# NOTTINGHAM AND NOTTINGHAMSHIRE JOINT STRATEGIC NEEDS ASSESSMENT

## Healthy Weight and Good Nutrition
## PROFILE PACK
### SEPTEMBER 2026

| Topic Information | |
|---|---|
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Nottinghamshire Health & Wellbeing Board

Nottingham City Council

# 1. Introduction

Healthy weight and good nutrition are essential components of good health and wellbeing, shaped by a complex interplay of biological, social, economic, and environmental factors. When healthy weight or good nutrition are not achieved, whether through overweight, obesity, underweight, or malnutrition, this can lead to poor health outcomes across the life course. Achieving and sustaining a healthy weight is shaped far more by our surroundings than individual choice, dependant on equitable access to the building blocks of health, such as secure housing, adequate income, stable employment, access to green space and affordable, nutritious food. For many individuals and communities, gaps in these building blocks create structural barriers that limit their ability to achieve good nutrition and a healthy weight.

The topic of weight is deeply personal and can be sensitive to individuals, particularly for people living with obesity who may face stigma, discrimination, and shame. Clear, non-stigmatising language is essential when discussing weight, nutrition, and physical activity, especially as different organisations, professional groups, and members of the public may use terms that vary in meaning and appropriateness depending on context. Recognising this, there is an increasing emphasis on using neutral, standardised, and compassionate language when discussing obesity, underweight, and related concepts. While this JSNA uses clinical terminology to describe population-level patterns, it is committed to avoiding judgemental framing by adopting an approach that acknowledges the complex determinants of weight and prioritises dignity, respect, and inclusion. The terms and definitions used in this JSNA can be found in the glossary, available here.

In developing this JSNA, it has been recognised that there is significant demographic variation across Nottingham and Nottinghamshire, particularly in relation to age structure, deprivation, ethnicity and rurality. Nottingham City's younger and more ethnically diverse population lives in more deprived and densely urban areas. This contrasts with the surrounding county's generally older and less diverse population. Living in less deprived and rural areas. This variation has significant effects on health and wellbeing and has been considered throughout, helping to make sure this JSNA reflects local need. More information on the population of Nottinghamshire and Nottingham can be found at Nottinghamshire Insight.

**Purpose**

The Healthy Weight and Good Nutrition JSNA profile pack has been jointly developed for Nottingham City and Nottinghamshire County to provide an up to date, comprehensive understanding of healthy weight and good nutrition across the life course. Its purpose is to assess current and future population needs and generate insights that will support coordinated systemwide action, inform local strategies, strengthen the weight management pathway, and guide future commissioning.

**Scope**

This JSNA takes a life course approach and focuses on residents of Nottingham City and Nottinghamshire County. It explores health outcomes linked to weight and nutrition and examines key influencing factors such as socioeconomic status, the food environment, cultural and social factors, and physical activity as it relates to healthy weight. It does not cover movement and physical activity as standalone health issues (to be

addressed in a 2026 JSNA), food security (covered in Nottinghamshire Food Security JSNA[1] and City JSNA in 2026), eating disorders, breastfeeding (which was explored in-depth in the Nottingham and Nottinghamshire Infant Feeding Framework for action[2]) or specialised diets including allergies.

Although underweight, overweight and obesity, malnutrition, and good nutrition are all within scope, there is less information and local data available on underweight and malnutrition. This is recognised as a limitation of the JSNA. While being underweight can negatively impact health outcomes, it should be noted that the prevalence of underweight is significantly lower than the prevalence of overweight and obesity.

## 2. National and local strategic context

National policy since 2020 has increasingly focused on reshaping the food environment to address rising obesity and diet-related ill health, with strategies such as the government's Tackling Obesity Strategy (2020)[3] and the National Food Strategy and plan (2020–2021),[4] [5] supported by regulatory measures including calorie labelling and high fat, salt and sugar (HFSS) restrictions.[6] [7] Alongside this, system-wide approaches have been influenced by the Obesity Health Alliance's 10-year Healthy Weight Strategy (2021)[8], calling for more integrated action across health and food systems. More recently, policy has shifted further upstream with the Good Food Cycle framework (2025)[9] and reports such as the Food Foundation's Broken Plate (2025)[10], highlighting inequalities in access to healthy food. Measures implemented from 2025–2026 including healthy retail standards[11], consultation on expanding the Soft Drinks Industry Levy,[12] widening access to school breakfast clubs,[13] the new UK Food Strategy (2025),[14] National Planning Policy Framework (2025) [15] and the HFSS advertising ban coming into law, reflecting a continued move toward whole-system, preventative approaches. In addition, the Fit for the Future: 10-year plan [16] outlines a shift from sickness to prevention, emphasising a focus on healthy weight and measures to reduce long-term conditions linked to excess weight. In April 2026, at time of writing, the UK Government launched a public consultation on updating the School Food Standards, aiming to align school meals with latest nutritional guidance.[17]

Nottingham and Nottinghamshire's strategic landscape is shaped by a shared focus on prevention, reducing health inequalities and creating environments that support healthy, active lives. Across the City and County, key strategies emphasise giving every child the best start,[18] [19] strengthening community wellbeing, and addressing the building blocks of health such as the food environment – access to affordable, healthy food, access to green space[20] and spatial planning.[21] Both areas prioritise healthy weight, physical activity, food security and sustainable food systems through a desire for whole system approaches, including Nottingham's Eating and Moving for Good Health Long Term Vision [22] and the Nottinghamshire Food Charter.[23] Council Plans, [24] [25] Joint Health and Wellbeing Strategies, [26] [27] district level wellbeing plans [28] [29] [30] [31] [32] and the ICS Integrated Care Strategy[33] all align around supporting healthier lifestyles, improving access to healthy environments, and enabling residents to lead long, independent, healthy lives throughout the life course.

## 3. Setting the scene

### a) What is good nutrition and healthy weight and why is it important?

| What is good nutrition? (Pre-conception, Pregnancy, Children and Young People) | How nutrition affects health and wellbeing (Pre-conception, Pregnancy, Children and Young People) |
|---|---|
| • Good nutrition for children and young people begins even before conception, as maternal **pre-conception** health influences fertility and future pregnancy outcomes. UK guidance advises that women take a daily folic acid supplement before pregnancy and up to 12 weeks' gestation to lower the risk of neural tube defects.[34] Alongside supplementation, following a balanced diet rich in natural folate sources, such as leafy green vegetables, and achieving a healthy weight can help support fertility.<br>• During **pregnancy**, these healthy eating principles continue to be important, with recommendations to follow the Eatwell Guide to promote optimal maternal health and foetal development. In addition, it is recommended that pregnant women take a daily vitamin d supplement and have an iron rich diet. [35] [36]<br>• The World Health Organisation (WHO) recommend exclusive breastfeeding for the **first six months** of life and in combination with solid foods up to two years or beyond.[37] Where breastfeeding is not possible or preferred, then infant formula will provide a good nutritional start. Solid foods can be introduced at around six months, focusing on varied, nutrient dense options low in salt and sugar.[38]<br>• **From one year**, children can have full fat dairy milk and need diets rich in protein, iron, fruit, vegetables, and carbohydrates.38[38] [39] [40]<br>• Between the ages of **two to five**, children need three meals and 2–3 nutritious snacks following 'Eatwell Guide' principles.[41]<br>• From age **five onward**, diets should emphasise nutrient dense foods including wholegrains, a range of proteins, fruits, | **Pre-conception and Pregnancy**<br>• Good nutrition before and during pregnancy is essential, as a balanced and nutritious diet supports healthy fertility and creates optimal conditions for pregnancy. [34]<br>• Early pregnancy is a particularly sensitive period because the baby's organs are forming, and poor nutrition at this stage can cause lifelong health problems. [34]<br>• Maternal nutrition during pregnancy supports optimal foetal growth and brain development and can influence a child's health, development and make young children more vulnerable to nutritional deficiencies. [46] [47] [48] [49]<br>• Later in pregnancy, poor maternal diet mainly affects the baby's growth, and energy needs of the mother rise only slightly, with guidance recommending about 200 extra calories a day in the third trimester. [50]<br>• Adequate micronutrient intake is essential, folic acid helps prevent neural tube defects, which is still a significant cause of disability, with a UK prevalence of 12.2 per 10,000 births[51] and taking the recommended allowance before conception and through the first 12 weeks can reduce this risk. [34] [52]<br>• Vitamin D supports the healthy development of the baby's bones, teeth and muscles [34]<br>• Iron is vital because 23% of pregnant women in the UK are anaemic, which can increase tiredness, reduce tolerance to blood loss, and raise the risk of preterm birth and low birthweight. [53] |

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| vegetables, and dairy or fortified alternatives, [42] with vitamin D supplements recommended in winter.[38]<br>• **Adolescents** require higher intakes of energy and nutrient rich food, including, protein, calcium, iron, and vitamin D to support rapid growth[43] with iron particularly important for girls after menstruation begins, [44] and additional nutrients such as zinc, iodine, and omega 3 supporting hormonal and metabolic changes. [45] | **Children and Young People**<br>• Faltering growth occurs when a child does not gain weight or grow as expected, usually because they are not getting enough energy, protein or essential nutrients to support healthy development. [54] [55]<br>• Ongoing malnutrition can lead to long-term problems such as stunted growth, delayed development and poorer cognitive and educational outcomes. [56]<br>• Good nutrition is also vital for a strong immune system, as children with nutrient deficiencies are more vulnerable to infections. [57] [58] [59] [60]<br>• Key micronutrients, including iron, iodine and vitamin D, are especially important in early life; deficiencies can affect brain development, growth and immunity, with iron deficiency linked to cognitive delays and vitamin D deficiency causing rickets and reduced bone strength. [61] [62] [63]<br>• From ages two to five, children begin forming eating habits, making exposure to a wide range of foods important, [42] and between five and adolescence, balanced nutrition supports learning, healthy growth, bone strength and long-term health [42] [64]<br>• During adolescence, good diet quality continues to support mental health, hormone changes, bone development and prevention of iron deficiency anaemia. [45] [65] [66] [67] |

| What is good nutrition? (Adults) | How nutrition affects health and wellbeing (Adults) |
|---|---|
| • Good nutrition for adults involves consuming a balanced variety of foods in the right proportions to support overall health, maintain a healthy weight, and reduce the risk of chronic diseases. [68] [69]<br>• The Eatwell Guide [70] shows the proportions of the main food groups that form a healthy, balanced diet. It is recommended that our diet is based on fruits and vegetables, wholegrain starchy carbohydrates, and a range of protein sources, alongside moderate amounts of dairy or fortified alternatives and small quantities of healthy fats. Red and processed meats, saturated fats, and foods high in fat, salt, and sugar should be limited, while hydration remains essential, with 6-8 cups of water advised daily.<br>• Good nutrition is not only about individual foods but about overall eating patterns that are balanced, varied, and sustainable over time, and incorporating principles such as variety, portion control, mindful eating, and meal planning helps support these long-term healthy eating habits for both physical and mental wellbeing. [69] | • Vitamin D deficiency is the most common nutritional deficiency worldwide and is linked to poor bone strength, including osteopenia and osteoporosis, as well as increased risk of falls (effects on muscle strength and balance) and fracture risk in older adults; in the UK, 30–40% of people are deficient in winter (2–13% in summer) [62]<br>• Iron deficiency is the leading cause of anaemia, affecting an estimated 3% of men and 7% of women in the UK. [53] [61]<br>• Low fibre intake raises the risk of constipation, diverticular disease and haemorrhoids, and is associated with long-term risks such as colorectal cancer and cardiovascular disease; fibre also supports healthy blood sugar and cholesterol levels, but average intake in the UK remains below recommendations. [71] [72]<br>• Protein is essential for growth, tissue repair, immune function and maintaining muscle mass, and inadequate intake can lead to muscle loss, frailty, slower recovery from illness, and greater need for health and social care, particularly among older adults, those with chronic illness, people experiencing food insecurity, or those on restrictive diets. [73]<br>• Dietary fats provide essential fatty acids, support cell structure, hormone and nerve function, and help the body absorb vitamins A, D, E and K; while deficiency is uncommon in the UK, poor-quality dietary fats and excess saturated or trans fats increase the risk of cardiovascular and metabolic disease. [74] |

| What is healthy weight? (Pre-conception, Pregnancy Children and Young People) | Why healthy weight is important for health and wellbeing (Pre-conception, Pregnancy, Children and Young People) |
|---|---|
| • A healthy pre-conception weight means having a BMI between 18.5 and 24.9 before becoming pregnant[75]<br>• Healthy weight in pregnancy is assessed using BMI, calculated at the first antenatal (booking) appointment. A BMI between 18.5 and 24.9 is considered a healthy weight, 25–29.9 is overweight, and 30 or above is classified as obese, which increases pregnancy risks [75]<br>• For babies and toddlers (up to 2 years), healthcare professionals use the UK-WHO growth charts found in the Personal Child Health Record (red book) to track weight and height. [76]<br>• Healthy growth is typically indicated when weight and length/height remain within 2 centile spaces of each other.<br>• A child's growth should ideally follow one of the centile lines. Crossing two or more centiles (up or down) may be a reason for a health professional to investigate.<br>• Once a child reaches the age of two years old, the primary tool for determining healthy weight in children aged two to eighteen is the Body Mass Index (BMI), which is weight (kg) divided by height squared ($m^2$). Unlike adults, a child's BMI must be compared against others of the same age and sex using growth charts which give BMI centiles. [77] [78]<br>  • Underweight: Below the BMI 2nd centile<br>  • Healthy weight: Between BMI 2nd and 91st centiles.<br>  • Overweight: BMI 91st centile<br>  • Clinical obesity: BMI 98th centile<br>  • Severe obesity: BMI 99.6th centile<br>• Recent NICE Guidelines have updated the assessment criteria for healthy weight to include waist-to-height ratios for children aged five and over to specifically measure central adiposity, which can | **Pre-Conception and Pregnancy**<br>• Body weight can affect fertility and pregnancy outcomes in several ways. Higher body weight may influence hormone balance, insulin sensitivity, inflammation and, in men, sperm quality; in women, this can affect ovulation and conditions such as polycystic ovary syndrome (PCOS), which may delay conception or reduce the success of fertility treatments. [79]<br>• Very low body weight can also disrupt menstrual cycles, making it harder for some people to conceive until their overall health improves. [80]<br>• Higher body weight during pregnancy is associated with increased risks including high blood pressure, gestational diabetes, blood clots, miscarriage, preterm birth, larger babies, stillbirth, and reduced accuracy of antenatal scans, as well as labour and birth complications such as longer labour, need for induction, assisted delivery or caesarean section, wound infection and postpartum haemorrhage. [75] [81] [82] [83]<br><br>**Children and Young People**<br>• Childhood obesity is recognised by the WHO as one of the most serious global health challenges of the 21st century [84] and is linked to a higher risk of early death and significant long-term health problems.<br>• Excess body fat in childhood can cause ongoing inflammation that increases the likelihood of heart disease, type 2 diabetes, hormone-related and autoimmune conditions, and asthma, while also affecting mental health and exposing children and young people to social stigma. [85] [86]<br>• Children living with obesity are more likely to remain living with obesity in later life. Around 55% continue to live with obesity into |

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| be a better indicator of health risks than BMI alone in some cases. [78] | adolescence. 80% of adolescents who are living with obesity, also experience obesity as adults. This placing them at higher risk of earlier onset type 2 diabetes and cardiovascular disease. [86]<br>• Maintaining a healthy weight in childhood also supports learning and academic success, with good nutrition linked to better concentration, memory, problem solving, attendance, and engagement in school. [87] [88] [89] [90] [91] [92] |

| What is healthy weight? (Adults) | Why healthy weight is important for health and wellbeing (Adults) |
|---|---|
| • Definitions related to weight are generally linked with Body Mass Index (BMI), which can be a useful measure for most of the population to estimate whether a person is a healthy weight, calculated by dividing weight in kilograms by height in metres squared, with standard categories:<br>  • Underweight: BMI 18 and below<br>  • healthy weight: BMI 18.5 to 24.9<br>  • overweight: BMI 25 to 29.9<br>  • obesity class 1: BMI 30 to 34.9<br>  • obesity class 2: BMI to 39.9<br>  • obesity class 3: BMI 40 or more. [93]<br>• However, lower BMI thresholds apply to some ethnic groups, including South Asian, Chinese, other Asian, Middle Eastern, Black African, and African-Caribbean populations. In these groups, overweight begins at 23 kg/m² and obesity at 27.5 kg/m².<br>• The limitations of BMI are increasingly recognised and should be interpreted cautiously in people with high muscle mass.<br>• Alongside BMI a person's waist-to-height ratio is a simple measure of central adiposity (excess fat around the abdomen and waist area) that compares an individual's waist circumference with their | **Health outcomes associated with high BMI**<br>• Higher body weight is linked to a wide range of serious health conditions and drives biological processes that increase the risk of coronary heart disease and stroke. Coronary heart disease is responsible for just under 10% of deaths per year in the UK[94] and strokes account for 5% of all UK deaths per year.[95]<br>• High BMI is the highest modifiable risk contributor to years of life lived with disabilities in the East Midlands, and the fourth highest modifiable contributor to disability adjusted life years (DALYs).[96]<br>• Global Burden of Disease data show that high BMI contributes to DALYs caused by cardiovascular disease, diabetes, musculoskeletal disorders, digestive diseases, chronic chest disease and neurological disorders.[96]<br>• High BMI (obesity) is the second biggest preventable cause of cancer after smoking, [97] with around 22,800 cancer cases in 2022 attributed to high BMI.[98]<br>• When more energy is consumed than the body needs, excess fat, particularly around the organs, can increase inflammation and reduce the body's ability to use insulin, raising the risk of heart disease and type 2 diabetes. [99]<br>• In 2021, around 3.6 million people in the UK were living with type 2 |

height. A ratio where the waist is less than half the height indicates a healthy level of central fat, while higher ratios are associated with increased health risks. [78]

- For adults over 65, slightly higher BMI levels may be protective, while low BMI is linked to frailty and sarcopenia, [78] therefore, weight maintenance is often prioritised unless there is clear clinical risk.

diabetes,[100] a condition that can lead to vision loss, nerve damage, poor circulation, higher risk of infection, and life-threatening complications. [99]

- Obesity also increases cholesterol levels and speeds up the build-up of fatty deposits in arteries, with 48% of adults in England found to have high cholesterol in 2024.[101]
- High BMI is a major contributor to high blood pressure, the leading preventable cause of cardiovascular disease in the UK, associated with around 80,000 deaths a year, in 2024, 32% of adults had diagnosed or undiagnosed hypertension, rising to over 70% in adults aged over 75. [102]
- Higher BMI is also strongly linked with Metabolic Dysfunction–Associated Steatotic Liver Disease (MASLD), which can progress to liver failure or liver cancer. [103] [104] [105]
- Higher body weight is strongly associated with musculoskeletal (MSK) conditions, which are a major cause of pain, disability and ill-health. Locally, around 70% of adults with long-term MSK conditions are living with overweight or obesity.[106] Both Nottingham City and Nottinghamshire have higher than national levels of ill-health related economic inactivity,[107] and MSK conditions are a key contributor, with excess weight likely playing a role in this.

**Health outcomes associated with underweight**

- While the prevalence of people who are underweight is significantly lower than the prevalence of overweight and obesity, being underweight can lead to negative health outcomes for individuals when compared to being a healthy weight. This can include reduced muscle mass, strength and functional capacity that can increase risk of falls and loss of independence. [108]
- Being underweight can also be linked to malnutrition, which can result in nutrient deficiencies, lower immune function leading to increased illness, slower wound healing and poorer outcomes following surgery and longer inpatient stays.[109]

## b) Determinants influencing healthy weight and good nutrition

**Healthy weight is shaped far more by our surroundings than individual choice, with everyday environments, inequalities and the cost of living strongly influencing what people eat.** At least 50% of health outcomes are shaped by where people are born, grow, live and work[110]. Factors such as income, transport, education, housing, and local food environments directly influence diet and healthy weight across Nottingham and Nottinghamshire, highlighting where local conditions create barriers, and opportunities for healthier lives [111] The following section briefly explores these determinants, however more detailed information can be found in the supplementary document available here.

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| **Access to Healthy Food** is uneven, with more deprived areas experiencing: [112] [113]<br><br>• Limited availability of affordable fresh food or fresh fruit/veg<br>• Higher exposure to unhealthy options<br><br>Groups most affected:<br>• people on low incomes<br>• disabled residents<br>• people in rural areas.<br><br>**8% of the most deprived UK areas** are classed as *food deserts*. | **The Out-of-Home (OOH) Food Environment** [114] [115] [116] [117] [118] [119] [120] [121]<br><br>• This refers to the food and drinks available to people outside the home, such as in restaurants, cafés, takeaways, schools, workplaces, and shops.<br>• Nearly half of UK adults eat food from takeaways weekly; calorie intake from takeaways has risen 50% since the pandemic.<br>• **Nottingham**: 135.4 fast-food outlets per 100,000 (above national average).<br>• **Nottinghamshire:** 98.6 fast-food outlets per 100,000 (below national average).<br>• Deprived areas have a higher number of fast-food outlets and much higher clustering, e.g. Market Warsop in Mansfield: 10 outlets for a relatively small population or~325 outlets per 100,000.<br>• Stronger 2024 National Planning Policy Framework planning powers now allow councils to restrict new takeaways near schools and in high-density areas. | **Affordability of Healthy Food** [10] [122] [1]<br><br>• Healthier foods cost over twice as much per calorie as less healthy options.<br>• Healthier food has increased in price at twice the rate of less healthy options in the past two years.<br>• The most deprived households would need to spend between 45 and 70% of disposable income to meet healthy diet standards, depending on household size.<br>• Cost-of-living pressures have increased food insecurity, meal skipping, and reliance on cheaper energy-dense foods.<br>• While national support schemes exist (e.g. Healthy Start, Free School Meals, Holiday Activity & Food) uptake remains limited due to stigma, awareness and access barriers |

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| **Marketing & Advertising of High in Fat, Sugar & Salt (HFSS) Foods & the Digital Food Environment** [123] [124] [125]<br>• HFSS marketing disproportionately affects children and more deprived groups, reinforcing unhealthy dietary patterns.<br>• Algorithms, influencers, delivery apps and targeted HFSS ads shape dietary choices.<br>• Higher screen time is associated with higher consumption of sugary drinks and energy-dense foods, particularly among younger and more deprived groups.<br>• New 2026 restrictions include, 9pm watershed & ban on paid-for online ads.<br>• Local advertising environments remain unregulated | **Food Literacy, Capability & Education** [126] [127] [128]<br>• Food literacy = knowledge, skills and confidence needed to plan, prepare and eat healthy food.<br>• Low food literacy is linked to poverty, limited time or cooking facilities, lack of nutrition education, high stress and competing pressures<br>• Improving food literacy strengthens autonomy and supports healthier, sustainable behaviours. | **Schools and Early Years Settings** [129] [130] [131] [132] [133] [134]<br>• Children consume up to 90% of daily energy intake in Early Years settings and around 30% in schools.<br>• School meals are healthier than packed lunches, better vegetable, fibre and protein, less sugar and salt.<br>• Settings influence food literacy, eating habits, movement, outdoor play and screen time<br>• Whole-setting food policies reduce HFSS exposure and support consistent healthy messages |
| **Global & Environmental Pressures**<br>• Food supply increasingly disrupted by climate impacts, global conflict and biodiversity loss.<br>• These food shocks threaten local access and affordability of healthy foods.<br>• Local resilience planning and Food Partnerships are key to mitigating this impact. | **Body Image, Weight Stigma & Wellbeing** [135] [136] [137] [138] [139] [140]<br>• Poor body image and weight stigma reduce physical activity, worsen diet quality, delay healthcare seeking and impact mental health.<br>• Positive body appreciation is linked to healthier behaviours and wellbeing.<br>• Evidence supports weight-neutral, stigma-aware approaches focused on behaviours and environments | **Family Eating Environment** [141] [142] [143] [144] [145] [146]<br>• Early eating habits track into adulthood.<br>• Parents influence what food is available at home, role-modelling, mealtime routines, type of guidance or restriction.<br>• Supportive parental approaches (rather than restrictive practices, not pressure or bans) support better intake of fruit and vegetables and reduces HFSS consumption. |
| **Cross Cutting Cultural & Social Influences**- Cultural identity, traditions, religion and community norms strongly shape dietary choices. Traditional foods promote belonging and social cohesion. Effective interventions must be culturally sensitive, family-centred and community-led. [147] [148] [149] | | |

## c) Role of physical activity in healthy weight

**Diet is the main driver of weight loss, while physical activity supports energy balance, prevents weight regain and provides significant health benefits at any weight**. [150] [78] Physical inactivity, sedentary time and features of the built environment contribute to obesity risk, with car dependent urban areas linked to higher obesity and dense, mixed-use environments associated with healthier weight. [150] [78] [151] [152] Physical activity is shaped more by living conditions and place than by individual motivation. Strengthening the building blocks of health enables movement whereas instability of these blocks widens inequalities.[110]

*The influences shown in this table represent a synthesis of evidence and professional knowledge developed by the Public Health team to illustrate the relationship between physical activity and healthy weight*

| Influences | How this *could* create barriers to being active |
|---|---|
| Poverty and cost of living pressures | Cost of activities and facilities; clothing and equipment costs; transport costs; digital and financial exclusion |
| Insecure work and lack of time | Shift work; multiple jobs; caring responsibilities; inactive/sedentary job roles |
| Unsafe and poorly designed environments | Poor urban design: lack of green space, lack of toilets and resting places, litter, fly tipping, dog mess and poor lighting |
| Poor transport connectivity | Car dominated spaces/danger; inadequate walking and cycling infrastructure; challenging topography; poor path/road maintenance |
| Poor housing and limited space | Limited space to move; lack of private or communal outdoor space; overcrowding; housing insecurity and evictions |
| Social isolation and low community cohesion | Weak community cohesion; low social connection; lack of local activities; crime and public unrest; limited digital connection |
| Poor education or access | Negative early movement experiences; limited embedding of physical activity in education and learning settings |
| Food access & experiences (including food insecurity) | Poor access to nutritious food; energy imbalance; weight stigma and body image concerns |

**Who is most impacted?** [150] [153]

Physical inactivity and unhealthy weight are concentrated among the same groups experiencing social, economic and structural disadvantage, with compounded effects where inequalities overlap:

- People living in deprivation
- Disabled people and those with long term conditions
- Older adults (65+)
- Women and girls
- Some ethnic groups

**Enablers to physical activity**

- Healthy, inclusive spatial planning [154]
- Walkable neighbourhoods, active travel [155]
- Affordable, accessible transport [155]
- High quality green and blue spaces [155]

**Nottingham City**: experiences a triple burden of high deprivation, high adult inactivity and high unhealthy weight [156] [157]
**Nottinghamshire:** lower overall rates mask hidden inequalities across districts; adult and child activity levels vary widely [156] [157]

**A supplementary document with more information can be found here**
**A Moving More JSNA, will be available later in 2026**

## 4. **Not all things are equal** (Inequalities and who is at risk of overweight, obesity and poor nutrition)

The prevalence of overweight and obesity has been observed to be increasing across England, while poor nutrition remains a concern, which carries significant implications on health. Inequalities between social groups regarding overweight, obesity and nutrition have also been observed. Understanding these inequalities and knowing which populations are at risk will help to inform more effective actions in tackling and preventing poor nutrition and unhealthy weight within our local population.

There are clear and persistent inequalities in overweight, obesity, and nutrition across England, with relevance for our local population in Nottingham and Nottinghamshire. These inequalities are patterned across socioeconomic status, age, gender, ethnicity, disability, early-life circumstances and environmental factors.

**Overweight and obesity** remain highly prevalent, affecting both adults and children, however the burden is not equally shared. [158] [159]

- **Deprivation** is one of the strongest drivers of inequalities. Adults and children living in the most deprived areas experience significantly higher rates of overweight, obesity, and severe obesity. [159] [160] [161] The gap between the most and least deprived areas continues to widen, particularly in older children.[158] [159] In the most deprived areas in England, prevalence of excess weight is 12% higher than the least deprived areas.[158] In Nottingham and Nottinghamshire data shows a relationship between healthy weight and deprivation, with higher proportions of adults living with obesity and lower proportions of people with healthy weight in the most deprived areas. The prevalence of adults who are overweight is more evenly distributed across deprivation indices in Nottingham, and in Nottinghamshire the prevalence of overweight is highest in the least deprived areas.[162] Considering children and young people, there is a much stronger relationship between deprivation and childhood overweight (including obesity) in Nottingham City compared with the County. In the City, overweight (including obesity) is concentrated in the most deprived areas, showing a clear and steep gradient. In Nottinghamshire County, the pattern is still evident but less pronounced and more variable. [163] [164] [165]
- **Ethnicity** shapes risk independently of socioeconomic position.[166] [167] Black ethnic groups experience the highest prevalence of excess weight in both adults and children. [159] [160] [161] Some Asian groups show mixed patterns, with Bangladeshi and Pakistani groups having higher risks of obesity in childhood. [160]
- **Age** plays a role: while middle-aged adults have the highest prevalence of excess weight, young adults (18–24) have the highest risk of weight gain among adults, especially those who are already overweight. [158] [168]
- **Gender** differences exist, with men more likely to be overweight but women more likely to experience obesity and stronger socio-economic inequalities.[158] [159] [169]
- **Disability and long-term illness** are strongly associated with higher prevalence of excess weight. [158] [169]
- **Early-life and parental influences**, including parental education, income, maternal obesity, smoking, and early-life socioeconomic circumstances predict later obesity risk. [170] [171] [172] [173]

- **Underweight** is significantly less prevalent than overweight and obesity but certain groups may be more likely to experience underweight including older adults, people who are in care homes or hospital inpatients, people with long-term conditions, people using drugs and alcohol and people experiencing deprivation or social isolation and people with learning disabilities. [174] [175] [176] [177]

**Nutrition**

Poor nutrition disproportionately affects those in disadvantaged circumstances:

- **Socioeconomic status** remains a dominant determinant of diet quality. Lower-income households consume fewer fruits and vegetables, more high-fat and high-sugar foods, and face financial and environmental barriers to healthy eating. [178] [179] [180] [181] [182] For example, the most deprived fifth of the population (without children) would need to spend 45% of their disposable income on food to meet the government's Eatwell guidance. [183]
- **Food insecurity** is strongly linked to poor diet quality, obesity risk, and poor physical and mental health outcomes—especially affecting households on Universal Credit, lone parents, disabled individuals, and those in temporary accommodation. [10] [184] [185] [186] [187] [188]
- **Ultra-processed foods (UPFs)** contribute significantly to weight gain and poorer diet quality, with consumption highest among deprived groups and adolescents in low-income households. [189] [190] [191]
- **Ethnic disparities** exist in dietary patterns, including lower fruit and vegetable consumption in several minority groups after adjusting for socioeconomic status. [192] [193] [194]
- **Early-life circumstances**, including parental education and early-childhood food environments, influence children's diet quality and UPF intake and continue to shape dietary patterns into adulthood. [195] [196] [197]
- **Environmental factors**, such as neighbourhood food environments and access to green space, also contribute to nutritional inequalities. [182] [198]

Together, these findings highlight a complex and interconnected system of structural, socioeconomic, cultural, and environmental factors that shape weight and nutrition outcomes throughout life, which can also drive inequalities in overweight and obesity and poor nutrition. Further detail can be found in a supplementary document on inequalities here.

## 5. Extent of the issue – Children and Young People

The National Child Measurement Programme (NCMP) provides a consistent picture of underweight, healthy weight, overweight and obesity among children aged 4–5 (reception) and 10–11 (year 6). Local data for Nottingham and Nottinghamshire show marked variation in weight outcomes between City, County and within County districts, with some areas experiencing significantly higher levels of overweight and obesity than the national average, while others show prevalence rates that are similar to or lower than national levels. The following section summarises these patterns, highlighting these significant differences across the City and County. A more detailed analysis and discussion can be found in a supplementary document available here. It is acknowledged that there is a lack of local data on nutrition among children and young people available at a local level.

Please note, where data is described as 'significantly' different this refers to a statistically significant difference rather than the size of the difference.

**Reception (4- 5 year olds)**

- Healthy weight prevalence among reception children is lower in both Nottingham (73.5%) and Nottinghamshire (73.8%) compared with England (75.4%) [199] indicating a higher proportion of children are underweight, overweight or living with obesity.
- In Nottingham, the prevalence of underweight children in reception (2.1%) is significantly higher than the national average (1.1%).[200] The prevalence in Nottinghamshire (0.7%), is significantly lower than the national average.[201]
- In Nottingham, overweight (including obesity) prevalence (23.7%) is similar to the East Midlands (23.7%) and England averages (23.5%), but obesity (including severe obesity) prevalence (12.1%) is significantly higher than the national average (10.5%). [200]
- In Nottinghamshire County, overweight (including obesity) prevalence (25.5%) and obesity (including severe obesity) prevalence (11.2%) are both significantly higher than the England prevalence (23.5% and 10.5% respectively).[202]
- Looking at prevalence across Nottinghamshire County Districts and Boroughs, Ashfield (29%), Mansfield (28.8%), Bassetlaw (27.7%), and Newark & Sherwood (25.9%) have significantly higher rates of overweight (including obesity) than England; Broxtowe (25.1%) and Gedling (22.2%) are similar, while Rushcliffe (18.5%) is significantly lower.[203]
- Obesity (including severe obesity) prevalence patterns mirror this, Ashfield and Mansfield are significantly higher than England average (10.5%), Bassetlaw, Broxtowe, Gedling, and Newark & Sherwood are similar to, and Rushcliffe remains significantly lower. [204]

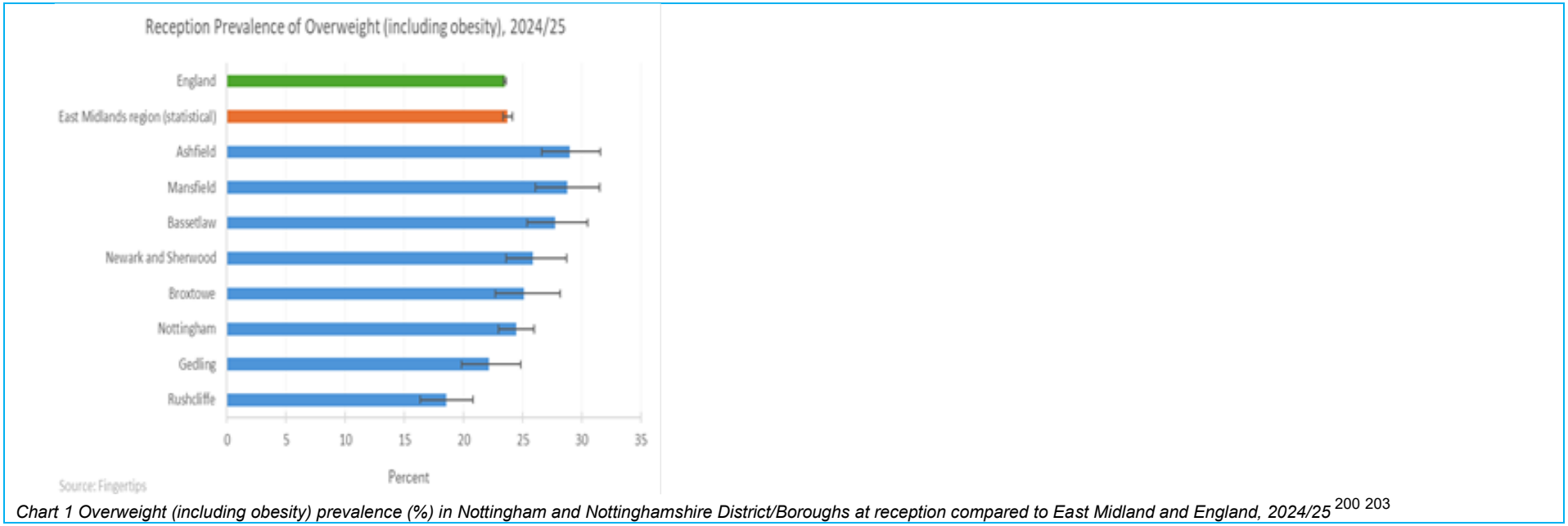
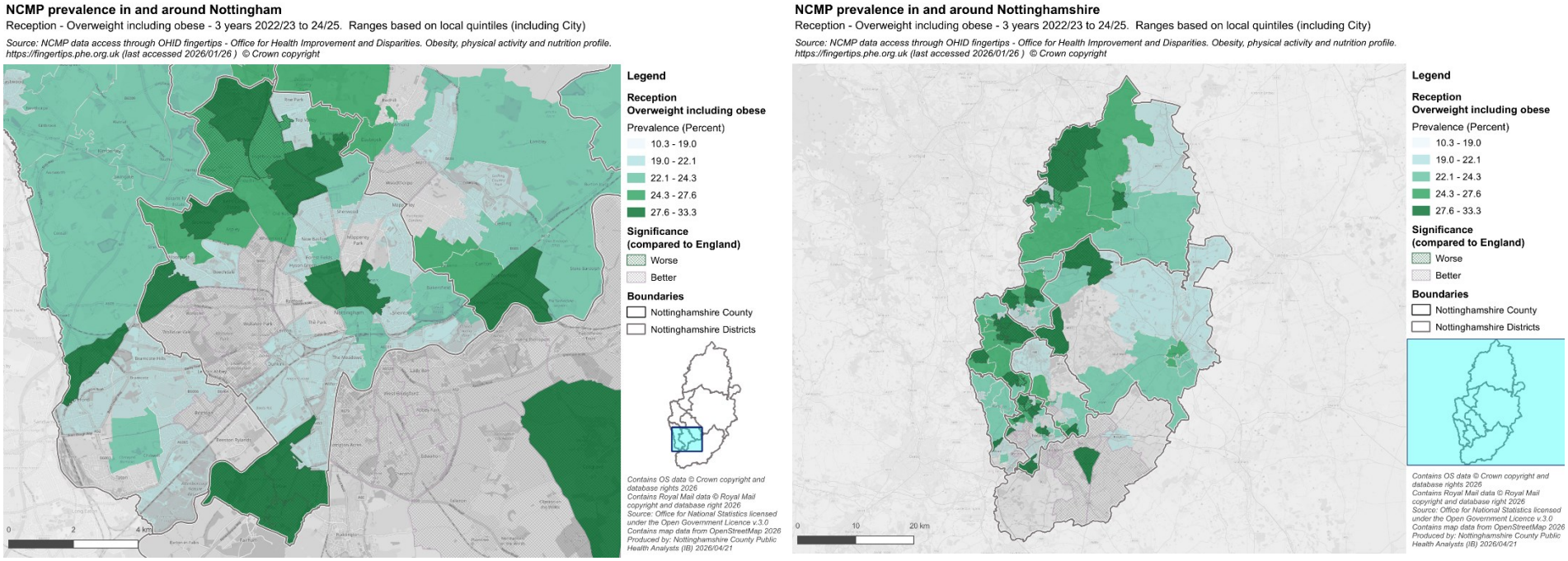



*Chart 1 Overweight (including obesity) prevalence (%) in Nottingham and Nottinghamshire District/Boroughs at reception compared to East Midland and England, 2024/25* [200] [203]

The maps show the prevalence of overweight (including obesity) among reception-aged children across Nottingham and Nottinghamshire. Prevalence is presented as a percentage and is based on the number of children measured who are overweight (including obese), averaged across three school years, and shown at small neighbourhood sized areas (middle super output area – MSOA) according to where children live. The map highlights clear geographic variation, with higher levels clustered in some local areas. Darker shading indicates higher prevalence.




*Map 1 and 2 Prevalence of overweight (including obesity) in Nottingham and Nottinghamshire in reception (2022/23-2024/25).* [205]

**Year 6 (10-11 year olds)**

- Healthy weight prevalence among year 6 children is significantly lower in Nottingham (58%) than nationally, meaning a higher proportion of children are overweight or living with obesity, whereas Nottinghamshire (61.3%) is not significantly different from England (62.2%).[206]
- In Nottingham, the prevalence of underweight children in year 6 (2.0%) is statistically similar to the national prevalence (1.6%). [200] For Nottinghamshire (1.3%) this is significantly lower than the national prevalence. [207]
- In Nottingham, overweight (including obesity) prevalence (40.1%) is significantly higher than both the East Midlands (36.3%) and England (36.2%); obesity (including severe obesity) prevalence (27.1%) is also significantly higher than the national average (22.2%). [200]
- In Nottinghamshire County, overweight (including obesity) prevalence (37.4%) is significantly higher than the England prevalence (36.2%) and obesity (including severe obesity) prevalence (23.1%) is similar to the England prevalence (22.2%) [202]
- Looking at prevalence across Nottinghamshire County Districts and Boroughs, Ashfield (42.6%), Mansfield (40.3%), and Bassetlaw (41%) have significantly higher overweight (including obesity) rates than England (36.2%); Newark & Sherwood (38.7%), Gedling (37.1%), and Broxtowe (34.4%) are not significantly different; Rushcliffe (27.7%) is significantly lower.[208]
- Obesity (including severe obesity) prevalence across Nottinghamshire follows the same pattern as overweight, highest in Ashfield, Mansfield, and Bassetlaw; similar to national levels in Newark & Sherwood, Gedling, and Broxtowe; and lowest in Rushcliffe.[209]

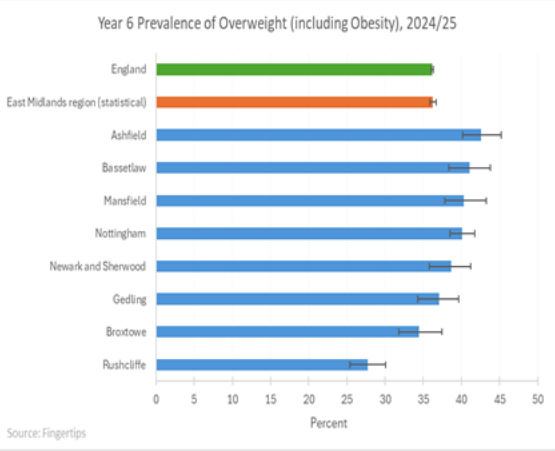
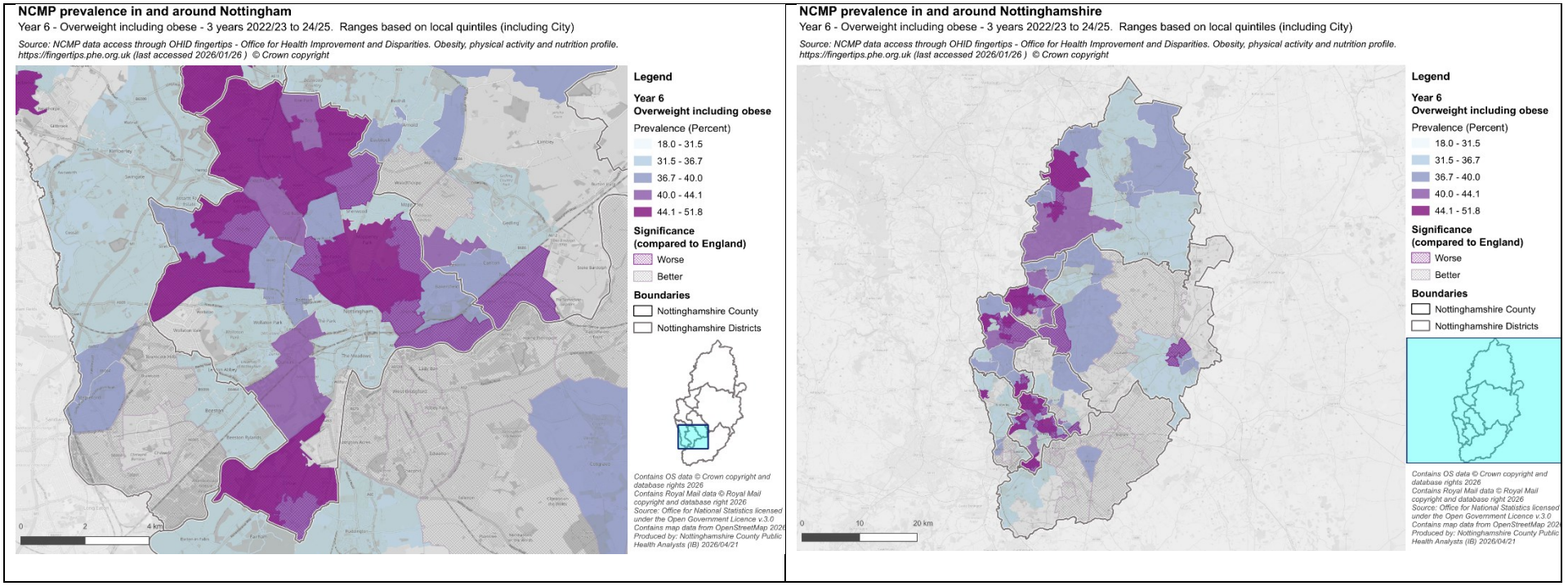



*Chart 2 Overweight (including obesity) prevalence (%) in Nottingham and Nottinghamshire District/Boroughs at year 6 compared to East Midland and England, 2024/25* [200] [202]

The maps show the prevalence of overweight (including obesity) among year 6 -aged children across Nottingham and Nottinghamshire. Prevalence is presented as a percentage and is based on the number of children measured who are overweight (including obese), averaged across three school years, and shown at small neighbourhood sized areas (middle super output area -MSOA) according to where children live. The map highlights clear geographic variation, with higher levels clustered in some local areas. Darker shading indicates higher prevalence.




*Map 3 and 4 Prevalence of overweight (including obesity) in Nottingham and Nottinghamshire in year 6 (2022/23-2024/25).* [205]

**Trends in prevalence of overweight (including Obesity)**

- The prevalence of overweight (including obesity) in children in reception and year 6 in Nottingham remains consistently higher than the England average as illustrated in the graphs below. [210] [211]
- The overall long-term trend however is fairly static for children in reception and in year 6. Local data collection was impacted by the COVID-19 pandemic restrictions in 2020/21.

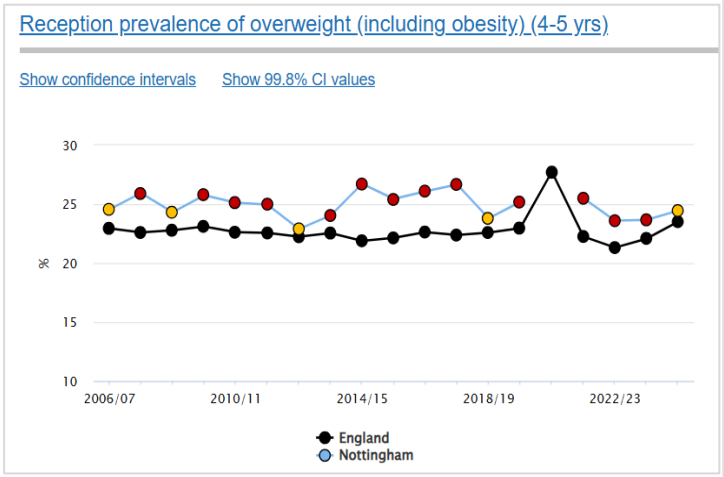






Chart 3 and 4 *Overweight (including obesity) prevalence (%) in Nottingham at reception and year 6 compared to England, 2006/07 to 2024/25.* [210] [211]

- In Nottinghamshire, the proportion of overweight (including obesity) in reception age children has remained largely stable over time and mirrors the recent national increase in prevalence. The proportion of overweight (including obesity) in year 6 age children also reflect national increases in recent years, having been consistently lower than national prevalence before 2020.
- Across Nottinghamshire, patterns vary. In Ashfield, in more recent years, the prevalence of overweight (including obesity) in children in both reception and year 6 has been on the increase. In Mansfield, Bassetlaw, Broxtowe and Newark and Sherwood, a spiked increase in prevalence in children in reception is observed but a similar pattern is not seen in children in year 6. In Rushcliffe, the prevalence of overweight (including obesity), remains consistently lower than the England average for children in reception and year 6, despite an increase in prevalence observed elsewhere in the County in children in reception in more recent years. In the charts below trends can be observed for the County, however trends at district/borough level can be viewed in the supplementary document here.

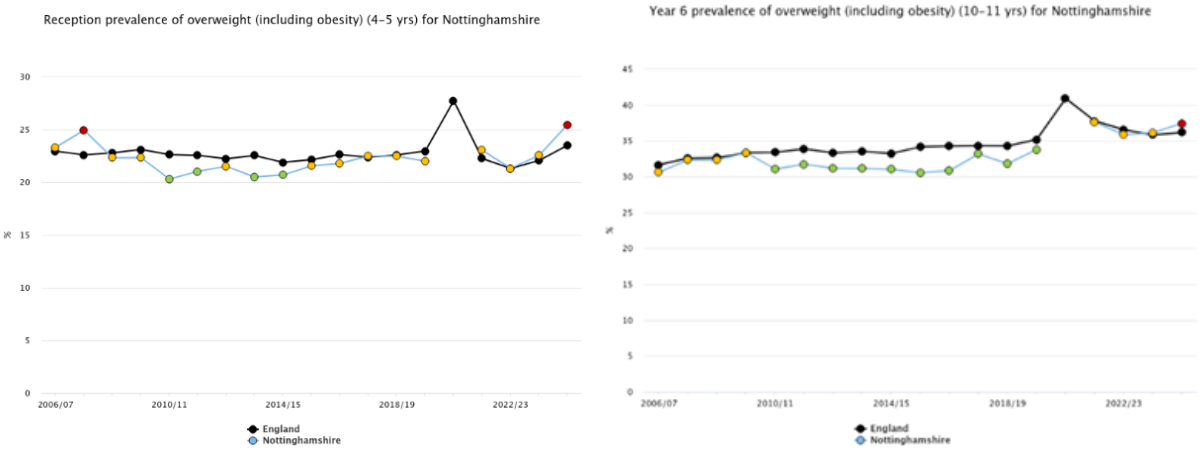



Chart 5 and 6 *Overweight (including obesity) prevalence (%) in Nottinghamshire at reception and year 6 compared to England, 2006/07 to 2024/25.* [212] [213]

**Trends in children moving from healthy weight in reception to overweight (including obesity) in year 6**

The following data shows how children's weight status changes during primary school, highlighting the proportion of children who begin reception (ages 4–5) at a healthy weight but become overweight (including obesity) by year 6 (ages 10–11). This is important because gaining excess weight during childhood increases the likelihood of obesity and related health problems later in life.[214]

- In Nottingham, 26% of children move from a healthy weight in reception to overweight (including obesity) by year 6, significantly higher than the national average (21.5%).[215]
- In Nottinghamshire 22% make this transition, similar to the national average (21.5%). [215]
- In Nottinghamshire, Ashfield (25.4%), Mansfield (24.4%), and Bassetlaw (23.8%) have the highest proportions, all above the national average, whilst Gedling (21.1%) and Newark & Sherwood (22%) are closer to national figures. Rushcliffe (17%) has the lowest rate in the county, significantly below the national average.[216]

**Prevalence of Overweight (including obesity) by Deprivation Decile**

There is a much stronger relationship between deprivation and childhood overweight (including obesity) in Nottingham City compared with the County. In the City, overweight (including obesity) prevalence is concentrated in the most deprived areas, showing a clear and steep gradient. In Nottinghamshire County, the pattern is still evident but less pronounced and more variable.

- In Nottingham City, the majority of children who are overweight (including obesity) live in the most deprived areas. Around 70% of reception and year 6 children living with overweight (including Obesity) live in the 20% most deprived neighbourhoods**,** while almost 1% live in the least deprived areas. [200]
- In Nottinghamshire County, the deprivation pattern is less steep**.** In year 6**,** overweight (including obesity) prevalence ranges from 48% in the most deprived areas to round 26% in the least deprived. In reception**,** the highest prevalence (32%) is in decile 3**,** and the lowest (19%) is in decile 10 (least deprived)**.** [202]

**Oral health: prevalence of tooth decay in 5 year olds**

Rates of tooth decay in young children provide an important indication of dietary patterns, as dental decay is strongly driven by frequent consumption of free sugars, which are the sugars added to foods and drinks and naturally present in juices, smoothies and syrups. When children consume these products often, bacteria in the mouth produce acids that damage tooth enamel, making tooth decay a largely preventable, diet-related condition. [217]

- Local data shows clear variation across Nottingham City and Nottinghamshire County.
- Bassetlaw (8.5%), Broxtowe (16.6%) and Rushcliffe (13.3%) show significantly lower levels of dental decay than the national average[218]

- Ashfield (21.5%), Gedling (17.7%), Mansfield (21.5%) and Newark & Sherwood (20.3%) [218] have similar levels to national average (22.4%)
- Nottingham City has a significantly higher proportion (28%).[219]

**Diet and Nutrition**

The National Diet and Nutrition Survey (NDNS) is the UK's nationally representative survey assessing what people eat and drink and their nutritional status and is used to inform public health policy and monitor progress against dietary guidelines. Data is not available at a local level, however nationally the 2019-2023 [220] survey has shown that:

- Most children and young people do not meet dietary recommendations.
- Fruit and vegetable intake is low, particularly among 11–18-year-olds, with fewer than one in ten meeting the 5 A Day recommendation.
- Intakes of free sugars and saturated fat exceed recommended levels for the majority, while fibre intake is very low across all child age groups.
- Nutritional concerns include low vitamin D status in around a quarter of adolescents and evidence of iodine insufficiency among girls aged 11–18 years, with implications for future health.

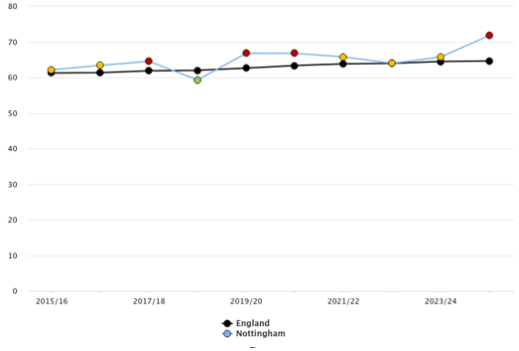
## 6. Extent of the issue – Adults

Based on self-reported height and weight, around two thirds of adults in Nottingham and Nottinghamshire are above a healthy weight and around one third of adults are living with obesity. There is variation across Nottinghamshire districts, with higher levels of overweight and obesity seen in Ashfield, Mansfield and Newark and Sherwood. A more detailed analysis and discussion can be found in a supplementary document available here. There are several gaps in local data which are noted as a limitation. This includes local data gaps or limitations on weight by ethnicity, underweight, and diet, nutrition and malnutrition.

Please note, where data is described as 'significantly' different this refers to a statistically significant difference rather than the size of the difference.

**Local prevalence**

- 71.8% of adults in Nottingham and 68.5% of adults in Nottinghamshire are above a healthy weight and this has been steadily increasing since 2015/16[221] (see charts 7 and 8 below)
- The proportion of adults with an unhealthy weight in Nottingham and Nottinghamshire is above the England average (64.6%). [221]
- 35.3% of adults in Nottingham and 28% of adults in Nottinghamshire are living with obesity. For Nottingham, this is significantly above the England rate (26.6%). [222]
- Prevalence of adult overweight and obesity varies across Nottinghamshire Districts. Ashfield (71.1%), Bassetlaw (71.8%) and Newark & Sherwood (72.5%) have the highest prevalence of overweight and obesity. [223]
- In Nottingham and Nottinghamshire, 35.3% of pregnant women are classified as obese or severely obese at booking. [224]



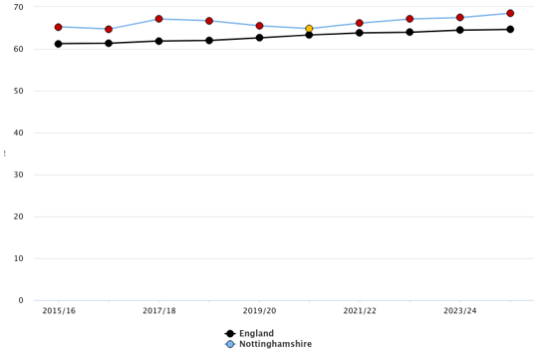




*Chart 7 and 8: Overweight (including obesity) prevalence (%) in Nottingham and Nottinghamshire compared to England, 2015/16 to 2024/25* [221]

**Deprivation and healthy weight**
Data shows a relationship between healthy weight and deprivation, with higher proportions of adults living with obesity and lower proportions of people with healthy weight in the most deprived areas in Nottingham and Nottinghamshire. The prevalence of adults who are overweight is more evenly distributed across deprivation indices, and in Nottinghamshire the prevalence of overweight is highest in the least deprived areas. Prevalence of underweight ranges between 4% and 8% and is significantly lower than the prevalence of healthy weight, overweight and obesity. Local data does not show a clear corelation between underweight and deprivation. Proportions of adults who are underweight are slightly higher in Nottingham compared to Nottinghamshire. [225]

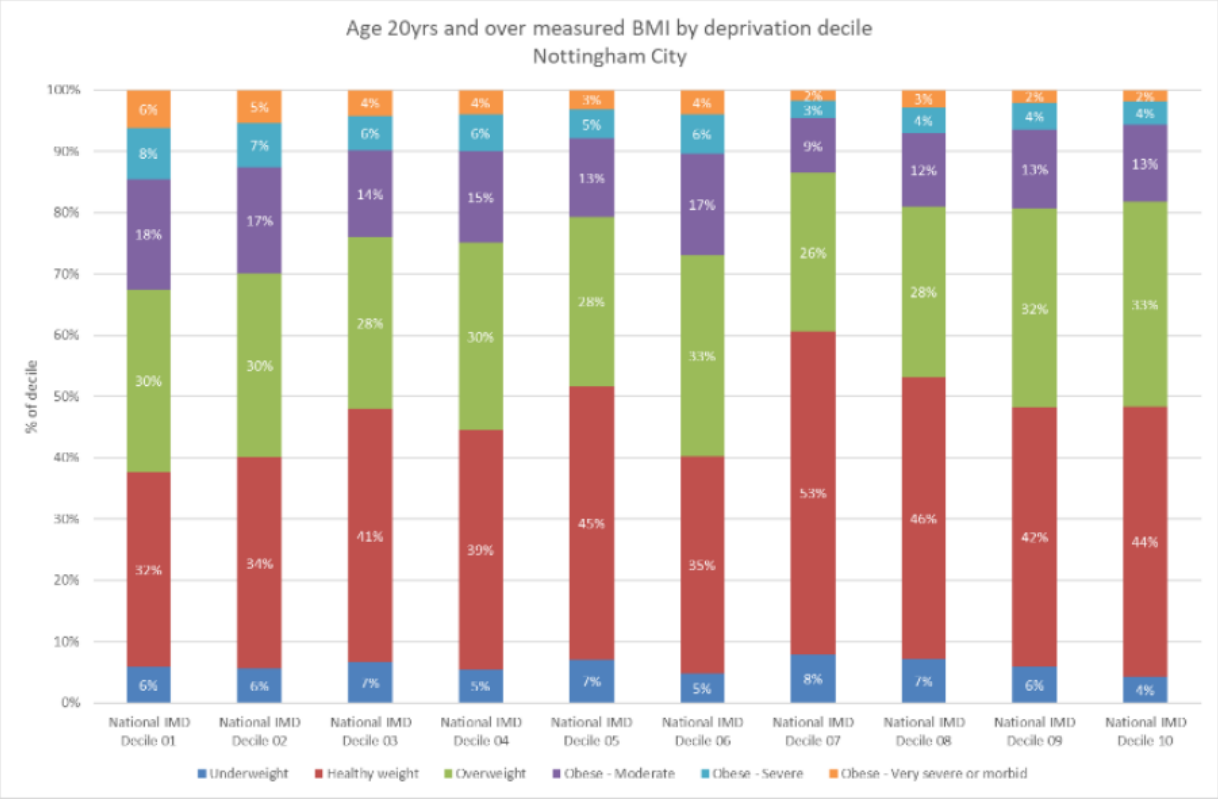



*Chart 9: Distribution of adult BMI by deprivation decile, Nottingham[225] (NB Decile 1= most deprived and decile 10= least)*

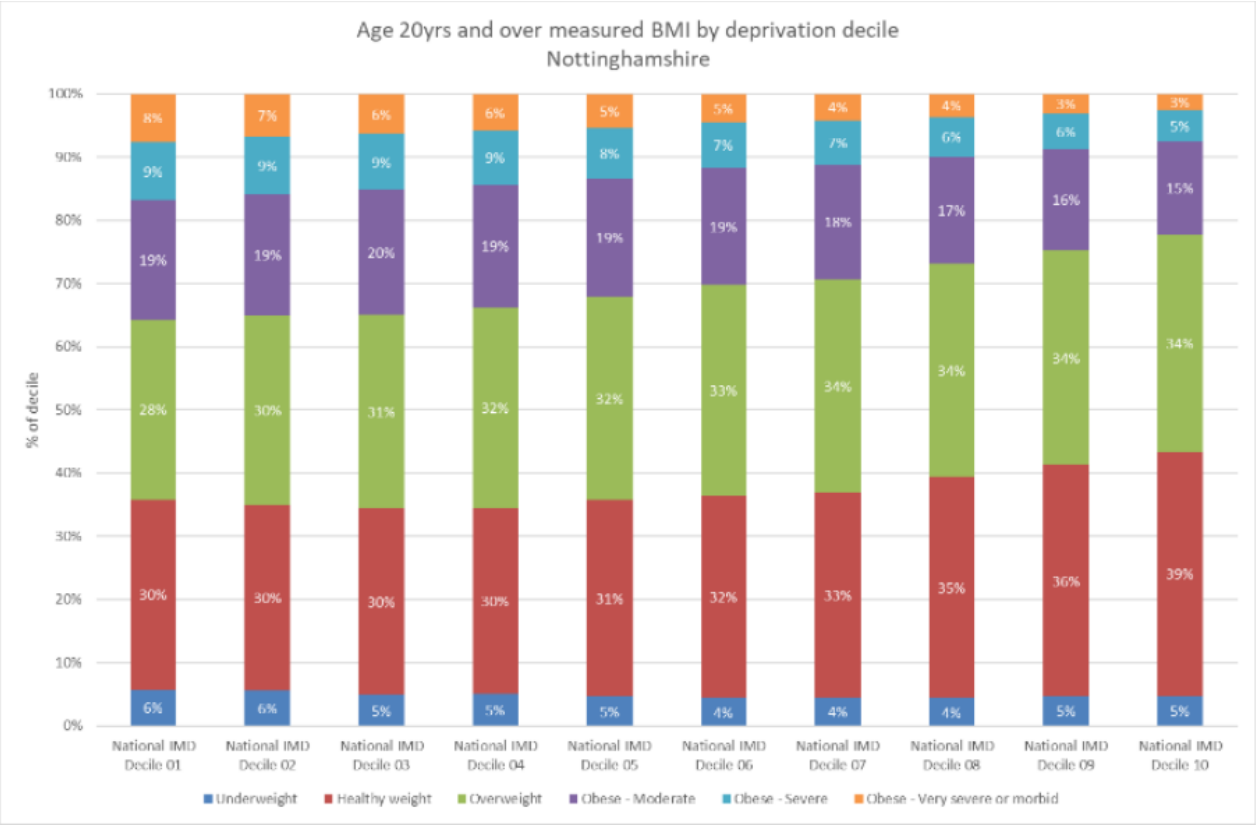



*Chart 10: Distribution of adult BMI by deprivation decile, Nottinghamshire*[225]
*(NB Decile 1= most deprived and decile 10= least)*

**Hospital admissions**

The rate of hospital admissions where obesity is a factor are higher in Nottingham and Nottinghamshire compared to England rates and have been increasing locally and in England since 2019/20. However, people in Nottingham and Nottinghamshire are less likely to have a hospital admission (planned or unplanned) that is directly attributable to obesity compared to England; a large proportion of these admissions involve a bariatric surgery procedure. This suggests the lower rates in Nottingham and Nottinghamshire may be reflective of access to bariatric surgery rather than need. Directly attributable admissions and bariatric surgery admissions have increased since a decline in 2020-21, likely due to the impacts of COVID-19, and the gap between local admissions and England admissions has reduced (2022/23). [226]

**Diet – fruit and vegetable consumption**

Around one-third of adults in Nottingham and Nottinghamshire meet the '5-a-day' fruit and vegetable consumption recommendations. [227]

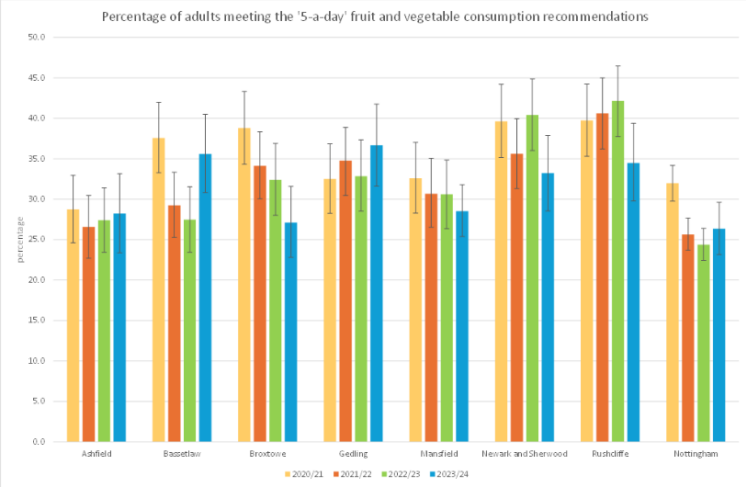



*Chart 11: Percentage of adults meeting the '5-a-day' fruit and vegetable consumption recommendation by Nottinghamshire District and Nottingham City, 2020/21 to 2023/24.* [228]

**Diet and Nutrition**

The National Diet and Nutrition Survey (NDNS) is the UK's nationally representative survey assessing what people eat and drink and their nutritional status and is used to inform public health policy and monitor progress against dietary guidelines. Data is not available at a local level, however nationally the 2019-2023 [220] survey has shown that:

- Adult diets fall short of dietary national guidance.

- Fewer than one in five adults meet the 5 A Day recommendation, while average intakes of free sugars and saturated fat remain above recommended limits and fibre intake is insufficient for most adults.
- Deficiencies in vitamin D affect a notable proportion of working-age adults, and low folate status among women of childbearing age remains a concern.
- Food and drink consumed outside the home contributes significantly to excess energy, sugar and saturated fat intake, highlighting the role of the wider food environment in shaping adult diets.

**Years lived with disability and high BMI**

- Years lived with disability is commonly used as a measure to indicate quality of life.
- Data shows that high BMI is the largest single (changeable or modifiable) contributor to years lived with disability in the East Midlands.
- High BMI is shown to contribute to several conditions, in particular diabetes and musculoskeletal conditions. High fasting plasma glucose (which in some cases can be linked to lifestyle factors such as weight, diet and physical activity) and dietary risks are also significant contributing factors to years lived with disability.
- When looking at dietary risks, high processed meat consumption, low whole grain consumption and high red meat consumption are the biggest dietary risk contributors to years lived with disability. [229]

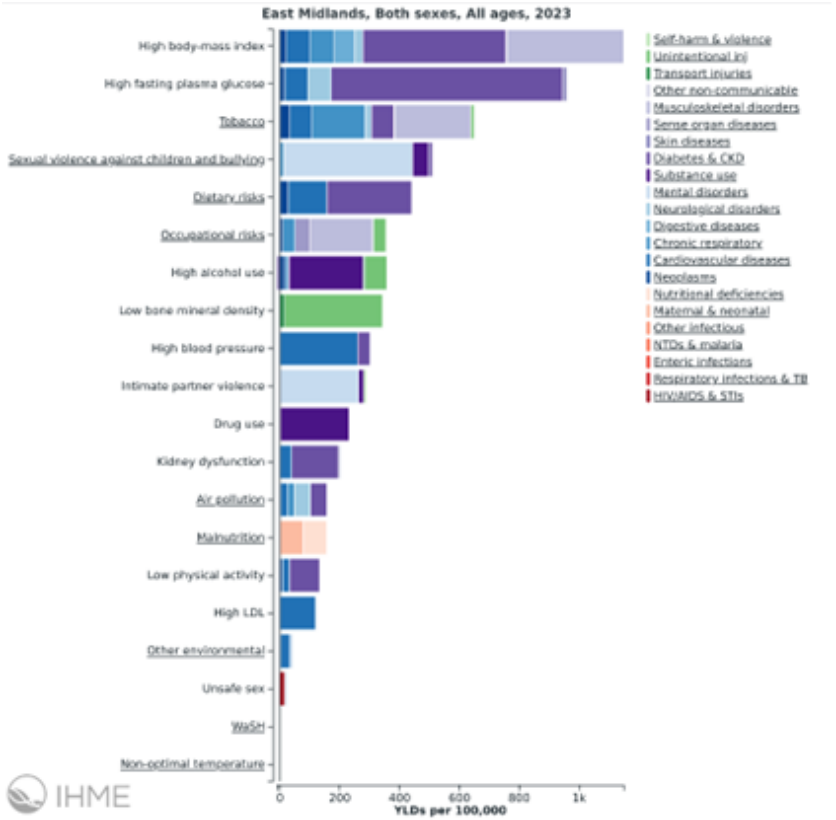
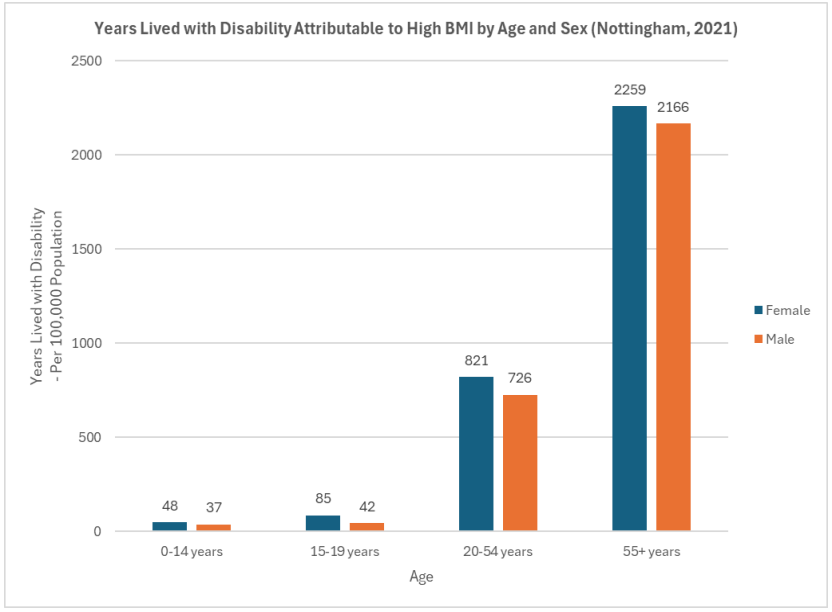



*Chart 12: Years lived with disability attributable to risk factors, East Midlands, 2023*[229]

## Years Lived with Disability – Nottingham and Nottinghamshire

The following 4 charts present years lived with disability attributable to high BMI and dietary risk factors, broken down by age and sex across Nottingham and Nottinghamshire (2021). High BMI and dietary risks contribute significantly to years lived with disability in Nottingham and Nottinghamshire, with the burden increasing with age. High BMI accounts for the greater share of years lived with disability, particularly among older adults. Females experience higher years lived with disability attributable to high BMI, while males experience higher years lived with disability attributable to dietary risks. Nottinghamshire shows consistently higher BMI-related disability, while diet-related disability is similar across both areas in later life.



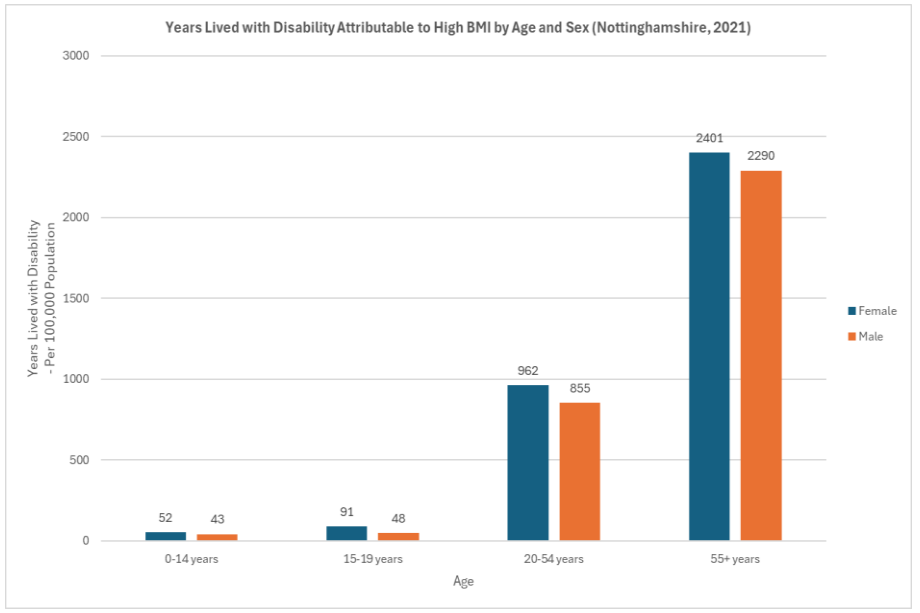
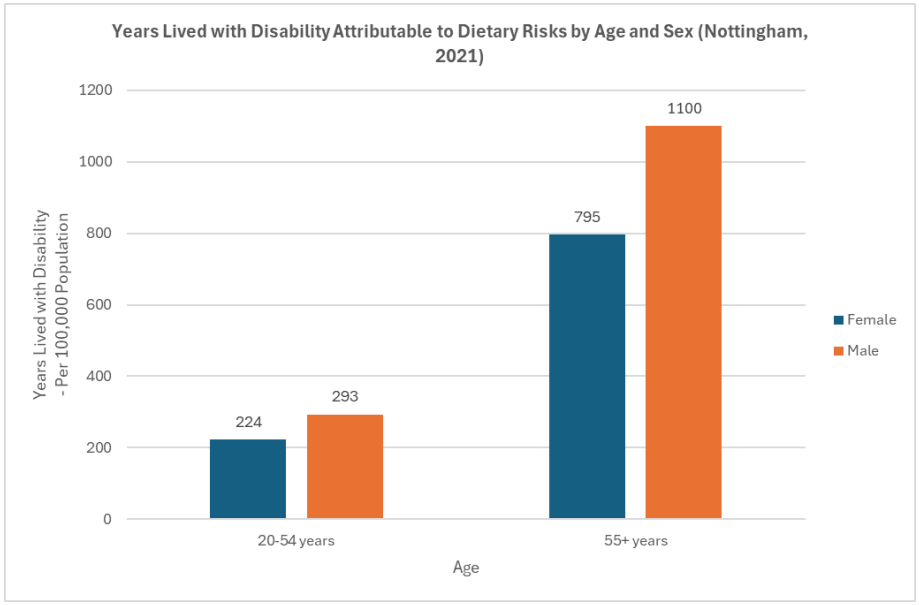




*Chart 13 and 14 Years Lived with Disability Attributed to High BMI by ages and Sex in Nottingham and Nottinghamshire (2021)* [229]



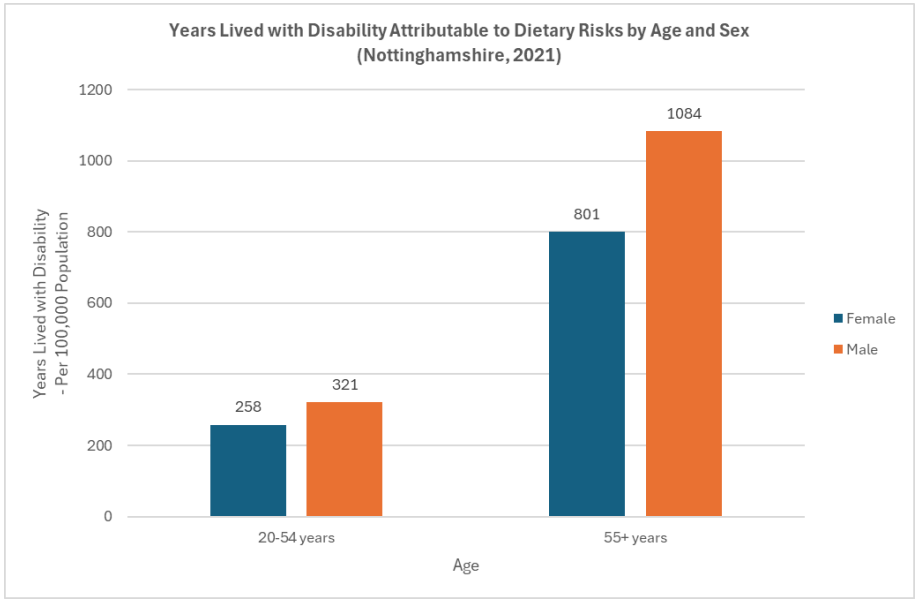




*Chart 15 and 16 Years Lived with Disability Attributable to Dietary Risks by Age and Sex in Nottingham and Nottinghamshire (2021)* [229]

## 7. Effective Interventions – Evidence of what works

Improving healthy weight and nutrition at a population level requires a co-ordinated, system-wide approach rather than isolated interventions. Evidence from NICE NG246: Overweight and obesity management, [78] NICE Guideline NG247: Maternal and child nutrition, [230] and wider research shows that the most effective interventions can be understood through three core themes that work together to create long-term, sustainable impact.

1. **Creating Supportive Environments** (Whole-system approaches, prevention and nutritional promotion)

Healthy behaviours are driven more by people's environments than by individual choice, for example eating a healthy diet is influenced by someone's local food environment and their access to and availability of affordable healthy food. Improving healthy eating and physical activity therefore requires systems, policies and partnerships that make healthy options the easiest ones. This includes clear prevention messaging, supportive local environments, trained staff and coordinated whole-system action. NICE NG246 and NG247 emphasises non-judgemental, person-centred support and attention to wider determinants of health. Overall, improving healthy weight and nutrition needs joined-up action across policy, environment, education and behaviour change. Key components of effective interventions include:

- Consistent, inclusive prevention messages across healthcare, schools, workplaces and communities. [78] [230] [70] [16]
- Healthy local environments, improving access to nutritious food and physical activity through planning, local policy and active-travel infrastructure.[78]
- A trained workforce able to hold sensitive, stigma-free conversations and support behaviour change. [78]
- Partnerships action to remove environmental barriers, strengthen primary care pathways and develop a shared local vision.[78]
- Life-course interventions, such as proactive support in the conception phase [230] peer education in schools, [231] free nutritious meals for younger children, [232] early-years behaviour-focused approaches. [233]
- Utilising policy levers (e.g., restricting HFSS advertising, regulating sugary drinks) that influence consumption and reformulation. [234] [235]
- Improved promotion of good nutrition through clear messaging,[78] healthier food environments, [236] education and skills support (including cooking skills), [237] [238] [239] behaviour-change tools, [16] [237] [238] [239] [240] and culturally relevant targeted interventions for higher-risk groups. [236] [240]

**What local people told us:** A 2025 survey responded to by Nottinghamshire residents receiving support from their local service, Your Health Notts, has told us that they most commonly accessed health, wellbeing, and local community information through websites, healthcare professionals, and social media. However, just over a quarter were unaware of available local resources, highlighting a need for stronger outreach. Email and written articles were the preferred communication formats, with videos and online courses also of interest.

**Reflections on what is happening in Nottingham and Nottinghamshire**

**Strengths:**

- Good progress in developing healthy and sustainable places, including embedding health considerations within planning processes.
- Promotion of good nutrition in schools through educational teams and integrated wellbeing services.
- Local policy/strategies reflect desire for healthy local environments through e.g. improving access to healthy affordable food and active travel

**Opportunities:**

- Enhance wider workforce training (e.g. MECC and Healthy Conversations) by incorporating compassionate, person-centred approaches, with potential to scale this consistently across the system.
- Use system levers, such as advertising controls and influence, to create environments that better support healthy weight and good nutrition.

**Challenges:**

- Lack of consistent, system-wide universal health promotion messaging focused on healthy weight and good nutrition.
- Need to strengthen Nottinghamshire wide partnership action beyond the existing food systems work (e.g., Sustainable Food Network activity in Nottinghamshire)
- Commercial Sector Engagement, proactively working in partnerships with local food businesses

**2. Identification & Personalised Support** (Assessment, referral, weight management & behaviour change)

Once overweight or obesity are identified, individual support should be offered through provision of a systemwide healthy weight pathway that recognises overweight and obesity as a chronic relapsing condition. This includes sensitive assessment, permission-based conversations, careful use of BMI and waist-to-height ratio, and tailored interventions. Support should be accessible to all ages and needs, culturally relevant and provide choice across interventions including dietary, moving well, physical activity, psychological, medical, surgical and digital tools.[78] In Nottingham and Nottinghamshire, there is a wide range of community assets, services, and support available to help residents improve their diet, maintain a healthy weight, increase physical activity, and access nutritious affordable food. These include local Integrated Wellbeing Services, Thriving Nottingham, and Your Health Notts, which provide tailored support to individuals seeking to achieve and sustain a healthy weight. For further details on local interventions, services, and support, please refer to the asset mapping supplementary document available via this link. Key components of effective interventions that should be included in service design, include:

**Identification and assessment** [78]

- Ask for explicit permission before discussing weight or taking measurements.
- Use BMI and waist-to-height ratio cautiously, considering co-morbidities and wider context.
- Explore personal goals and ensure people understand available support.
- Pregnant people should have their BMI measured at the first antenatal appointment to support early identification of risks associated with overweight and obesity in pregnancy. Sensitive, non-judgemental discussion when assessing weight-related risks are emphasised. [230]

**Support and management** [78]

- Offer a full range of interventions: behavioural approaches, dietary options, medicines and surgery. (More details can be found in the asset mapping document here)
- Provide physical activity and diet advice, emphasising benefits beyond weight loss.
- Tailor dietary guidance to cultural, personal and family context; support balanced, lower-energy diets where weight loss is desired.
- Support long-term behaviour change through self-monitoring, goal setting, self-management and relapse-prevention.
- For children and young people, ensure multidisciplinary input and consider additional needs.
- For pregnant people, support should not be focused on intentional weight loss during pregnancy**,** instead focusing on healthy eating and appropriate physical activity, tailored lifestyle advice and support that promotes healthy behaviours without stigma. [230]

**Digital health interventions (DHI's)**

- Digital tools (apps, wearables, online platforms) can support short-term behaviour change, especially when offering personalised feedback and self-monitoring. [241] [242] [243] [244]
- Digital programmes can aid short-term weight loss but may have higher relapse rates than in-person support; [244]
- Blended digital and face-to-face models improve effectiveness [245]
- Gamification can enhance engagement for children and young people [246]
- Programmes must consider digital access, literacy, cultural needs and data privacy [246] [247] [248] [249] [250]

**Weight loss medication**

Weight loss medicines are prescription medicines that are proven to support weight loss. GLP-1s (such as semaglutide, liraglutide and tirzepatide) are a type of medicine that can help some people to manage appetite and blood sugar levels helping them to lose weight. Orlistat is a different type of medication that can help people to lose weight by blocking absorption of some dietary fats. Medicines alone will not solve the issue of obesity. NHS licencing and NICE guidelines set out that weight loss medicines can only be prescribed alongside 'wrap-around' care to support and advise on nutrition, a reduced-calorie diet, physical activity and behaviour change. People who are stopping weight management medicines should be offered long-term support to help maintain weight loss. [251]

- GLP-1 weight loss medicines have been available through the NHS since 2025, but only for people who meet nationally defined eligibility criteria and very highest level of need.
- Demand far exceeds NHS availability. 24% of a national survey respondents would use these medicines if offered by the NHS, 40% among those self-reporting living with obesity. [252] However, tirzepatide rollout will reach only 6% of the population who would meet NICE recommendations for eligibility due to NHS commissioning guidance determining who can access during a phased rollout period. [253]
- People responding to Healthwatch have reported difficulties in accessing weight loss medicines through the NHS with availability and waiting lists for assessment for the most appropriate intervention, varying by geographical area. Some people unable to access NHS prescriptions reported accessing weight loss drugs privately. [254]

- Private prescription use is widespread, with an estimated 2.4 million people in the UK accessing GLP-1 medicines for weight loss, with NHS prescriptions estimated to account for less than 10% of the total.[253]
- Women, particularly those aged 30–49, use GLP-1s at far higher rates. This is the highest use seen among adults aged 30–59
- People in the most deprived areas are far less likely to access private prescriptions, despite higher obesity rates; when adjusted for obesity rates, prescribing rates are 120% higher in the least deprived decile. [253]
- High levels of private prescribing and limited NHS access risk widening existing inequalities, as people in less-deprived areas access treatment at lower BMIs than those in more-deprived communities. [253]

**What local people told us:**
A 2025 survey with Nottinghamshire residents who are clients of the local service, Your Health Notts, suggest that digital support and services are generally accepted and often useful, for the people who responded to this online survey, respondents still placed high value on human interaction and tended to prefer blended or face-to-face approaches. Coaching and community-based support options were viewed positively, especially when they offered accountability, encouragement, and opportunities for connection. *It should be noted that the survey was conducted online and this is unlikely to represent people who are less confident using digital solutions or who are digitally excluded.*

**Feedback from respondents included:**

*'I think digital support is great but works best as an additional tool to in person support'*
*'I prefer a blended service face to face and digital'*
*'I prefer having a date in the diary for me to attend. It gives me focus throughout the week and I therefore feel more accountable'*
*'Personal check in for accountability rather than anonymity that would allow for more ducking out!'*
*'I found I ran out of steam being supported from a distance - no real sense of someone supporting me personally and easy to ignore digital contact - in the nicest possible way'*

**Reflections on what is happening in Nottingham and Nottinghamshire**
**Strengths:**
- There are a wide range of community assets, services, and support available to help residents improve their diet, maintain a healthy weight, increase physical activity, and access nutritious affordable food.
- Within local integrated wellbeing/lifestyle services physical activity is embedded throughout to support holistic healthy weight approaches.
- Commissioned Tier 2 and beyond support is tailored to reflect local community contexts, ensuring culturally appropriate and accessible interventions, using behaviour change tools.
- For children and young people, the Single Point of Access (SPOA) model provides a coordinated, multidisciplinary approach, more information can be found on this in the asset mapping available here.
- Healthy weight in pregnancy interventions emphasise good nutrition and safe physical activity, supporting both maternal and infant wellbeing.
- Local Integrated Wellbeing Service's include digital tools that facilitate behaviour change, self-monitoring, and engagement. Digital

approaches are delivered alongside face-to-face support, enhancing reach and flexibility.
- Gamification features in the delivery of the local children and young people offer, increasing engagement and motivation for behaviour change.
- Promotion of good nutrition in schools through education teams and integrated wellbeing/lifestyle services

**Opportunities:**
- Establish a comprehensive approach to weight management as a disease/chronic condition that provides individuals with a choice in interventions.
- Develop clear local communications to set realistic expectations about eligibility of weight loss medicines, how medicines work, risks, and why lifestyle wraparound advice is essential. In addition to promote evidence-based messages and avoid misinformation.
- Extend the SPOA offer across all ages.
- Strengthen links with existing digital inclusion projects to widen equitable access to digital support.
- Undertake further work to understand any waiting list for tier 4/surgery including eligibility.

**Challenges:**
- Access to the GLP1's via NHS aligned, to NHSE commissioning guidance, is currently limited, with a lack of a long-term maintenance pathway for those transitioning off GLP1's locally. A long-term maintenance pathway is needed to ensure that people are supported to maintain weight after completion of GLP1's, this is important to stop weight regain, patient demotivation and re-entry into weight management pathways.
- NHSE funding for CEW (Complications from Excess Weight) clinics (Tier 3 for children) is currently to the end of March 2027. If funding for this is unavailable locally, this would cause a significant gap that could mean a lot of extra demand lower down the child healthy weight pathway.

### 3. **Monitoring, Evaluation & Evidence** (Outcomes)

Effective services rely on measuring what truly matters. This moves beyond weight alone to include wider outcomes such as diet, nutrition, physical activity, mental wellbeing, quality of life and personalised goals. A broad and holistic approach is needed to understand impact of interventions. [78]

**Monitoring and outcomes:** [78]
- Focus on outcomes beyond weight, using a broad set of validated tools and measures.
- Include outcomes such as dietary intake, physical activity, sedentary behaviour, obesity-related diseases and other physical health indicators.
- Capture wider impacts including mental health, wellbeing, self-esteem, quality of life, and progress toward personalised goals.

**Reflections on what is happening in Nottingham and Nottinghamshire:**

**Strength:**

- Commissioners collect and monitor service data using validated tools, incorporating wellbeing measures and personalised goal-setting approaches.

**Opportunity:**

- Explore weight neutral outcome measures, such as medical indicators (e.g., blood pressure, glycaemic markers) and social/functional outcomes (e.g., personalised goals), to complement or move beyond weight-based metrics.

## 8. Assets, services and interventions

An asset-mapping exercise carried out in January–February 2026 gathered up-to-date information on the services, interventions and community activities that support healthy weight and nutrition across Nottingham and Nottinghamshire. The findings are grouped into three sections: Community initiatives, Local Authority-led or commissioned services, projects and partnerships, and NHS-provided or commissioned clinical and specialist weight-management services, including national programmes. Along with this, is it recognised the role of policy/frameworks and strategies in supporting healthy weight and good nutrition, and some examples are given below. The diagram below offers a visual representation of the information gathered along with some examples of local services/activities. To view all the information gathered please follow this link.

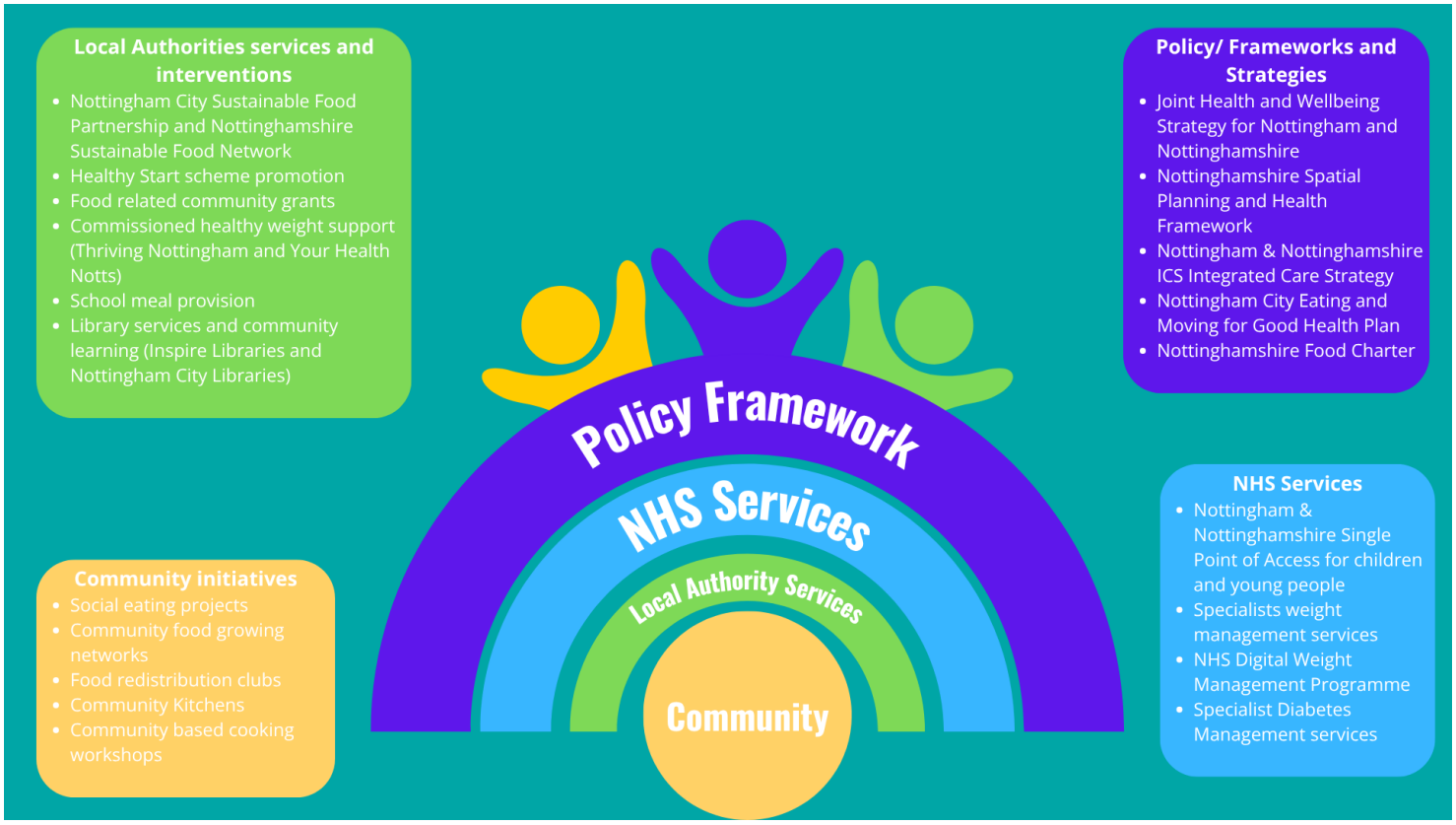



*Figure 1 Diagram to represent the levels of policy, NHS services, Local Authority Services and community interventions*

## 9. Key findings

Healthy weight and good nutrition are fundamental to health and wellbeing and are shaped primarily by wider social, economic, and environmental factors rather than individual choice. They play a crucial role in supporting physical and mental wellbeing, enabling healthy growth and development in childhood, and promoting healthy ageing across the life course.

Nottingham and Nottinghamshire have a wide range of community assets, local authority and NHS commissioned services, partnerships and policy frameworks that support healthy weight and nutrition across the life course.

The following section outlines the key findings of the JSNA profile pack, highlighting patterns and inequalities in healthy weight and nutrition across Nottingham and Nottinghamshire and identifying opportunities for co-ordinated whole-system action. These findings have informed the recommendations found in the subsequent section.

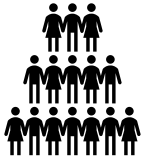
| Section | Key findings |
|---|---|
| Determinants influencing healthy weight and good nutrition | • Deprived areas have poorer access to affordable healthy food and greater exposure to unhealthy options<br>• Healthier foods cost significantly more than less healthy options with cost-of-living pressures contributing to food insecurity<br>• Marketing and digital influences increase exposure to unhealthy food, especially for children and more deprived groups<br>• Family, cultural, social and educational influences, alongside food literacy play an important role in shaping lifelong eating behaviours |
| The role of physical activity in healthy weight | • Physical activity supports healthy weight maintenance and overall health<br>• Physical inactivity and unhealthy weight are concentrated among people experiencing social, economic and structural disadvantages |
| Not all things are equal | • Healthy weight and nutrition inequalities exist and are not experienced equally across the population<br>• People most likely to experience unhealthy weight and poor nutrition are those living in the most deprived communities, where socioeconomic disadvantage drives poorer diet quality, higher |

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| | food insecurity, and increased risk of overweight, obesity, and underweight. Additional groups at higher risk include certain ethnic minority populations, people with disabilities or long-term conditions, and those exposed to adverse early life and environmental factors.<br>• Higher deprivation is linked to higher obesity and poorer diet, especially among children. In Nottingham City, 70% of reception aged and year 6 children living with overweight (including obesity) live in the 20% most deprived neighbourhoods**,** while almost 1% live in the least deprived areas<br>• Low income, food insecurity, and environment drive poorer diet and higher reliance on unhealthy foods. |
| Extent of the issue – children and young people | • In Reception-aged children, the prevalence of healthy weight is lower than the national average across both Nottingham and Nottinghamshire, indicating a higher proportion of children who are underweight, overweight, or living with obesity. By Year 6, healthy weight prevalence in Nottingham remains below the national average, whereas in Nottinghamshire it is comparable to the national figure<br>• Overall, the prevalence of overweight (including obesity) among children in Nottingham and Nottinghamshire is higher than national average. Nottingham also has a higher prevalence of obesity among children. Differences in prevalence are seen in the City, County and across Nottinghamshire districts and boroughs<br>• National evidence suggests that many children do not meet dietary recommendations, with low fruit and vegetable intake, high sugar and saturated fat consumption, low fibre intake and some nutrient deficiencies<br>• Oral health can reflect poor diet, and higher dental decay is seen in children in Nottingham compared to England rates |
| Extent of the issue - adults | • Around 7 in 10 adults in Nottingham and Nottinghamshire are above a healthy weight, with around 3 in 10 living with obesity<br>• There is variation the prevalence of overweight and obesity across Nottingham and Nottinghamshire districts, with higher levels of overweight and obesity seen in Ashfield, Mansfield and Newark and Sherwood<br>• Only around one-third of adults in Nottingham and Nottinghamshire meet the recommended ‘5-a-day’ |

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| | • In Nottingham and Nottinghamshire high BMI is a major contributor to ill health and disability, particularly through conditions such as diabetes, cardiovascular disease and musculoskeletal conditions |
| Effective interventions | • Improving healthy weight and nutrition requires a whole-system approach that combines prevention, supportive environments, personalised support and ongoing monitoring and evaluation<br>• There are opportunities to strengthen prevention and early intervention, partnership working, consistent health messaging, and equitable access to support<br>• Local challenges include persistent health inequalities, increasing demand for specialist support and wider environmental factors that make healthy choices more difficult for communities |

## 10. Recommendations

These recommendations set out clear priorities for action based on the evidence and insights from the JSNA, reflecting the most significant current and future needs of our population.

| Theme | No. | Recommendation | Lead(s) |
|---|---|---|---|
| **Systemwide prevention, messaging and partnership action**  | **1** | Establish a consistent, system-wide universal approach to healthy weight and good nutrition messaging, grounded in compassionate, non-stigmatising, weight-neutral and culturally appropriate principles, and aligned to the building blocks of health across the life course. | Public Health City and County |
| | **2** | Strengthen system-wide messaging during pre-conception and pregnancy by promoting consistent, compassionate and weight-neutral support for healthy weight and good nutrition, recognising the importance of the building blocks of health | Nottingham and Nottinghamshire Preconception Health Group<br>Nottingham and Nottinghamshire Healthy Weight in Pregnancy Group |
| | **3** | Identify and consider opportunities to use a whole system approach and work in partnership to co-ordinate action on healthy weight and good nutrition, building on Nottinghamshire's Sustainable Food Network, Nottingham City Sustainable Food Network and Nottingham City's Eating & Moving for Good Health Group | Public Health City and County |
| | **4** | Strengthen a consistent, whole-system approach to healthy weight and good nutrition, including opportunities for movement, for children and young people across early years, schools and wider settings, recognising the critical role these environments play in shaping lifelong healthy behaviours. | Public Health City and County |
| | **5** | Consistent systemwide messaging that promotes the safe and effective use of GLP1's, including advice on nutrition, activity, maintenance and unregulated products. | Nottinghamshire ICB and Public Health City and County<br>Nottingham |

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| | **6** | Use available opportunities to advocate for approaches to provision of GLP1's that do not increase existing health inequalities. | Public Health City and County<br>Nottingham and Nottinghamshire ICB |
| **Supporting the workforce**  | **7** | Strengthen Making Every Contact Count (MECC) and wider workforce training to include sensitive and compassionate conversations about weight, food literacy, food security and understanding the building blocks of health, enabling systemwide delivery of consistent advice on nutrition, healthy weight and active living across the life course, supporting residents into services. | All Nottingham and Nottinghamshire Local Authority organisations<br>East Midlands Combined County Authority<br>Nottingham and Nottinghamshire ICB<br>Voluntary, Community and Social Enterprise (VCSE) sector<br>Nottinghamshire Fire and Rescue Service<br>Office of the Police and Crime Commissioner |
| | **8** | Encourage local key anchor institutions to commit to considering how their policies, practices and workplace environments support healthy weight and good nutrition for staff, recognising their role as major employers and influential organisations within their communities and local system. | As above |
| **Healthy Weight Pathway** | **9** | Strengthen the healthy weight pathway for all ages to ensure seamless transitions between universal, targeted and specialist services, while also assessing the long-term sustainability of provision, to support consistent, high-quality outcomes across Nottingham and Nottinghamshire. | Public Health City and County<br>Nottingham and Nottinghamshire ICB |
| | **10** | Review which groups are and are not accessing services to ensure equitable access. | Public Health City and County<br>Nottingham and Nottinghamshire ICB |

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|  | **11** | Review the use of BMI in assessing need and eligibility for healthy weight and related services, considering the role of alternative or complementary measures where appropriate, and ensuring assessment approaches align with pathway design, access and inclusive practice. | Public Health City and County, Nottinghamshire ICB and Service Providers |
| | **12** | Implement a local approach to weight-neutral outcome monitoring, using measures beyond weight (e.g. wellbeing, diet quality, physical activity, metabolic markers). | Public Health City and County, Nottinghamshire ICB and Service Providers |
| **Food Environment and Commercial Determinants**  | **13** | Improve the Out of Home food environment by addressing policy gaps and using a whole system approach to reduce HFSS exposure, limit fast food density in deprived areas, and make healthy eating an easier choice across the life course. | Public Health City and County<br>Planning Policy teams<br>Planning Teams in District & Boroughs<br>Environmental Health Teams |
| | **14** | Tackle food insecurity and inequalities by improving affordability and access to good food through intelligence led action, improved uptake of support schemes, and compassionate, culturally relevant communication that recognises structural barriers and reflects lived experience | Nottinghamshire's Sustainable Food Network<br>Nottingham City Sustainable Food |
| | **15** | Strengthen approaches to commercial engagement, supporting healthier local environments, and enabling collaboration with businesses and industry partners to promote equitable access to nutritious, affordable food. | Public Health City and County<br>Economic Development<br>Trading Standards<br>Environmental Health Teams |
| | **16** | Encourage local anchor institutions to consider the food and drink offer at events they deliver or host, supporting access to affordable, healthy food and healthier local food environments. In addition, discouraging advertising/sponsorship with companies who profit from HFSS sales. | All Nottingham and Nottinghamshire Local Authority organisations<br>East Midlands Combined County Authority<br>Nottingham and Nottinghamshire ICB<br>Voluntary, Community and Social Enterprise (VCSE) sector<br>Nottinghamshire Fire and Rescue Service |

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|---|---|---|---|
| | | | Office of the Police and Crime Commissioner |
| **Physical Activity and Healthy Weight**  | **17** | Ensure physical activity is embedded in healthy weight pathway interventions and health promotion messaging, particularly the role of physical activity in healthy weight maintenance. The future Moving More JSNA will make further recommendations relating to physical activity. | Public Health City and County<br>Nottingham and Nottinghamshire ICB |
| **Data and Using Local Insight**  | **18** | Strengthen shared intelligence on healthy weight and nutrition to enable evidence-led, place-based action including local data collection to increase understanding on inequalities at a local level and on diet and nutrition within local services. | Public Health City and County<br>And Nottingham and Nottinghamshire ICB |
| **Cross-cutting JSNA Themes**  | **19** | Ensure that action on healthy weight and good nutrition is co-ordinated with, informed by, builds on and does not duplicate, relevant recommendations from other JSNAs, relating to other themes such as Food Security, Work and Health, 1001 Days and Moving More, which address key drivers and enablers of healthy weight outcomes. | Public Health City and County |

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