Delivered by a multi-disciplinary team – Dietitian, physiotherapist and Occupational therapist, along with women's health specialist as needed. he service run for up to 18 months post-partum and the pathway also helped expectant mothers, and their wider families access other services including smoking cessation, breastfeeding networks and healthy-start services to name a few.

[116] Rasmussen KM and Yaktine AL. 2009. Weight gain during pregnancy: Re-examining the guidelines. Washington DC: National Academies Press

[117] https://www.nice.org.uk/guidance/ph27/chapter/Recommendations#recommendation-2-pregnant-women

Some headline outcomes included:

- One woman who had gained 5 stone in her previous pregnancies managed to maintain her weight throughout.
- Most women reported being highly motivated to change their diet at their first appointment (mean score 8.2 out of 10).
- At their final appointment 67% of service-users had increased in confidence in making dietary changes (mean score 8.8 out of 10).

Since then, further guidance has built on this with focus around person centre care before, and between pregnancy. Including the NHS Long Term Plan which as mentioned above, has a strong focus on obesity and mapping work is underway to identify best practice in weight management services for pregnant women.

Healthy weight before and between pregnancy is one of 6 priority areas identified by the then Public Health England (PHE) 'Maternity High impact areas', though the first and the sixth priority areas are also opportunities.

The maternity high impact areas addressed in this publication suite are:

- ***improving planning and preparation for pregnancy***
- supporting parental mental health
- **supporting healthy weight before and between pregnancy**
- reducing the incidence of harms caused by alcohol in pregnancy.
- supporting parents to have a smokefree pregnancy.
- ***reducing the inequality of outcomes for women from Black, Asian and Minority Ethnic (BAME) communities and their babies***

Table 46: Summary of Recommendation/Pathway for maternity, as per NICE Guideline (PH27)

	Recommendation
Preparing for pregnancy (preconception) **(BMI 30/+)**	For a woman with a BMI of 30 or greater: • Call for a range of healthcare professional to advise, encourage and help women before she becomes pregnant. Aiming for 5 – 10% reduction in body weight significant benefit that could increase chances of becoming pregnant. • Support should offer around diet and physical activity support, in line with Tier 1/ 2 support/programme. • Communicate risk and benefits for weight loss.
Pregnancy (Universal)	• Weight maintenance is the focus. • Promotion and use of healthy start vitamins, fruit and veg. • Myth Busting round the need to 'eat for two'. • Promotion of moderate physical activity – CMO guidelines, reduction of sedentary behaviour, particularly for those who find recommended level of activity difficult to achieve. • Collecting data around height and weight as early into pregnancy as possible – give a steer. However, do not routinely take measurements at each appointment. Offer

BMI 30+	women with a BMI of 30 or more at the booking appointment a referral to a dietitian or appropriately trained health professional for assessment and personalised advice on healthy eating and how to be physically active. Encourage them to lose weight after pregnancy
Supporting women after childbirth Universal	• Use the 6–8-week check, to engage in conversation about new mum's concern about weight and whether they'd like support. The option to take this up later should be given and followed up • provide clear, tailored, consistent, up-to-date and timely advice about how to lose weight safely after childbirth. Managing expectation/being realistic is key to this conversation. • Promotion of breastfeeding • Physical activity promotion – taking into consideration recovery post birth. Check may be needed
For women with a BMI 30/over	• Raising awareness • Referral to structure weight management programme or referral to dietitian or train professional. • Evidence based behaviour change techniques. • Promotion of evidence base healthy eating info • Encourage breastfeeding

Headline Figures for Maternity Services

Royal Berkshire Maternity, likely to be facing significant additional challenges with:

- 14,500 childbearing age women in Reading alone who are likely to be obese, who could become pregnant.
- Over 30,000 childbearing age women are likely to be carry additional weight (overweight or obese) at the time of falling pregnant.
- Excess weight is a key determinate for pregnancy loss, and complication during pregnancy and labour for mother and child.

Skills, competency, and training opportunity

Integral to the delivery of such care pathways, particularly in the community, is the need to ensure that all health professionals, healthcare assistants and support workers have the skills to advise on the health benefits of weight management and risks of being overweight or obese **before, during and after pregnancy**, or **after successive pregnancies**. Training on raising the issue, behaviour change and being compassionate and non-stigmatising is therefore crucial to a safe and effective maternity service with healthy weight at the core. The development of individualised and flexible plans for avoiding adverse outcomes of obesity in pregnancy will require investment in training of health professionals and better integration into normal antenatal care (Langley et all, 2022).

10.5.3 Medication to support Weight Loss

Semaglutide (Wegovy) is a pharmaceutical drug, initially developed for management of diabetes and recently approved for weight management. Semaglutide is recommended as an option for weight management, including weight loss and weight maintenance, alongside a reduced-calorie diet and increased physical activity in adults. Launched in the UK on 4 September 2023 it is now available on the NHS as an option for weight management in line with NICE guidance,

This new drug is available for a maximum of up to 2 years, and prospective patients would require referral to an NHS specialist weight management service for the patient to receive the appropriate Multiple Disciplinary Team approach evidenced in the NICE technical annex (Access via Tier 3 and 4).

Eligibility criteria exist:

- BMI 35 or
- BMI 30 -34.9 and meet the criteria for referral to specialist weight management services Recommendations | Obesity: identification, assessment and management | Guidance | NICE

Nationally, there are challenges with access to this drug, with supply in high demand in other parts of the world. ICBs have 90 days to ensure there is the infrastructure to enable residents to access this drug. There is currently concerns about the number of people who would be eligible for this drug and current capacity within the system.

Many areas do not have a Tier 3 service, and this makes access particularly challenging. There is also a significant cost to ICB both in terms of developing and implement a pathway and for the drug itself. Currently, primary care cannot prescribe Wegovy.

10.5.4 Recommendations

- In line with Recommendation from the National Association of Directors for Public Health (ADPH), Local Government association (LGA) and former Public Health England (PHE) body, **adopting a whole systems approach to weight** is needed.

- Investing in a **menu of adult weight management services** to meet the needs of Readings diverse population. Taking on board feedback outline in public engagement means these services need to be tailored to the needs of specific communities, holistic and compassionate in nature – particularly sensitive to the needs of people with mental health concerns and ideally longer than the traditional 12 week/ consider strong maintenance.
    - Ensuring we Tailor interventions to reach men, ethnic minorities, low-income groups, and other seldomly heard/engaged populations.

- Collaborative working across Buckinghamshire, Oxford and Berkshire (West) Integrated Care board colleagues (BOB ICB) and healthy weight public health leads across this area to ensure the development of a clear and effective adult weight management pathway from Tier 1- 4.

- Conduct a review of existing Tier 1 - 4 pathways in Reading and implement improvements based on evidence and insight.

Ensure public engagement feedback is taken onboard when developing a weight management pathway for Reading residents, which as a compassionate and holistic approach.

- Regularly review/assess the effectiveness of implemented strategies and policies for promoting healthy weight and make adjustments as needed.

10.6 Weight management pathways - Local

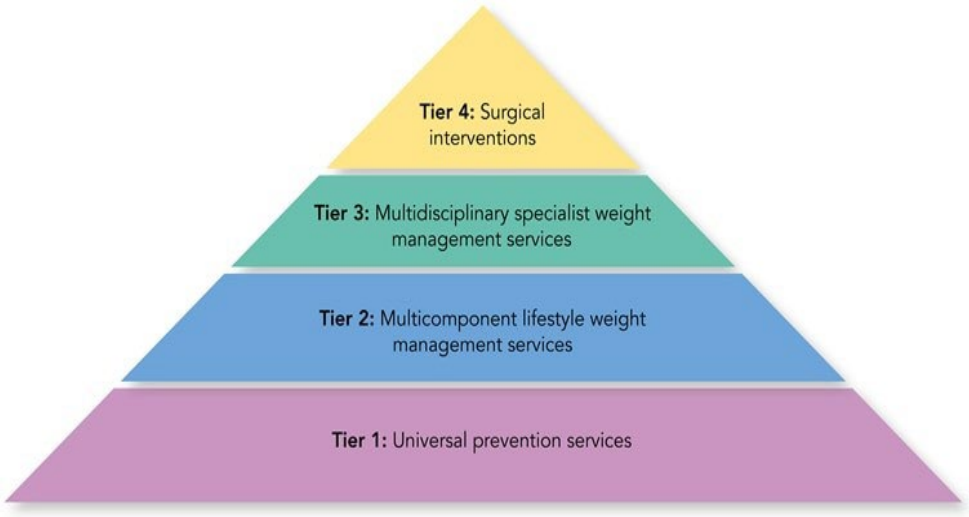
Weight management interventions are categorised into four different 'Tiers' in the UK (see Figure 10.3).

Tier 1 and Tier 2 are the responsibility of the local authority, whereas Tier 3 and Tier 4 are provided by the NHS.

Provision across Berkshire West is inconsistent; there are some areas of excellence, but there are also significant gaps.

Weight management services are tiered as below:

Figure 10.3: Summary of Weight Management Tiers in England



A summary of activity/service at each Tier below can be seen in table below:

Adult Weight Management Pathway Summary in Berkshire West (*correct as of September 2023*) ***Weight Management Pathway in BOB as of 8th September 2023 (updated December 2024)***					
Tier	**Description**	**Commissioner**			
			Berkshire West		
			West Berkshire	**Reading**	**Wokingham**
Tier 4	Surgical and non-surgical – Bariatric Surgery, supported by MDT pre- and post-op	ICB	Service provided at Royal Berkshire Hospital (RBH), takes 550 referrals a year. The entry route is through the Endocrinology service, the expectation is that clients will progress to surgery, the waiting time from referral to surgery is around 3 years. The Acute Provider Collaborative Group have commissioned a deep dive into Bariatric Surgery.		
Tier 3	Semaglutide (appetite suppressant injectable) has been used to treat diabetes. Available on NHS for weight loss. Only effective with dietetics and physical activity advice.	ICB	**Pharmaceuticals: Wegovy** ICB have not commissioned a pathway to provide access to weight loss drugs including Semaglutide. A non-NHS provider, Oviva, are providing access to a Tier 3 pathway including weight loss medications (Semaglutide and liraglutide). The consultant led service is available to patients across BOB under the Right to Choose Framework. A further weight loss drug, Tirzepatide, is due for NICE approval in December 24. Tirzepatide will not immediately be available and will not be accessible to everyone who wishes to use it. The ICB are still waiting for further information from NICE and NHSE on implementation for the roll out. Initially, Tirzepatide will only be available on the NHS to those expected to benefit		

			the most and this will be directed by NHSE/NICE. Tirzepatide will be offered to individuals facing the most significant health risks related to their weight, starting around **spring 2025** through specialist weight management services. People who are eligible for Tirzepatide through primary care services should not expect to start to getting access until **mid-2025 at the earliest**, but the timeline depends on further clarification on funding, service delivery models and wraparound services from NHSE. Likely to impact Tier 2 - increase demand as patients must have tried Tier 2 before can be prescribed.
Tier 3	Clinician led multidisciplinary team (MDT) – A MDT clinically led team approach, potentially including physician (including consultant or GP with a specialist interest), specialist nurse, specialist dietitian, psychologist, psychiatrist, and physiotherapist.	ICB	No current service To note: Royal Berkshire Hospital are a Tier 4 pathway and only patients appropriate and willing to be referred to a surgical pathway should be referred.

Tier 2		Local Authority	**No current service**	**Healthwise Tier 2 Adult Weight Management Service: Healthwise GLL Adult weight management** – 12-week free Tier 2 programme physical activity, behaviour change and diet. Free access to gym during engagement with programme. 2-year access to leisure facilities at discounted price. **Capacity:** 144 spaces for Reading only residents Cost: Unclear on specific – part of a wider block contract. **Access** (IFR, eligibility criteria): overweight 25 with comorbidities; obese 30kg/2 or 27.5 for those from minority	**No current service - decision to be taken following Health Weight Needs Assessment completed - end October 2023**

				Contract: (Block, reviewed annually etc.) block **Waiting times** (and volume waiting)- none at present – but anticipate this will be different going forward AOB – Looking at longer term support/peer support.	
		Community Dietetics	**Service:** 3-month online weight management programme called 'Weight Off Your Mind. Delivered by Community Dietitian Clinic **Eligibility Criteria:** Patients without Type 2 Diabetes or hypertension but do have other weight related comorbidities (e.g. PCOS, IHD, OA, OSA, dyslipidemia, CKD3) **Exclusion:** no weight related comorbidities, active eating disorder, unstable mental health not under MH team. Learning disabilities – refer to Community Team for People with Learning Disabilities (CTPLD). This service has been subject to staff/capacity to deliver in the past 24 months.	
Tier 2	Lifestyle weight management services. Normally time limited.	NHSE	Digital Weight Management Service **Service:** The programme offers online access to weight management services to people living with obesity who also have a diagnosis of either diabetes, hypertension, or both. With three levels of support and a choice of providers, it is designed to offer service users a personalised level of support to help them manage their weight and improve longer term health outcomes. https://www.england.nhs.uk/digital-weight-management/information-for-healthcare-professionals/		

			Capacity: 2022/23 BOB Target: 4107, Actual: 1314 - Lots of options in Buck and Oxon however so patients may be choosing more local services. Could be an option to promote where there are no Tier 2 services. **Access:** Criteria: are over the age of 18; have a body mass index (BMI) of 30 or more (adjusted to ≥27.5 for people from black, Asian and ethnic minority backgrounds); have a diagnosis of diabetes (type 1 or type 2), hypertension or both. Exclusions: recorded as having moderate or severe frailty; is pregnant; has an active eating disorder; has had bariatric surgery in the last two years; people for whom a weight management programme is considered to pose greater risk of harm than benefit Contract: NHSE is commissioner, spec at https://www.england.nhs.uk/wp-content/uploads/2023/03/PRN00269-enhanced-service-specification-weight-management-23-24.pdf
Tier 1	Universal interventions (prevention and reinforcement of healthy eating and physical activity messages), which includes public health and national campaigns, providing brief advice	LA/ ICB	• Personalised Care / Universal Interventions: MECC (supported but not necessarily got capacity to drive, available from ICB team for HSCWs and vol sector), Brief Advice. • Communications: Better Health Campaign, signposting on websites. • Whole Systems Approach to Obesity - https://www.gov.uk/government/publications/whole-systems-approach-to-obesity • Promotion of physical activity, leisure and green spaces (Newly Formed Physical Activity Alliance in Reading). • Food Partnership – infancy – looking to address food insecurity – Community Food Worker in Reading • Reading Service Guide -weight management and Physical Activity • **Healthwise Physical Activity Referral Programme and Cardiac Referral Pathway** contact via **Healthwise.Reading@GLL.ORG**. Access via referral to support people with whether for specific long-term conditions, weight management, or developing confidence

			• **Walks** in and around the town to promote activity, connection with nature and community if done in a group. More info please see RBC Walks webpage • Reconditioning programme, delivered by Get Berkshire Active to increase physical activity and support with preventing falls. • Gamification as a means of increasing active travel/physical activity more broadly – Intelligent Health run their Beat The Street programme between 25 September 2024 to 6 November 2024 for South and East Reading • Community Wellness Outreach programme: Delivered by the Royal Berkshire Hospital Meet PEET in Reading to deliver NHS Health Checks in local community settings and identify people who may be at risk of high blood pressure, diabetes or cardio-vascular disease

Table 5: Summary of Reading Adult Weight Management Referral Pathway

10.6.1 Local weight management services

Reading offers an array of activities that contribute to helping people keep active and manage their weight. There is a need however to ensure that all those activities and initiatives are coordinated and more joined up so as to increase their visibility and effectiveness.

Reading Borough Council commissions and delivers lifestyle and behavioural weight management services for children, families, and adults. Currently, there are four main services that deliver weight management support which are Free Swims, Physical Activity Referral Scheme (PARS), Adult Weight Management (AWM), and Cardiac, which is a PARS version for those who have had a cardiac episode. PARS, AWM, and Cardiac are delivered under a contract with Greenwich Leisure Ltd (GLL). See Appendix 10.3 – Healthwise programme report 2023

The 'Free Swims' service delivers free swims for senior residents of Reading at Reading Sport & Leisure Sites who qualify through the 'Your Reading Passport' card. The primary purpose of the service is to help secure a level increase in physical activity and to promote healthy lifestyle choices by removing barriers to sport and physical activity, especially for those currently inactive and from the most deprived areas of the Borough. The other group now being supported through the 'Free Swims' offer is young people accessing the holiday programmes.

In addition, Reading Voluntary Action, through the Community Wellness Outreach project, has funded 10 "Give it a Go" memberships (£30 per membership) delivered by GLL. The six-week programme allows individuals to try different activities within the leisure centres. GLL added a "Week 0" as an introductory session that includes a tour of the leisure centre, tea & coffee, a Q&A session (covering topics such as what to wear and what to bring), and assistance with membership applications. This is not a Healthwise product or programme and is not monitored for any related outcomes.

10.6.2 Gaps

- Tier 3 provision
- Lack of choice for Tier 2 adult weight management programmes, as Healthwise is the sole current provider in Reading
- Current pathway for children needs to be mapped – No Tier 2 which is the responsibility of the Local authority

10.7 Commercial Determinants

Definition of Commercial determinants:

Strategies and approaches used by the private sector to promote products and choices that are detrimental to health (Kickbusch et al, 2016).

Commercial determinants of health are the private sector activities that affect people's health, directly or indirectly, positively, or negatively (WHO 2023).

What are the commercial determinants of health and how does this differ from the wider determinants of health?

Commercial determinants of health have been more recently acknowledged than the more widely known 'wider determinants of health'.

Essentially, the private sector influences the social, physical and cultural environments through business actions and societal engagements; for example, supply chains, labour conditions, product design and packaging, research funding, lobbying, preference shaping and advertising. (WHO 2023). Commercial determinants can therefore be considered another dimension of the wider determinants of health.

The leading causes of mortality in the UK – Tobacco, alcohol and unhealthy foods - are all heavily influenced by the private sector. The true scale of the effect of commercial determinants is challenging to estimate due to the lack of comprehensive data and specific studies on this topic. The 2019 Global Burden of Disease (GBD) study estimates that just **four commercial products** (tobacco, alcohol, ultra-processed food, and fossil fuels) **account for 19 million global deaths annually** (34% of the 56 million total deaths or 41% of the 42 million Non-Communicable Disease deaths)[118].

Simply by being consumers of products, people are all subject to commercial determinants of health.

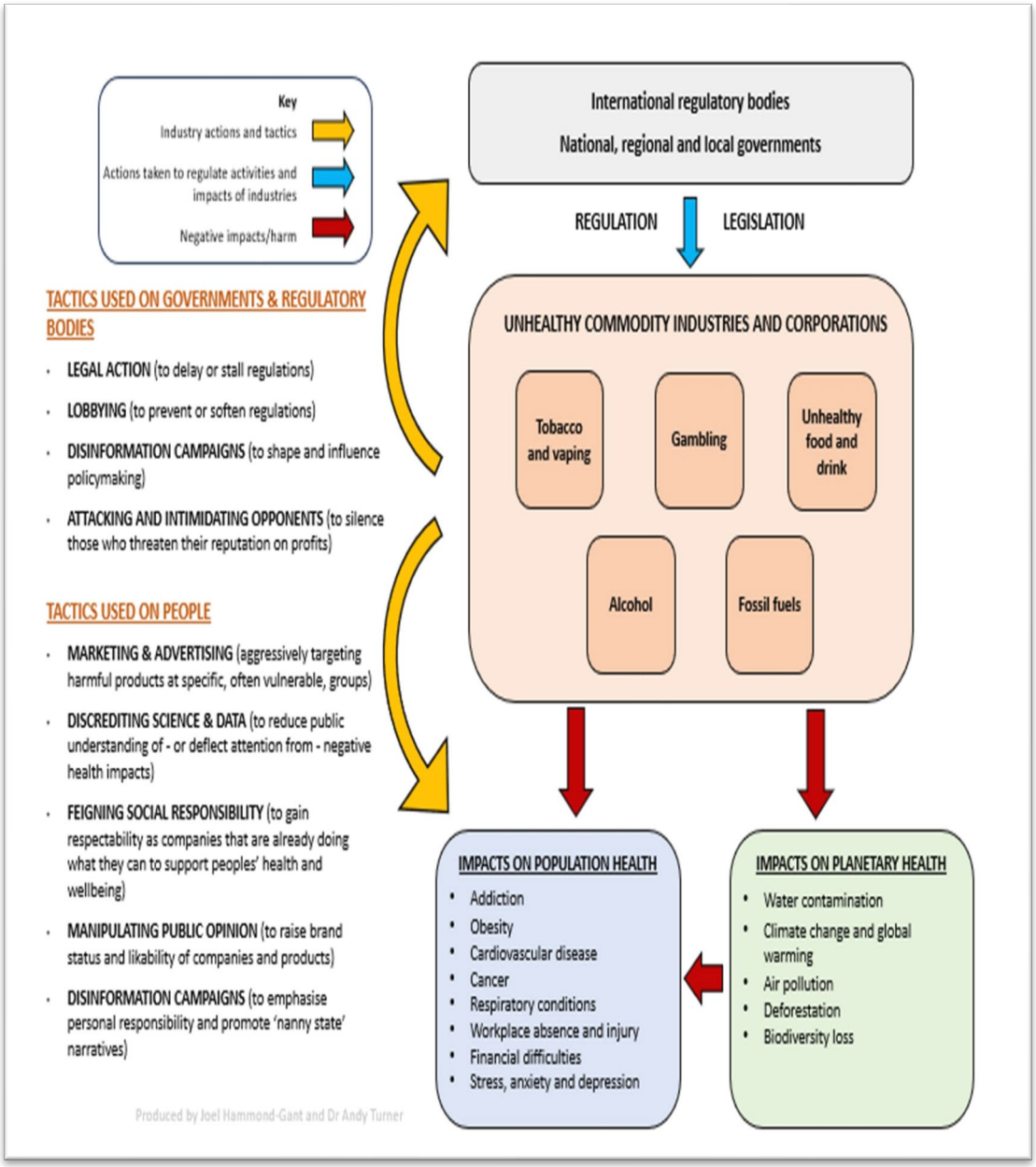
The following diagram, developed by Public Health Colleagues in Cheshire, attempts to explain the impact of commercial determinants[119]. The scale of the challenge is huge, but there are positive things public health can do. The Health Foundation~~,~~ has produce a framework for Local Authorities addressing the 3 biggest causes of mortality, including unhealthy foods[120]. A system's change can be initiated on the influence of commercial determinant by focusing energy upstream, for example using the local authority's influence on shaping policies around planning, licensing, advertising.

It's It is important to note there are positive contributions the private sector makes to public health; for example, when pharmaceutical and medical technology

[118] Gilmore AB, et al. Defining and conceptualizing the commercial determinants of health. The Lancet. Series on Commercial Determinants of Health. April 2023. 401; 10383: 1194-1213.
[119] Commercial determinants of health (who.int)
[120] Risk_factors_framework_handout_PDF.pdf (health.org.uk)

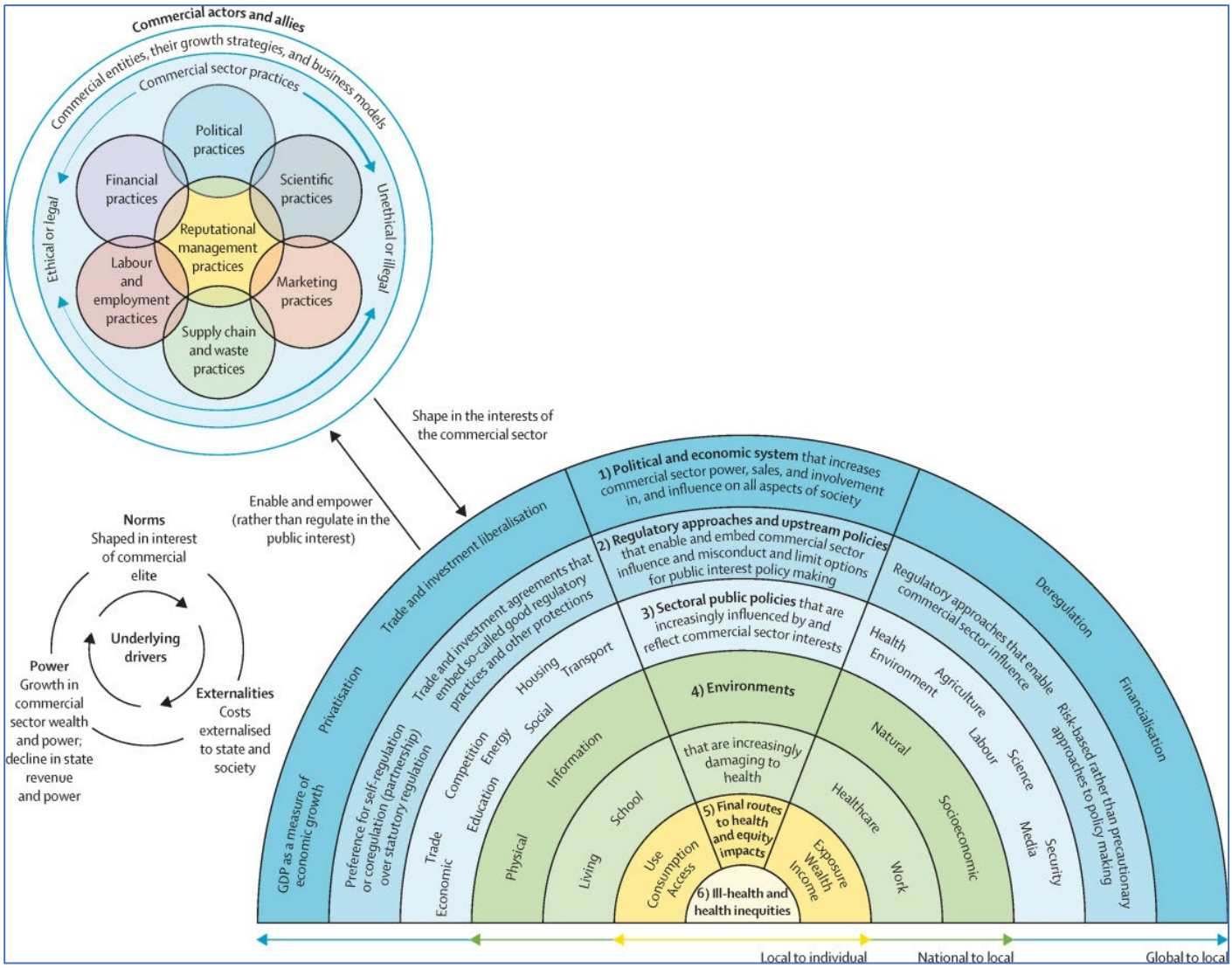
companies develop new medications and make essential medications and health technologies more available.

Figure 10.4: Commercial Determinants pictorial summary



Example of how commercial determinates influence health:

Figure 10.5: An illustration of current pathological system that is damaging to health. The black arrows signal the complex interactive nature of the system: the straight arrows show how commercial actors shape political and economic systems and are, in turn, shaped by



10.7.1 Recommendation

- Explore and exploit opportunities available at local level to create a social norm, where healthier is the more accessible option. Whole system approach which is reliant on collaboration across colleagues in planning, licencing and leisure for example is key.

Further reading

Good governance toolkit | ADPH /UniDoc-WIP.indd (adph.org.uk)

Consider for policy section - Is Obesity Policy in England Fit for Purpose? Analysis of Government Strategies and Policies, 1992-2020 - PubMed (nih.gov)

Turning the Tide Strategy - Obesity Health Alliance

10.8 Compassionate approach to healthy weight

Weight stigma and discrimination are widespread issues. Weight stigma is described as prejudice against individuals due to their weight or size. It is characterized by a bias towards a lower Body Mass Index (BMI) or smaller body size, and negative perceptions or assumptions associated with obesity, which lead to discrimination.

Weight discrimination is experienced in a variety of settings, including education, the workplace and healthcare settings, but also in personal relationships and the media[121]. It is a common assumption that weight stigmatisation is a motivating factor for weight loss, despite vast amounts of evidence which show it is harmful to both physical and psychological health, creates health inequities and perpetuates weight-based discrimination[122]. In the study completed by Lambert et al. evidence showed exposure to weight stigma actually significantly increased BMI at one month follow up in obese women[123] Victims of weight stigmatisation and discrimination face increased risks of maladaptive eating behaviours, psychological distress, exercise avoidance, lower success in weight-loss treatment and are less likely to utilize healthcare services[124].

As discussed throughout this needs assessment, it is now acknowledged that a range of wider determinants play a significant role in a person's weight. These can take the form of social, economic, or environmental factors. These determinants are multifactorial and interwoven, determining an individual's physical, social, and personal resources, which affect their ability to live healthy lives or make changes to their circumstances.

The need to adopt a more upstream approach is becoming increasingly clear. In addition to Whole Systems approach, an additional layer to be considered is adopting a compassionate approach to healthy weight. This is a fairly new approach which was shared at the Association of Directors of Public Health (ADPH) / Office for Health Improvement and Disparities (OHID) regional meeting early in 2023 and looks to address weight stigma and discrimination associated with it. Doncaster Council are early adopters of this innovative approach to issues of weight and health, which is driven primarily by compassion. It takes blame away from individuals and fully acknowledges the mental and financial burden poverty and inequality places on people.

[121] Weight Stigma | World Obesity Federation

[122] Puhl RM, Heuer CA. Obesity stigma: important considerations for public health. Am J Public Health. 2010; 100(6), 1019-1028. doi:10.2105/AJPH.2009.159491

[123] Lambert, E. R., Koutoukidis, D. A., & Jackson, S. E. Effects of weight stigma in news media on physical activity, dietary and weight loss intentions and behaviour. *Obesity Research & Clinical Practice*, 2019; 13(6), 571-578. https://doi.org/10.1016/j.orcp.2019.09.001

[124] Puhl R, Peterson JL, Luedicke J. Motivating or stigmatizing? Public perceptions of weight-related language used by health providers [published correction appears in Int J Obes (Lond). 2013 Apr; 37(4):623]. *Int J Obes (Lond)*. 2013; 37(4): 612-619. doi:10.1038/ijo.2012.110

The approach Doncaster are taking adopts the following **principles**:

• Advocate for social justice and reducing inequalities.

• Protect citizens, where possible, from the unfair environmental, social, and economic factors that constrict their lives.

• Accept and respect the inherent diversity of body shapes and sizes, and that we can promote health and wellbeing without focusing on being a certain body size.

• A 'gentler' approach to food and nutrition that supports a positive relationship with food and eating; does not place moral value on one food over another; does not shame or police.

• Support physical activities that allow people of all sizes, abilities, and interests to engage in enjoyable movement, to the degree that they choose.

• Intervene upstream at a population/community level wherever possible. Unsustainable individual interventions are least preferable.

Doncaster Council vision or mission statement:

"Our vision is for everybody in Doncaster to be fully able to pursue their own health goals and are fully supported to do so by society, without judgement or assumptions. They feel valued as an individual, just the way they are. Compassion is at the heart of how we move together towards a healthier society for future generations."

An unpublished grey paper conducted a scoping review into alternatives to a weight-centred health paradigm. The paper explored health at every size (HAE), self-compassion, intuitive eating, weigh stigma and health. 47 relevant papers were retrieved, and 18 met the inclusion criteria.
In reviewing the evidence of these 18 studies that used alternatives to the Weight-Centred Health Paradigm the authors took into consideration the long-term challenges to weight loss and the potential harm in loss of motivation and self-worth. Alternatives to a weight-centred health paradigm provide an opportunity to improve both physical and psychological health, even in the absence of weight loss, while also removing possible harms. In order to achieve this, five recommendations have been recognised in this review:

1. Interventions should take a holistic approach and should address and acknowledge the wider determinants of health, in social, economic and environmental factors.

2. Interventions should avoid weight stigma as a tool, and should include anti-stigma campaigns, policy to prohibit weight stigmatising and promote body diversity, self-esteem and body satisfaction.

3. Interventions that focus on eating and physical activity should be centred on approaches that promote enjoyment and self-compassion, as opposed to restrictive or unrealistic guidelines.

4. Consultation and an understanding of the population's lived experience should inform practice.

Reading would do well to consider such an approach which chimes well with feedback from residents. See chapter 9 – Local engagement with adults and family.

11. Local engagement

11.1 Adults & Families Survey results

11.1.1 Introduction

The survey was targeted at adults aged 18+ and families. It contained 33 questions (Appendix 1) and the total number of people who responded was 208. The survey was open between the 5th of May and the 16th of June 2023.

11.1.2 Population representation in the survey

The adult (18+) population in Reading is 137,789 persons which means that the survey respondents were equal to 0.15% of the adult population. The survey had a higher representation of females, older adults, and the white population. Although it is not strictly representative of the general population, it can be used with some caution as the number of responses was below expectations. In terms of geography, the majority (93%) of the respondents were Reading residents (190 respondents gave a Reading postcode out of 205. Some respondents lived in Wokingham and West Berkshire but close to the borders with Reading.

Over 70% of responses were adults without children under the age of 18. Thus, limited information can be drawn from this data about the needs of families. 8% (17) people identified as unpaid carers.

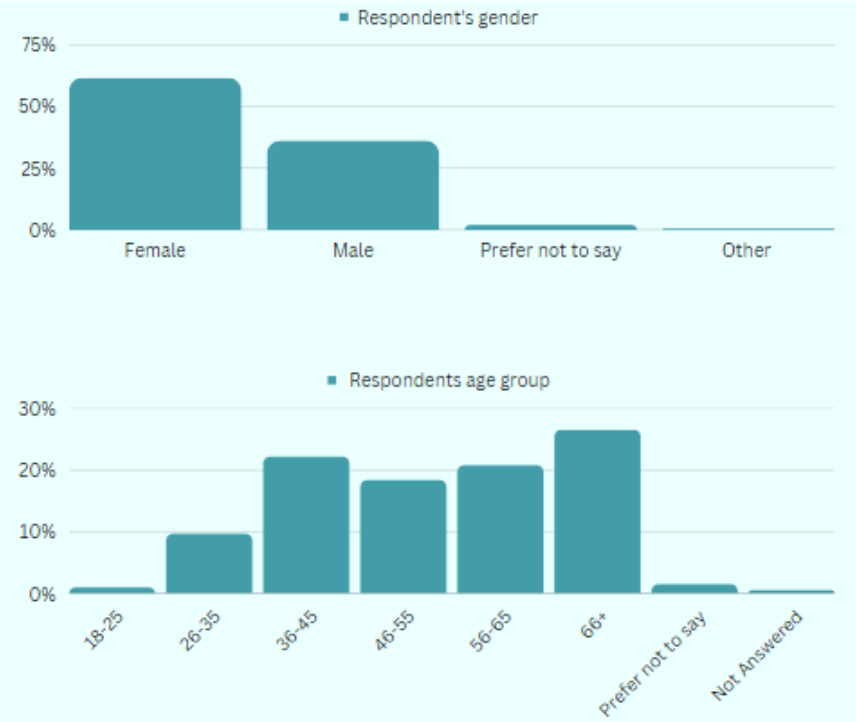
The table below shows the proportion of the general population broken down by gender, age category and ethnicity compared with the survey respondents.

Table 7 : Demographics

	Reading population 18+	A&F survey respondents
Male	50%	36%
Female	50%	61%
Other/PNTS	N/A	3%
White	67%	84%
Other ethnicities	33%	10%
No answer	N/A	6%
18-25	16.67%	0.96%
26-35	22.19%	9.62%
36-45	19.32%	22.12%
46-55	15.78%	18.27%
56-65	11.74%	20.67%
66+	14.30%	26.44%

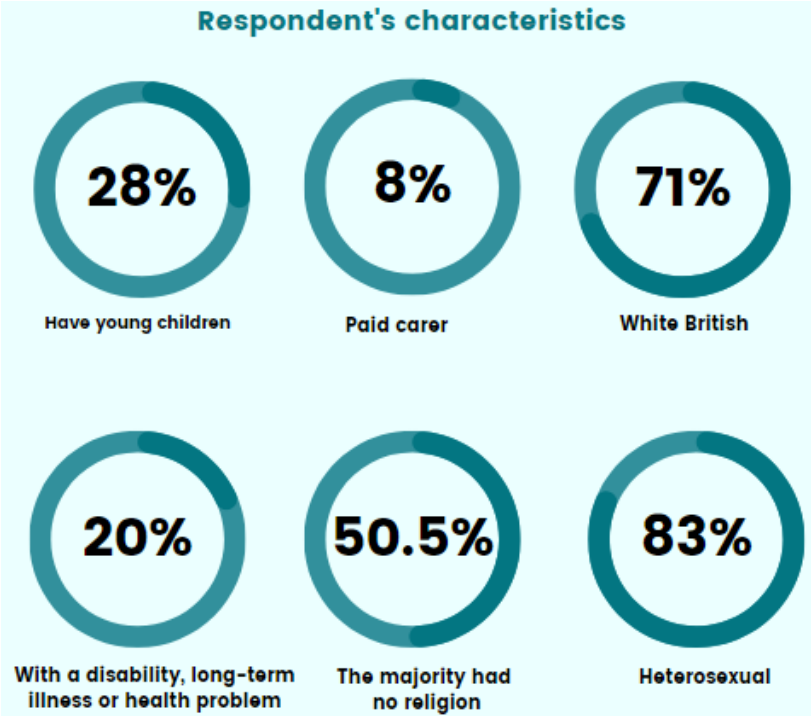
11.1.3 Survey respondents' demographics

Most respondents were females (61.5%) and the age group with the highest response rate was 66+ (26%). The majority (71%) were White British, and the remainder were Other White, Irish, or Irish Travellers (13%), Mixed (2.5%), Asian (4%), Black (1.5%), Other (1.5%), and those who preferred not to say (6.5%).



Infographic 11.1: Survey's respondents by gender and age group

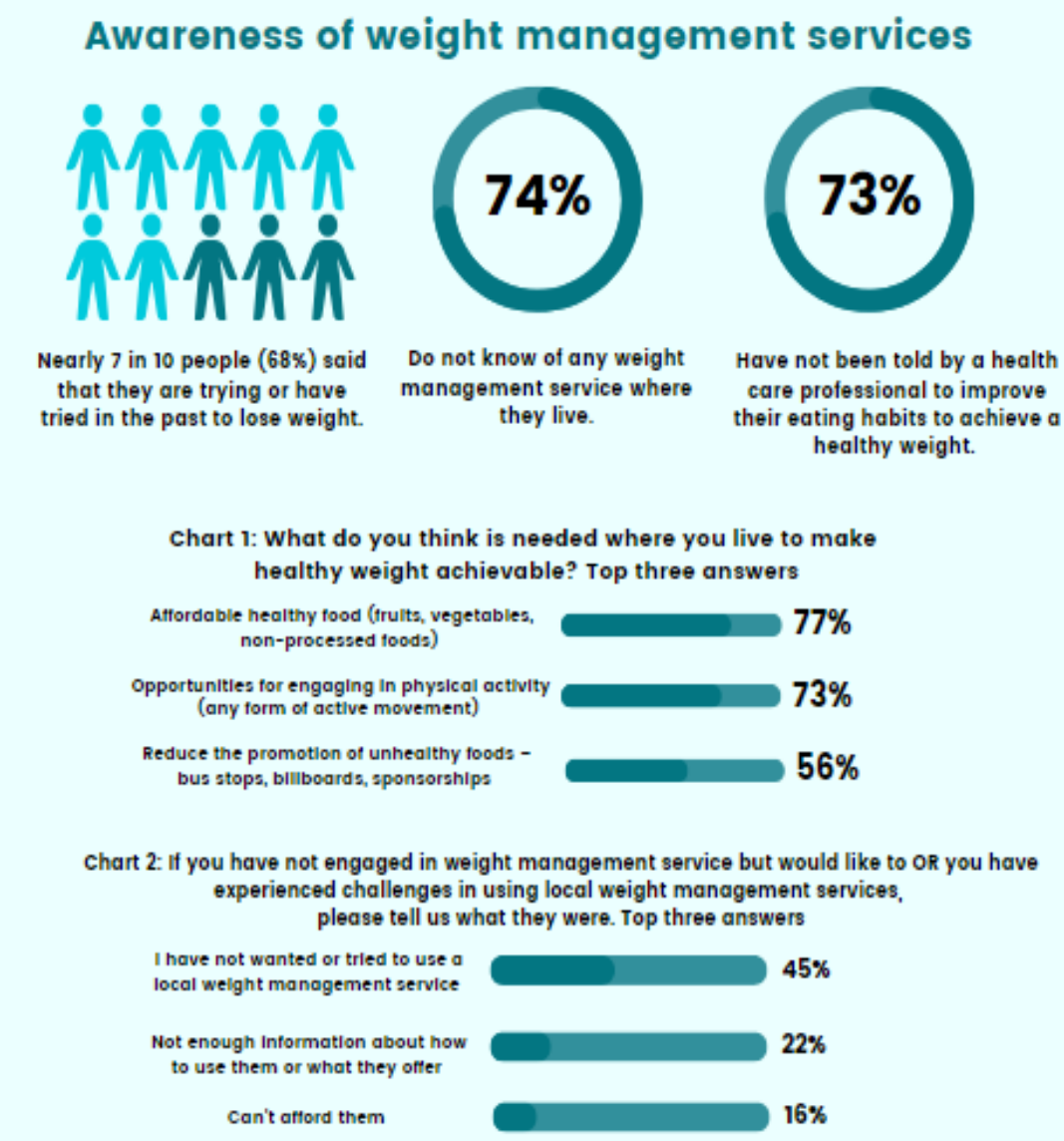
Only 8% of the respondents were paid carers. Two in ten had a disability, long-term illness, or health problem. Over 7 in 10 respondents said that they did not have children or that their children were over 18. Of those that had young children, the majority said that their children were aged 12-18 years old.



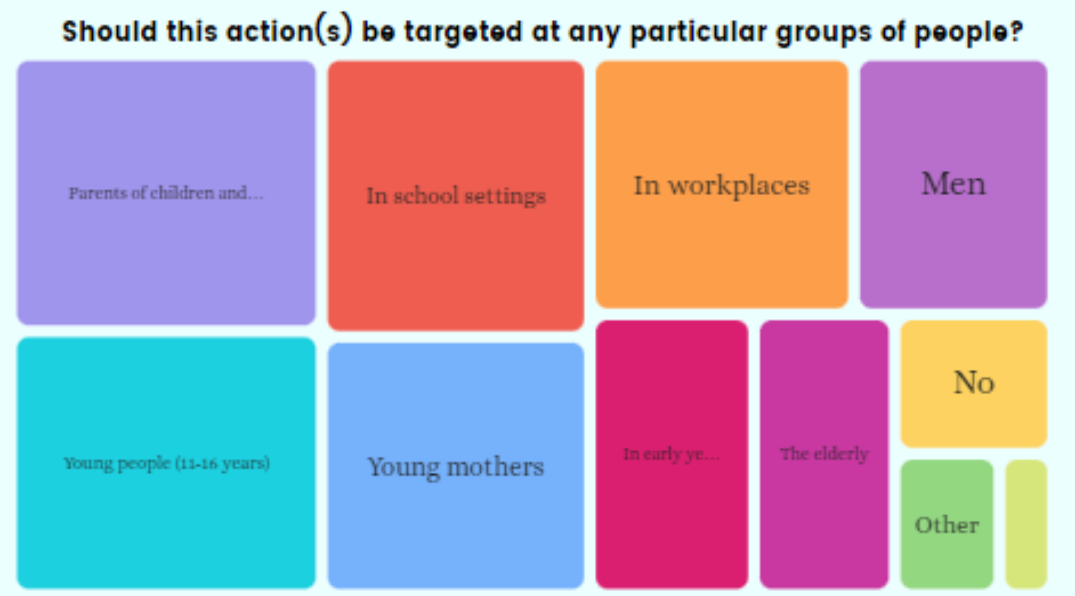
Infographic 11.2: Equality and diversity characteristics of survey's respondents

11.1.4 Healthy weight and service awareness

Nearly 7 in 10 respondents said that they had tried or were trying to lose weight. Interestingly 74% said that they did not know of any weight management service where they live, and 73% had not been told by a healthcare professional to improve their eating habits to achieve a healthy weight. Of those who were told by a healthcare professional to improve their eating habits to achieve a healthy weight, 73% (50 out of 68) had made changes as a result. The majority of those who had not engaged in weight management services, said that they had not wanted to do so, or they tried to use a local weight management service (Chart 2). The majority (77%) think that affordable healthy food is needed where they live to make a healthy weight achievable (Chart 1).



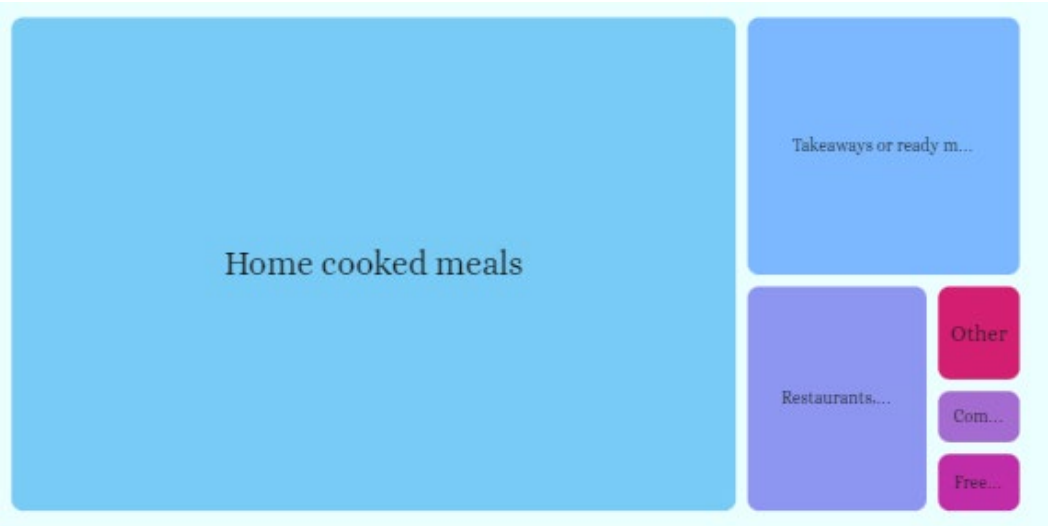
Those respondents who answered the question *"what do you think is needed where you live to make healthy weight achievable?"* said that the action(s) they have selected should be targeted at parents of children and young people (61.5%), young people (11-16 years) (59%) and in school settings (55%).



Services that resident were aware of included GLL leisure, and Slimming World. More needs to be done to create better awareness of local provision. At the time, Reading had just decommissioned Slimming World and had a contract with Healthwise programmes offering Tier 2 adult weight management.

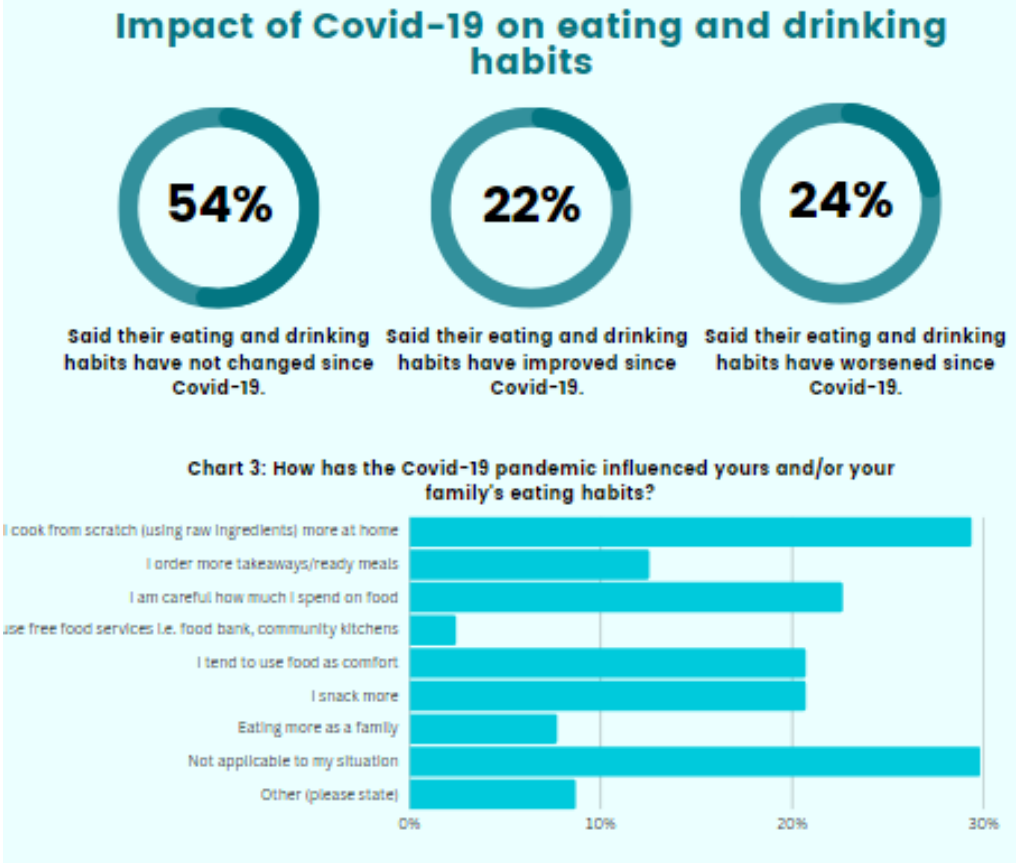
11.1.5 Eating habits

Over 9 in 10 respondents said that they ate home-cooked meals at home most of the time. However, 20% said they also ate takeaways or ready meals at home, and 11.5% ate in restaurants, pubs, or cafes. The majority (7%) of those that did not eat at home most regularly did so because of work patterns.



11.1.6 Covid-19

Most of the respondents (54%) said that their eating and drinking habits had not changed since Covid-19. Of those that said that their eating and drinking habits had changed since Covid-19, 22% stated that their eating and drinking habits had improved and 24% that they had worsened. Of those that reported their eating habits had changed, 29% said they cook more at home from scratch ingredients, 22% that they are more careful about how much they spend on food, 20% tend to use food as comfort, and 20% that they snack more often (Chart 3).



11.1.7 Food crisis

In response to the question '*With the recent increase in food prices in the last 12 months, have you experienced any of the following?*', 41% said that the increase in prices had not affected them much or at all. The next two most prevalent answers were that they prioritized paying bills/rent over food shopping (13.5%) and having to skip meals (7%). 17% of respondents opted for "*other*." Overwhelmingly all of these responses talked about the pressures the increase had on choices they make as a household, some of which resulted in debt and having to compromise their health. Many identifying themselves as 'fortunate' or 'privileged' and yet still had to make changes.

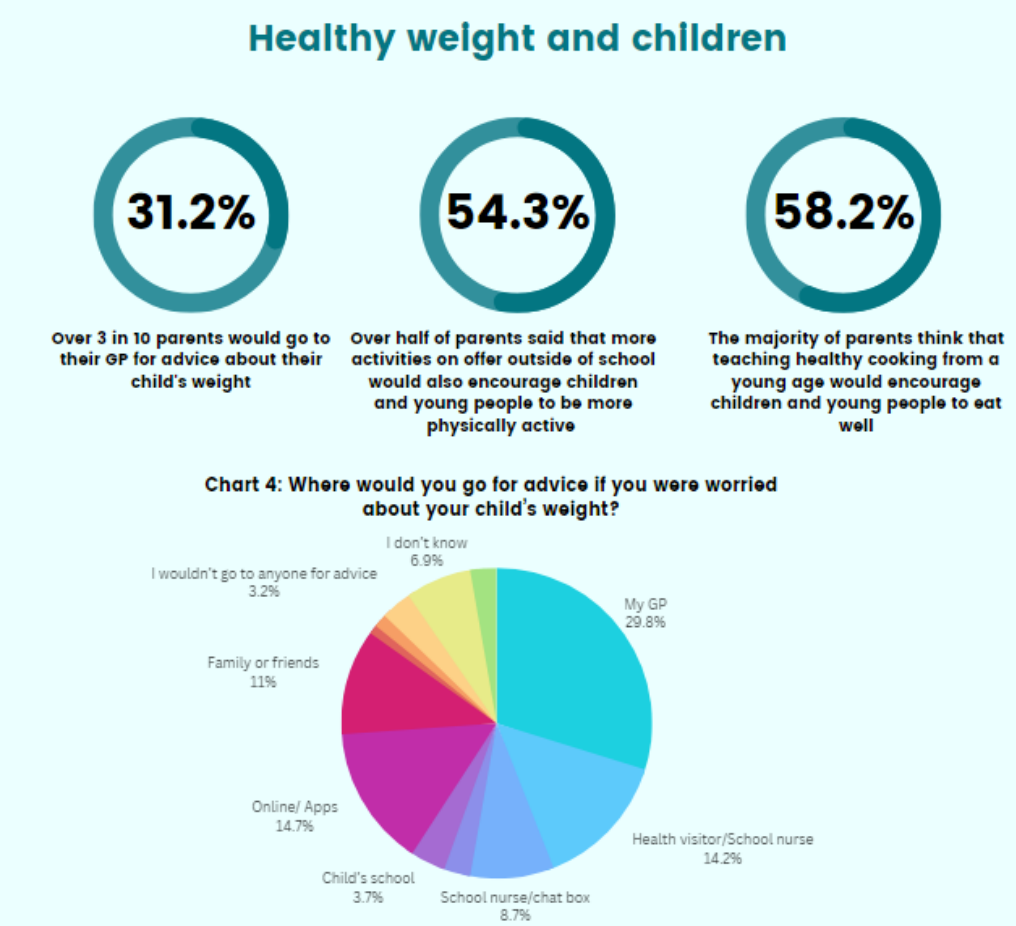
- *"Fortunately, we can pay the increased price of food, but we certainly notice that the price increases are staggering. "*
- *"I have adjusted what products I buy to save some money and reduced food waste by labelling foods in the fridge etc. Also recognise that in losing weight I eat less which costs less...so food might be costing 15% more but I'm eating 15% less. "*
- *"I am fortunate in that I can afford to buy food at current prices. I certainly check prices much more carefully than previously and plan menus with greater care, bulk buy and freeze food etc to save money. "*
- *"Increased prices have led to credit card debt "*
- *"More conscious about spending but thankfully have not been prevented from buying food, we are still able to do so but there has been an evident increase in awareness of cost leading to more careful shopping."*
- *"Altered family budget - more on food, less travel "*
- *"Bought less food and stuff on sale, prioritising value over health."*

Over 9 in 10 respondents had never used free food services (i.e., community kitchens, pantries, food parcels). The majority of those that did use them said that they use them very rarely or no more than once a fortnight.

11.1.8 Healthy weight and children

This part of the survey was applicable to respondents with children aged 0-18.

Most (31.2%) parents would go to their GP for advice if they were worried about their child's weight (Chart 4). When they were asked about the most important broader actions outside of the home that might encourage children and young people to eat well, 58% said teaching healthy cooking from a young age, and 52% said using positive adverts and healthy messages in the media, including social media/'Influencers' (Chart 5).



Most parents (54.3%) thought that more activities on offer outside of school would encourage children and young people to be more physically active. A large percentage (53.3%) of parents thought that being more active in day-to-day life, for example choosing to walk or cycle, would also encourage children and young people to be more physically active. A significant percentage also said that more free or low-cost activities should be on offer for children eligible for free school meals and more Physical Education (PE) lessons and/or activities at school (including after-school clubs).

The largest proportion (45%) of parents think that ensuring most meals have a portion of vegetables and/or fruits is important/helpful in encouraging children to eat well at home. A high percentage (43%) thought that trying to ensure balance across the food groups (proteins/carbohydrates/fats) would also encourage children to eat well at home (Chart 6).

Chart 5: Are there any broader actions outside of the home that might encourage children and young people to eat well?

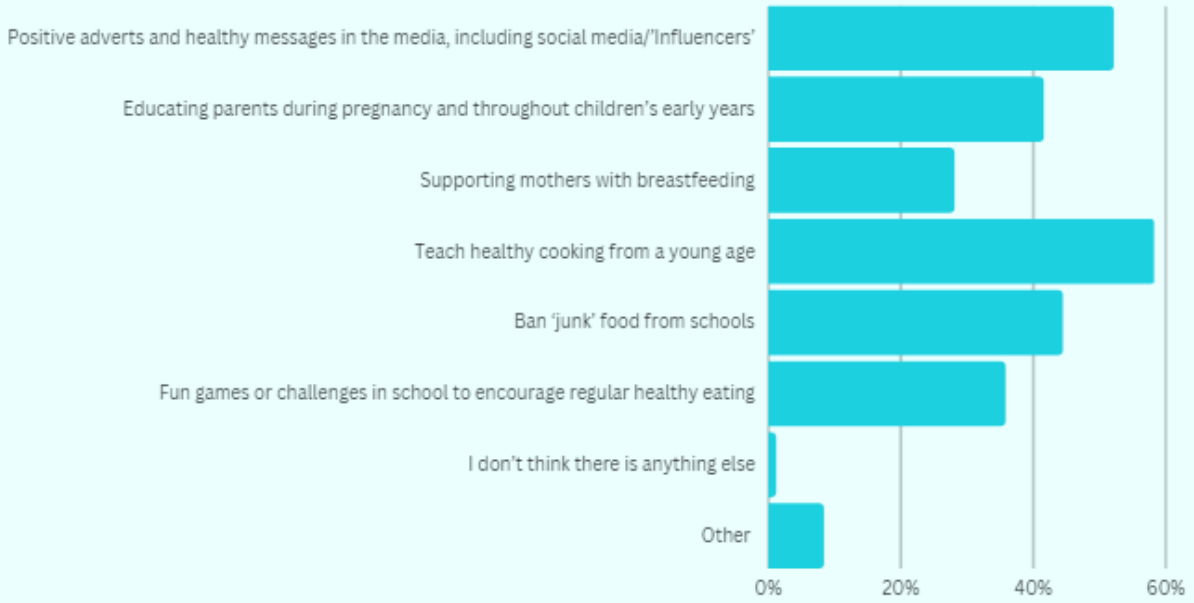
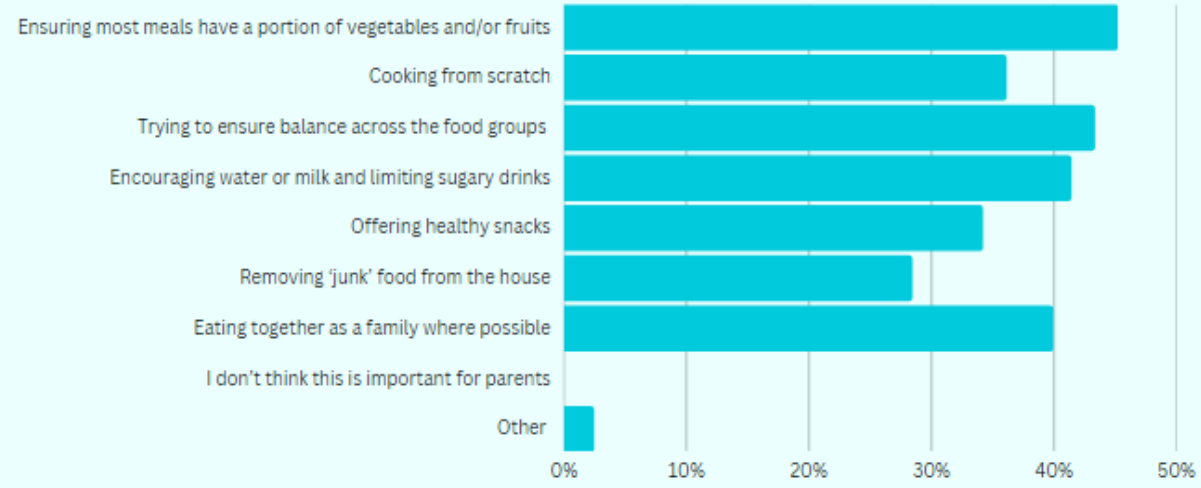


Chart 6: What do you think is important/helpful in encouraging children to eat well at home?



11.1.9 Physical activity

Most of those respondents who reported that they didn't engage in much or any physical activity said that what prevent them from doing so is lack of time (30%) and lack of motivation (25%).

A total of 457 individualised responses were coded and analysed using the inductive coding thematic approach.

The top five themes concerning actions to encourage individuals and/or action the local authority could take to support physical activity were:

1. Subsidised/concessionary physical activity options (19.91%)
2. Diverse accessible and affordable options – indoor/outdoor (19.25%)
3. Active travel safety, accessibility & infrastructure (13.56%)
4. Awareness raising/education (5.68%)
5. Incentives/engaging/rewarding options (5%)

Stigma and health limitation were the common themes for barriers to physical activity.

Below is a summary of each of the five themes.

1. Subsidised/concessionary physical activity options (19.91%)

The **cost of accessing leisure facilities**, courses and physical activities was the main concern raised by the majority of respondents, with requests for *"having access to free physical activity facilities and gyms in the community"* and to *"bring back schemes like the Reading Passport, discounts for local community"*. People said that *"it is too expensive to join clubs and activities"* and that overall prices should be *"cheaper for us all not just those on benefits who don't have jobs and can easily go for walks in their free time"*. Some of the comments addressed the need to lower the cost of accessing physical activities **for all in the community**, including the need to *"provide free access to sports centres for school children"*, *"offer cheaper exercise classes at local gyms for children and vulnerable adults"*, *"offer more physical exercise classes for people on low incomes"*, *"provide more exercise at a reasonable or free cost for disabled people"* and *"free classes more for older people"*.

Below is a sample of what people said:

- *"Make sure that council run leisure facilities are good and affordable"*
- *"Having access to free physical activity facilities and gyms in the community"*
- *"It is too expensive to join clubs and activities"*
- *"Cheaper gym memberships and classes or free options in local parks (like the outside gym stuff you can get)"*
- *"Affordable access to more sports facilities"*
- *"More low-cost options for group exercise. For example, a privately run, 45-min exercise class is typically £7+, which many can't afford"*
- *"Provide more exercise at a reasonable or free cost for disabled people"*
- *"cheap gym memberships, free classes, more free group activities after 5pm"*
- *"Access to free/subsidised swimming sessions"*
- *"Make it more accessible and affordable. Make it easier for people who need help to get that help without feeling they are being a nuisance"*

To see a full set of all the responses, please go to Appendix 12.1.

2. Diverse accessible and affordable options – indoor/outdoor (19.25%)

The lack of a wider range of activities indoors and outdoors, for various age groups and abilities and at various times of the day to reach a wider spectrum of the population (including those employed), was highlighted by 17.28% of respondents. The responses covered a range of areas including the **choice of activities available** "*people need to be able to easily try a variety of activities to find*", "*more yoga, fitness, basketball or volleyball, and less football*", "*gardening*"; the **timing of activities** "*more access to leisure facilities in Reading - needs to be cheaper and open later*" "*Park Tai Chi/Qi Gung on local parks at weekend or even during the week*"; **addressing offer and access** for people with "*mobility issues. Disabled. Need more groups for us*".

A few respondents mentioned the need for more outdoor activities "*more outside gyms*" "*Outdoor gym stuff in parks*" "*free gym equipment in parks*" and to "*properly maintain outdoor spaces, provide outdoor gyms, provide equipment hire services that are affordable*".

Below is a sample of what people said:

- *"Free group activities in parks"*
- *"Meetings like "walking together" "*
- *"more yoga, fitness, basketball or volleyball, and less football. Park gyms."*
- *"Build more skate parks, basketball & tennis courts (& all to be free)"*
- *"Try new sports that are not accessible for low-income children golf, horse riding and water polo"*
- *"Park Tai Chi/Qi Gung"*
- *"Japanese-style pre-work/school light exercise sessions"*
- *"Access to qualified fitness teachers at an affordable price"*
- *"more local classes help with activities in area like gardening or park facilities"*
- *" More allotments, exercise & grow own veg"*
- *"Widen choices. Include dance, gardening, treasure hunts"*
- *"Advertise and organize and build ice rinks bowling alleys everything that a large town should offer"*
- *"Provide more swimming facilities"*
- *"More outdoor gyms. More quality sports surfaces...tennis courts, 3G pitches"*
- *"kayaking or paddle boarding but there aren't really any places to hire the equipment and if they are they are unaffordable"*
- *"Nature trails"*
- *"Dog ownership"*
- *"Publish some local and accessible ""wellness walks"" from 1km up to 10km"*
- *"local bike runs"*
- *"Set up more local groups for walking, gardening, playing outdoor games"*

- *"Support yoga, pilates and similar studios. Support local dance groups such as those that teach jive, tango, blues, salsa"*

To see a full set of all the responses, please go to Appendix 12.1.

3. Active travel safety, accessibility & infrastructure (13.56%)

A substantive number of respondents talked about the importance of **active travel initiatives** such as walking, cycling, running, using public transport and highlighted barriers to engaging in active travel such as feeling **safe and the quality of the build infrastructures** that provide physical activity spaces – indoors and outdoors - including pavements, the provision of cycling lanes.

Below is a sample of what people said:

- *"Encourage cycling/walking"*
- *"making lives more active generally e.g. walking or cycling rather than getting in the car this is better than driving once a week to an activity"*
- *"Improve cycling in Reading "*
- *"Make it easier and cheaper for people to use buses rather than cars"*
- *"Reasonable prices and availability without using cars"*
- *"Better cycle routes, Holding drivers to account for close passes Walking school buses"*
- *"Safer pavements where we could walk without danger from speeding bicycles and illegal electric scooters"*
- *"More running and cycling infrastructure"*
- *"Provide lockable cycle storage local to areas of housing for residents to use conveniently and securely"*
- *"Design the physical environment to encourage physical activity, such as walking and cycling"*
- *"plan streets and areas around safe walking and cycling"*
- *"Better active travel options and reduced dependence on the car"*
- *"cut road speed limits to 20 across the whole borough to make it safer to cycle, and just as fast"*
- *"Invest in a free and more extensive public transport system so that car use would seem didn't seem relevant"*
- *Dedicated cycle lanes would get more kids cycling*
- *"If people can walk or cycle to work really safely (rather than having to cycle/ walk next to huge lorries and speeding cars) this would make the biggest difference and also be excellent for the environment"*
- *"Prioritise pedestrian access over vehicle traffic in planning"*
- *"Congestion charge - higher car park prices"*
- *"Facilitate greener travel by introducing thought into the transport system with buses having their rest periods at the stations (Tilehurst, Reading West, Green Park) when the trains are due or at Rivermead, shopping centers"*

- *"Fine businesses that do not encourage at least 20% of employees to use green transport to work"*
- *"Continue with the initiatives to increase cycling and reduce car use in the town"*
- *"Swimming pools more accessible by public transport"*
- *"Reduce car use. Ban them in urban areas, except for disabled people who need one"*

To see a full set of all the responses, please go to Appendix 12.1.

4. Awareness raising/education (5.68%)

The **availability of information** about the sports and leisure activities that are locally available appears to be an area for improvement. A number of respondents mentioned the need for "*education and good information and discounted sports and fitness centres*". Some respondents said that there needs to be more **health promotion and education** around the benefits of keeping an active lifestyle including "*Educate the young*" and "*Health checks that flag serious risks they are facing but also show them where they could get to without excess cost*", "*More education about the benefits of exercise in managing mental and physical health*" "*More information about walks and benefits of walking as an activity*"

Below is a sample of what people said:

- *"Information about good walks and the benefits of a simple walk"*
- *"Advise of the social side of taking part and the physical benefits"*
- *"more publicity about opportunities for activity, and about dangers of not doing it"*
- *"more messages about the value of exercising"*
- *"Providing information about the health benefits of being physically active, including about the mind / body connection"*
- *"Incorporate healthy choices into people's everyday lives"*
- *"Making people more aware of the facilities that council has to offer"*
- *"Advertise local groups in a way that makes them seem accessible & friendly to newcomers"*

To see a full set of all the responses, please go to Appendix 12.1.

5. Incentives/engaging/rewarding options (5%)

A number of respondents suggested **incentives and rewards** could be a **motivating factor** in engaging people to take up physical activities. The suggestions include "*a buddy and support from family*", "*Free bus pass if you give up your car*", "*Monthly step challenges*" or "*Prizes for local sports competitions*".

Below is a sample of what people said:

- *"Make it fun, find things that engage them, not just PE and football"*
- *"have people who might be willing to assist disabled people to do more physical activity - possibly like a buddy system"*
- *"More opportunities to help others with physical help such as gardening and odd jobs"*
- *"Could do trial days for new activities- allowing ppl to test out a new sport or activity"*
- *"Free bike if you give up your car"*
- *"Walking schemes…..Maybe collect enough 'points' to get a free fruit drink or coffee."*
- *"meet a local football player"*
- *"Offering incentives like exercise-based currencies (e.g. sweatcoin) – maybe PAYG phone credit and utilities credit, and healthy food for exercise might appeal to many who struggle to access healthy options?"*

To see a full set of all the responses, please go to Appendix 12.1.

Other themes that arose from the qualitative analysis in fewer than 3% of responses include:

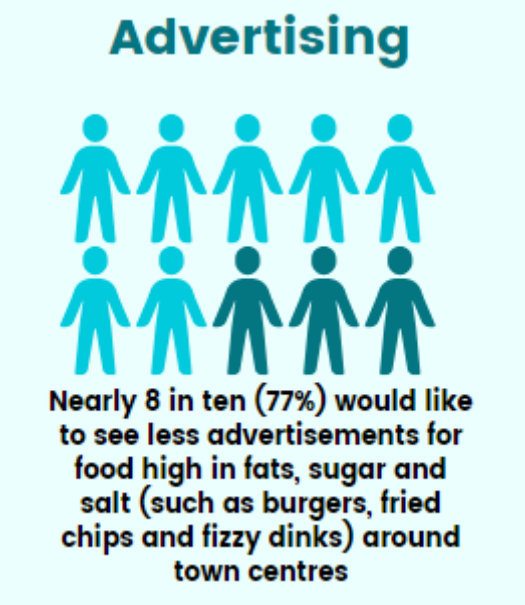
- Address whole system infrastructure
- Accessibility and infrastructure and safety
- Accessible Physical Activity directory
- Address stigma
- Address volunteering
- Culture Change – Whole Systems Approach
- Appropriate settings
- Be active at work
- Commercial determinants of health
- Digital access
- Eating habits/nutrition
- Family based interventions
- Gamification – reward based
- Green space activities
- Health limitations
- Health promotion
- Holistic approach
- Increased provision

- Mental health
- Normalising Physical Activity in daily living
- Perceived limitations/stigma
- Physical health limitations
- Programming of activities
- Role modelling
- Safety, accessibility and Infrastructure
- Schools
- Screen time
- Social Cohesion & community events
- Tailored, age appropriate, inclusive interventions
- Targeted social marketing
  Tier 3 offer

To see a full set of all the responses, please go to Appendix 12.1.

11.1.10 Advertising

Nearly 8 in 10 people said they wanted to see fewer advertisements for food high in fats, sugar, and salt (such as burgers, fried chips, and fizzy drinks) around town centers.



11.1.11 Stigma

Around 4 in 10 respondents had experienced, or were aware of, the stigma[125] around accessing support for weight management.

The most popular (70%) response to the question *'What do you think could be done to challenge this stigma?'* was to use local campaigns that are focused on eating well and being active, rather than being all about how much someone weighs. The second most popular (51%) response was to share information about the impact of weight on mental health and well-being.

Respondents were also asked *'What do you think could be done to challenge this stigma?'*

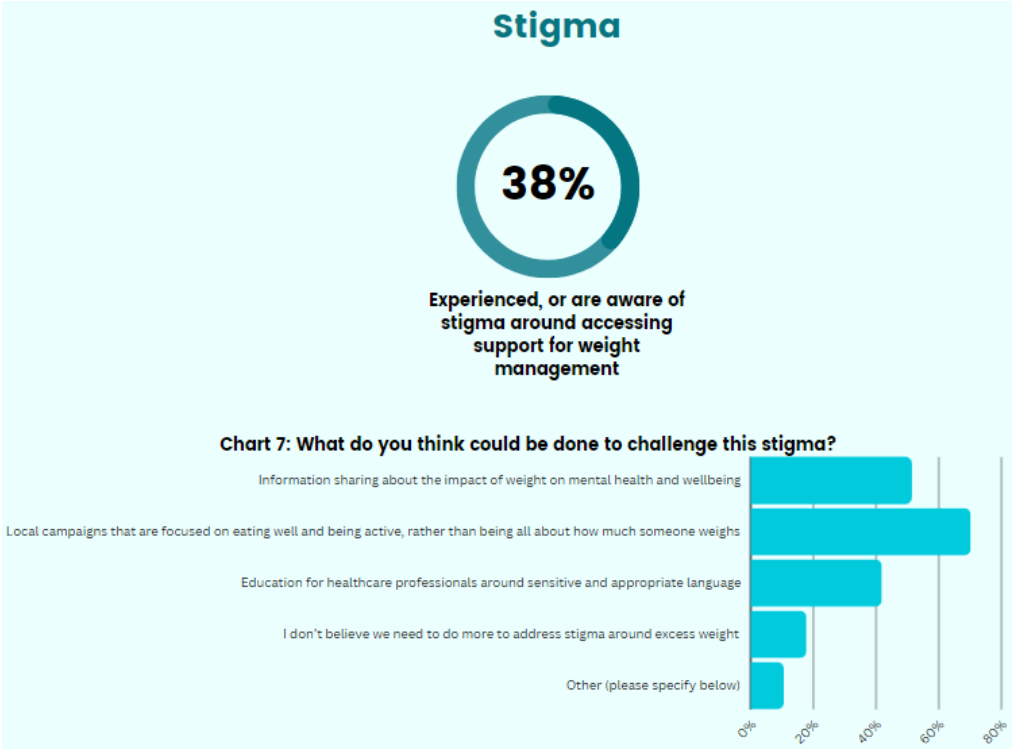
A total of 41 individual responses were analysed using the thematic inductive coding approach. This resulted in identifying 3 main themes as follow:

[125] Stigma' is referring to "a set of negative and often unfair beliefs that a society or group of people have about something"

1. Addressing benefits of promoting inclusive healthy weight initiatives (34.14%)

2. Addressing appropriate language and conversations, training skills and support for staff and residents (29.26%)

3. Addressing effective messaging about measuring and causes of weight (24.3%)



1. Addressing benefits of promoting inclusive healthy weight initiatives (34.14%)

Constructive health promotion on the benefits of losing weight and the risks of putting on weight was highlighted as the main theme to counteract stigma "*stigma is around weight not just accessing weight management services so a campaign or work to remove stigma in general would be ideal*" " *More positive information on the effectiveness / success of services and the theory behind programmes - dispel myths that it's just a 'con' to get your money*" "*Normalize wanting to eat healthily for every body - Normalize wanting to be active for every body - Normalize wanting good mental health for everybody*"

Below is a sample of what people said:

- *I want my GP to tell me about the risks around obesity*
- *as a public health team we should not shy away from stating the impacts of unhealthy weight. Language is really important here*
- *Show overweight people being active (like the ""this girl can"" campaign)*
- *Local authority and other campaigns putting large/ fat people in posters and adverts, promoting healthy eating and active lifestyles to show people are all shapes and sizes*
- *Show skinny people worrying about eating healthily, or being depressed and sedentary*
- *Stop assuming fat people are too lazy or too stupid to lose weight*
- *Less assumptions and more enquiry around food and weight*
- *More services focused on men - for and by men. My husband joined slimming world and it's mainly women*
- *different people different cases, different circumstances such as depression, lifestyle, loneliness, lack of money, or self- esteem*
- *shift the whole way policy at all levels is increasingly about 'personal, individual responsibility': eating well and keeping fit and a healthy weight are increasingly the preserve of the rich or well-off with poverty, poor housing, poor jobs, difficulty in accessing health care and a poor social environment overall making it most difficult to manage to stay healthy*
- *The increasing emphasis on individual agency and on the supposed 'influence' of language is much less relevant than addressing the wider issues around poverty, education and health care*

2. Addressing appropriate language and conversations, training skills and support for staff and residents (29.26%)

Respondents talked about the way society portrays and views overweight people and how this affects the way they are talked to and about "*People always find fat people funny and it seems that this is ok by society*" "*A lot of people refer to slimming groups or weight management groups as 'Fat Club' this is inappropriate and can put people off going*" "*Gyms are too scary for very fat people - the people who work there and are supposed to help have no idea what it is like to be very overweight and recommend totally inappropriate activities*". This raises the need to educate the general population and people in front line service about using appropriate language and conversations skills "*people who use and work at the swimming pools in Reading are very judgey and make comments that mean very overweight people feel too embarrassed to swim*"

Below is a sample of what people said:

- *I don't think there is a stigma. But I'm not aware of any support there to be accessed*
- *Health professionals do not need more education. They need more time: sensitive and patient-responsive conversations/communication take more time*
- *It has been good to see the word 'obesity' used less in campaigns*
- *stop people being judgmental*
- *Being fat and obese needs to be stigmatised! Just like smoking has been. We are teaching people that it is normal to be morbidly obese. It isn't!*
- *we need to be clear that obesity is unhealthy – the anti-""fat-shaming"" drive has moved us to a place where criticising obesity is 'hateful', which is absurd…..people should absolutely not be shamed for accessing help*
- *It's one of the last socially acceptable stigmas. People always find fat people funny and it seems that this is ok by society*
- *Stop the ""fat and lazy"" pairing in your plans*
- *Be cruel to be kind?*

3. Addressing effective messaging about measuring and causes of weight (24.3%)

The official process for measuring weight and the general perception of causes of weight were raised as potential reasons for stigmatising people "The current BMI range we class as "healthy" is outdated, and BMI should not be used to assess health anyway. It is not fit for purpose" "Some people who are overweight may have the wrong genes or a medical condition that makes them overweight. Metabolism controls weight loss" "Education for health professional on eating well and being active, rather than being all about how much someone weighs". The influence of how weight is portrayed in the media and in general was also highlighted as a possible way to address stigma "Alter the dialogue in the media" "the problem is that excess weight has become too normalised"

Below is a sample of what people said:

- *"There needs to be more understanding and education that people's metabolisms are different and my body did not like the carbs I was getting from fruit, oats, pulses and starchy veg"*
- *"People (both the public and health professionals) need to stop focusing on weight and start adopting a 'health at every size' approach. It is possible to be overweight and healthy"*
- *"same should be done in a general move away from being weight-centric (although perhaps this is different for very overweight individuals"*

- *"It is easy to say do more exercise but exercise needs to be more than just walking - a lot of us fatties walk a lot anyway"*
- *"being overweight is being more commonly accepted and even possibly glorified if anything when it's actually highly damaging!"*

Additional themes identified from the responses are:

3. Finding the motivation and confidence to lose weight (7.31%)
4. Addressing promotion of unhealthy food options (4.87%)

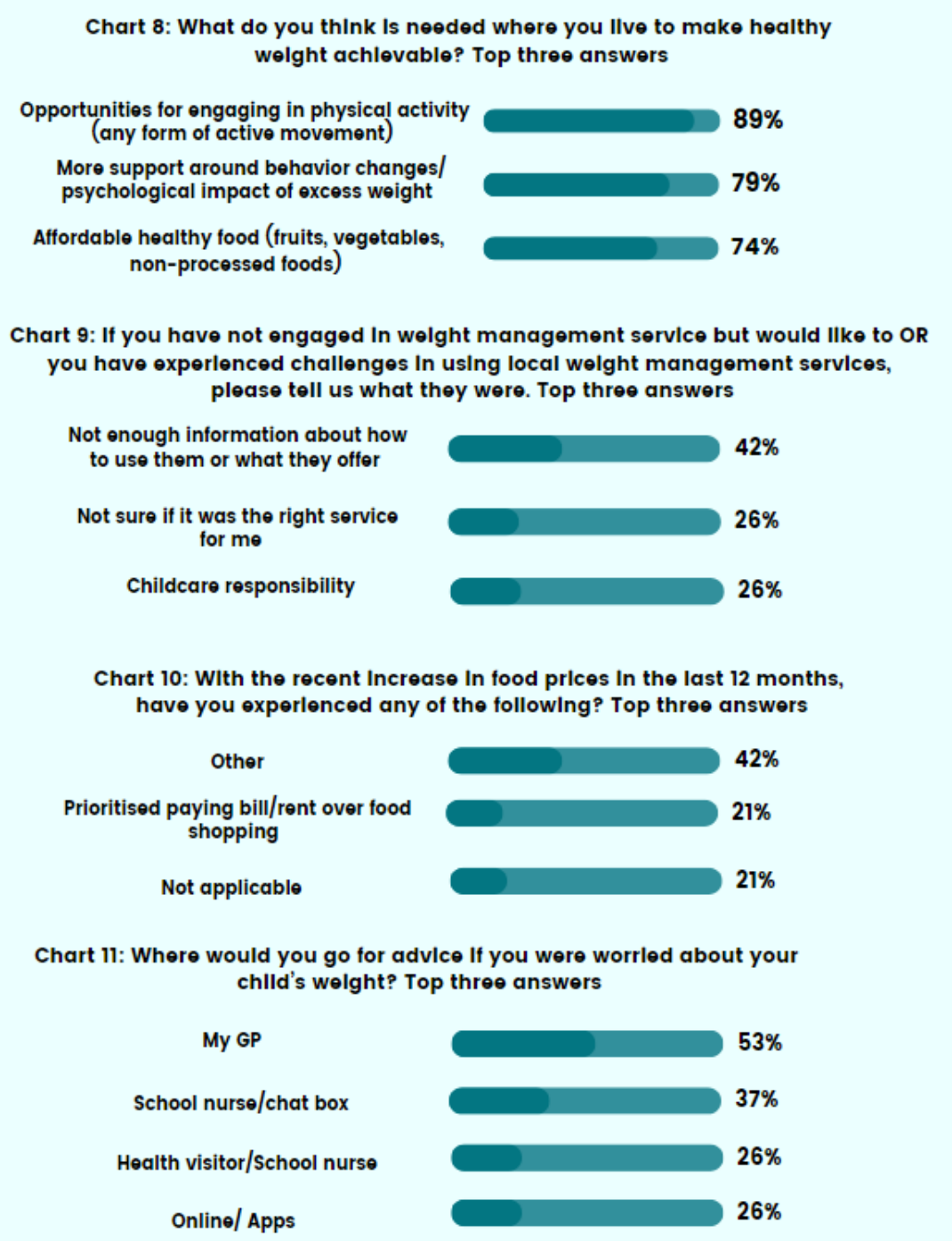
To see a full set of all the responses, please go to Appendix 12.1.

11.1.12 Analysis of ethnic minority responses

Due to the small proportion of people from ethnic minority groups, a subset of questions was looked at, filtering responses to examine the responses/ voices of people from ethnic minority group. This is detailed below.

The infographic below summarises the top answers from ethnic minorities to questions 1, 5, 12, and 18 (Appendix 12.1). Qualitative responses to 'Other' can be seen below the infographic.

Nearly 9 in 10 respondents from ethnic minorities think that more opportunities for engaging in physical activity are needed where they live to make healthy weight achievable, as opposed to more affordable healthy food: this was the highest response from all respondents. The second highest (79%) response to the same question among respondents from ethnic minorities was more support around behaviour changes/psychological impact of excess weight (Chart 8). In response to the question concerning challenges using local weight management services the highest (42%) response from ethnic minorities was that they do not have enough information about how to use them or what they offer (Chart 9). The highest response (45%) from all respondents was that they had not wanted or tried to use local weight management services.



Over 4 in 10 respondents from ethnic minorities answered *'Other'* to the question of whether they had experienced any of the following about the recent food price increase in the last 12 months. This compared to 41% of all respondents who said that the increase in prices had not affected them much or at all.

Answers to *'Other'* responses included increased prices had led to credit card debt, being more conscious about spending on food and buying cheaper options of fruits and veg even if the quality is worse.

Qualitative answers from respondents from ethnic minorities:

- **Question 1**: **What do you think is needed where you live to make healthy weight achievable? Tick all that apply**

Food poverty – *"offers vouchers to parents to buy just veggies and fruits and milk not just till the child is 4 and u stop giving them ,we really need is after they turn 4 ,when they try be picky or when they grow they want more foods ,we need at list till they are 14 or 16 years ,is when we should stop receiving the vouchers"*

Weight, stigma and mental health – *"Stop targeting bmi and support mental health"*

Continuous messaging and cultural norm – campaigns, innovation and variety of services

- *"Better education at school with respect to how to weight under control and cookery classes for all regarding of gender"*

- *"Continuous and ongoing but innovative promotion of health and wellbeing in the Town Centre needs to done"*

- *"It maybe resource intensive but the messages such as diet and healthy eating will become embedded".*

Addressing the food environment - No deliveries of fast food at all hours of the day and night

Access to support

- *"Greater availability and access to sports facilities especially swimming pools within Reading" "Make gym membership cheaper and accessible from adolescence. Create marketing campaigns for healthy lifestyles to promote healthier behaviours"*

- *"I've lost weight before and find it hard to maintain it. It would be good to have options available other than commercial weight loss services, as well as alternative method to access them whether, app based services, online and in person"*

- *"People need more 1 to 1 support or group support in their local area. Travelling somewhere is an extra barrier"*

Question which explored **Barriers to access** to weight management services. **Financial barriers where a key theme to barrier to weight loss**. Sample responses include:

- *"I tried and i lost some weight, now i keep doing some kind of diet but life style doesn't let me or lack of funds to keep going, bc i have 4 children with special needs"*

- *"Walking would be a better option for someone seriously overweight than the gym. Doesn't seem to be much on offer - or if there is I'm not aware of it"*

Struggle of maintaining weight despite being active or regularly trying to live a healthy life. Poignant quote: "*We are a product of our environment. Having a goal in mind is important too."*

When it came to where a resident would go for advice if they were worried about their child's weight *online search online; NHS 111 website where responses given.*

11.1.13 List of survey questions by theme

Healthy weight and service awareness

Are you trying to lose weight, or have you tried to in the past?

1. What do you think is needed where you live to make healthy weight achievable? Tick all that apply.

2. Should this action(s) be targeted at any particular group of people? Tick all that apply.

3. Do you know of local weight management services where you live?

4. Please list the services that you are aware of:

5: If you have not engaged in weight management service but would like to OR have experienced challenges in using local weight management services, please tell us what they were (tick all that apply)

6: Have you been told by a health care professional to improve your eating habits to achieve a healthy weight?

7: As a result, have you made any changes?

Covid-19

8: Have you or your family's eating habits changed since the Covid-19 pandemic and/or the cost-of-living crisis?

9: How has the Covid-19 pandemic influenced your and/or your family's eating habits? Tick all that apply.

Eating habits

10: Where do you eat most regularly? Tick all that apply.

11: If you are not eating at home most regularly, please tell us the reason for where you choose to eat most regularly (Tick all that apply)

Food crisis

12: With the recent increase in food prices in the last 12 months, have you experienced any of the following?

13: Have you ever used free food services (community kitchens, pantries, food parcels)?

14: If you have used free food services, how often have you done so?

Healthy weight and children

15: As a parent, what do you think is important/helpful in encouraging children to eat well at home? Tick all that apply.

16: Are there any broader actions outside of the home that might encourage children and young people to eat well? Tick all that apply.

17: What do you think would encourage children and young people to be more physically active? Tick all that apply.

18: Where would you go for advice if you were worried about your child's weight? Tick all that apply.

Physical activity

19: If you don't engage in much or any physical activity, what prevents you from doing so?

20: What do you think would encourage people to be more physically active?

21: Is there anything the local authority could do to encourage more physical activity?

Advertising and stigma

22: Would you like to see less advertisements for food high in fats, sugar and salt (such as burgers, fried chips and fizzy dinks) around town centers?

23: Have you experienced, or are you aware of, the stigma around accessing support for weight management? 'Stigma' is referring to "a set of negative and often unfair beliefs that a society or group of people have about something."

24: What do you think could be done to challenge this stigma? Tick all that apply.

Survey respondents' demographics

25: Are you responding as a parent of children under 18 years old?

26: Are you responding as an unpaid carer?

27: Are you: (gender question)

28: Which age group do you belong to?

29: Do you have a disability, long-term illness, or health problem (12 months or more) that limits your daily activities or the work you can do?

30: What is your religion or belief?

31: To which of these ethnic groups do you consider you belong?

32: What is your sexuality?

11.2 Professional Survey Results: Engagement with a wide range of Professionals working with people who may experience excess weight

11.2.1 Introduction

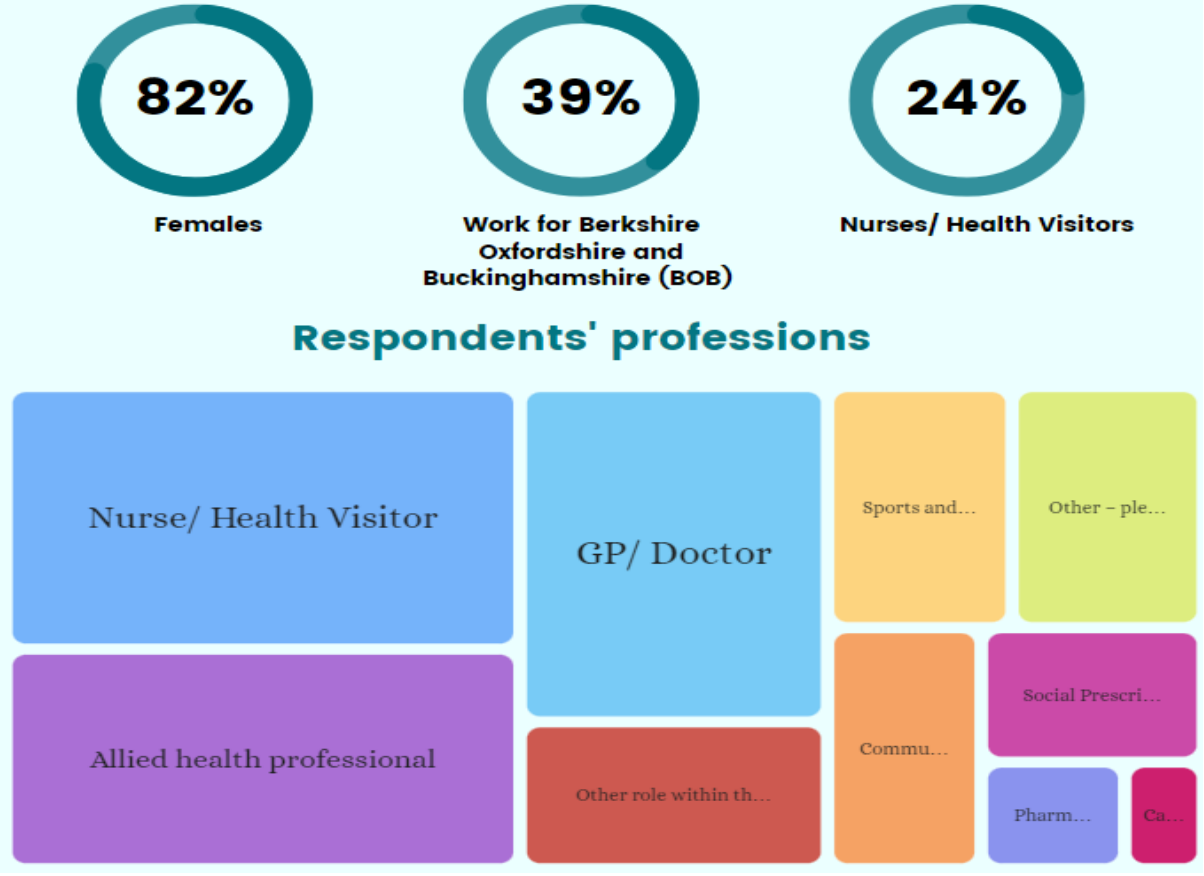
This 19-question survey was aimed at understanding the challenges a wide range of professionals face when supporting people to eat well, engage in physical activity and/ or supporting people who maybe experiencing excess weight. Those invited to complete the survey came from a range of backgrounds, including health care professionals, commissioned services and community and voluntary sector. The survey was open for just over a month, from 9th May to the 16th June 2023. 77 responses in total were received.

This chapter provides a summary of the key findings from this survey.

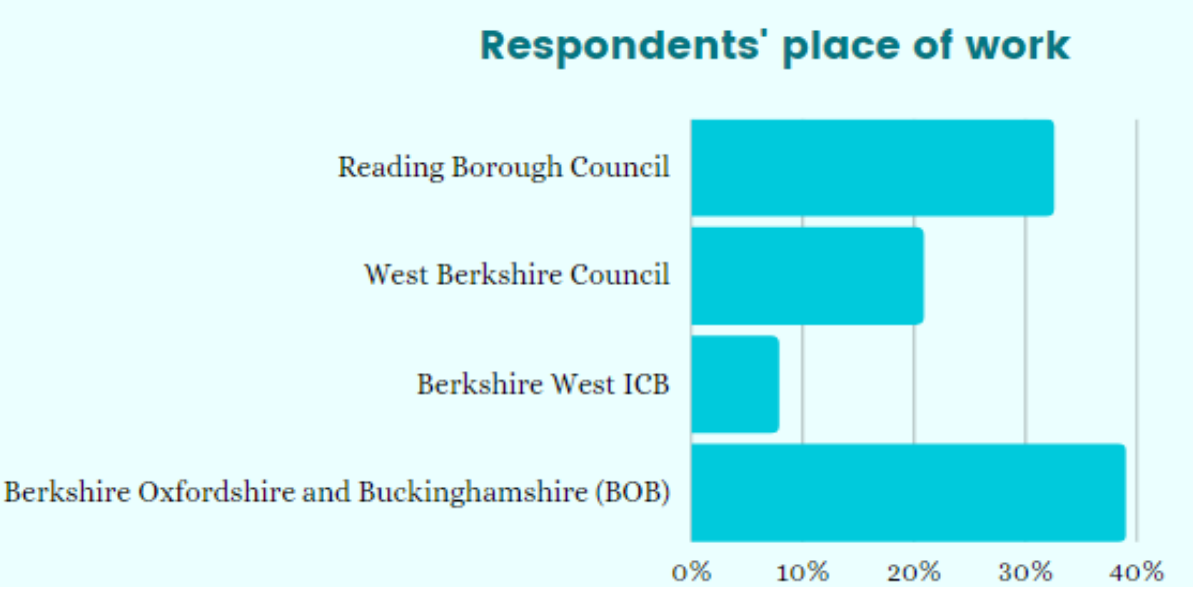
11.2.2 Respondents' characteristics

Most of the professionals who completed the survey were female (82%) and worked for the Berkshire Oxfordshire and Buckinghamshire Integration Board (39%) and Reading Borough Council (32%). The most dominant profession among the respondents was nurse/health visitor (23%). The second and third most prevalent professions were allied health professionals (19%) and GP/doctors (18%).

Infographic 11.3: Respondent characteristics



Infographic 11.4: Respondents place of work



11.2.3 Weight management services

The aim was to establish awareness of services and resources in the area, and to establish whether this awareness translated into referrals and/or signpost to services.

11.2.4 Signposting

Most professional workers felt they did signpost people to support their weight management.

Infographic 11.5: Proportion of professional signposting resident to services

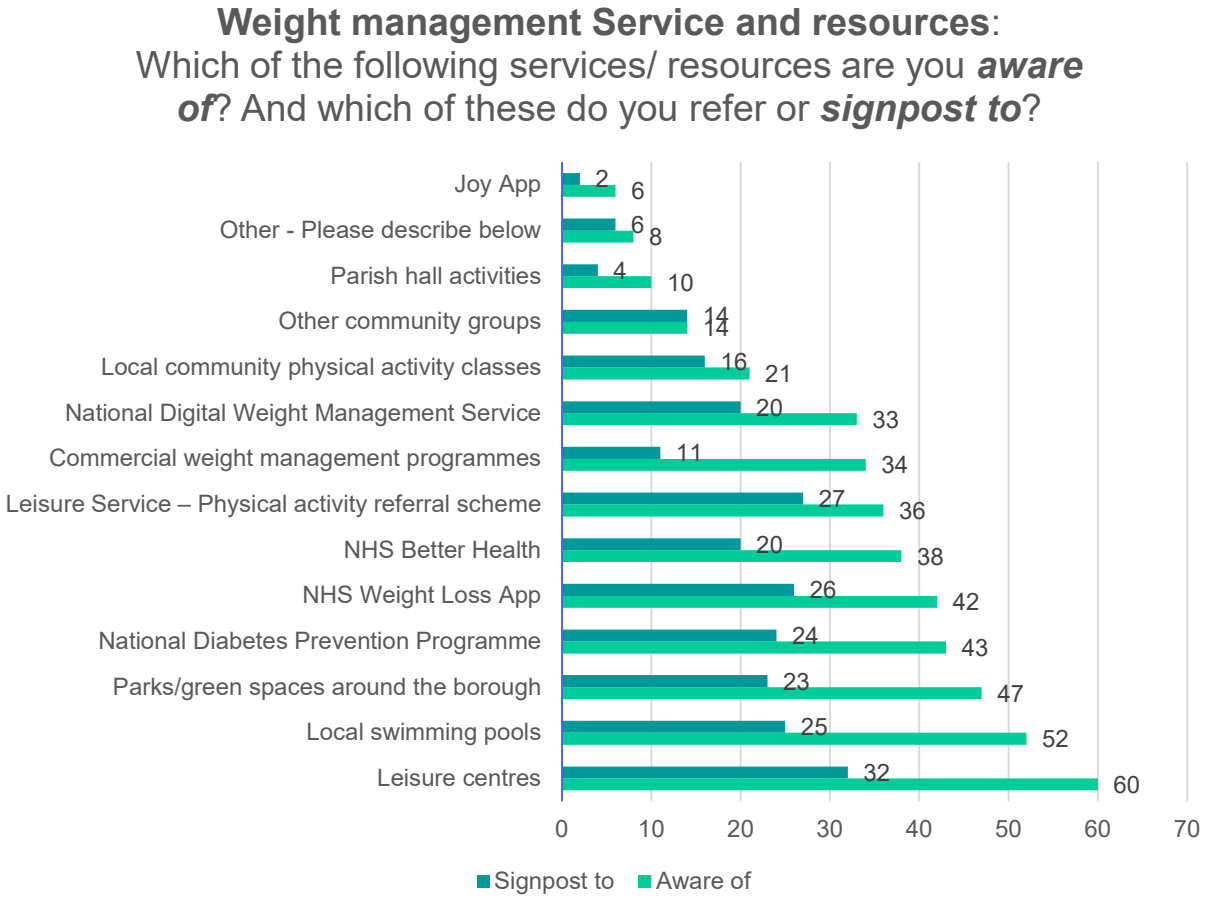
Nearly 7 in 10 professionals signpost people to services (i.e. national digital weight loss programmes, commercial weight management services, and physical activity services) to help them manage their weight.

The main reasons for not signposting people to services were not enough knowledge of what is available locally (12%) and no clarity on how to signpost people to the services in an appropriate way (8%). Some respondents answered that the services available are ineffective (5%) and that they would not signpost people to services because it is not appropriate for their role (5%).

Broadly speaking *awareness* was generally higher across all services and resources than *referrals and or signposts*, suggesting the workforce have awareness of at least some assets in the borough but more than awareness is needed to translate into action i.e. signposting or referring.

For example, in response to the question '*Which services and resources you are aware of*?' most respondents answered leisure centres (78%), swimming pools (67%) and parks and green spaces around the borough (61%). When they were asked '*Which services and resources do you refer or signpost residents to*?' most answered leisure centres (42%), leisure service/physical activity referral scheme (35%), NHS weight loss app (34%), local swimming pools (32%), and the national diabetes prevention programme (31%). The difference being half as frequent for taking action as it was for awareness for an asset.

Infographic 11.6: Awareness of resources signposting and/or referring residents



Some of the reason behind the barriers to signposting and referred was shared by 10 respondents and included:

- A gap in professionals' knowledge and competency to raise issue of weight and signpost accordingly. Combination of lack of awareness and capabilities around having the conversation around weight.
- Lack of Specialist provision was the most common theme, with specific reference to provision for Children and Young People, Prenatal and Tier 3
- One response highlighted the need to ensure everyone is clear that Whole Systems Approach is everyone's business. Though, there was also support for the opportunity to adopt whole systems approach to healthy weight.
- Challenge with opportunity to influence the right people – particularly for those who worked with children
- Lack of inclusivity – specific to people with learning disabilities but was also be extended to those that are digitally excluded.
- A few professional express concerns ineffective services
- A lack of time was a theme, in the sense of the time needed to establish trust with service users/patients but also for professional themselves to stay connected with the information available on service. A particular challenge when someone is on the front line.
- Lastly, competing priorities of their patients/residents was also a reason signposting/referral where not made.

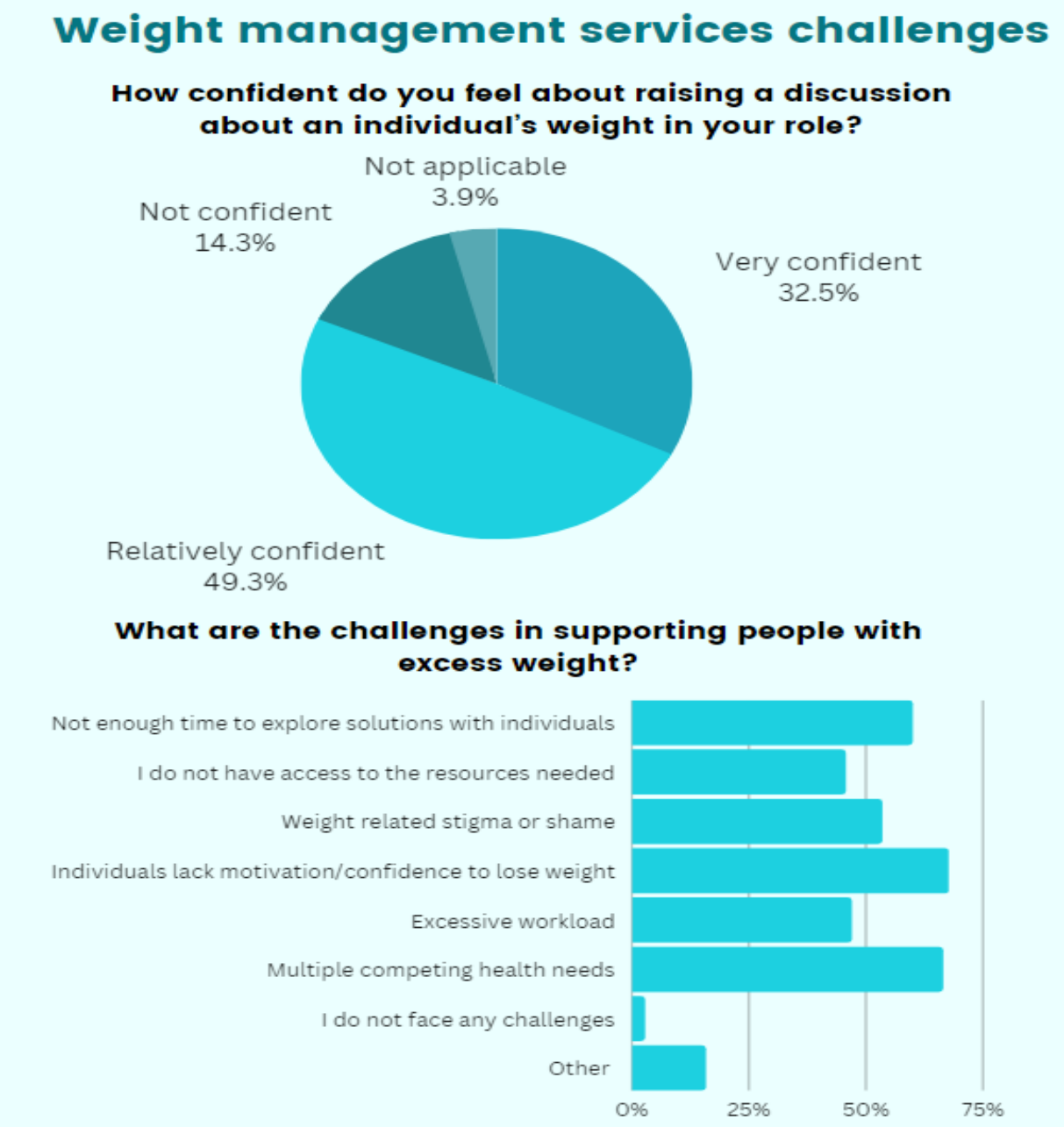
11.2.5 Raising the issue of weight

Opening a conversation about weight and health is deemed a key step to gauging someone readiness to make change and therefore support them on the journey to healthy weight, as stipulated in NICE guidelines[i].

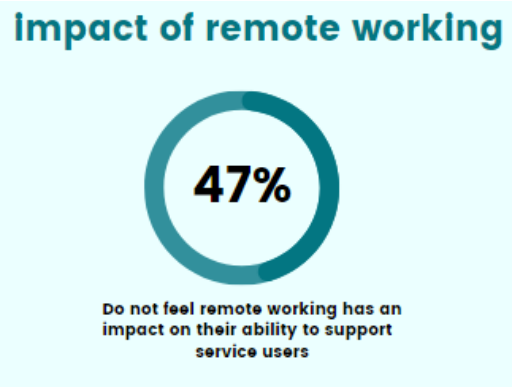
Nearly 5 in 10 respondents said that they felt relatively confident and over 3 in 10 that they felt very confident about raising a discussion around the patients/ service user weight within their role.

When they were asked about the challenges in supporting people with excess weight a large proportion answered Individuals lack motivation/confidence to lose weight (67%), Multiple competing health needs (66%) and not enough time to explore solutions with individuals (58%).

Infographic 11.7: Challenges with supporting individuals and weight



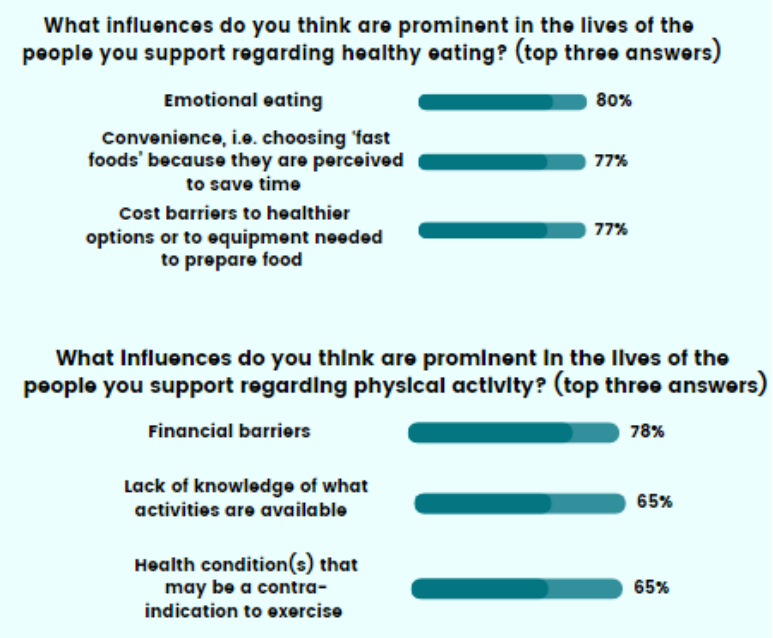
11.2.6 Impact of remote working



Nearly 5 in 10 of the respondents believe that remote working has not had an impact on their ability to support service users. **17% think that remote working has an impact on their ability to support service users** and the question was not applicable to the remaining (36%).

11.2.7 Healthy Eating and Physical Activity Influences

Eight in ten respondents said that emotional eating was the most prominent influence of unhealthy weight in the people they support. The other two most dominant responses were convenience (77%) and cost barriers to healthier options or to the equipment needed to prepare food (77%). In terms of what influences physical activity, most respondents said financial barriers (78%), lack of knowledge of what activities are available (65%) and health condition(s) that may be contra-indication to exercise (65%).



Infographic 11.8: Influences on healthy eating and physical activity

11.2.8 What support is needed to improve healthy weight

The last part of the survey contained five questions about what additional support is required to improve healthy weight under five broad themes which are:

1) weight management services,

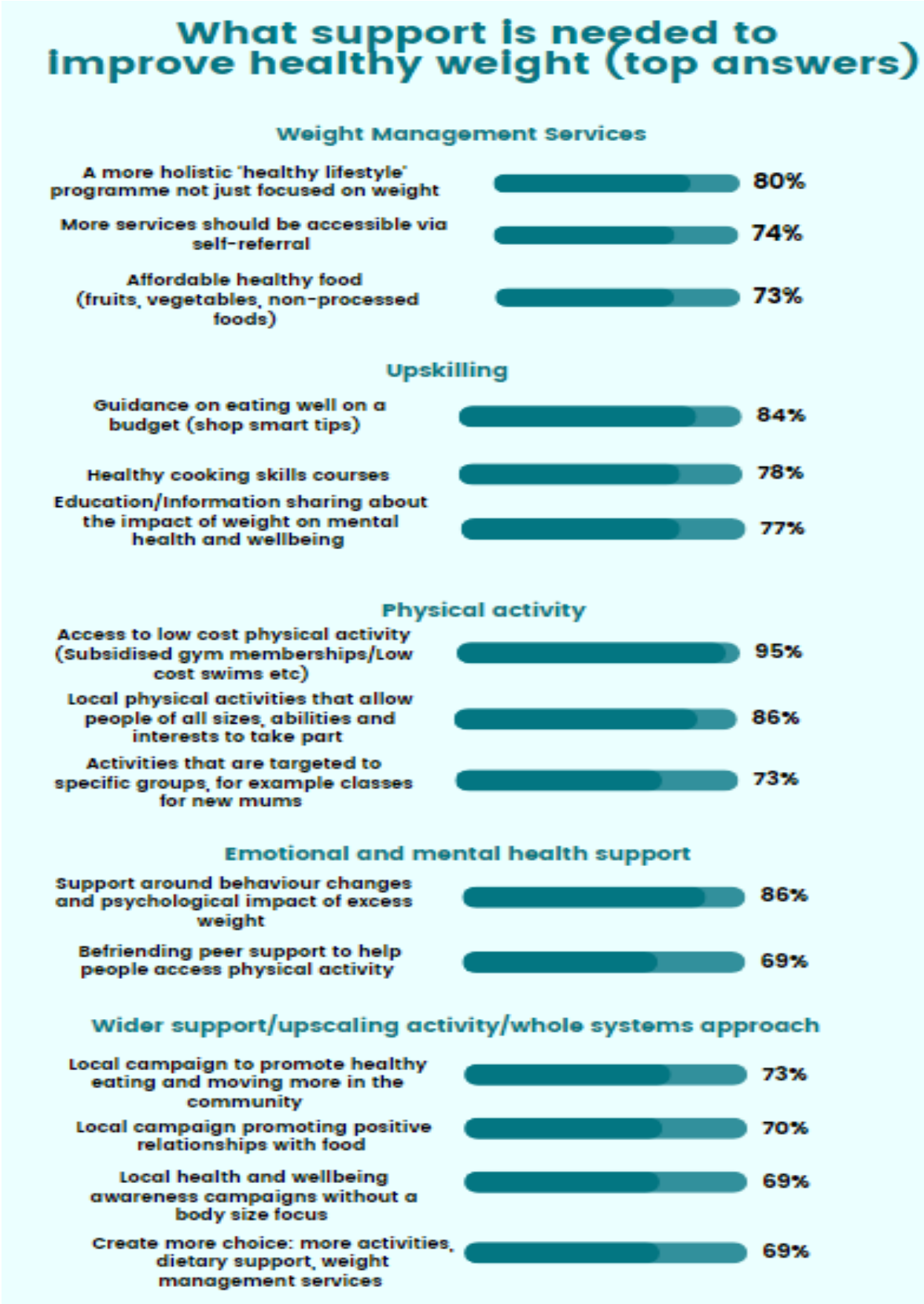
2) upskilling,

3) physical activity,

4) emotional and mental health support, and

5) wider support/upscaling activity/whole system approach.

The infographic 11.9 below summarises the top 2-3 answers given by the respondents under each theme.



Some key comments to highlight:

"Support not focused on weight that focuses more on moving and exercise, eating well and emotional health and wellbeing services"

"People generally know why and how to lose weight. They need support with motivation and commitment. *(This actually say more about the need to improve the environment, so motivation and commitment become the default option)"*

"Services need to be supportive and non-judgemental"

"I think a collaborative approach to wellbeing, healthy eating, exercise and mental health promotion would be really powerful. Taking the approach not just to do this for the individual themselves but also showing the positive impact it would have on their families"

"Awareness that 'self care' is not selfish but good for you and the whole family - gives permission prioritising living well"

11.2.9 Summary of Recommendation

Referral Pathway

- Clear Summary of pathway made available from Tier 1 to Tier 4. This would aid referrals and those who signpost to understand what services are available and to whom.

- Public Health, integrated care board (ICB) and Dietitian set up a working group to review pathway and explore what can be done to minimize some of the gaps. With particular urgency around the launch of Wegovy (Semaglutide) (*This is now in action since the development of this recommendation)*

- Work with service providers to reduce waiting times and improve access such as self-service.

Service provision

- Holistic, compassionate services which provide a variety of options including non-traditional weight management services including:

    - Exercise only groups (Tier 1)
    - Smaller groups
    - Age/life/gender course appropriate
    - Longer term support
    - Targeted specific cohort such as Learning Development

- Provision should be inclusive - Nneurodiversity, mental health, cultures, physical disability and ethnicity, particularly important when it comes to physical activity.

Training

- Upskilling workforce including adult social care, on eating well, signposting
- Making Every Contact Count or similar programs
- Support/training for carers including practical cooking session, not limited to carers also supporting those living in shelter/supported living accommodation.

Marketing and Communication

- Exploring ways to better connect service providers, including Community Voluntary sector CVS with HCP i.e. JOY app.

12. Appendices

Appendix 12.1 Full report: Healthy Weight Needs Assessment 2023 - Adults & Families survey

This report was created on Wednesday 21 June 2023 at 13:54

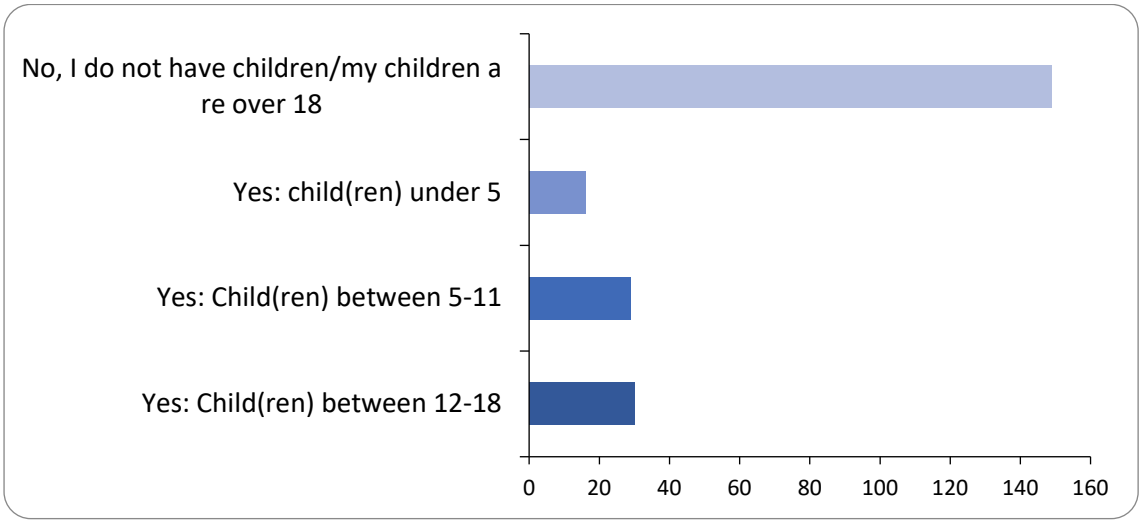
The activity ran from 05/05/2023 to 16/06/2023

Responses to this survey: **208**

Are you responding as a parent of children under 18 years old?

Respondents' category

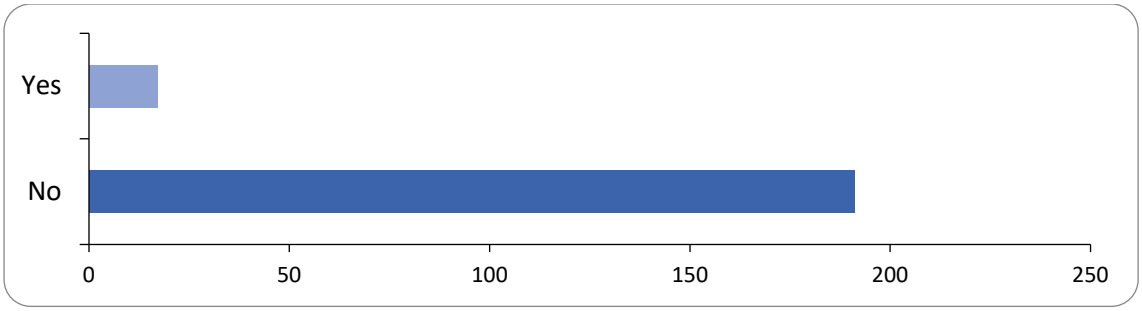
There were 208 responses to this part of the question.



Option	Total	Percent
No, I do not have children/my children are over 18	149	71.63%
Yes: child(ren) under 5	16	7.69%
Yes: Child(ren) between 5-11	29	13.94%
Yes: Child(ren) between 12-18	30	14.42%
Not Answered	0	0.00%

Are you responding as an unpaid carer? Y/N

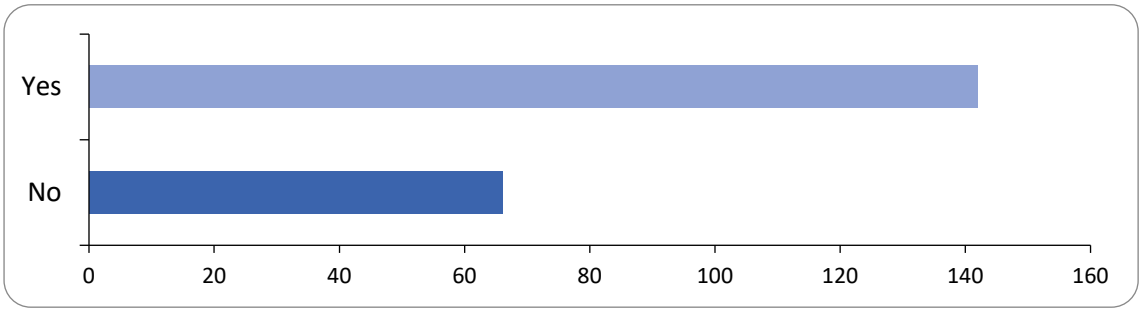
There were 208 responses to this part of the question.



Option	Total	Percent
Yes	17	8.17%
No	191	91.83%
Not Answered	0	0.00%

Are you trying to lose weight or have you tried to in the past? Y/N

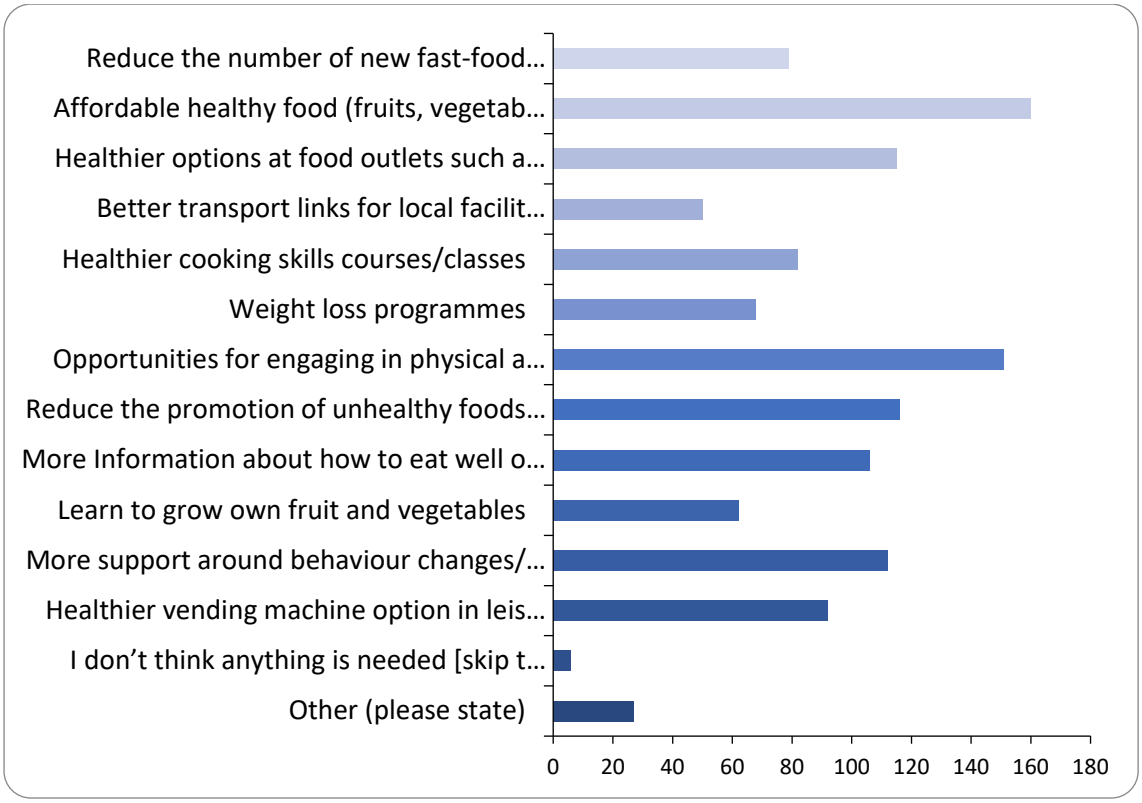
There were 208 responses to this part of the question.



Option	Total	Percent
Yes	142	68.27%
No	66	31.73%
Not Answered	0	0.00%

Question 1: What do you think is needed where you live to make healthy weight achievable? Tick all that apply

There were 208 responses to this part of the question.



Option	Total	Percent
Reduce the number of new fast-food outlets opening	79	37.98%
Affordable healthy food (fruits, vegetables, non-processed foods)	160	76.92%
Healthier options at food outlets such as cafes, coffee shops and restaurants	115	55.29%
Better transport links for local facilities	50	24.04%
Healthier cooking skills courses/classes	82	39.42%
Weight loss programmes	68	32.69%
Opportunities for engaging in physical activity (any form of active movement)	151	72.60%
Reduce the promotion of unhealthy foods - bus stops, billboards, sponsorships	116	55.77%
More Information about how to eat well on a budget (shop smart tips)	106	50.96%
Learn to grow own fruit and vegetables	62	29.81%
More support around behavior changes/ psychological impact of excess weight	112	53.85%
Healthier vending machine option in leisure centre, hospitals and other public spaces	92	44.23%

I don't think anything is needed [skip to question 3]	6	2.88%
Other (please state)	27	12.98%
Not Answered	0	0.00%

Q1 – Other please state

There were **54** responses to this part of the question.

More easily accessible and affordable sport and leisure options including swimming

There needs to be a shift of mindset in society generally. Excess weight is not a normal condition, and it shouldn't be normalised. It's a hugely expensive and growing challenge for an already overburdened health service. It can be very difficult for people to lose weight - or even for people to recognise that they need to lose weight, so education and support is vital. Encouraging the right behaviour that people can build into their lifestyle would be good, such as incentivising walking/cycling to work & school pickups etc. There also needs to be an emphasis on the quality of weight, not just the quantity. More media coverage of the health damage of being overweight could help, as well as showcasing places/countries where the % of the population that is overweight is far lower, like Japan. On a recent trip to Barcelona there were quite a lot of outdoor gyms that seemed to encourage more activity and strength training in the general population.

Online based self-help group with ideas for weight loss, cooking etc. plus opportunity for users to ask questions and seek support from fellow overweight people. Maybe daily exercise class online. Not everyone who is overweight or obese like going out or have limited means. Lots of carrots needed! Walking groups for slow walkers around Reading.

For hospitals to have more funding available to help people with weight management and the causes of obesity. It is not enough to tell someone to lose weight and send them on their way. Sometimes there is a psychological or physical reason why a person is overweight. This needs to be addressed and close monitoring and assistance given to the person. Sometimes an operation may be needed in order to give the person more mobility - not told you are too heavy for an operation. Do the operation and help the person get mobile and fit.

More vegan options and promotion of healthy diets

community garden would be helpful where people could grow and pick veg and fruit and interact with the community

A better understanding re emotional eating.

Affordable healthy food (e.g. vouchers for more people, community fridges in more locations, better wages) and more realistic work/ life balance that includes time for individuals and families to enjoy physical activity (e.g. low-cost memberships, green spaces, safe streets, clean and accessible parks/ pavements/ crosswalks, nutrition education in schools from primary through professional

training to GPs) call for structural change beyond obesity prevention. Moving onus to make health priority from the individual to societal is critical. Keeping onus on individual ostracises people who struggle with weight and will not promote their participation in interventions.

"Incorporate healthy choices into people's everyday lives. Encourage things that people enjoy and make their lives more enjoyable. For example:

- So many people would love to cycle as part of their daily lives but instead take the car as habit because cycling in Reading is frequently dangerous. We live in Peppard Rd, Caversham and it's not possible to safely cycle to Reading less than a mile away.

- Join up cycle lanes.

- Enforce the speed limit/highway code for drivers & prevent them running red lights to encourage more people to cycle.

- enforce parking limits around school"

offers vouchers to parents to buy just veggies and fruits and milk not just till the child is 4 and u stop giving them ,we really need is after they turn 4 ,when they try being picky or when they grow they want more foods ,we need at list till they are 14 or 16 years ,is when we should stop receiving the vouchers

No deliveries of fast food at all hours of the day and night

"Affordable/discounted/free gym memberships or exercise classes for those on low incomes. People really don't have much money.

Buddies to get people to places."

I've lost weight before and find it hard to maintain it. It would be good to have options available other than commercial weight loss services, as well as alternative method to access them whether, app-based services, online and in person.

"Surely these people need to take responsibility for themselves.

It's very easy to exercise i.e. go for a walk etc

It's also easy not to keep going to fast food places which is just being lazy. On the rare occasions I go to somewhere like McDonald's I am astounded by the number of people there, especially obese children

Those parents wouldn't want help, they must know it is wrong"

Safer, more direct, cycle routes across town

I have found that since I've taken on an allotment, I am more active and I'm making better food choices. As a result, I'm starting to lose weight. I also feel happier, which in turn also allows me to avoid comfort eating.

There needs to be more awareness of the issues associated with overweight and obesity. Warnings on packaging, posters detailing the harm of overeating.

Something like cigarette advertising. Every technology that is introduced encourages sloth and therefore weight gain - Deliveroo and the like, robot lawnmowers, electric scooters.

The "Nanny State," does not need replacing by a "Nanny council" for ever interfering with peoples' private lives & poking their noses into matters which are no concern of the councils or of the burgers who make up the Council.

"I achieved a significant weight loss through a local weight loss class. However, that class has now moved out of the area and others are not accessible to those, like me who do not drive.

I think local support for healthier lifestyle habits would make a different e.g. free/low-cost exercise programmes, weight loss groups, activity groups, gardening/growing groups."

Access to scales at places other than Boots, which aren't working and you can only use money.

More swimming pools open all hours

Prioritising cycling and other active travel options over cars

"I think you need to be more specific about what you want to achieve.

You seem to be mixing up weight-loss and fitness. Weight loss comes primarily from eating better. Fitness comes from exercise. Which one are you focusing on? I have assumed weight loss."

"Better education at school with respect to how to weight under control and cookery classes for all regarding of gender.

Greater availability and access to sports facilities especially swimming pools within Reading"

Support for very overweight people to access exercise classes and groups. Very overweight people feel too embarrassed to go to mainstream classes and groups because they know it will be full of very slim healthy people who ridicule and judge anyone overweight trying to get fitter

"Make gym membership cheaper and accessible from adolescence. Create marketing campaigns for healthy lifestyles to promote healthier behaviours

Stop targeting bmi and support mental health"

"Tackle the root cause: the defects of the political-economic system that takes resources from the many to feed the greed of a few due the believing the 16th century myth ""that Anything that boosts the profit of Anyone (of your sponsors) must create wealth for All - despite businesses getting subsidies for not compensating all harmed by their activities.""

If the council is not prepared to correct the political-economic system a simple byelaw to Require all sellers / importers (e.g. Amazon) to take reasonable steps to

ensure what they sell does not harm customers, workers, society or Our Life-Support System - the Environment - would work.

People hold on to excess weight to protect themselves from the toxins they can not process due to lowered immune vitality caused by negative thought programmes & exposure to stressors like poverty & emr - so

Use healing music instead of ""News"" in shopping malls & public spaces."

"Healthier food in schools!

Healthy food is affordable for most people, and there's plenty of info on cooking skills online. But families who are struggling financially and with weight may struggle to afford and access healthy food, or to cook proficiently. Lack of time probably plays into this, so focussing on fast but healthy food options would be good. Likewise, encouraging healthy options in local shops will improve accessibility.

Reducing alcohol intake may help some people."

More affordable & easy to access healthy living (eating & exercise) options should be made available.

I live in a food desert. Sometimes I feel I use Deliveroo because I don't have any nearby food shop

Educational awareness regarding healthy eating and how to cook in schools, hospitals and colleges. Eating disorders are at an all time high and there is virtually no educational awareness and access to help in the community locally.

Better provision for cycling / walking.

Affordable local facilities...pools and gyms

Make cheaper options for engaging in physical exercise and release more personal time off to be able to take up these options,

Greater active travel encouragement and facilitation.

The promotion and enablement of healthy eating/exercise as a joyful thing rather than the policy of disapproval and negative attitudes towards ‘unhealthy’ eating/ habits.

"People need more 1 to 1 support or group support in their local area. Travelling somewhere is an extra barrier.

Persistent reminders needed to be healthy."

"I think the work should be put in to stop people getting overweight. Once you are obese it is really difficult to lose weight.

So, for example primary school children should walk to school (unless extenuating circumstances).

Bus prices should be subsidised to decrease use of cars - and car parking costs increased.

Everything should be done to encourage more exercise.

Increase taxes of calorie intensive snacks

Until we have legislation, we will not have a slimmer population"

Affordable subsidised/off peak gym memberships - I am over 70 and would like a gym membership but £20+ per month is just not doable on a state pension

Weight management and healthy lifestyle coaching sessions

Reduction of poverty and better funding for the NHS and social care

"Healthy alternative snacks in pubs e.g. low-salt nuts and crisps.

Publicity campaign and tax on throw-away packaging e.g. cardboard boxes and cups which are rarely recycled.

Totally ban advertising of all high fat/sugar/ salt foods e.g. crisps, fizzy drinks, burgers."

It's a really difficult one but certainly a lot more education around why weight gain can cause significant co-morbidities.

"It is obvious that allowing on screen publicity for unhealthy food and drinks is a direct challenge to any attempts to encourage healthy eating.

However, the power of the companies that sell unhealthy food is such that our government fails to implement effective legislation time and again."

"Continuous and ongoing but innovative promotion of health and wellbeing in the Town Centre needs to be done.

It maybe resource intensive but the messages such as diet and healthy eating will become embedded"

Would love there to be more low sugar / healthy treats available in cafes rather than cakes.

Make it possible to cycle instead of drive - e.g. cycle lanes. Make it mandatory for new / refurbished shops to have a bike stand within 100m for example

Encourage less car use/more walking

"Cheaper access to fitness

Better education in schools

Centralised website on (a) healthy diet (b) weight loss options as not everyone does sensible research and lots of contradictory information so an unbiased source with pros and cons would be good"

"Encouraging people to walk more will help people to lose weight - so reducing traffic and encouraging cycling, as the council is doing, is great. Walking beside traffic clogged roads is neither pleasant nor healthy. Maybe a 20mph speed limit throughout Reading would help?

More green space is essential too - people eat when they are stressed, and green spaces help reduce stress, and also encourage physical activity. Reading has a lot of roads with terraced housing without front gardens or with very small gardens - they, and all the new flats planned for Reading, especially need public green space within walking distance, and which is accessible without having to walk beside or ideally even cross busy roads.

The allotments where the Civic Centre used to be where a great addition of green space to a part of the town with little easily accessible green space!"

Above all, we need healthy food to be both affordable and convenient to access. It must be cheaper than the fast-food convenience options. When there are money and time pressures, people will go for the cheap, carb-rich, option that quickly fills you up (fast-food) and the option that is available to them easily due to location. Where I live in East Reading, the area within easy walking distance of where people live is dominated by fast-food outlets, not big brand name ones, but local fish and chip shops, pizza shops, fried chicken shops, kebab shops, burger shops/restaurants, greasy spoon cafes.

"Healthy foods are already affordable. They certainly cost less than eating fatty takeaways all the time.

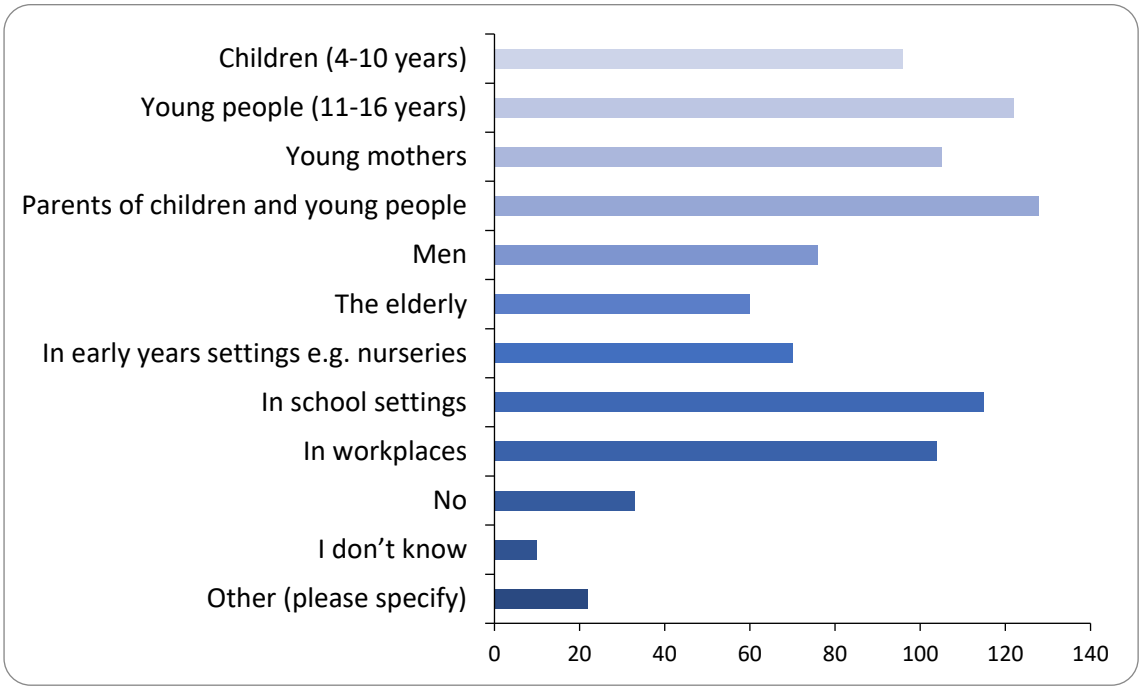
As a taxpayer who is a keen keep fit addict and active sports person, with two teenage kids who are the same, I don't want a penny of my taxes spent on helping fat people lose weight. There is plenty of information and opportunity already available but for reasons known only unto themselves they just don't follow it."

Better NHS support for high BMI

Support for families to ensure they are not feeding their children and themselves food that is making them ill in the long term. Better quality ingredients for school and hospital meals. A move away from so much meat and dairy in these meals and a move towards healthier options that are not just focussed around legumes!

Question 2: Should this action(s) be targeted at any particular groups of people? Tick all that apply – See comment in Red below regarding missing 'women' as an option

There were 208 responses to this part of the question.



Option	Total	Percent
Children (4-10 years)	96	46.15%
Young people (11-16 years)	122	58.65%
Young mothers	105	50.48%
Parents of children and young people	128	61.54%
Men	76	36.54%
The elderly	60	28.85%
In early years settings e.g. nurseries	70	33.65%
In school settings	115	55.29%
In workplaces	104	50.00%
No	33	15.87%
I don't know	10	4.81%
Other (please specify)	22	10.58%
Not Answered	0	0.00%

Q2 - Other (please specify)

There were **32** responses to this part of the question.

Everyone

You have Men listed as an individual choice. You do not have Women listed in the same way. To choose Women you need to choose young mothers - Are women only classed as young mothers? Bit of an oversight and discriminative description I think.

Women going through the menopause

In the school they already have loads of choices to choose

Certain cohorts who find it difficult to lose weight because of the medication that they are on, low self-esteem etc… e.g. SMIs and ASD where specialist help is required

I find this applies to all groups

"Across all ages but start young - prevention is easier that to try to lose the weight or change engrained behaviours - not impossible but hard

Ethnic minority groups"

All

I think this should be targeted to all adults, mainly younger, parents and children.

See above

As many people as possible.

I don't think they should be targeted at any particular group, as this may exclude others outside of that target audience who also need help.

ALL THE POPULATION NEED INFORMATION

All

It will depend on the type of service.

Menopausal woman most likely need to change lifestyle.

"Which overweight people are you concerned about?

Is it young people? Is it poor people? Is it fat cat bankers with private health insurance?

If it is anyone who is overweight then it is hard to be focused with your actions."

Very overweight people not just those who need to get ‘summer ready’ or to lose a few pounds

Business owners as they are the ones who co-create the obesity by putting addictive substances like fat, sugar & salt in their products so they can sell more to extract more profit from customers wanting to feel better.

The elderly often struggle to access healthy food for completely different reasons – sometimes poverty, but often declining skills and mobility. There's probably no easy fix here.

No specific group ... we **all** need a healthy diet.

"Anywhere the statistics show are problem areas.

Workplaces are awful- people bring in unhealthy food to share plus stress equals bad eating all day."

I think targeting teens may increase body image anxiety so I agree with primary school work - but not secondary school.

People on low incomes tend to eat more (cheaper) unhealthy food and would benefit from being able to access fitness equipment/classes

people who are low-income and who cannot access support privately

Should be targeted at all age groups

Women

I think younger to help set healthy eating for life but also applicable to other age groups, particularly as dietary needs change and access to food may be more of an issue.

"Everyone

And why are you stating young mothers and men as opposed to young fathers and women. Sexist much?"

"It is hard to give an answer just using the tick boxes above because some actions cannot be targeted and/or they can benefit all, e.g. Reduce the number of new fast-food outlets opening; affordable healthy food (fruits, vegetables, non-processed foods); Reduce the promotion of unhealthy foods – bus stops, billboards, sponsorships...etc..

Whereas some actions (i.e. those that will cost more to implement and/or may have differential benefit in different groups) could be targeted to achieve best impact/value for money. For example, actions that involve giving people improved knowledge and skills, e.g. Healthier cooking skills courses/classes; More Information about how to eat well on a budget (shop smart tips) - these would give most benefit if targeted at children and young people, and parents of children and young people to help form patterns of healthy behaviour in early life, as a building block for lifelong healthy weight.

But simply providing knowledge and skills is not sufficient, as the environment we live in/ financial pressures people have can still make it difficult for people with the healthy eating knowledge and skills, to actually eat healthily and maintain a healthy weight if the healthy food options or the physical exercise opportunities are not affordable or not available in their location. Actions need be part of a holistic strategy to make the environment one which supports healthy weight. It will cost money, but it is worth doing, as the long-term benefits on health (and thus reduction of the massive burden on NHS which obesity poses both directly but also in terms of increased risk of other disease such as diabetes, stroke, cancer etc.) could be huge."

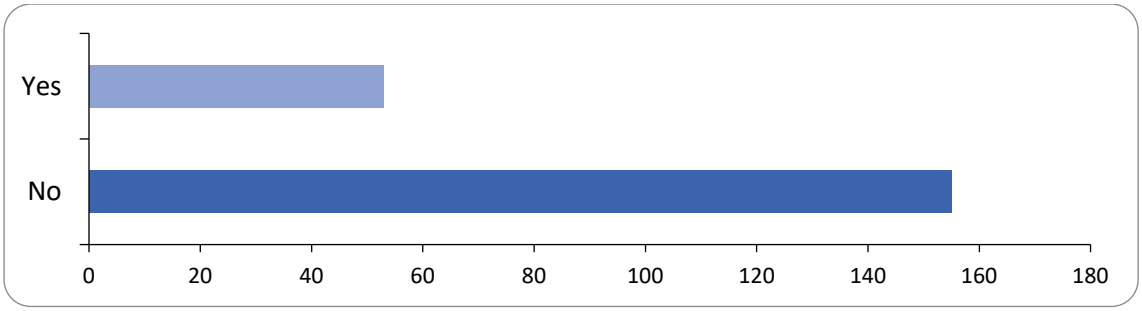
"Workplaces are important for this as many of us spend more time at work than at home each day. Changing workplace culture for proper, well-spaced breaks to eat sociably at work, sitting down, away form the job.

Eating unhelpful types of food, with nowhere to do basic prep. (therefore processed foods all too useful!) in a rush, too late (already over-hungry) and on the go are all factors known to be bad for us. Employers might quite possibly find that sickness rates and productivity (in the NHS, even patient safety!) would improve, if better quality meal breaks were facilitated and some of the factors which force poor eating habits were addressed."

Everywhere and in hospitals

Question 3: Do you know of local weight management services where you live?

There were 208 responses to this part of the question.



Option	Total	Percent
Yes	53	25.48%
No	155	74.52%
Not Answered	0	0.00%

Question 4: Please list the services that you are aware of.

There were **208** responses to this part of the question.

NA

None

"Better gym healthwise

GP service"

Not aware of any, but I haven't searched.

"Slimming World

Programme at local gym"

"Slimming World

Weight Watchers

Noom

Healthwise at Rivermead"

unaware

"NHS programme via GP

Weight watchers / Slimming World type meetings advertised locally"

Second nature and noon . Weight watchers

None

"Weight Watchers

Slimming World"

Weight Watchers, Slimming World

Not aware

None

weightwatchers but never attended

Slimming world

Various diet groups and GP surgeries offering courses.

"Healthwise/ weight management at Rivermead, Meadway, etc (Better leisure centres)

Support via NHS surgeries

School nutrition via caterer services

Various community exercise offers (community centres, church halls, charities like Sport in Mind)"

Slimmimg World

Did one at a leisure centre and lost weight healthy eating.

N/A

I am not aware of any services.

"GP can refer us

and NHS websites

eat for heath too"

"Slimming world

Weightwatchers"

Not aware of any

GLL

n/a

Slimming World but it would be good to have other options and specific options e.g. tailored to elderly, men etc where the generic offer may not be suitable.

slimming world

Not overweight so haven't looked into what services are available

Weight watcher. Slimming world. Cambridge diet

Slimming world

N/a

None

I answered NO to above so not sure why I need to put something here?

None

I'm not aware of any

None

gym

"Slimming World

Weight Watchers"

N/a

none

I assume WeightWatchers (WW).

None

How can I list services of which I have just indicated I am not aware? Even by the standards of this council that is pretty stupid.

I am jot aware of any services regarding weight loss

None

I don't know

none.

none

Weight watchers

Slimming World The Hill School

None

N/A

"WEIGHT WATCHERS AND SIMILAR

Doctors surgery sessions

Hospital info and classes -post op et

schools lessons"

None

None

NA, I educate myself from Online resources. Or, any gym has PT's who should be able to educate clients.

SW at the Avenue School

None

None

None

Don’t know any

N/A

I don't know

None

None

None

"Weightwatchers

GP Run"

none

None

Wellbeing Wednesdays at Whitley Community Cafe, Northumberland Avenue.

N/A

?

none

slimming world, WW

N/A

I haven't used any but have heard of weight watchers etc

NHS Living Well Taking Control

Nothing council run.

Na

"No council services that I know.

Joe Wicks - the Bodycoach app

Weight Watchers

Slimmers World"

not aware of any

none

None

Do not know of any weight management services

Only commercial ones like weight watchers and Slimming World which cost a fortune

Not aware

"I suspect I don't understand question 4.

In Q3 I answered no, and so logically since I said I don't know of any services this answer to Q4 will be blank. Yet I'm required to write something here.

Or, I've misunderstood the question."

"Slimming groups are scams, please show me evidence of how anyone had kept off weight long term.

Make healthy food accessible for all. Make exercise free to reduce the strain on then NHS

Discouraged social media with unrealistic body types"

None

"There is a Weight Watchers group - that uses guilt to get people to loose weight.

There are private hypnotherapists that can help."

"NHS dietician

Weight watchers online service."

none

None

Not aware of local options, but generally aware of things like weightwatchers and exercise like Couch to 5k and park run.

not known

I don't know any, weightwatchers?

Not aware of any

i am not aware of any

None

Not aware of any.

None

Better UK

None

None known

"Weight watchers

Slimming world"

None that I'm aware of

weight watchers

None

I have seen slimming world posters in my local area with meetings at a few different locations locally

"Weight watchers

Slimming world"

I said no!

I don't know of any other services other than wright loss programmes via my GP- not applicable for myself.

"Courses, activities at leisure centres

Local slimming groups

GP"

Slimming World, online Weight Watchers.

I don’t know about any services

NA

None. The GPs just say eat less.

None

Not aware of any

Unaware

Not aware of any. Don't know if you include weightwatchers but that disappeared at start of pandemic and I don't know if it is back. That wasn't nearby anyway.

Not aware local groups

None

n/a

None

I am not aware of the services as neither I nor any of my family members have had weight control problems so far.

But I am aware of the Palmer Park Leisure Centre which gives opportunity for physical activity through swimming and the gym

Not aware

Weight Watchers

None

Na

"Weight watchers

GP/NHS services, but only for the morbidly obese"

None

Doctor's surgery, but not sure if they still do it.

Weight Watchers, Dieticians

N/a

None

None. (Southcote)

"Slimming world

Weight watchers"

Exercise work outs at Palmer Park leisure

Currently waiting for an appointment with the health and wellness person in my doctors surgery.

Advice Citizen Bureau

N/A

Nothing

No idea

NHS; programmes such as Weight Watchers and other branded support groups

none

As advertised in doctors' surgery.

Slimming world at the British legion

None

None

I do not know of any

Local Gym, Local GP, Own friend networks.

Not aware of any services

I don't know of any.

Weight Watchers

Not aware

Weight watchers (maybe??)

"Not too sure what you class as ‘services’

Slimming clubs? Commercial slimming companies

Weight watchers

Slimming world"

Slimming World

I have replied "no" to Q 3.

Videos and posters in GP waiting areas

I am not aware of any services

None that I am aware of

"Weight watchers

Sliming world"

NONE

NHS health program

N/a

None

Slimmers World; Weightwatchers

None

none. The GP just says eat less

Weight watchers

Diet & exercise groups/outside gym equipment

NA

"Slimming World classes

Weightwatchers"

None but not looked

Slimming world

"Weight watchers

Slimming world"

I am not aware of such services

None

Weight watchers, Slimming world, local sport centres and their services. personal trainers, FB groups, mobile apps etc

None

None

None

I'm not aware of any services

N/a

"Slimming World

A lot of services seem to be better suited to people with regular working hours, though. So many of us who struggle to plan meals and eat healthily cannot be available for a regular, weekly slot/appointment"

Weight watchers

Not known

"Weight watchers

Slimming world"

None

I don't know any, didn't know there were any local services for weight management

"I'm not aware of any and I don't need to be. It's easy to take exercise, buy and cook decent food, and avoid takeaways.

If calories in are more than calories out, you will get fat. It really is that simple!"

None.

"Slimming world

Weight watchers

The gym"

"slimming world

1:1 Cambridge diet

Through GP

Bariatric Service at the hospital."

none

none

Slimming world, weight watchers, NHS programme

"NHS funded nutrition sessions to help with weight loss

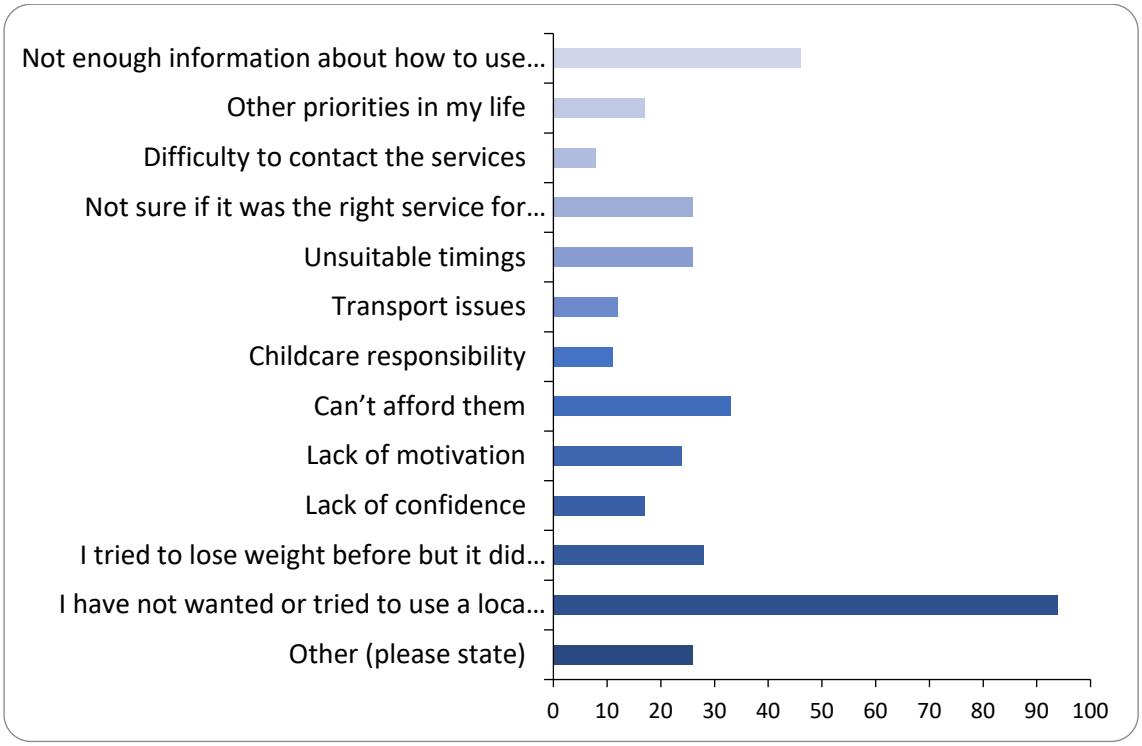
Subsidised and free exercise sessions run by Get Berkshire Active to assist with weight loss"

None

Slimming World

Question 5: If you have not engaged in weight management service but would like to OR you have experienced challenges in using local weight management services, please tell us what they were (Tick all that apply)

There were 208 responses to this part of the question.



Option	Total	Percent
Not enough information about how to use them or what they offer	46	22.12%
Other priorities in my life	17	8.17%
Difficulty to contact the services	8	3.85%
Not sure if it was the right service for me	26	12.50%
Unsuitable timings	26	12.50%
Transport issues	12	5.77%
Childcare responsibility	11	5.29%
Can't afford them	33	15.87%
Lack of motivation	24	11.54%
Lack of confidence	17	8.17%
I tried to lose weight before but it didn't work/ I couldn't keep it off	28	13.46%
I have not wanted or tried to use a local weight management service	94	45.19%
Other (please state)	26	12.50%
Not Answered	0	0.00%

Other please state

There were **36** responses to this part of the question.

Haven't used a local weight management service. Monitor my own weight and simple equation to lose weight is more energy out and less energy in.

Health issues

Not particularly accessible to people with mobility difficulties (getting onto and off of scales)

i tried and i lost some weight, now i keep doing some kind of diet but life style doesn’t let me or lack of funds to keep going ,because i have 4 children with special needs

Walking would be a better option for someone seriously overweight than the gym

I did do a course via the NHS on healthy lifestyles. It was great but needs long term and on-going support to keep motivated

Doesn't seem to be much on offer - or if there is I'm not aware of it.

I know what I need to do but don't always have the willpower.

No need - keep active and eat healthy (most of the time)

Various organizations kept closing down their services. I am doing better by myself.

There was a good weight management service in Lower Caversham that was very well attended, but it has now been moved to Emmer Green and is not easy to get to if you don't drive. There is now nothing like it in Lower Caversham.

I don't need to lose weight, if anything I'm slightly under weight

Have used NHS online support

Previous experience with them when I was diagnosed with type 2 diabetes was pointless as my problem is inability to exercise and not enough money to afford swimming/ gym membership

"Did not have the energy/discipline to make eating healthier part of my everyday routine.

I'm doing well now though."

Fed up of being judged by very thin women who think that all you have to do is stop eating cakes

I am aware of the dietitian because my husband is type 2 diabetic and has appointments. I have used weight watchers myself in the past.

Didn't know they existed and I doubt they're targeted at my social/economic group. I'm not entitled to any benefits so imagine this would be yet another chargeable service that I'd have to pay for.

I have seen my doctor who assessed that I have a binge eating disorder- I am 60 years old and have dieted the whole of my adult life. I am not overweight at the

moment but have yo yo'd between being underweight and putting the weight back on. I am now aware that this is linked to my mental health and have requested counselling services for this disorder from my GP. Suffice to say to get a referral will take up to a year!!!! In the mean time I am left to continue to educate myself and deal with my disorder alone. It is quite frankly an absolute joke!!

Used to go to WW but don't know of anything around here now.

Neither my family members nor I have had weight problems.

N/a

Never seen any of these services advertised.

"Personal motivation is important as well as support from family to prompt a visit to the gum or healthy eating at home etc.

We are a product of our environment. Having a goal in mind is important too."

N/A I have never tried/wanted

I was able to lose the weight myself with the support of an organic fruit and vegetable delivery service - this worked very well for me and continues to do so, but then I am luckily able to afford this.

Luckily, I've been 10st. 7lb. all my life and don't need to lose weight, just try to keep healthy...I've just retired.

I attend

Unaware of this service

I am not overweight

I walk everywhere - an average of 20 km per week keeps my weight steady but still overweight

In the past I have used Weightwatchers and Rosemary Conley classes

does not apply. I don't need to lose weight. I love exercising and am a very active person. It is important to me what I and my family eat at home.

Diets do not work and can lead to lifelong issues with disordered eating and altered metabolism. We should not be promoting dieting, but should be promoting gentle, daily activity that is sustainable. The cost of quality fruit/veg/meat is also an issue.

i don't know of any

"Have tried on my own in the past:

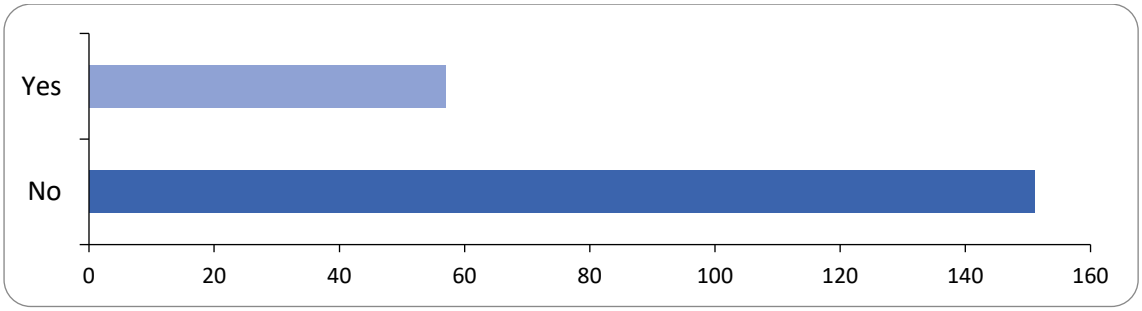
Cambridge diet

5:2 intermittent fasting

Slimming world -recipes from magazines/newspapers"

Question 6: Have you been told by a health care professional to improve your eating habits to achieve a healthy weight?

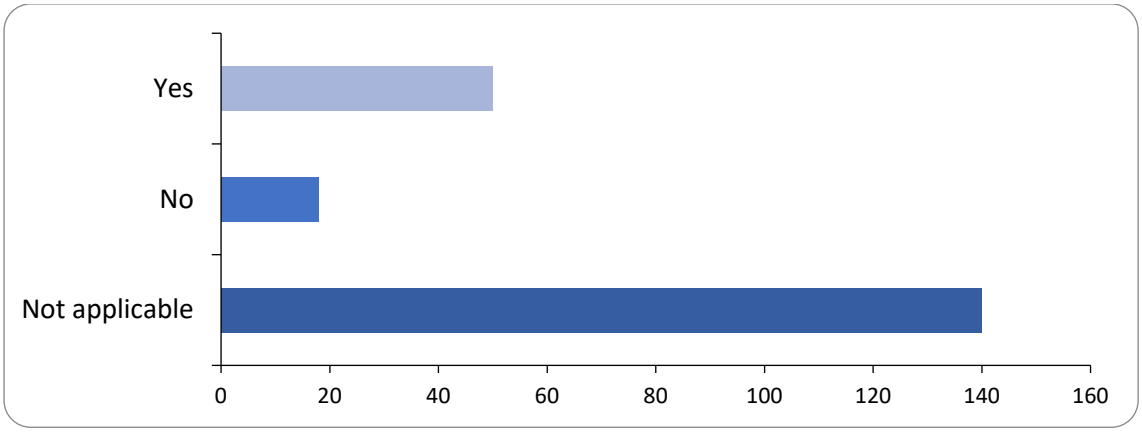
There were 208 responses to this part of the question.



Option	Total	Percent
Yes	57	27.40%
No	151	72.60%
Not Answered	0	0.00%

Question 7: As a result, have you made any changes?

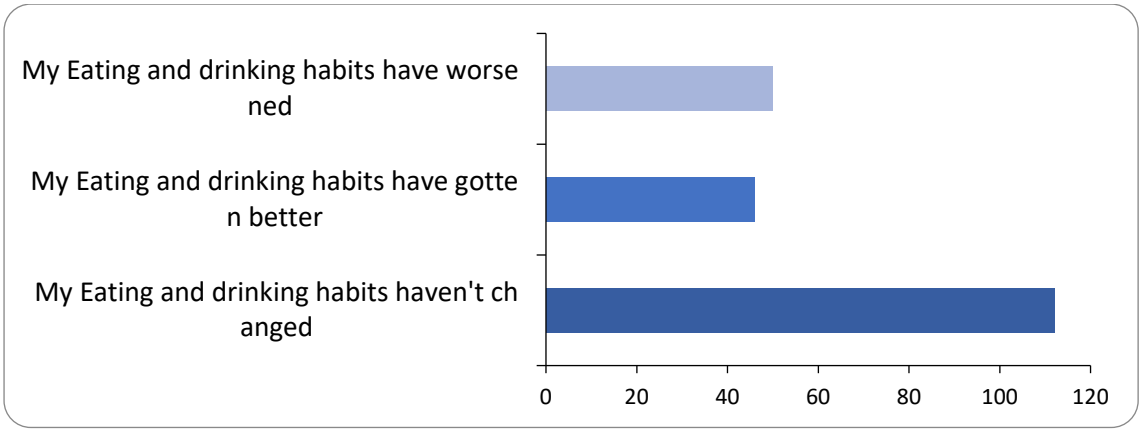
There were 208 responses to this part of the question.



Option	Total	Percent
Yes	50	24.04%
No	18	8.65%
Not applicable	140	67.31%
Not Answered	0	0.00%

Question 8: Have you or your family's eating habits changed since the Covid-19 pandemic and/or cost of living crisis?

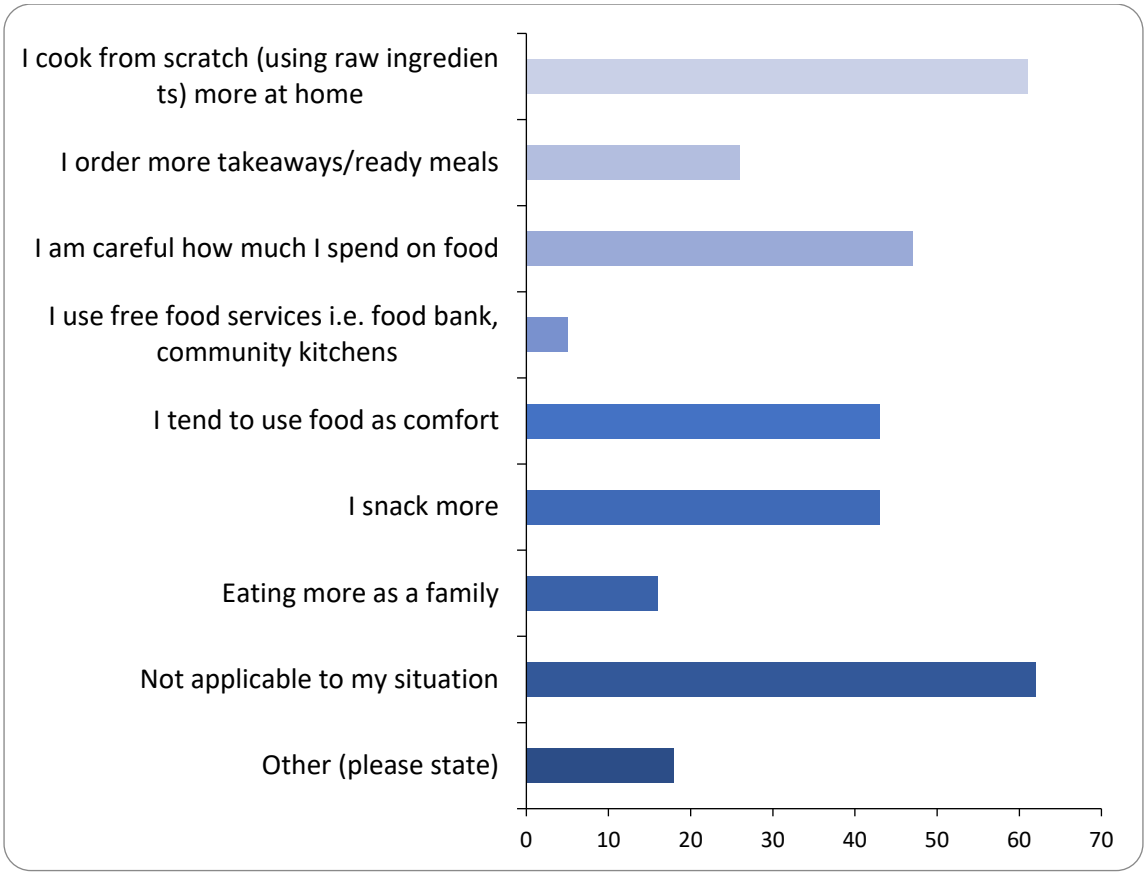
There were 208 responses to this part of the question.



Option	Total	Percent
My Eating and drinking habits have worsened	50	24.04%
My Eating and drinking habits have gotten better	46	22.12%
My Eating and drinking habits haven't changed	112	53.85%
Not Answered	0	0.00%

Question 9: How has the Covid-19 pandemic influenced yours and/or your family's eating habits? Tick all that apply

There were 208 responses to this part of the question.



Option	Total	Percent
I cook from scratch (using raw ingredients) more at home	61	29.33%
I order more takeaways/ready meals	26	12.50%
I am careful how much I spend on food	47	22.60%
I use free food services i.e. food bank, community kitchens	5	2.40%
I tend to use food as comfort	43	20.67%
I snack more	43	20.67%
Eating more as a family	16	7.69%
Not applicable to my situation	62	29.81%
Other (please state)	18	8.65%
Not Answered	0	0.00%

Other please state

There were **30** responses to this part of the question.

Put a bit of weight on during Covid-19 period and it has made me more aware of not letting that happen again.

I don't think the pandemic has impacted my eating/cooking habits. I have always cooked from scratch. During the pandemic I began growing some of my own fruit and vegetables, so in fact my diet has improved.

I have lost weight successfully through diet and increasing my activity levels. I started 11 years ago, reached my goal weight two years later and am now successfully embracing my lifestyle changes and maintaining my weight. I have recognised that this is a life-long journey.

Although we have moved into the new normal it has become hard to unlearn the bad habits picked up during the pandemic.

Went fully vegan from vegetarian

No change

No, it hasn't.

"Stop blaming covid for anything!

There are no vegetables in the grocery stores, no eggs, and fish is limited to salmon. Only new fast-food shops in town and junk food.

Prices keep increasing not because of covid"

We always cook from scratch and have 3-4 takeaways a year we don't snack or eat junk food

We made a big improvement by creating a weekly meal plan so we know what we're eating for the week, and then one weekly shop for food.

"I always have cooked from fresh ingredients and eat as a family.

COVID hasn't changed anything about the way I eat"

I don't think it has.

No change from covid19 as I already worked from home – but moving to working from home has increased snacking.

I used to cook most meals from scratch at home. Now that I live with constant fatigue, due to long covid, this is not something I can do as easily.

Na

Always have cooked from scratch. Haven't changed anything due to pandemic.

We already mostly cook from scratch using fresh/raw ingredients at home. We already eat as a family.

We now make our own bread and baked goods as well as cooking meals from scratch. The reduced salt and sugar really makes a difference!

I suspect people are reviewing how much they spend on food due to the cost-of-living crisis which isn't totally as a result of the Covid-19 response.

I eat out less, and when I do I buy less

During lock down lots of overeating as comfort. Getting better now.

No change

My wife and I retired 2 years ago and we drink more wine and beer now, but otherwise our diet hasn't changed much.

I've always cooked from scratch

I don't think our eating habits have changed to any measurable extent since the pandemic.

Covid pandemic has not affected my eating habits

"In some respects cost of living had made us eat better - less eating out, less take aways, more veg to stretch out meat, and less alcohol/sweet treats. However also prioritise fruit/veg for child rather than ourselves. Also make smaller portions (less protein?) and stretch meat out with oats.

Also use olio for treats and extra bread to make ours last longer."

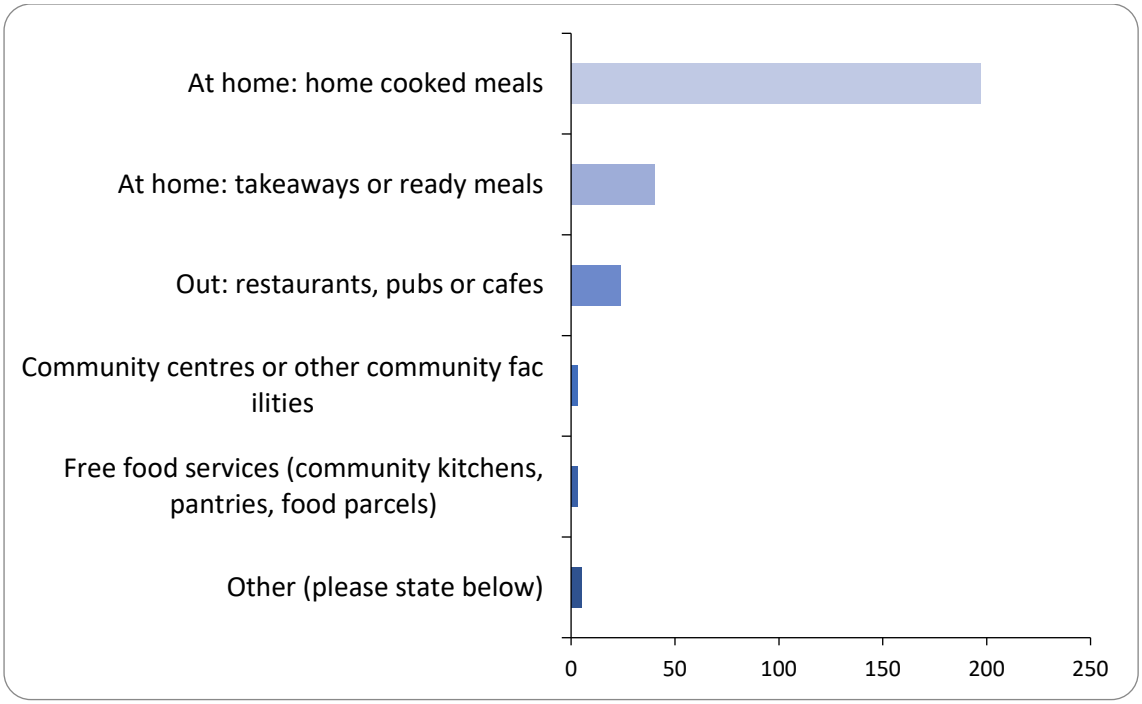
Eating less as a family

I know what to do but I am too tired when I come back from work. I have less money to buy healthy food

Question 7. Over 30 years ago, I was told by my GP that the reason she could not find my vein to take my blood was that I was too fat. I weighed 10 & half stone! In today's world this is not big but it shamed me into losing weight & keeping it down.

Question 10: Where do you eat most regularly? Tick all that apply

There were 208 responses to this part of the question.



Option	Total	Percent
At home: home cooked meals	197	94.71%
At home: takeaways or ready meals	40	19.23%
Out: restaurants, pubs or cafes	24	11.54%
Community centres or other community facilities	3	1.44%
Free food services (community kitchens, pantries, food parcels)	3	1.44%
Other (please state below)	5	2.40%
Not Answered	0	0.00%

Other please state

There were **11** responses to this part of the question.

Mindful chef organic meals you cook from scratch

at work as i volunteer in the community, and mostly during the day i ate once or twice per day, weekeends because i have the kids i ate more meals with them because they are at school

At the canteen at work

At friends homes

"At work or if we go out we take packed lunches

Son has school dinner for lunchtimes"

At home but lots of snacks rather than proper meals

At work - microwave food + fruits

Use cafes (mostly community cafe) once a week.

"At work, on the go.

Or at home, home cooked meals on days off.

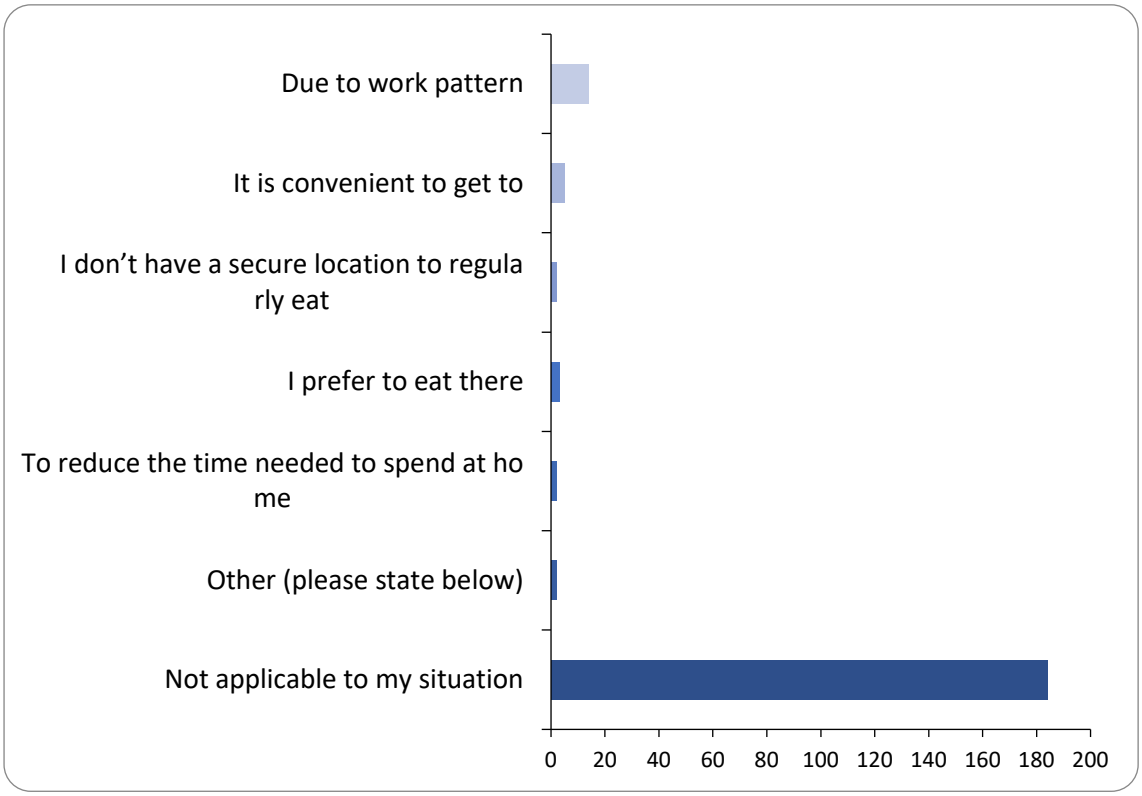
I spend one of my days off each week planning/shopping/cooking ahead to try to eat healthily at work. Losing battle."

Eat at work

At home usually, but out in restaurants, pubs, cafes once or twice a week

Question 11: If you are not eating at home most regularly, please tell us the reason for where you choose to eat most regularly (Tick all that apply)

There were 208 responses to this part of the question.



Option	Total	Percent
Due to work pattern	14	6.73%
It is convenient to get to	5	2.40%
I don't have a secure location to regularly eat	2	0.96%
I prefer to eat there	3	1.44%
To reduce the time needed to spend at home	2	0.96%
Other (please state below)	2	0.96%
Not applicable to my situation	184	88.46%

Not Answered	0	0.00%

Other please state

There were **5** responses to this part of the question.

Eat at home or take from home to work

Na

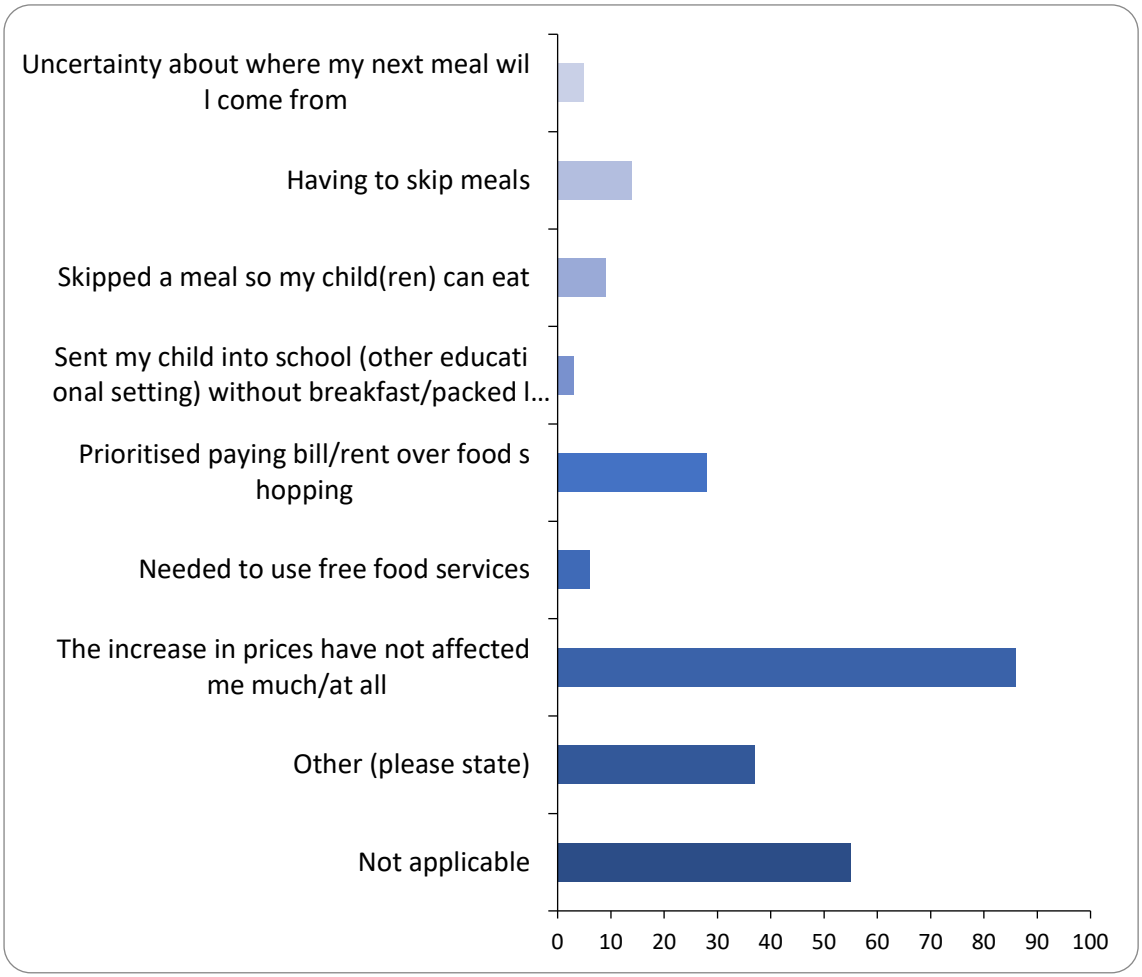
"Work.

Long working days/shifts combined with on call days and nights"

Cost, at free food services. I can't afford to eat three meals a day

Question 12: With the recent increase in food prices in the last 12 months, have you experienced any of the following? Tick all that apply

There were 208 responses to this part of the question.



Option	Total	Percent
Uncertainty about where my next meal will come from	5	2.40%
Having to skip meals	14	6.73%
Skipped a meal so my child(ren) can eat	9	4.33%
Sent my child into school (other educational setting) without breakfast/packed lunch	3	1.44%
Prioritised paying bill/rent over food shopping	28	13.46%
Needed to use free food services	6	2.88%
The increase in prices have not affected me much/at all	86	41.35%
Other (please state)	37	17.79%
Not applicable	55	26.44%
Not Answered	0	0.00%

Other please state

There were **43** responses to this part of the question.

I don't buy certain types of food anymore e.g. salmon

Have adjusted what products I buy to save some money and reduced food waste by labelling foods in the fridge etc. Also recognise that in losing weight I eat less which costs less...so food might be costing 15% more but I'm eating 15% less.

Fortunately, we can pay the increased price of food, but we certainly notice that the price increases are staggering.

I am fortunate in that I can afford to buy food at current prices. I certainly check prices much more carefully than previously and plan menus with greater care, bulk buy and freeze food etc to save money.

As I cook a lot from scratch, although there have been price increases I am still able to feed two adults for approx. £60 a week (less than £10 a day)

My family have to support me to pay for food shopping (My Mum)

Increased prices have led to credit card debt

More conscious about spending but thankfully have not been prevented from buying food, we are still able to do so but there has been an evident increase in awareness of cost leading to more careful shopping.

Altered family budget - more on food, less travel

Meal planning to avoid waste.

Trying to by in a smart way with discounts.

We can afford the expensive food, but it is a prioritising challenge.

I'm fortunate to be able to afford food, but it is hugely expensive

I've noticed the increase in food prices, but not enough to have to go short.

Bought less food and stuff on sale, prioritising value over health.

The price increase has affected me but it hasn't caused me to do any of the things in the list

Food is a priority for buying other things - Holidays, new (unnecessary) clothes, entertainment- are luxuries. I spend appropriately and cut back where necessary.

I have seen my weekly food bill increase by 50% since last year. Absolute disgrace that as someone that works full time and with no longer children at home that I have to watch every penny until my next payday.

I'm learning where to buy cheaper food, and I often decide to not buy fancy food, but just basics.

I am most definitely buying less meat / fresh food because of the increase in costs.

Made our shopping bills go ridiculously up.

We are fortunate to have sufficient disposable income

Just more careful, considered spending and more meal planning. Less meat.

Have bought or given more food to my daughter who is a single parent.

I've cut back buying certain foods & reduced the amount of branded food I buy

Tried to find the cheaper options of fruits and veg even the quality is less

More selective shopping

Having recently retired and being reasonably OK for money, we eat what we enjoy and what's good for us regardless at the moment...we feel very lucky! But that could change...

I now batch cook and use less meat so I add more veggies to bulk it out

Be more selective about what I buy

Have to opt for low cost options like frozen food or price reduced items.

Buying more food from the basics ranges, or from the reduced shelves

we are more selective with food purchasing

Very careful and selective of what I buy for the family

Buying own brand food, never eating out, not purchasing fruit/ veg/ food which is expensive or has a short life.

"Shopping at more outlets to get best price - spend more time shopping.

Reduce portion sizes.

Substitute cheaper alternatives - less meat."

Cut back on what I buy

The increase in prices means we have less to spend on other things which is not "not much or not at all affected" but we've not had to make the kind of choices as listed above

I am coeliac but no longer buy gluten free substitutes like bread, cake or biscuits as they are ridiculously expensive and have gone up in price more than their 'normal' equivalents

"I am more careful what I buy and ensure that there is no waste in food at home.

Food shopping is very expensive and as a result of this we can hardly ever eat out or have takeaways."

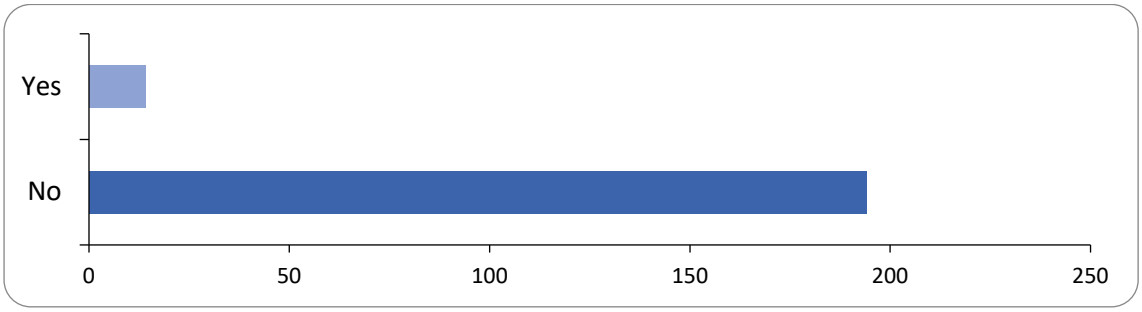
have noticed increase in food shop prices

Stopped buying certain types of food that I occasionally purchased before, like meat and fish

We budget very carefully and live a frugal lifestyle anyway. As a result, we are not happy with the food price rises, but have thus far coped OK.

Question 13: Have you ever used free food services (community kitchens, pantries, food parcels)?

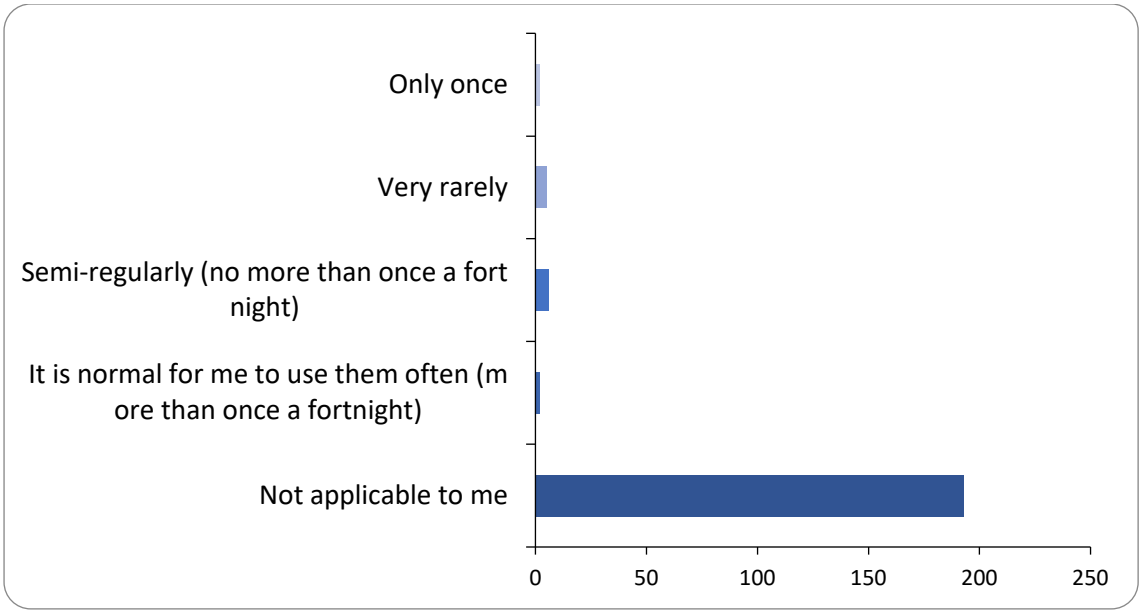
There were 208 responses to this part of the question.



Option	Total	Percent
Yes	14	6.73%
No	194	93.27%
Not Answered	0	0.00%

Question 14: If you have used free food services, how often have you done so?

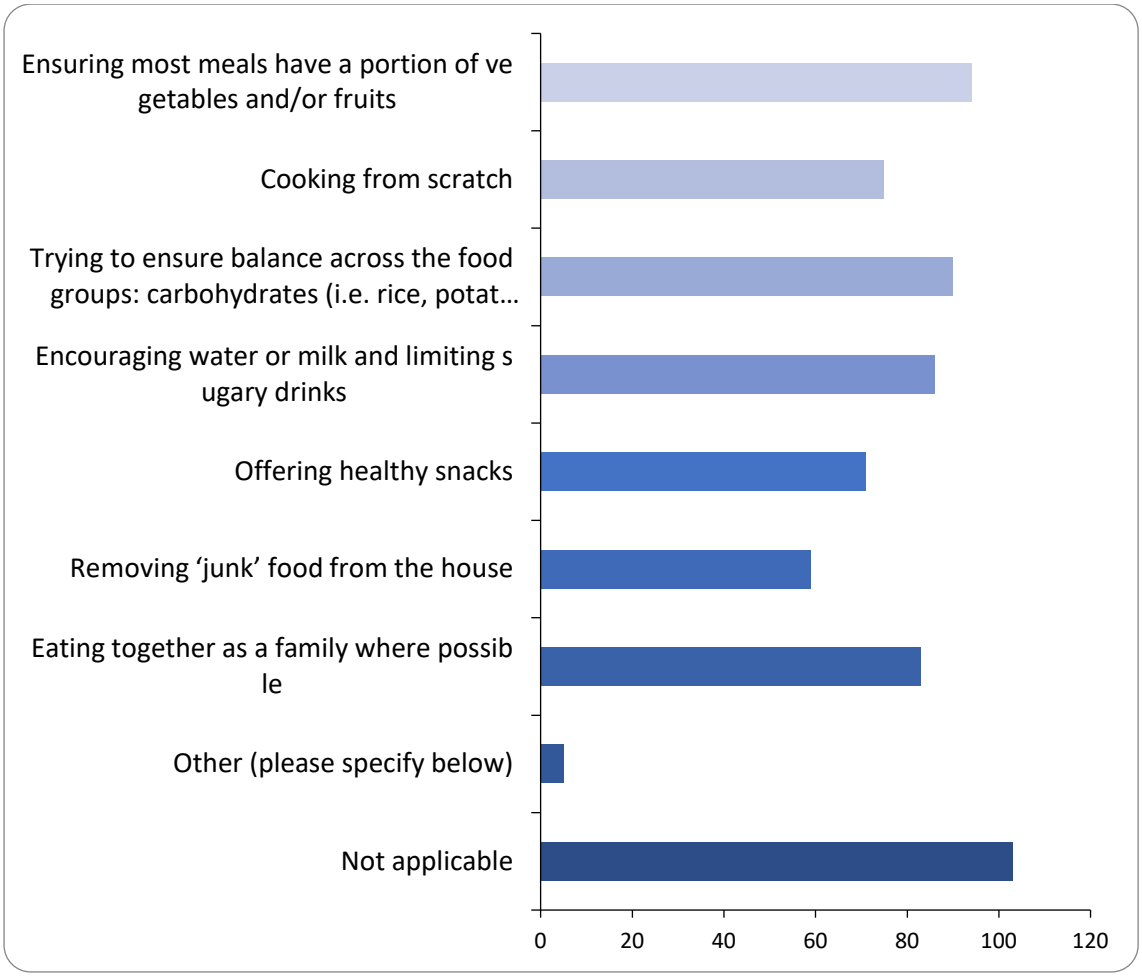
There were 208 responses to this part of the question.



Option	Total	Percent
Only once	2	0.96%
Very rarely	5	2.40%
Semi-regularly (no more than once a fortnight)	6	2.88%
It is normal for me to use them often (more than once a fortnight)	2	0.96%
Not applicable to me	193	92.79%
Not Answered	0	0.00%

Question 15: As a parent, what do you think is important/helpful in encouraging children to eat well at home? Tick all that apply

There were 208 responses to this part of the question.



Option	Total	Percent
Ensuring most meals have a portion of vegetables and/or fruits	94	45.19%
Cooking from scratch	75	36.06%
Trying to ensure balance across the food groups: carbohydrates (i.e. rice, potatoes, pasta), proteins (i.e. tofu, pulses, fish, meat, eggs) and fats (i.e. nuts, cheese, yoghurts, olive oil)	90	43.27%
Encouraging water or milk and limiting sugary drinks	86	41.35%
Offering healthy snacks	71	34.13%
Removing 'junk' food from the house	59	28.37%
Eating together as a family where possible	83	39.90%
I don't think this is important for parents	0	0.00%
Other (please specify below)	5	2.40%
Not applicable	103	49.52%
Not Answered	0	0.00%

Other please specify

There were **13** responses to this part of the question.

I don’t think people should remove junk food from their homes. I think it leads to children craving what they cannot have. Instead, they should be encouraged to have limited amounts of treats.

But all of this is easier said than done when you are a struggling single parent with children that have vastly different food tastes

I'm not a parent but think the above is important.

Totally depending on the specific situation

Modelling behaviour. Kids are more likely to eat well if everyone else in the household does too

Eating as a family and cooking from scratch are essential - it amazes me how few families seem to do this these days

Ensuring children have a varied diet and wide tastes helps to avoid them getting stuck on only eating a limited diet.

Avoiding snacks altogether, whether healthy or unhealthy

I have answered this question because although no longer an active "parent" I have raised three children.

'Junk' food such as burgers as a treat is fine once in a while

Cooking as a family

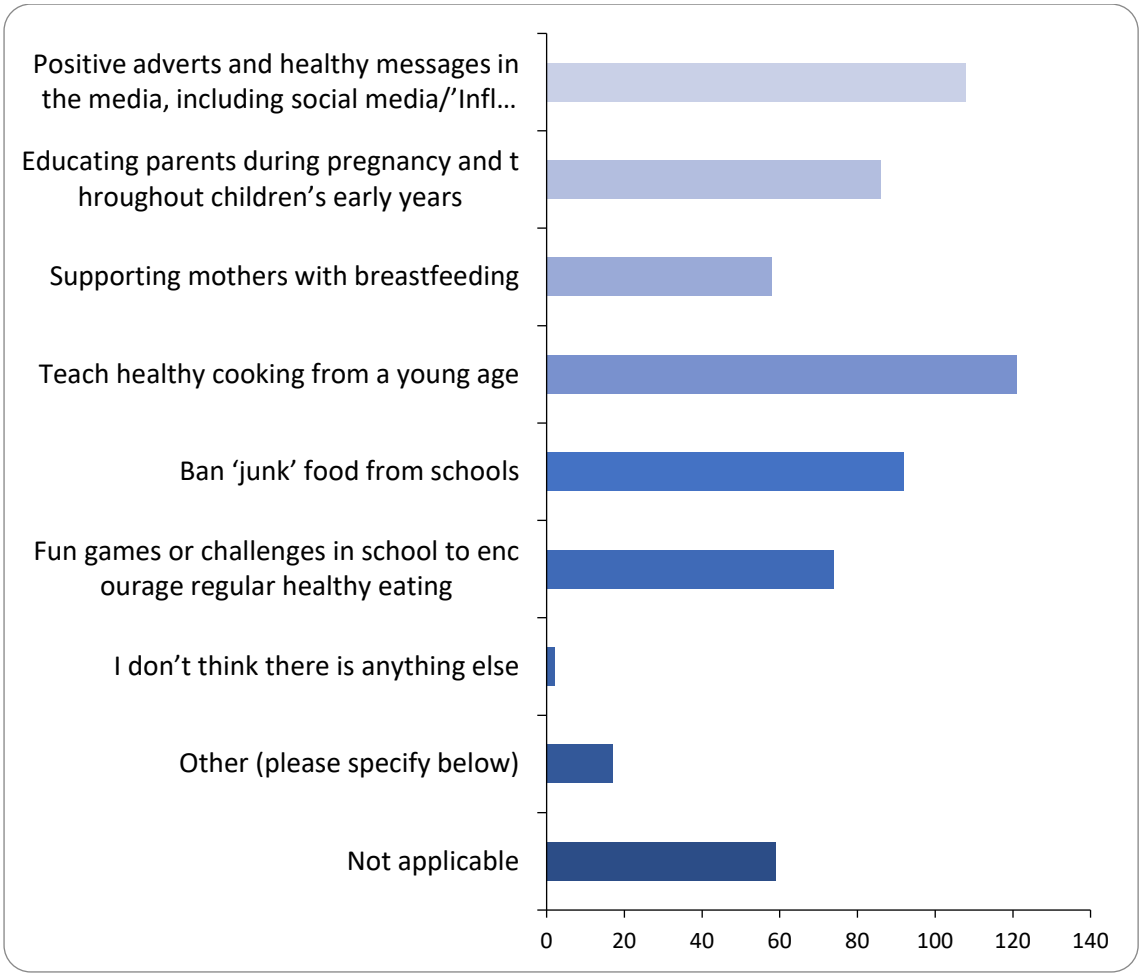
Be a good role model. Educate children the importance of a good balance diet.

"It really isn't rocket science is it! We've never given our kids fizzy drinks, juice in cartons, cheap takeaways, and when they were younger we strictly limited treats to holidays or days out only.

Now they are in their mid-teens they simply haven't got a taste or craving for all those unhealthy foods, quite the opposite in fact."

Question 16: Are there any broader actions outside of the home that might encourage children and young people to eat well? Tick all that apply

There were 208 responses to this part of the question.



Option	Total	Percent
Positive adverts and healthy messages in the media, including social media/'Influencers'	108	51.92%
Educating parents during pregnancy and throughout children's early years	86	41.35%
Supporting mothers with breastfeeding	58	27.88%
Teach healthy cooking from a young age	121	58.17%
Ban 'junk' food from schools	92	44.23%
Fun games or challenges in school to encourage regular healthy eating	74	35.58%
I don't think there is anything else	2	0.96%
Other (please specify below)	17	8.17%
Not applicable	59	28.37%
Not Answered	0	0.00%

Other please specify

There were **32** responses to this part of the question.

"Reduce advertising in public places

Incentives for local food businesses to offer healthier options"

Clear messaging about the long-term risks of not eating well - and particularly the dangers of becoming overweight...but also lots of encouraging messaging that people can lose weight.

Free school meals - All children should be provided with a free school meal. They should have a choice of a hot meal or a packed lunch. this way it could be ensured that the child was eating healthily at least whilst they were at school.

I'm unsure about home economics being taught in schools but if not it should be.

"Wages that support families to make healthy affordable food purchases

Modelling healthy behaviours in other settings, such as sport arenas, shopping centres, etc."

Making healthy food more affordable

Less fast-food advertising in prominent locations

"It would be good for children to be encouraged to grow their own vegetables/food, as this may persuade them to try different things.

My daughter is more likely to eat something that she has grown and is proud of.

It may even be good for schools to have a lesson where they plant, nurture and crop - then to take them home to try."

Regular activity after school, like Basketball.

Teach kids to grow and cook their own food.

Teach children what are the downsides of eating junk food to their future

Growing vegetables in schools, and communities. Cooking from scratch classes in school and wider community.

"Return to Home economics lessons in school for all.

Easily available classes in youth organisations and place for mums e.g. toddler groups"

More swimming pools

Go back to teaching proper home economics, not food tech which is pointless

As a teacher my main job is to teach my subject, please not assume I have time in my working hours to facilitate or teach more lifestyle skills.

Availability of Cheaper fresh food, fruit and vegetables.

Not labelling children who are a healthy weight obese would be a start - getting rid of the ultra skinny is beautiful culture

"Grow their own food/herbs.

Remove the tax subsidies for junk food/ litter creation/ non sustainable packaging.

Ban adverts to kids."

"Reducing fast food adverts on TV

Removing toys from fast food meals"

School clubs: there is cake decorating club at school, but no healthy cooking club :(

Making healthy food far more accessible financially

reduce poverty and increase funding for social care and NHS

See previous answers = ban junk food advertising...

Teach "healthy snacking" not just cooking. Kids don't really want to cook, but they do love to snack.

By making healthier food readily available. Currently it is the junk food, high sugar, high fat foods that are readily and easily available. If the ready availability of healthier food increases, more families are likely to opt for the same.

Teaching consequences

Demonstrate the effects of poor health and benefits of eating well. Bring in free fruit/nut bowls for snacking.

"Everything should be done to eliminate unhealthy eating/drinking displays from the media. Allowing the advertising of junk food is ludicrous in one of the most overweight populations in Europe but also showing examples of people eating junk food and enjoying alcoholic drinks in a fictional setting is perhaps even more persuasive because it is not seen as an advert but normal conduct of people like ourselves.

Hence product placement's popularity."

"Stop advertising of unhealthy foods

Higher tax, therefore price, on unhealthy food

Stop opening so many fast food and unhealthy junk food places in town"

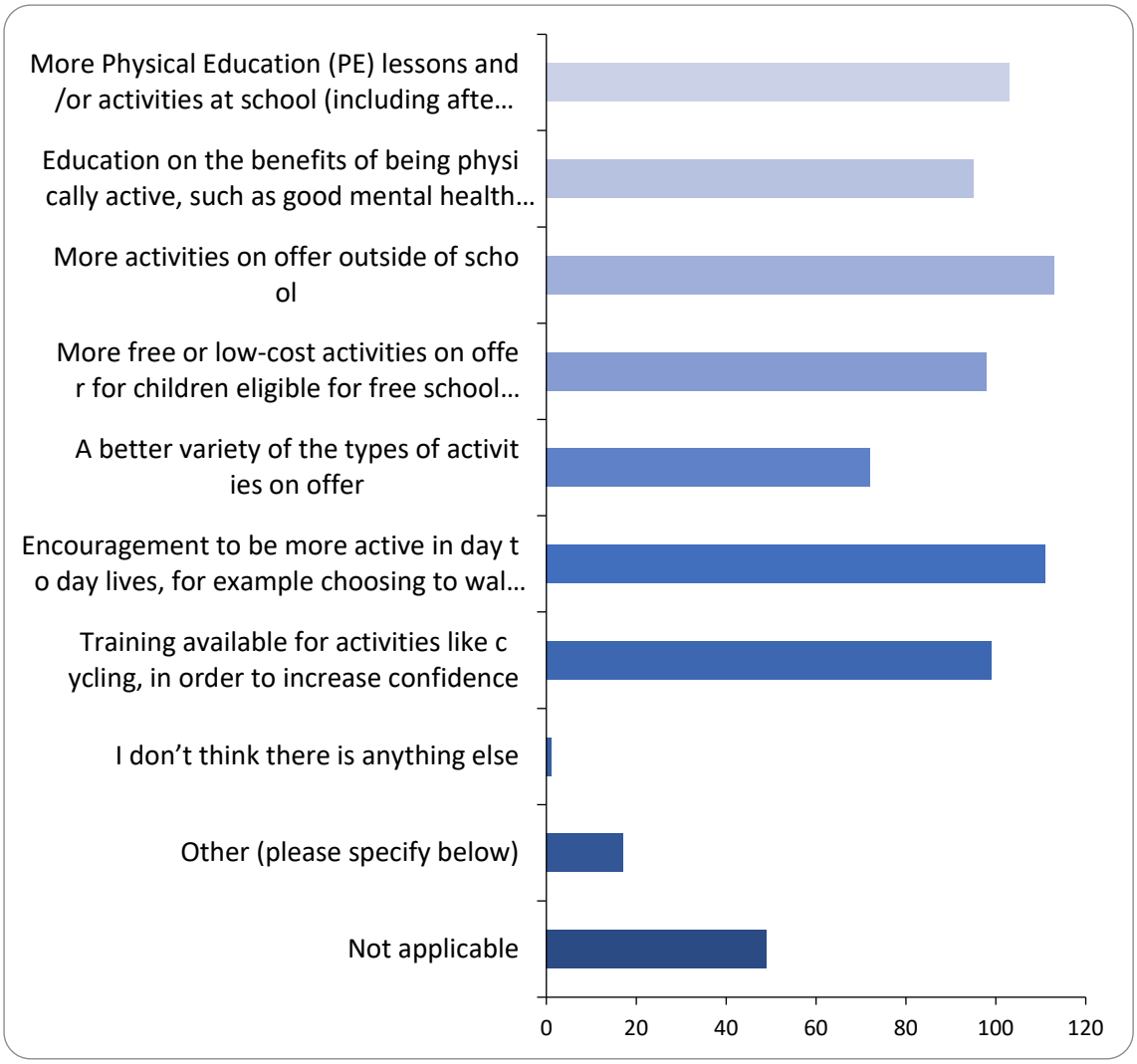
Encourage food growing at school and in the community

"Ban junk food in schools is a good one. When I was a kid, all schools had their own kitchens and served for the most part 'normal' meals. These days it's all outsourced and in secondary school the offerings in the canteen are pretty much of the junk

variety. Jamie Oliver had a go, which fizzled out. Why is it so hard to ban junk food in school canteens?"

Question 17: What do you think would encourage children and young people to be more physically active? Tick all that apply

There were 208 responses to this part of the question.



Option	Total	Percent
More Physical Education (PE) lessons and/or activities at school (including after school clubs)	103	49.52%
Education on the benefits of being physically active, such as good mental health, reducing risks of excess weight and diabetes, improving fitness and self-esteem	95	45.67%
More activities on offer outside of school	113	54.33%

More free or low-cost activities on offer for children eligible for free school meals	98	47.12%
A better variety of the types of activities on offer	72	34.62%
Encouragement to be more active in day to day lives, for example choosing to walk or cycle	111	53.37%
Training available for activities like cycling, in order to increase confidence	99	47.60%
I don't think there is anything else	1	0.48%
Other (please specify below)	17	8.17%
Not applicable	49	23.56%
Not Answered	0	0.00%

Other please specify

There were **36** responses to this part of the question.

More affordable options for exercise for young people

Encourage PE in schools as they do in the USA

"Also providing equipment - not all kids have bikes for example

Providing more opportunities for girls to be physically active - activities that they want to do"

Protecting open spaces for out of school activities. Protecting school outdoor spaces so that schools can easily timetable outdoor activities rather than have to factor in commuting times to faraway sports centres. Campaigning for more exercise and outdoor time in the school day - it has shrunk alarmingly in recent years as schools come under pressure to meet academic targets. I think this is terrible. Caversham primary school used to have an allotment where children learnt about growing their own food, but they no longer do so.

Activities outside of school hours are prohibitively expensive for many families. Also, it can be difficult for some parents to actually get their child/children to activities. For example a disabled single parent may not be able to manage to get the child to/from an activity without help. If you have more than one child it can be difficult/impossible to get them to different places for activities.

More PE is NOT the way forward! It can be traumatic for so many kids and especially ones with weight issues.

Wages that support families to make time for physical activity, and areas for that activity - safe streets, parks, leisure centres, etc.

the think is everything cost money and for me single mum with 4 children, its really really expensive

PE lessons are horrifying for children, in fact, there is nothing more likely to put kids of sport and exercise that PE at school

Ease of access to council leisure facilities

As someone who's child doesn't get free school dinners. I am appalled by the option to give help once again only to those on benefits. Those of us employed full time by RBC also are struggling. We would love some help or a pay rise which is not lower than inflation.

Parental support and shared exercise.

Stop parents using car on school run

Reduce the amount of children taken to school by car, encourage walking to school if possible. Set up walking to school groups and give incentives to those that do.

"role models- e.g. good teachers/youth leaders who enjoy physical activity and encourage people to join

removing stigmas for girls and sports"

Free access to facilities for anyone in full time education, not just those with free school meals

"Urban planning to prioritise safe active travel. Reading feels quite a dangerous place for kids to walk or cycle to school.

Often parents drive kids to activities but it would be better to walk/cycle to local things instead"

"DO NOT STIGMATIZE PEOPLE FOR BEING OVERWEIGHT

Active parents encourage kids to be more active.

Good role models for inactive parents, and for kids with inactive parents.

More mixed-sex activities and more activities for girls.

More lower intensity activities as an entry-point for people who are self-conscious about their weight.

More free swimming for everyone.

More gardening for everyone - combine exercise with growing food for healthier eating.

More environmental conservation - combine exercise with increasing biodiversity."

Free activities for all children - particularly team sports and not just for the very talented - encourage children to do sport for fun rather for competition- not everyone can be a winner but everyone can have fun

"Education on how to tap into their own inner wisdom e.g. mussle testing, sacral sounds and how to let emotions go -eft; meditation; healing music/sounds.

Correcting the defects of the political-economic system that puts the greed of a few (profit) before the Health or Wellbeing of All, by creating stress, uncertainty & poverty (the growing need for Charity Food Banks in the 21st century)."

Regular exercise is important to staying healthy. Our school has done "mile a day in may" which has been great to keep kids active. Maybe someone could come up with 11 other challenges for other months...

As not quite on low enough income for free school meals my child has not been able to access many facilities

Imbedding exercise as a norm to daily life from a young age…rather than packaging it into pockets.

"To encourage cycling by children of all ages including those at the secondary schools, the local authority must make sure by providing special measures for safety on highways.

Safety is paramount for parents to allow their children to cycle between home and school.

Local authority ought to encourage residential street closures, so that families and carers feel safe to let children play in the residential street, and young ones are encouraged to be active outdoors, and not being minded by television or other electronic devices."

Encouraging children to connect with the outdoors, nature and food growing eg initiatives like Nature Nurture, Freely Fruity, Food for Families, Community Gardens, Wild About Reading

Free activities for all children

Teach it alongside having a healthy balanced lifestyle that includes no screen time and having am active family environment.

Increase availability of safe areas to exercise, for instance separate cycling paths, safer pavements for walking, good street lighting, less traffic, more and better quality parks.

Our media constantly promotes unhealthy food. Most of the ads on TV and Internet are for unhealthy food, which is widely promoted and make readily available. Adults and kids are often influenced by this. Healthy foods need to be promoted similarly and should be made readily available.

Things like apps (counting steps) are very popular therefore 'gamifying' activity might be the way forward - with apps or schoolwide competitions.

I think that physical exercise is obviously healthy it is not key to weight loss. Eating less unhealthy food is what counts.

safe routes to cycle

Couples with more walking/cycling above you need to make the roads safer so more people can walk or cycle. I and other people I know drive to school as the roads are so dangerous and busy. (I realise the irony)

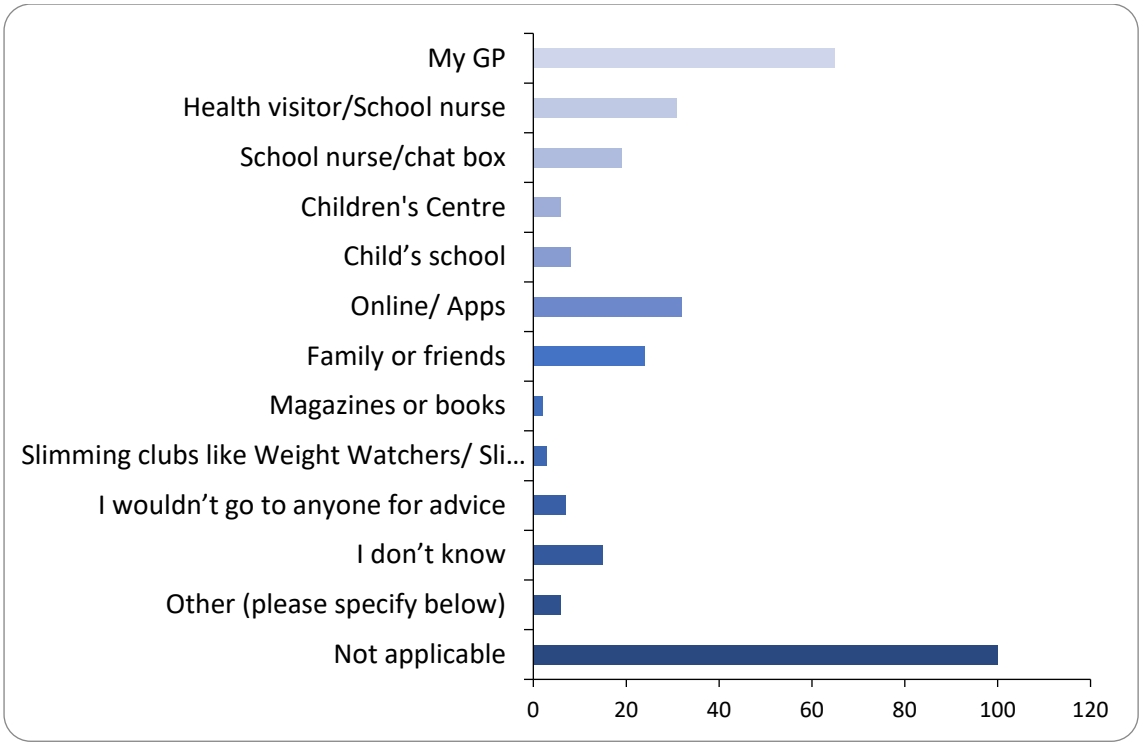
Safe green spaces

Well, I've ticked quite a few above, but I don't think lack of opportunity is the issue. It's the mental attitude and ambition that is lacking. There are plenty of sports clubs and facilities in Reading. Fat people just don't go!

Sport at school was never fun for me and I hated it. A wider range of activities especially for young children that are inclusive to all (boys and girls) and from all backgrounds would be better.

Question 18: Where would you go for advice if you were worried about your child's weight? Tick all that apply

There were 208 responses to this part of the question.



Option	Total	Percent
My GP	65	31.25%
Health visitor/School nurse	31	14.90%
School nurse/chat box	19	9.13%
Children's Centre	6	2.88%
Child's school	8	3.85%
Online/ Apps	32	15.38%
Family or friends	24	11.54%
Magazines or books	2	0.96%

Slimming clubs like Weight Watchers/ Slimming World	3	1.44%
I wouldn't go to anyone for advice	7	3.37%
I don't know	15	7.21%
Other (please specify below)	6	2.88%
Not applicable	100	48.08%
Not Answered	0	0.00%

Please specify below

There were **7** responses to this part of the question.

search online

Would initially manage ourselves by increasing their exercise and reducing snacks. Would only go to a professional if that failed.

Research from knowledgeable and renowned food nutritionists

NHS 111 website

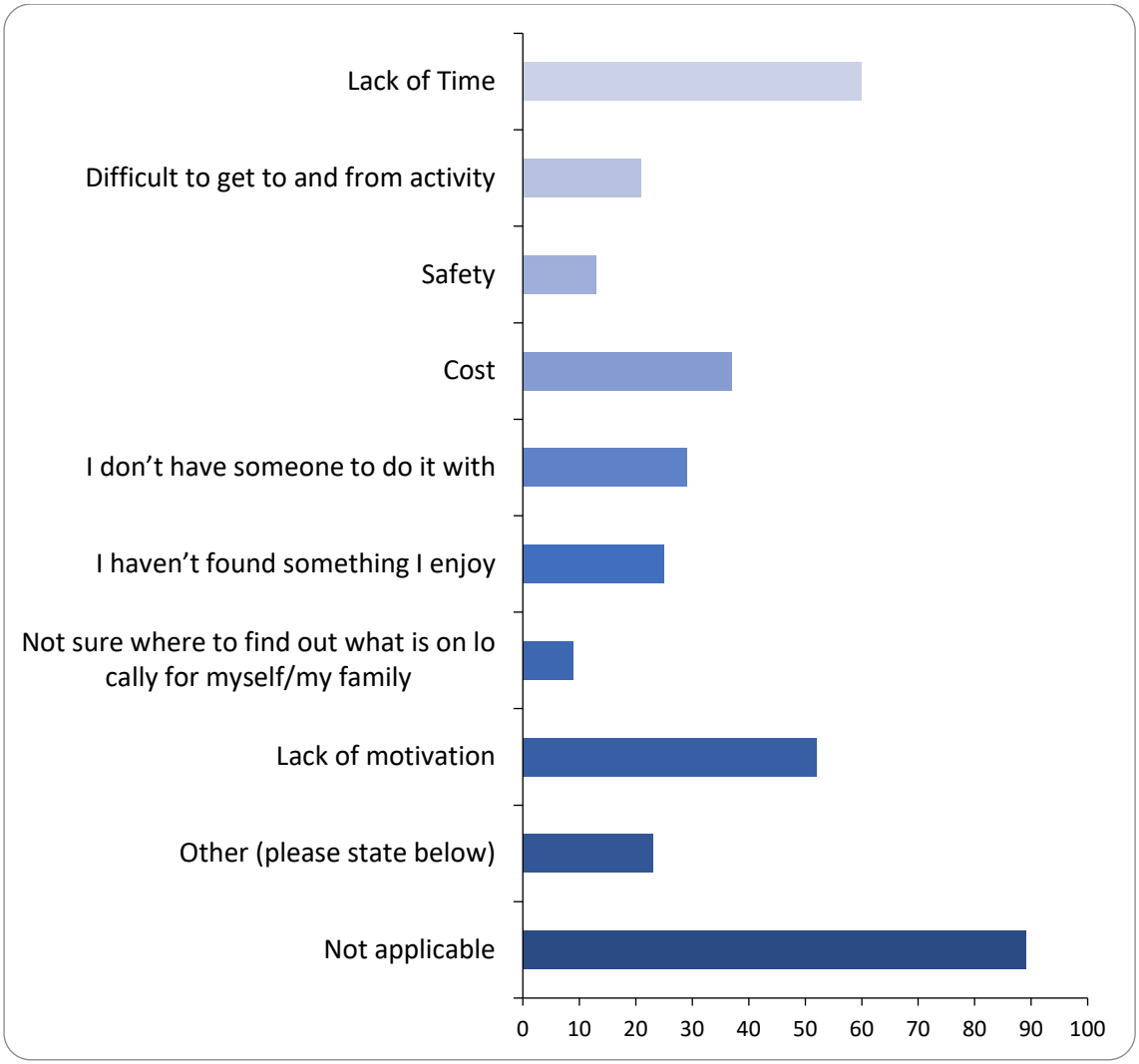
If your child is overweight it's only one persons fault (or two people's).

Being a good role model and exercise together with children

I would look at what they eat, especially snacks and see how they are feeling, if they have any problem. GP to check for any health issue that explains weight gain

Question 19: If you don't engage in much or any physical activity, what prevents you from doing so?

There were 208 responses to this part of the question.



Option	Total	Percent
Lack of Time	60	28.85%
Difficult to get to and from activity	21	10.10%
Safety	13	6.25%
Cost	37	17.79%
I don't have someone to do it with	29	13.94%
I haven't found something I enjoy	25	12.02%
Not sure where to find out what is on locally for myself/my family	9	4.33%
Lack of motivation	52	25.00%
Other (please state below)	23	11.06%
Not applicable	89	42.79%
Not Answered	0	0.00%

Other please state

There were **34** responses to this part of the question.

Chronic health condition

I get plenty of exercise - eating too much is my challenge!

Pain

no child care

I feel too fat to engage in exercise, telling myself that I will start classes when I have lost weight etc. Instead my weight just increases.

Dangerous roads. I'd love to cycle more and leave the car at home.

My weight and fear of injury

Lack of confidence

I gym 5 days / wk

I want to but my arthritis is stopping me

Work

Back pain

Physical limitations

"Embarrassment and lack of self confidence

Fear of being judged/ridiculed"

I sometimes don't go out due to my mental health issues. When I'm well I go out for walks. Sometimes I do exercise dvd at home.

Prefer to spend my relaxation time doing other things.

Severe fatigue due to long covid. Before that I exercised several times a week.

age

Walk the dog, walk to shops. Don't have a car.

I can only walk or run in the evening, but I'm too scared in my neighbourhood to do it. I'm also worried to go to the gym in the evening. My neighbourhood is too dangerous, and I never see any police patrols here (RG30 4YN).

I do engage in activity - walking, cycling, gardening.

Mobility limited and this affects motivation and ability to participate in various activities

Hip problem which can be aggravated by certain activities ... some days are better than others. Try to compensate by setting a target of 50,000 steps a week, usually achieved.

Lack of exercise facilities in local area

Health problems I.e. arthritis and shoulder injury from a fall

Until a few years ago I was too tired after work to do anything physical, because work was active anyway. Now I know I should have found time to keep fit as although I'm still slim, my body is showing lack of good maintenance!

Mobility issues. Disabled. Need more groups for us.

I have an impairment which limits what I'm able to do.

I walk two huskies every day.

"I don't do anything specific but often walk 2-4 miles a day to access facilities and try to do activities outside playing games.

If I didn't do the above I think I would find it hard to do activities - fitting them in the evening, not having someone to buddy with, cost and access (I.e like walking but can get repetitive in local area also safety at night when dark)."

my health restricts most activities

Lack of confidence

Do lots of gardening but no sport.

Leisure centres are too far and too basic.

Question 20: What do you think would encourage people to be more physically active?

There were **167** responses to this part of the question.

"Lower cost activities

Targeted activities i.e. mums groups, teen girls groups, overweight men's groups

Active travel: encourage more walking and cycling

Promote other activities not funded by the Council. There is loads happening in Reading but people don't always know about it - the council could have a signposting Hub that organisations could apply to be listed on.

Encourage a different variety of activities - not just sport/exercise but nature type things too."

More affordable and accessible options. My children loved swimming, closure of central pool, poor facilities at Rivermead put them off and I've been unable to get them back in the water. You've caused the problem with poor strategy and terrible execution.

More leisure centres with heat area (spa) and social space

Affordable access to more sports facilities so being physically active is more about fun and competition rather than being physically active just for the sake of it. More physically demanding sports for older ages and messaging that older ages can and do participate.

More variety and local options to choose from

More low cost options for group exercise. For example a privately run, 45-min exercise class is typically £7+, which many can't afford.

Scheduled group activities. Social dimension of encouragement.

Making the connection between exercise and better mental and physical health.

Free step trackers

Social means like walking, exercise groups, cooking healthy food

"To make activities more inclusive.

For example;

Swimming is prohibitive for many disabled people because they are unable to walk safely from the changing room (wet slippery floors and distance) or get in and out of the pool yet swimming is a great exercise but really not inclusive.

Provide more exercise at a reasonable or free cost for disabled people."

Finding a suitable activity that fits in with their everyday life and that can become a part of their daily routine.

More outside gyms, cheap gym memberships, free classes

more free group activities after 5pm

"For me - it would be affordable one to one classes in anything. I like the idea of yoga or Pilates but would feel like a beached whale.

A personal chef or at the very least affordable cookery classes."

"Affordable access

Lack of stigma

Safe, accessible spaces"

Cheaper cost. More choices.

"Encourage cycling/walking.

More frequent buses in Caversham & bus lanes & then people would walk to the bus stop."

probably more accessibility, and more friendly groups sessions, and more free events, free engagement as a family and as a single individuals

"Better cycle routes

Holding drivers to account for close passes

Walking school buses

Congestion charge - higher car park prices

More open air events - open air music, walks etc."

Cost and availability

1:1 encouragement

Affordability, time, leisure centres being accessible, more variety of exercise classes

Social element, making it fun and part of day to day. How it can be incorporated as our normal not just as an official intervention alone but part of everyday life, campaigns, challenges, cooking skill as well as sessions for group support etc would be good.

Access to free/subsidised swimming sessions, more physical activity programmes for both adults and children/young people

More social sessions - e.g. golf open days or turn up and play sessions

Price. Make it cheaper for us all not just those on benefits who don't have jobs and can easily go for walks in their free time

Free groups for weight management, activities. With the cost of living rising, it is difficult to afford anything extra.

"Easier availability

Better quality of local council facilities and opening times"

Good social group to habitually get active with

Parents taking responsibility and not pampering to their children and/or being lazy

"More direct cycle routes.

Cheaper gyms and pools for Reading residents."

Free access to leisure centers

"If they got a sense of achievement from it. For example, working an allotment results in the sense of achievement when something grows. When you eat something you've grown you appreciate it more and generally make better choices regarding food.

I also enjoy dancing, you get a sense of achievement when a dancing goes well, or you win a medal/ competition."

education and good information

Increased fuel prices on private transport.

Their future health and wellbeing

Don't do any such thing. Leave people to do what suits them.

Lazy people will be lazy

"Awareness of their own health.

Positive messages from respected individuals.

Ease of access to free exercise - outdoor gyms, nice running and walking environments."

Evening sessions, free classes more for older people

Low cost or free organised activities. Community participation?

Nicer open areas, eg by river with decent public toilets, well-lit for safety.

N/A

it has to be built into a family's life from a young age and all the family need to go on walks do sport together but activities must be cheap enough for those on low incomes to do

"Easier access to gyms etc and more attractive environments. Reduced costs.

Information about good walks and the benefits of a simple walk"

More affordable activities around.

I don't know

Better local facilities

Not sure

More places where they can do activities for free or at lower costs, e.g., I'd love to do kayaking or paddle boarding but there aren't really any places to hire the equipment and if they are they are unaffordable

Make it fun, find things that engage them, not just PE and football. Provide the promised facilities at rivermead

Range of options, Inc locally, at different times. Sessions targeted for people who have never been to gyms before

More pools

Free access to sports facilities at convenient times

"Build an additional high-speed rail line, using the M1 or M40 as a track bed. Travelling by train involves more physical activity than sitting in a car.

Switch off all TV and video streaming services and make people listen to radio instead. Screen watching precludes all other activity, whereas many other activities can be combined with listening to the radio."

No comment.

Availability

A non-critical, welcoming venue.

Hard evidence of benefits no

More time.

Again I think it's just making lives more active generally eg walking or cycling rather than getting in the car this is better than driving once a week to an activity

"Using the car less, safer roads for cyclists.

Fun runs and walks.

Nature trails.

Walking to next bus stop, not the nearest one"

Probably more time .... people work long hours and are tired. 4 day week would help. More free crèches for parents at sports centres etc

Helping people to build activity into their daily routine, so it becomes an everyday thing like brushing your teeth.

Widespread facilities that are not closed to public use because a club is using the facilities at the same time

Adverts to scare people about the impact of obesity - similar to those we've all got used to seeing for smoking. "Fat Kills"

Don't know.

If other people could stop being so judgmental and unkind to people with a weight problem - this includes people who work in gyms and sports centres

Safer cycling and walking routes, better road surface quality

Family exercise so people don’t need to look for childcare.

Having more time for themselves: working from home, working 4 days/week, etc.

Being rewarded for doing it.

Reduction of screen time somehow!

Cheaper public transport and more activities/areas for sports

"Dog ownership!

Safe, pleasant places to walk and cycle.

A proper connected cycle network which doesn't leave cyclists in the lurch at each junction.

Clamping down on parents driving kids to school.

Offering incentives like exercise-based currencies (e.g. sweatcoin) – maybe PAYG phone credit and utilities credit, and healthy food for exercise might appeal to many who struggle to access healthy options?"

"Social Media influencers

Parents!"

More classes, near where I live, not too expensive and outside work hours (after 7pm)

Courses at local sports centres to be more affordable.

More education about the benefits of exercise in managing mental and physical health.

Safe spaces where people can exercise without fear of being judged by others.

More places they could afford to go more local classes help with activities in area like gardening or park facilities

Incentives

"Better public transport links to local sports facilities, or more centrally located facilities.

Cheaper rates at leisure centres.

Safe walk & cycle routes."

"Group activities

Stop treating everyone the same"

More encouragement

better weather

Safer pavements where we could walk without danger from speeding bicycles and illegal electric scooters

More local clubs. Encourage parents to join in activities. Make it fun and be inclusive to children who are socially awkward.

More affordable groups and during reasonable times for single parent homes

More running and cycling infrastructure

Encouraging cars to be left at home for the school run- bike clubs at school, more outdoor activity centres

"Motivation showing how it makes you feel better and happier, not just weight loss or getting muscles

Buddy system to give people confidence to take part in activities"

More allotments, exercise & grow own veg

"1. Safe neighbourhood.

2. Meetings like “walking together” should be more often and not in ridiculous hours - I would like to go with my son, meet new people, walk with them, discover new places, but they walk once a month, and in the middle of work/school time.

3. Free or low cost trainings in the park, but more yoga, fitness, basketball or volleyball, and less football.

Q4. Park gyms."

"Making it safer to cycle everywhere.

Offer cheaper exercise classes at local gyms for children and vulnerable adults.

Placing all the unhealthy foods at the far end of the supermarket so people don't see them."

Education.

Better cycle / walking facilities.

Positive atmosphere

Don't know. It's a very personal thing. Maybe dances, etc., rather than 'sport' would interest some.

Free group activities in parks

Reasonable prices and availability without using cars...

Releasing more time and making exercise easily to engage.

We must first and foremost create such an environment that people would want to get out there, to be engaged in physical activities.

"Knowing how it fits into health and the long-term consequences of a) lack of physical fitness; b) being overweight.

Finding something enjoyable for them to do alone, with friends or with family."

Reduce time on phones/ tablets

Health checks that flag serious risks they are facing but also show them where they could get to without excess cost.

Cheaper gyms/leisure centres would be best.

"Make it less expensive

Invest in a larger range of activities

Invest in a free and more extensive public transport system so that car use would seem didn’t seem relevant.

Use of celebrities as role models"

Free access to gyms and trainers to assist weight loss

In school how PE is done. I hated PE and regarded it as something I didn't really need to bother with once I had left school. Only in later years did I discover that playing badminton could be fun; would still be playing now if the hip permitted.

Advise of the social side of taking part and the physical benefits.

Unsure

Cheaper, fun organised activities

"A buddy and support from family.

An activity nearby and a huge dose of motivation and a goal."

"Better accessibility

Reading has insufficient swimming facilities"

Widen choices. Include dance, gardening, treasure hunts etc.

Access to qualified fitness teachers at an affordable price. Specific group activities e.g. walks for slow/medium/fast walkers. Park Tai Chi/Qi Gung on local parks at weekend or even during the week if possible. Permanent fixed Fitness circuits in local parks. Free online exercises available for different fitness levels showing exactly how to do the exercises. Access to online fitness expert to ask questions

Having access to free physical activity facilities and gyms in the community

Dedicated cycle lanes would get more kids cycling

Having time and cheap facilities to do physical activities

"Japanese-style pre-work/school light exercise sessions

Less media depicting 'healthy' overweight persons

Community challenges using gamification with mobile apps"

Make it not just about exercise, make it about meeting up with people and sharing the experience while exercising.

Safe places to exercise outside and inside: the greatest impediment to physical activity on a day-to-day basis is simply cars: having more safe cycling routes separated from cars, safer pavements (lighting included) and more parks and outside venues is key. If people can walk or cycle to work really safely (rather than having to cycle/ walk next to huge lorries and speeding cars) this would make the biggest difference and also be excellent for the environment

more publicity about opportunities for activity, and about dangers of not doing it

Work-place advice. Unfortunately trade unions are less important than they used to be in work places, but there is a purpose here for them I think, as well protecting people in their occupations.

Free taster sessions but more than one

Better local facilities at low cost

At home, online exercise programmes to include disability exercise. I for one am to anxious to exercise out of my house. I do believe more needs to be done in schools in regard to confidence and self-esteem.

More people doing it. More visible activities. A wellness or fitness festival in Reading.

Note community group activity options/ more accessibility and awareness of existing ones.

It'd be good to have people who might be willing to assist disabled people to do more physical activity - possibly like a buddy system.

An event somewhere where people can try out different activities before committing to a paid-up number of sessions, or a membership, etc.

Free biscuits and cake

The pain of things that can happen later in life, the increased energy (and therefore happiness) from increased activity. Essentially you are 'levelling up' :)

"Educate the young

Walking schemes…leave the car at home"

not make them feel bad if they aren't

I don't think this is relevant.

"Messaging across multiple media

More opportunities to participate in sports

More opportunities to help others with physical help such as gardening and odd jobs"

Good real reasons to be active

It is too expensive to join clubs and activities. We tend to walk as a family and go to the park for exercise. However, if there is no local park then getting to the park can be expensive for people too. Transport costs are high but most of all there is nothing free for the kids to join. They have PE at school but apart from this every club needs to be paid for whereas other things such as swimming- an important life skill also needs to be paid for. Free gym memberships for children should be a must- where they can learn to swim or do some sports in a safe space. Moreover,

after school sports clubs should also be free with more spaces as they get booked up really quickly.

Maybe taster sessions? I think though a lot of resistance stems from motivation and time which can be very individual.

Cheaper, more accessible, help remove confidence barriers.

Fun, free activities to join in locally

make it easier than driving

Make the roads less dangerous/ensure cars don't speed/run red lights/park on pavements to encourage more walking/cycling.

Choice and accessibility. I think people need to be able to easily try a variety of activities to find something that suits them and their preferences and that they are not then barred from taking up.

"Free gym equipment in parks

Cost conscious solutions"

Cheaper gym memberships and classes or free options in local parks (like the outside gym stuff you can get)

Improvement to pavements for walking and protected cycle lanes and other cycle facilities such as secure bike lock areas

not offering FREE health care for those with high BMI

Good role models of relatable people

Not sure

"I think having someone or a group of people to do an activity with is very encouraging and motivating.

So promoting free to access and inclusive group opportunities might help. For example, Parkrun is a great and inclusive way to do some exercise, at whatever level each person feels comfortable with, in a supportive environment.

Prompts to build physical activity into daily/regular activities e.g. cycling to work, walking/running to the supermarket, might encourage some people."

"Broadcast a popular TV programme of groups of friends having fun with exercise - free, no equipment and no booking required.

Why are local swimming pools continue to require booking sessions? Almost impossible for workers who do !on calls""?"

Education

Don't know

cost of classes/gyms

more messages about the value of exercising. There are not enough sports and leisure facilities in Reading

Bring back fat shaming! Call being fat, fat! In this wonderful new 'diverse' society we are actually teaching people it's OK to be fat - it's the new normal!

Providing information about the health benefits of being physically active, including about the mind / body connection. Also need to address the underlying issues, such as trauma.

More free classes in a variety of sports/dance etc. Mum friendly groups too for things like clubbercuse, pole fitness, swimming... fun exercise. The same for Dads, sports clubs with a social side for Dads to bond with their lifestyle of parenting

Cheaper or free gym membership.

Free classes at appropriate times

Less traffic on roads to encourage more walking and cycling. Lower cost swimming sessions and other waterspouts such as paddle boarding and kayaking etc to ensure a range of options. Free or subsidised exercise sessions in outdoor spaces that parents can bring children along to.

More knowledge of local activities. Less stigma about body size. More time for mums to exercise.

21: Is there anything the local authority could do to encourage more physical activity?

There were 161 responses to this part of the question.

All of the above

See answer 20

"Improve cycling in Reading although I am not sure how

Run campaigns to educate cyclists and drivers so they respect each other more

Offer discount vouchers to sports facilities eg Nuffield or Nirvana spa"

More outdoor gyms. More quality sports surfaces...tennis courts, 3G pitches etc.

Provide more variety of classes / activities not just the gym! Lots of classes have waiting lists, or they're expensive or in an inaccessible part of town

Provide more low cost options for group exercise in the community. Not everyone wants to or is able to get to a leisure centre.

"I participated in OAP activities such as swimming and 50 Plus by using a Reading Passport. Those options have been withdrawn, which makes my participation more difficult. I used to swim at Highdown and Central pool for free, or maybe one pound, now I unaware of any facility.

Also, night school courses were reasonably priced and encouraged social ties and physical activity. Unaware of any opportunities now."

Promote more “this girl can” type of advertising. Promote reduced price/accessible exercise packages both out of doors and at sports centres.

Very cheap classes for under 5and over 55

Advertise what they do at the moment. Maybe include info in any communication from the council

Make it more accessible and affordable. Make it easier for people who need help to get that help without feeling they are being a nuisance.

"- I have seen there are apps that we can get points for walking or cycling but they are not working properly so if there are apps that are being develop it is important that they work and record the activity correctly

- community garden"

Better facilities - RBC is currently investing in two sports clubs - but prior to this Reading lost two swimming pools and unless you are a member of a very expensive spa there was nowhere to swim. I don't know if this happens but local schools should be able to take groups to sports clubs at a very low cost so that children get the chance to see if there is a sport that they can get into.

"Affordable access

Lack of stigma (obesity prevention seems a dated phrase)

Safe, accessible spaces"

More choices.

"Incorporate healthy choices into people’s everyday lives.

- Make cycling safer.

- Join up cycle lanes.

- Enforce the speed limit/highway code for drivers & prevent them running red lights to encourage more people to cycle.

- enforce parking limits around school"

Make it easier and cheaper for people to use buses rather than cars

Lower the price of rents in community building for groups of people to get together for activities

Vouchers for swimming

More green spaces, more playgrounds, improved cycle infrastructure

"More promotion of what exists

Making it an easy choice to make - part of daily life, encouraging individuals and families etc. Offer fun options not solely gym based options which are not everyone's preference."

"Offer wide range of physical activity programmes for the residents.

Access to leisure centre/bus routes

Subsidised monthly membership at leisure centre

share more information around these activities on a regular basis"

Could do trial days for new activities- allowing ppl to test out a new sport or activity

Free outdoor gyms. Decent play areas which are free.

As above

Yes, have better facilities for sports like Basketball and make it easy to book for swimming sessions

Ni

"More direct cycle routes.

Cheaper gyms and pools for Reading residents.

More school playing fields."

Free access to leisure centres

"Preserve and increase green spaces where activities are held.

Ensure allotments are promptly let out, as many are not worked in spite of lengthy waiting lists."

education and good information and discounted sports and fitness centres

Provide free access to sports centres for school children

No.

"Clean the parks more regularly,

Safeguard the parks from irresponsible adults.

Educate the youth what are the parks for."

I don’t think so

"Make access to free exercise environments easier - park gyms, nice running and walking areas.

Making commuting routes better for cyclists and walkers - as long as driving is more convenient you will not get people to leave their cars."

Don't know

Set up more local groups for walking, gardening, playing outdoor games. Also some low cost classes or other activities.

As above

inclusive clubs and community events encouraging involvement of all.

make access easier to sporting facilities, maintain the courts and pitches that have become disused; keep swimming poops and lessons open

It's really not for the local authorities to be trying to influence anyone's lifestyle

More information about walks and benefits of walking as an activity

Organise activities in parks for kids, for parents. Put out more of exercising equipment.

I don't know

Making people more aware of the facilities that council has to offer

Properly maintain outdoor spaces, provide outdoor gyms, provide equipment hire services that are affordable

Finish the pool at Rivermead

Reduce price of sports

Yes, see previous answer

It won't happen, of course. But if millions of extra pounds fell from heaven, the money could be used to fund a proper Dutch-style (dare I say it, EU-style) network of cycle lanes and tracks, quite separate from existing roads, so that cyclists and motorists would not have to mix. In Reading e-bikes could be issued to those who do not want to pedal up the town's steep hills. Finally, the (Labour) council should not be giving planning permission for housing developments that take away green space where the public could exercise in one form or another. I am thinking of Emmer Green (Reading) golf course in particular. The decision on that is an absolute betrayal.

"Make sure that council run leisure facilities are good and affordable.

Encourage parents to walk children to school."

Don’t know

Schedule some exercise sessions, eg swimming, only for people who identify as overweight or obese.

Reduce car use. Ban them in urban areas, except for disabled people who need one.

Better active travel options and reduced dependence on the car. Thinking about facilities needing to be local for everyone rather than planned around people

always getting in their cars. Potentially finding some way of, say, supervised groups walking to school so if parents work they don't have to drive kids to school.

"Nature trails.

Safe cycling.

Fun runs and walks.

Free sports playing and training"

Greatly Reduced prices at sports centres for the unemployed / disabled / elderly / those in universal credit.

"Be good role models.

Cycle machines in the waiting room of the customer service centre.

Free bus pass if you give up your car

Free bike if you give up your car"

Provide more sports facilities and not closing them such as the closure of the golf driving range near Rivermead

I'd stop driving into Reading from Caversham Heights if the bus service was more frequent - I appreciate the bus service is under utilised out here and therefore expensive to run but an hourly service isn't very practical if you have jobs to get to.

Provide cheap activities

Be more understanding about people who are very overweight and recognise that their needs are different to those who just have a couple of stone to lose

Improve the road surfaces (the recent programme appears to have been done "on the cheap" as the new surfaces are already splitting) and supply secure cycle storage facilities.

Monthly step challenges meet a local football player. Youth clubs, athletics clubs, tennis. Try new sports that are not accessible for low income children golf, horse riding and water polo

Build more and good maintenance on existing leisure centers

"Design developments to encourage walking & cycling with direct access to places of interest instead of going the same route as cars to decrease Health & Safety.

Having cycle ways that make sense instead of having to give way to cars more often than just using the road.

Reduce the amount of traffic on roads. The through traffic is still directed along Oxford Road although the long planed for Cow Lane bridge works was completed years ago. Making the section of Oxford rd no entry (except buses & residents

after 5pm) and single lane to facilitate local use (as lockdowns showed were useful).

Facilitate greener travel by introducing thought into the transport system with buses having their rest periods at the stations (Tilehurst, Reading West, Green Park) when the trains are due or at Rivermead, shopping centers.

Fine businesses that do not encourage at least 20% of employees to use green transport to work."

Continue to invest in sports & leisure centres and holiday clubs

Cheaper gym memberships and more areas to play sports in

Make reading safer to walk around – clamp down on drug dealers and the kids/dealers bombing it round on electric bikes way too fast and jumping lights.

Build more outdoor gyms, physical activity centres

Provide replacement swimming pools free gym membership for local people

More taster sessions to encourage people to up exercise, sports and activities.

Keep recreation centre costs low and not just for the young, the elderly, the unemployed? What about the middle aged employed?!

Advertise local groups in a way that makes them seem accessible & friendly to newcomers.

Yes they could offer more free opportunities

Promote more activities

Subsidise leisure centre entry fees.

Deliver better services on time

Gym accessibility

not shut local facilities like small swimming pools

See above

Make activities cheaper. Free swimming periods for people on universal credit, provide more information in schools for local activities outside school hours. Make gym classes free to under 16's.

Open affordable centres

Open a pathway from Nire Rd to Henley Rd through Ruskin

Bike clubs in schools, local bike runs, outdoor lido not privatised but a community based not for profit project

Discourage car use as much as possible

"1. Police patrols in the evening, specially during summer months.

2. Build park gyms."

"Make the streets safer for cycling.

Offer more physical exercise classes for people on low incomes.

Banish all the fast food outlets.

Banish all the unhealthy foods from the supermarkets.

Banish all advertising of unhealthy foods from streets."

Prizes.

Better bike lanes, easier pedestrian access, better public transport

Include adverts firm such groups in RBC magazine.

Make it easier to access leisure services, and publicise what's available more. I found it difficult to work out how to go for a swim after central pool closed because Rivermead is run by a private company and it is very confusing.

Drop the cost of using local facilities

Advertise and organize and build ice rinks bowling alleys everything that a large town should offer...

Ensure places are not limited. Ensure pricing is affordable for all not just a few.

Yes, I have already stated my opinion above in this respect.

Messaging its benefits and how to access

Keep council leisure centre costs low for local residents

Prizes for local sports competitions

More integrated/connected active travel routes and maps to help all find them

Make the council leisure centres cheaper. I can join a private gym for around £20 a month so this would be my budget.

"See above re transport.

Continue with the initiatives to increase cycling and reduce car use in the town

Provide lockable cycle storage local to areas of housing for residents to use conveniently and securely."

As above

"Swimming pools more accessible by public transport.

Pricing more accessible."

The answers are there already, perhaps the local authority could target those who are couch cabbages. Still they need motivation within themselves to take on exercise.

Unsure

Better advertising on what is available

Promote the local activities, leisure centres and services more at every opportunity. In every newsletter and every leader email. Consistent reminders.

Provide more swimming facilities

"Legislate.

This is sadly the biggest changer of behaviour - think seat belts, stopping smoking (in pubs, cars etc)"

Access to qualified fitness teachers at an affordable price. Specific group activities e.g. walks for slow/medium/fast walkers. Park Tai Chi/Qi Gung on local parks at weekend or even during the week if possible. Permanent fixed Fitness circuits in local parks. Free online exercises available for different fitness levels showing exactly how to do the exercises. Access to online fitness expert to ask questions

Having access to free physical activity facilities and gyms in the community

"Build more skate parks, basketball & tennis courts (& all to be free)

More access to leisure facilities in Reading - needs to be cheaper & open later"

More equipment in parks

"Safer streets and green areas

Cleaner streets and green areas

Prioritise pedestrian access over vehicle traffic in planning"

Yes, ensure that cycling paths are separate from car traffic; make pavements safer (smoother and with good lighting): plan streets and areas around safe walking and cycling and include as many parks as possible.

see 20

Yes but I think Reading does a fairly good job already - it's a pity that we've been without good swimming facilities for so long, but I'm lazy anyway!

More adverts as I have no idea what's available near me

As above - especially not closing facilities before new ones are open

As above

"Publish some local and accessible ""wellness walks"" from 1km up to 10km.

Publish on website a list of parks with public outdoor gyms with photos of the equipment and demonstration videos of how to use the equipment.

Organise outdoor gym sessions where people attend in person and are shown by a trainer how to use the equipment and given some sample routines of what to do."

"Local Authority can encourage opening of local gyms. There are Gyms in certain parts of Reading, however the centrally located Gym and pool have relocated to Rivermead.

Outdoor gyms are not usable during winter time or during inclement weather or during late hours. There are no lighting around outdoor gyms or local walk paths around parks. Instead of outdoor gyms, the local authority should focus on proper indoor workout areas , which are available 24/7, especially during winter.

It can encourage private Gym operators to open gyms where other gyms are not easily accessible (for e.g. Coley area) and offer some discount for council tax payers. Also information on local activities is not always available easily and more should be done so that this information is available."

Sports/ activity group days to promote local teams/groups to join

Maybe the local authority could help to put people together who could go to sports centres, etc.

Start in the schools, and workplaces even, with what I have mentioned in 20. above

Bring back schemes like the Reading Passport, discounts for local community

Free gym 'machines'/equipment in EVERY park, people really do use even the basic things like bars and frames. Palmer park and a few others have none in when they can make a huge difference at a low cost.

"Walking schemes

A few years ago my grandchildren took part in ‘Walking the streets’. Think that’s what it was called.

Maybe something similar for adults.

Walking costs nothing…no fees etc

Maybe collect enough ‘points’ to get a free fruit drink or coffee."

they shouldn't have to

Encourage the use of swimming pools, parks and recreation grounds etc. by all means possible.

"Messaging across multiple media

Promote use of leisure centres and sports clubs

Encourage use of allotments and parks

Encourage volunteering to improve the environment (litter picking etc)"

"The Town must be illustrated as having a culture of physical activity.

All barriers need to come down with a minimal of social and financial cost

ANYBODY CAN DO IT!!!"

Please see above

I think there are a lot of facilities to use. Maybe free taster sessions/membership?

Reduce the price of using the sport centre

Provide more opportunities for community activities

cut road speed limits to 20 across the whole borough to make it safer to cycle, and just as fast

More free or low-cost options for physical activity, better alternative access to sport facilities that doesn't require a car, more cycle lanes and education on their use for pedestrians, cyclists and drivers, more parks.

Make the roads less dangerous/ensure cars don't speed/run red lights/park on pavements to encourage more walking/cycling.

Set up community exercise groups particularly those which are accommodating of gender, ethnicity and cultural requirements (e.g. women's sessions in pools / gyms) where equipment is provided. For example swimming and cycling are relatively easy, low impact forms of exercise that are good starting points for people looking to improve their fitness but both require facilities, equipment and skills that could be barriers to entry.

Place more gym equipment in parks, more easily accessible swimming pools (cost and locations)

"Outdoor gym stuff in parks

Cheaper gym memberships /classes to supported gyms"

Support community activities such as fun runs, park run, walking festivals

Subsidise considerably the cost of joining activity classes

free gym & swimming classes - the gym membership are very expensive especially now with the massive increased living cost

As much public open space as possible that people can walk to. The Reading Walks Festival was brilliant, and hopefully will grow! Presenting examples of local people becoming more physically active (not celebrities whose level of fitness is beyond most people's reach!). Park runs are very inclusive. More physical activity in schools and after school clubs, that make it easy for and help people to continue the activity when they leave school.

Better public transport links. Swimming pools (so many have shut across Reading and have taken a long time to reopen). Cheaper options.

"Reading is quite walkable, but it is not good for cycling.

So developing a comprehensive, well-connected cycling network would help - it's no good if there is no separation from cars/motor vehicles, and if cycle routes/paths abruptly end - people who currently don't cycle won't feel safe to start cycling. With a good cycle path network it would be feasible for people to use active travel via bike for journeys that might previously have been done by car, i.e. longer journeys that are too long to walk."

"Continue to protect pleasant, public spaces.

RBC does a great job with our parks. Many, many thanks - lifesaving!"

Encourage healthy eating

Don't know

advertise? Put on free things like park run

yes, offer financial incentives to go to leisure centres. Support yoga, pilates and similar studios. Support local dance groups such as those that teach jive, tango, blues, salsa

"Give grants to volunteer run grass roots sports clubs! My club (Reading Canoe Club) is run entirely by volunteers. Decent funding would help us keep membership prices lower, and thereby attract more people who might otherwise not be able to afford to join.

As things currently are with utilities costs through the roof, and repairs to buildings costing the earth, it's as much as we can do just to survive."

Design the physical environment to encourage physical activity, such as walking and cycling.

Invest into schemes for free clubs like this

maybe start a local challenge, like what area can get the most steps..... or what school can get the most steps

Create more pedestrianised areas, reduce the cost of public transport and offer council tax reductions for homes without a car apart from any needed for business use.

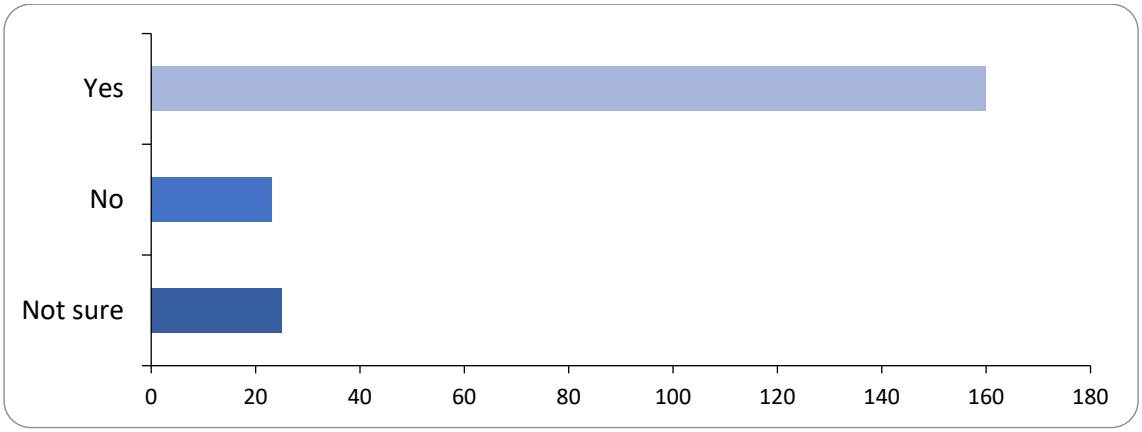
"Improve the fitness centres reduce their cost and have childcare for classes.

Make the buses cheaper and easier to use.

Improve the cycle paths."

Question 22: Would you like to see less advertisements for food high in fats, sugar and salt (such as burgers, fried chips and fizzy dinks) around town centres?

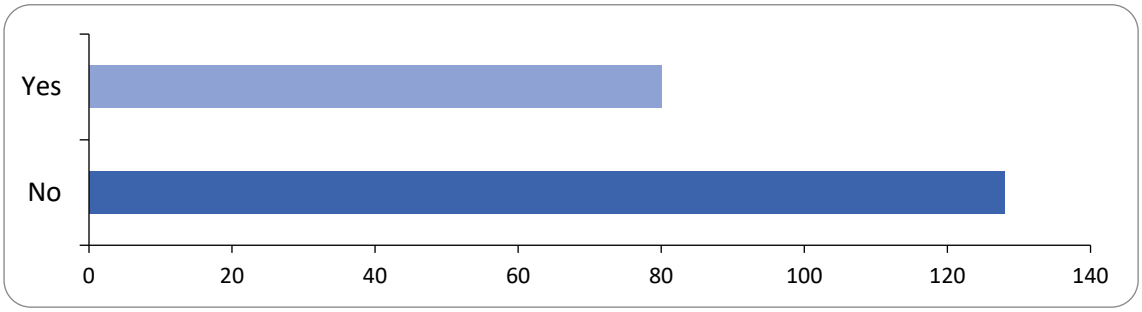
There were 208 responses to this part of the question.



Option	Total	Percent
Yes	160	76.92%
No	23	11.06%
Not sure	25	12.02%
Not Answered	0	0.00%

Question 23: Have you experienced, or are you aware of, stigma around accessing support for weight management? 'Stigma' is referring to "a set of negative and often unfair beliefs that a society or group of people have about something".

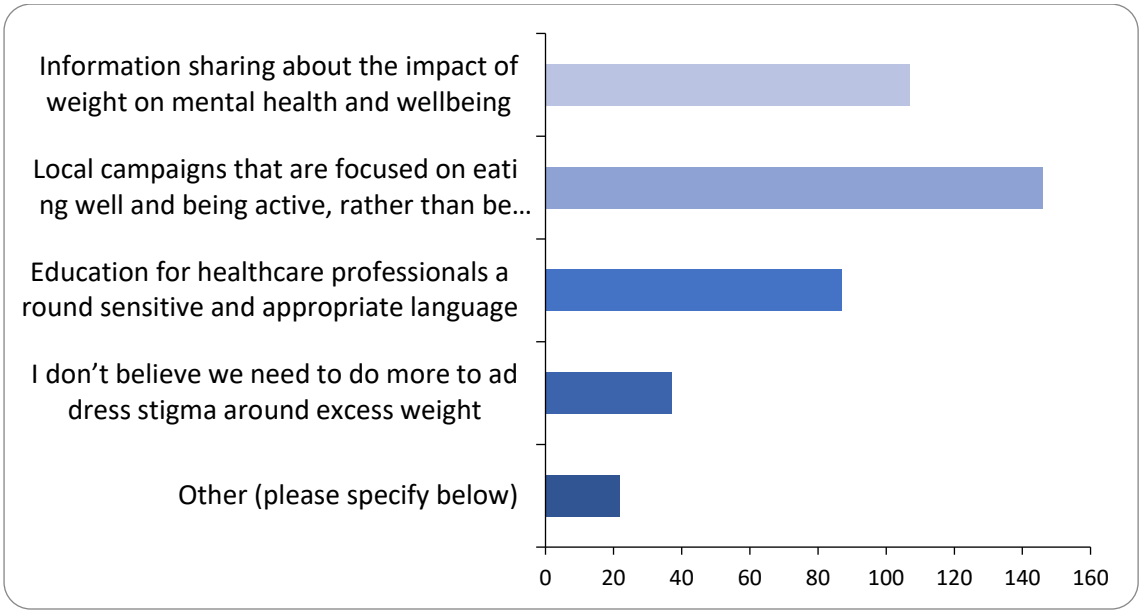
There were 208 responses to this part of the question.



Option	Total	Percent
Yes	80	38.46%
No	128	61.54%
Not Answered	0	0.00%

Question 24: What do you think could be done to challenge this stigma? Tick all that apply

There were 208 responses to this part of the question.



Option	Total	Percent
Information sharing about the impact of weight on mental health and wellbeing	107	51.44%
Local campaigns that are focused on eating well and being active, rather than being all about how much someone weighs	146	70.19%
Education for healthcare professionals around sensitive and appropriate language	87	41.83%
I don't believe we need to do more to address stigma around excess weight	37	17.79%
Other (please specify below)	22	10.58%
Not Answered	0	0.00%

Other please state

There were **31** responses to this part of the question.

It has been good to see the word 'obesity' used less in campaigns etc now. I think the same should be done in a general move away from being weight-centric (although perhaps this is different for very overweight individuals?).

I think the problem is that excess weight has become too normalised...it seems like these days a majority of the population is overweight. It shouldn't be so acceptable to be overweight, same way it shouldn't be acceptable to do other things that are highly damaging to long term health (smoking, drugs, excess alcohol).

"More positive information on the effectiveness / success of services and the theory behind programmes - dispel myths that it's just a 'con' to get your money

More services focused on men - for and by men. My husband joined slimming world and it's mainly women!"

I agree that campaigns should not be all about how much someone weighs, but equally people do need to understand the impact of an unhealthy weight on their physical health (and their mental health). I'm aware there are voices out there that deplore any idea of "fat shaming" (for example people should celebrate their fatness and not contemplate any negative consequences). However, as a public health team we should not shy away from stating the impacts of unhealthy weight. Language is really important here.

Some people who are overweight may have the wrong genes or a medical condition that makes them overweight. Metabolism controls weight loss. Not many people are aware of this.

A lot of people refer to slimming groups or weight management groups as 'Fat Club' this is inappropriate and can put people off going.

Enabling people who have made significant and long-term changes to their life-style or who have successfully lost weight being able to share their stories (including their struggles!) with community groups.

It's one of the last socially acceptable stigmas. People always find fat people funny and it seems that this is ok by society

"I sometimes think that we can be over sensitive when it comes to weight. I am overweight, I know this, I'm not just being coy about carrying an extra pound or two - I am 5ft 6in and today weighed in at 15st 4lb

I want my GP to tell me about the risks around obesity."

"Education for health professional on eating well and being active, rather than being all about how much someone weighs

Local authority and other campaigns putting large/ fat people in posters and adverts, promoting healthy eating and active lifestyles to show people are all shapes and sizes

Education to policy makers on cost of living and how that affects everyday people in making healthy food and active living choices (when you shift work, live on a busy road, rely on school meals, can't afford a bike for your children and don't have any place to store it in your flat, etc)"

but we shouldn't forget that different people different cases, different circumstances such as depression, lifestyle, loneliness, lack of money, or self-esteem

I think stigma is around weight not just accessing weight management services so a campaign or work to remove stigma in general would be ideal.

Be cruel to be kind?

There needs to be so much more info about how companies create 'addictive' food.; They should be taken to task by government - advertising banned and greater tax on -say - sugary drinks as promised and not fulfilled.

Leading question, why ask previous question?

"Stop the ""fat and lazy"" pairing in your plans.

Show overweight people being active (like the ""this girl can"" campaign)

Show skinny people worrying about eating healthily, or being depressed and sedentary

Normalize wanting to eat healthily for everybody

Normalize wanting to be active for everybody

Normalize wanting good mental health for everybody"

Stop assuming fat people are too lazy or too stupid to lose weight. It is not that we don't know we need to lose weight or even that we don't know how to lose weight but when you have a lot to lose it really isn't as simple as cutting out biscuits and fried food. It is easy to say do more exercise but exercise needs to be more than just walking - a lot of us fatties walk a lot anyway. Gyms are too scary for very fat people - the people who work there and are supposed to help have no idea what it is like to be very overweight and recommend totally inappropriate activities, swimming would be good but again the people who use and work at the swimming pools in Reading are very judgey and make comments that mean very overweight people feel too embarrassed to swim

"I think we need to be clear that obesity is unhealthy – the anti-""fat-shaming"" drive has moved us to a place where criticising obesity is 'hateful', which is absurd.

Like alcoholism or smoking, Obesity is unhealthy, and we need to be clear on that, but people should absolutely not be shamed for accessing help."

I don't think there is a stigma. But I'm not aware of any support there to be accessed.

Personal motivation and confidence.

I think what is key is to shift the whole way policy at all levels is increasingly about 'personal, individual responsibility': eating well and keeping fit and a healthy weight are increasingly the preserve of the rich or well-off with poverty, poor housing, poor jobs, difficulty in accessing health care and a poor social environment overall making it most difficult to manage to stay healthy. The increasing emphasis on individual agency and on the supposed 'influence' of language is much less relevant than addressing the wider issues around poverty, education and health care

I'm really fed up (sorry!) with seeing obese people - it's getting like North America, where my niece lives, and says almost every kind of food you get just tastes of sugar, salt, fat, and flavourings. WHY IS BAD FOOD ALWAYS CHEAPER?

Alter the dialogue in the media

I think being overweight is being more commonly accepted and even possibly glorified if anything when it's actually highly damaging! I think it's not about challenging stigma, it's about people being aware of why it's detrimental to be overweight so they can make their own decisions, no one can actually fight stigmas but the people involved themselves.

stop people being judgmental

"Less assumptions and more enquiry around food and weight.

I thought I ate healthily, lots of fruit and veg, oats at breakfast, no high sugar cereals, potatoes and pasta (gf) as a treat, veggie 3-4 days a week but I was still putting on weight. There needs to be more understanding and education that peoples metabolisms are different and my body did not like the carbs I was getting from fruit, oats, pulses and starchy veg. I am losing weight now"

'Woke' thinking makes a nonsense of the whole thing. If people cannot be told they are overweight because it is 'fat shaming', there is no hope of improving the situation.

N/a

Health professionals do not need more education. They need more time: sensitive and patient-responsive conversations/communication take more time.

People (both the public and health professionals) need to stop focusing on weight, and start adopting a 'health at every size' approach. It is possible to be overweight and healthy. The current BMI range we class as "healthy" is outdated, and BMI should not be used to assess health anyway. It is not fit for purpose

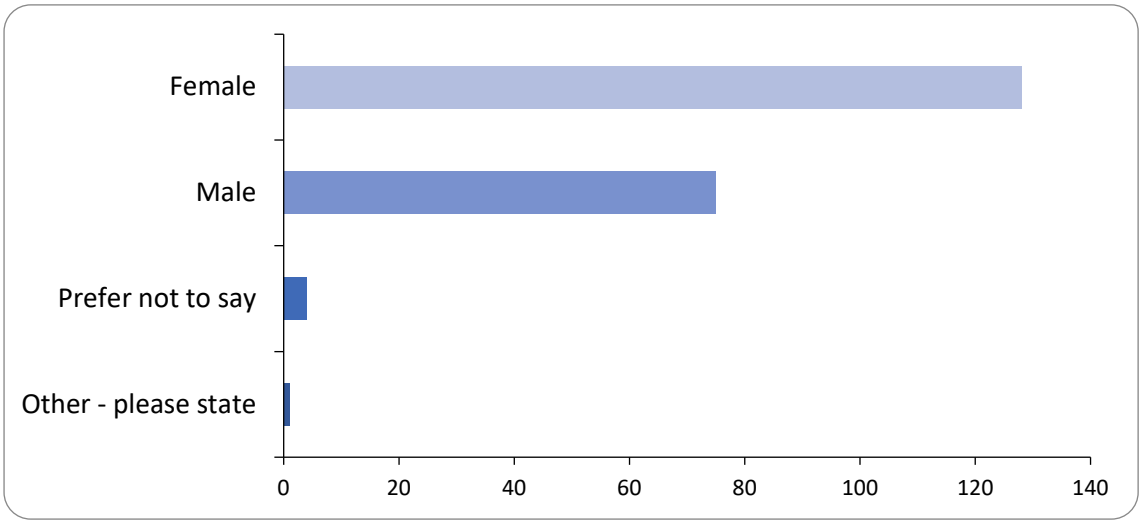
Being fat and obese needs to be stigmatised! Just like smoking has been. We are teaching people that it is normal to be morbidly obese. It isn't!

Demographics

Question 25: Are you?

Gender

There were 208 responses to this part of the question.



Option	Total	Percent
Female	128	61.54%
Male	75	36.06%
Prefer not to say	4	1.92%
Other - please state	1	0.48%
Not Answered	0	0.00%

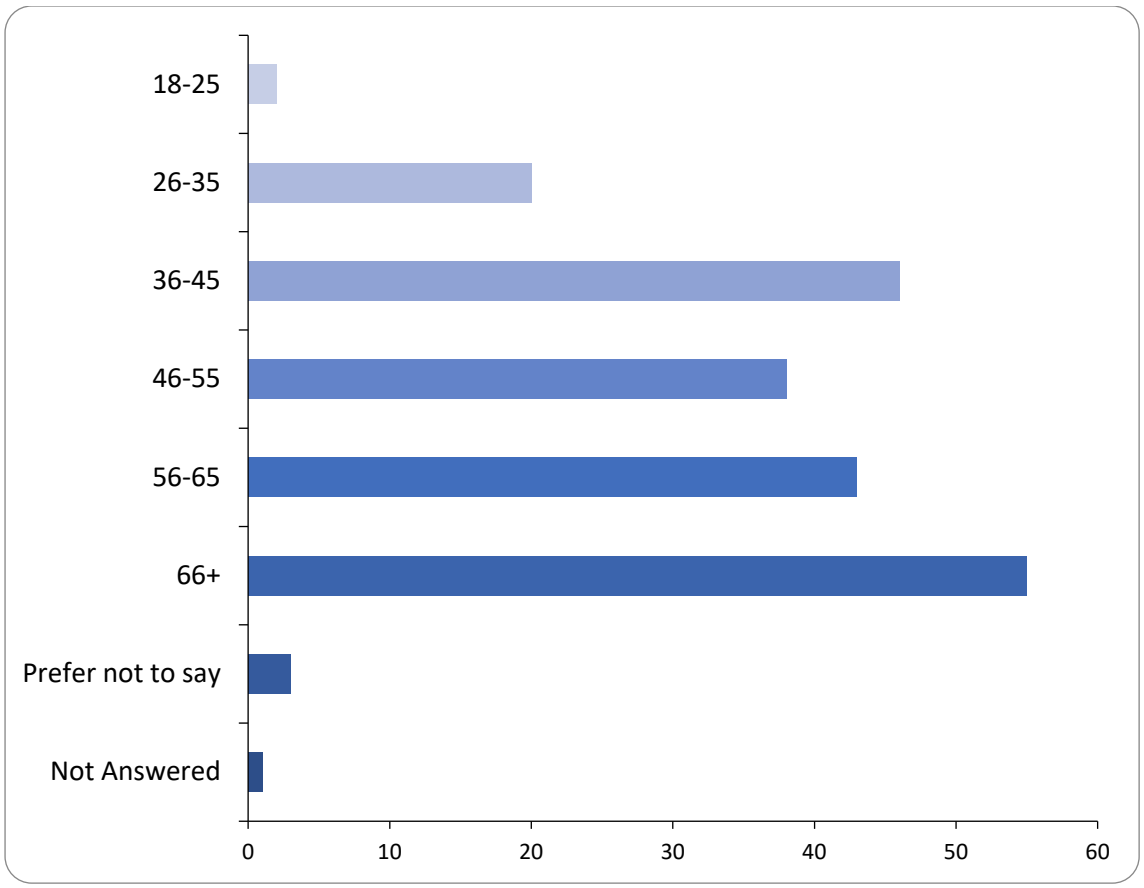
If you prefer to self-describe, please say here

There was 1 response to this part of the question.

Non Binary

Question 26: Which age group do you belong to?

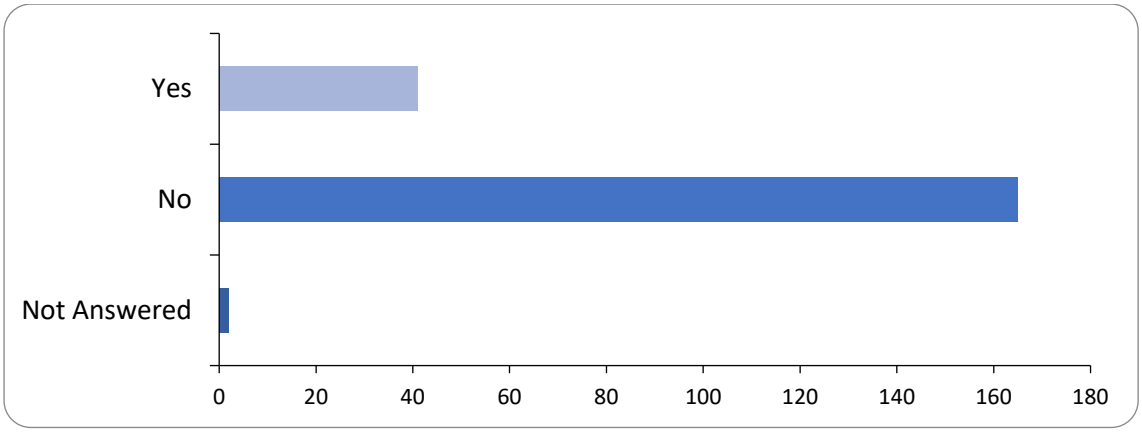
There were 207 responses to this part of the question.



Option	Total	Percent
Under 18	0	0.00%
18-25	2	0.96%
26-35	20	9.62%
36-45	46	22.12%
46-55	38	18.27%
56-65	43	20.67%
66+	55	26.44%
Prefer not to say	3	1.44%
Not Answered	1	0.48%

Question 27: Do you have a disability, long-term illness or health problem (12 months or more) which limits your daily activities or the work you can do?

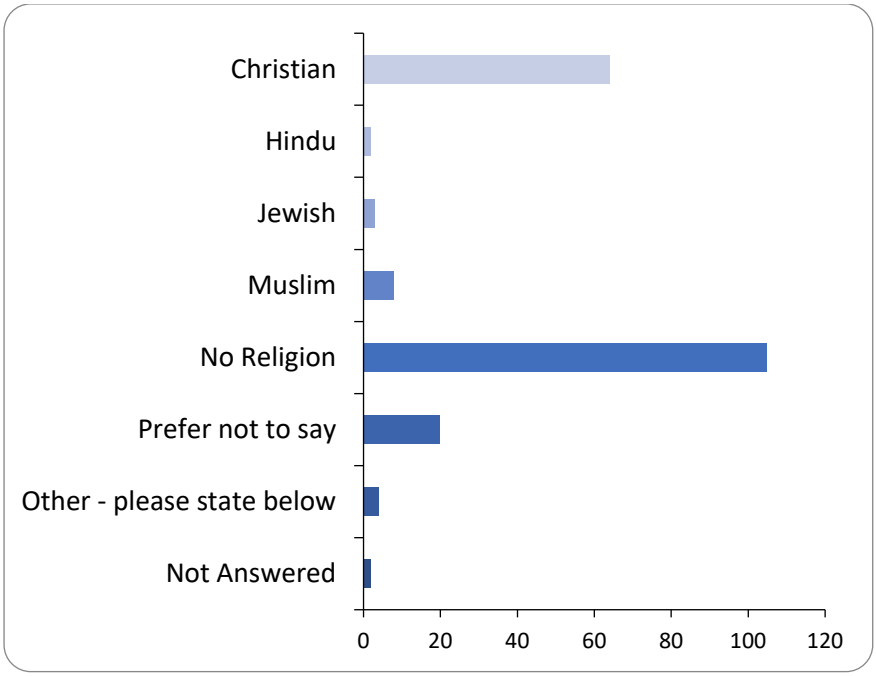
There were 206 responses to this part of the question.



Option	Total	Percent
Yes	41	19.71%
No	165	79.33%
Not Answered	2	0.96%

Question 28: What is your religion or belief?

There were 206 responses to this part of the question.



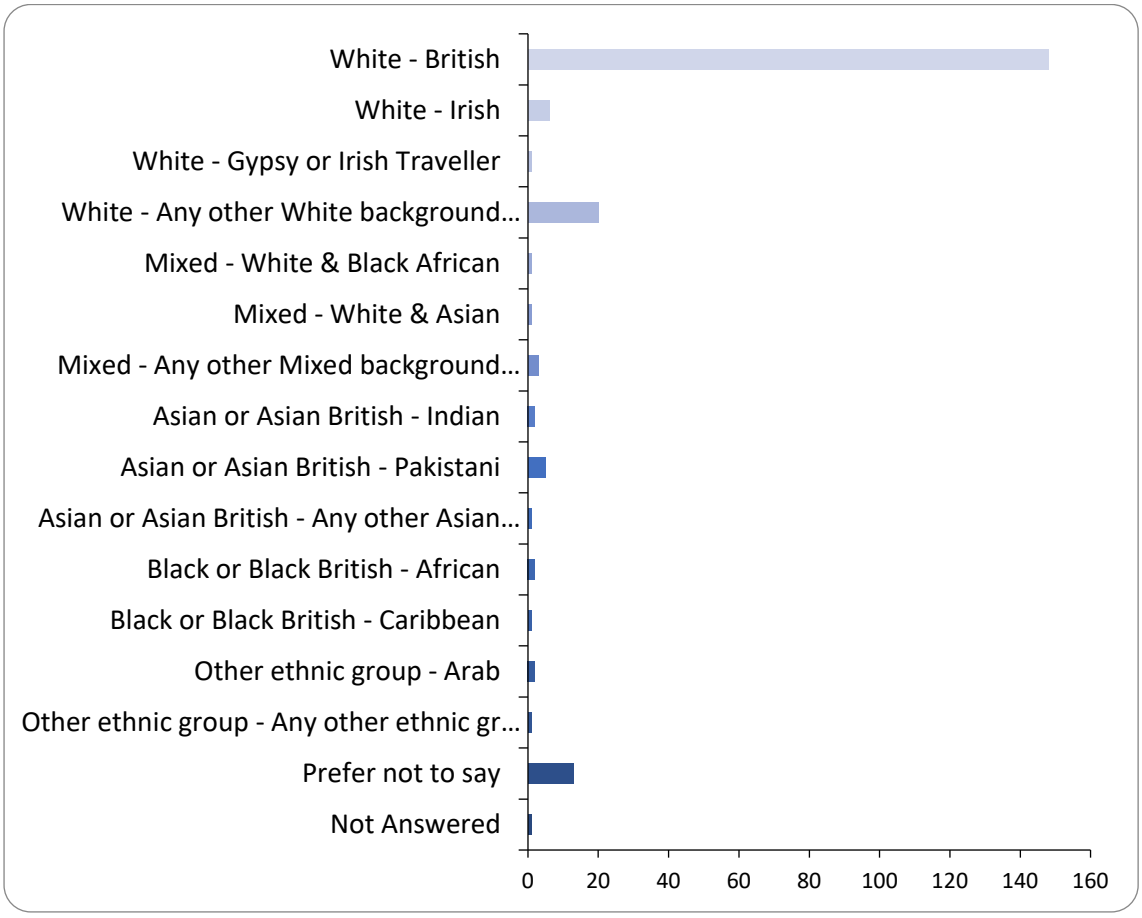
Option	Total	Percent
Buddhist	0	0.00%
Christian	64	30.77%
Hindu	2	0.96%
Jewish	3	1.44%
Muslim	8	3.85%
Sikh	0	0.00%
No Religion	105	50.48%
Prefer not to say	20	9.62%
Other - please state below	4	1.92%
Not Answered	2	0.96%

Other religion

There were 6 responses to this part of the question.

Question 29: To which of these ethnic groups do you consider you belong?

There were 207 responses to this part of the question.



Option	Total	Percent
White - British	148	71.15%
White - Irish	6	2.88%
White - Gypsy or Irish Traveller	1	0.48%
White - Any other White background (Please specify below)	20	9.62%
Mixed - White and Black Caribbean	0	0.00%
Mixed - White & Black African	1	0.48%
Mixed - White & Asian	1	0.48%
Mixed - Any other Mixed background (Please specify below)	3	1.44%
Asian or Asian British - Indian	2	0.96%
Asian or Asian British - Pakistani	5	2.40%
Asian or Asian British - Bangladeshi	0	0.00%
Asian or Asian British - Chinese	0	0.00%
Asian or Asian British - Any other Asian background (Please specify below)	1	0.48%
Black or Black British - African	2	0.96%
Black or Black British - Caribbean	1	0.48%
Black or Black British - Any other black background (Please specify below)	0	0.00%
Other ethnic group - Arab	2	0.96%
Other ethnic group - Any other ethnic group (Please specify below)	1	0.48%
Prefer not to say	13	6.25%
Don't know	0	0.00%
Not Answered	1	0.48%

Ethnicity Other

There were 16 responses to this part of the question.

American

Polish

USA

European

British/ N african

White British/Irish

American

Greek

European

White European

White Scottish

Black and Asian

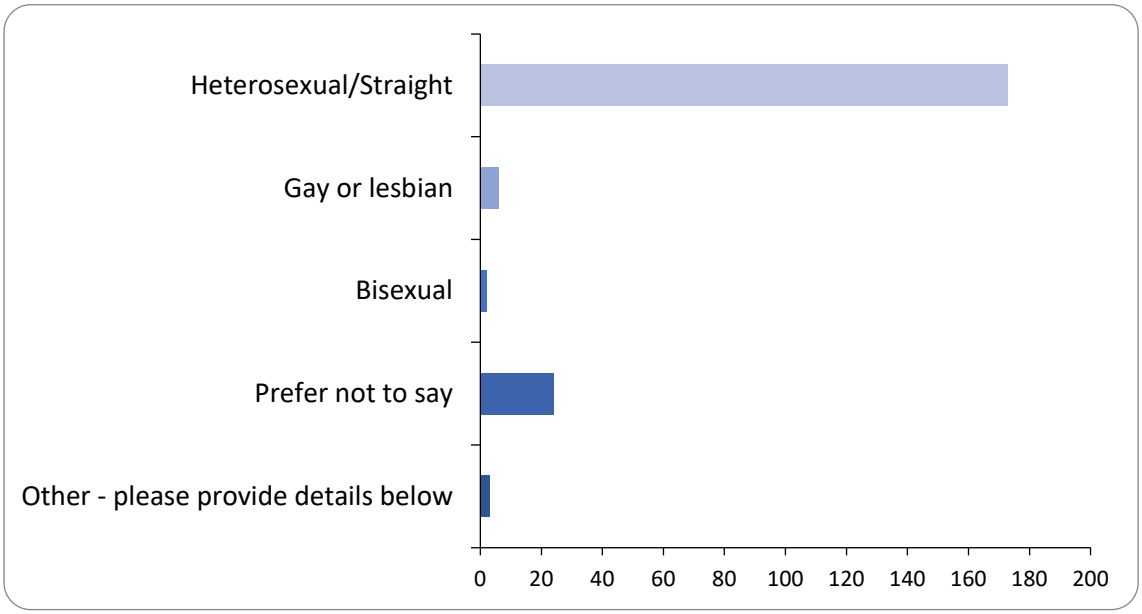
Eastern Europe

European White

Czech

Question 30: What is your sexuality?

There were 208 responses to this part of the question.



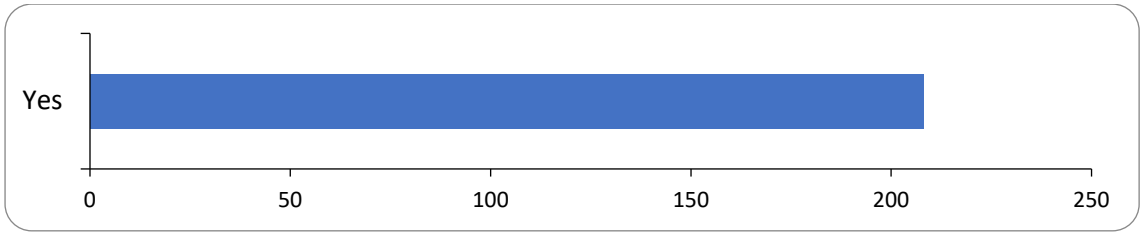
Option	Total	Percent
Heterosexual/Straight	173	83.17%
Gay or lesbian	6	2.88%
Bisexual	2	0.96%
Prefer not to say	24	11.54%
Other - please provide details below	3	1.44%
Not Answered	0	0.00%

Sexual orientation - other

There were **2** responses to this part of the question.

Pansexual

Not object oriented



Option	Total	Percent
Yes	208	100.00%
No	0	0.00%

Postcode

In order to establish which areas your comments relate to, please provide your home postcode

There were 205 responses to this part of the question.

Data protection

I agree to the above statement

There were 208 responses to this part of the question.

Appendix 12.2 Full report: Healthy Weight Needs Assessment 2023 - Professionals survey

Professionals supporting people experiencing challenges maintaining a healthy weight

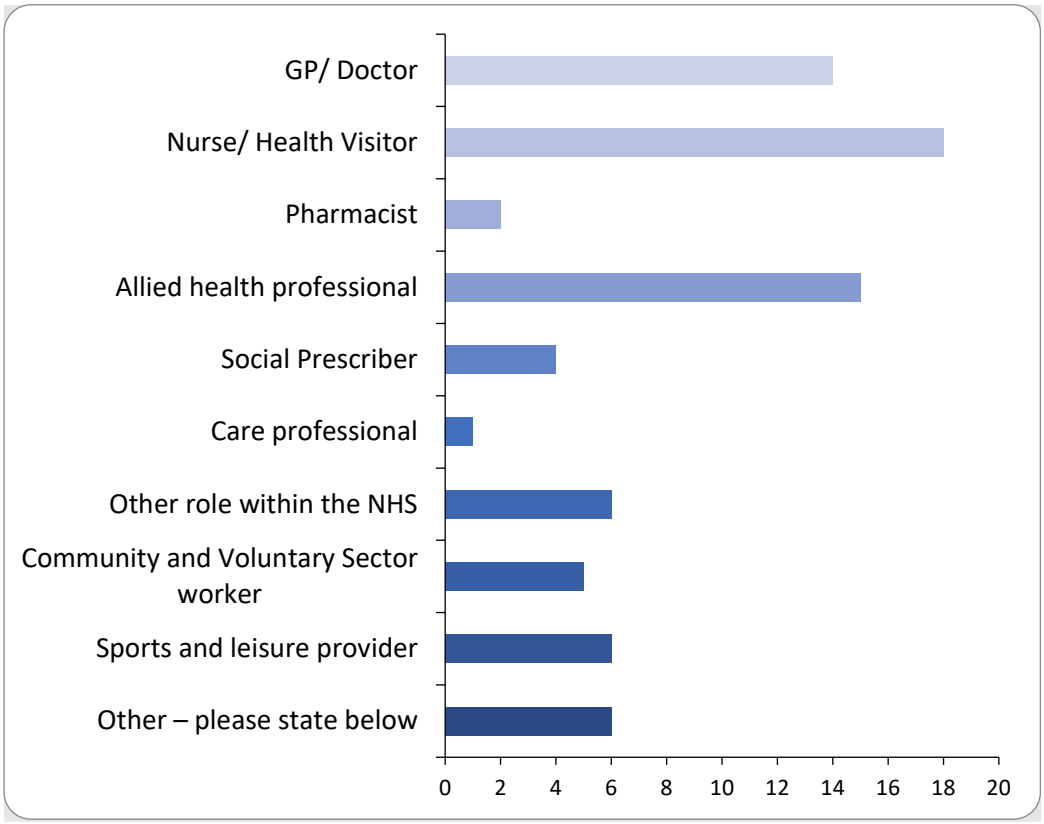
This report was created on Wednesday 21 June 2023 at 14:06

The activity ran from 09/05/2023 to 16/06/2023

Responses to this survey: **77**

Question 1: Are you responding as a...

There were 77 responses to this part of the question.



Option	Total	Percent
GP/ Doctor	14	18.18%
Nurse/ Health Visitor	18	23.38%
Pharmacist	2	2.60%
Allied health professional	15	19.48%
Social Prescriber	4	5.19%
Care professional	1	1.30%
Other role within the NHS	6	7.79%
Community and Voluntary Sector worker	5	6.49%
Sports and leisure provider	6	7.79%
Other - please state below	6	7.79%
Not Answered	0	0.00%

Other please state

There were 15 responses to this part of the question.

social worker

Social Care Coordinator at Reading Borough Council

Children Centre family development worker

Volunteer with Reading's Climate Change Partnership, leading the actions grouped under the Resources & Consumption theme of Reading's Climate Emergency Strategy which contribute to Reading's aim of becoming a zero waste town with a thriving circular economy. It is a broad theme and includes the impact of diet and the food system on carbon emissions. Hard to talk about diet and the food system without also talking about their impacts on health, biodiversity and inequality as well.

School Nurse - SCPHN

Climate policy officer (working with colleagues in public health and local NHS trusts on climate/health inter-face)

School Nurse

A cycling instructor, working within the Reading Borough Council area and other local authorities

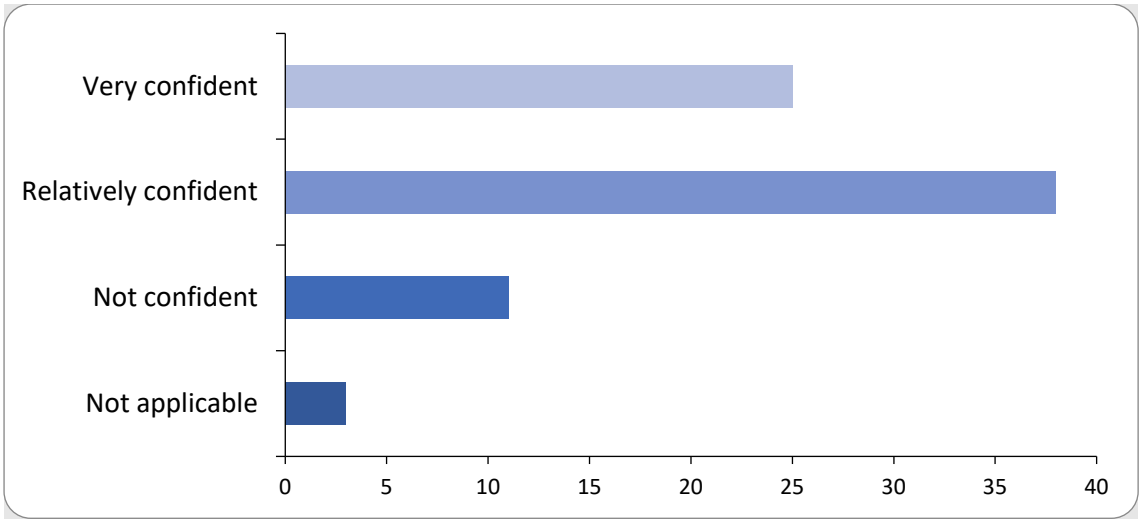
Midwife x 5

Physician associate

I am part of the MeetPEET team from the RBH doing mini health checks in the community

Question 2: How confident do you feel about raising a discussion about an individual's weight in your role?

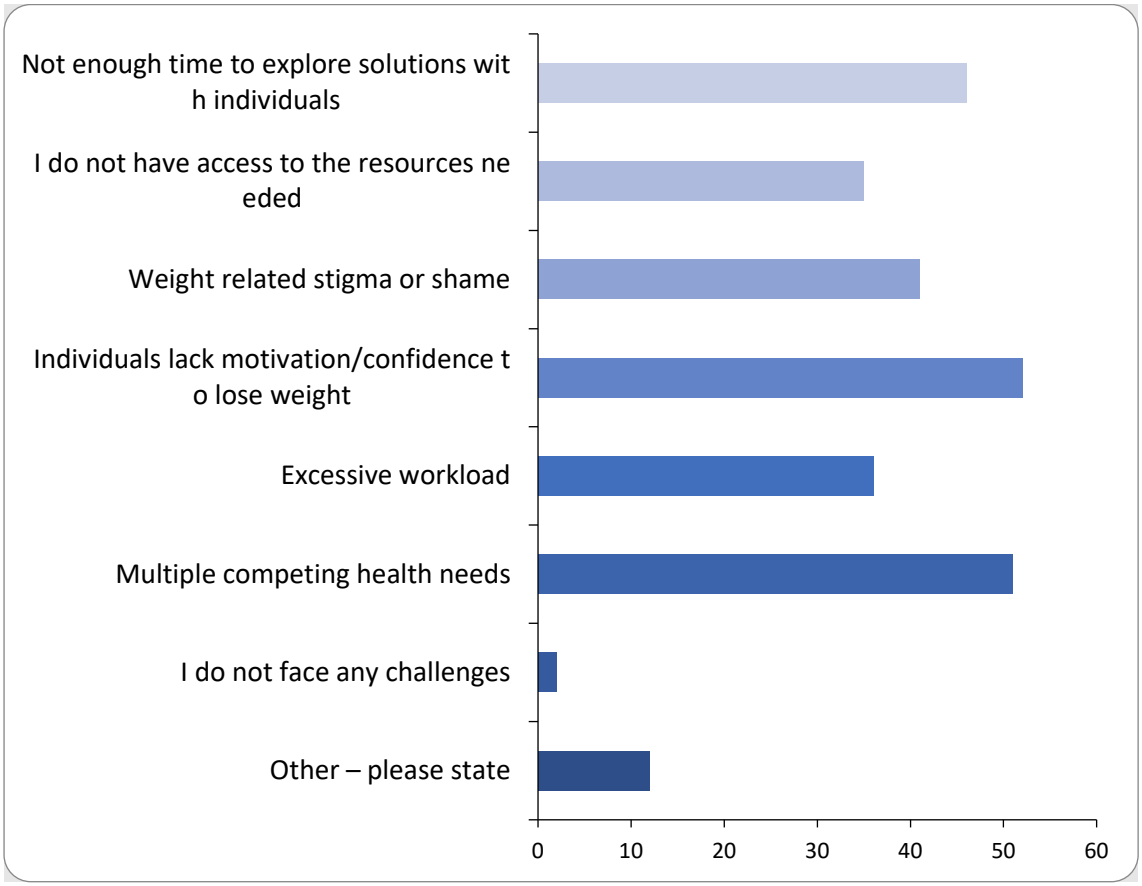
There were 77 responses to this part of the question.



Option	Total	Percent
Very confident	25	32.47%
Relatively confident	38	49.35%
Not confident	11	14.29%
Not applicable	3	3.90%
Not Answered	0	0.00%

Question 3: What are the challenges in supporting people with excess weight? Tick all that apply

There were 77 responses to this part of the question.



Option	Total	Percent
Not enough time to explore solutions with individuals	46	59.74%
I do not have access to the resources needed	35	45.45%
Weight related stigma or shame	41	53.25%
Individuals lack motivation/confidence to lose weight	52	67.53%
Excessive workload	36	46.75%
Multiple competing health needs	51	66.23%
I do not face any challenges	2	2.60%
Other - please state	12	15.58%
Not Answered	0	0.00%

Other - tell us more

There were 17 responses to this part of the question.

"Patients needs regarding weight loss differ. Most people have tried several diets in their life.

Behavioural change is essential.

I believe the education regarding healthy foods, short and long term support.

Many people still enjoy face to face, but there is a role for Online for some."

I'm not sure it's my role to discuss this as I'm an allied health professional dealing with eyes. I think these are missed opportunities though as carrying excess weight could be causing the diabetes/ high bp etc and ensuring you can direct the patient to appropriate resources would be really helpful. Even having some basic stage 1 training would be useful. I know a lot myself from personal research but don't use this - as professionals we all seem to stick to our own areas but I do feel that this needs to change.

patient financial, access to fitness classes etc

Too much work therefore can only see the children and young people for a short amount of time and if they are not ready to make the necessary changes or they need additional support there is no where to refer them onto

In terms of talking about healthy weight, my role mainly calls for me to have an understanding of the interconnected influences on people's dietary choices. I cannot think of situations in which I would talk to someone individually about their weight. As indicated in my response to question 1, although my primary focus is the impact of our dietary choices (and the system in place to 'feed' them), I see food as one of those things that impacts, and connects, a range of issues. Just read Henry Dimbleby's 'Ravenous'. Started to read Chris van Tulleken's 'Ultra-Processed People'!

Previous community support groups have not always been well attended by students. Students do not have the self confidence to join a group to address their eating/exercise habits. These sessions will need to be free and easily accessible e.g. in school.

Our patient group have learning disabilities and there is no group or health promotion activities that they can access.

We do not accept referrals for excess weight so it is always secondary to the main reason for contact - I am a dietitian.

"Lack of free or very low cost local programmes, gym memberships, information and advice which are non-digital to assist people with losing weight.

Long waiting lists for the one free programme at Better Leisure Centres for those who are motivated (now) to lose weight.

Transport - some individuals cannot drive and leisure centres, community centres, etc are not necessarily easily accessible via public transport.

Some people are not online or do not want to access information and advice about weight loss online.

Some people would like a ""buddy"" with whom they can attend a gym, swimming, session, etc."

Poor mental health.

Some overweight people are otherwise fit and healthy - especially strong cyclists

Most of the people I work with are children. Whilst the issues of excess weight are relevant, and most young people understand the need for a good diet and regular exercise, they are not often in control of what they eat or drink. Not all are motivated to exercise effectively and don't often have parental support.

Resources to address pain-fibromyalgia, osteoarthritis, mood needed to support consultation

we refer to nursing or dietetics to support the individual

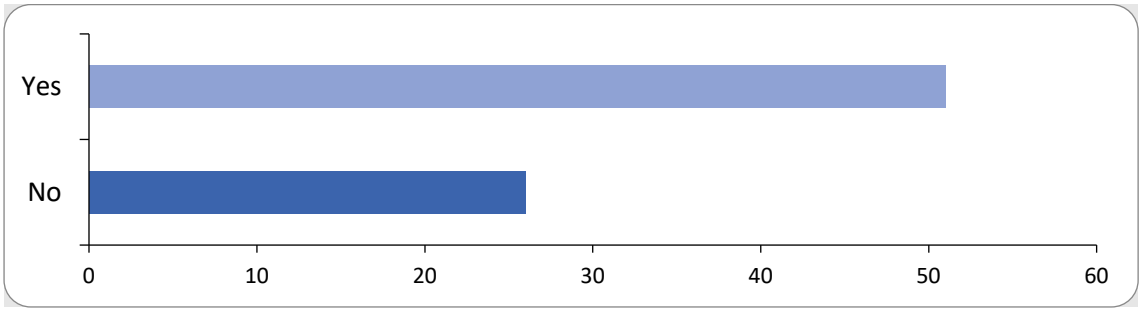
I know nothing about existing support for people with excess weight

We are in a fast moving environment, in very public areas so we do not always have the time or resources to meaningful conversation with people

Too busy and not enough volunteers to deliver the session

Question 4: Do you signpost people to services to help them manage their weight? These could include national digital weight loss programmes, commercial weight management services, and physical activity services.

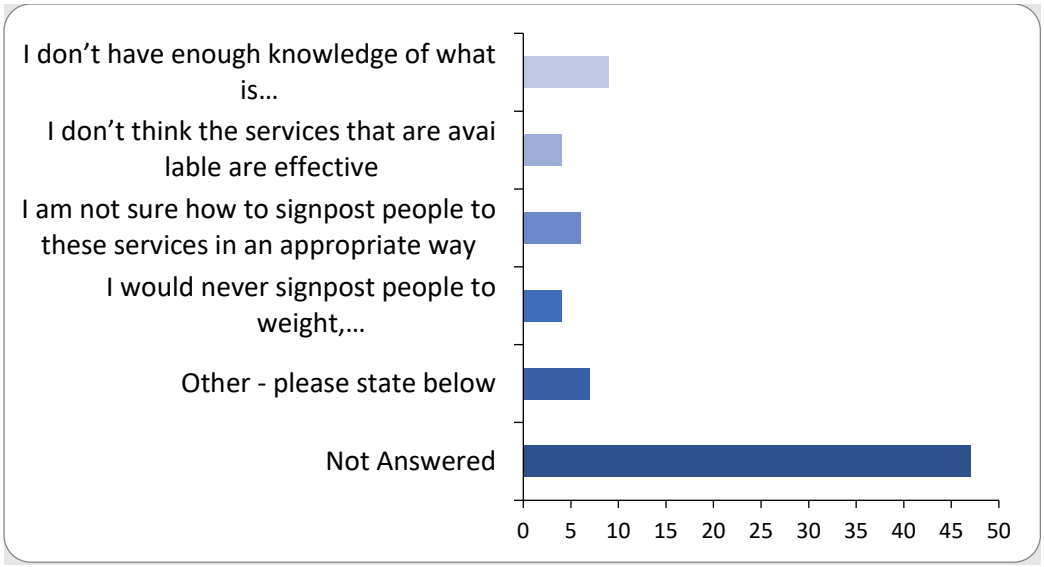
There were 77 responses to this part of the question.



Option	Total	Percent
Yes	51	66.23%
No	26	33.77%
Not Answered	0	0.00%

Question 4a: If you have answered No, please tell us why

There were 30 responses to this part of the question.



Option	Total	Percent
I don't have enough knowledge of what is available locally	9	11.69%
I don't think the services that are available are effective	4	5.19%
I am not sure how to signpost people to these services in an appropriate way	6	7.79%
I would never signpost people to weight, healthy eating or activity services, it is not appropriate for my role	4	5.19%
Other - please state below	7	9.09%
Not Answered	47	61.04%

Other please state

There were 13 responses to this part of the question.

I am also not sure how to signpost people in an appropriate way

all above

There are no services available locally. Signposting to leisure facilities isn't normally effective in isolation, cost can be a huge barrier and not always appropriate for children and young people depending on their age.

"To date it has not been appropriate in my role. Strategically, I seek to engage with a range of organisations and networks with a shared interest in encouraging healthy diets and a sustainable food system. Where I see connections I try to highlight them and make introductions, but mainly at an organisational level

rather than at an individual level. If I were to find myself on a stall or writing a blog about healthy eating I would probably want to make connections to the sorts of services mentioned (having done a bit more research to ensure any mention is appropriate). It explains my interest in the idea of a sustainable food partnership in Reading (similar to ones developed in Brighton, Oxford and Bristol).

Within the Reading Climate Change Partnership are themes (and theme groups/theme leads) focused on Health, Transport and Nature (as well as Water and Energy), as well as cross cutting activities focused on particular audiences. These are likely to be able to make complementary connections."

The students I support are often vulnerable and young and may not have parental support. They need an individual plan.

There is no service that support client groups with LD on weight management as compared to the general population. They are usually referred to the learning disabilities dietitian, however, we know from evidence that a multidisciplinary group is required for a successful outcome.

I work with children and young people

I tend to work in schools and generally don't get access to the parents.

Learning Disability clients have not been routinely signposted to services due to requiring access to easy read adapted resources and care plans.

Also, not sure of which services are appropriate for my role as a midwife, can pregnant women be offered the same services as the general population.

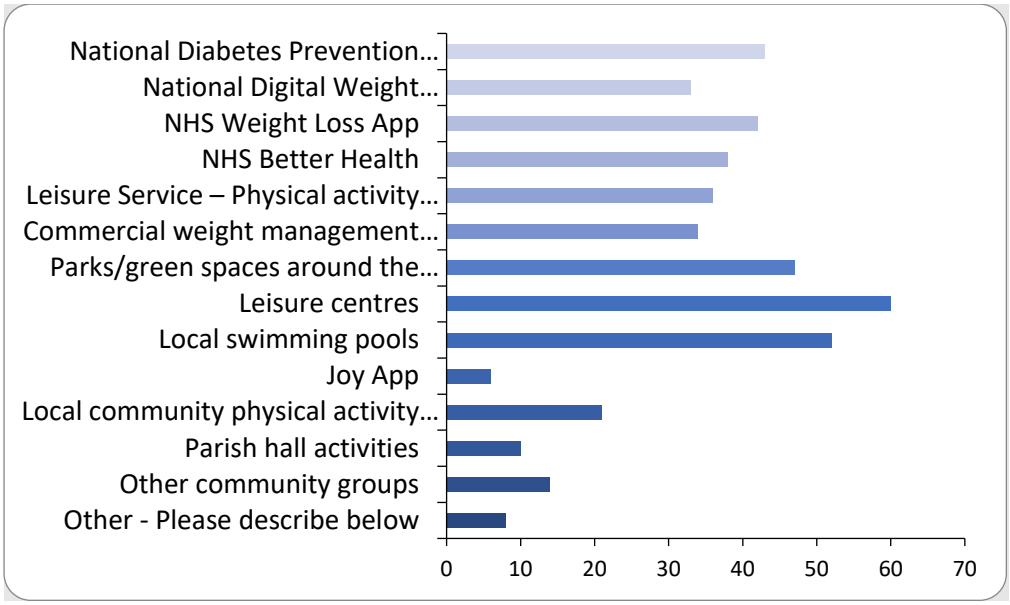
I am not sure how to signpost people. We distribute free food in the street, I talk to recipients but don't know if I should try and signpost them when they talk to me about their weight or diabetes. We have no resources and they usually dismiss any advice

Often the people we see cannot engage in digital resources and need more F2F or direct support.

I don't have time and I do not want to intervene in service users' lives as it puts them off when I try to have a conversation about alcohol or smoking. It takes time to get their trust

Question 5: Which of the following services and resources are you aware of?
Tick all that apply

There were 77 responses to this part of the question.



Option	Total	Percent
National Diabetes Prevention Programme	43	55.84%
National Digital Weight Management Service	33	42.86%
NHS Weight Loss App	42	54.55%
NHS Better Health	38	49.35%
Leisure Service - Physical activity referral scheme	36	46.75%
Commercial weight management programmes	34	44.16%
Parks/green spaces around the borough	47	61.04%
Leisure centres	60	77.92%
Local swimming pools	52	67.53%
Joy App	6	7.79%
Local community physical activity classes	21	27.27%
Parish hall activities	10	12.99%
Other community groups	14	18.18%
Other - Please describe below	8	10.39%
Not Answered	0	0.00%

Please describe

There were 13 responses to this part of the question.

The programmes produced should be co-produced with those with ASD, with mental health issues as neurodiversity and medication affects ways of thinking and appetite. Cooking for healthy eating should also be part of a weight loss programme.

At the Weller Centre we provide fitness classes especially for the over 50s to focus on complete body conditioning and also provide workshops for those going through Menopause

"University-led projects on access to food

Research

Books (e.g. Ravenous, Ultra-Processed People)"

"Sport in Mind

Reading Green Well Being Network events"

NHS BHFT Virtual weight management programme

Commissioned dietetic work, e.g, groups; Nutrachek blogs, myfitnesspal etc; online NHS exercises, local authority/council funded schemes, e.g., Healthwise in Reading; Talking Therapies if mental health impacting on weight/changes

Sport In Mind sessions and the Community Activator role.

Sports in Mind.

General healthy low cost activities - walking / gardening / cycling etc

"Local cycling clubs and organisations.

Local football clubs"

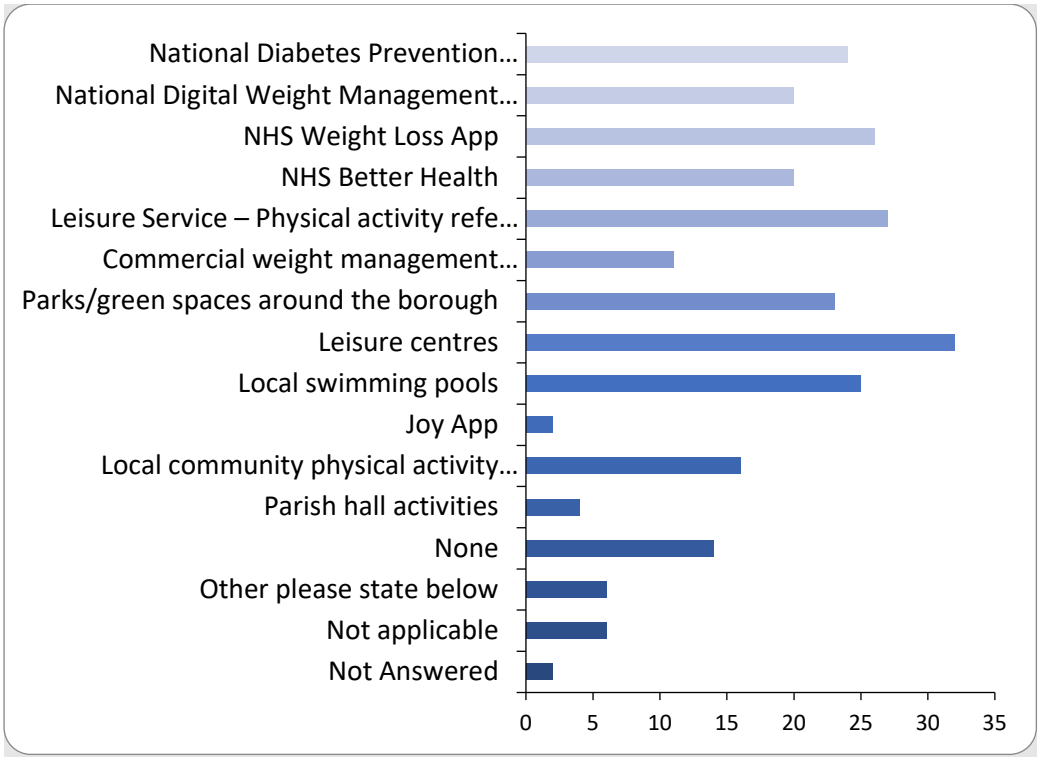
There are not many free physical/community programmes available for school-aged children. There is Activ8 but as the name suggests is only from age 8 and in some areas this is not available until the child turns 11.

There are a wide variety of referral options, each with different referral criteria, all of which are constantly changing. It is hard to keep up with what services are currently available. A single, central point of referral would be very useful.

Pure Gym, The Gym

Question 6: Which of the following services and resources do you refer or signpost residents to? Tick all that apply

There were 75 responses to this part of the question.



Option	Total	Percent
National Diabetes Prevention Programme	24	31.17%
National Digital Weight Management Service	20	25.97%
NHS Weight Loss App	26	33.77%
NHS Better Health	20	25.97%
Leisure Service - Physical activity referral scheme	27	35.06%
Commercial weight management programmes	11	14.29%
Parks/green spaces around the borough	23	29.87%
Leisure centres	32	41.56%
Local swimming pools	25	32.47%
Joy App	2	2.60%
Local community physical activity classes	16	20.78%
Parish hall activities	4	5.19%
None	14	18.18%
Other please state below	6	7.79%
Not applicable	6	7.79%
Not Answered	2	2.60%

Other please state

There were 10 responses to this part of the question.

Activities run by Reading Green Wellbeing Network members

Green well being network. Cookery programmes (limited) Sport in Mind community activators, drama activities eg Rabble Theatre

Primary care discussion

GP

See answer to 4a

Commissioned dietetic work, e.g, groups; Nutrachek blogs, myfitnesspal etc; online NHS exercises, local authority/council funded schemes, e.g., Healthwise in Reading; Talking Therapies if mental health impacting on weight/changes

They are not tailored to cater for people with Learning Disabilities

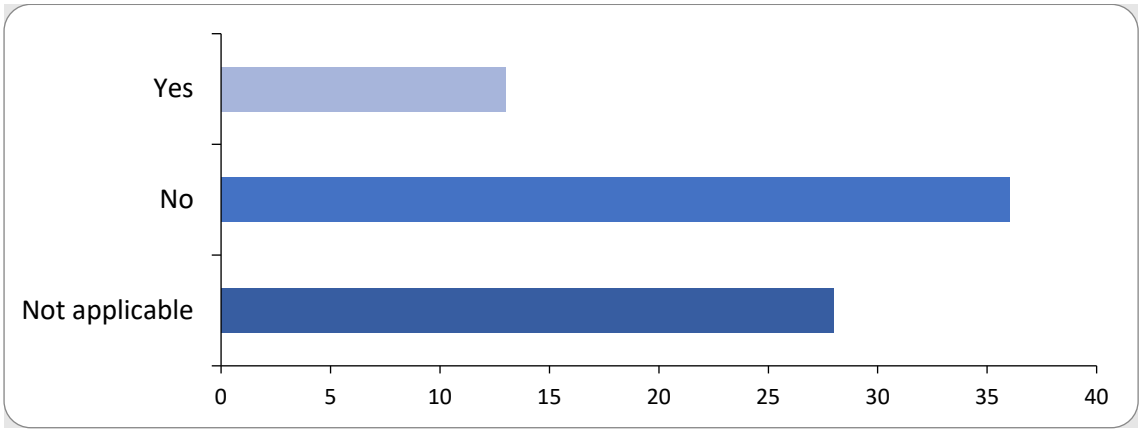
Sport In Mind: sessions and Community Activator.

Cycling clubs

I avoid health related discussions

Question 7: Do you feel remote working has an impact on your ability to support your service users?

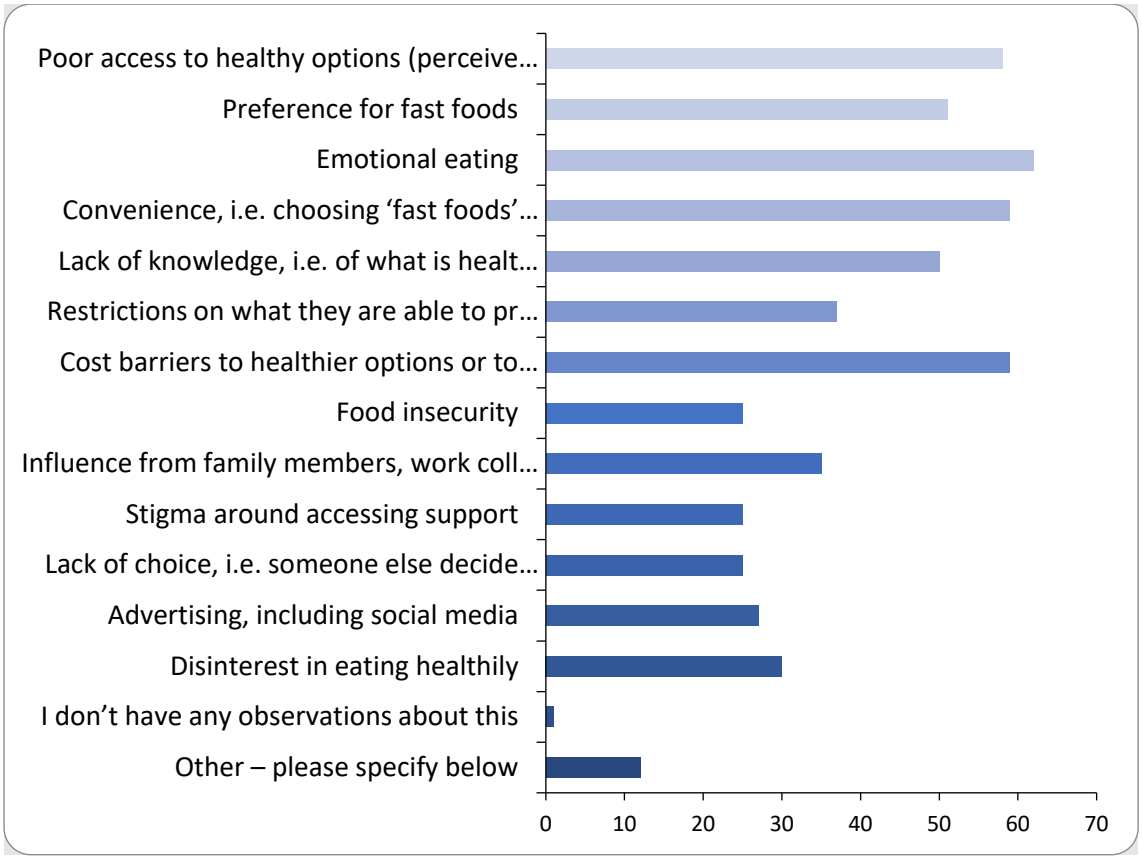
There were 77 responses to this part of the question.



Option	Total	Percent
Yes	13	16.88%
No	36	46.75%
Not applicable	28	36.36%
Not Answered	0	0.00%

Question 8: Please select what influences you think are prominent in the lives of the people you support regarding healthy eating (Tick all that apply)

There were 77 responses to this part of the question.



Option	Total	Percent
Poor access to healthy options (perceived or actual)	58	75.32%
Preference for fast foods	51	66.23%
Emotional eating	62	80.52%
Convenience, i.e. choosing 'fast foods' because they are perceived to save time	59	76.62%
Lack of knowledge, i.e. of what is healthy or how to cook	50	64.94%
Restrictions on what they are able to prepare where they live, i.e. if they don't have an adequate kitchen	37	48.05%
Cost barriers to healthier options or to equipment needed to prepare food	59	76.62%
Food insecurity	25	32.47%
Influence from family members, work colleagues and friends	35	45.45%
Stigma around accessing support	25	32.47%
Lack of choice, i.e. someone else decides and prepares what they eat	25	32.47%

Advertising, including social media	27	35.06%
Disinterest in eating healthily	30	38.96%
I don't have any observations about this	1	1.30%
Other - please specify below	12	15.58%
Not Answered	0	0.00%

Other please state

There were 14 responses to this part of the question.

Problems with dental health resulting in ability to chew foods and therefore restricting the diet

Effects of medication

patients who live by themselves, use it to justify not cooking properly (they say its not worth it just for me)

"Cost of all food has risen therefore people generally stick to buying what they know, they are afraid of trying new food for fear of waste.

Children do not have the power to choose what they eat or what food is bought therefore dependent on their parents/carers to provide their meals"

Haven't answered this question as I am not directly supporting people with healthy eating choices.

Very little face to face support available and unable to access online support

"Often patients don't want to raise it with GP's as there is a sense that they feel they should be able to manage their weight themselves.

they often stop going to GP's for other health conditions as they often get told that losing weight is the solution to all of their other problems"

"Some of our mild LD clients live alone and may have little or no knowledge on healthy choices and due to various reasons, lack motivation to make any healthy changes.

For patients living in supported living or care homes, staff do the cooking and so the access to healthy foods depend on staff knowledge on healthy eating. Our biggest challenge at the moment is high staff turnover and new staff members are not trained or inadequately trained on nutrition."

"Working hours - some individuals work shifts and this does not help with eating healthily.

Lack of free / low cost healthy cooking courses which are easily accessible via public transport."

Inability to take personal responsibility for health - and huge importance of eating on wellbeing

Constant marketing of poor foods, pester power of children in checkouts of shops with sweet counters. Sweet and junk food dispensing machines in leisure centres - including northcroft and hungerford legacy leisure centres.

All of the above. The 'obesogenic environment' is a complex subject.

More pressing issues including poor income, homelessness or insecure housing, substance abuse and alcoholism. Looking after their weight is not a priority

"alcohol and substance abuse

poor housing situation

family trauma

homelessness

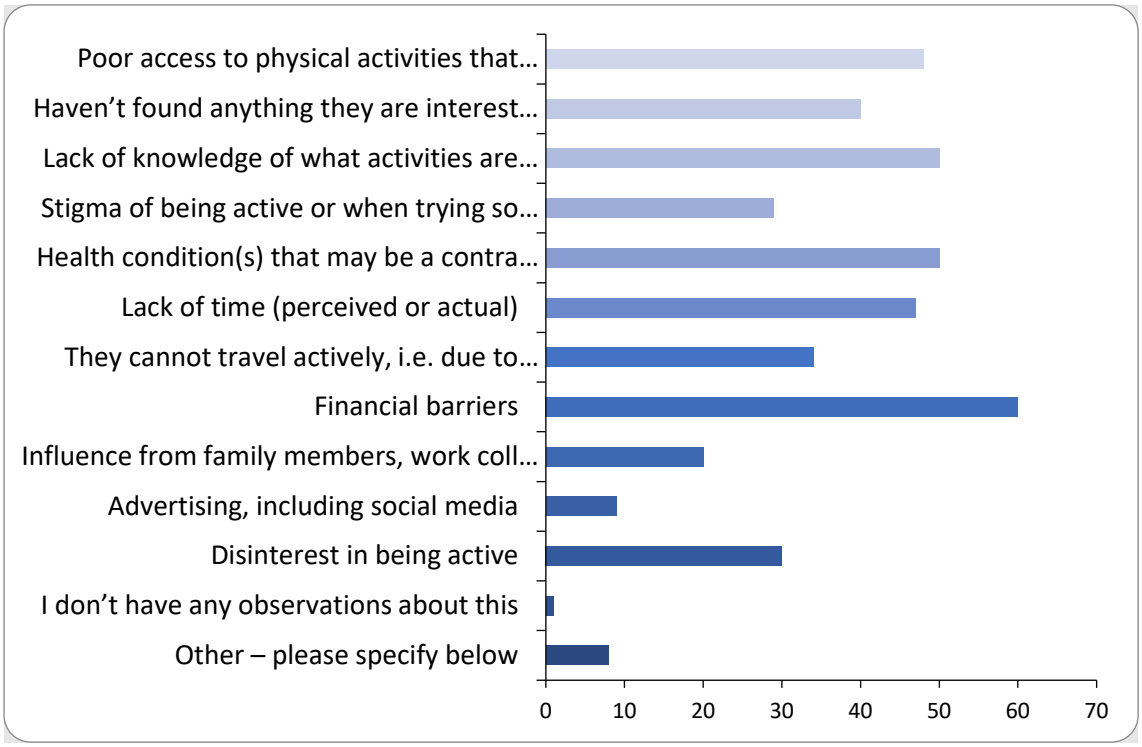
dislike of anything that requires commitment

unsafe neighbourhoods

mental health conditions"

Question 9: Please select what influences you think are prominent in the lives of the people you support regarding physical activity (Tick all that apply)

There were 77 responses to this part of the question.



Option	Total	Percent
Poor access to physical activities that they want to do (perceived or actual)	48	62.34%
Haven't found anything they are interested in doing	40	51.95%
Lack of knowledge of what activities are available	50	64.94%
Stigma of being active or when trying something new	29	37.66%
Health condition(s) that may be a contra-indication to exercise	50	64.94%
Lack of time (perceived or actual)	47	61.04%
They cannot travel actively, i.e. due to health condition, this isn't an option where they travel, no time	34	44.16%
Financial barriers	60	77.92%
Influence from family members, work colleagues and friends	20	25.97%
Advertising, including social media	9	11.69%
Disinterest in being active	30	38.96%
I don't have any observations about this	1	1.30%
Other - please specify below	8	10.39%
Not Answered	0	0.00%

Other please state

There were 12 responses to this part of the question.

Transport to and from activities

anxiety about covid or wearing sportswear

Cost and space are huge issues with accessing physical activity. Leisure activities can be very expensive, there are very few free school clubs now and then time can also be a barrier when trying to get somewhere after school for an activity.

"Haven't answered this question as I am not directly supporting people with healthy eating choices.

However, I think that the way we design places has a major impact. I lived in London for 10 years and cycled to work throughout. During that time I saw the numbers of cyclists, and diversity of cyclists, grow. Still not enough. But an indication of what careful investment can do.

I also think there is something about creating opportunities for people to try stuff out. Using cycling as an example (and clothes as a metaphor), letting people try cycling on and seeing if they like what they see.

Across all campaigns for change, think there needs to be a sense of hope. Not only the need to change. Or the possibility of change. But also that change will lead to something desirable, and ideally fun."

Lack of options - majority are too expensive and not local

Financial barriers - sometimes perceived rather than actual. A walk is free

"Lack of free or very low cost local programmes, gym memberships, information and advice which are non-digital to assist people with losing weight.

Long waiting lists for the one free programme at Better Leisure Centres for those who are motivated (now) to lose weight.

Transport - some individuals cannot drive and leisure centres, community centres, etc are not necessarily easily accessible via public transport.

Some people are not online or do not want to access information and advice about weight loss online.

Some people would like a ""buddy"" with whom they can attend a gym, swimming, session, etc."

lack of effort to make a change

Especially in women, poor self esteem around gym / sports environments based on appearance, not knowing what to do. Barrier of cost. Exercise seen as a punishment by many people. The cruel and poorly evidenced "advice" that by eating less and moving more that people will lose weight. Patients take up exercise but don't lose weight and become disheartened.

It varies from one patient to the next

Disinterest in being active for their health: they are active when they live on the streets, may walk for hours every day but it's a necessity for getting to places. They experience too much hardship to care about their weight

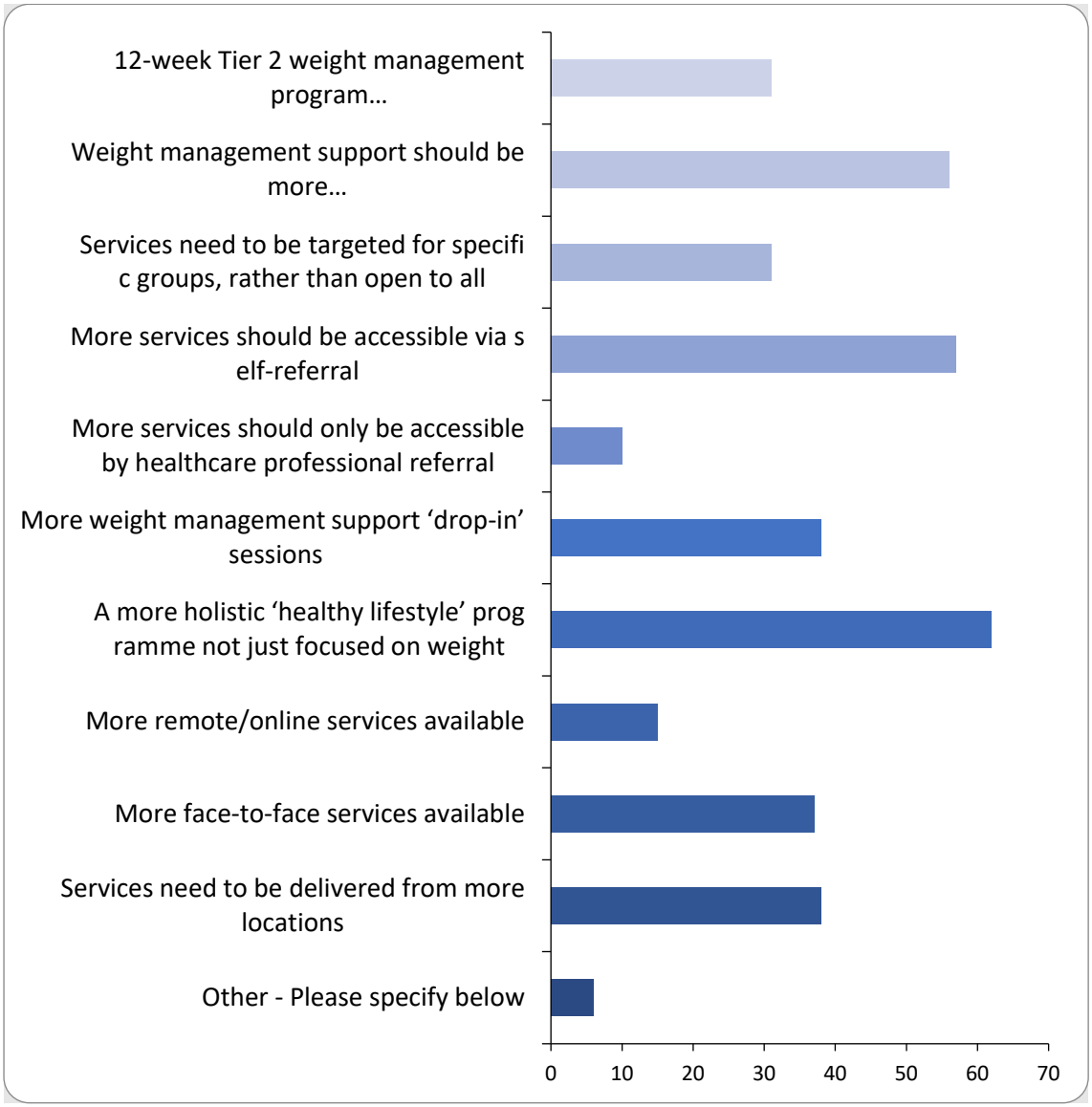
"disinterest in being active for health

mostly concerned with surviving not thriving"

Question 10: What type of support do you think is needed to support residents to live well and be active? Please tick all that apply.

Section 1: Weight Management Services

There were 77 responses to this part of the question.



Option	Total	Percent
12-week Tier 2 weight management programme	31	40.26%
Weight management support should be more long-term (beyond 12 weeks)	56	72.73%
Services need to be targeted for specific groups, rather than open to all	31	40.26%
More services should be accessible via self-referral	57	74.03%
More services should only be accessible by healthcare professional referral	10	12.99%

More weight management support 'drop-in' sessions	38	49.35%
A more holistic 'healthy lifestyle' programme not just focused on weight	62	80.52%
More remote/online services available	15	19.48%
More face-to-face services available	37	48.05%
Services need to be delivered from more locations	38	49.35%
Other - Please specify below	6	7.79%
None of the above	0	0.00%
Not Answered	0	0.00%

Please specify

There were 15 responses to this part of the question.

Stimulate interest in meal preparation and shopping

support not focused on weight that focuses more on moving and exercise, eating well and emotional health and wellbeing services

Key messages need to be delivered around healthy lifestyles, it really isn't just about weight, it needs to be a way of life. Support needs to be targeted and long term, available easily for those who are ready to change.

Haven't answered this question as I am not directly supporting people with healthy eating choices.

More self-referral to Tier 1 and 2 services however introduction of a Tier 3 service only accessible by HCP referral

"Weight management Services to cater for people with LD - easy read resources, streamlined sessions which will be easy to follow, working with carers, etc.

Service to support regular staff training at LD residential homes/care agencies on nutrition and healthy eating"

"Patients do not need to see a doctor for support with weight loss and to access services- this medicalises a predominantly lifestyle issue at a time when GP access is restricted. Self referral is essential.

Services need to be supportive and non-judgemental "

"Free or very low cost for those who are unable to afford costs.

Shorter waiting lists / times.

""Buddy"" systems so people can attend any sessions / services with someone."

More low - key activities promoted and focus on "fun" aspect not "health"

A tier 3 service including psychological support, physiotherapy support, sleep support, nutrition advice and finally medical support including injectable treatments like wegovy / semaglutide.

"Reasonable adjustments for learning disability

Educational courses for paid carers in residential / supported living organisations"

Facilitate peer support groups as they exist for alcohol and drugs

in pregnancy

"I think a collaborative approach to wellbeing, healthy eating, exercise and mental health promotion would be really powerful. Taking the approach not just to do this for the individual themselves but also showing the positive impact it would have on their families.

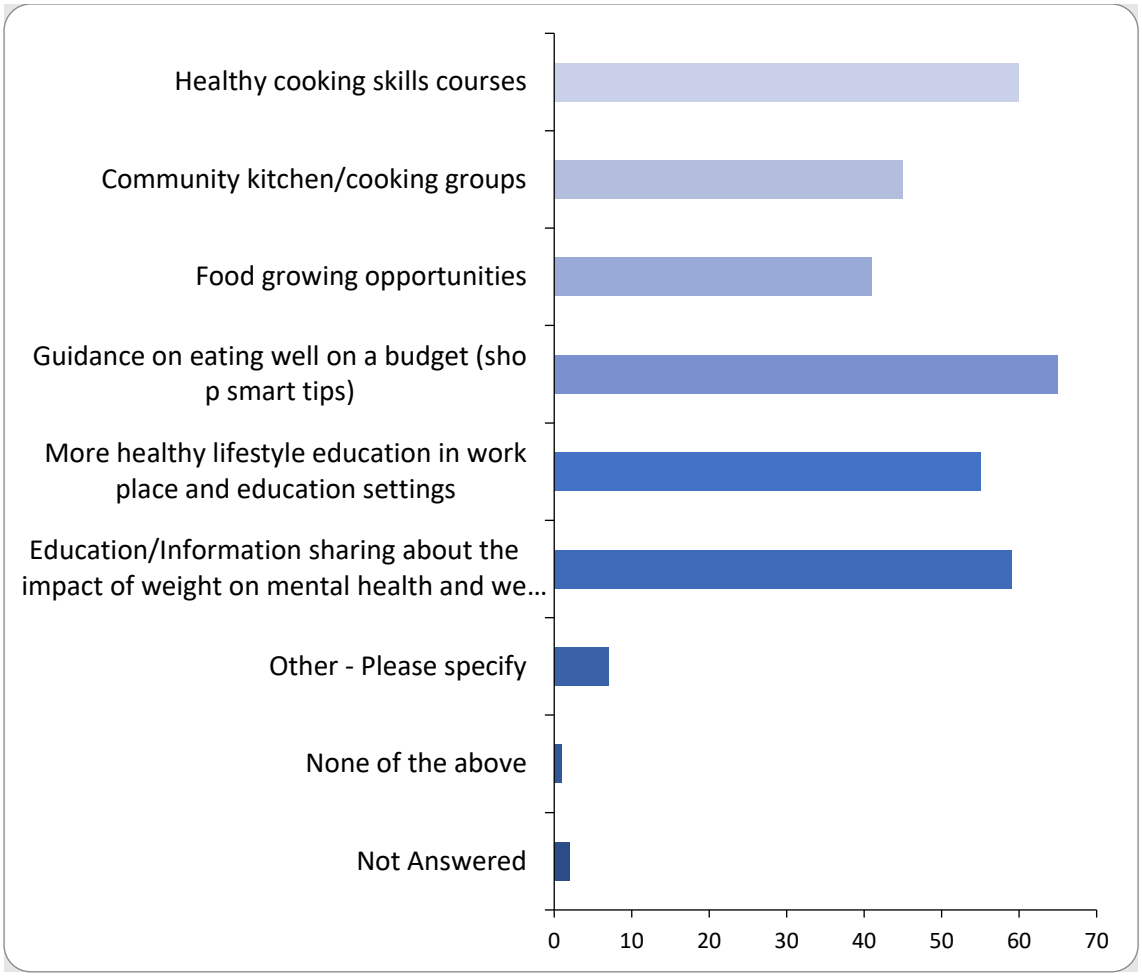
Sometimes people see this as being selfish but helping them to understand that self care is essential to their whole family wellbeing would be more powerful and long lasting."

"financial support so that people can take some time to look after their health

Local discounts to leisure centers/gyms as they do in London"

Section 2: Upskilling

There were 75 responses to this part of the question.



Option	Total	Percent
Healthy cooking skills courses	60	77.92%
Community kitchen/cooking groups	45	58.44%
Food growing opportunities	41	53.25%
Guidance on eating well on a budget (shop smart tips)	65	84.42%
More healthy lifestyle education in workplace and education settings	55	71.43%
Education/Information sharing about the impact of weight on mental health and wellbeing	59	76.62%
Other - Please specify	7	9.09%
None of the above	1	1.30%
Not Answered	2	2.60%

Please specify

There were 9 responses to this part of the question.

Explaining facts - what being overweight does to the body in the longer term

cooking for one (single people)

This is a major are where I think the focus on health and wider consideration of what a healthy, sustainable food system might look like overlap.

"Often patients have a good knowledge of what they should eat and have skills in cooking but are unable to sustain the effort of managing a healthy diet.

Supporting patients at the points of their life cycle where they may be more motivated (just after pregnancy / quitting smoking) is critical

Patients need to be supported to address any root cause of their poor eating patterns - often emotional eating and given tools to manage emotional eating and snacking."

Guidance on eating well on a budget (shop smart tips)- ideal for families and carers supporting clients with LD

In all community settings - for example, in Tilehurst and Calcot.

People generally know why and how to lose weight. They need support with motivation and commitment.

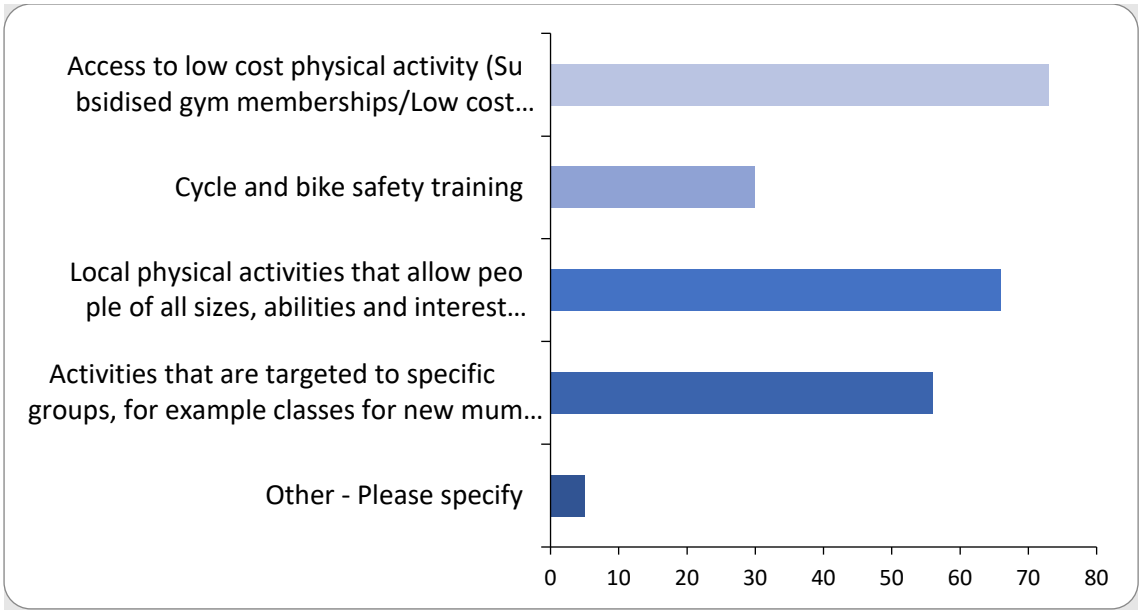
Upskilling aimed appropriately for learning disabilities clients

"more support for food growing activities

fewer fast food outlets"

Section 3: Physical activity

There were 77 responses to this part of the question.



Option	Total	Percent
Access to low cost physical activity (Subsidised gym memberships/Low cost swims etc)	73	94.81%
Cycle and bike safety training	30	38.96%
Local physical activities that allow people of all sizes, abilities and interests to take part	66	85.71%
Activities that are targeted to specific groups, for example classes for new mums	56	72.73%
Other - Please specify	5	6.49%
None of the above	0	0.00%
Not Answered	0	0.00%

Please specify

There were 13 responses to this part of the question.

Gardening skills training and access to community gardening sessions

Specific cohorts should include mental health, neurodiversity and different cultures

This is a major are where I think the focus on health and wider consideration of what a healthy, sustainable food system might look like overlap (cutting across the themes of the Climate Emergency Strategy).

Infrastructure to support physical activity, particularly active travel in the form of safe, segregated cycling and walking routes connecting people to education, employment and recreational opportunities.

Transport

More low - key activities promoted and focus on "fun" aspect not just "health"

"better cycle lane provision.

more female friendly exercise services."

"Those who use wheelchairs

Hoist facilities in swimming pools"

To include learning disability clients

I have lots of patients who say their joint pain limits how much activity they can do. it would be useful if there were targeted classes that help them find appropriate exercises to do.

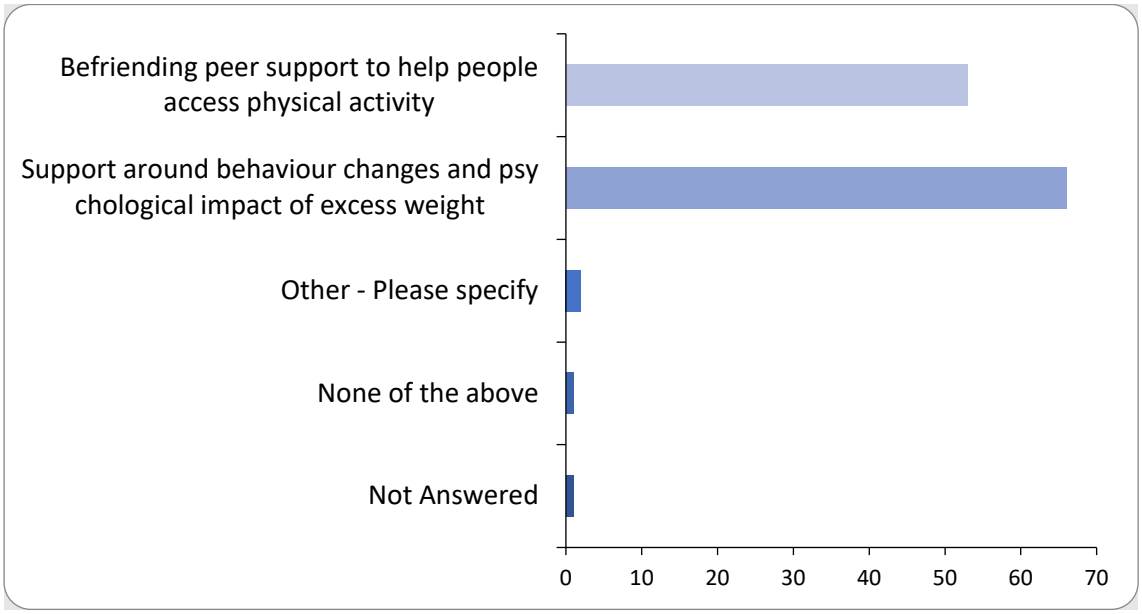
More leisure centres in different areas of Reading

support to groups that teach dance, sports or organise walks (for adults)

Ethnic groups, LD groups, Neuro diverse groups, so individuals are with like for like people

Section 4: Emotional and mental health support

There were 76 responses to this part of the question.



Option	Total	Percent
Befriending peer support to help people access physical activity	53	68.83%
Support around behaviour changes and psychological impact of excess weight	66	85.71%
Other - Please specify	2	2.60%
None of the above	1	1.30%
Not Answered	1	1.30%

Please specify

There were 5 responses to this part of the question.

Eating psychologists, and any alternatives eg hypnosis with some success rate

Haven't answered this question as I am not directly supporting people with healthy eating choices.

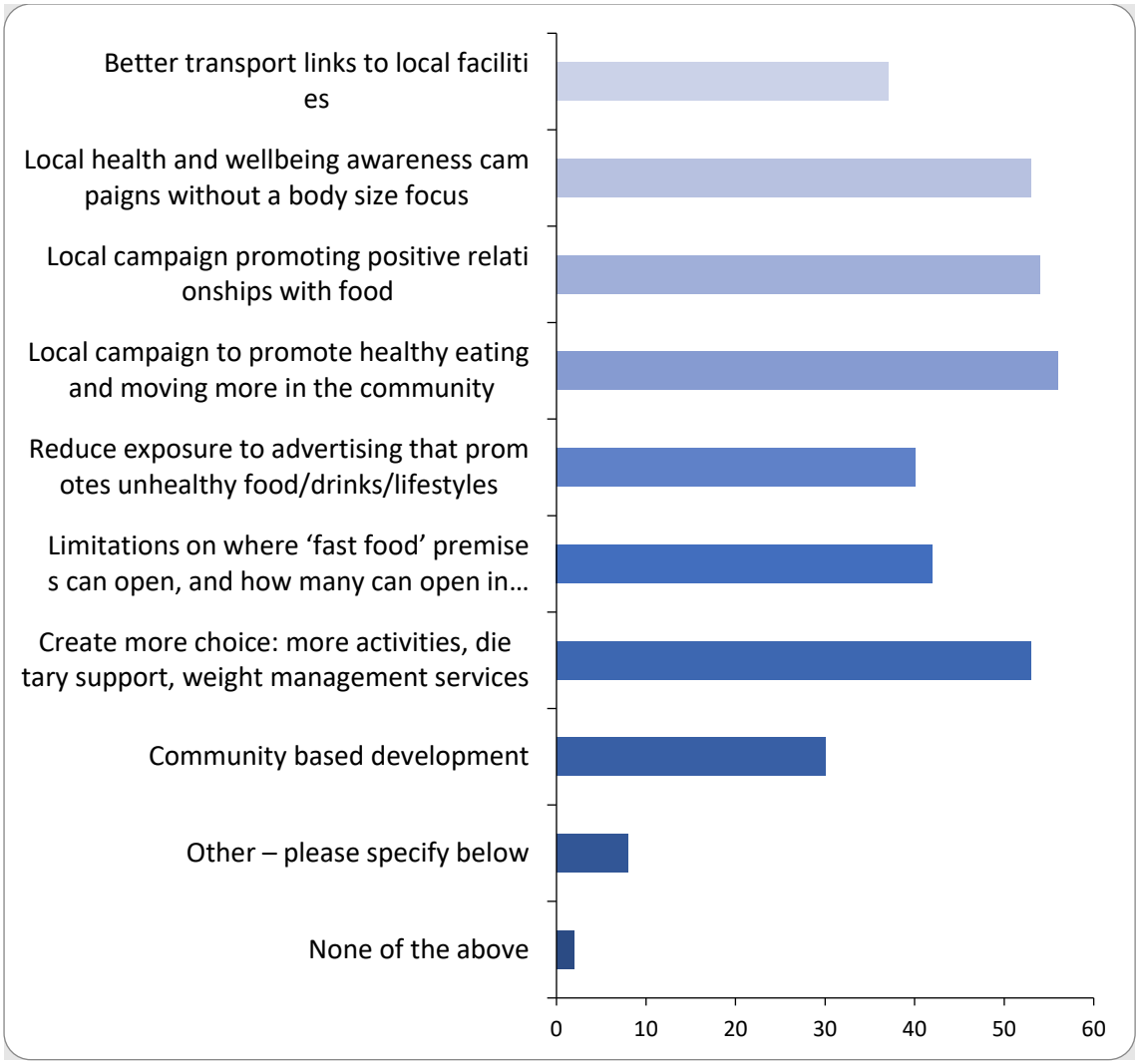
training for social carers working with LD clients to access physical activity

Its all about mindset, focus should be on the psychological aspects of weight gain and loss

Financial support. Among service users, money worries are the most important concern, nothing else matters as much. Vouchers/reduced fees to local gyms, yoga studios, etc, according to postcode

Section 5: Wider support/upscaling activity/whole systems approach

There were 77 responses to this part of the question.



Option	Total	Percent
Better transport links to local facilities	37	48.05%
Local health and wellbeing awareness campaigns without a body size focus	53	68.83%
Local campaign promoting positive relationships with food	54	70.13%
Local campaign to promote healthy eating and moving more in the community	56	72.73%
Reduce exposure to advertising that promotes unhealthy food/drinks/lifestyles	40	51.95%
Limitations on where 'fast food' premises can open, and how many can open in any given area	42	54.55%
Create more choice: more activities, dietary support, weight management services	53	68.83%

Community based development	30	38.96%
Other - please specify below	8	10.39%
None of the above	2	2.60%
Not Answered	0	0.00%

Please specify

There were 11 responses to this part of the question.

Men only and women only sessions eg for swimming as body image can prevent participation

"Advertising is only an issue when a product is endorsed by a celebrity tik tokker.

need to move away from terminology like healthy as it is all about balance rather than restricting what you eat."

This is a major are where I think the focus on health and wider consideration of what a healthy, sustainable food system might look like overlap (cutting across the themes of the Climate Emergency Strategy).

Increased promotion of currently available services e.g., Healthwise, Shape up 4 Life

By 'better transport links' I would emphasise active travel links - we want people walking and cycling to the gym (and other facilities) not driving - or even just walking and cycling without the gym being involved at all!

Free services, information, advice and support: nutrition, swimming, gym, sessions, evening / weekend sessions for those who work, "buddies", healthy eating / cooking workshops, healthier alternatives to meals/snacks individuals are currently eating.

Reduce offers in supermarkets and other shops on unhealthy food types and cheap alcohol

Prevention of sweet counters in checkouts of shops, removal of junk food machines in public places like gyms!

I think this question (and a lot of the others) would be better answered by experts in public health taking an evidence-based approach, rather than a straw poll of random stakeholders.

more funding for food growing groups to help them deliver sessions to teach skills and promote community growing schemes

we don't need more education but more support to act on what we know

Question 11: Do you have any other comments regarding weight management, healthy weight, or obesity?

There were 35 responses to this part of the question.

I think it's much more important to support people to be active and to eat healthily than to focus on their weight

"Behavioural Change is essential.

National and local communication and promotion of healthy lifestyles, appropriate for all ethnic groups are essential."

Needs to be more info given to workers to be able to sign post

My view is weight management programmes can only be successful if there is a strong emphasis on behaviour change and initially addressing the psychological reasons of resulting weight gain. Without the psychological component being addressed, diet and physical activity input will not be effective for the long term. Weight Management Programme should be delivered as a multidisciplinary team with a stronger focus on the psychology then diet and physical activity can effectively follow.

massive problem, under funded at present. time bomb for the future

"Quite a lot of the weight management support offered is only open to those who are obese, whereas when someone is gaining weight/is overweight, then this is when support should be offered so it does not seem like such a mammoth task to lose weight.

If certain groups of people are known to gain weight eg those on certain medication, or other social groups, then could there not be early intervention and education to make healthy eating and exercise second nature from the start, rather than introducing once someone has gained weight and is at risk of other health conditions developing."

"Lack of money to join gyms/commercial weight loss programs is a big barrier.

Link with mental health is a massive barrier - there is a lot of comfort eating in my patient group so tying in mental health services with weight loss services would be good."

Co-production with those who have a weight problem and those whose medication have an effect.

"Long term support / continuing support

Targeted activities to reduce lack of self esteem and body consciousness

Exercise only courses of shorter duration and small groups"

My husband himself has been told to eat better to lower his cholesterol but with no support from the cardiologist or referral to any services. I'm quiet educated so have the knowledge and means but not everyone does. This will quiet often result in patients not doing anything until they are in a worse situation and having a cardiac event or being forced to go on medications when the damage has probably already been done. We are very reactive rather than preventative in the NHS and this I believe needs to change.

"Discussions take a long time and GPs do not have enough time to holistically deal with this so it usually waits until weight is the most prominent and overriding issue. However, people often feel that support offered is 'one size fits all' and is very impersonal.

I have the skills to conduct a complex communication to establish main contributing factors to weigh gain/management. However when the root cause is psychological eg. low mood, depression, emotional eating, trauma, abuse there is little in the way of support for this people. Their excess weight is a symptoms of other psychological issues and if they do not have access to therapy services to combat this then I don't think their weight loss will be successful, these management programs and support focusing on healthy eating and exercise are great - but only if patients are already in the psychological state where they are ready to make changes. Prior to this there is little available and what is available has long waits and is hard to access."

"I think there all covered. However; I am a midwife and i don't think people realise how being overweight can impact on a pregnancy/ delivery/ postnatal recovery.

I do think you need to start young at preschool age . If you get an overweight preschool child then chances are the whole family may have issues and need access to education on healthy lifestyle/ eating. Maybe parent doesn't have an idea how to cook and thinks that for example burger or chips is quicker and cheaper but in actual fact by someone showing them that cooking can be quick and cheaper it may help .

Also getting people to go to homes assessment and give advice / help . No t just cooking but budget and that they don't need to have to have sweets or cake or biscuits available every day and that children only get used to eating unhealthy because there parents do.

An overweight preschool child shouldn't happen its all down to re-education of the family.

By targeting children who are overweight you will probably capture the parents and they may have health issues and then can assess all and provide holistic healthy education to the whole family .

In the long term if people stay healthy then less burden on community and health services."

"We have to explore access and availability to what diets are needed for that person, taking into consideration their backgrounds and cultural differences. Food sessions that needs and get them involved in the process.

Some families are placed in homes that don't have cooking facilities, which means takeaways are their only option, or they are given food that is not what they would normally eat.

Speaking on things we see in our line of work, if we have placed families in hotels and they have a cultural diet, how is this being met? with giving them food that are not normal to them and expecting them to all eat the same meals.

Not only has this caused obesity, but also diet problems with anorexia with children and parents not wanting to eat the food provided.

have small kitchen hubs that are run to form small community groups to cook their home cultured foods that they can eat afterwards or take home. not only sharing home recipes but also a sense of belonging."

Any support offered needs to be inclusive and widely available

"I think that the systems approach is an important one. Weight is about more than (solely) diet and exercise. Everyone is interested in food and food can be the entrance to so many other conversations, as well as a wonderful facilitator of conversations - lunch'n'learns, discussions over a meal. Exciting to explore connections.

Comments originally included under 10.5 (but went over character count):

Think it'd be great if all schools were involved, providing opportunities for young people to learn about food and cooking. Perhaps offering opportunities for parents to learn with their children as well.

Perhaps engage the planning department (more) in conversations about spaces to grow and ensuring all now developments make it easy to make the active choice when moving around.

May be organise some events that bring community organisations, professionals and businesses with an interest in healthy eating and sustainable food together to share knowledge and imagine a healthy food future for Reading. (Could capitalise on Reading's growing independent food sector.)"

"There are currently very few options available for face to face support. The 12 week weight and exercise course is great but it has very long wait times and people need ongoing support beyond the 12 weeks, just some form of drop in or peer support.

Leisure centre memberships are beyond the reach of most residents on benefits or working part time."

I am seeing an increased interest in Ozempic/Wegovy (semaglutide) injections as a weight management aid however under current NICE guidance, this is only

available under a Tier 3 or Tier 4 specialist weight management service, which is not available in the Berkshire area. For those who I have seen using semaglutide as a weight loss aid, where GP is managing dosing, I have seen positive results in that people are able to form healthier relationships with food where they tend to experience emotional eating. Their weight reduces alongside supporting Tier 2 dietary advice, and Tier 2 support is able to help the individual to maintain their reduced weight and prevent weight regain in the future when ceasing the medication. I do not think it is currently viable for GP's to closely manage these medications and I think Berkshire is currently missing an opportunity to utilise this medication to improve the health of our population however adequate support is required through a Tier 3 service for this to be effective.

"There is a gap in specialist wt management services for children in the area. there needs to be support across all points of the life course

Support should not be educational - telling people to eat better and move more is insulting to most"

exclusion criteria from weight management services eg no one over 65. I appreciate many older adults are frail and require support with nutrition, but some younger older adults would still benefit from weight loss to improve mobility and reduce risks of heart disease/diabetes/stroke.

Focus on longer term goal that these food and lifestyle changes are for rest of their lives to improve their health and well-being. Before they can engage, their mental health and relationship with food should be well-supported (e.g., address binge eating, disordered eating, depression/anxiety) so that weight management can be more successful (even if it is just getting fitter, stop smoking/less drinking etc). Need support and set expectations for lapses, avoiding them turning into 'collapses' with right, timely support.

"People with Learning Disability are at high risk of facing health inequalities and are at higher risk of premature death when compared to the general population and Obesity is one of the factors for this. Sadly, there is no service available on healthy eating and weight management for these client groups when compared to what is available for the general population in all of Berkshire.

Referrals to the Learning Disability Service is not the solution to this issue. Staff working in external settings like Weightwise and other weight management groups should have some training one working with the LD population and resources can be jointly produced with the help of the LD team to make them easy read or picture based so that they are accessible to clients.

There was one collaboration with an external company and the West Berkshire LD team, which happened some years ago, but that did not proceed beyond planning phase.

Alongside this, there should also be focus on training for staff working in care homes, residential homes, care agencies on nutrition so that they can support the clients better with making healthy changes."

No

Incredibly complex area with individual, local, national and international internal and external influencing factors. currently there is just a complete lack of suitable services to support people.

"I think for people's mental health there needs to be a shift in focus to wellness over weight loss. People in larger bodies can get healthier without dieting.

Effective weight loss from dieting rarely lasts long term. I think we need to be encouraging health and wellness, both mentally and physically. Focus on the wellbeing improvements from eating healthily (a well balanced diet, not a calorific deficit or restrictive food regime) and moving your body, such as improved mood, mobility, more energy, better sleep and so on."

Taxing sugar like alcohol

I think talking about it isn't easy, particularly raising it with someone I feel should think about it.

The BMI measurement system is flawed and outdated, and needs to be re-evaluated/something new introduced to more accurately include those at the top and bottom of our height ranges, and also those from a non-white background. We are currently pathologising people who do not necessarily have weight related risk factors, purely because the BMI system isn't accurate or appropriate for them

"Healthy diet and lifestyle should start from as early as age 1. Parents and carers should have access to more free baby/toddler groups and this should be extended to pre-school aged children as well. This is a place where parents/carers can share learning experiences raising their families including challenges with diet and feeding their families healthier meals.

At the moment we only have three in West Berkshire which is not as accessible to many of our parents.

We also need to more places where we can signpost/refer children/young people (age 4-18) for physical activities and for dietary support. Dietitians no longer accept referrals for overweight/very overweight children."

The growing overweight and obese population is currently hugely under-served. Support should be first through good Public Health and secondarily through local promotion with self referral to services

"Its all so piecemeal - i can never remember who is offering what and where so struggle to tell patients

No tier 3 service in west berks needs a commissioning sort out

Only national diabetes program is consistent

You try and refer to other service and they don’t meet x or y criteria so either they cant go or their friend cant go with them...its hopeless I’m afraid"

"need to think about good services for the obese school children- poor provision locally

need good sustainable programmes- council like to retender everything so no continuity causes confusion in patients and HC workers as who's delivering what and when-

solid investment and real commitment to deliver good services

need to make it priority which I'm afraid you do not or have not done"

rt with the individual in the first instance. It is impossible to motivate someone if they have no desire to follow a plan

Difficult topic during pregnancy, due to expected weight gain and lack of knowledge regarding weight loss and safety in pregnancy. Would be great to see more targeted resources specific to pregnancy and healthy lifestyle choices. Would be good to have a service we could refer pregnant women directly to - self referral or professional referral would work well, if not both!

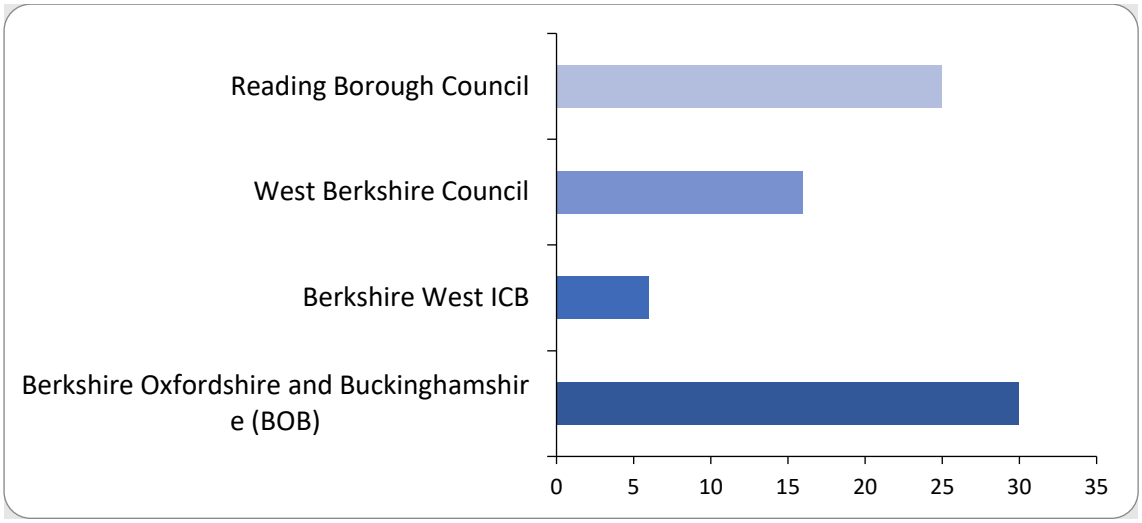
I think it's important we teach people how to build healthy habits. A lot of people may know what they 'should' do but they do believe they do not have the time. I think people are unaware of the health consequences of being overweight.

"Weight management problems often stem from difficult social circumstances. It is also often linked to increased alcohol consumption and other concerns such as smoking. The vicious cycle of poor circumstances / poor eating & weight management lead to increased alcohol intake / poor mental health etc etc....

A holistic approach to general wellbeing and improving mental health for self and family might be more successful."

Question 12: Please tell us which Local Authority/Place you work for

There were 77 responses to this part of the question.



Option	Total	Percent
Reading Borough Council	25	32.47%
West Berkshire Council	16	20.78%
Berkshire West ICB	6	7.79%
Berkshire Oxfordshire and Buckinghamshire (BOB)	30	38.96%
Not Answered	0	0.00%

Question 13: Please provide the first section of your post code

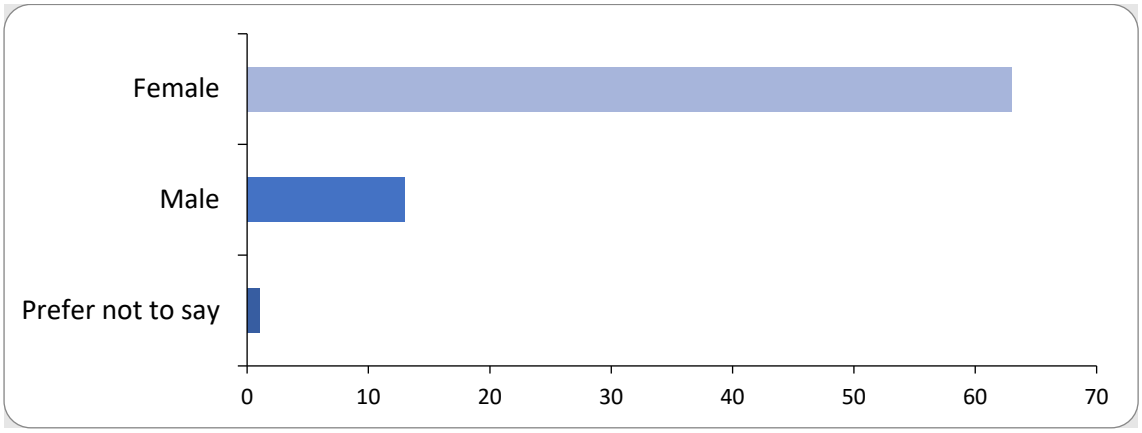
Please provide the first section of your postcode

There were 77 responses to this part of the question.

Demographics

Question 14: Are you?

There were 77 responses to this part of the question.



Option	Total	Percent
Female	63	81.82%
Male	13	16.88%
Prefer not to say	1	1.30%
Prefer to self-describe	0	0.00%
Not Answered	0	0.00%

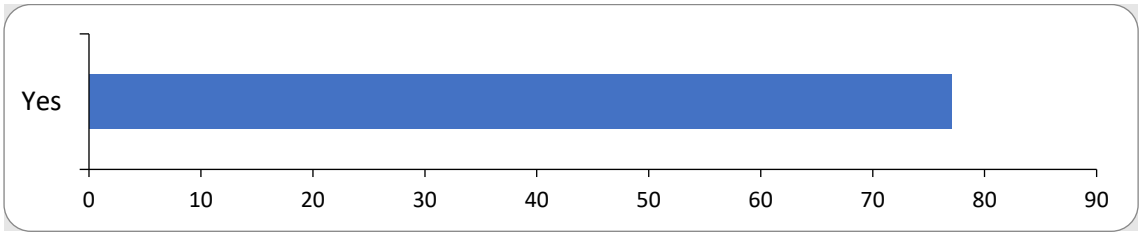
If you prefer to self-describe, please say here

There were 0 responses to this part of the question.

Data protection

I agree to the above statement

There were 77 responses to this part of the question.



Option	Total	Percent
Yes	77	100.00%
No	0	0.00%

Appendix 12.3 Summary report of the Healthwise programme – 2023

Reading Partnership Annual Healthwise Review January – December 2023

1.0 Healthwise Overview

GLL's Healthwise physical activity referral pathways are designed to keep individuals fit and healthy, whether they're living with a health condition or looking for support and guidance. There are currently three Healthwise pathways operating in Reading:

1) Physical Activity Referral Scheme (PARS)

Physical activity plays an essential role in preventing and managing a wide range of health conditions. Health professionals can refer patients to these low-cost programmes to help improve, manage or prevent health conditions such as diabetes, hypertension, depression and many more. Our affordable exercise referral courses are designed to help participants develop the knowledge, skills and confidence they need to improve their health and wellbeing. This comprehensive 12-week programme features one-to-one assessments, individually tailored activity plans, and teaches how to change behaviours for lasting impact.

2) Cardiac Rehab

Our Cardiac rehabilitation programme is designed for those who may have had a cardiac event or those living with cardiovascular disease and have been referred either by their GP or from a Phase 3 team at the local hospital. The programme safely explores the benefits of physical activity and provides individuals with the tools to develop the lifestyle behaviours needed for a smother recovery, including heathy eating habits and stress management techniques. This programme is built upon the British Association for Cardiovascular Prevention and Rehabilitation Standards.

3) Adult Weight Management

Our 12-week group weight loss programme has been designed to help individuals to explore motivation, increase nutritional knowledge and discuss techniques, to help make the changes that can lead to lasting difference. We combine activity and exercise options to support weight loss and help keep the weight off. We understand that we need to place individuals at the centre of their own journey and are here to help by providing support, motivation and the tools needed to identify and address the factors that relate to an individual's weight.

All three pathways mentioned above are available at each of the BETTER Leisure Centre's in

Reading (Rivermead, Palmer Park, South Reading and Meadway). The Healthwise membership is £25.00 per month and an individual can remain on this membership for up to two years (after this time the membership will increase to £32 per month (subject to annual increases). There is also a PAYG (Pay & Play) offer available for those who would prefer.

1.1 Healthwise Timetable

Figure 1 – Healthwise Timetable, correct as of January 2024

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Be Active Supervised Gym Session 2pm- 3pm MEADWAY (James)	Healthwise Badminton Open Court Session Between 1pm -3pm RIVERMEAD (Vic)	Adult Weight Management 10 am-11.30am RIVERMEAD (James)	Be Active Supervised Gym Session 1.30pm- 2.30pm RIVERMEAD (James)	
				Better Healthwise Circuits 1.30pm-2.30pm PALMER PARK (Zita)
Be Active Supervised Gym Session 11am -12pm PALMER PARK (Zita)	Adult Weight Management (2024) 6pm - 7.30pm Palmer Park (James)		Adult Weight Management (2024) 6pm -7.30pm Rivermead(James)	
Cardiac Rehab Phase IV 2pm - 3pm PALMER PARK (Zita)		Dementia Friendly Supervised Gym 9.30am-10.30am SOUTH READING (Vic)		Adult Weight Management 10 am-11am PALMER PARK (Zita)

2.0 Healthwise Raw Data

Measure	Total	Percentage (%)	Contract KPI
Active Healthwise Memberships			
REFERRALS			
Total Referrals	**619**	**124%**	**500**
PARS	303	49%	
AWM	278	45%	
Cardiac	18	3%	
Awaiting Pathway Allocation	20	3%	
Total Rejection	32	5%	
Referral Reason			
Obesity	337	54%	
Osteoarthritis	14	2%	
ACOPD	30	5%	
Fibromyalgia	2	0%	
Hypertension	46	7%	
Anxiety & Depression	43	7%	
Other	102	16%	
Cardiovascular Disease	14	2%	
Diabetic	8	1%	
Family History of Diabetes	4	1%	
Pre-Diabetic	2	0%	
Chronic Fatigue Syndrome	4	1%	
MSK	7	1%	
Cholesterol	1	0%	
Cancer	4	1%	
Peripheral Arterial Disease	1	0%	
Referral Source			
GP	479	77%	
PHA	10	2%	
Self	123	20%	
Physiotherapist	6	1%	
Pharmacist	1	0%	

Hospital	0	0%	
NON-STARTERS			
Non-Starters (Other)	68		
Client Active	3		
Client Moved Away	20		
Client Not Ready	18		
Uncontactable	24		
DNA (did not attend)	5		
Non-Starters (Not Interested)	53		
Non-Starter Referral Expired	3		
DROP OUTS / NOT COMPLETING			
Other	55		
Illness / Injury	6		
Moved Away	12		
Personal Reason	5		
Non-Attendance	32		
DEMOGRAPHICS			
Age			
0-17	2	0%	
18-24	44	7%	
25-34	71	11%	
35-44	133	21%	
45-54	131	21%	
55-64	131	21%	
65-74	69	11%	
75+	28	5%	
Not Given	10	3%	
Gender			
Female	425	69%	
Male	193	31%	
Non-Binary	1	0%	

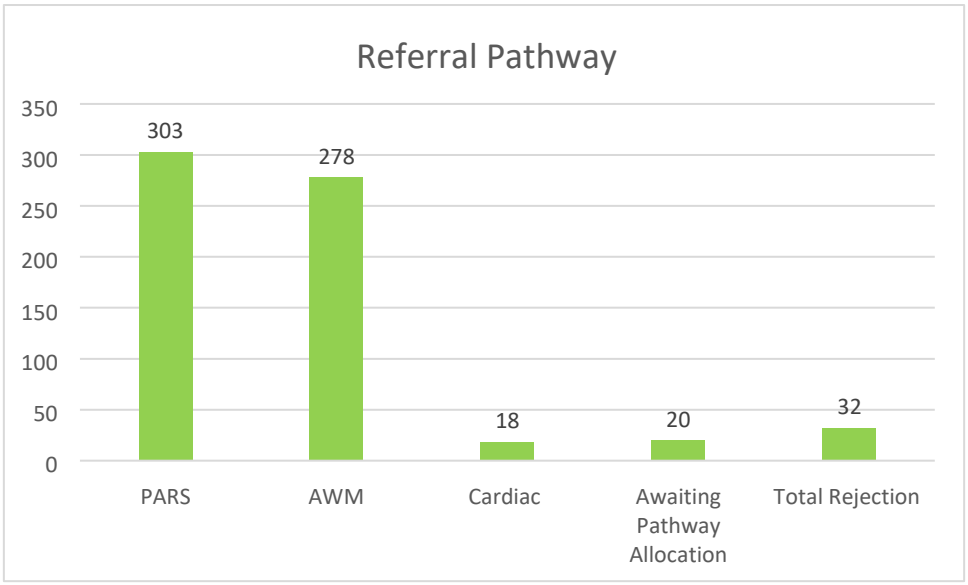
Employment			
Employed	157	25%	
Unemployed	13	2%	
Retired	55	9%	
Students	2	0%	
Long term sick / disabled	6	1%	
Homemaker	2	0%	
Volunteers	3	0%	
Not Given	381	62%	
Ethnicity			
Any other ethnic group	23	4%	
Black or Black British African	24	4%	
Mixed White & Black African	9	1%	
Chinese	0	0%	
White British	278	45%	
White Irish	3	0%	
Black or Black British Caribbean	25	4%	
Mixed White & Black Caribbean	8	1%	
Asian or Asian British Pakistani	24	4%	
Asian or Asian British Bangladeshi	2	0%	
Asian or Asian British Indian	33	5%	
Any other Asian background	15	2%	
Any other Black background	3	0%	
Any other White background	32	5%	
Any other Mixed background	11	2%	
Mixed White & Black Asian	5	1%	
Not Given	124	20%	
OUTPUTS (PARS and Cardiac)			
Starters			

PARS	181	60%	
Cardiac	12	67%	
Completers			
PARS	**88**	**49%**	**50%**
Cardiac	**11**	**92%**	**50%**
CMO Activity Guidelines			
0 minutes	20	20%	
30-89 minutes	8	8%	
90-149 minutes	29	29%	
150+ minutes	42	42%	
Weight Change			
Gained Weight	4	4%	
No change	43	43%	
Lost <3%	16	16%	
Lost 3% +	**13**	**36%**	**35%**
Lost 5% +	**23**		
Overall Health			
No change	11	11%	
Improved	**63**	**64%**	**75%**
Not Given	25	25%	
Exercise Self Efficacy			
No change	9	9%	
Improved	26	26%	
Not Given	64	65%	
Anxiety			
No change	7	7%	
Improved	4	4%	
Not Given	88	89%	
OUTPUTS (AWM)			
Starters	141	51%	
True Starters	93	33%	
Completers			
True Completers	46	**49%**	**70%**
6 Month Follow Ups (YTD)	**61**	**52%**	**60%**
CMO Activity Guidelines			
0 minutes	0		
1-29 minutes	18		
30-89 minutes	10		

90-149 minutes	5		
150+ minutes	13		
Weight Change			
Gained Weight	0	0%	
No change	2	3%	
Lost <3%	6	8%	
Lost 3% +	10	**83%**	**35%**
Lost 5% +	28		
Weight Change at 6 month follow up			
Gained Weight	1		
Lost Weight	9		
Maintained	12		
Not Reported	39		
VAS Health			
Improved	43	**93%**	**75%**
No Change	2	3%	
Not Given	1	1%	
ONS Happiness			
Improved	0	0%	
Not Given	46	58%	
ONS Healthy Living Self Efficacy			
Not Given	11	14%	
No change	23	29%	
Improved	12	15%	

3.0 Referrals

In 2023, Healthwise received a total of **619** referrals, achieving 124% of the 500 referrals target set out within the contract. **3.1 Referral Pathway**



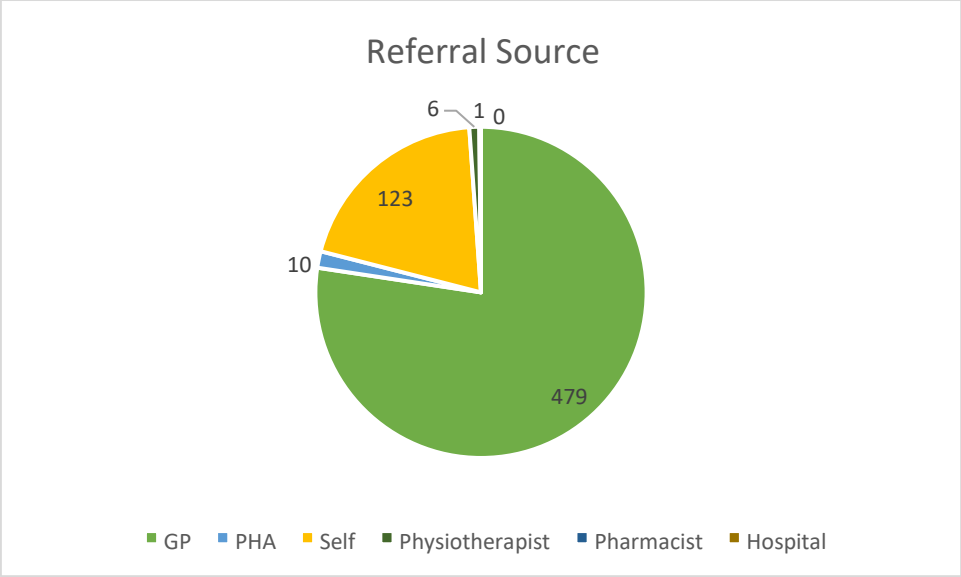
49% of referrals were for PARS, 45% for AWM and 3% for Cardiac. Cardiac referrals were lower than expected; the Healthwise team has been completing bi-weekly visits to the cardiac ward at the Royal Berkshire Hospital to rebuild this referral pathway.

8% of referrals were awaiting pathway allocation or rejected. Awaiting pathway allocation indicates that 20 individuals had been referred into the Healthwise programme, but had not yet been assigned to PARS, AWM or Cardiac pathways. This is because all attempts of contact had been unsuccessful at the time the data was pulled and some individuals are not assigned to a pathway until their Initial Assessment (the second stage after triage). 32 referrals were rejected throughout the year; this is largely due to duplicate referrals (either duplicate referrals via health professionals, or via health professional and self-referral) but also due to individuals not meeting the referral criteria (being too early in their diagnosis, for example).

3.2 Referral Reason

The most common reason for referral was obesity, accounting for 54% of referrals. Although this is the primary reason for referral, some individuals enrol onto the

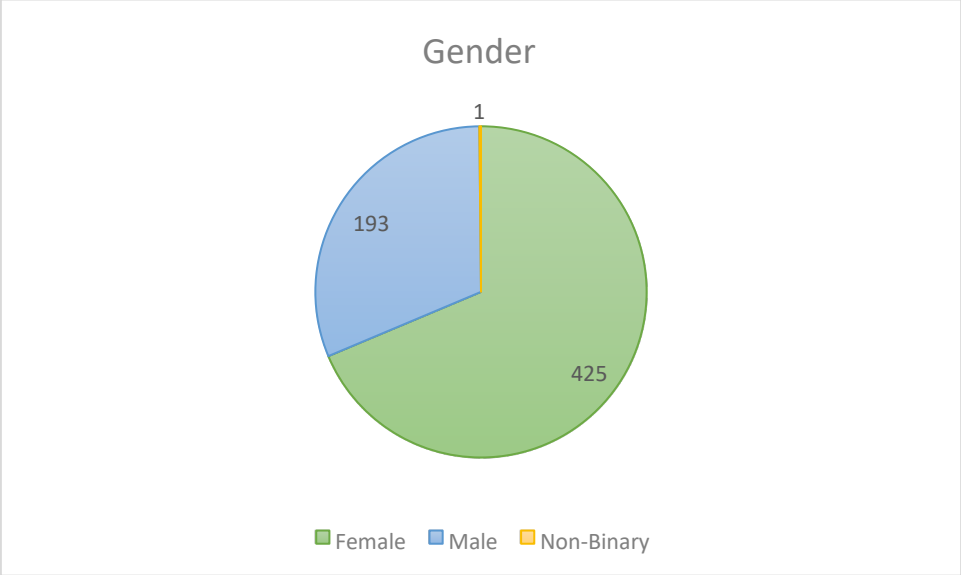
PARS pathway as they would like the physical activity and not the education – this is something which is discussed during the initial assessment. The second highest Category is 'other', this category supports conditions that don't comply with the standard data set or where the referring professional has not listed the reasons for referral. High blood pressure (7%) and Anxiety & Depression (7%) were the third most common referral reason.



Predominantly (77%) referrals came from GP, followed by self-referrals into Adult Weight Management. A total of 45% of the referrals into the AWM programme were self-referrals. PHA represents Allied Health Professionals, this includes roles such as Social Prescribers and Healthcare Assistants.

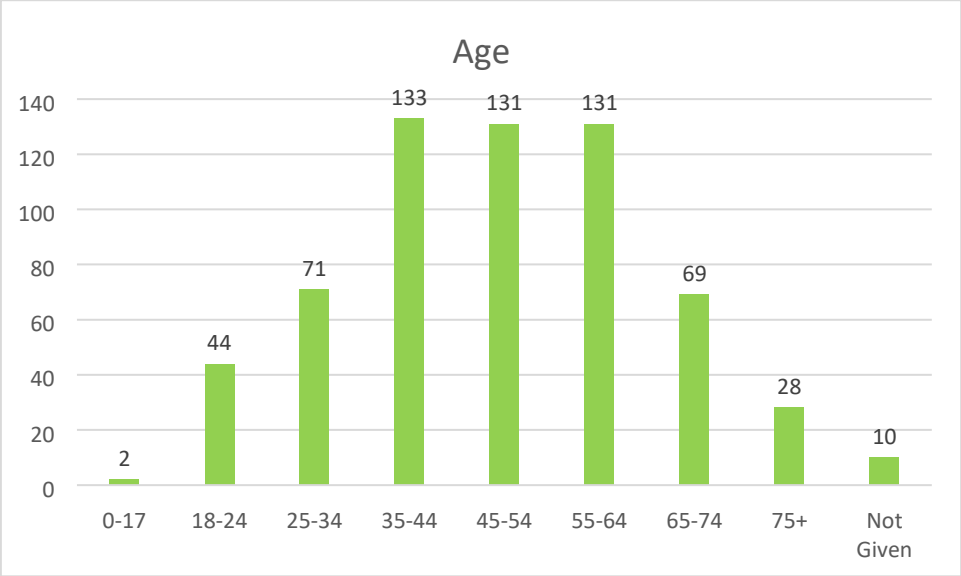
4.0 Demographic Data

4.1 Gender



Females more commonly access the Healthwise programme and Health services in general. In 2024, our Healthwise team will work with partner organisations, such as Ascension Health, to increase the number of males being referred into Healthwise. Health promotion events, such a Men's Health Awareness, will also aim to increase the referral of men into the service.

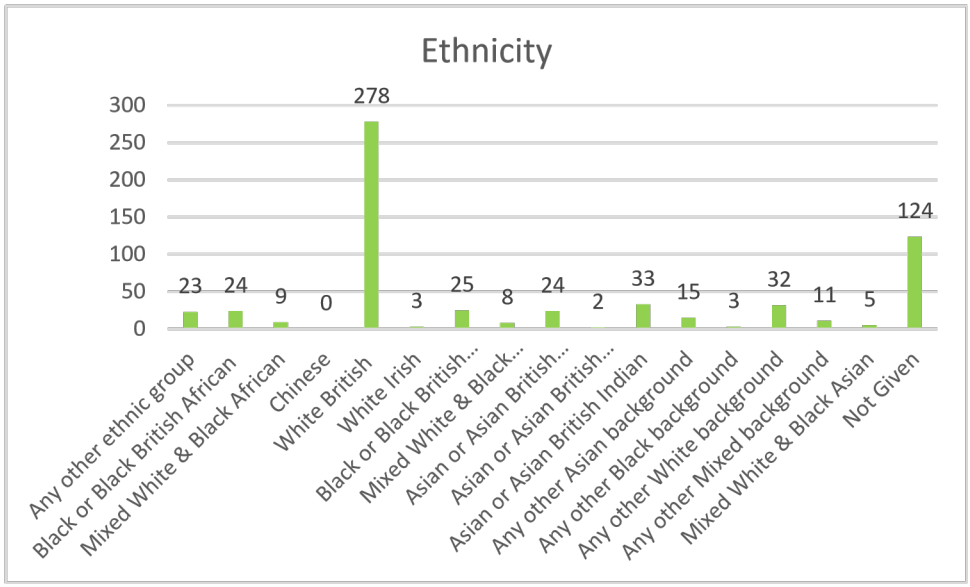
4.2 Age



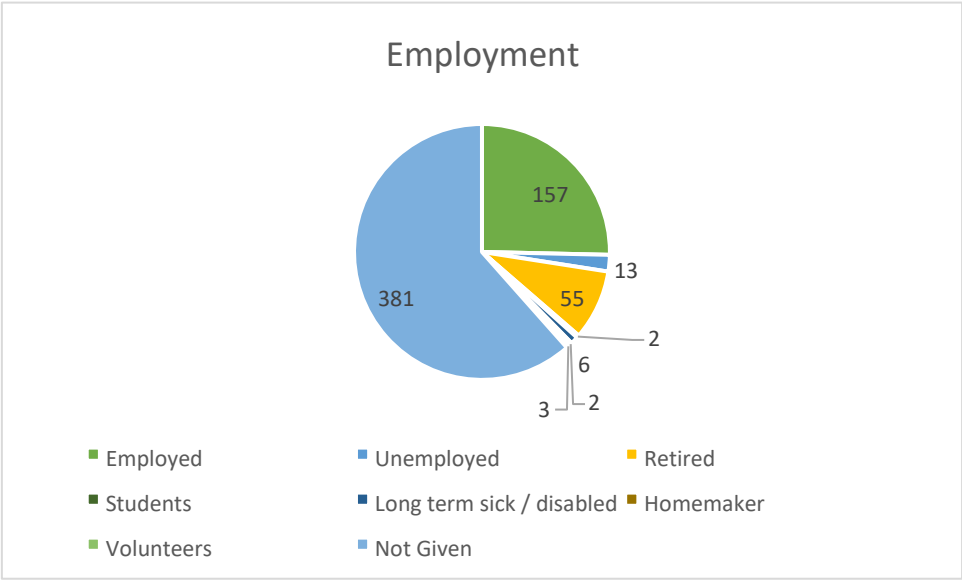
The majority of referrals into the Healthwise programme are of working age (35-65). This is why it's important that our programme offers evening activities in addition to daytime

programming. The majority of referrals in the age group 45-74 are referred into the Healthwise programme following their routine NHS Health check.

4.3 Ethnicity

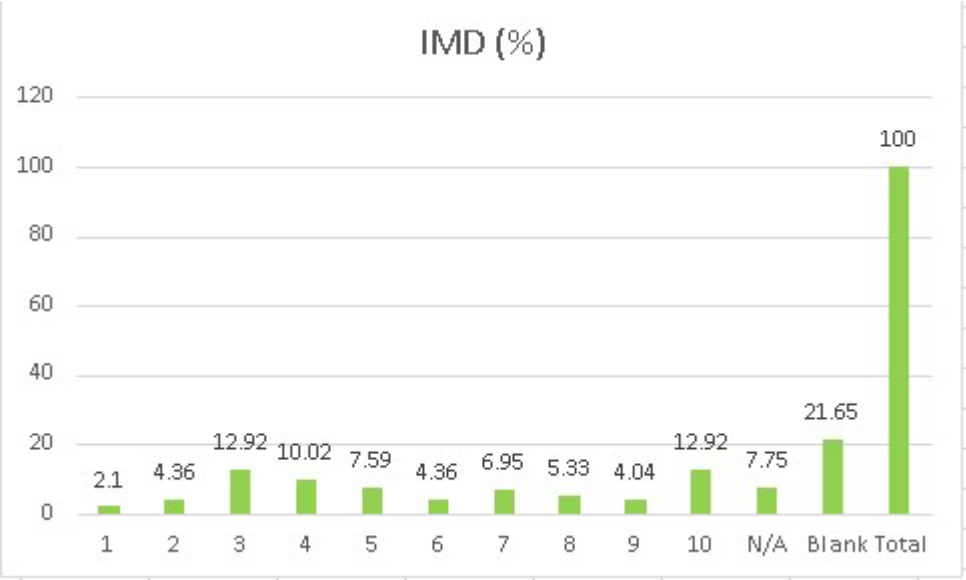


White British is the most represented ethnic group (45%) within the Healthwise programme. This reflects the fact that White British is the most represented ethnic group (67%) within the Borough. 17.7% of Reading's population are Asian, Asian British or Asian Welsh and therefore 12% representation of those from Asian backgrounds is representative of the Borough. **4.4 Employment**



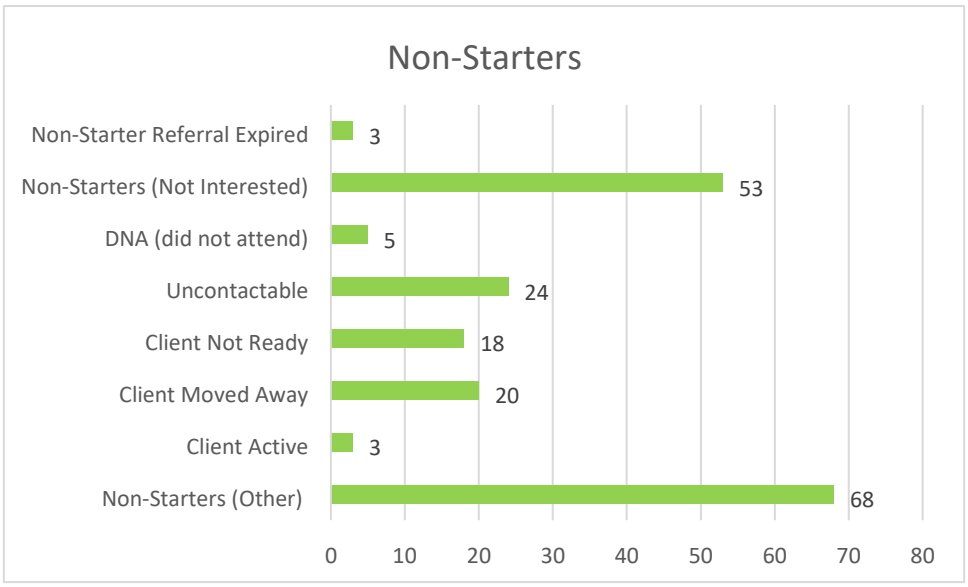
The most reported answer is 'not given' (62%) – this is largely due to the employment question being asked on the referral form (which is often completed by the GP). Our Healthwise team are now focusing on asking the question during the initial assessment, hopefully resulting in a more accurate report of individuals' employment status.

4.5 Indices Multiple Deprivation

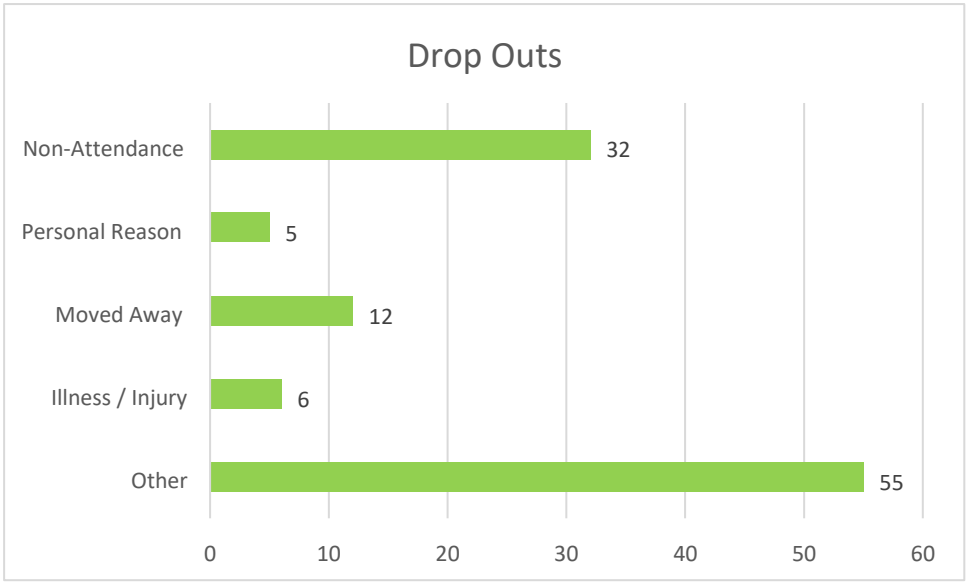


Postcode information is collected and anonymously linked to Index of Multiple Deprivation (IMD). The above graph shows that the majority of referrals come from IMD 10 (least deprived) and 3. There is outreach required in 2024 to increase the number of referrals being received from areas in IMD 1 and 2; predominantly the areas which are served by South Reading Leisure Centre.

5.0 Non-Starters & Drop Outs



Non-starters refers to those who have completed a triage call however upon finding out further information in regards to the programme have opted to not engage. In addition to this this category includes those we are unable to contact - the service attempts 3 phone calls, an email contact where possible and a letter. There is a high proportion of referral that once spoken with inform the service they are not interested in joining the pathway.



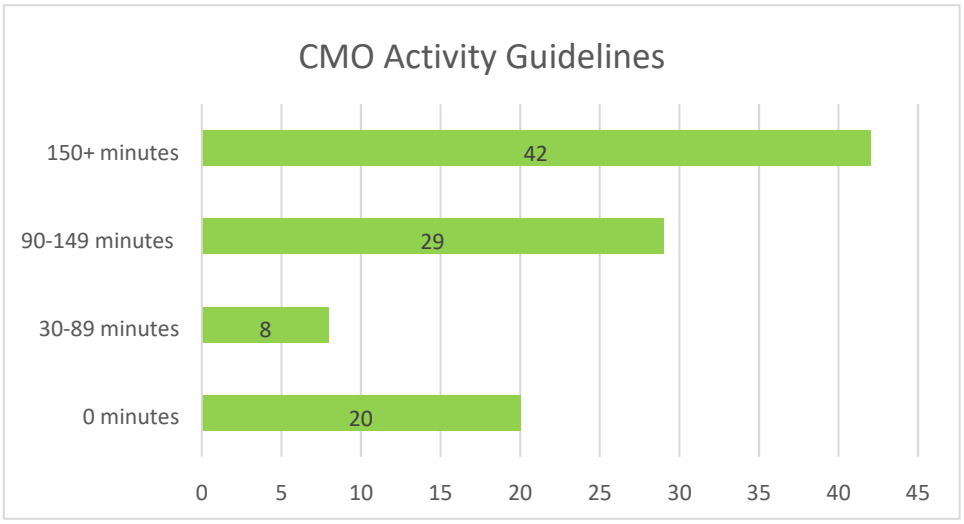
Drop outs are individuals who enrolled on a pathway but didn't attend at least nine of twelve sessions. The largest reason for individuals not completing a programme was 'other', this includes reasons such as; activity programming, childcare and motivation. Non-attendance was the second highest reason; this is mainly reflective of the AWM programme. As this programme has been offered free of charge, there is no consequence of not attending the sessions or additional

motivation to attend. Therefore, we have re-introduced the charge for AWM (in-line with other programmes, £25.00 per month) and have seen a higher retention rate since doing so. Where individuals cannot financially afford the weight management course, an individual approach is taken.

6.0 PARS and Cardiac Outputs

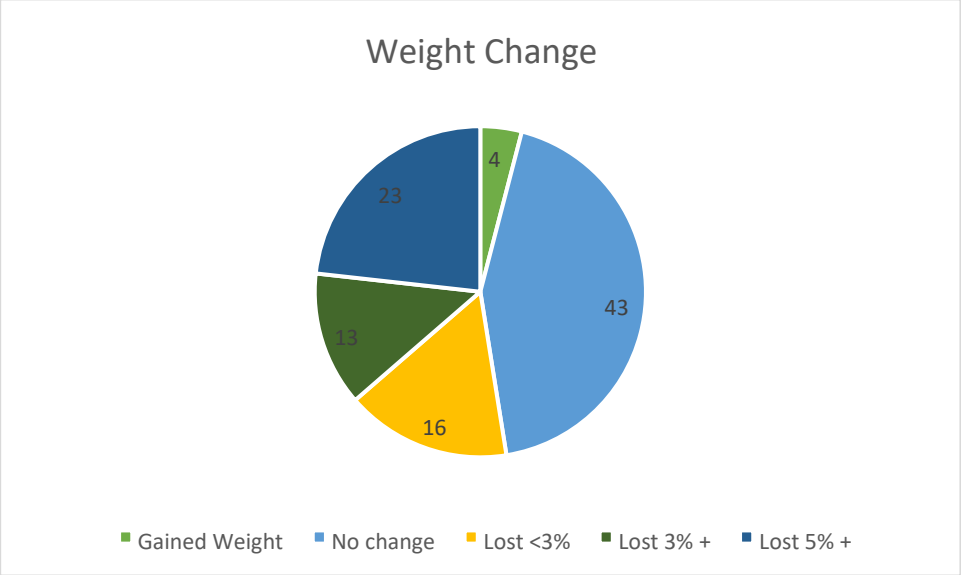
Over the course of 2023, there were **181** starters on the PARS programme (60% of the total referrals received) and **12** starters on the Cardiac programme (67% of the total referrals received). Of these starters, **88** individuals completed the PARS programme (49%, narrowly missing the annual target of 50%) and 11 individuals completed the Cardiac programme (92%). A completer is anyone who attends a minimum of nine out of twelve sessions.

6.1 Activity Levels



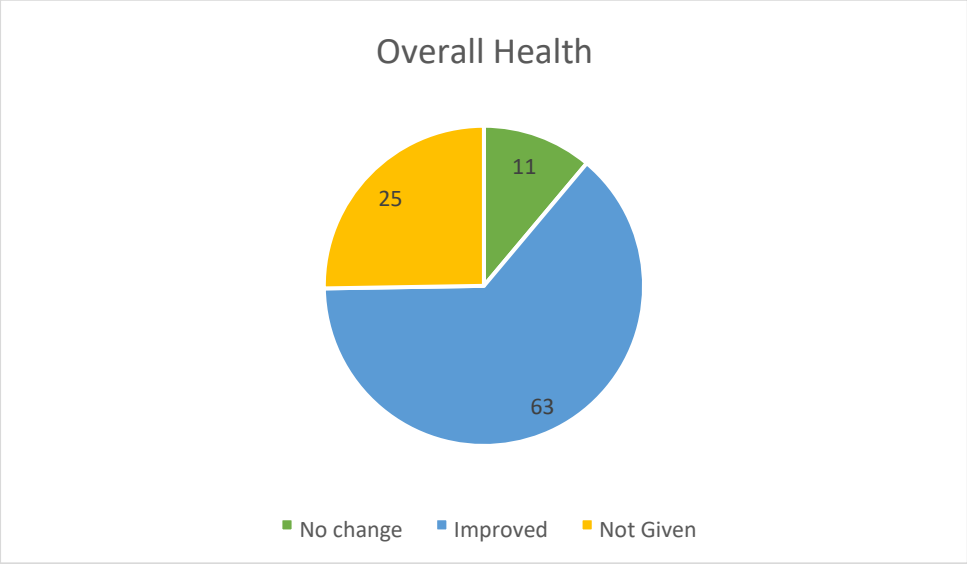
Chief Medical Officer (CMO) Guidelines recommend that adults complete at least 150 minutes of moderate intensity activity per week or at least 75 minutes of vigorous intensity activity per week (or a combination of both). Upon completion of the PARS and Cardiac pathways, individuals self-report their activity levels.

6.2 Weight Change



Participant's weight is measured by the Healthwise Facilitators at the start and end of the PARS and Cardiac pathways. It is important to note that weight loss is not the desirable / main outcome for all participants, for example those who are referred predominantly for mental health (anxiety and depression).

6.3 Health, Anxiety & Self-Efficacy



Overall Health and Anxiety are both measured using the Warwick Edinburgh Scale, used to assess an individual's mental wellbeing. These measures are taking pre and post intervention where possible.

64% of participants who completes PARS and Cardiac pathways reported an improvement in their overall health.

89% of individuals did not provide information on their anxiety; this likely means that the questionnaire was complete d pre but not post intervention. If the information was only provided / collected pre or post intervention it is reported as not given as it's incomplete.

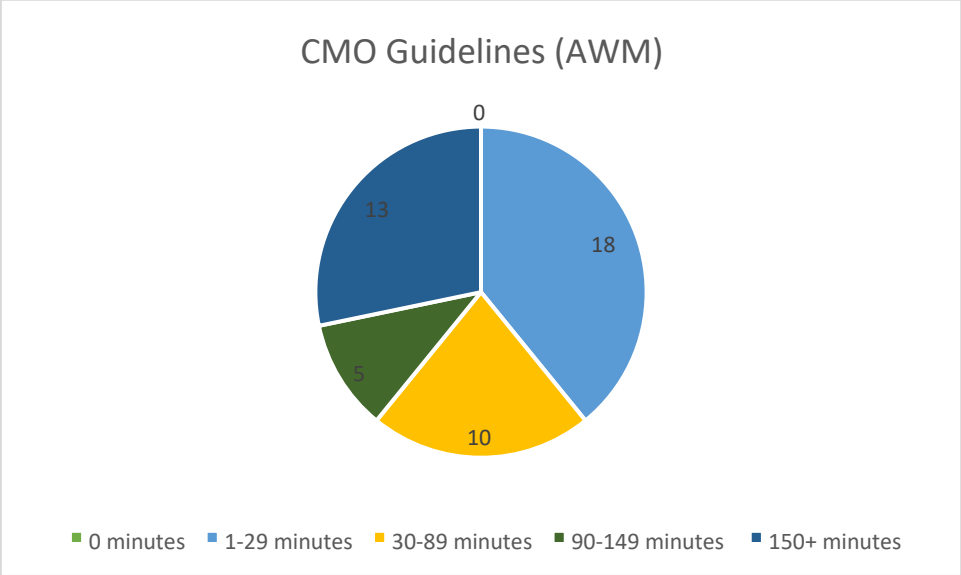
The final measure used on PARS and Cardiac pathways is Exercise Self -Efficacy, this is an individual's self - reported confidence in being physically active. As above if the information was only provided / collected pre or post intervention it is reported as not given as it's incomplete.

7.0 Adult Weight Management Outputs

7.1 Starters and Completers

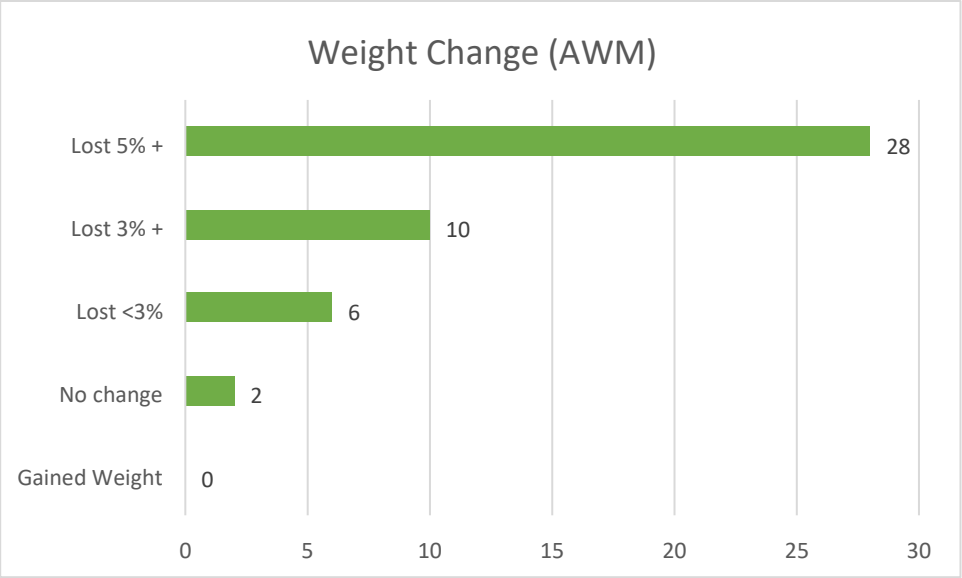
51% of those referred into AWM were enrolled into the pathway (meaning they completed triage and initial assessment) but in reality, only 33% truly started the AWM pathway by attending the first session(s). There are two courses which started in 2023, yet to complete. We estimate that the completion rate will increase to 65% based on attendance at the continuing sessions.

7.2 Activity Levels



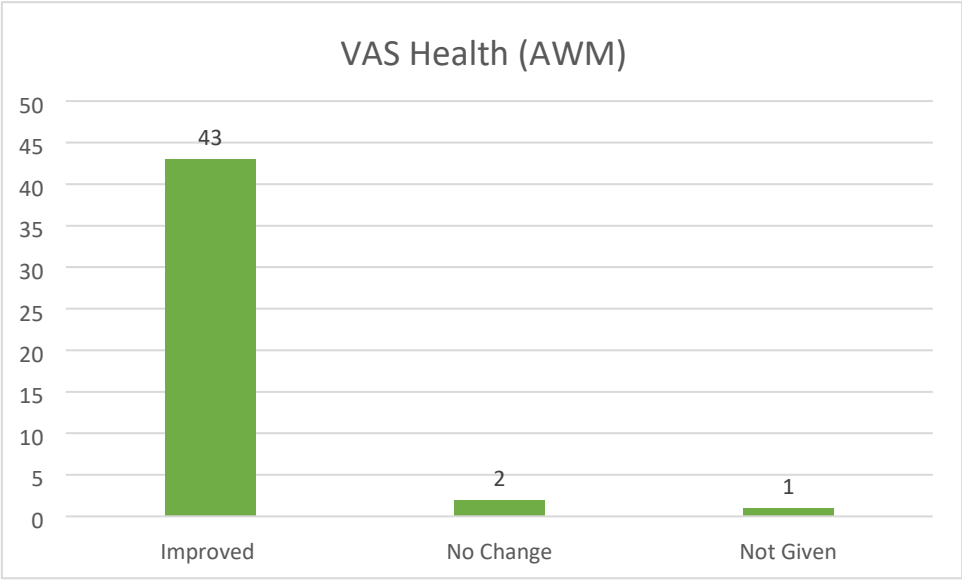
The same outcome measures are used for AWM (as with PARS and Cardiac). CMO activity guidelines are self-reported by the individuals at the end of the AWM programme. Individuals who enrol in the AWM course are provided with 1 x 60-minute activity session per week as part of the intervention; individuals with a membership can use the facilities at their leisure to increase this. The new delivery model of AWM will in future sessions see the delivery of the education component only and individuals directed into the Healthwise Supervised sessions and use of facilities as per their membership.

7.3 Weight Change



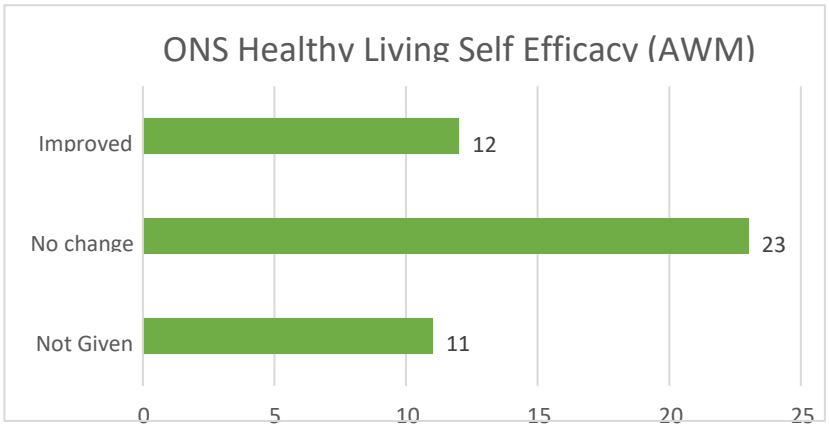
Weight loss is the main outcome of the AWM pathway. All individuals enrolled in the programme aim to lose weight by the end of the programme and often continue to lose weight following the end of the 12-week programme. 83% of completers lost >3-5% weight, which shows that the pathway is successful in achieving its aims. 8% lost less than 3% weight, 3% maintained weight and no one gained weight during the programmes.

7.4 Overall Health



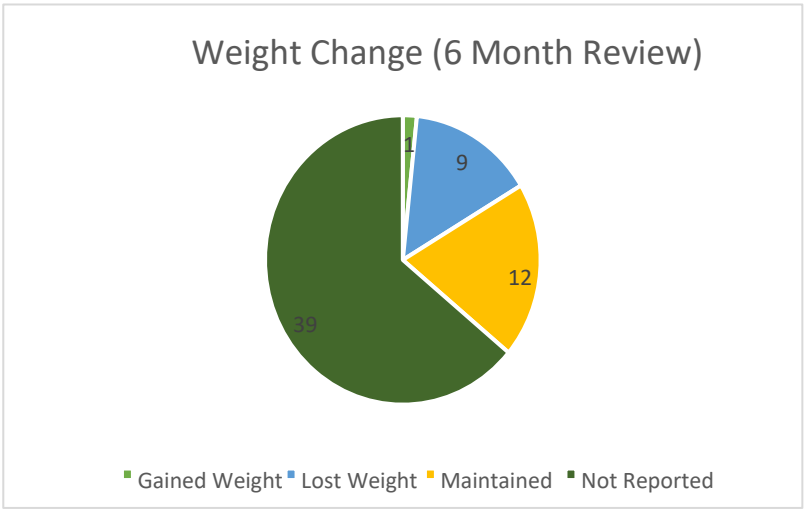
VAS Health is a self-reported scale of an individual's perceived level of overall health. Individuals complete this pre and post intervention. AWM shows that 93% of completers felt their health had improved overall.

7.5 Healthy Living Self Efficacy



ONS Health Living Self efficacy is also recorded on the AWM programme. This measure utilises a self-report scale completed by the individual regarding how confident and capable they feel to lead a healthy lifestyle. 29% of completers reported no change, this indicates that those individuals had the knowledge on *how* to lead a healthy lifestyle but needed to be held accountable to do so.

7.6 6 - Month Review's Weight Change



A total of **61** 6-months follow ups took place (higher than the number of completers as this takes into account those who completed 2022). Weight change is reported on during the 6month review. In table 21, the individuals who gained weight were weighed in centre, 3 of those who lost weight were self-reported and 6 were weighed in centre. All of those who maintained weight were self-reported. 6-month follow up provides challenges with re-engaging with the individual's post-intervention, especially if they are no longer members of a BETTER centre.

8.0 Health MOTs

Across all four leisure centres in Reading, we carry out non-invasive Health MOTs which consist of a healthy conversation (utilising MECC and Healthy Conversations skills), height and weight measurements (BMI) and a blood pressure check. The guidance given has been agreed with public health and is in line with NHS guidance to advise an individual when to visit a pharmacy, GP or Hospital. We held 7 specific Health MOT events in 2023, before moving to a more fluid model where Health MOTs are available upon request by an individual or at events (in and out of centres). A calendar of the Health MOTs was published and shared with Social Prescribers, RVA, local community cafes / centres and advertised in the centres. A breakdown of the Health MOTs is provided in the table below:

Date	Venue	Time	Total Checks	Total High BP	Total Pre-High BP	Total Overweight	Total Obese	Taster Session	Feedback / Summary
05/01	RM	2-4	4	0	1	1	0	N	All members
22/02	PP	2-4	6	2	1	1	1	Y	All members
30/03	SRLC	10-2	7	3	1	3	1	Y	Location in entry area, easy to see and approach but lacked privacy, predominantly members, quiet and more promotion required
27/04	RM	10-2	11	4	2	2	3	Y	Combinations of members and non-members, those in obese category were given AWM / Healthwise contact and info
25/05	PP	10-2	4	1	1	0	0	Y	All members
29/06	MSC	10-2	5	1	3	1	0	Y	All members
27/07	SRLC	10-2	0	0	0	0	0	N	event had no attendees, taster session removed due to lack of sign ups

9.0 Health Promotions

The 2023 calendar of Health Promotions can be seen in the table below. These Health Promotions are in line with Public Health England. Materials promoting each topic are displayed in centres on the noticeboards and TV screens. On an ad-hoc basis, we held information stands in centres promoting the topic. For example, Dry January was supported by Tessa completing questionnaires and discussions with individuals about their alcohol consumption and Stoptober was supported by Solutions4Health.

Month	**Promotion**
January	Dry January
February	Heart Health
March	Sleep
April	Stroke awareness
May	Dementia awareness
June	Diabetes awareness
July	5 ways to wellbeing
August	10 min shake up, Change 4Life
September	Know your numbers
October	Stoptober & breast cancer awareness
November	Every mind matters & men's health
December	Stay well this winter (warm spaces)

10.0 2024 Plan

10.1 Healthwise Pathways

In 2024, two new pathways will be available as part of the Healthwise offer. **Falls Prevention** will start in March 2024: GLL's product Better Balance will be delivered by the Healthwise team. This will follow the same referral and pricing structure as the other Healthwise pathways. **Cancer Rehab** will be an additional pathway available under Healthwise from May 2024. The objective of GLL's Cancer Rehabilitation is to enable people to be physically active at all stages of their cancer journey, which in turn can improve both clinical and quality-of-life outcomes. This includes rehabilitation after cancer treatment. Physical activity can reduce the risk of cancer recurrence and mortality for some cancers and can reduce the risk of developing other long-term conditions. Physical activity improves clinical and quality-of-life outcomes. Evidence is growing to support the integration of physical activity promotion into cancer care. Outcomes can include: Post-treatment (Rehab), increasing cardiorespiratory and muscular fitness, reducing cancer related fatigue, improving the range of movement/mobility/functional fitness dependent on cancer sites and treatment, enhancing wellbeing and social engagement and improved confidence and independence. This programme will follow the same pricing and referral structure as other Healthwise programmes. Additionally, we are introducing Aquatics for Health as an activity for those who participate in the PARS scheme; broadening the intervention.

10.2 Health Promotions

The calendar of Health Promotions for 2024 can be seen below:

Month	Promotion
January	5 Ways to Wellbeing & Blue Monday
February	Time to Talk / Children's Mental Health Week
March	National No Smoking Day
April	Stroke awareness
May	Mental Health Awareness Week & Dementia Action Week
June	Diabetes awareness
July	Addiction (Gambling & Alcohol)
August	Children's Physical Activity, Change 4Life
September	Know your numbers
October	Stoptober & Women's Health (Breast Cancer & Menopause)
November	Men's Health (Movember and Testicular Cancer)
December	Stay well this winter (Flu Jabs, warm spaces)

In 2024, our Health Promotion information will be distributed via our Social Media channels (Facebook, Twitter and Instagram) as well as having the promotion

boards in centres. We aim to work with partner organisations to host specific information stands / events in centres on rotation. Stroke Awareness, Mental Health Awareness, Dementia Action Week are just a few examples where we are currently engaging partners to support delivery of events and raise awareness.

10.3 Referral Outreach

University Health Centre and Balmore Park Surgery provide the highest number of referrals into the service. We receive a good number of referrals from: Abbey Medical Centre, The Potteries Surgery, Emmer Green Surgery, Western Elms Surgery, Milman and Kennet Surgery and Chatham

Street Surgery. We receive a small number of referrals for South Reading and Shinfield Group Medical Practice: Increasing the number of referrals from GPs serving the South Reading area is a priority for 2024.

GP Surgery	Count of Referrals
Balmore Park Surgery	**57**
University Health Centre	**63**
Mortimer Surgery	1
Parkside Practice	19
Melrose Surgery	21
Tilehurst Surgery Partnership	50
Milman Road Surgery	35
Westwood Road Surgery	8
Emmer Green Surgery	12
Western Elms Surgery	41
Woodley Practice	5
Brookside Practice	2
Chatham Street Surgery	19
Wilderness Practice	1
The Rycote Practice	6
Reading Walk-In Health Centre	8
Grovelands Medical Centre	19
Chapel Row Surgery	2
London Street Surgery	2
Sonning Common Health Centre	4

Long Barn Lane Surgery	10
Pembroke Surgery	40
Loddon Vale Practice	2
Circuit Lane Surgery	12
Goring & Woodcote Medical Practice	1
Abbey Medical Centre	8
Dawn Clinic	1
Theale Medical Centre	2
Little Waltham & Notley Surgery	3
Tilehurst Village Surgery	21
Finchampstead Practice	3
Crown Heights Medical Centre	2
Gillies & Overbridge Medical Partnership	1
Bramblys Grange Medical Practice	1
The Boat House Surgery	2
Grovelands Medical Centre	1
London Road Surgery	1
Twyford Surgery	3
Tadley Medical Partnership	1
Whitchurch Surgery	1
Clements and Christmas Maltings Surgery	1
N/A (Non-GP)	127

We have referral routes established with co-located health services (those services delivered within our centres) such as the National Diabetes Prevention Programme and Pulmonary Rehab, providing follow on routes for their service users. Continuing to develop this pathway and ensuring a smooth transition for these individuals is key for 2024.

Outreach for 2024 includes:

Attending and presenting at GP surgery team meetings to promote the Healthwise service

(from March onwards, to enable promotion of new pathways).

TV screens promoting Healthwise in GP surgeries

Closer working with Social Prescribers and Pharmacies, as well as utilising the Joy app

Working with Health Champions to increase representation from lesser-represented groups

Events: Health promotion events in partnership with local organisations

Healthwise presence at local events; providing Health MOTs at Community Events throughout the year.

11. Miscellaneous

11.1 Make Every Contact Count

Make Every Contact Count (MECC) training has been delivered to all front-line staff (including the Healthwise team who all have higher level Motivational Interviewing training too).

11.2 Office Space

Public Health use of office space has been sparsely used; Compass Recovery College benefitted from free usage to deliver their workshops throughout 2023. This was facilitated by GLL's Healthy Community Manager.

11.3 Diabetes Prevention

The National Diabetes Prevention Programme is delivered across all four centres in Reading by Live Well Take Control.

12.0 2024 Reporting

Monthly reporting will be presented in the same format as per 2023. Information will be presented on; Referrals, Demographics, PARS & Cardiac Outputs and AWM Outputs. AWM will be reported on a course-by-course basis, making tracking the courses easier for all. Monthly reporting will be available on the second week of the following month.

Additionally, a quarterly summary sheet will be included and can be seen below:

Q1, JAN - MARCH 2024: HEALTHWISE SUMMARY

Total Healthwise Memberships	INSERT NO.

Participant Feedback		
Comment	Pathway	Month

Q1 Jan - March: Postcode and IMD		
Row Labels	Count of PMI ID	Count of PM ID2
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
N/A		
Blank		
Total		

Q1 Jan - March: Blood Pressure				
		Status at End		
Status at Start	Total	Ideal	Pre High	Unknown
Ideal				
Pre High				
Stage 1				
Stage 2				
Unknown				
Total				

Referral Source *(Top 3 organisations referrals received from this quarter)*	
1	
2	
3	

Healthwise KPI's	KPI	Actual
Total number of referrals received	500	
Completion rate for PARS & Cardiac	50%	
Overall improvement in health (PARS & Cardiac)	75%	
Completion rate for AWM	70%	
6 month follow up for AWM	60%	
Lost =/>3% weight in AWM	35%	
Overall improvement in health (AWM)	75%	

Healthwise Summary
Insert here: Strengths of the quarter, weaknesses, opportunities for next quarter. Include any outreach that took place or is planned for next quarter (including events).

Health Promotions	
January: 5 Ways To Wellbeing	
February: Time to Talk & Children's Mental Health	
March: National No Smoking Day	

Health Checks								
Date	Venue	Time	Total Checks	Total High BP	Total Pre-High BP	Total Overweight	Total Obese	Feedback / Comment

Taster Sessions					
Month	Venue	Session	No. Booked	Actual Attendees	Feedback
January					
February					
March					

Appendix 12.4 Food Initiatives in Reading - Case studies

Churches in Reading Drop-in Centre (CIRDIC)
Safe and welcoming drop-in centre for homeless people who are disadvantaged and living in the local community.

CIRDIC - Home

Reading homeless shelter faces threat of closure - BBC News

Food poverty interlinked with cost-of-living crisis and homelessness as the drop-in centre was at risk of closing but it successfully raised funds to stay open, which emphasises the importance of these providers among most vulnerable residents:

'Could you imagine this morning not having anywhere warm to go? Not to be able to eat this morning?'
'It's where I eat, shower, get my hair cut and sit quietly four times a week. Where am I going to go when they go?'

Food Systems Equality Project (FoodSEqual)

Food Systems Equality - Co-production of healthy, sustainable food systems for disadvantaged communities (reading.ac.uk)

The project brings together academic researchers, food industry representatives, civil organisations and policy makers to reimagine how food policy, food products and food supply chains can be developed. The project will focus on working together with disadvantaged communities to jointly imagine new solutions to address a lack of access to healthy, sustainable food.

Previous attempts at transforming the food-health system to become more equitable, sustainable and integrated have had limited impact as they fail to engage disadvantaged communities in the research process and the policy design, leading to a failure to impart knowledge sharing or social innovation. The disconnect between households, communities and national supply and production networks presents one of the greatest challenges to developing a socially just, healthier, and sustainable food system for everyone.

The vision is to provide citizens of culturally diverse disadvantaged communities choice and agency over the food they consume, by co-developing new products, new supply chains and new policy frameworks that deliver an affordable, attractive, healthy and sustainable diet.

Incredible Edible Reading

Incredible Edible Reading (incredibleediblerdg.org)

Their mission is to inspire planet-friendly food and food-growing in Reading. Incredible Edible Reading (IER) was launched in Reading's Broad Street on 18 June 2023 as part of the Reading Climate Festival. A group of dedicated urban food growers are on a mission to encourage and support Reading's residents to grow food locally. We will make connections between communities, organisations and businesses that want to grow food and contribute to the town's biodiversity. We're in the process of establishing Incredible Edible Reading and keen to hear from people in the town about how the network can support food and food-growing ideas and aspirations. Making connections between the various initiatives around the town and bringing everyone together to imagine a fully-fledged and sustainable Incredible Edible Reading are the current goals. Partners: Transition Town Reading, RISC, Transition together, food4families, Reading Food Growing Network.

Refugee Support Group Sanctuary Cafés

Reading City of Sanctuary - (refugeesupportgroup.org.uk)
Refugee Support Group - Drop Ins

Buy an extra coffee on top of your order for a refugee.
Refugees can then go into the coffee bank and enjoy a free hot drink or snack.

The Atrium Café – Greyfriars Church, Friar Street, Reading RG1 1EH
Café 12 – LifeSpring Church, The Pavilion, 143-145 Oxford Road, Reading RG1 7UY
Monty's Café – 41 Addington Road, Reading RG1 5PZ
Shed Café – 8 Merchants Place, Reading RG1 1DT
University of Reading Cafés (All Cafes on Campus) – Whiteknights, Reading RG6 6AH
Atrium Café, Greyfriars Church, Friar Street, Reading RG1 1EH, Friday, 2 – 4 pm

Friday Drop-In provides a safe space for refugees to socialise, make friends, enjoy some refreshments and access support. Led by our Befrienders and staff, at the Drop In, refugees can get advice, meet with charities, statutory agencies, and employers, and be signposted to specialist services.

Reading International Solidarity Centre (RISC)
World Shop and Zero Waste Refill Shop
www.risc.org.uk/global-refills

Inspired by the zero-waste movement, RISC brought bulk foods to central Reading. The goal is to help empower the local community to reduce packaging waste and single-waste plastics. A range of approximately one hundred Fairtrade, organic or locally produced food and household items. Dispensers are filled with wholefoods, including pulses, nuts, seeds, dried fruits, cereals, pastas, and rice. They stock fresh veg, Beechwood Farm eggs and fresh local artisan bread. Local wines and local and global drinks. Household liquids are also available to be dispensed in customers' own bottles, including laundry liquid, washing up liquid, hand soap,

shampoo and conditioner. The World shop stocks ethically sourced pantry food items such as fairtrade coffee, olive oil, snacks, condiments, and flours. The World Shop and Refill Café seek to provide a full shopping experience to customers looking for an ethical alternative to mainstream supermarket and the high street.

'Parking in the vicinity is a problem. I come here with my bike and bring my own craft bags and empty household containers. It's affordable, I am by no means a high earner but it's possible to eat healthy, organic food and reduce plastic usage thanks to places like these. It's time people realise eating well and opting for less wasteful consumption does not mean spending more money. It means you can't get everything from your local supermarket, and maybe you spend a little more but to me, we have to prioritise our health, the environment and paying people a living wage. '

ReadiFood

ReadiFood is an independent food bank affiliated to "IFAN" the "Independent Food Aid Network'', and partners with Reading Borough Council. It delivers emergency food parcels to clients referred by local agencies and endeavours to avoid developing dependency by working closely with the referring agencies to discover the best way of supporting people. "Food Parcels" are designed to meet the needs of the recipients, thus providing a different size parcel depending on whether it is intended for a 1- or 2-person household or a family (3-4 people). Each parcel will contain enough food for at least three days, but many report making them last a week. Items in the food parcel can include pasta, rice, cereals, cooking sauce, ready meals, tinned vegetables, tinned fruit, tinned meat and/or fish, biscuits, tinned soup, tinned or instant potatoes and a variety of other useful cupboard items. Thanks to ongoing collaboration with partners such as Launchpad, parcels can include fresh fruits and vegetables during the growing season.

Reading Pantries

Reading Pantries – Faith

Local Pantries are all about dignity, choice and hope, bringing people together around food. Pantries stock a wide range of top-quality food including fresh fruit and veg, frozen and chilled food, meat and dairy products, and long-life tinned and packaged food.

Members pay £5 per visit and in return can choose groceries worth many times more, often saving up to £1,000 a year on shopping bills. Pantries have been shown to strengthen communities, improve health, wellbeing and household finances, reduce waste, prevent hunger and build dignity and agency. There are currently seven pantries across the town of Reading that operate in partnership with local churches or community centres.

Tackling Poverty Partnership

Closing the Gap programme
Working with our partners can also mean investing in them to create more capacity to support our resident's educational attainment and improved life chances. The Council actively commissions services from the voluntary and community sector within its Closing the Gap programme to provide a strong local voluntary and community sector infrastructure, enhance resilience, independence, and wellbeing for residents, and to help people get out and stay out of poverty.

Tackling Inequality Strategy 2023-2026

£1 Million in Council Funding to Voluntary Sector to Tackle Poverty and Inequality (reading.gov.uk)

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