Cheshire West and Chester
Nutrition and Health Needs Assessment
June 2026

Contents

Executive Summary

This Nutrition and Health Needs Assessment shows that many adults in Cheshire West and Chester want to eat well and support their health, but their ability to do so is shaped far more by social, environmental and commercial determinants than by knowledge or motivation alone.

The majority of residents do not meet national dietary guidance, with low intakes of fruit and vegetables, and high intakes of free sugars, salt and saturated fat. These patterns are worse in more deprived communities where there are also higher levels of obesity, hypertension, type 2 diabetes, cancer and dementia.

Food insecurity remains a significant issue for many residents of Cheshire West and Chester. A sixth (16.7%) of residents live in areas at highest risk, and foodbanks as well as affordable food projects continue to play an important role. Survey and focus-group feedback shows that cost, time pressures, limited cooking facilities, lack of transport and poor mental health are often barriers for people eating well.

Access to affordable, healthy food is inequitable largely due to the rurality of the borough. While many residents live close to supermarkets, others particularly those in rural areas or without their own transport face significant challenges. Data from the Food Equalities Tool shows wide variation across neighbourhoods in how easy it is to access affordable food and how much of household income is spent on food shopping.

Confidence and skills in cooking healthy meals vary across different groups. The survey found that people living in more deprived areas, men, and those unable to work were more likely to report lower confidence in cooking healthy meals and greater reliance on convenience food. Exposure to unhealthy food advertising is common and is felt most strongly in more deprived areas.

At the same time, Cheshire West and Chester has strong foundations to build on. There is a well-established whole-system approach through Eat Well Be Active, the Food for All Plan and the West Cheshire Food Partnership. The borough has taken meaningful action on healthier advertising, planning and food environments, and offers a tiered weight-management pathway aligned with national guidance. There is a clear commitment to dignity-based, compassionate support rather than blame or stigma.

The main gaps identified are not a lack of activity, but uneven access, affordability and local data. More needs to be done to make healthy food easier to buy, prepare and choose especially for people facing poverty, disability, neurodivergence, mental ill health or unstable housing and to improve insight into the experiences of underserved groups.

Overall, this needs assessment has identified the need to continue shifting from individual behaviour change alone to practical, system-wide action. Making healthy

food affordable, accessible and realistic in everyday life, while maintaining compassionate, joined-up support, offers the greatest opportunity to improve nutrition, reduce inequalities and support better health across the borough.

Introduction

A healthy diet is a foundation for good health throughout life, yet national dietary surveys consistently show that most people in the UK do not meet recommended nutritional guidelines. The Eatwell Guide sets out what a balanced diet should look like, but the National Diet and Nutrition Survey highlights persistent gaps, including low consumption of fruit, vegetables and fibre and higher intakes of sugar, saturated fat and salt than recommended. These patterns vary across the life course and are strongly shaped by wider social conditions meaning that dietary opportunities are not equal for all. As a result, poorer diet quality is more common in communities facing financial hardship, limited transport, fewer healthy local food outlets and greater exposure to low-cost, calorie-dense foods. Evidence suggests a stronger association between diet quality and the Index of Multiple Deprivation than with household income, indicating that the drivers of poor diet extend beyond financial constraints alone[i].

Poor diet is also a major contributor to obesity and a range of diet-related long-term conditions, including cardiovascular disease, type 2 diabetes, some cancers and mental ill health. Additionally, nutrition and health influence each other in both directions. Long-term conditions, disability, insecure employment, disrupted sleep patterns and financial strain can all affect what and how people eat. This reinforces the importance of prevention and wider support to help people maintain healthier diets, particularly in the face of the everyday pressures that shape eating patterns.

Weight stigma adds another layer of complexity. Evidence shows that stigma and discrimination can reduce confidence, discourage physical activity, increase social isolation and worsen mental health. A compassionate, non-judgemental approach to supporting nutrition and weight is therefore essential if we are to reduce health inequalities and improve outcomes for all groups. Nutrition also spans multiple agendas beyond health alone. Planning, transport, environmental sustainability, community development and economic policy all influence the affordability, availability and accessibility of food. Recognising these interconnections is vital for building healthier and more resilient communities.

This Adult Nutrition and Health Needs Assessment should be considered alongside the existing 0–19 Eating Well Joint Strategic Needs Assessment[ii] and the 0-19 Healthy Weight Joint Strategic Needs Assessment[iii], which focus on early years and childhood nutrition. These chapters cover the community food offer for families experiencing food insecurity, food and drink provision in educational settings and the support available to help families prepare healthy, affordable meals. The 0–19 Healthy Weight chapter also explores the wider determinants of healthy weight and the impact of weight stigma.

Taken together, the adult needs assessment and the 0–19 chapters provide a life-course view of nutritional need in Cheshire West and Chester. They highlight the shared challenges residents face in accessing an affordable, healthy diet and support a coordinated approach to action across childhood and adulthood.

Policy Context

National Policy Context:

National policy provides a consistent and strengthening narrative that poor diet is a major upstream driver of obesity, cardiovascular disease, type 2 diabetes and other long-term conditions and that its health impacts are distributed unequally. The National Food Strategy[iv] synthesises evidence demonstrating this and frames diet-related ill health as both a public health and equity challenge, concluding that approaches focused on individual behaviour change and voluntary industry action have been insufficient. Instead, it identifies the food environment as a key determinant of diet quality and calls for sustained population-level intervention to reduce harm at scale, including reformulation of processed foods and improved affordability of healthier options for lower-income households.

This population-level framing is reinforced by the Major Conditions Strategy[v], which highlights that many of the conditions with the greatest contribution to years lived in poor health share common, modifiable dietary risk factors. The strategy emphasises that these conditions frequently coexist and place cumulative pressure on health and social care services, strengthening the case for earlier and more systematic action on diet quality as a preventative measure. Crucially, it recognises that people's diets are shaped by access, affordability and local food environments, rather than knowledge or motivation alone.

National obesity policy further develops this by identifying excess weight as one of the most urgent public health challenges and recognising its strong social gradient. The policy paper on tackling obesity[vi] highlights that current food environments promote over-consumption through product formulation, pricing, placement and marketing. The focus on food environments reflects a clear shift towards reducing population exposure to less healthy food, rather than relying solely on individual choice, reinforcing the role of structural drivers in shaping diet.

The 10 Year Health Plan for England[vii] positions poor diet and obesity as central to the shift from a system responding to disease to one focused on prevention. It highlights that people are developing long-term conditions earlier and spending longer in poor health, particularly in more deprived communities where access to affordable, healthy food is constrained. The 10-year plan strengthens expectations for system-level action to reshape food environments and improve accountability

across the food system, reinforcing the need to address dietary risk as a foundation for prevention and reducing health inequalities.

Finally, government guidance on obesity and the food environment[viii] provides additional context on how national drivers manifest locally. It identifies obesity as strongly socially patterned and linked to local food environments, particularly the density of fast-food outlets in deprived areas. It also highlights the impact of weight stigma, noting evidence that people who are overweight or living with obesity may avoid physical activity in public due to fear of judgement or discrimination. The publication emphasises the role of local authorities in shaping healthier environments through a whole-systems approach, including planning, catering standards, and partnership working, underlining the importance of local context in determining dietary risk.

Taken together, this national evidence base establishes a clear rationale for local analysis and action in Cheshire West and Chester. It highlights that diet-related ill health is driven by structural factors such as affordability, availability and local food environments, which sit within local authority influence through planning, regulation, commissioning and partnership working. For Cheshire West and Chester, this reinforces the importance of assessing how national policy translates locally. This includes identifying communities most exposed to unhealthy food environments and greatest financial barriers to healthy eating, as well as understanding where additional local action may be required to reduce inequalities.

Key national context takeaways

- Poor diet is a major upstream driver of obesity and multiple long-term conditions.
- Diet-related ill health is socially patterned, with greater impact in deprived communities.
- Individual behaviour change alone is insufficient to address diet-related harm.
- Food environments, affordability, and availability strongly shape dietary behaviour.
- Local food environments and stigma can create additional barriers to healthy behaviours.
- National policy supports local action to assess and reduce structural dietary inequalities.

Local Policy Context:

The national evidence base on diet, obesity and health inequalities strongly aligns with the priorities set out in the Cheshire West and Chester Health and Wellbeing Strategy – Our Place Plan for the Borough 2026-2031[ix]. Nutrition ties in with multiple priorities, reinforcing the need for coordinated local action on nutrition as a determinant of health. The strategy's commitment to "ensuring a healthy standard of living for all" directly connects with the national recognition that affordability and

access to healthy food are core drivers of diet-related ill health. Delivering the local strategy and creating environments where healthy living is the easy choice provides an important mechanism for addressing the structural and spatial factors. This includes factors such as food affordability, availability and local retail mix which national policy identifies as essential for improving population diet and reducing inequalities.

The priority to “create and develop healthy and sustainable places and communities” mirrors national calls for a whole-systems approach that acts on the wider determinants of diet. Integrated neighbourhood systems and community-led delivery models create opportunities to embed nutrition support closer to residents, linking healthcare, community food initiatives and local voluntary, community, faith and social enterprise organisations (VCFSE). Ensuring equitable access to services also aligns with the need, highlighted nationally, to identify which communities face the greatest barriers to healthy eating and to tailor interventions accordingly. Supporting the VCFSE sector further reinforces the role of local assets in building resilient, nutrition-supportive environments.

The Strategy’s focus on “strengthening the role and impact of ill-health prevention” is strongly aligned with the national shift from treatment to prevention. Increasing support to prevent long-term conditions such as cardiovascular disease directly reflects the national evidence that poor diet and obesity are major, modifiable drivers of multimorbidity. The emphasis on mental health prevention also links to national recognition of the relationship between diet, wellbeing and weight stigma. Additionally, promoting good health to keep people in work aligns with national findings that diet-related ill health contributes to reduced productivity and working-age morbidity.

Finally, the Strategy’s priority to “pursue environmental sustainability and health equity” together complements national policy recognising the need to address health inequalities and environmental impacts. Delivering the Council’s Climate Emergency Response Plan[x] and the Greener NHS Plan[xi] creates opportunities to align sustainability actions with improvements in dietary health. This would encompass areas such as improving local food systems, supporting sustainable procurement and reducing the environmental impact of food. This reflects the national direction of travel that positions food system reform as essential for both population health and environmental resilience.

Sub-regionally, work has been taking place since 2021 to co-create and deliver on priorities to reduce health inequalities across Cheshire and Merseyside. Taking a Marmot approach and led by the Institute of Health Equity, the All Together Fairer Programme[xii] built on existing efforts to address health inequalities in the subregion. This aimed to develop new momentum and ensure that the most effective approaches are developed, with health inequalities prioritised by the Cheshire and Merseyside Health and Care Partnership, local authorities, and place-based

partnerships. The priority actions for the All Together Fairer programme that relate to nutrition and health include ‘Giving every child the best start in life’; ‘Enabling all children, young people and adults to maximise their capabilities and have control over their lives’; ‘Ensuring a healthy standard of living for all’; ‘Create and develop healthy and sustainable places and communities’; and ‘Strengthen the role and impact of ill health prevention’.

These priorities support a whole-system, place-based approach, including giving every child the best start through strengthened early years nutrition and food security support; building food skills, confidence and choice across the life course; addressing food affordability and access as part of wider anti-poverty action; shaping healthier and more sustainable food environments within communities; and embedding nutrition within prevention and early intervention services. Central to this approach is partnership working across the council, NHS, VCFSE sector and communities to reduce inequalities, support dignity and choice, and ensure that healthy food is accessible, affordable and achievable for all residents.

Taken together, these strategic priorities position Cheshire West and Chester to act on the structural drivers of poor diet highlighted in national policy. They provide a local framework for addressing the affordability, accessibility and environmental determinants of nutrition, enabling Place partners to reduce diet-related health inequalities, support healthier communities and create conditions for long-term improvements in population health.

Key local context take-aways:

- Improving diet aligns directly with the aim to “ensure a healthy standard of living”**,** particularly by creating healthier local environments
- Nutrition is central to creating “healthy, sustainable communities”, with opportunities to embed diet improvement into integrated neighbourhood teams, community-led models and VCFSE partnerships.
- Addressing poor diet supports the strategy’s ambition to “strengthen prevention”, reducing the risk of cardiovascular disease and other long-term conditions while supporting mental wellbeing and work participation.
- Food system action contributes to Cheshire West and Chester’s commitment to “health equity”, by targeting structural barriers to healthy eating, and to “environmental sustainability”*,* through healthier and more sustainable food provision and procurement.

What is happening locally - data

Adherence to nutritional advice and guidelines

Eatwell Guide

The UK Government advice on a healthy, balanced diet is presented in the UK's national food model, the Eatwell Guide[xiii]. The Eatwell Guide reflects the latest dietary recommendations and key public health messages. The Eatwell Guide applies to most people regardless of weight, dietary restriction or preferences or ethnic origin. The proportions shown are representative of food consumption over the period of a day or even a week, not necessarily each mealtime.

Figure 1: Eatwell Guide

Source: UK Government, Department of Health and Social Care

The Eatwell Guide (Figure 1) provides a visual representation of the types and proportions of foods needed for a healthy balanced diet to promote long-term health at a population level. The recommendations include advice to consume at least five portions of fruit and vegetables per day, wholegrain, higher fibre carbohydrates and lower fat, sugar and dairy options. The Eatwell Guide also recommends consumption of no more than 70g of red and processed meat a day, and replacing meat with lower

fat, higher fibre proteins such as beans, pulses, fish and eggs. Other recommendations include choosing unsaturated oils and spreads, limiting consumption of foods high in fat, salt and sugar, and drinking six to eight glasses of fluid every day.

Research led by the London School of Hygiene and Tropical Medicine, in collaboration with the University of Oxford, found that people who adhered to any five or more of the Eatwell Guide recommendations had an estimated 7% reduction in their risk of dying early. The biggest contributor to this was consuming 5-a-day of fruit and vegetables consistently. Using data from the National Diet and Nutrition Survey (NDNS), the researchers also found that less than 0.1% of people adhered to all nine of the recommendations evaluated in the study, most adhering to three or four[xiv].

The National Diet and Nutrition Survey 2019 to 2023

The National Diet and Nutrition Survey (NDNS) is designed to assess the diet, nutrient intake and nutritional status of the general UK population. The most recent report, published in June 2025, presents data for 2019 to 2023. Whilst the survey presents national data, without data at smaller geographic levels, the sample is designed to be nationally representative.

5-a-day

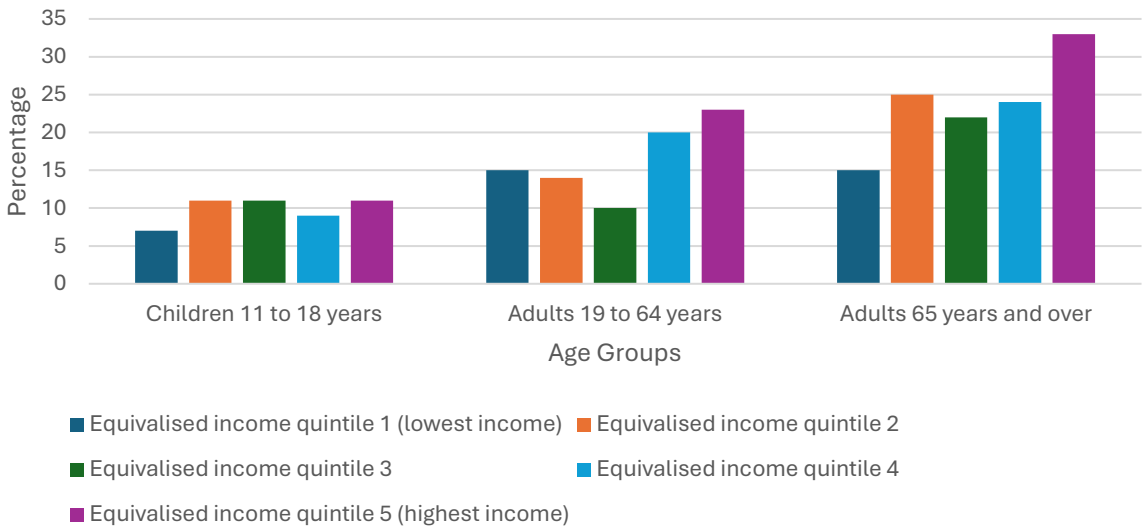
Evidence from the World Health Organization[xv] shows that consumption of more than 400g of fruit and vegetables a day is associated with a lower risk of heart disease, stroke and some cancers. Therefore, government advice for adults is to consume at least five 80g portions of a variety of fruit and vegetables a day. Despite the programme being known as ‘5 a day’, the recommendation emphasises consuming at least five portions a day, implying that this is a minimum consumption recommendation.

Data from the NDNS reported that most participants did not meet the UK government recommendation to eat at least 5 portions of a variety of fruit and vegetables each day. On average, adults consumed 3.3 to 3.7 portions per day, varying by age. Less than 1 in 5 adults (17%) met the ‘5 a Day’ recommendation. Consumption for adults (19+) was lower for the most recent survey than all previous published data, though a recent change in survey questions may account for some of this difference[xvi] as it is not directly comparable to previous estimates. It may also reflect a real reduction in fruit and vegetable consumption, which has been suggested is due to a combination of lack of availability during the COVID-19 pandemic and cost of living pressures.

When analysing the NDNS by Indices of Multiple Deprivation, for adults the data shows a social gradient with the average consumption of ‘5 a Day’ portions lowest in

the most deprived IMD quintile (2.8 portions per day in adults aged 19 to 64 years compared with 2.6 portions per day in 65 years and over). When looking at income quintile, the NDNS data (Figure 2) shows that the percentage of adults aged 65 years and over who achieved the '5 a Day' recommendation in the highest income quintile (33%) was more than double that in the lowest income quintile (15%). No clear pattern by income quintile was observed in the other two adult age groups. Data from the Active Lives Adult Survey[xvii] demonstrates that, for Cheshire West and Chester, 35% of adults met the 5-a-day recommendations for 2024-25 which is significantly better than the England average and an increase from 31% the previous year.

Figure 2: % of participants achieving 5 A Day fruit and vegetable portions by equivalised income quintile and age group

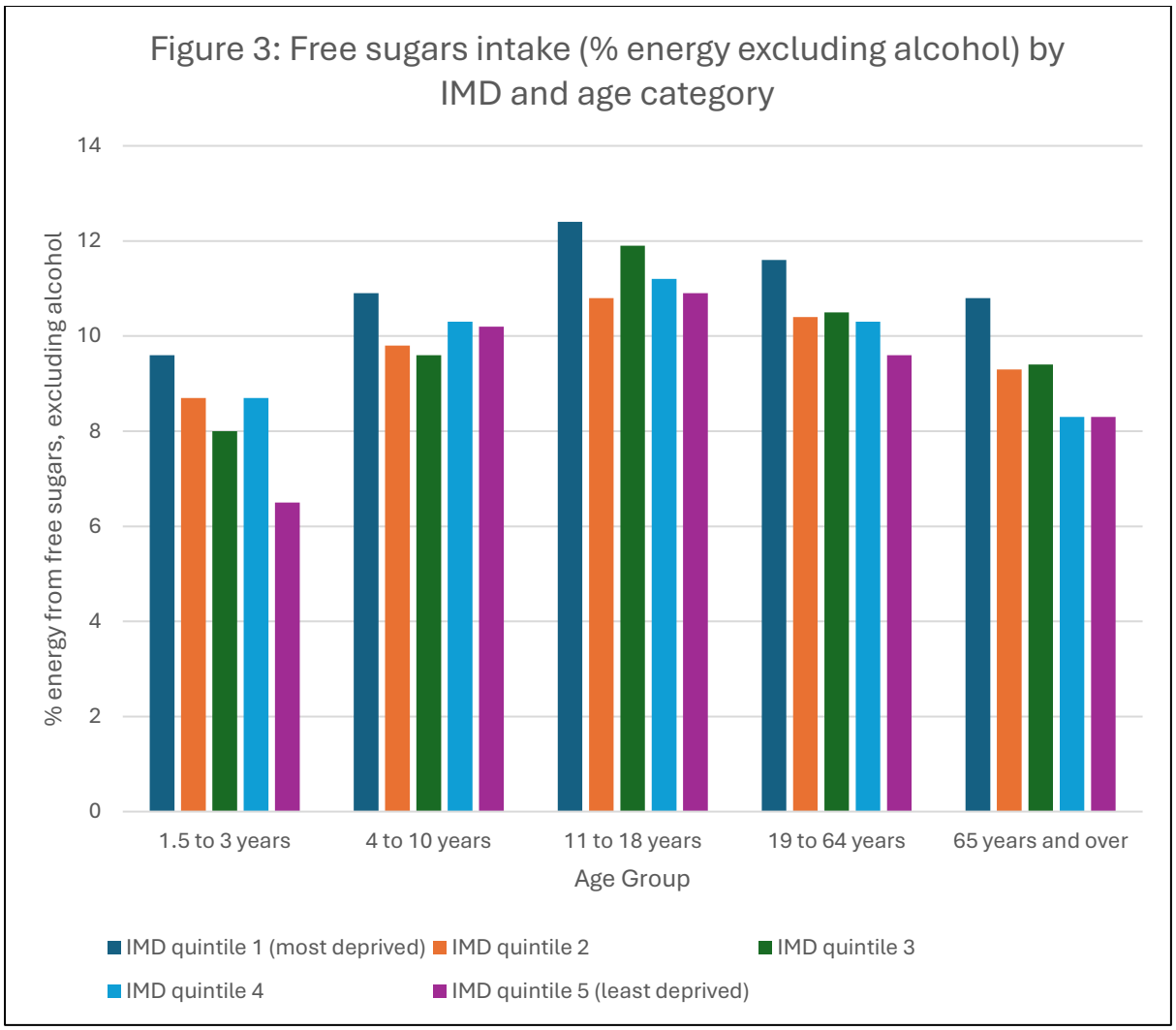


Source: National Diet and Nutrition Survey 2019-23 and OHID Public Health Outcomes Framework 2025

Free sugars

Free sugars are sugars that are added to foods or drinks, or found naturally in honey, syrups and fruit juices, they do not include sugars that are naturally present in intact fruits, vegetables or dairy products. Sugar in fruit and vegetables become 'free sugars' once the fruit flesh and skin is broken down, for example if they are pureed or juiced. Free sugars should be limited to no more than 30g/day for children from age 11 and adults, which equates to no more than 5% of energy from free sugars. The NDNS data shows that average intakes were 10.4% of energy for adults. The recommendation for intake of free sugars was met by 17% of those aged 19 to 64 years, 30% of those aged 65 to 74 years and 15% of those aged 75 years and over.

When split by IMD quintile, for all age groups, intake of free sugars was highest in the most deprived IMD quintile (Figure 3).

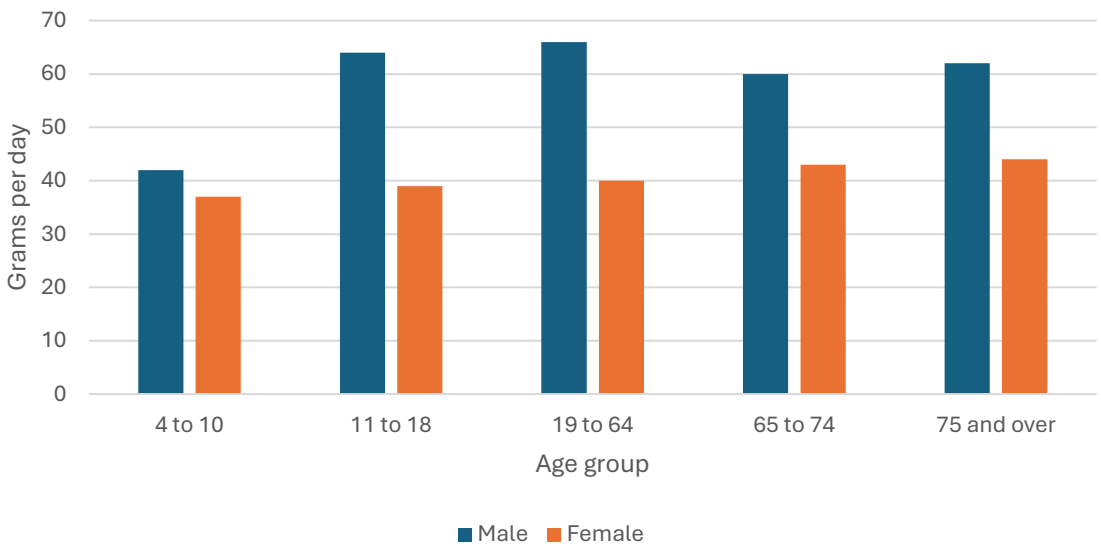


Source: National Diet and Nutrition Survey 2019-23

Red and processed meat

The UK government recommends that people who eat more than 90g of red or processed meat a day should cut down to 70g. In 2019 to 2023, average consumption of red and processed meat was below 70g per day in all age and sex groups. Men aged 19 to 64 years ate the most red and processed meat. On average, men aged 19 to 64 years ate 66g per day but about a quarter (27%) ate more than 90g per day (Figure 4).

Figure 4: Red and processed meat consumed per day (grams) by participants, by age and sex for years 2019 to 2023



Source: National Diet and Nutrition Survey 2019-23

Saturated fats

The UK government recommends that no more than 10% of energy comes from saturated fats. For 2019 to 2023, average intakes exceeded the recommendation. Saturated fats provided 12.6% of energy for adults. Overall, 82% of adults did not meet the recommendation.

Fibre

As recommended in the Scientific Advisory Committee on Nutrition report Carbohydrates and health[xviii], the average intake of fibre for adults should be 30g per day. In the latest NDNS survey 96% adults did not meet this fibre recommendation.

Key Dietary Adherence Take Aways

- The Eatwell Guide outlines the proportions of foods needed for a healthy, balanced diet, including 5-a-day fruit and vegetables, higher-fibre wholegrains, lower-fat dairy, choosing unsaturated oils, limiting foods high in fat, salt and sugar, and keeping red/processed meat to ≤70g/day.
- Adhering to at least five Eatwell Guide recommendations is linked to a 7% lower risk of early death, but less than 0.1% of people meet all recommendations, with most meeting only three or four.
- NDNS data shows most adults fall short of key dietary guidelines: adults consume only 3.3–3.7 portions of fruit and veg per day and just 17% meet the 5-a-day target, with the lowest intake in the most deprived groups.

- Free sugar intake remains well above recommendations, providing 10.4% of energy (recommended ≤5%), with the highest intake in the most deprived quintile.
- Although average red and processed meat consumption is below 70g, 27% of men still eat more than 90g/day.
- 82% of adults exceed saturated fat recommendations and 96% fail to meet the 30g/day fibre guideline.
- Locally, 31% of adults in Cheshire West and Chester meet the 5-a-day recommendation, similar to the England average.

Food Insecurity

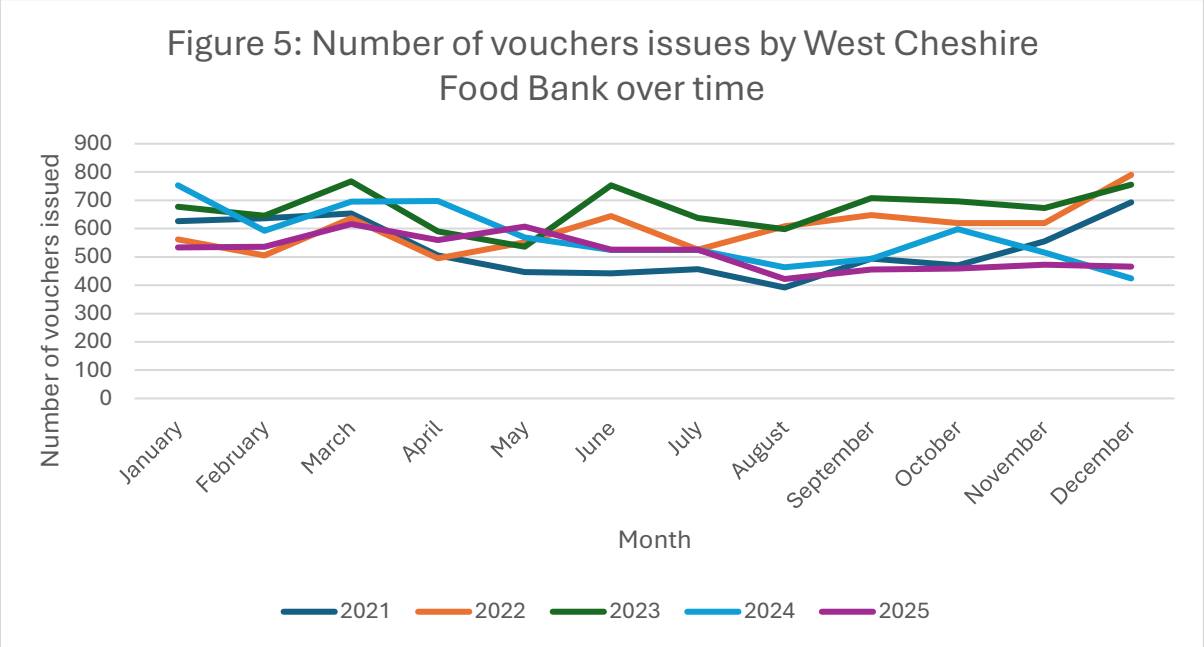
National data[xix] suggests rising food insecurity with one in nine households experiencing this in January 2026, increasing from one in ten in June 2025. This equates to roughly six million adults across the UK experiencing food insecurity. This evidence also outlines that 53% of food insecure households cut back on fruit and 40% on vegetable purchasing, limiting the nutritional quality of diets. The North West has the highest levels of food insecurity in England (13%) with greater eligibility for free school meals than national averages[xx]. In Cheshire West and Chester, an estimated 16.7% of the population, equivalent to around 62,000 people based on the 2021 census, live in areas at the highest risk of food insecurity[xxi]. Food insecurity can also be evidenced through foodbank use. There are three foodbank offers within Cheshire West and Chester, outlined below.

West Cheshire Foodbank

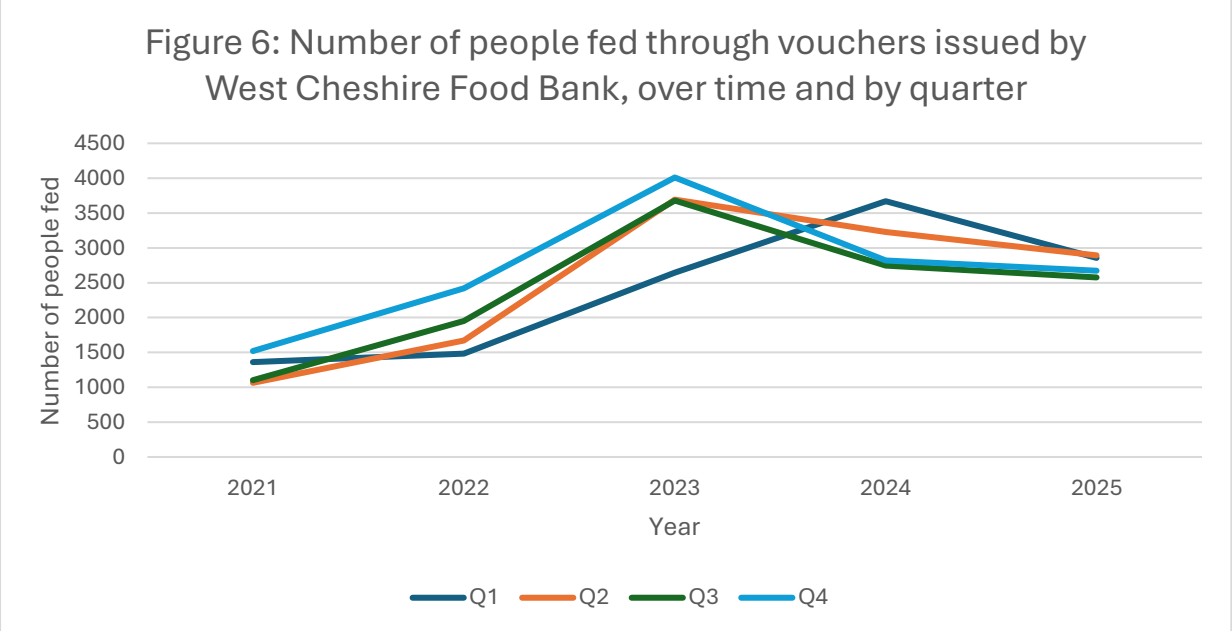
West Cheshire Foodbank, part of the Trussell network of Foodbanks, covers Ellesmere Port, Chester, Neston, Helsby, Elton and rural areas stretching to Malpas. It operates out of 17 locations, offering around 30 sessions each week which provide 3 days of emergency food to people with a referral provided by trusted partners such as GPs, schools, Citizens Advice and the council. All food is donated by the public via collection points all around West Cheshire or purchased using donated funds. The Foodbank is supported by more than 100 volunteers and five staff members. WCFB provide more than food, and many of their sessions include the active involvement of partner agencies, enabling residents to access immediate support with issues such as debt, benefits, mental health or housing alongside their food provision.

West Cheshire Foodbank is committed to ending the need for foodbanks, and current projects include the provision of Citizens Advice financial inclusion workers in many of the sessions, the delivery of a participation project gathering deeper insight from people who use the Foodbank and a cash-first programme with local schools.

In 2025, West Cheshire Foodbank fulfilled 6181 vouchers, which reflects a 10.5% drop in use compared with 2024 (Figure 5). This equates to 11,001 people fed by the foodbank in 2025 as compared with 12,463 in 2024 (Figure 6). The main difference in these figures is a reduction in people using the foodbank in the first and second quarter of 2025 with similar numbers using the foodbank in quarters 3 and 4 between 2024 and 2025 (Figure 5).



Source: West Cheshire Food Bank



Source: West Cheshire Food Bank

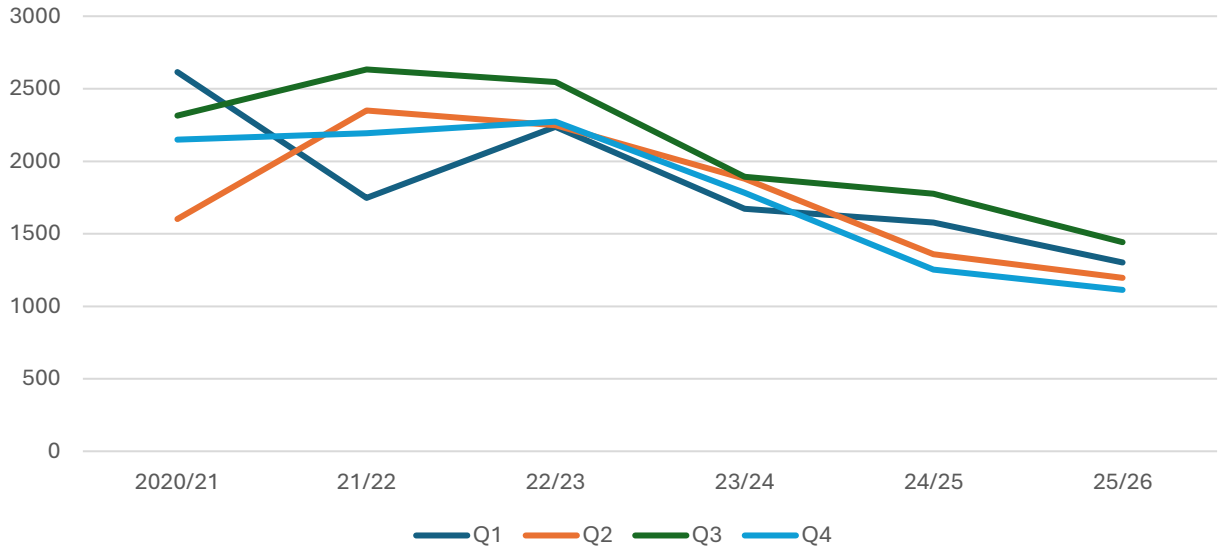
Mid Cheshire Foodbank

The Mid Cheshire Foodbank supports Northwich, Winsford and nearby rural areas through nine foodbank sites in churches and community venues. It operates every weekday in both towns, with two additional evening sessions to ensure access for people who work. The foodbank is run entirely by around 165 volunteers. Improving nutrition has been a priority, with parcels now including fresh fruit and vegetables, eggs and a loaf of bread to provide five days' worth of food. Collaboration with University of Chester dietetics students has supported this work with their review valuing a family-of-four parcel at around £144.

In 2025, the Foodbank processed 2,308 vouchers, supporting around 970 households, a significant decrease from the previous year. Approximately 20% were first-time users and most households (58%) used the Foodbank once, 20% used the Foodbank twice and approximately 10% used it three times.

Figure 7 shows the number of people fed over time. The data is shown per quarter and illustrates a decline in the number of people fed over time, with a high of 2314 people fed during Q3 (October to December) of 2020/21 and low of 1113 fed during Q4 (January to March) of 2025/26.

Figure 7: Number of people fed through vouchers issued by Mid Cheshire Food Bank, over time and by quarter



Source: Mid Cheshire Food Bank

Provision has been adapted as local needs change. Some sessions have closed due to reduced demand, while new tailored sessions have been developed for people seeking asylum, including adjustments to dietary preferences such as offering bagged pulses instead of tinned. Although the importance of data around reasons for

use has been recognised as being crucial for advocacy and understanding root causes, this has been undermined to date by poor-quality data and is an area of focus going forward.

Runcorn Food Bank

Runcorn and District Foodbank serves the Frodsham Distribution Centre and forms part of the national Trussell Trust network. Established in 2012, it supports residents across Runcorn and surrounding areas. The foodbank is heavily reliant on community support through volunteering, food donations and fundraising. Most donated food comes from churches, schools, businesses and supermarket collection points. People are referred through frontline agencies, who issue vouchers that can be exchanged for nutritionally balanced parcels containing three days' worth of food.

In 2025, the Frodsham Distribution Centre fulfilled 83 vouchers, providing 132 food parcels for adults and 90 for children. These figures reflect ongoing demand within the area. The Foodbank continues to emphasise inclusion and the belief that everyone has the right to food, dignity and hope, recognising the skills and contributions each person brings to their community.

Key Take Aways for food insecurity:

- One in nine households in the UK experience food insecurity, equating to roughly six million adults across the country.
- Common reactions to food insecurity are to reduce the purchase of expensive and perishable products such as fruits and vegetables, limiting diet quality.
- In Cheshire West and Chester, an estimated 16.7% of the population, equivalent to around 62,000 live in areas at the highest risk of food insecurity.
- Local foodbanks in Cheshire West and Chester continue to meet need:
    - West Cheshire Foodbank fulfilled 6181 vouchers in 2025
    - Mid Cheshire Foodbank supported around 970 households in 2025 and has improved the nutritional content of parcels.
    - Runcorn & District Foodbank via Frodsham Distribution Centre fulfilled 83 vouchers in 2025

Rates of disease where nutrition is a modifiable risk factor

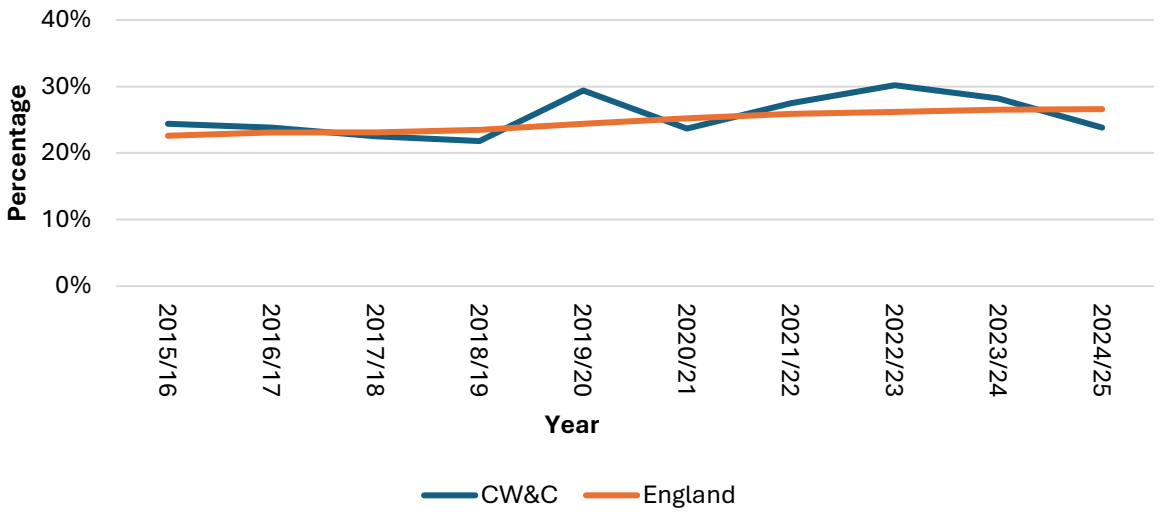
As outlined in the introduction and the national and local policy contexts, nutrition plays a crucial role in modifiable risk factors for various non-communicable diseases. These include obesity, hypertension, type 2 diabetes, cardiovascular disease, cancer and dementia. Evidence shows that the North West of England has higher levels of obesity, hypertension, type 2 diabetes, and preventable cardiovascular and cancer mortality than England averages[xxii]. These impacts are unequally distributed, with

more deprived communities experiencing poorer diet and worse related health outcomes[xxiii]. The local data for each of these conditions is outlined below.

Obesity

Obesity is defined as a Body Mass Index (BMI) of 30 and above, while overweight is a BMI of 25-29.9. In Cheshire West and Chester, the latest data from 2024/25 shows that 66.9% of adults are living with overweight or obesity, which is statistically similar to the England average of 64.6% and the North West average of 67.0%. Additionally, 23.8% of those within Cheshire West and Chester are living with obesity, which is statistically similar to both the England average of 26.6% and the North West average of 28.6%. The overall trend for both Cheshire West and Chester and England has been an increase over time, though with more variation in Cheshire West and Chester than nationally as seen in Figure 8.

Figure 8: Obesity prevalence in adults over time in both Cheshire West and Chester and England

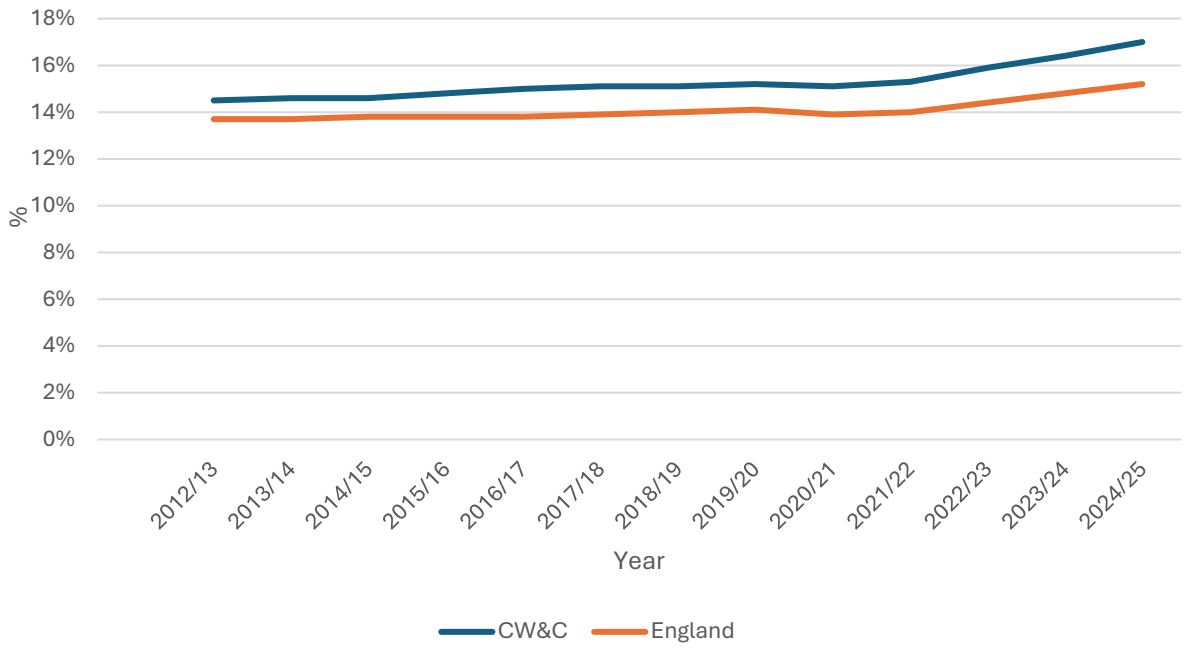


Source: Department of Health and Social Care Fingertips: Public Health Profile

Hypertension

A similar upward trend is seen with hypertension over time, as seen in Figure 9. The prevalence of hypertension in Cheshire West and Chester in 2012/13 was 14.5% of the population and in 2024/25 reached 17%. This consistently sits above the England average, which in 2024/25 was 15.2%. It also is higher than the North West average which in 2024/25 was 16.0%. Additionally, the estimated prevalence of undiagnosed adult hypertension within the area in 2021 was 9.0%, which is similar to the England estimate of 8.6%.

Figure 9: Hypertension prevalence in adults over time in both Cheshire West and Chester and England



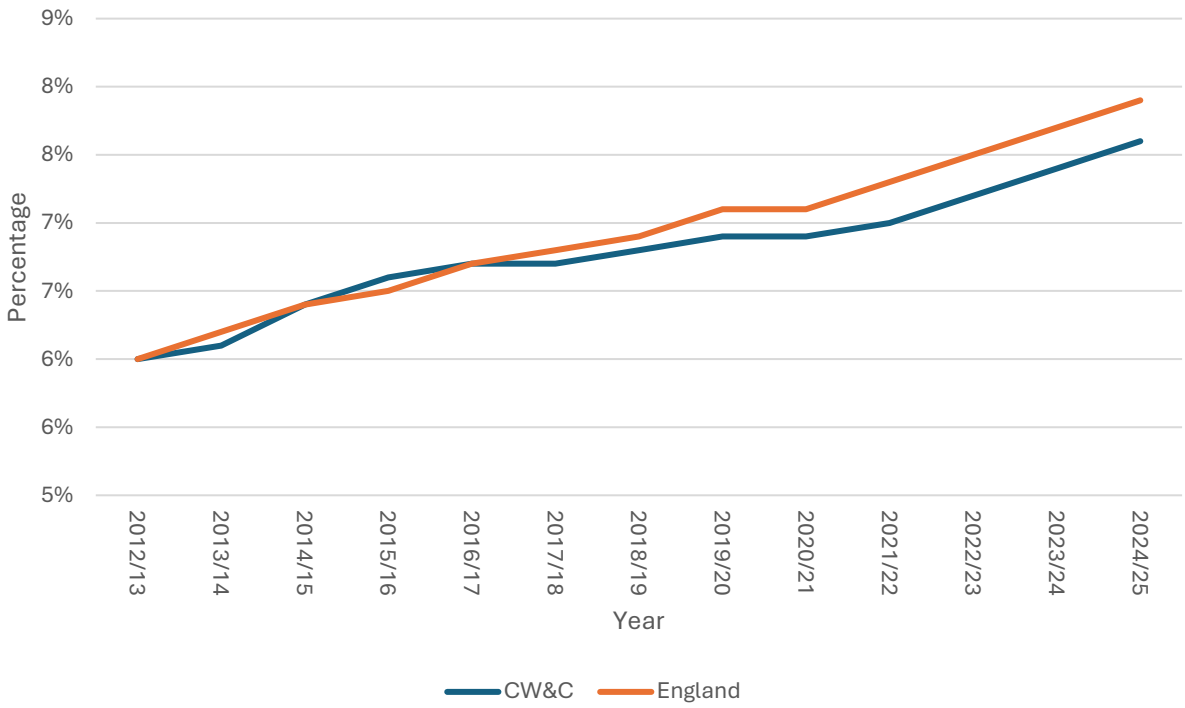
Source: Department of Health and Social Care Fingertips: Public Health Profile

Type 2 Diabetes

The estimated prevalence of diagnosed and undiagnosed type 2 diabetes in Cheshire West and Chester in 2021 was 7.2% of the population, which was similar to the national average of 7.8% and less than the North West average of 8.1%. The overall prevalence of diabetes has been increasing both nationally and locally, with the Cheshire West and Chester prevalence following the national average trend (Figure 10). The mortality rate for all deaths involving diabetes is however lower in Cheshire West and Chester than the national average and has been since 2012-14. In 2022-24, this was 76.7 per 100,000 population in Cheshire West and Chester and 109.6 per 100,000 population in England.

Although not available for Cheshire West and Chester specifically, data from Cheshire (which also includes Cheshire East) demonstrates that there are 42,879 patients with type 2 diabetes. Sub-analysis shows an age, sex and demographic gradient with higher rates of type 2 diabetes in older, female and more deprived populations.

Figure 10: Diabetes prevalence in adults over time in both Cheshire West and Chester and England



Source: Department of Health and Social Care Fingertips: Public Health Profile

Cardiovascular disease

Cardiovascular disease (CVD) includes ischaemic heart disease, heart failure, stroke and vascular dementia. The mortality rate in Cheshire West and Chester for ischaemic heart disease in those under 75 is similar to the England average and has closely followed the overall trend since 2001-03. In 2022-24, in Cheshire West and Chester the mortality rate was 40.3 per 100,000 population and for England was 40.6 per 100,000 population. Cheshire West and Chester had lower than average hospital admissions due to coronary heart disease in 2024/25 (325.1 per 100,000 population and 386.6 per 100,000 population respectively). However, it had significantly higher than national average hospital admissions due to heart failure in the same time frame (291.2 per 100,000 population and 175.0 per 100,000 population respectively).

The mortality rate for stroke in those under 75 in 2021-23 is also similar for Cheshire West and Chester to the England average (12.6 per 100,000 population and 12.7 per 100,000 population, respectively). Likewise, the mortality rate for those over 74 broadly follows the England average since 2004-06 and in 2022-24 was statistically similar (396.1 per 100,000 population and 409.9 per 100,000 population respectively). In contrast, hospital admissions due to stroke in Cheshire West and Chester have been mostly below the England average since 2003/04, with the latest

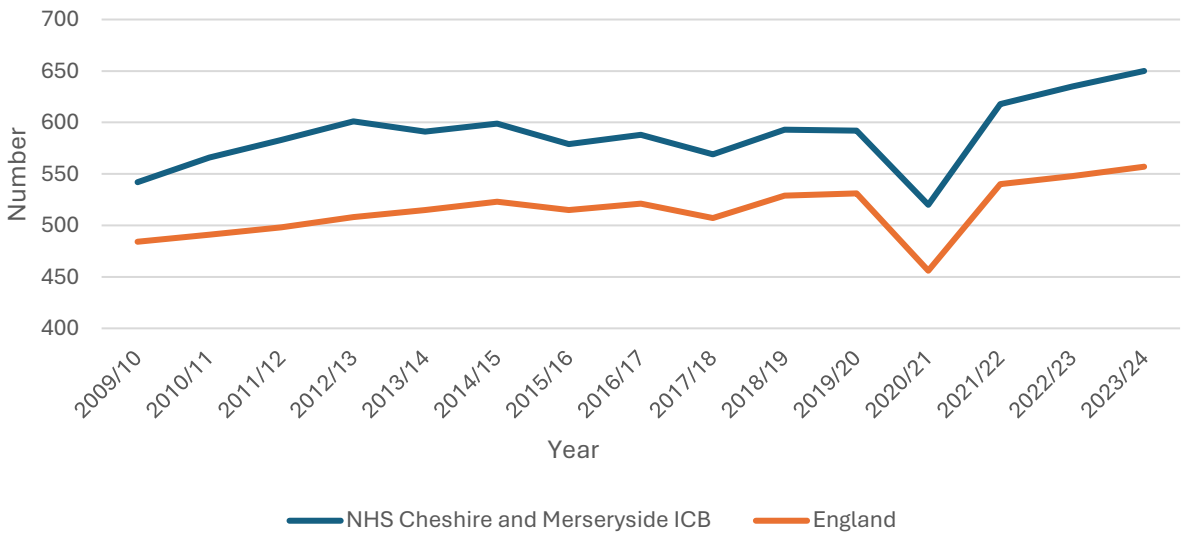
data in 2024/25 showing local admissions for stroke are significantly less than average (124.9 per 100,000 population and 172.7 per 100,000 population respectively).

Cancer

Although public health cancer data is not available at a local authority level, there is data around new cancer diagnoses available at Integrated Care Board (ICB) level for Cheshire and Merseyside. The trend in both England and Cheshire and Merseyside is of rising cancer incidence with the incidence being higher locally than the national average (Figure 11). The most recent data in 2023/24 showed an incidence locally of 650 new cancer diagnoses per 100,000 population as compared with the national average of 557 per 100,000 population. This is also higher in Cheshire and Merseyside than in other North West ICBs with Greater Manchester having an incidence of 508 per 100,000 population and Lancashire and South Cumbria ICB having an incidence of 614 per 100,000 population.

Looking at cancer prevalence in 2024/25, for Cheshire and Merseyside 4.3% of the patient population had a cancer diagnosis (excluding non-melanotic skin cancers) as compared with the England average of 3.8% and the North West average of 3.9%. Cheshire and Merseyside were the same as Lancashire and South Cumbria who also had 4.3% of the patient population with a cancer diagnosis, though both were higher than Greater Manchester in which the value was 3.3%.

Figure 11: Cancer incidence over time in both Cheshire and Merseyside ICB and England (new cancer cases)



Source: Department of Health and Social Care Fingertips: Public Health Profile

Dementia

Dementia prevalence within Cheshire West and Chester has exceeded the national average since 2014/15, with the latest data from 2024/25 showing local prevalence of 1% of the population as compared with the England average of 0.8%. Cheshire West and Chester is similar in this to nearby local authorities including Cheshire East and Wirral who both have a local prevalence of 1%. Looking at the estimated dementia diagnosis rate in those aged 65 and older, which is the proportion of those over 65 with a formal diagnosis of dementia per the estimated number of those with dementia based on the demographics of each local authority population, Cheshire West and Chester has a similar diagnosis rate to the national average (68.0 per 100 and 65.6 per 100 respectively).

Key take aways from rates of disease where nutrition is a modifiable risk factor

- Nutrition is a modifiable risk factor for obesity, hypertension, type 2 diabetes, cardiovascular disease, cancer and dementia.
- In Cheshire West and Chester, 61.6% of adults live with overweight or obesity, and 28.2% live with obesity, with rates similar to England averages.
- Hypertension prevalence has increased to 17% locally and is higher than both England and North West averages.
- Type 2 diabetes prevalence (7.2%) is similar to England averages, with higher rates in older and more deprived populations.
- For cardiovascular disease, mortality rates are similar to England averages, but hospital admissions for heart failure are higher.
- Cancer incidence and prevalence (at ICB level) are higher than national averages.
- Dementia prevalence locally (1.0%) exceeds the England average (0.8%), with estimated diagnosis rates similar to England.

Recommendations

1. Build on existing obesity prevention activity with renewed focus on impact, as local obesity rates continue to rise in line with national trends.
2. Improve equity-focused intelligence, by developing more robust local data on diet-related disease and nutrition access among underserved groups, including people with learning disabilities, ethnic minority communities and adults with neurodivergence.
3. Embed nutrition within routine care, ensuring primary and community care settings are supported to deliver brief, compassionate dietary conversations linked to local support offers.

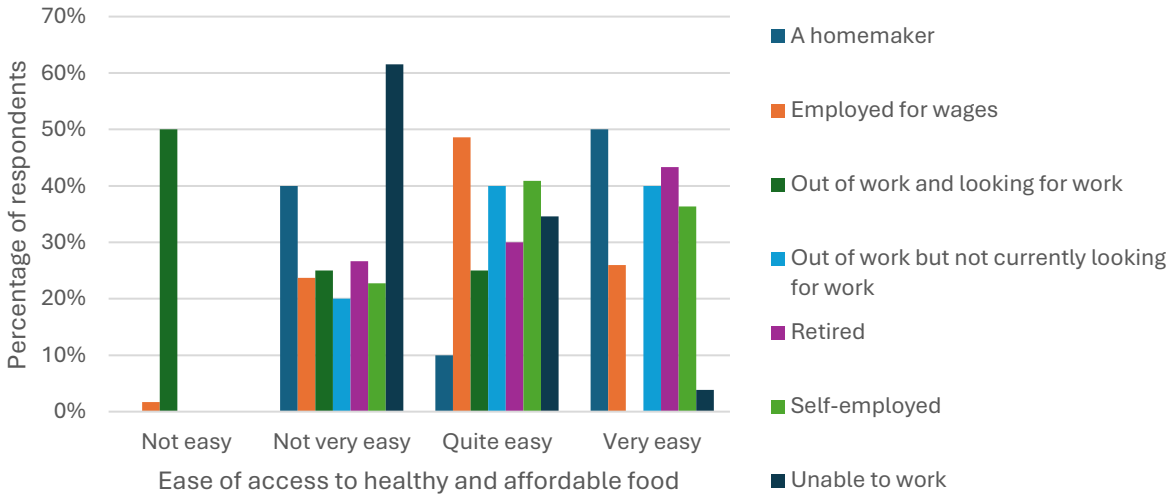
Eating Well Survey

To support the Adult Nutrition and Health Needs Assessment, an online resident survey was conducted between 20 November and 20 December 2025. The aim was to explore local behaviours, attitudes and experiences relating to food, nutrition and healthy eating. In total, 278 valid responses were received, following removal of 200 spam responses and one blank entry. The survey contained 16 core questions alongside demographic items. Respondents were predominantly female (83.1%) and spanned a broad range of ages, though most were between 35–64 years. Responses were polarised across deprivation levels: 11.2% lived in IMD decile 1 (most deprived areas) and 18.7% in IMD decile 10 (least deprived areas), with fewer respondents in middle deciles.

Access to healthy and affordable food

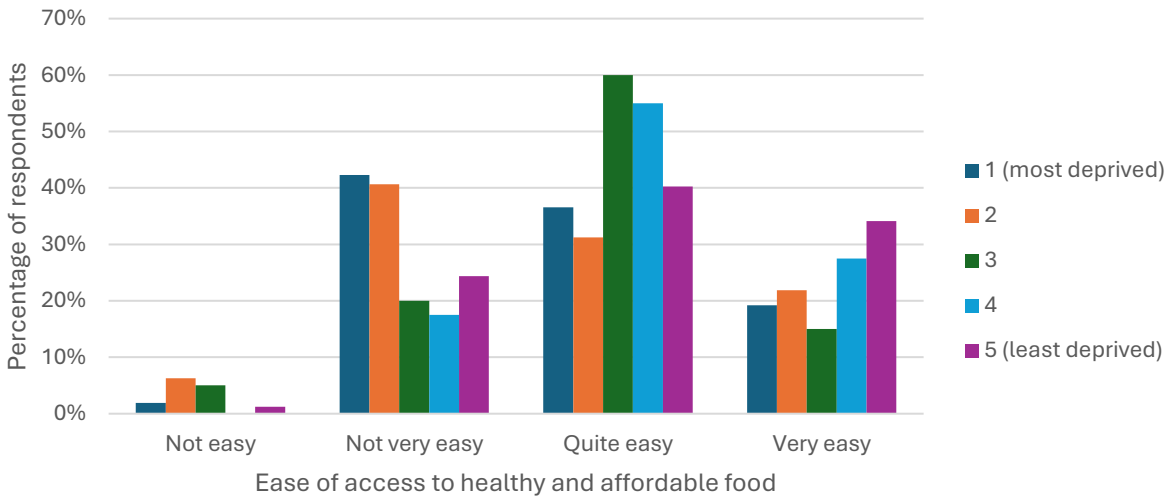
Most respondents felt able to purchase healthy and affordable food locally, with 42.8% describing access as “quite easy” and 27.0% as “very easy.” However, 27.7% reported it was “not very easy,” and 1.8% “not easy”. These overall patterns concealed important inequalities. Respondents out of work and looking for employment were the only group in which none reported finding access “very easy” and 50.0% of this group reported access was “not easy” (Figure 12). Analysis by deprivation (Figure 13) demonstrated that a greater percentage of respondents in quintiles 4 and 5 (less deprived areas) thought it was “very easy” to buy healthy, affordable food locally (27.5% and 34.2% respectively) as compared with quintiles 1, 2 and 3 (19.2, 21.9% and 15.0% respectively).

Figure 12: Percentage responses to ease of access to healthy and affordable food by employment status



Source: Cheshire West and Chester Eating Well Survey 2025

Figure 13: Percentage responses to ease of access to healthy and affordable food by IMD quintile



Source: Cheshire West and Chester Eating Well Survey 2025

Inequalities were also reflected in where people sourced their food. While 82.0% primarily relied on supermarkets, 1.8% reported using foodbanks. Although the numbers were small, all those using foodbanks were women. Additionally, older adults aged 75+ had the highest percentage reporting that they sourced their food from convenience stores (16.7%), indicating potential access constraints (Figure 14).

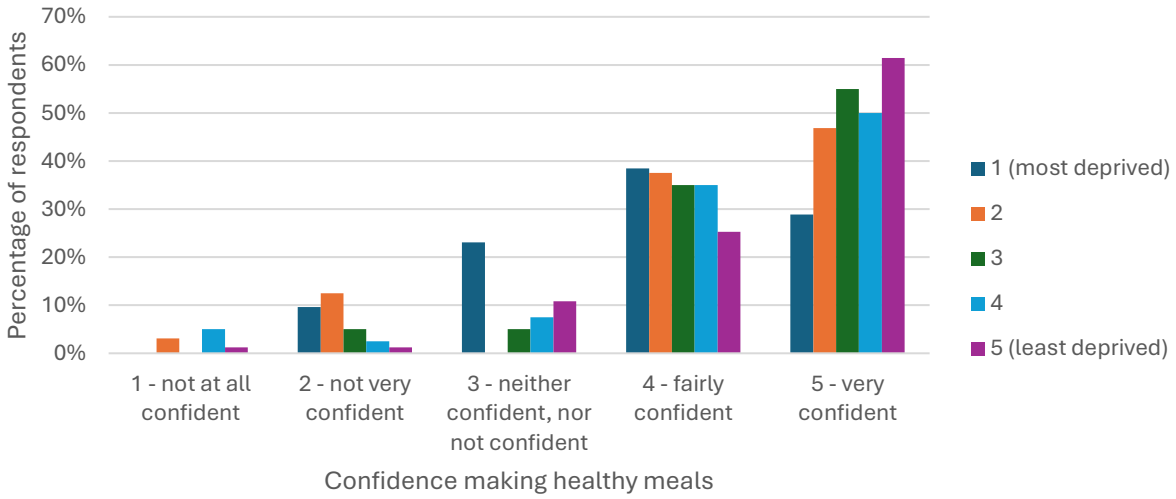
Figure 14: Percentage responses to source of food by age

Source: Cheshire West and Chester Eating Well Survey 2025

Confidence in preparing and cooking healthy meals

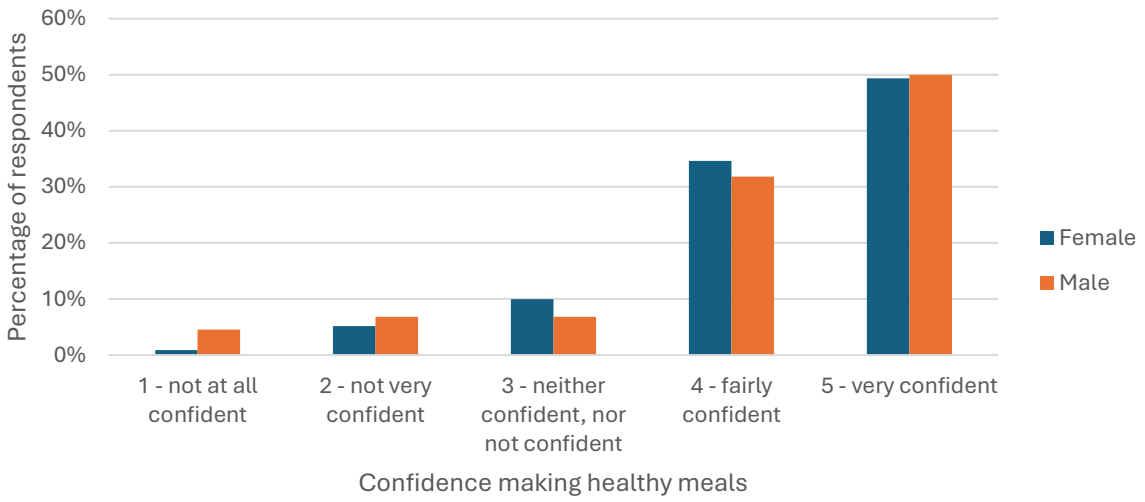
Confidence in preparing healthy meals was generally high, with 49.3% reporting they were “very confident”. However, confidence varied between groups. Looking at confidence by deprivation, within the “very confident” response, there was a clear discrepancy between IMD quintiles with 61.4% of those in IMD 5 (least deprived) reporting they were very confident as compared with 28.8% in IMD 1 (most deprived; Figure 15). Similarly, the greatest percentage of those reporting they were “not very confident” lived in the more deprived areas (IMD 2; 12.5% and IMD 1; 9.6%), with only 1.2% of those in IMD 5 (least deprived) reporting this. Additionally, as seen in Figure 16 a greater percentage of men than women were “not at all” confident (4.6% and 0.9% respectively).

Figure 15: Percentage responses to confidence in preparing and cooking healthy meals by IMD quintile



Source: Cheshire West and Chester Eating Well Survey 2025

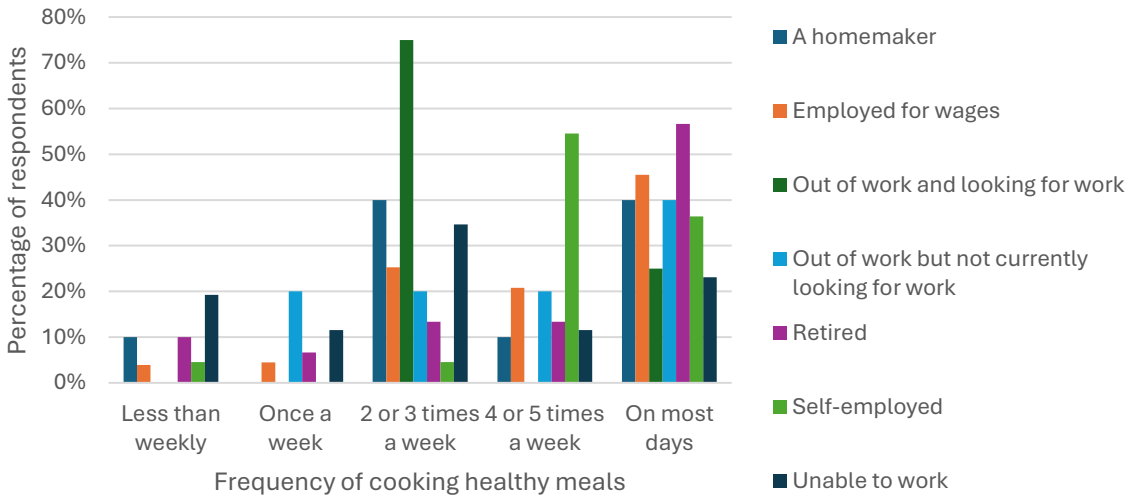
Figure 16: Percentage responses to confidence in preparing and cooking healthy meals by gender



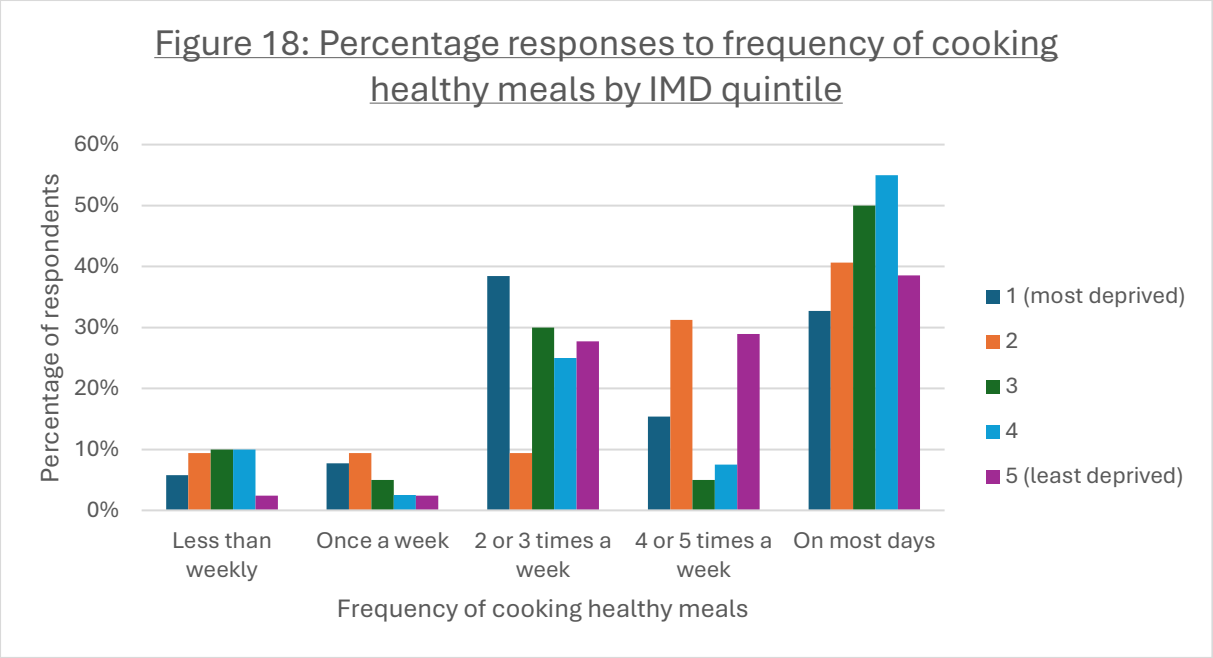
Source: Cheshire West and Chester Eating Well Survey 2025

These disparities were echoed in cooking behaviours. While 43.5% cooked healthy meals on most days, 19.2% of those unable to work cooked less than weekly (Figure 17) and only 2.4% of respondents living in the least deprived areas (IMD 5) reported such infrequent cooking (Figure 18). Older adults, particularly those aged 65–74, showed the most consistent healthy cooking habits with 80.0% cooking healthy meals most days (Figure 19).

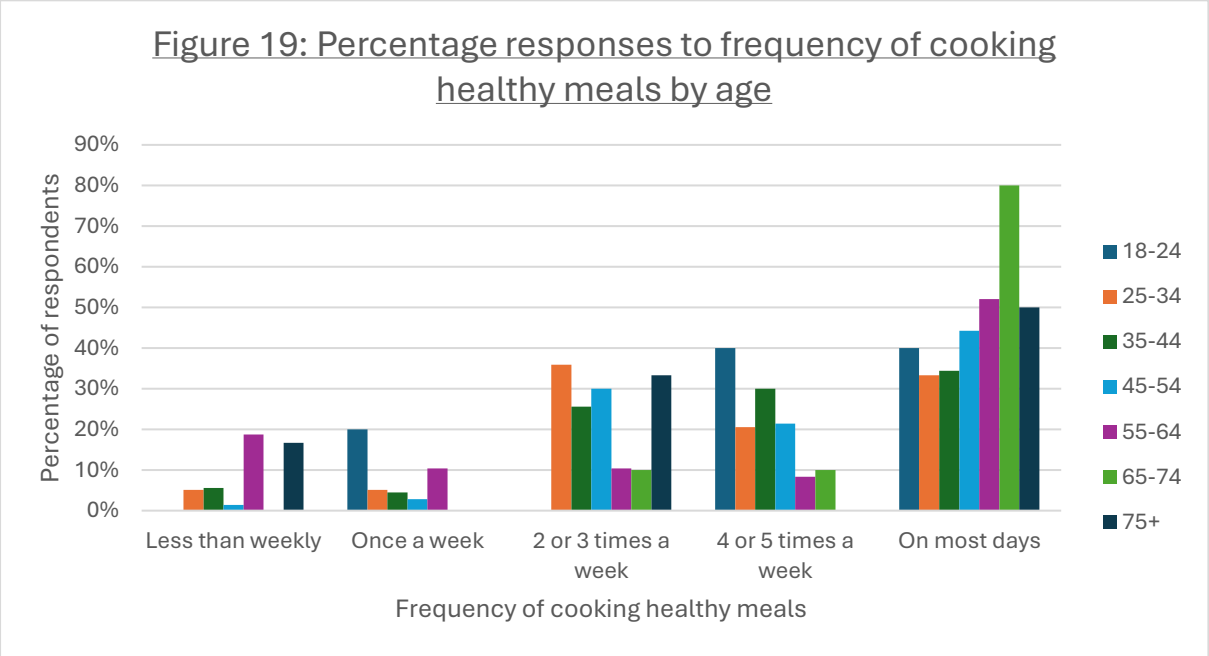
Figure 17: Percentage responses to frequency of cooking healthy meals by employment status



Source: Cheshire West and Chester Eating Well Survey 2025



Source: Cheshire West and Chester Eating Well Survey 2025

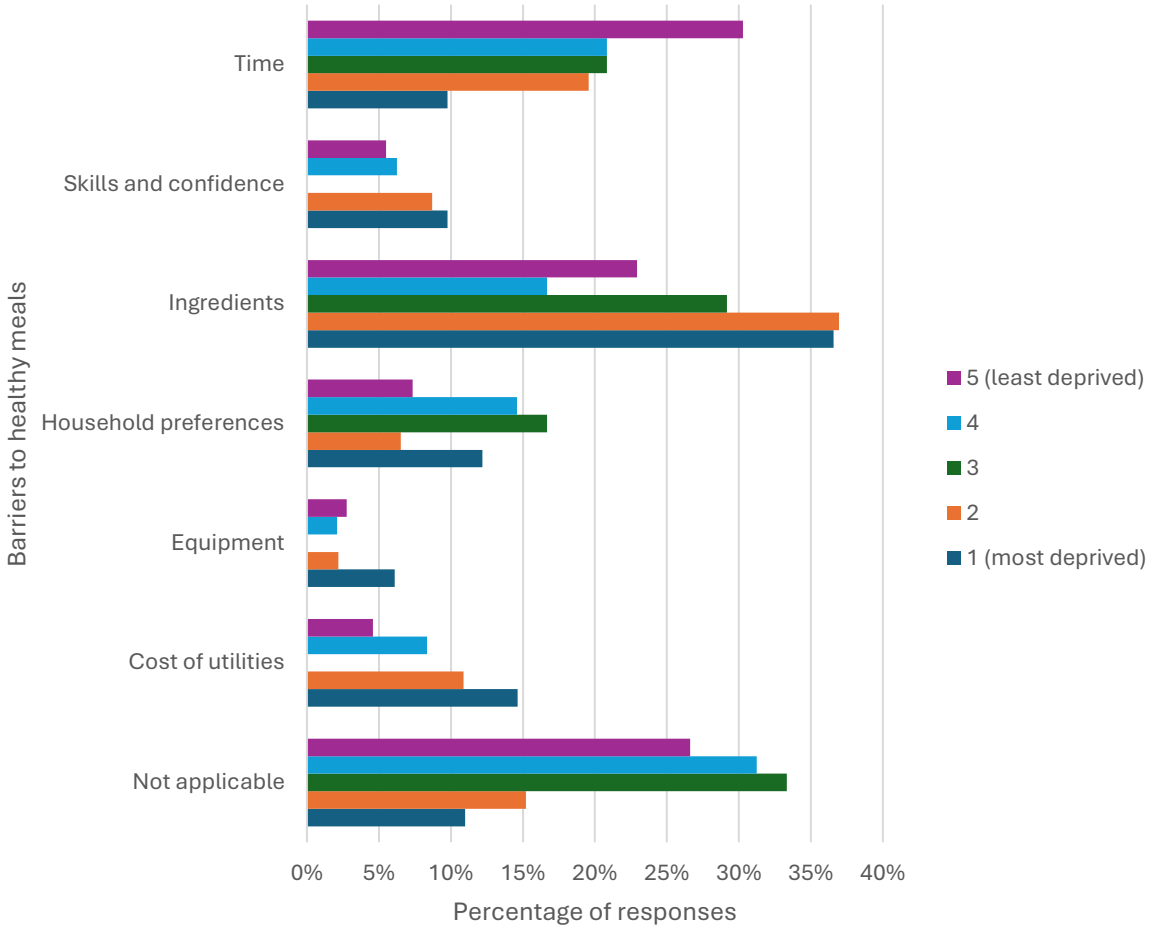


Source: Cheshire West and Chester Eating Well Survey 2025

Barriers to cooking healthy meals

Barriers to healthy cooking further illustrated socioeconomic differences. Although 32.4% of residents reported no barriers, 37.8% identified the cost of ingredients as a challenge. Those out of work and unable to work had the highest percentage reporting the cost of ingredients as a challenge (43.9% and 51.3%, respectively). Time pressures were commonly mentioned (27.0% of respondents), particularly among those living in the least deprived areas (IMD 5; figure 20). Cost-related barriers aligned strongly with deprivation, being highest among respondents living in more deprived areas (IMD 1; 36.6% and IMD 2; 40.0%). Whereas skills and confidence had a higher percentage of males (12.7%) than females (5.2%) reporting this as a barrier.

Figure 20: Percentage responses to barriers to healthy meals by IMD quintile

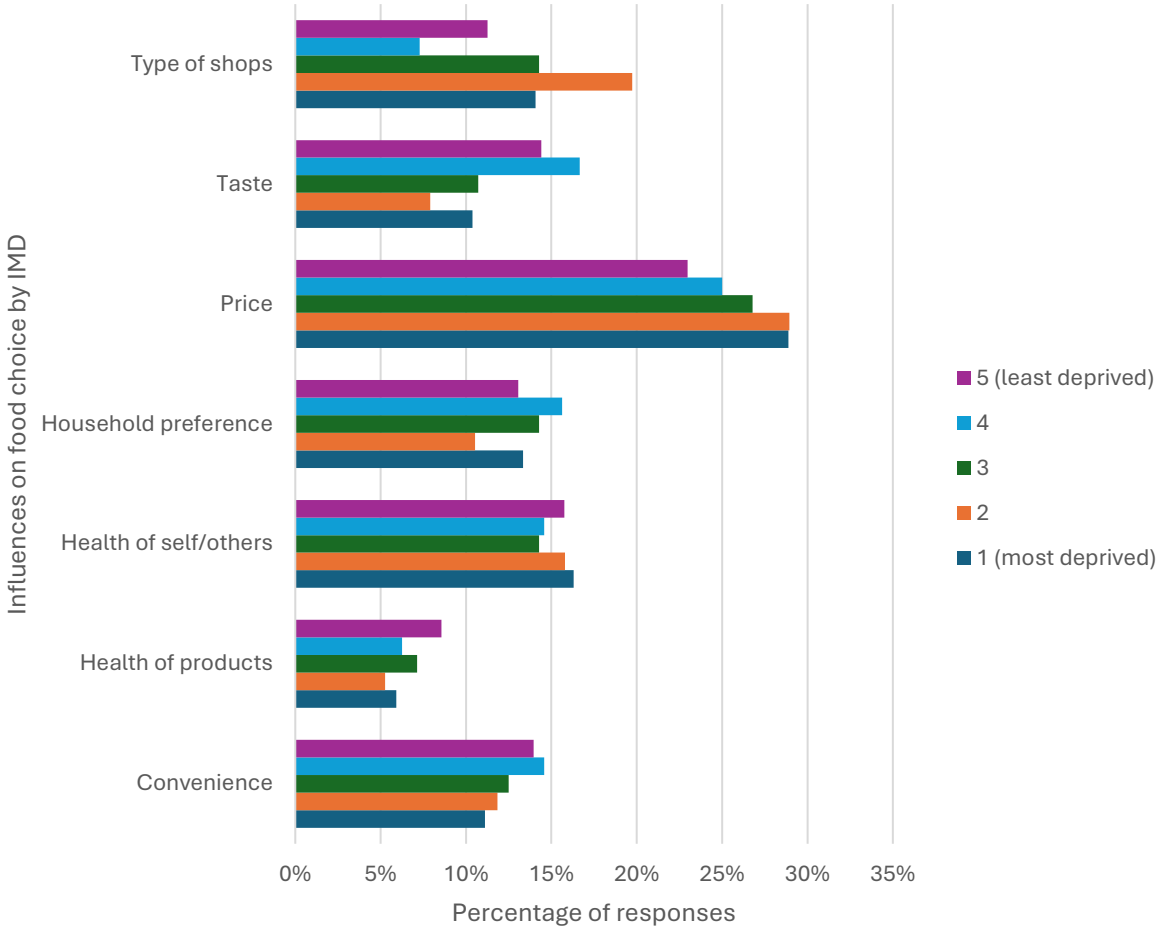


Source: Cheshire West and Chester Eating Well Survey 2025

Influences on food choices

Food choices were shaped most strongly by price (66.9% of respondents) and the health of self or others (41.4% of respondents), though patterns again varied across groups. As seen in Figure 21, there was a clear deprivation gradient in price sensitivity, with influence decreasing from IMD 1 (most deprived; 28.9%) to IMD 5 (least deprived; 23.0%). Convenience had a greater influence among older adults (23.1% of those aged 75+), and price was particularly influential for younger adults (33.3% of those aged 18-24). Females had a greater percentage than males reporting being influenced by household preferences (13.6% and 10.8% respectively) and the types of shops available (13.7% and 9.0% respectively). Whereas males had a higher percentage than females reporting being influenced by product health (10.8% and 6.7% respectively) and taste (15.3% and 12.3% respectively).

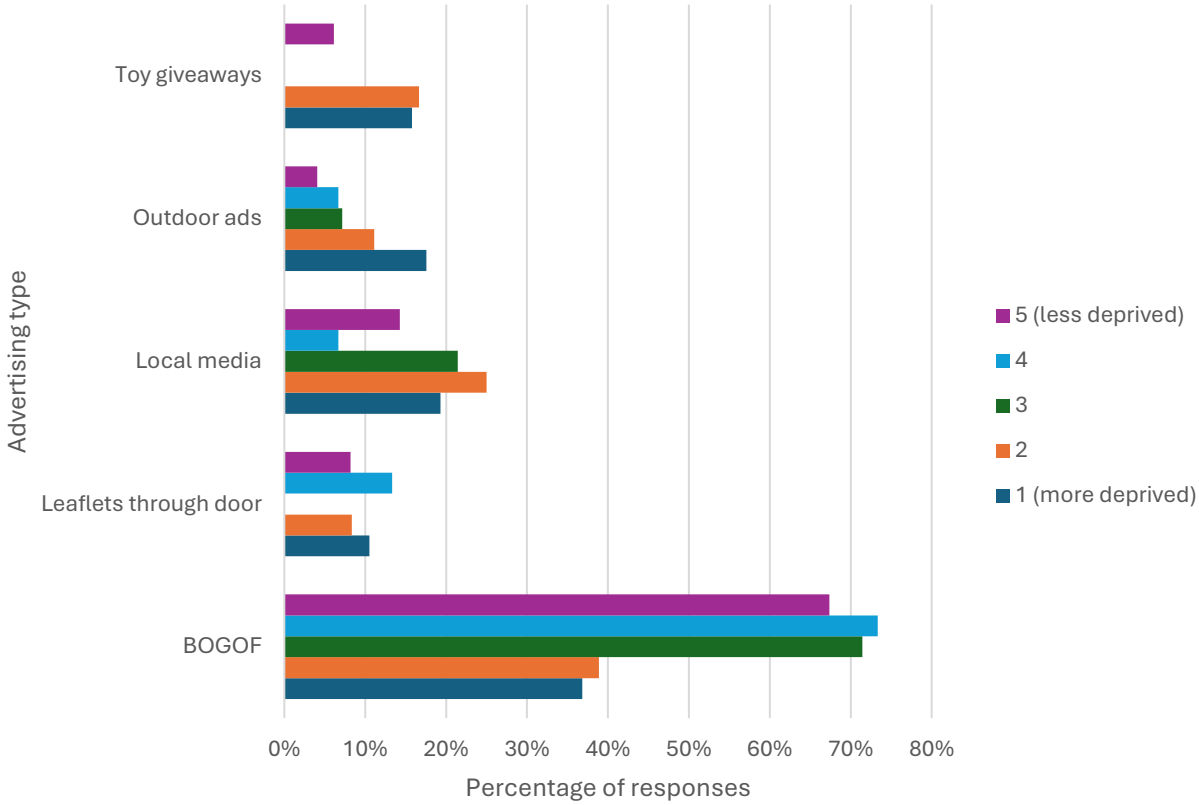
Figure 21: Percentage responses to influences on food choices by IMD quintile



Source: Cheshire West and Chester Eating Well Survey 2025

Exposure to unhealthy food advertising was extremely common, with 79.5% receiving leaflets, 58.3% seeing buy-one-get-one-free promotions and 51.1% encountering outdoor advertising. Residents in the most deprived areas (IMD 1) were more likely to report exposure to local media advertising (16.3%) and toy giveaways (15.7%) compared with residents in less deprived areas. Despite high exposure across all age groups, those aged 75+ did not report being influenced by any form of advertising. Conversely, promotional offers such as buy one, get one free (BOGOF) disproportionately influenced less deprived groups, while local media and outdoor advertising had greater influence in deprived areas (Figure 22).

Figure 22: Percentage responses to influence of advertising by IMD quintile



Source: Cheshire West and Chester Eating Well Survey 2025

Achieving a healthy weight

Interest in achieving or maintaining a healthy weight was high (86% of respondents). The most common challenge was managing time and work-life balance (19.1% of respondents), while key motivators included improved affordability of physical activity (14.7% of respondents) and better access to healthy food (12.9% of respondents). While support preferences differed notably across groups, the gym or personal

trainers (37.1% of respondents) and online support (34.5% of respondents) were the most common sources residents reported they would turn to.

A greater percentage of responses from females than males reported they would seek support from the GP (23.2% vs 13.8%), online (28.1% vs 23.1%) and weight loss groups like slimming world and weight watchers (16.5% vs 7.7%). In contrast, a greater percentage of responses from males than females reported they would seek support from the gym/personal trainer (43.1% vs 26.3%) and independent community groups (12.3% vs 6.0%) Respondents unable to work or seeking employment were far more dependent on GP support (43.8% and 50% respectively), whereas those in the least deprived areas (IMD 5) most often favoured online (32.4%) or gym-based (30.5%) support.

Qualitative findings

The quantitative aspects of the survey highlight inequalities across multiple dimensions of the local food environment. Deprivation and employment status in particular were related to access to affordable healthy food, confidence and skills, exposure to marketing, cooking patterns and the types of support residents felt able to access. Alongside these findings, in the qualitative components of the survey, residents also identified a number of changes that would help them to eat more healthily. Many emphasised the need for clearer signposting and easier navigation of existing nutrition and weight-management support, including stronger social-prescribing pathways and community-based hubs offering practical, non-judgemental advice.

Additionally, improving the affordability and availability of healthy food was seen as essential, with suggestions such as subsidised or discounted fresh produce, vouchers for healthier choices, single-portion fruit and vegetable options to reduce cost and waste and healthier, more appealing options across schools, nurseries and foodbanks. Respondents also highlighted the value of practical education, including cooking skills, budgeting and batch-cooking guidance to help residents confidently prepare nutritious meals.

Some respondents also called for policy and environmental measures, such as limiting the density of unhealthy food outlets, reducing exposure to unhealthy food advertising and encouraging retailers and cafés to promote healthier options. A smaller number noted the importance of accessible clinical and pharmacological support, including clearer links between medical services and community-based nutrition support. Although not diet-specific, many respondents outlined the key contribution of physical activity suggesting accessible gyms and classes and safe outdoor spaces to support active travel and outdoor activity.

Taken together, these suggestions reinforce the importance of addressing structural, financial and practical barriers to healthy eating so that nutritious, affordable food becomes easier to access and prepare for all communities across Cheshire West

and Chester. While these insights are helpful in informing future work, it is important to recognise gaps in representation. The sample includes relatively few males, meaning findings largely reflect female perspectives. There was also insufficient representation from non-white ethnic groups to enable sub-analysis, so insights are predominantly drawn from white individuals. Addressing these gaps will be important in future engagement and intelligence gathering.

Key take aways from the local survey

- In total, 278 residents responded. Most were women and middle-aged, with responses spread across deprivation levels.
- While many found healthy food easy to access, those out of work and living in more deprived areas had a greater percentage reporting difficulty.
- Confidence and cooking habits varied. A greater percentage of those living in more deprived areas and unable to work reported less confident in cooking healthy meals and reported doing so less often.
- Cost, time pressures and skills were the most frequently reported barriers to healthy eating, with a greater percentage of residents living in deprived areas reporting these barriers.
- Food choices were strongly shaped by price, with greater percentages reporting this among younger adults and those living in deprived areas.
- Exposure to unhealthy food advertising was common, with a greater proportion of those living in deprived areas reporting this.
- Respondents wanted clearer signposting to support, more affordable healthy food, practical cooking/budgeting help, and healthier local food environments.
- Insights are limited by sample representativeness as respondents were predominantly white and female

Recommendations:

1. Increase cooking confidence and skills, with a focus on men, residents in more deprived areas and those unable to work, through accessible, informal cooking sessions, budgeting support and community food hubs.
2. Strengthen healthier food provision across schools, nurseries, leisure settings and foodbanks, building on existing healthier vending and food pledge initiatives.
3. Improve visibility and navigation of support, ensuring all frontline services actively promote the weight-management pathway, Live Well Cheshire West and the Food Partnership map.
4. Address survey representation gaps, with targeted engagement to better capture the views of men and ethnic minority communities in future needs assessments.

Focus Groups

Alongside the survey of residents, focus groups were undertaken by Cheshire West Voluntary Action through targeted engagement with Food Partnership members and the Mental Health Alliance. This was undertaken between December 2025 and the end of January 2026. Three focus groups were held across Chester, Ellesmere Port and Northwich as well as a fourth group involving residents from both Chester and Ellesmere Port with lived-experience of food poverty. As these sessions took place as informal drop-ins within community settings, exact attendance was not recorded, although an estimated 32 people took part in total. This comprised 6 from the lived-experience group and around 26 across the community drop-ins.

Although detailed demographic data was not collected, participants were predominantly over 30, White British and included both men and women. Most were unemployed and receiving benefits, although a smaller number of people in work also contributed. The findings from these focus groups were grouped into themes and highlighted several intertwined barriers that make healthy eating difficult for many residents.

Cost and affordability were frequently mentioned challenges, with participants noting that fresh fruit and vegetables feel expensive and often spoil quickly, making healthier choices harder to justify on a limited budget. Alongside this, limited skills and confidence in cooking meant some residents relied heavily on convenience foods because they did not know how to prepare healthy meals. Many participants described how other priorities and underlying challenges, including homelessness, addiction, long-term health conditions and mental ill health, often took precedence over healthy eating. Time pressures linked to work, caring responsibilities and busy routines also pushed people towards quick, less healthy options.

Practical access barriers were also common. Some communities rely on small, higher-cost local shops, with expensive or unreliable public transport limiting access to larger supermarkets. People living with neurodiversity faced additional challenges. Participants reported that ADHD made planning and budgeting difficult, while families supporting children with autism or avoidant restrictive food intake disorder (ARFID) described extremely limited “safe food” diets.

Residents also noted the limitations of surplus food provision, where reliance on donations meant healthier options were inconsistent. For those in temporary or unstable housing, limited access to cooking and storage facilities, such as lacking a fridge, freezer or kitchen, made preparing fresh meals particularly difficult. Finally, some participants raised concerns about growing reliance on weight-loss medications, with some feeling less motivated to focus on healthy eating because they perceived the medication to be doing the work for them.

Focus group participants offered a range of practical suggestions to help make healthy eating more achievable in everyday life. A recurring theme was the need to

make healthy food more affordable, with residents emphasising the value of expanding low-cost fruit and vegetable schemes, improving access to discounted produce through local retailers and sharing simple, inexpensive recipe ideas that help reduce waste and stretch budgets further. Alongside affordability, people stressed the importance of building skills and confidence in cooking, suggesting informal, welcoming cooking sessions and easy-to-follow recipe cards, particularly for those living in temporary accommodation or with limited equipment. Many felt that support must also recognise the broader challenges they face, such as poor mental health, unstable housing or long-term health conditions like Polycystic Ovary Syndrome (PCOS), calling for non-judgemental, trauma-informed approaches and stronger links between food support, housing, benefits advice and primary care.

Participants also highlighted the need for solutions that reflect the realities of busy and pressured lives, such as promoting quick, nutritious meal ideas, low-preparation food options and opportunities for community meal-preparation sessions. Improving the practical availability of healthy food was another priority, including pop-up fresh food stalls, better community and public transport options and targeted action in areas with limited supermarket access. Suggestions for supporting those with neurodiversity included tools like visual meal planners, simple shopping lists and tailored guidance for families supporting children with very restricted diets, such as those linked to autism or Avoidance/Restrictive Food Intake Disorder (ARFID).

Participants also identified ways to strengthen surplus food provision, including improving the nutritional balance of what is offered, providing healthy top-ups supplies and ensuring that community kitchens can turn surplus into balanced meals delivered with dignity and choice. For those struggling without reliable access to a kitchen, fridge or freezer, residents stressed the need for healthier ready-to-eat options, shared cooking spaces and basic equipment starter packs. Finally, suggestions to support those managing long-term health conditions included clearer nutritional guidance tailored to their symptoms, better-informed primary care support and opportunities to connect with specialist or peer-led services.

Overall, participants emphasised that meaningful solutions must be practical, empathetic and rooted in real-world challenges to make healthy eating easier, more realistic and more dignified for everyone.

Key take aways from the focus groups

- Cost was a key barrier, with fresh produce seen as expensive and quick to spoil.
- Limited cooking skills and confidence led to reliance on convenience foods.
- Pressures such as homelessness, poor mental health and long-term conditions often took priority over healthy eating.
- Participants faced access issues, relying on costly local shops and lacking transport to supermarkets.

- Neurodiversity created additional challenges, including budgeting difficulties and restricted diets
- Surplus food provided was inconsistent and not always healthy.
- Participants in unstable housing often lacked cooking/storage facilities, limiting what they could eat.
- Participants expressed reduced motivation to eat well when using weight-loss medications.
- Suggested solutions focused on affordable healthy food, simple cooking support, non-judgemental services, better local access, neurodiversity-friendly tools, improved surplus provision, and tailored support for long-term conditions.

Recommendations:

1. Expand affordable fresh food initiatives, including pop up markets, low cost produce schemes and closer links to local growers and farmers' markets, especially in deprived areas and signposting to those experiencing food insecurity.
2. Deliver cooking and nutrition support that reflects real world constraints, focusing on low equipment, low energy and time efficient meal options.
3. Integrate food support with wider services, strengthening links between nutrition, mental health, housing, welfare advice and primary care expanding on pre-existing links and integrating compassionate approaches.
4. Promote behavioural change as core to weight support, ensuring programmes focus on nutrition, habits, confidence and wellbeing, not weight alone.

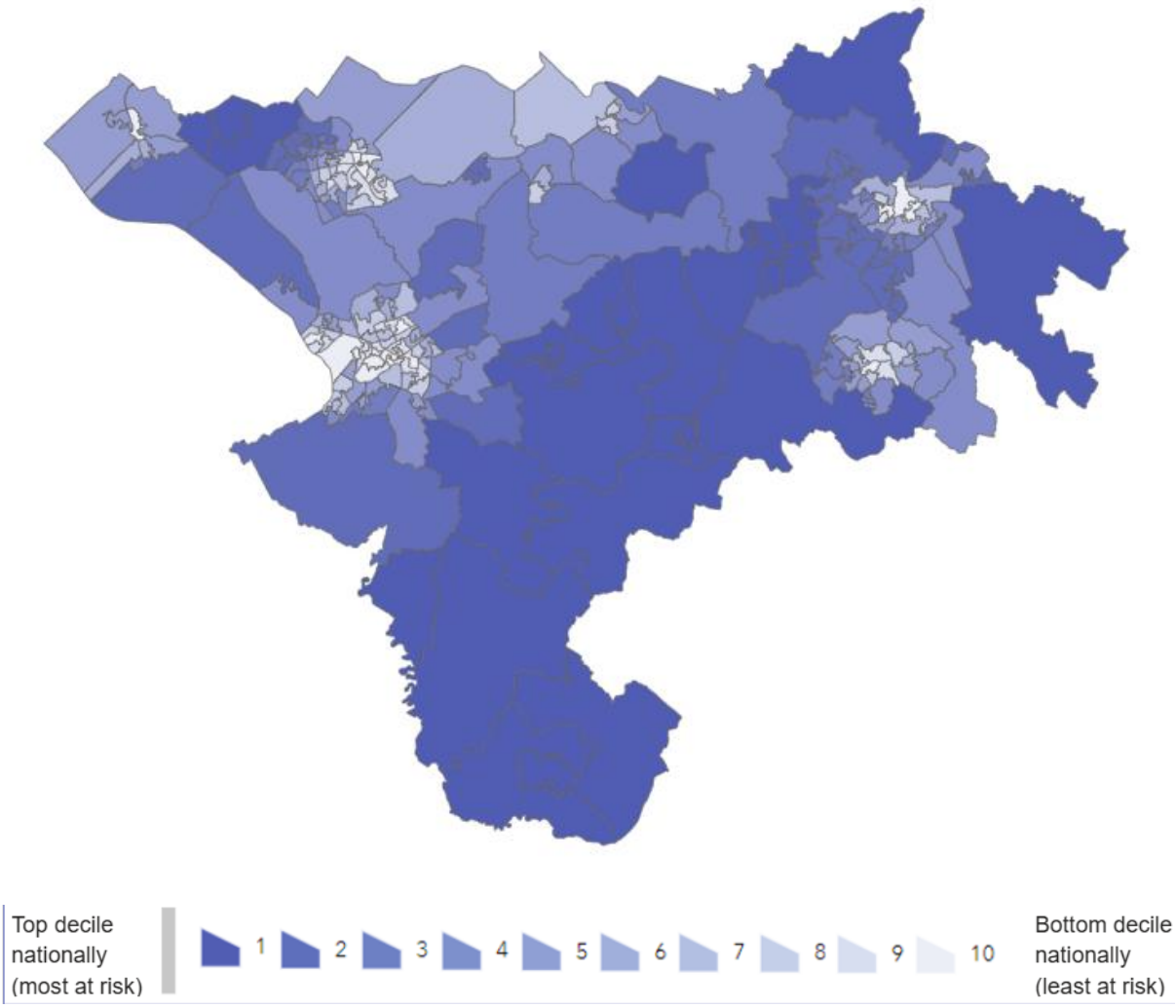
Food Inequalities Tool

Although the survey and focus group provide critical insights into the perspectives of residents, these is not representative of the whole population within Cheshire West and Chester. The Food Equalities Tool[xxiv] provides information on food availability and accessibility in West Cheshire representative of the whole population. Incorporating demographic information, the tool can help identify areas more at risk of food insecurity. Developed during 2023 and updated in 2024, the tool is based on an index published by The University of Leeds and Which?. It works by visualising the deciles for each indicator at Lower Super Output Areas (LSOAs) relative to England as a whole. A LSOA placed within decile one is within the 10% worst areas of the country for that indicator. Conversely, a decile of 10 indicates that LSOA is within the best 10% of the country's LSOAs for that indicator.

The indicators included cover areas that are also touched on by the survey such as supermarket proximity, supermarket accessibility, non-supermarket accessibility and

expenditure on food. Supermarket proximity is comprised of both the average count of stores within one kilometre and average distance to the nearest large grocery store. The average decile for this indicator is five across the region but this average hides wide variation in supermarket proximity, as seen in Figure 23. LSOAs in decile one, reflecting the worst 10% in the country, include areas of Farndon, Sandstone, Tarvin and Kelsall, Malpas, Tattenhall, Willaston and Thornton, Weaver and Cuddington, Marbury, Shakerley and Tarporley, most of which are considered rural areas of the borough.

Figure 23: Map of West Cheshire showing national deciles for supermarket proximity



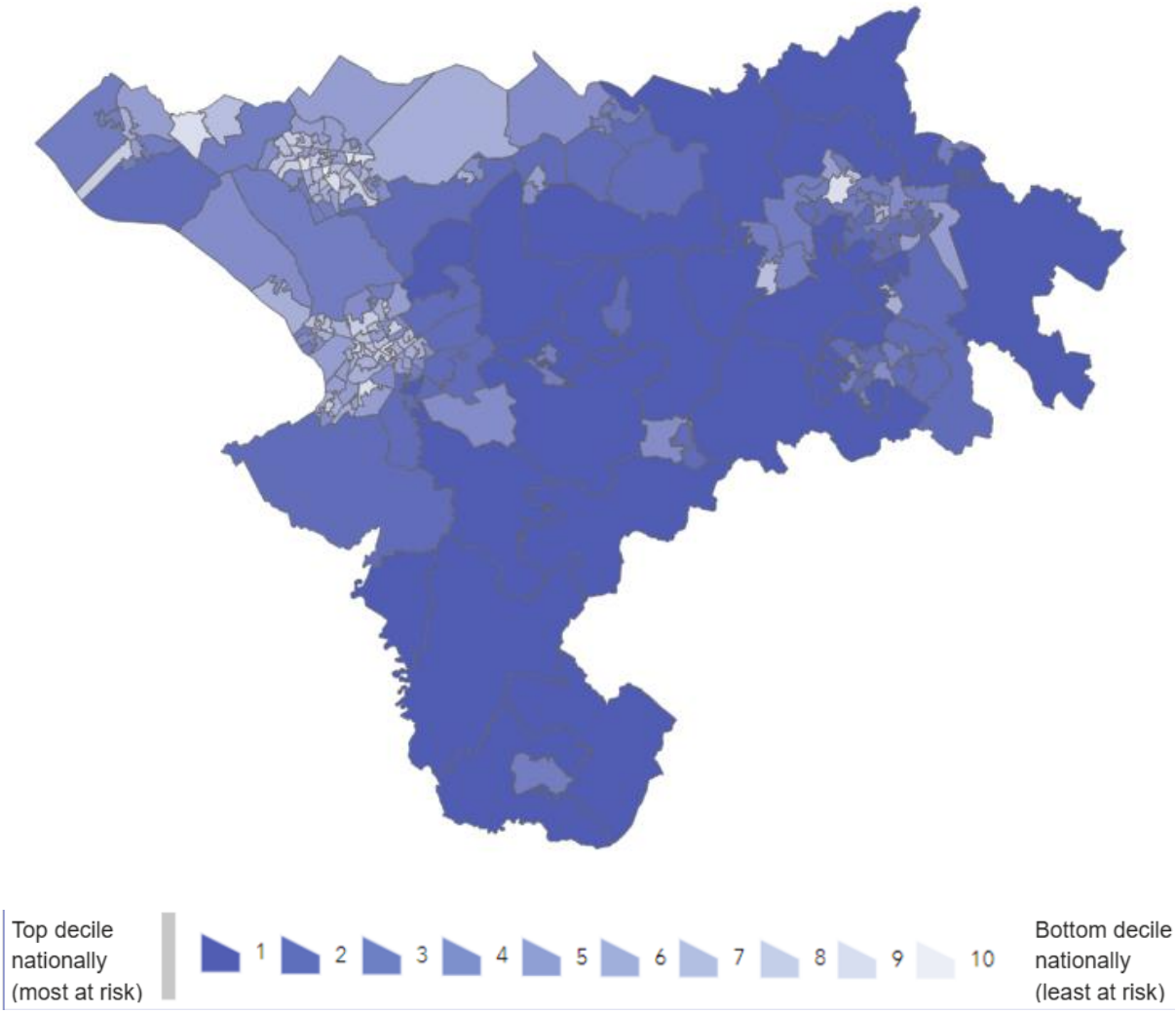
Source: Food Equalities Tool, Cheshire West and Chester Council

Non-supermarket proximity includes the average count of markets within the nearest 1 kilometre, the average distance to the nearest market, the count of non-supermarket retail stores with 1 kilometre and the distance to the nearest non-supermarket retail food store. This indicator averages decile 5 and shows very similar variation to supermarket proximity with LSOAs in decile 1 reflecting areas of

Farndon, Malpas, Tarvin and Kelsall, Tattenhall and Tarporley. Again, these areas are primarily within the more rural areas of the borough.

Supermarket accessibility comprises both accessibility via public transport and the average travel distance to the nearest supermarket. A similar picture is seen to that with supermarket proximity, as seen in Figure 24, with an average for the region of decile 4 which is the worst performing indicator average in West Cheshire across all the included indicators.

Figure 2: Map of West Cheshire showing national deciles for supermarket access

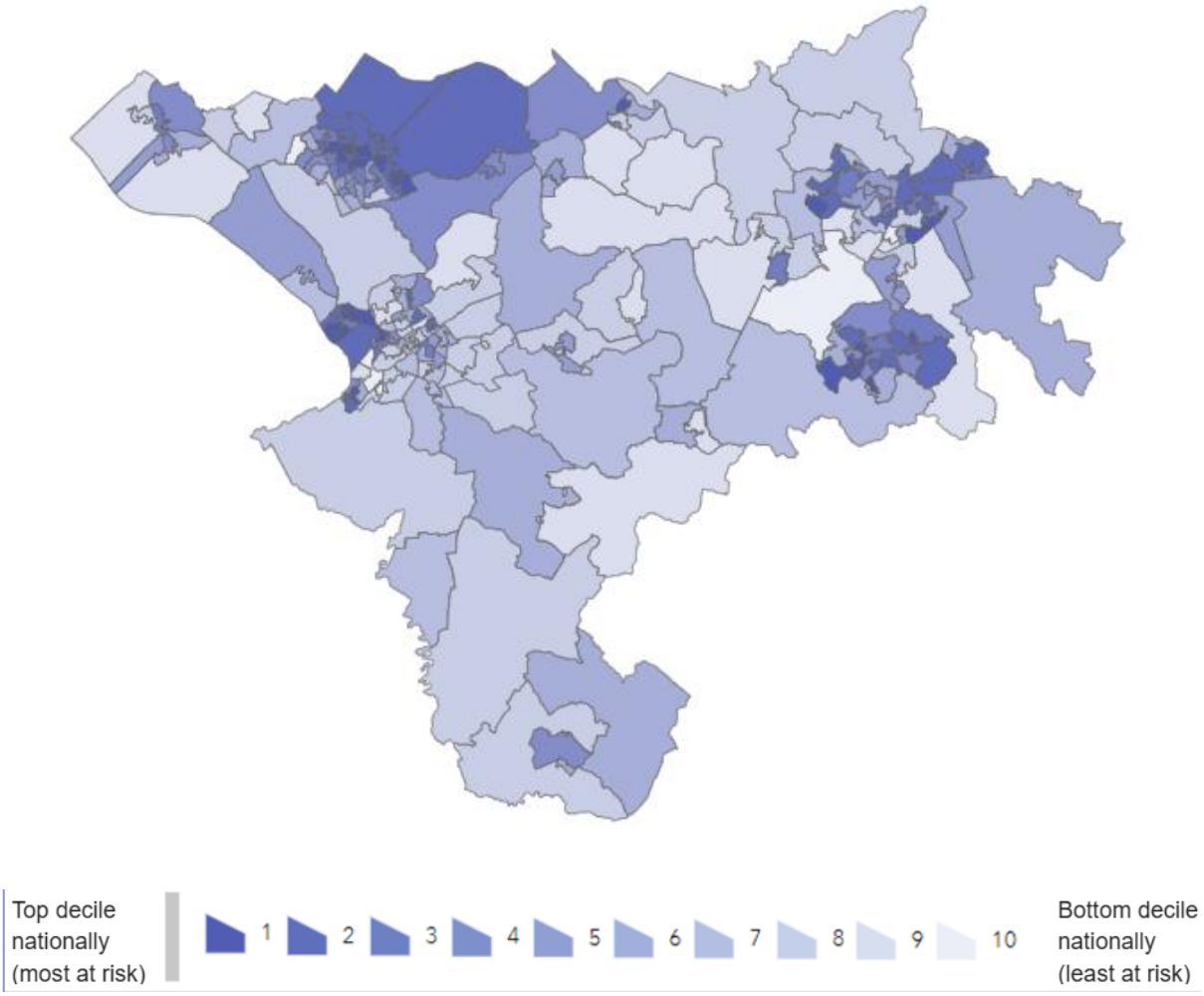


Source: Food Equalities Tool, Cheshire West and Chester Council

Food expenditure, calculated as proportion of mean income spending on food based on data from Paycheck CACI, has an average decile of 5 across the region. This also masks wide variation, as seen in Figure 25, with only 4 LSOAs ranking in decile 10 which are in Handbridge Park, Ledsham and Manor, Winsford Over and Verdin and Davenham, Moulton and Kingsmead. Indicating that on average residents living

in these LSOA's, which are in areas of less deprivation, spend a smaller proportion of their mean income on food than other LSOA areas.

Figure 3: Map of West Cheshire showing national deciles for food expenditure



Source: Food Equalities Tool, Cheshire West and Chester Council

Although not exclusive to adults, as it includes some data pertaining to children, the food for families indicator is a useful composite for risk of food insecurity. It includes the distance to the nearest food bank, free school meal eligibility and healthy start voucher usage. The borough performs well on this, averaging decile 8 reflecting the highest scoring indicator for West Cheshire. No LSOAs are in decile 1 or 2 nationally for this indicator, though equally none are in decile 10 with the majority of LSOAs in decile 8 or 9.

Key take aways from the food inequalities tool

- The Food Equalities Tool highlights LSOA-level food insecurity risk by comparing areas to national deciles (1 = worst 10%, 10 = best 10%).

- Supermarket and non-supermarket proximity averages around decile 5 for Cheshire West and Chester, but some areas fall into decile 1, indicating poorer access.
- Supermarket accessibility, which includes public transport, is the weakest area for Cheshire West and Chester overall, averaging decile 4.
- Food expenditure varies widely, with only four LSOAs in Cheshire West and Chester performing strongly (decile 10).
- The food for families indicator, incorporating distance to a food bank, free school meals and healthy start, is a relative strength averaging decile 8 with no areas in the deciles 1 and 2.

Recommendation:

1. Use the Food Equalities Tool proactively to prioritise neighbourhoods for food access interventions and transport planning, particularly for those in rural areas where supermarket access is limited and without private transport, by exploring transport solutions and local retail partnerships to improve access to healthier options.

The overall picture from local data

Taken together, the local evidence shows that although many residents in Cheshire West and Chester want to support their health through nutrition, structural constraints continue to limit the ability to follow dietary guidance. Nationally most adults fall short of the Eatwell Guide with only a minority meeting 5-a-day, free sugars and saturated fat recommendations and almost all adults missing the 30 g/day fibre target. Locally, 31% of adults meet 5-a-day recommendations, broadly in line with England averages, indicating some positive behaviours but substantial opportunity for improvement, particularly in communities facing deprivation given adherence to guidelines follows a social gradient.

The resident survey and focus groups point to relevant barriers including the cost of ingredients, time pressure, skills and confidence, and wider pressures such as poor mental health, unstable housing and limited kitchen and storage facilities which all make healthy eating hard to sustain. Lived experience also highlighted transport and access issues and the influence of unhealthy food marketing. These accounts are mirrored by the Food Inequalities Tool, which maps uneven access across Cheshire West and Chester. Average deciles for supermarket and non-supermarket proximity sit mid-range nationally though supermarket accessibility is the weakest area and there is wide variation in the share of income spent on food. This combination of local data suggests that areas of focus would be clearer signposting to services, more affordable healthy options and practical, non-judgemental cooking and

budgeting support highlighting the importance of system-level action alongside individual support.

This behavioural and environmental picture sits alongside a rising burden of conditions where nutrition is a modifiable risk. In Cheshire West and Chester, 61.6% of adults live with overweight or obesity, including 28.2% with obesity. Hypertension affects 17.0% with an additional 9.0% estimated undiagnosed. Estimated type 2 diabetes prevalence is 7.2% with clear social and age gradients in those diagnosed with type 2 diabetes. Cardiovascular outcomes are mixed. Under-75 mortality from ischaemic heart disease is similar to England and stroke mortality broadly follows the national trend but heart-failure admissions are higher locally and cancer incidence at ICB level is above the national average. Dementia prevalence is also higher locally than England. These conditions are all shaped by diet quality and by the same environmental barriers residents describe.

In summary, the clinical picture we see is consistent with the local resident data in that affordability, access and capability constraints are driving unequal opportunities to eat well, which in turn sustain unequal risks of diet-related disease. Addressing these constraints through more affordable healthy food, improved local access and transport, practical cooking and budgeting support, compassionate, stigma-free services, and clear signposting along the weight-management pathway offers are suggested routes to improve adherence to nutritional recommendations and improve rates of obesity, hypertension, type 2 diabetes, cardiovascular disease and dementia across the borough.

What is happening locally – local offer

Eat Well Be Active

The borough's healthy weight work is coordinated through the Eat Well Be Active framework. This consists of a reference group chaired by the Cabinet Member for Fairer Futures (Poverty, Public Health and Mental Health) and has wide representation from partners across the borough. The Eat Well Be Active Reference Group reports into the Health and Wellbeing Board. Several working groups report into the reference group reflecting input from a range of stakeholders, namely The West Cheshire Food Partnership, The Get Cheshire West Moving Working Group, Healthy Places Working Group, Children and Young People Healthy Weight Working Group and the Infant Feeding Group.

Cheshire West and Chester Council adopted the Healthy Weight Declaration[xxv] (HWD) in 2019 and supported the development of the HWD Partner Pledge in 2020. Led by the multiagency Eat Well Be Active partnership, the HWD has supported the Council and partnership organisations to progress a number of key policy areas. The

Eat Well Be Active partnership is now undertaking the co-development of a strategy which will include the re-adoption of the HWD with the updated commitments from 2020.

A key feature in the approach taken across Cheshire West and Chester has been the important role of system leadership in supporting cross-sector working to facilitate change and engage different parts of the local system to contribute to this important public health priority. The current lead member for health and wellbeing has a wide-ranging portfolio that supports the Council's ambition for a 'Fairer Future'. The portfolio encompasses: Health Improvement, Health Care Public Health and Health Protection, Tackling Poverty Refugee and Asylum Seeker support Equality, Diversity and Inclusion Libraries, Museums and Arts and Culture. This pivotal role has helped to facilitate partnership working and collaboration, whilst engaging a range of stakeholders both internally and externally. The role of system leadership in addressing complex issues can help to:

- Set the tone for an organisation to work more systemically and encourage staff and wider partners to embed systems approaches in their work.
- Influence other leaders, at all levels, to shift the collective focus towards key priorities.
- Developing and maintaining cross-departmental and cross-directorate relationships to support shared understanding of goals and the system.
- Work across agendas and boundaries to work together for mutual gain through co-development and incorporating insight from lived experience.
- Enable and empower leaders at all levels, whilst supporting innovation.

Recommendation:

1. Continue to resource and strengthen whole systems working, maintaining cross-sector leadership and accountability for nutrition and healthy weight.

Food for All Plan

The approach to food insecurity in Cheshire West and Chester is shaped by the Food for All Plan[xxvi], a borough-wide framework developed through years of partnership working, community engagement and lived experience insight. The plan sets out a shared vision in which everyone can eat decent meals, defined by the dignity-based principle of having the power to choose what, where, when and with whom you eat. It identifies five essential ingredients needed for people to achieve food security: Money (adequate income and financial support), Food (a nourishing and sustainable supply), Facilities, Knowledge and Equipment (spaces, skills and tools for preparing and sharing food), Mental Health and Wellbeing Support, and

Local Provision so that these essentials are available within communities. A range of initiatives feed into enacting the Food for All Plan.

West Cheshire Food Partnership

Since 2017, the West Cheshire Food Partnership (formerly the Welcome Network) has played a central role in shaping the borough's response to food insecurity. Hosted by Cheshire West Voluntary Action, the Partnership works to ensure that all residents can access an affordable, healthy, sustainable and enjoyable diet. Although its work spans the whole food system, the Partnership approaches every activity through a food-insecurity lens, ensuring that dignity, equity and resilience remain at the core of its mission. Its role includes connecting and coordinating partners across the system, sharing best practice and identifying opportunities to strengthen the local food landscape.

Over the years, the Partnership has supported a wide and influential group of community food providers, enabling them to work together to deliver a joined-up, stigma-free food offer that includes wrap-around support to help people move out of poverty. This collaborative model has been recognised as an example of good practice, with national colleagues visiting in the autumn of 2025 to hear directly from the borough's providers. The Partnership has also supported Cheshire West and Chester's ambition to become a Sustainable Food Place, reflecting the area's commitment to sustainable and equitable food systems.

Strategic work has been undertaken to build a diverse membership representing the whole food system, despite the challenges of coordinating across a large geographical borough. Strong relationships have been formed with community organisations, and engagement with larger private-sector partners now actively involved in Partnership activity. The Partnership has embedded data and insight throughout its work, co-developing the Food Equalities Tool with Public Health and the Insight and Intelligence team, while drawing on local and national data and continually seeking insight from residents and partners.

Links with the University of Chester have further strengthened the Partnership's work. Collaboration spans multiple disciplines and in July 2025 the Partnership was invited to present at a Food Futures event. Current work with the University includes planning a project to explore food and "eating well" across the whole school day, engaging directly with both children and staff. A pilot with a local school is planned for later in the year. This academic partnership complements ongoing practical support for community food groups, ensuring that both evidence and lived experience inform future development.

The partnership maintains an interactive public map[xxvii] that brings together emergency food provision, affordable and surplus food projects, community cafés and wider food initiatives.

A diverse network of charities and community organisations contributes to this system, helping residents access both emergency and low-cost food. Among these are the Very Green Grocery and The Bread and Butter Thing (TBBT), both of which redistribute surplus food and are open to all.

Although their models differ, the Very Green Grocery and TBBT offer significantly reduced-cost weekly shops compared with supermarkets. The Very Green Grocery is partnered with Mid Cheshire Food Bank in Winsford and Northwich and emphasises environmental benefits through reducing food waste and tackling climate change. TBBT operates four hubs in west Cheshire, three in Ellesmere Port and one in Blacon, some co-located with foodbank provision. The link between foodbanks and these two services strengthens the pathway away from crisis food support. This offer directly links into the food, money and mental health and wellbeing components of the Food for All Plan through local provision.

Within Cheshire West and Chester, substantial efforts are made to reduce reliance on emergency food by addressing root causes of hardship. Foodbanks across the borough adopt a dignified, holistic approach, with services such as Citizens Advice, debt advice, housing and mental health support engaging directly with residents, reflecting all components of the Food for all Plan. The Community Food Security sub-group of the Food Partnership further strengthens the Plan's emphasis on collaboration. This brings together providers of affordable or emergency food support to share insights, challenges and surplus food. They hold alternate meetings face-to-face and rotate the venue so that providers can visit other provisions to take inspiration. These efforts sit alongside the Council's wider commitment to a cash-first approach, with the Tackling Poverty Team supporting income maximisation. Furthermore, clear public information is provided through the "Worrying About Money?" leaflet[xxviii] and the cost-of-living website[xxix] to support residents.

The Food for All Plan also highlights the need for skills, confidence and connection around food. Many community organisations deliver cooking sessions, slow-cooker projects and budgeting workshops that help residents build long-term food resilience. The Let's Cook Recipe Kits[xxx], delivered through the Holiday Activities and Food Programme, support family cooking and shared mealtimes. Targeted work to improve Pension Credit, Healthy Start and Free School Meal uptake further strengthens the 'money' component of the Plan.

Lived experience is central to local efforts, with groups such as Beans on Toast[xxxi], a group of volunteers with lived and living experience of food insecurity who worked

closely with the West Cheshire Food Partnership. Whilst no longer an active group, members have used their experience and lived expertise to support the work of the Food Partnership, particularly the Food Insecurity Sub-Group, to advise the Poverty Truth Advisory Board and work with emergency food providers informing improvements to services. Additionally, Cheshire West Voluntary Action's Lived Experience Leadership Programme provides structured opportunities for people with direct experience of food insecurity to influence decision-making. Further to this, the Food Ambassadors which is delivered by Cheshire West Voluntary Action is a structured model to bring together community voices (including people with experience of food insecurity) and wider food system voices too, including growers/farmers, local food producers etc.

Recommendation:

1. Sustain and expand collaborative delivery of the Food for All Plan, continuing to centre dignity, choice and lived experience.

Compassionate Approaches

In line with NICE guidance[xxxii], Cheshire West and Chester have adopted a compassionate approach to weight management. The public health team has co-developed and commissioned training to support frontline staff to have positive conversations about weight. This training 'Why Weight to Talk' empowers and encourages colleagues to have conversations about weight which are trauma informed, free from stigma and supportive. It has been successfully delivered to NHS staff across Cheshire West and Chester, including most of the Cheshire and Wirral Partnership Starting Well team.

Public Health has also worked with place partners to embed Making Every Contact Count (MECC) training and advice within the Countess of Chester Hospital NHS Foundation Trust, Cheshire and Wirral Partnership NHS Foundation Trust and Mid-Cheshire Hospitals NHS Foundation Trust delivery. This MECC programme uses existing service interactions to support patients to make positive changes to their health and wellbeing. It includes advice for eating well, being active, quitting smoking, reducing alcohol, looking after mental wellbeing, reducing gambling harms, and financial support. Patients are signposted to a directory of health, wellbeing and welfare services, support groups and activities on the Live Well Cheshire West platform.

Furthermore, Cheshire West and Cheshire is represented within the Compassionate Weight Management Practice Group. This is a national community of interest that brings together partners from across sectors to develop, share and safeguard best

practice in compassionate, non-stigmatising approaches to weight. It is chaired by the Public Health Improvement Coordinator from the City of Doncaster Council and operates to clear core values which all members are committed to uphold. The core values include compassion and relentless kindness, collaboration, honesty and openness, systems-thinking and gentle challenge.

The group meets quarterly to share learning and progress, exchange knowledge and practical tools, explore joint working and maintain the integrity of the compassionate approach so it is applied consistently across organisations. Members act as advocates inside their own organisations, helping the compassionate model spread and remain faithful to its principles. The group's shared vision is that all individuals can pursue their own health goals without judgement or assumptions and feel valued just as they are, with compassion at the heart of how society moves toward better health for future generations. Practically, this means accepting and respecting diverse body sizes, promoting a gentle, non-moralising approach to food, encouraging joyful, inclusive movement and prioritising upstream, equity-focused action that improves the conditions of people's lives.

Additionally, the Cheshire and Merseyside Cancer Alliance have commissioned weight stigma training for primary and secondary care. To date, One Ellesmere Port and Central Chester primary care networks have participated in the training equating to 23 health care professionals trained. The training is being developed into an e-Learning module, to make this more accessible.

Recommendation:

1. Embed compassionate, non-stigmatising approaches system-wide, ensuring consistency across primary care, community services and non-specialist settings.

Wider Determinants

A briefing from the Health Equalities Group for elected members within local authorities outlines recommendations as to how commercial determinants of health can be addressed at a local level. This briefing sets out how local commercial practices, such as marketing, sponsorship, promotions, procurement and the use of public assets, shape what people see and buy. Their recommendations include restricting unhealthy food advertising and sponsorship across council assets and transport, using planning to curb unhealthy outlet growth, tightening vending and procurement standards, controlling permits for pop-up unhealthy food promotions, ensuring the availability of free drinking water, avoiding industry-funded 'education' materials and applying a governance toolkit to manage commercial influence.

Cheshire West and Chester has already made substantial strides towards a whole systems approach to healthy weight, driven in large part by the borough's adoption of the Healthy Weight Declaration by Cheshire West and Chester partners. This commitment has enabled partners across the system to work collaboratively through the Eat Well Be Active Reference Group and its sub-groups, embedding healthy weight considerations into policies, environments and services.

A significant focus of this work has been addressing the commercial determinants of healthy weight, which aligns closely to the Health Equalities Group recommendations. Cheshire West and Chester Council has implemented the healthier advertising policy which restricts the promotion of high fat, salt and/or sugar (HFSS) food and drink on council owned advertising sites and bus shelters. Alongside this, the council has taken action on planning and the wider food environment through restrictions to hot food takeaways in areas where children and young people congregate or where additional outlets would negatively impact on population health. This impact of this is reflected in national data[xxxiii] in which Cheshire West and Chester has 100.3 fast food outlets per 100,000 population, which is lower than the national average in England of 115.9 per 100,000 population. Additionally, updated council catering and procurement guidance is under review to support nutritious and sustainable food options for Council meetings and events.

Working closely with Council's Planning Team on healthier developments, partners have also contributed to the co-production of a new design guide that supports healthier place-shaping. This includes creating safer, more active environments through high-quality green spaces, play areas, extended cycling and walking routes, improved street design, traffic-calming measures, safe crossings and better lighting. Building design has also been considered, promoting features such as accessible stairways, cycle parking and changing facilities to encourage everyday physical activity. This work will be further advanced through a Healthy Place-Making Workshop led by the Town and Country Planning Association in July 2026.

Recognising the importance of financial security as a determinant of diet, the system continues to work closely with the Tackling Poverty Team to help maximise household income so that families are better able to afford nutritious food. Schools have also been a central focus of this agenda. The borough has supported settings to embed the Pledge for a Healthy and Active Future, which uses evidence-based approaches to improve the food offer for pupils, staff and families, with particular attention given to schools in the most disadvantaged communities to help address inequalities in excess weight and physical inactivity.

Several programmes have been delivered to support healthier dietary habits among children and families, including Give Up Loving Pop (GULP) and the Milk and Water Only Schools initiative, which aim to reduce sugary drink consumption and increase

fruit and vegetable intake. Schools have also been offered a suite of resources to encourage healthy eating and physical activity both at school and at home. This includes local school involvement in the national Veg Power Campaigns[xxxiv], as funded by The Westminster Foundation, which aim to get children excited about vegetables, fruit and beans and empowers everyone to make healthy eating simple. In addition, the co-developed Healthier Families videos are under development and will provide families with practical tools to establish supportive routines for nutrition and healthy weight.

Thanks to funding from The Westminster Foundation, public health colleagues are also working with a wide range of partners, including Bite Back, the Youth Service, Education teams, Brio Leisure, the Countess of Chester Hospital NHS Foundation Trust, Cheshire and Wirral Partnership NHS Foundation Trust, and young people aged 14–17, to introduce a healthier vending offer across leisure, hospital and education settings.

This work is enhanced by ongoing support from Food Active, commissioned annually to help embed a whole-systems approach, deliver training and co-create tools and resources. The Food Active programme is co-developed each year with commissioning local authorities and the public health team continues to work closely with other North-West councils to share learning and best practice.

Together, these initiatives demonstrate the borough's strong commitment to addressing the wider determinants of nutrition and health, ensuring that healthier choices are supported not just through individual behaviour change, but through environments, systems and policies that make those choices easier and more accessible for all residents. The actions taken by Cheshire West and Chester Council align closely to the guidance for local authorities to address commercial determinants of health. These local steps complement higher-level actions such as national online and TV restrictions on high fat salt and sugar (HFSS) foods as well as efforts to reformulate foods through engagement with the food industry[xxxv].

Recommendations:

1. Build on existing healthier advertising and planning policies, maintaining focus on reducing exposure to unhealthy food environments, especially within areas of deprivation.
2. Advocate nationally for stronger commercial regulation, particularly around promotions and marketing including buy-one-get-one-free offers
3. Expand access to free drinking water, pop-up promotions and healthy choice nudges across council and community settings.
4. Align nutrition and physical activity action, delivering joint approaches through the Get Cheshire West Moving Strategy 2025–28.
5. Continue healthier vending and procurement commitments, ensuring public sector settings lead by example.

NICE Guidance for weight management services

The NICE guidance for overweight and obesity management[xxxvi] provides comprehensive recommendations for preventing, identifying and managing overweight, obesity and central adiposity. The guidance brings together all previous NICE advice into a single framework, emphasising respectful, person-centred care and the need to consider the wider determinants of health when discussing weight. Although it covers both adults and children and young people, this section will only focus on the adult components given the remit of this needs assessment.

Identifying and Assessing Weight-Related Risk

NICE advises that adults should be assessed using both BMI and waist-to-height ratio, as BMI alone does not show central adiposity, which is strongly linked to cardiometabolic risk. For adults with a BMI under 35 kg/m², waist-to-height ratio should be used to classify central adiposity and guide conversations about health risk. The guideline also stresses that some ethnic groups, including South Asian, Chinese, other Asian, Middle Eastern, Black African and African-Caribbean populations, experience higher risks at lower BMI levels, so lower BMI thresholds should be used for assessment and for decisions about treatment pathways. Discussions about weight should always be sensitive, non-judgemental and led by the person's preferences, with permission sought before measurements are taken or results are discussed. NICE emphasises avoiding stigma and focusing on overall health, not weight alone.

Behavioural and Lifestyle Approaches

The guideline prioritises multicomponent behavioural weight-management programmes as the foundation of support. These programmes should include:

- Practical and flexible dietary advice tailored to the person's culture, preferences, comorbidities and financial circumstances.
- Support to increase physical activity in ways that fit daily life, focusing on enjoyment, confidence and sustainability.
- Behaviour-change techniques such as goal-setting, problem-solving, self-monitoring and positive feedback.

NICE is clear that even small improvements in diet and physical activity can bring significant health benefits, even if weight loss is modest. Restrictive, unbalanced diets are discouraged. Low-energy and very-low-energy diets (800–1,200 kcal/day or <800 kcal/day respectively) can be used only short-term and only in specialist services, with clinical supervision and a clear plan for maintenance afterwards.

Medicines for Weight Management

Pharmacological treatment can be considered once dietary, physical activity and behavioural approaches have been initiated and reviewed. NICE references its technology appraisals and sets out when each medicine may be used:

- Tirzepatide may be prescribed in primary care or specialist services for adults with BMI ≥35 kg/m² plus a comorbidity.
- Semaglutide is available via specialist services for adults with BMI ≥35 kg/m², or 30–34.9 kg/m² when specialist referral criteria are met.
- Liraglutide is used in specialist services for adults with BMI ≥35 kg/m², non-diabetic hyperglycaemia and high cardiovascular risk.
- Orlistat can be prescribed more broadly from BMI ≥30 kg/m², or ≥28 kg/m² with risk factors.

All medicines must be combined with lifestyle change, and treatment should be stopped if a minimum of 5% weight loss is not achieved within the required time frame which is specified in the guidance for each medication. Lower BMI thresholds should again be used for the ethnic groups identified above.

Bariatric Surgery

NICE recommends referral for multidisciplinary assessment for bariatric surgery for adults with:

- BMI ≥40 kg/m², or
- BMI 35–39.9 kg/m² with a significant obesity-related condition that may improve with weight loss

People with recent-onset type 2 diabetes may be offered expedited assessment, including at lower BMI levels (30–34.9 kg/m²). Lower thresholds are also advised for high-risk ethnic groups. Surgery must only take place within specialist services with appropriate equipment, psychological and dietetic input, and the ability to provide at least 2 years of structured post-operative follow-up, with ongoing annual monitoring after discharge.

Commissioning and System-Wide Action

The guideline calls for accessible services with no upper BMI or age limits, adapted for adults with complex needs such as those with very high BMI, learning disabilities, mental health conditions, older adults. Interventions must be of sufficient duration of at least 3 months, delivered by trained staff and designed to support long-term behavioural change.

Commissioners and providers should collect robust data, contribute to the National Obesity Audit and ensure local pathways are clear, well-publicised and easy for residents and professionals to navigate. The guideline also encourages local areas

to adopt broader whole-system measures that create healthier food and activity environments in workplaces, communities and public spaces.

Weight Management Services

Nationally it is recognised that the services available to support people to achieve a healthy weight cover four tiers:
Tier 1 – Universal obesity prevention services – education, healthy eating (including cookery classes), physical activity.
Tier 2 – Lifestyle services – multidisciplinary team delivering integrated diet, physical activity and behavioural programmes to children and families who are overweight or living with obesity using group and/or one-to-one support.
Tier 3 – Specialist weight management services – clinical treatments provided by specialist multidisciplinary services for adults with severe or complex obesity (including comorbidities).
Tier 4 – Pharmacological or surgical treatments for obesity – Bariatric surgery is available in exceptional circumstances through specialist commissioning via NHS England

Locally, NHS and Council partners across the Cheshire West and Chester system are working together to provide a range of weight management services, as outlined in the Weight Management Pathway (Appendix A), for those living with obesity. Whilst there are eligibility criteria for some of the services, there is a weight management offer for all residents with a BMI over 30, including a range of digital offers and face-to-face services. There is also a strong tier 1 universal offer in terms of access to affordable, healthy food and opportunities to be active. The local offer at each tier is outlined below

Tier 1

Prevention and population level interventions are delivered through the Eat Well Be Active (EWBA) Partnership group including promotion and delivery of the following via the Cheshire West and Chester Live Well platform[xxxvii]:

- Strong community offer helping residents to access to affordable, healthy, sustainable and enjoyable food, supported by the West Cheshire Food Partnership.
- Get Cheshire West Moving Strategy to support being active.
- Better Health and Food Active resources promoted.
- Brief advice ‘Make Every Contact Count’ messages delivered by Primary and Secondary Care and Brio Leisure staff; social prescribing link workers supporting eating well and being active.
- The adopted Local Authority Declaration on Healthy Weight and EWBA Partner Pledge commitments, supporting healthier food environments.

- Healthy developments through the Health Impact Statement and wider work with the Council planning team, including restriction of hot food takeaways.

Tier 2

Tier 2 management is open to adults aged 18 and over who live in, or are registered with a GP in, Cheshire West and Chester, with no upper age limit, although additional support should be considered for those aged 65 and over. Eligibility requires a BMI of 30–39.9 kg/m² (or 27.5–37.4 kg/m² for people of Black African, African-Caribbean or Asian origin) and a diagnosis of learning disability, severe mental illness, medicated hypertension or a physical disability that limits the ability to exercise. Individuals are excluded if they are pregnant or breastfeeding, have an eating disorder, have a medical cause of obesity requiring more intensive clinical management or have significant unstable or complex co-morbidities. The tier 2 offer comprises the following:

- Community weight management – Brio Integrated Wellbeing Service – multidisciplinary team delivering integrated diet, physical activity and behavioural programmes.
  - Free 12-week programme.
  - 2 x 60 min classes per week. Delivery 30 minutes of education and 30 minutes of practical skills including physical activity.
  - On completion of the programme, they can access a subsidised Brio Wellbeing membership - £24 per month for 12 months or £200 annual membership.
- NHS Better Health App **-** Access to support, including the option to download a free NHS Weight Loss plan.
- NHS Digital Weight Management Programme **-** 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.

Tier 2 enhanced

- Countess of Chester Hospital NHS Foundation Trust – 10-week education programme. Sessions subject to change but currently include: Your healthy weight; Balancing your lifestyle; Healthy mind, healthy life; Nutrition groups; What is on your food label?; Creating healthy habits; Physical activity; It’s not just what we eat; Eating out & takeaways; Weight maintenance.
- Weight loss medication (GP prescribed, wrap around weight management support delivered by Reed Wellbeing) **-** Tirzepatide medication prescribed for

24 month duration. Consistent offer across the Cheshire and Merseyside ICB footprint.

Tier 3

The Countess of Chester Hospital NHS Foundation Trust specialist weight management service is a 6-12 month multi-professional pathway leading to consideration for bariatric surgery for patients BMI > 40 (>35 with comorbidities). The Bariatric pathway is for 12 months (it can be completed in 6 months for those with BMI >50kg/m2 if they complete the necessary components in that time).

- A 60-minute detailed online group information session regarding bariatric surgery to help patients decide if this is the route they wish to take, prior to their first assessment.
- Medical Assessment and discussion with a doctor and dietitian.
- Regular one to one diet and lifestyle guidance from a specialist dietitian.
- Regular support and guidance from an exercise physiologist.
- Support from a psychotherapist if required.
- Signposting to local physical activity sessions and opportunities.

Mid Cheshire Hospitals NHS Foundation Trust (CCICP and ECT) currently provide a 12- 24 month Specialist Pre-Bariatric Surgery Weight Management Service (SWMS). This programme is a hybrid programme for individuals considering bariatric surgery with a BMI over 40 * , or greater than 35* with comorbidities such as Diabetes (*adjusted by 2.5kgm2 for Asian and African backgrounds in line with current NICE Guidance). The individual must complete the programme, achieve 5% weight loss and be nicotine free to meet eligibility for referral for surgical assessment. CCICP are commissioned to provide a Multidisciplinary Team service, led by a CCICP Dietitian with a specialist interest in weight management for both the CCICP and ECT footprint. The service is designed to aid and support weight loss, whilst preparing the individual for bariatric surgery. The programme includes virtual online education and 1:1 diet and lifestyle counselling. This intensive hybrid weight management programme includes the following interventions:

- Individual diet and lifestyle counselling from a specialist weight management Dietitian.
- Group education sessions on topics such as mindful eating, hunger and satiety signals and peer support including discussion on bariatric surgery from University Hospitals of North Midlands Bariatric surgeons.
- 4-week group psychology sessions, with onward referral to one-to-one psychology intervention, to support the patient journeys if required.
- Medical review and optimisation prior to onwards referral for surgery.
- Signposting to local services to support increased activity.

Tier 4

- Bariatric Surgery - Delivered by Royal Stoke University Hospital. Upon successful completion of Tier 3, patients are referred to Royal Stoke University Hospital for surgical assessment and surgery under their care.

Although not formally within any tier of services, NHS weight management webinars[xxxviii] are available online covering: The Dieting Cycle, Regular Eating, Triggers to Eating. Diet Myth Busting and Balanced Eating.

Recommendations:

1. Align local services more closely with NICE guidance, ensuring behavioural interventions meet minimum recommended duration.
2. Adapt services for people with complex needs, including learning disabilities, severe obesity, mental health conditions and older adults.
3. Promote consistent compassionate communication, especially outside specialist services with success reframed to expand beyond weight loss emphasising sustainable, health-promoting behaviours and wellbeing across all tiers.

The overall picture of what is happening locally

Taken together, the local system in Cheshire West and Chester demonstrates a coordinated and increasingly whole-systems approach to improving diet, supporting healthy weight and reducing food-related inequalities. The Eat Well Be Active partnership provides the overarching structure, drawing together public health, the NHS, VCFSE partners, planning, housing, community food providers and wider stakeholders under a shared ambition to make healthier choices easier and more accessible. This system leadership has enabled the adoption of the Healthy Weight Declaration, strengthened cross-sector alignment and created a platform for equity-focused action across prevention, early help and specialist support.

Within this landscape, the Food for All Plan acts as the borough's framework for addressing food insecurity which places dignity, choice and lived experience at the centre. The West Cheshire Food Partnership operationalises this vision by supporting a diverse network of emergency, affordable and surplus-food providers. They maintain an interactive public map of food support and champion collaborative, wrap-around models that integrate financial, mental-health and practical cooking support. Community initiatives, such as cooking classes, budgeting sessions and recipe kits reinforce residents' skills, confidence and connection around food, while cash-first approaches and social-prescribing pathways strengthen the links between food access, income maximisation and wider wellbeing. This integrated community

infrastructure ensures that responses move beyond crisis provision towards long-term resilience and reduced reliance on emergency food.

Alongside this, the local system provides a tiered offer of weight-management support, ranging from universal prevention through Eat Well Be Active and Live Well resources, to Tier 2 community programmes from Brio Integrated Wellbeing Service, enhanced Tier 2 education and Tier 3 specialist services via the Countess of Chester Hospital NHS Foundation Trust and Mid Cheshire Hospitals NHS Foundation Trust. These pathways connect into Tier 4 bariatric surgery delivered regionally, ensuring a route from early intervention to specialist clinical care for those who need it. Importantly, this service landscape is underpinned by compassionate, stigma-free approaches, including the “Why Weight to Talk” training and embedded “Make Every Contact Count” delivery across NHS contracts.

Finally, these programmes sit within broader action on the wider determinants of nutrition and health. The Council’s Healthier Advertising Policy, planning restrictions on hot food takeaways and collaborative work on healthy place-shaping, such as improved street design, active-travel routes and healthy-development guidance, demonstrate recognition that the food environment fundamentally shapes dietary behaviour. Partnerships with the Tackling Poverty Team, schools and youth settings further reinforce this, ensuring affordability, access and long-term prevention are embedded across the system. Together, these efforts illustrate a borough-wide commitment to creating healthier food environments, stronger community support systems and compassionate health services.

Conclusion

This needs assessment shows that while many adults in Cheshire West and Chester want to eat well and maintain a healthy weight, their ability to do so is strongly shaped by structural factors rather than knowledge or motivation alone. National data and local insight consistently indicate shortfalls against core dietary recommendations such as fruit and vegetables, free sugars, saturated fat and fibre and that these shortfalls are most acute where affordability, access and exposure to unhealthy marketing are most challenging. The resident survey and focus groups add essential lived-experience detail highlighting key barriers such as the cost of ingredients, time pressure, varying confidence and cooking facilities, mental health pressures and transport constraints which all make healthy eating harder for some residents. The Food Equalities Tool reinforces this by mapping place-based differences in supermarket access, public transport and the proportion of income spent on food thereby spotlighting neighbourhoods where healthy choices are objectively less easy to make.

Alongside these needs, the borough has strong foundations in supporting nutrition. The Eat Well Be Active partnership, Healthy Weight Declaration and the Food for All Plan demonstrate collaborative system leadership. Policies on HFSS advertising,

takeaway density and healthy place-shaping show the Council is using the levers it controls to create healthier environments. A tiered weight-management pathway, aligned with NICE guidelines, provides routes from universal prevention through community programmes to specialist multidisciplinary care and bariatric surgery. Additionally, the system is working to embed compassionate, stigma-free practices across services. Together, these actions show a clear commitment to tackling dietary and related health inequalities through environments, services and partnerships, not just individual behaviour change.

The main limitations identified by this needs assessment relate to local data rather than service intent. Specifically, there is insufficient, consistent local intelligence on the experiences and outcomes of underserved groups such as those with learning disabilities, ethnic minority communities, residents living with neurodiversity and those without reliable cooking and storage facilities. Consequently, although there is some local evidence there is scope for more complete data clearly linking need, access and outcomes across neighbourhoods and populations. Although overall data on diet-related conditions for the area is informative, strengthening equity-focused data, such as by deprivation, ethnicity, disability, neurodiversity and age would support the insight this could provide. Additionally, maintaining and expanding participation routes for people with lived experience in these groups will improve targeting and tailoring of interventions to enhance the significant progress already made.

In summary, the evidence points to an approach to nutrition in Cheshire West and Chester in which there is continued shaping of healthier local food environments, expansion of practical affordability and skills support, especially where the Food Equalities Tool shows greatest constraint, maintenance and expansion of compassionate, stigma-free services across the tiered pathway and the closing of local data gaps, especially for underserved groups, to ensure the right support reaches the right people at the right time. This approach will help improve nutrition and diet-related inequalities across the borough while preserving dignity and choice for every resident.

Recommendations

1. Build on existing obesity prevention activity with renewed focus on impact, as local obesity rates continue to rise in line with national trends.
2. Improve equity-focused intelligence, by developing more robust local data on diet-related disease and nutrition access among underserved groups, including people with learning disabilities, ethnic minority communities and adults with neurodivergence.
3. Embed nutrition within routine care, ensuring primary and community care settings are supported to deliver brief, compassionate dietary conversations linked to local support offers.

4. Increase cooking confidence and skills, with a focus on men, residents in more deprived areas and those unable to work, through accessible, informal cooking sessions, budgeting support and community food hubs.
5. Strengthen healthier food provision across schools, nurseries, leisure settings and foodbanks, building on existing healthier vending and food pledge initiatives.
6. Improve visibility and navigation of support, ensuring all frontline services actively promote the weight-management pathway, Live Well Cheshire West and the Food Partnership map.
7. Address survey representation gaps, with targeted engagement to better capture the views of men and ethnic minority communities in future needs assessments.
8. Expand affordable fresh food initiatives, including pop up markets, low cost produce schemes and closer links to local growers and farmers' markets, especially in deprived areas and signposting to those experiencing food insecurity.
9. Deliver cooking and nutrition support that reflects real world constraints, focusing on low equipment, low energy and time efficient meal options.
10. Integrate food support with wider services, strengthening links between nutrition, mental health, housing, welfare advice and primary care expanding on pre-existing links and integrating compassionate approaches.
11. Promote behavioural change as core to weight support, ensuring programmes focus on nutrition, habits, confidence and wellbeing, not weight alone.
12. Use the Food Equalities Tool proactively to prioritise neighbourhoods for food access interventions and transport planning, particularly for those in rural areas where supermarket access is limited and without private transport, by exploring transport solutions and local retail partnerships to improve access to healthier options.
13. Continue to resource and strengthen whole systems working, maintaining cross-sector leadership and accountability for nutrition and healthy weight.
14. Sustain and expand collaborative delivery of the Food for All Plan, continuing to centre dignity, choice and lived experience.
15. Embed compassionate, non-stigmatising approaches system-wide, ensuring consistency across primary care, community services and non-specialist settings.
16. Build on existing healthier advertising and planning policies, maintaining focus on reducing exposure to unhealthy food environments, especially within areas of deprivation.
17. Advocate nationally for stronger commercial regulation, particularly around promotions and marketing including buy-one-get-one-free offers
18. Expand access to free drinking water, pop-up promotions and healthy choice nudges across council and community settings.

19. Align nutrition and physical activity action, delivering joint approaches through the Get Cheshire West Moving Strategy 2025–28.
20. Continue healthier vending and procurement commitments, ensuring public sector settings lead by example.
21. Align local services more closely with NICE guidance, ensuring behavioural interventions meet minimum recommended duration.
22. Adapt services for people with complex needs, including learning disabilities, severe obesity, mental health conditions and older adults.
23. Promote consistent compassionate communication, especially outside specialist services with success reframed to expand beyond weight loss emphasising sustainable, health-promoting behaviours and wellbeing across all tiers.

Appendix A

Cheshire West and Chester Adult Weight Management Pathway

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