# Community Wellness Outreach Project Evaluation

## Report by Healthwatch Reading, 2025

healthwatch Reading

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# About Healthwatch

Healthwatch Reading is the health and social care champion for people who live and work across Reading.

As an independent statutory body, we have the power to make sure local NHS leaders and other decision makers listen to people's feedback to improve standards of care

We use feedback to better understand the challenges facing the NHS and other care providers locally, to make sure people's experiences improve health and care services for everyone. We are here to listen to the issues that really matter to our local communities and to hear about people's experiences of using health and social care services. We also offer information and advice.

We are entirely independent and impartial, and any information shared with us is confidential.

# About Reading Community Wellness Outreach Project

## Background

The Community Wellness Outreach (CWO) project in Reading is a pilot designed to reduce health inequalities in vulnerable communities by bringing free NHS Health Checks and wellbeing support directly into local community spaces. The pilot focused on reaching people living in deprived areas and certain community groups, who are deemed to be most at risk of serious health issues, especially cardiovascular disease (CVD).

Research from 2022/23 found that only 6% of eligible people in England (aged 40–74) had an NHS health check, despite not having one in the past five years.*

Feedback from local Reading communities is also showing that many people are not visiting their General Practitioner (GP) when they have health concerns.

This pilot project was funded by Buckinghamshire Oxfordshire Berkshire West Integrated Care Board (BOB ICB) and was delivered to communities across Reading in partnership with Royal Berkshire NHS Healthcare Foundation Trust (RBHFT), Meet PEET Team (Patient Experience Engagement Team), made up of specialist nurses, Reading Borough Council, Reading Voluntary Action (RVA), local GP surgeries and the Primary Care Alliance.

## Purpose

Healthwatch Reading was commissioned to evaluate the impact and effectiveness of the CWO project in respect of people receiving a check with the CWO team and being referred to their GP for follow-up.

## Scope

Assess experiences and outcomes for participants in Reading using the wellness pathway.

*Community Wellness Outreach Programme: Reading Borough Council | Local Government Association

# What we evaluated: Objectives

| | |
|---|---|
| **1. GP services: registration and consultation** | **1.1** Assess whether the individual has consulted their GP or healthcare professional.<br><br>**1.2** Assess what the outcomes of those consultations were. |
| **2. CWO project support** | Whether the support provided through the CWO project, listed below, positively influenced their ability to access appropriate care and resulted in improved outcomes.<br><br>**2.1** Increase the awareness of the impact of cardiovascular disease and opportunities to prevent or effectively manage conditions and reduce cardiovascular disease health inequalities.<br><br>**2.2** Reduce inequalities concerning accessing Health Checks and wellbeing advice and support.<br><br>**2.3** To provide other support about issues impacting on wellbeing. |
| **3. Checks in community settings** | Enable people to feel more comfortable in accessing the checks in community settings and increasing opportunities to address health and wellbeing concerns. |

# How we did it, 1/2

## Participants’ information received

We received a data set comprising of **164** participants who undertook health checks in various community settings between the period of September and October 2024. The data set was provided by RVA to enable evaluation activities on behalf of the CWO project. Out of the 164 participants:

- **162** had telephone numbers though a tiny proportion were invalid.
- **149** had valid email addresses.
- **19** were identified as needing interpreters during their health check.

## Participants contacted

Telephone calls were made over a 3-day period to introduce Healthwatch, our role in the project and asked if they could share their experience with us.

Majority opted for an online survey as the dates, times and locations we offered were not convenient for them.

We prepared and sent three bulk email invitations to **149** participants over a five-week period. These emails invited participants to register their interest in taking part in the evaluation, included reminders, and provided links to the online survey. We also sent follow-up messages to thank participants for their involvement.

In addition to email communication, we telephoned all **149** participants. During this process, we found that **19** participants required interpreters to take part in the evaluation, and 15 participants did not have an email address. Of the **19** participants who needed interpreters, **8** – all from the same background took part in the evaluation with interpreter support.

## Survey designed

A survey was designed in collaboration with Public Health at Reading Borough Council and Healthwatch Reading to be used online as well as in face-to-face interviews.

# How we did it, 2/2

## Data gathered

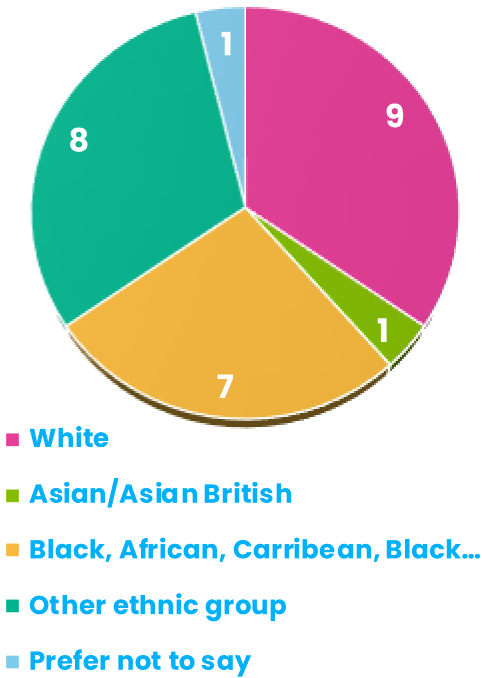
Data was gathered using a combination of an online survey, face-to-face interviews and postal surveys.

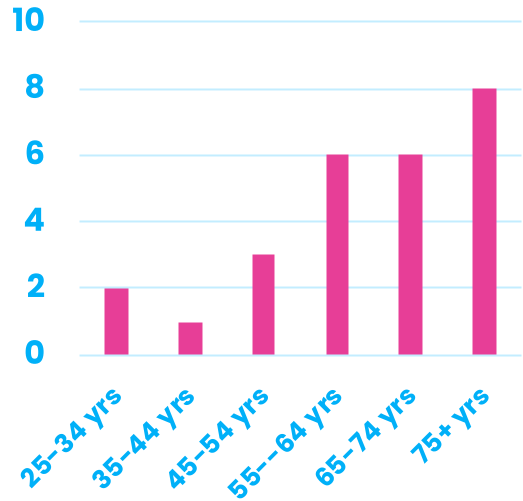
- **11** online survey responses were received.
- **1** fully completed postal survey was received.
- **14** face-to-face interviews were conducted.
- **8** out of the 14 interviews were conducted with the help of a volunteer interpreter organized by Healthwatch Reading.
- Interviews were conducted at following community centres:
  - Alliance and Cohesion for race and equality (ACRE)
  - Weller Centre (Caversham)
  - South Reading Community Centre
  - The Warehouse
  - Forgotten British Gurkha Centre
- **2** postal surveys were returned to Healthwatch Reading out of which only **1** could be included in the dataset for analysis. The other postal survey was discarded due to incomplete data.

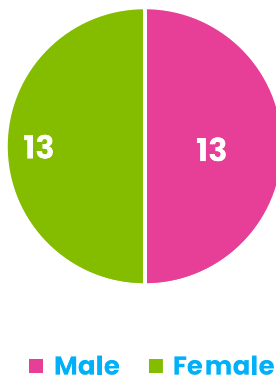
## Data stored and analysed:

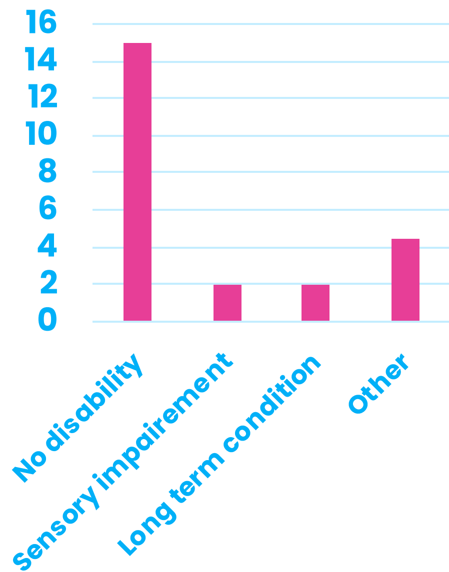
Data gathered was stored in MS Forms. Survey questions were quantitively and qualitatively analysed. Inductive reasoning was used to extract themes from the data gathered.

# Who was involved



# What we found

Findings relating back to the objectives were grouped in the three main categories listed below. They are presented in the following subsections.

## GP services

*Registration and referrals*

*Consultation outcomes*

*Care and support*

## CWOP support

*Heart health awareness*

*Health improvement since CWO check*

*Accessing health checks*

*Well-being advice and support*

## Community checks

*What worked well*

*What needs improving*

## What we evaluated

### 1.1 GP Registration and referrals

*"Excellent service, provided help and encouragement to register for a new GP"*

*"I was advised to register with a GP - received a call from the Broad St Mall"*

*"She[CWO team] provided information and signposting on how to change and register with a new practice - was quite challenging as had to move to a GP practice out of area. The CWO nurse followed up and encouraged me to continue to register for practices further away and finally got accepted and have a new GP and very happy"*

## What we found

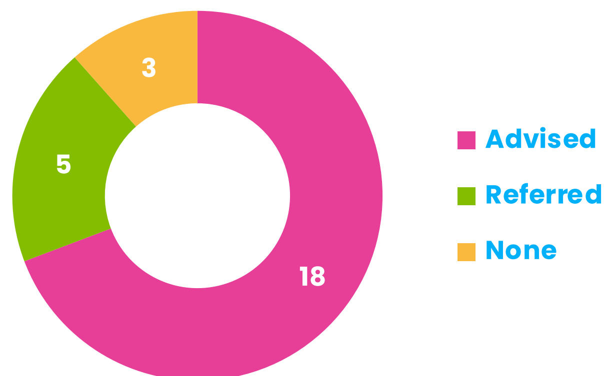
**81%** (21) of the respondents visited their GP due to CWO checks.

### GP Registration:

- **77%** (20) were registered with a GP before the CWO check.
- From the remaining **23%** (6), **8%** (2) were helped by the CWO team to register.

### Referral to GP by the CWO team:

- **69%** (18) were advised to see their GP.
- **19%** (5) were immediately referred by the CWO team.




### Appointment help

- **4%** (1) were helped to book an appointment.
- Most of the appointments happened within a **week - month**.

Many participants informed us that they were told why they needed to see a GP, however, **8%** (2) told us they received no explanation.

| What we evaluated | What we found |
|---|---|

## 1.2 GP consultation Outcomes

*"Was referred for colonoscopy - identified growths which lead to hospital procedure"*

*"Didn't go back for test as very busy - new mum baby is 3-4 months old"*

*"I was told that I was diabetic. GP confirmed high cholesterol"*

*"Dosage of my medication was increased. Was also given new medication"*

*"I was advised to do more exercise like walking and to eat healthily"*

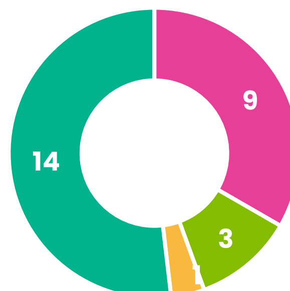
GP consultation outcomes broadly fell into following categories:

1. Lifestyle advice
2. New diagnosis
3. Monitoring of new/existing conditions
4. Treatment of new/existing conditions

### 1.2.1 Referral to other services:

**35%** (9) were referred to other services or advised to make lifestyle changes such as: pain management, heart clinic, stop smoking, nutrition /diet and exercise related.

### 1.2.2 Further health checks/ follow up appointments




■ GP ■ Other Health professional ■ CWO ■ None

**44%** (12) saw their GP/other healthcare professional for further health checks or follow up appointments. These include:

- General check up
- Further blood and/or urine tests
- Session with nutritionist
- Session with pharmacist
- New patient check up
- Follow-up for other conditions

| What we evaluated | What we found |
|---|---|

*"Received existing medication and increased dose of BP medication"*

*"Was advised to see the GP but didn't make an appointment as felt confident of self management by making some recommended changes from the CWO"*

*"Self managed by increasing activity levels and eating more healthily"*

*"I used to walk for about an hour before but because I now have problems with my foot. I do other exercises at home like sitting down and standing up to keep active. I feel stressed because of other challenges like family left back home"*

## 1.2.3 Clinical changes

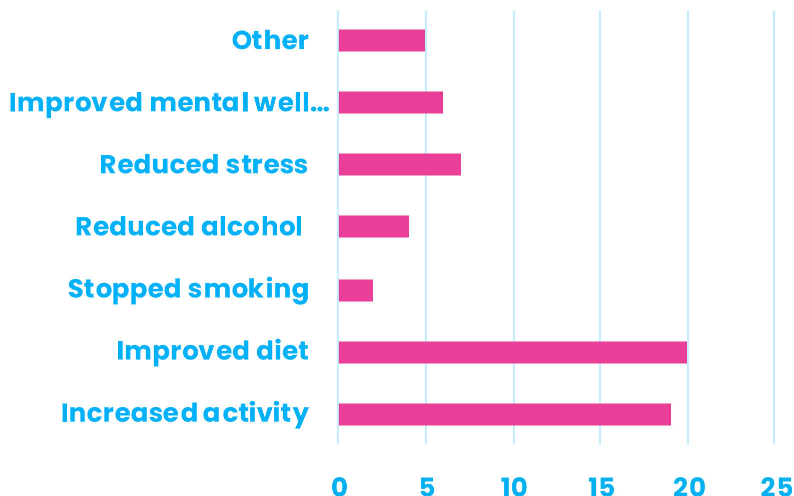
**54%** (14) saw changes such as:

- New medication
- Dosage increase
- Further/continued monitoring

*"I now have 2 BP medications and a new medication to manage my cholesterol levels"*

## 1.2.4 Lifestyle changes

Following the CWO checks, respondents made some important lifestyle changes such as smoking cessation, starting/continuation of exercise and following changes recommended at the CWO checks.




*"Stopped smoking and improved diet - cut down on red meat significantly, eat more fish and chicken and veg"*

| What we evaluated | What we found |
|---|---|

*"Last health check offered was over 50 health check pre covid"*

*"I have been invited to do a blood test in October but not sure if this is related to a health check"*

*"Not always sometimes have to take my own translator otherwise I don't understand"*

*"Go back to Nepal and get better treatment and care there and fully understand what is going on with health. Medication access seems limited here. Don't receive the results from checks"*

*"Sometimes if the person speaks slowly can understand but would always prefer the option of translator but not offered"*

*"Sometimes they provide a translator, sometimes they don't. Hard to know (mostly not) will bring someone to translate for me"*

## GP Care and support:

- **73%** (19) did not receive any support or an invite from their GP to do a health check before the CWO check. Many participants were unaware of GP health checks. Some had their checks long ago and health concerns triggered checks for others.

> *"I was not aware that GPs do health checks"*
>
> *"At my previous practice the GP invited me to health check but then had to change practice and current practice doesn't offer them so very glad to have the CWO - very helpful as had the growths removed and made lots of lifestyle changes"*

- Although most participants were happy with their GP care, **15%** (4) thought it did not suit their need.

> *"It is all a bit vague and disjointed. I was invited on a pre-diabetes course at the end of which a blood test would be provided to check progress. GP knew nothing about it"*

- **31%** (8) did not receive the extra help (translator /BSL/ reasonable adjustments) they needed.

> *"Translators are rarely available"*
>
> *"I need translation, but I don't always get a translator. Sometimes the staff at the surgery can translate for me otherwise I take someone with me"*

## What we evaluated

*“GP listened to my concerns and discussed my health”*

*“Pharmacist was very good - knowledgeable and gave me a prescription”*

*“Not very clear or sure about how well they listen - would like to move GPs”*

*“Experience excellent since the diagnosis after the blood test and surgery - excellent follow up care”*

*“Very efficient, answer questions”*

*“They provide a good service, and I feel supported”*

*“They always provide the help that I need”*

## What we found

- Many participants felt listened to, respected and well supported. A few were unsure, had language barriers or felt supported due to translator availability.

| | Yes | No | N/A |
|---|---|---|---|
| **Felt listened to and well supported** | 21 | 3 | 2 |
| **Understanding information advice and confidence managing health** | 23 | 2 | 1 |

*“Had dizziness, went to see GP - told her how was feeling - balance was not right - called ambulance and treatment was very quick and supportive - felt listened to and respected”*

*“Does not feel like they understand me, and I don't understand them”*

*“I believe that because there is a translator it makes it easy for me to tell the doctor what I need, and I understand what I am told.”*

*“Mostly the issue is language barrier - don't feel they understand me very well - I hope they understand me, but I don't know as often I don't understand them”*

| What we evaluated | What we found |
|---|---|

## 2.1 Heart health awareness and/or condition management

*"I have been particularly mindful of my health because of the boarder line diagnosis of cholesterol levels and my BMI. So, I try my best to keep active with intentional activities about 3 times a week as well trying have at least one vegetarian meal a week"*

*"Yes, made lots of changes and had diagnosis and follow up care with GP - feel a lot fitter, active and less stress"*

*"Because the health check found out about my cholesterol and HBP and advised me to see my GP, I believe the medication has helped"*

### Heart health awareness

**85%** (22) saw an improvement in their heart disease knowledge, ranging from little to very much.

### Health Improvement since CWO check

**92%** (24) saw an improvement in their health ranging from a little to very much. These include:

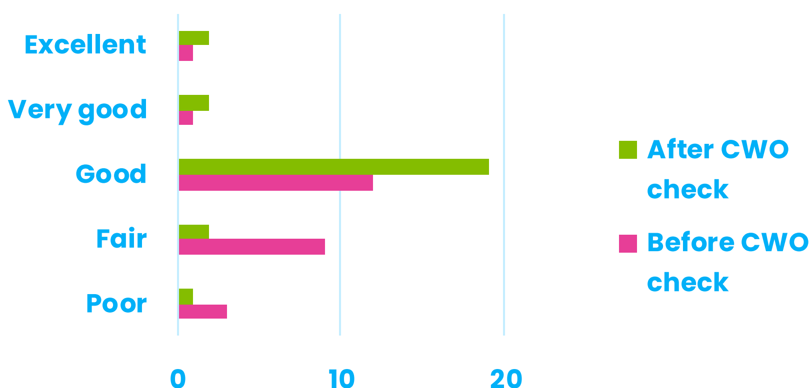
- Lifestyle changes: keep active, eating healthy, weight loss, alcohol and smoking reduction.
- Increased awareness: more understanding of health risks, monitoring and self-care.
- Management of conditions such as BP, sugar and cholesterol levels under control; treatment and ongoing pain management at pain clinic for chronic health problems.

*"Eat healthy lost 3 stone, I drink less"*

*"understanding of risks of high cholesterol - made lifestyle changes"*

*"My BP is well managed and under control"*

### How participants rated their health?



| What we evaluated | What we found |
| --- | --- |

## 2.2 Reduce health check inequalities

*"When I receive letters or text messages, I will ask someone to explain what it means"*

*"Because there is a translator when I go to see the doctor, It is easy for me to understand what the doctor is saying so that I know what to do for myself"*

*"It helps when there is a translator or someone to interpret"*

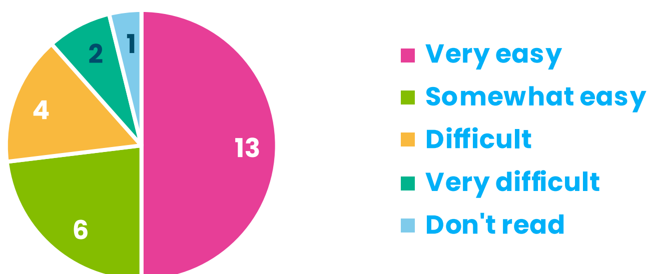
### Accessing health checks:

The CWO team made it easier for **69%** (18) to access health advice or services.

### Well-being advice and support:

**88%** (23) understood the advice and information given and felt confident managing their health. However, many of them had **language barriers** and needed help from a translator /interpreter.

### Understanding written health information




## 2.3 Other support

### Support with issues impacting well being

There were hardly any participants who received support with non-clinical issues such as housing, money or getting to work.

| What we evaluated | What we found |
| --- | --- |

## 3. Accessing checks in community settings

*"Check up as GPs don't have appointments for routine blood tests"*

*"Check itself was good", "The checked helped me to now monitor my BP at home"*

*"General health check which informed me of what I needed to do and work on to improve my health"*

*"Improved awareness and more conscious - peace of mind, help prevention, easy to attend - no need for appointment"*

## What worked well?

Key themes emerged from the responses reviewed include:

- **Opportunity to do the checks:**

  Participants were grateful to have the opportunity to do the checks. It helped them become aware of health conditions, the need to monitor those conditions and receive the required support.

  > *"Grateful for the check - without it could have been very ill"*
  >
  > *"I am very happy for the opportunity to me to do the check. It has highlighted the need to keep an eye on my blood pressure"*

- **Easy access:**

  Participants appreciated the ease of access, not having to book appointments and clear visibility of session information.

  > *"No need to make an appointment - just walked in - very welcoming, information about sessions was clearly displayed on noticeboards in lots of community centres"*

| What we evaluated | What we found |
|---|---|

*"I thank the nurse and GP who listened to any concerns I had"*

*"Very welcoming, easy explanation"*

*"Explained who they were and the purpose of the project"*

*"The whole situation was very good and very professional throughout my experience"*

*"The opportunity to access the check easily and the advice and guidance given by the team afterwards"*

- **Care quality and professionalism**:

Participants often mentioned staff were friendly and professional. They valued this experience, and it led to trust in the service.

> *"Good set up - privacy, very professional team, faith in NHS system"*
>
> *"Passing and saw the noticeboard, walked in with friend - very accommodating, staff were friendly and professional"*

- **Information and advice**:

Participants found it helpful to receive information and advice related to health monitoring, and consulting healthcare professionals.

> *"It was a very good experience, and I got more information to help me manage health. Even though I know I had diabetes the advice I got to see my GP where they advised me about my diet and exercise - this has helped me a lot"*
>
> *"Advised to monitor BP using both arms not just one"*

| What we evlauated | What we found |
|---|---|

*"The referral back to GP led to diagnosis and surgery - then follow up appointments to make lifestyle changes"*

*"Got referred to GP due to high cholesterol - taking statins now and more aware of BP"*

*"Facilitates quicker access to GP, Conditions may not be identified but the health check can show this quickly and easily"*

*"Provided help and encouragement to register for a new GP"*

- **Identification of issues and treatment**:

  The checks brought to light health conditions and prompted actions such as visiting a GP /healthcare professional, medication and/or lifestyle changes.

  *"If I had not done the health check, I would not have visited the GP when I did and had my medication increased."*

  *"I welcome the opportunity because they were able to identify health issues like high cholesterol and my blood sugar was showing as borderline diabetes. I would not have known this if the check was not available to me"*

- **Inclusivity/additional needs**:

  Community setting and the availability of translators made the CWO project more inclusive for those who faced language/cultural barriers.

  *"Feel better to have [health check] in the community because translator available, not like at the GP"*

| What we evaluated | What we found |
|---|---|

*"More information about project and how it links with GP"*

*"Follow up was about 3 months after original appointment. Perhaps this needs to be sooner"*

*"There was a long queue, people left as couldn't wait - would be better to have more capacity (x 2)"*

*"They need to increase the number of staff (capacity)"*

*"Like having a doctor present when someone needs to address something"*

*"Translation was done on the phone and this was difficult for me as I don't hear very well. I use hearing aids"*

## What could be improved?

Thematic analysis of responses revealed four main improvements:

- **Follow up and ongoing monitoring:**

  Participants mentioned a lock of or delayed follow up. They expected:
  - Information on how the project links with the GP
  - A follow up to see what was done about the advice given
  - Follow-up done sooner

  > *"I was advised that I will get a call 3 months later but don't believe I got one to check on what I had done with the advice I was given"*

- **Centre capacity/staffing:**

  Participants have informed:
  - Long queues and insufficient capacity
  - People leaving without being seen
  - Staffing should increase to improve queue management

  > *"On the day I did my check, there was a long queue and not everyone was seen"*

- **Inclusion and access:**
  Participants need:
  - Face-to-face interpreters as phone translation was difficult

| What we evaluated | What we found |
|---|---|
| *"Need more regular checks which could include checking the heart, kidneys and liver. I have a heart condition but do not know how to keep regular checks because it is hard to get GP appointments"*<br><br>*"It would help if the medication needed was provided during the health check rather [than] wait[ing] to see the doctor"*<br><br>*"Would be helpful to have ongoing checking - not just one off, maybe 6 monthly, checks facilitate quick and better access to GP"*<br><br>*"Ensure translators are available - increase access to information in all languages"* | - Information in multiple languages<br>- Centre accessibility via public transport<br><br>*"Ensure all the centres are easily accessible by public transport, include centres in universities /colleges/GP surgeries"*<br><br>• **Scope, frequency of health checks:**<br><br>Participants would like to see:<br>- More frequent checks (e.g. every 6 months)<br>- Inclusion of full blood tests rather than going back to the GP.<br>- Inclusion of ECG and checks for heart, kidney, and liver conditions.<br>- Provision of on-site medication /prescription service<br><br>*"Have a full blood test at the health check rather than being referred back to GP as that can often take a few months"*<br><br>*"Make checks more regular - every 6 months. Can we have a full blood test as part of CWO?"* |

# Summary

We evaluated the impact and effectiveness of the CWO project by collecting and analysing feedback gathered from participants coming from a varied background.

Our findings revealed that participants were happy with the CWO project and want it to continue. They valued:

- **Having checks without having to book appointments**
- **Information and advice given**
- **Early identification of health issues**
- **Quick referrals to GPs/other healthcare professionals, sometimes leading to early diagnosis and/or treatment**
- **Professional, friendly and welcoming staff**

Participants have also suggested the following improvements:

- **Quicker follow-up and ongoing monitoring**
- **Increase centre capacity and staffing**
- **Improve inclusion and access**
- **Increase frequency of checks and include additional tests**

We conclude that the CWO project should continue running with the recommendations provided. In addition, the CWO project also supports the goals of the Government's NHS 10-Year Plan; bringing care closer to where people live and empower communities to play a greater role in delivering healthcare.

# Recommendations

## 1. Improve understanding and communication of the CWO Project

Participants reported confusion about the link between the CWO project and their GP. While many praised the CWO service, they found the follow-up process and remaining healthcare pathway difficult to understand or navigate. To address this, we recommend:

- **Clarify the role of the CWO Project and GP responsibilities**
  - ❖ Provide clear information to participants about what the CWO project does and the role of healthcare staff.
  - ❖ Explain which aspects of care are managed by CWO project, GPs and other healthcare professionals, or both to reduce confusion.

- **Improve communication about follow-up and care pathways**
  - ❖ Clearly explain when follow-ups will occur and who is responsible.
  - ❖ Improve coordination and information sharing between CWO team and GPs to create a seamless integrated journey for participants.
  - ❖ Ensure participants understand the process so they experience smooth, joined-up care across services.
  - ❖ Review the use of call ID for follow-up calls. Calls showing as "private" are more likely to be ignored, which may result in participants missing important follow-ups.

# Recommendations

## 2. Expand the range of services offered at health checks

Many participants valued the CWO project and suggested:

- Making additional services available, such as full blood tests and kidney or liver checks.
- Offering diagnostic checks, for example providing ECGs for participants with existing or suspected heart conditions.

Some participants told us of their frustration of delays when booking separate GP appointments after their health checks (as advised by the CWO team), sometimes waiting for up to a month before being able to see a GP, with their health deteriorating whilst waiting.

- We recommend exploring the option of providing an onsite GP, so participants can access immediate advice, have clinical decisions made about their health and wellbeing on the day, and receive prescriptions on the same day.

## 3. Increase staffing levels to ensure timely and comprehensive delivery of health checks

Some participants reported long queues and extended wait times for health checks. As a result, some left before completing their checks, while others waited for a long time only to be told they could not be seen. We recommend:

- Where possible, increase the number of staff conducting health checks. Review attendance data to identify the busiest community locations and assign additional staff to these areas, ensuring everyone who attends can be seen.

# Recommendations

- Consider setting up health check services in additional community locations (if available) in these busy areas.
- Consider extending hours of health checks to reduce waiting times.

## 4. Improve translation and interpretation services

Participants who required an interpreter and used the telephone interpreter service told us it was ineffective. To ensure equitable access and clear communication, we recommend:

- Reviewing the telephone interpreter service used within the CWO project.
- Explore other alternative translation options, such as face-to-face interpreters, video interpreting, or translated written materials.
- Ensure the translation methods used in the CWO project meet the needs of participants with hearing impairments or other communication needs.

## 5. Review and improve accessibility for participants

Accessibility issues were identified when speaking to participants. To improve the service, we recommend improving accessibility for people with different communication needs, including those who have hearing impairments by offering suitable communication support or alternative interpretation options.

# Case study 1: Identification of health issues and improved wellbeing

BL, a 65-year-old female, unaware of health checks at the GP, happily had her check through the CWO programme. BL was advised to see her GP immediately due to high blood pressure(BP) and blood sugar levels. Lack of interpreter at the GP made BL rely on her husband, with limited English skills, for translation. In contrast a face-to-face interpreter was provided at the CWO check. Since then, BL's heart disease knowledge has significantly improved. BL described her CWOP experience as:

*"I have lost weight and I feel very well because I walk, I eat healthy food (and only small portions). I am now able to walk further and faster and just feel ok in myself .These changes are due to the support and guidance provided through the programme."*

**Community Wellness Outreach programme success**

Overall, BL described her experience with the CWOP as very positive.

- New diagnosis leading to further assessments and treatment.
- Weight loss through healthier eating habits and portion control.
- Increased physical activity; improved stamina.
- Improved physical fitness and overall wellbeing.
- Better self-management of blood pressure and blood sugar levels.
- Increased knowledge and awareness of heart health.

When asked how the CWOP could be improved, BL said,

*"The service was very good and has helped me a lot, but I feel that there is a need to do more checks including checks for the liver and kidney function."*

# Case study 2: Support for an elderly, hearing impaired resident

DR, a 75-year-old male, unaware of health checks at the GP welcomed the CWOP health check opportunity. Although telephone interpretation was available at the CWO health check, DR found it challenging due to his hearing difficulties.

*Translation was done on the phone, and this was difficult for me as I don't hear very well. I use hearing aids."*

Following the check, DR was referred to his GP for high BP. The GP advised DR to monitor his BP at home. Submitting home readings prompted a face-to-face appointment at the GP resulting in an increased medication dosage.

*"They provide a good service and I feel supported. I will usually ask for a face-to-face appointment as I am deaf and this helps, rather than a telephone appointment. I know that the practice has a doctor who speaks Hindi, so I will ask to see him, and this helps. If he is not available, sometimes I can manage with the very little English I have. I can remember one time, a doctor used Google translate."*

**Community Wellness Outreach programme success**

Overall, DR's CWOP experience was very positive

- The CWOP community setting improved accessibility and engagement.
- The CWO check enabled timely follow-up and treatment from the GP.
- The programme has increased awareness of preventative health checks.
- Access to a home BP monitor has improved DR's confidence in self-managing his health.
- DR tries walking to stay fit, but foot problems have reduced his mobility. He now does simple seated exercises.

When asked about improvement to the CWOP, DR said:

*"The health checks were helpful, but more could be done to make it work better, like having a doctor present when someone needs to address something. They could also do ECGs (Electrocardiogram)."*

# Case study 3: Early intervention

SB, a female over 65yrs of age, was previously diagnosed with high BP. SB chose to make lifestyle changes over taking medication which also improved her mental wellbeing.

Before the CWOP check, SB was unaware of health checks at the GP. The CWOP check outcome led to a GP appointment where SB had further tests. Following these tests, SB received a text message from her GP saying she would be prescribed statins. SB was worried about the lack of explanation or a chance to discuss this decision with her GP, leaving her alarmed and unsure about the treatment.

*"I did not know what statins were so I researched it and found they could affect other medication I was on"*

SB contacted her GP surgery and was informed that no GP appointments were available for a further two months. She was, however, offered an appointment with the practice's in-house pharmacist who was able to confirm the test results.

*"The pharmacist was very helpful in explaining why I needed statins and the benefits."*

**Community Wellness Outreach programme success**

SB was so impressed by the programme that she booked a CWO health check for her partner. The CWO check outcome led to SB's partner being referred to the GP, and later to Royal Berkshire Hospital. The CWOP team followed up with her partner via a phone call, after the appointment.

When asked how the CWOP could be improved, SB said her health check took place in a very busy location.

*"The programme should consider carrying out health checks regularly in a town centre location like Broad Street Mall which can be more accessible and where people are more likely to interact. People don't know where the Civic Centre is or may not want to go there."*

SB felt, people would benefit from more support and accessible information about the project and its locations.

*"Not everyone checks websites for information and advice."*

# Case study 4: From screening to surgery the impact of early detection

The CWO team advised VN to see his GP as his sugar, cholesterol and blood pressure levels were high. The GP surgery secured an appointment within a week, and further tests were ordered. Test results led to a hospital procedure to address the abnormalities found. VN also saw a nurse at his GP surgery for wellbeing advice - diet, exercise, smoking, alcohol intake and guidance on managing stress levels. VN had never been invited to have a health check by his GP before.

*"It feels like you must fall ill before you get an appointment to see a doctor these days."*

**Community Wellness Outreach programme success**
VN made significant lifestyle changes that have a positive impact on his life.  He believes all these improvements might never have occurred without the CWOP.

- CWO check enabled timely diagnosis and prompt treatment.
- CWO checks led to improved wellbeing, reduced stress and better fitness levels.
    - Diet and nutrition improvements - reduction in red meat intake, increased consumption of fish, chicken and vegetables.
    - Fitness and mobility – regular walks have improved fitness and stamina.
    - Smoking cessation, significant reduction in alcohol consumption.

*"I have cut back on red meat consumption. I eat more fish, chicken, and am increasingly trying to eat more vegetables. I walk most of the time although I have a bus pass. I stopped smoking, significantly reduced my alcohol consumption, feel a lot less stressed and feel a lot fitter."*

# Acknowledgements

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- **Weller Centre, Caversham**
- **South Reading Community Centre**
- **The Warehouse**
- **The Forgotten British Gurkhas Centre**

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