

"Why weight to talk?"

Embedding compassionate brief advice to support healthier weight and challenge stigma across systems in Cheshire and Merseyside

Phase 3 and Phase 4 Impact Evaluation: 2023-25

HEG Health Equalities Group

Why weight to talk?

About Health Equalities Group and Food Active

Health Equalities Group (HEG) is a public health charity working to improve the wellbeing of communities across the UK. We're an independent voice for preventative public health in the North-West and beyond.

We believe everyone deserves to live a long, healthy, and happy life. But right now, not everyone gets that opportunity. That's why we work with local authorities, charities, the NHS, and central government to help improve the conditions that hold back so many of our communities.

Food Active is a programme of work delivered by HEG, working with local authority public health teams to address the social, environmental, economic, and legislative factors which influence people's lifestyle choices and behaviours, with a specific focus on healthy weight.

HEG Health Equalities Group • FOOD ACT!VE

Project overview

Project name:	*"Why weight to talk?"*: Phase 3 + Phase 4	
Contract period:	April 2023 to February 2025	
Client:	Health Equalities Group	
Project oversight:	Michael Viggars Nicola Calder	michael.viggars@heg.org.uk nicola.calder@heg.org.uk
Project sponsor:	NHS Cheshire and Merseyside's Children and Young People's Transformation Programme *(Beyond)*.	
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Partner organisations:	Cheshire West and Chester Council, Cheshire East Council, Halton Council, Knowsley Council, Liverpool City Council, Sefton Council, St Helens Council, Warrington Borough Council.	

Acknowledgements

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We would also like to express our sincere thanks to local authority public health colleagues from Cheshire West and Chester, Cheshire East, Halton, Knowsley, Liverpool, Sefton, St Helens, and Warrington. Their commitment, insight, and local leadership were instrumental in shaping the programme's delivery, tailoring content to local needs, and embedding the training within wider systems of support.

This evaluation reflects their dedication to improving health outcomes for children, young people, and families across the region.

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1. Executive summary

The *"Why weight to talk?"* programme was commissioned by Beyond on behalf of the Cheshire and Merseyside Children and Young People's Transformation Programme to support professionals in holding compassionate, stigma-informed conversations around healthier weight. Delivered by Health Equalities Group (HEG) across 2023–2024, the programme reached 616 practitioners from a wide range of settings, including 0–19 services, early help teams, education, and the voluntary, community, faith, and social enterprise (VCFSE) sector.

This evaluation, structured through a mixed-methods approach, presents clear evidence of the programme's impact across five key domains: enhanced practitioner knowledge and confidence; improved referral practices; cultural shifts towards more compassionate care and trauma-informed service delivery; increased safeguarding awareness; and alignment with strategic system priorities.

Quantitative data showed statistically significant gains in practitioner confidence (+1.00 for initiating weight-related conversations; +0.92 for making referrals) and a measurable shift away from individual-blame perspectives. Qualitative insights reflected a growing practitioner awareness of the social determinants of weight and a cultural move towards more respectful, relational approaches to childhood obesity.

Strategically, *"Why weight to talk?"* functioned as a system enabler. It helped local areas identify gaps in provision, consolidate healthier weight pathways, and surface tensions between statutory and VCFSE approaches. Buy-in from senior leadership proved instrumental in promoting cross-departmental working. Meanwhile, delivery to weight management teams in some areas enhanced their capacity to support families more holistically.

Challenges included limited engagement from NHS primary and secondary care, logistical barriers to in-person training, and varying levels of local service readiness. Nevertheless, online delivery improved access in rural geographies, while Halton's internal delivery model suggested opportunities for train-the-trainer scale-up.

The programme was delivered at a cost of £60,843, approximately £98.77 per participant, representing strong value for money given its reach, adaptability, and alignment with whole-system ambitions. A suite of practitioner resources and referral tools were provided, with all content hosted online for sustained access.

Key recommendations include improved NHS engagement, strengthened train-the-trainer pathways, further integration with family hubs and early years reforms, and longitudinal evaluation of long-term outcomes. Future delivery should prioritise deprived communities and continue to centre practitioner discretion, compassion, and dignity.

In conclusion, *"Why weight to talk?"* is an evidence-informed, scalable intervention that supports more equitable, coordinated, and compassionate responses to childhood obesity and its root causes across Cheshire and Merseyside.

2. Background and rationale

Overweight, obesity and weight stigma

Overweight and obesity remain significant and growing public health concerns across the UK. In England, almost two-thirds of adults live with overweight or obesity, and one in three children leave primary school with excess weight. These patterns are especially pronounced in areas of socioeconomic deprivation, where exposure to poverty, food insecurity, trauma, housing instability, and other social inequalities increase risk.

Overweight is typically defined as having a body mass index (BMI) between 25.0 and 29.9 kg/m^2, with obesity defined as a BMI of 30 kg/m^2 or greater. While these thresholds provide a common language for public health monitoring and service eligibility, they offer only a partial understanding of the complex factors that influence body weight and its health consequences. Obesity is now considered a chronic relapsing progressive disease process (1).

The rise in overweight and obesity reflects major systemic changes across food environments, physical activity patterns, and commercial determinants of health. Ultra-processed foods, high in fat, sugar, and salt, are widely available, heavily marketed, and often priced cheaply, driving overconsumption. Simultaneously, changes to work, transport, and daily living have reduced opportunities for physical activity. These obesogenic conditions disproportionately affect lower-income populations, contributing to widening health inequalities both nationally and across Cheshire and Merseyside.

Public discourse and some policy approaches continue to frame obesity as a matter of personal responsibility, positioning weight as something that individuals can and should control through willpower, better choices, and lifestyle adjustments (2). This narrative fails to account for the complex biological, psychological, social, and environmental factors that contribute to weight gain and overlooks the profound structural barriers many people face in achieving and sustaining healthier weight (3).

Crucially, the persistence of this individualised framing also sustains weight stigma – the negative stereotyping, devaluation, and discrimination directed toward individuals living with higher body weight (4). Research consistently shows that weight stigma can worsen physical and mental health outcomes (5), undermine practitioner-patient relationships (6–8), and deter individuals from accessing health services (9). Moreover, stigma itself may function as a driver of weight gain, contributing to stress (10), disordered eating (11), low self-esteem (12), and social isolation (13).

Recognising these dynamics, colleagues in public health, the NHS, and individuals with lived experience are calling for more compassionate and systemic approach to addressing overweight and obesity, one that explicitly challenges weight stigma and acknowledges the broader determinants of health. The "*Why weight to talk?"* programme adopts this position, embedding compassionate care and trauma-informed principles throughout its training model. Rather than narrowly focusing on individual behaviour change, it supports practitioners to hold respectful, reflective conversations that recognise complexity, uphold dignity, and address weight within the wider context of people's lives.

What is weight stigma?

Weight stigma refers to the systemic devaluation and discrimination of individuals with higher body weight, sustained through interpersonal bias and reinforced by health policies, clinical practices, media narratives, and political ideologies. It is driven by cultural ideals that equate health with moral worth and individual responsibility, often framing larger bodies as unhealthy, irresponsible, or morally deficient.

Weight stigma is not merely a matter of prejudice; it functions as a tool of social and political governance, helping to obscure structural drivers of weight gain such as poverty, trauma and the food environment. It contributes to health inequalities through mechanisms including chronic stress, reduced access to care, internalised shame. Its effects are experienced unequally, compounding other forms of marginalisation such as poverty, racism, or sexism, and reinforcing social hierarchies.

Barriers to conversations

Despite policy recognition of the importance of brief interventions around healthier weight, frontline practitioners face well-documented barriers when initiating conversations with children, families, and adults about weight-related issues (14). These barriers operate at multiple levels:

- Practitioner-level barriers include limited knowledge, lack of confidence, concern about damaging rapport, and personal discomfort with the topic, particularly where practitioners themselves live with excess weight or feel insufficiently trained.
- Parent or client-level barriers include denial, resistance, or defensiveness, which can be shaped by prior experiences of stigma, cultural norms, or complex family dynamics.
- Relational barriers involve the risk of undermining trust or damaging therapeutic relationships, particularly in sensitive contexts such as safeguarding, ACEs, or mental health.
- Systemic barriers include time constraints, workload pressures, a lack of clear referral pathways, and the normalisation of overweight within communities, which collectively discourage meaningful dialogue.

Compounding these difficulties is the pervasive stigma surrounding obesity. As multiple studies have shown, weight stigma is not simply an interpersonal issue but a structural one, often reinforced through healthcare systems, public discourse, and institutional practices (15). Practitioners therefore face the dual challenge of broaching a difficult topic while actively working to minimise the risk of further stigmatisation or harm.

Compassionate approaches

Recognising these barriers, *"Why weight to talk?"* is explicitly grounded in the principles of compassionate care, drawing on contemporary theoretical work to frame weight-related conversations not as simple health education, but as relational, responsive acts of care.

Compassionate care, as articulated by Singleton & Mee (2017), Mol (2008), and Tveit & Raustøl (2017), requires practitioners to exercise professional discretion, remain attentive

to power dynamics, and recognise the structural conditions shaping people's lives (16–18). Rather than delivering prescriptive messages, practitioners are encouraged to:

- Build trust and psychological safety, recognising that conversations about weight may evoke vulnerability or shame.
- Use person-first, non-judgemental language, actively resisting stigmatising or moralising narratives.
- Consider the broader social and economic realities facing individuals and families, such as poverty, housing insecurity, trauma, or food insecurity.
- Apply discretion, knowing when to offer advice, when to listen, and when to prioritise other forms of support that may better meet the person's needs at that time.

Crucially, compassionate care does not imply avoidance of difficult topics; rather, it demands the relational and reflective skill to engage with them in ways that uphold dignity and acknowledge complexity. As Mol (2008) notes, care is not a one-off transaction but an ongoing, negotiated process; one that may require "tinkering" with standard protocols in response to real-life conditions (17).

For practitioners delivering "*Why weight to talk?"*, this model of compassionate care is not a soft skill but a serious, skilled practice requiring structured training, supervision, and system-level support. Embedding these principles within local authority systems helps ensure that brief interventions are delivered not only with technical competence but with ethical sensitivity and contextual awareness.

A note on language and terminology

The field of compassionate approaches and stigma-informed care is saturated with diverse and sometimes conflicting terminology. Within this project, terms such as "compassionate care," "trauma-informed practice," and "strengths-based approach," each carry distinct conceptual underpinnings and practical implications for how practitioners engage with children and families adults about healthier weight.

These terms reflect differing ways of framing the professional-client relationship, the sources of health inequalities, and the role of discretion within practice. It was not the purpose of this project, nor would it be feasible, to resolve these terminological complexities. Instead, "*Why weight to talk?"* has deliberately adopted language that supports an ethos of relational, non-judgemental, and person-centred practice. In doing so, we have also sought to surface and challenge language, assumptions, and practices that risk perpetuating stigma or undermining trust.

Project aims and objectives

The *"Why weight to talk?"* (WWTT) programme was developed to improve how practitioners engage in weight-related conversations with children, young people, and families, particularly those affected by health inequalities. Building on principles of compassionate care, trauma-informed practice, and upstream prevention, the programme sought to move

beyond traditional health promotion approaches to embed more context-sensitive, stigma-aware engagement.

The overarching aim of the project was to strengthen local systems by equipping frontline practitioners with the knowledge, skills, and confidence to deliver respectful, informed, and effective brief advice on healthier weight.

More specifically, the objectives were to:

- Deliver tailored training across Cheshire and Merseyside.
- Support professionals to understand the complex and intersecting causes of overweight and obesity, including trauma, adversity, and socioeconomic factors.
- Reduce reliance on blame- and behaviour-focused narratives by promoting systemic and relational understandings of weight.
- Improve practitioner confidence in holding sensitive conversations and referring appropriately to local services.
- Contribute to wider safeguarding, early intervention, and workforce development strategies.

These aims and objectives are underpinned by a logic model, which outlines the programme's theory of change from inputs to long-term impact. This can be found in **Appendix 1**.

3. Programme development and partnerships

Commissioning process

This project was commissioned and funded by NHS Cheshire and Merseyside's Children and Young People's Transformation Programme (*Beyond*), building on the successful delivery of an initial pilot and subsequent Phase 2 project previously commissioned by Cheshire West and Chester's public health team.

Due to the success of the pilot and Phase 2 project, *Beyond* sought to extend delivery across the region, providing funding for HEG to work with an initial four local authorities in a Phase 3 project across Cheshire and Merseyside. Strong engagement resulted in delivery across six local authority areas during this phase.

Following the success of Phase 3, Beyond subsequently commissioned Phase 4 to offer training to the remaining local authorities within Cheshire and Merseyside. This report covers both the Phase 3 and Phase 4 delivery of "*Why weight to talk?*" **Table 1** outlines the local authority partners who supported delivery of the training on the ground across the four current phases of delivery.

The project was delivered by:

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Table 1. Delivery phases and locations in Cheshire and Merseyside

Pilot and Phase 2	Phase 3	Phase 4
April 2021 – May 2023	April 2023 – March 2024	April 2024 - March 2025
• Cheshire West and Chester	• Cheshire West and Chester • Cheshire East • Halton • Sefton • St Helens • Warrington	• Knowsley • Liverpool

Stakeholder engagement and collation of provision

A key component of the *"Why weight to talk?"* project was its proactive engagement with local authority public health teams across Cheshire and Merseyside. Recognising that the training programme needed to reflect the local service landscape in each area, the project sought not only to deliver training but to embed it meaningfully within existing healthier weight provision.

Following the commissioning of Phase 3, all nine local authorities in Cheshire and Merseyside were invited to engage through an Expression of Interest (EOI) process. To ensure that the training was responsive to local needs and system capacity, participating local authorities were asked to confirm the presence of, or commit to developing, up-to-date weight management pathways for children and families prior to delivery. This conditionality reflected a shared understanding that effective practitioner training must be accompanied by accessible, appropriate referral options if brief interventions are to translate into meaningful support for families.

Throughout the engagement process, HEG collaborated closely with local authority public health teams to collate a comprehensive picture of each area's existing "healthier weight provision." This extended beyond statutory weight management services to include a wide range of relevant local support offers, including:

- Clinical and community-based weight management services for children and families.
- Programmes addressing food insecurity and household nutrition.
- Physical activity offers and community exercise referral schemes.
- Cooking skills classes and healthy eating education.
- Social prescribing pathways that linked families into wider support networks.

Collating this provision served multiple purposes. Firstly, it allowed the training content to be locally tailored, ensuring that practitioners received accurate information on referral options available within their own areas. Secondly, it facilitated broader conversations within local systems about service gaps, commissioning responsibilities, and opportunities for greater integration across health, education, and VCFSE sectors.

In several areas, this process of collating local provision also functioned as a catalyst for system-level reflection and strengthened collaborative relationships between public health teams, service providers, and frontline practitioners. The approach was deliberately pragmatic and iterative, recognising that local provision is often dynamic, complex, and shaped by multiple funding streams and organisational partnerships.

The collation of provision thus functioned not simply as a preparatory exercise for training, but as an enabling mechanism that aligned workforce development with wider system change across Cheshire and Merseyside.

Governance and oversight arrangements

Governance for *"Why weight to talk?"* was delivered through a combination of regional oversight and strong local operational coordination. At the local authority level, dedicated working groups were established to oversee and coordinate programme delivery. These groups brought together relevant public health, NHS, voluntary sector leads and other local stakeholders, providing a structured forum to adapt training content to reflect the distinct service pathways, referral mechanisms, and community assets available within each area.

The working groups also took responsibility for identifying and recruiting appropriate practitioner cohorts, managing the scheduling and organisation of training sessions (both in-person and online), and ensuring that safeguarding, weight management, and wider healthier weight provision were accurately represented within the training materials. HEG

managed recruitment for two local authorities; most had internal systems that monitored staff CPD exercises over time. This embedded local ownership was critical in ensuring that the training offer was relevant, contextually appropriate, and positioned to strengthen existing work around healthier weight at place level.

4. Target and audience and delivery model

Professional groups targeted

The "*Why weight to talk?"* programme was designed to build capacity across a broad range of professionals who routinely engage with children, families, and communities, with a particular focus on workforce groups positioned to influence health inequalities.

An implicit focus was placed on 0–19 service staff, reflecting their direct work with children and families throughout the early life course. All local authorities identified their respective service as potential target cohorts in early initiation meetings. This included school nurses, health visitors, and early years practitioners who are uniquely placed to engage families at key developmental stages and who often act as trusted sources of support. Given their frequent and sustained contact with families, these professionals represent a critical workforce for initiating sensitive, compassionate conversations about healthier weight.

Social prescribers were also targeted, recognising their growing role in linking primary care with voluntary and community sector provision, particularly in addressing the wider social determinants of health. Educational staff, including teachers and pastoral support staff, represented another important workforce group, reflecting their daily engagement with children and their capacity to provide early support, signposting, and safeguarding.

Primary care professionals, including GPs and allied health practitioners, were engaged on a smaller scale, primarily where local interest and workforce availability allowed. In several participating areas, specialist weight management teams were also included, enabling staff directly delivering weight management services to strengthen their skills in compassionate care and trauma-informed approaches.

Importantly, participating local authorities exercised flexibility in identifying priority staff groups, with workforce targeting aligned to existing local strategies, service development plans, and wider system initiatives. This allowed each area to maximise relevance and integration with their broader whole systems approaches to healthier weight.

Table 2. Delivery phases and locations in Cheshire and Merseyside

• Health Visitor	• Teacher
• School Nurse	• Project Officer
• Public Health Nurse	• Student Dietitian
• Social Prescribing Link Worker	• Trainee Youth Worker
• Lifestyle advisor	• Manager
• Portage Practitioner	• Student
• Family Hub Navigator	• Environmental Protection Officer
• Trainee Nurse Associate	• Senior Library and Outreach Officer
• Support Worker	• Orthoptist
• Nursery Nurse	• Speech and Language Therapy Apprentice

Recruitment strategy

Recruitment of participants for the "*Why weight to talk?"* programme was led locally by each participating authority, reflecting the importance of local ownership and alignment with existing service priorities. Once target workforce groups were identified, local authority public health teams took primary responsibility for disseminating information to relevant services and teams. This was supported by HEG who provided tailored communications materials, briefing documents, and promotional content through a dedicated communications pack to assist local leads in generating interest and uptake.

HEG staff also provided direct briefing sessions to service leads and managers, ensuring consistency of messaging and addressing any queries about the training content, format, or expectations. In many cases, these service leads were already engaged in local working groups established to coordinate project delivery at place level, further strengthening lines of communication and coordination.

Some local authorities chose to phase or delay the timing of training delivery to accommodate the implementation of new services or recruitment of additional staff, ensuring that new teams could benefit from the training offer once operational. This flexibility in delivery scheduling allowed the programme to integrate with evolving local service developments, maximising relevance, and longer-term embedding.

Registrations were managed by local authority public health teams with support from council communications teams in most instances, although a small number requested that HEG manage registrations which we facilitated through Eventbrite.

Delivery mechanisms

The *"Why weight to talk?"* training was delivered through two core formats to ensure accessibility and flexibility across diverse workforce settings. The first was a 90-minute online session delivered via Microsoft Teams, allowing for broad reach across geographies and facilitating participation from staff with limited capacity to attend in-person events. The second was a 2-hour in-person session, hosted at local authority or local partner venues, which provided greater opportunity for discussion, interaction, and locally contextualised delivery.

To support the scaling of in-person training capacity, colleagues from Halton Health Improvement Team were recruited and trained by HEG to deliver sessions locally. This not only enabled a wider reach across the subregion but also supported the sustainability of the model through the development of place-based delivery expertise.

5. Training content and learning approach

Training objectives

1. Raise awareness of the complex range of factors that influences weight gain.
2. Understand the impact of weight stigma on individuals living with overweight and obesity.
3. Consider the impact of adversity, stress, and trauma on weight gain.
4. Explore the concept of brief advice and how we can successfully engage children and families about healthier weight.
5. Provide an overview of local referral pathways.

Core modules

Core training was developed during the pilot in Cheshire West and Chester and has been refined following feedback from participants and commissioners. **Table 3** provides an overview of the current curriculum.

Table 3. Overview of training content

Module 1	
Public health framing	**Stigma and trauma-informed practice**
• Reframes obesity as a complex condition driven by structural and social inequalities. • Aligns with whole systems approaches and upstream prevention to reduce population-level risk.	• Addresses how stigma and bias undermine care, motivation, and service uptake. • Promotes trauma-informed, compassionate practice that supports psychological safety.
Module 2	
Behavioural techniques and communication	**Practical application and local integration**
• Introduces evidence-based tools to guide respectful, strengths-based approaches. • Encourages person-first, culturally competent language to build trust and reduce resistance.	• Maps clear local referral pathways and services for families and adults. • Safeguarding information is embedded, with clear guidance on how unhealthy weight may present as part of wider concerns.

Resources and tools

To support the practical application of learning, all *"Why weight to talk?"* participants received a post-training resource pack. This supplementary toolkit was designed to consolidate key messages from the training, offer structured conversation aids, and signpost to relevant local and national services. Its purpose was to help practitioners embed compassionate, stigma-informed approaches into their routine practice. The resource pack included:

Training summary slides: A structured recap of the core training content, including key principles for weight-inclusive and trauma-informed practice, practical guidance for initiating conversations about weight, and the public health rationale for upstream intervention.

Practical conversation tools: These included the "Ask–Provide–Ask" (APA) conversation model, reflective listening techniques, and a detailed checklist to support practitioners in holding respectful, effective conversations about healthier weight.

Referral and signposting information: A locally developed map of services across universal, targeted, and specialist levels, including statutory and community-led provision. This document was designed to support clear signposting, responsive referrals, and a shared understanding of local support pathways.

Community and VCSE directory: A curated list of cost-of-living, food support, physical activity opportunities, and parenting services within Liverpool. This reinforced a whole systems approach to healthier weight by highlighting broader determinants of health.

Safeguarding and professional boundaries guidance: A prompt reminding practitioners about when and how to escalate weight-related concerns that may indicate neglect, emotional harm, or unmet needs, and the importance of documenting and sharing concerns appropriately.

Links to national tools and learning: These included the Food Active Weight Stigma Resource Hub, NHS Better Health – Healthier Families, First Steps Nutrition, and guidance on the Healthy Start scheme and latterly the *Why Weight Hub*.

6. Evaluation design and methods

Design and analyses

While *"Why weight to talk?"* was primarily a practice-based intervention rather than a formal research study, the project incorporated a structured evaluation framework to assess its effectiveness and support reflective practice. To that end, all participants were encouraged to complete surveys at three time points: prior to the training, immediately following the session, and again at a three-month follow-up. Surveys were administered digitally via Microsoft Forms to enable efficient data collection and facilitate longitudinal comparison.

The survey instrument was aligned with the programme's five training objectives and included both quantitative and qualitative items. Quantitative components captured participants' knowledge of the complex determinants of weight gain, including the influence of stigma, adversity, and trauma, and their understanding of the relationship between overweight and comorbid health conditions. Practitioners' beliefs about responsibility and causation in relation to overweight and obesity were assessed at three time points (pre-training, post-training, and follow-up) using a non-parametric Friedman test to analyse changes in ordinal Likert scale responses over time.

The survey also measured self-reported confidence in initiating conversations with families and making appropriate referrals to local services. Open-ended questions were included to elicit reflective responses on the relevance of the training to professional practice and perceived impact on day-to-day roles.

By employing a repeated measures design, the evaluation allowed for the assessment of immediate learning gains as well as the extent to which these were retained and applied in the medium term. The mixed-methods approach enabled triangulation of insights and provided a robust indication of impact within the operational constraints of a commissioned training programme.

In addition to quantitative analyses, qualitative data, also captured via Microsoft Forms, were thematically analysed using Braun and Clarke's reflexive thematic analysis approach (19) . For Analysis 5, participants' open-text responses across all three survey waves were coded inductively and interpreted through the lens of compassionate care theory, drawing on the sensitising concepts of reflection, discretion, and relational practice. Analysis 6 involved a thematic review of feedback from local authority public health leads and stakeholders. Themes were initially generated inductively and subsequently retrofitted to the strategic categories identified within the programme's logic model. This dual-level qualitative analysis supported triangulation of findings, providing both practitioner- and system-level insights that contextualised and enriched the quantitative results.

The evaluation was informed by a programme logic model (please see **Appendix 1**) that mapped inputs through to long-term impact, helping to structure data collection, triangulate findings, and assess effectiveness across multiple domains.

Sample size

Across the delivery period, a total of 616 practitioners were trained through 48 sessions, spanning both online and in-person formats, with representation from eight local authority areas in Cheshire and Merseyside. Further information concerning sessions and participants by local authority area can be found in **Table 4**.

To evaluate the impact of the training, participants were invited to complete surveys at three time points. A total of 276 pre-training surveys and 236 post-training surveys were returned, yielding 206 matched responses suitable for paired analysis. At three-month follow-up, 67 surveys were completed, of which 35 were from participants who had completed both the pre- and post-training surveys. This provided a suitable sub-sample for assessing sustained change in knowledge, attitudes, and confidence across a diverse workforce, including early years practitioners, social prescribers, educational staff, and weight management professionals.

Table 4. Sessions and participants per local authority

Local authority	Population	Sessions			No. registered	No. attended	Mean attendance
		Online	In person	Total			
Cheshire East	398,800	6	4	10	130	93	9.3
Cheshire West and Chester	357,200	3	4	7	127	78	11.1
Halton	128,500	0	1	1	3	3	3.0
Knowsley	154,400	3	0	3*	57	50	16.6
Liverpool	486,100	3	2	5	91	77	15.4
Sefton	279,200	4	4	8	68	48	6.0
St Helens	183,200	5	2	7	126	129†	18.4
Warrington	210,900	5	3	7**	153	138	19.7
Totals:		**29**	**22**	**51**	**755**	**616**	**12.8**

**Knowsley has three outstanding sessions to receive*

***Warrington has one outstanding session to receive*

† St Helens received an online session during a weather event that forced staff to work from home which increased numbers.

Limitations and considerations

While this evaluation sought to adopt a proportionate and robust approach, several limitations should be acknowledged. Firstly, participation in the surveys was voluntary and not all training attendees completed each survey wave.

Of the 616 practitioners trained, 206 provided matched pre- and post-training responses, and only 35 participants completed all three surveys, limiting the strength of longitudinal analysis and generalisability of sustained outcomes. Secondly, some variation in delivery occurred between localities: for example, session formats (online vs. in-person), timing of delivery, and participant recruitment were determined by local authorities and tailored to local service contexts. This flexibility supported local relevance but may have introduced variability in implementation and experience.

7. Key outcomes and impact

Analysis 1: Self-reported knowledge scores

Participants rated their knowledge across five core domains aligned to the training objectives: causes of overweight and obesity; wider determinants of health; weight stigma; adverse childhood experiences (ACEs); and the relationship between stigma, ACEs, and weight gain. Using a 5-point Likert scale (1 = not at all knowledgeable; 5 = very knowledgeable), baseline scores were modest, ranging from 2.66 to 3.06, with the lowest reported understanding in relation to weight stigma and its intersection with trauma.

Post-training scores increased across all domains, with means rising to between 3.97 and 4.23. Gains were particularly notable in areas addressing structural and psychosocial factors, reflecting the training's emphasis on compassionate care and trauma-informed practice.

Three-month follow-up scores demonstrated strong knowledge retention, with no meaningful decline across domains. This suggests that the training was effective in consolidating understanding and that supplementary materials supported ongoing reflection and application in practice.

These findings indicate that the programme significantly improved participants' knowledge of the complex, systemic drivers of overweight and obesity, and enhanced their awareness of stigma and its consequences for engagement, health outcomes, and equity in service delivery.

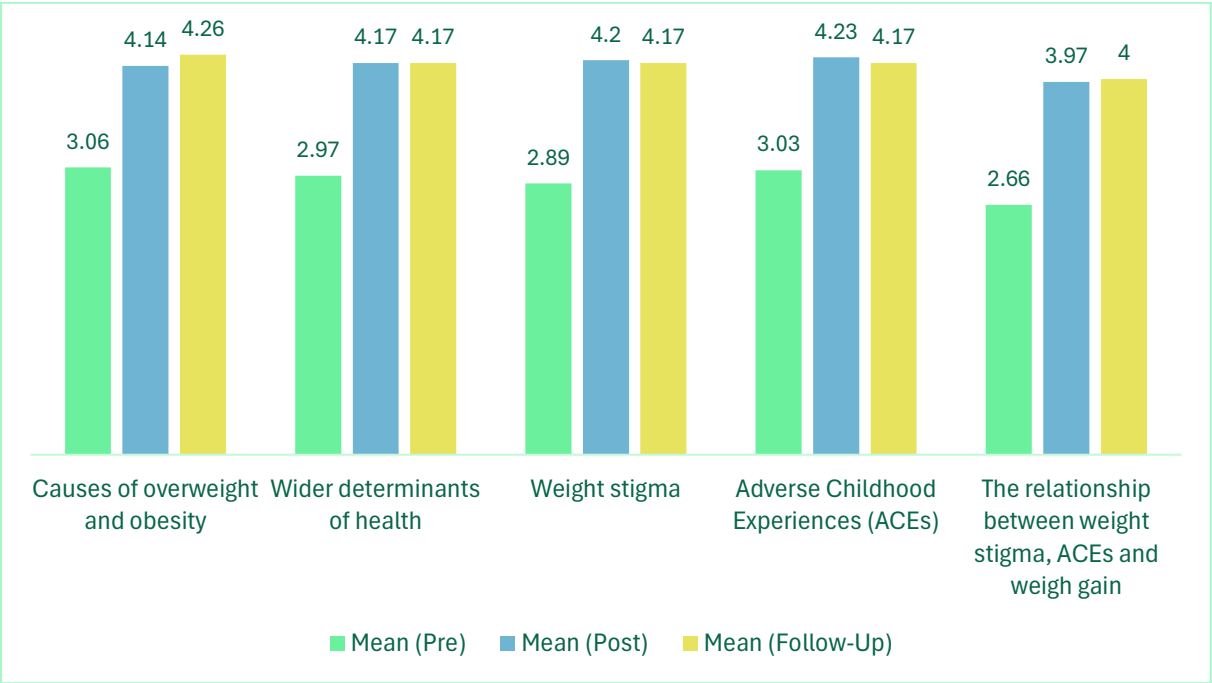


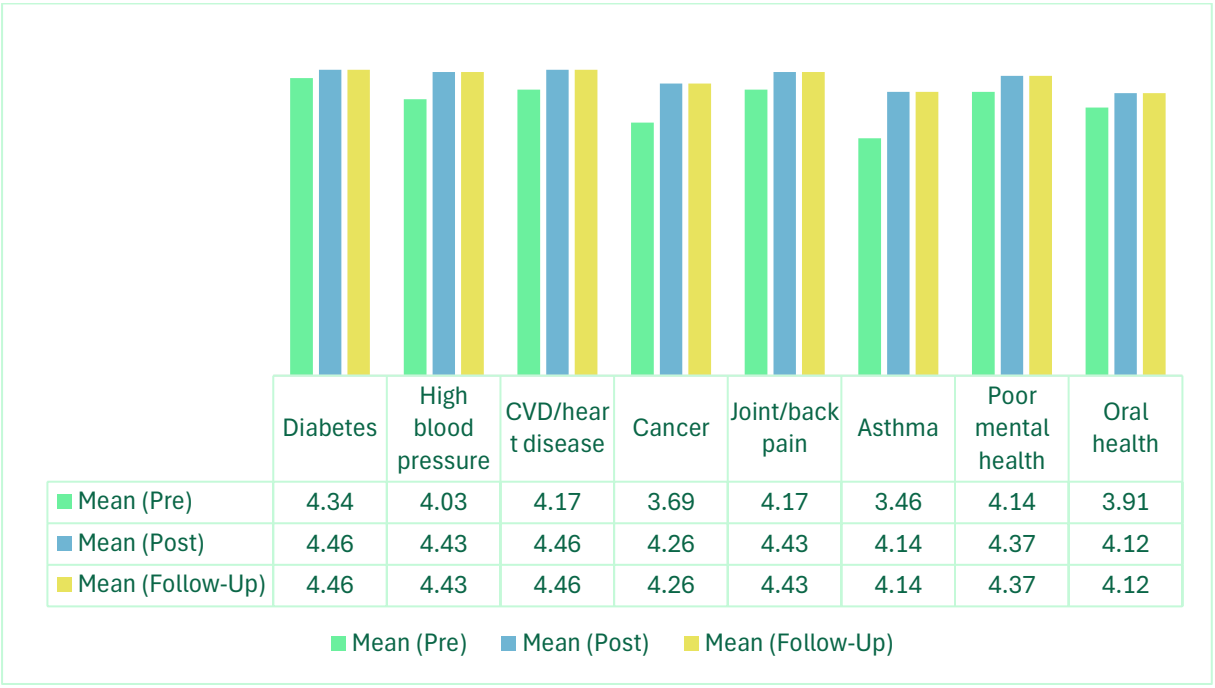
Figure 1: Change in self-reported knowledge across core training topics over time

Analysis 2: Knowledge of health conditions linked to overweight

Participants were asked to rate their knowledge of the relationship between overweight and a range of physical and mental health conditions at three time points: pre-training, post-training, and three-month follow-up. As shown in **Figure 2**, baseline scores were already relatively high across most conditions, particularly for diabetes (M = 4.34), cardiovascular disease (M = 4.17), and joint/back pain (M = 4.17). This reflects existing awareness of these commonly acknowledged comorbidities.

The most substantial knowledge gains were observed for conditions that are less routinely associated with excess weight in public discourse. Notably, understanding of the links between overweight and cancer increased from a mean of 3.69 at baseline to 4.26 post-training and was retained at follow-up. Similarly, awareness of associations with asthma and oral health showed marked improvement, both increasing from below 4.0 at baseline to 4.14 and 4.12 respectively, at post- and follow-up assessments.

Across all domains, knowledge scores were either maintained or improved, with negligible decline at three-month follow-up. These results suggest the training successfully consolidated and extended practitioner understanding of the broader health impacts associated with overweight, including conditions that are less intuitively or publicly linked to excess weight. This has practical significance, particularly in enabling practitioners to engage in more holistic conversations that connect weight with a wider set of physical and psychological outcomes.



	Diabetes	High blood pressure	CVD/heart disease	Cancer	Joint/back pain	Asthma	Poor mental health	Oral health
Mean (Pre)	4.34	4.03	4.17	3.69	4.17	3.46	4.14	3.91
Mean (Post)	4.46	4.43	4.46	4.26	4.43	4.14	4.37	4.12
Mean (Follow-Up)	4.46	4.43	4.46	4.26	4.43	4.14	4.37	4.12

Figure 2: Changes in perceived associations between overweight and comorbid health conditions

Analysis 3: Practitioner beliefs on responsibility and causation

Analysis of repeated measures data (Friedman test) revealed statistically significant shifts in practitioner beliefs about the causes of overweight and obesity, as well as the effectiveness of brief interventions. Notably, there was a marked decline in agreement with the idea that individuals living with overweight or obesity "have poor self-control or lack motivation," with mean scores falling from 2.60 pre-training to 2.23 at follow-up (p = 0.0183). Similarly, the belief that "losing weight is primarily an individual's responsibility" decreased from 3.17 to 2.63 ($p < 0.001$), indicating a move away from individualised, blame-oriented narratives and toward a more systemic understanding of weight-related challenges.

Participants also further rejected the notion that "shaming people because of their size can help them lose weight," with already low agreement levels declining from 1.46 to 1.23 (p = 0.0498). These changes suggest a strengthening of compassionate, non-stigmatising attitudes among practitioners.

Alongside reductions in blame-based thinking, there was an increase in confidence regarding constructive engagement. Belief in the statement that "even small weight loss can produce health benefits" rose significantly from 4.17 to 4.54 (p = 0.0008), and confidence in the value of brief advice as an effective tool to support children and families improved from 3.76 to 4.38 ($p < 0.001$).

Together, these findings suggest the training contributed meaningfully to a shift in practitioner mindset: away from personal blame, and toward respectful, evidence-informed, and system-aware approaches to supporting healthier weight.

Table 5. Changes in practitioner beliefs on responsibility, causation, and intervention effectiveness

Item – 5-point Likert scale *"Strongly agree" to "Strongly disagree"*	**Interpretation**	**Mean** *Pre → follow-up*	**p-value**
Individuals living with overweight and obesity have poor self-control / lack motivation to lose weight	Decline in blame-oriented belief	2.60 → 2.23 ↓	0.0183*
Losing weight is primarily an individual's responsibility	Significant shift toward systemic understanding	3.17 → 2.63 ↓	<0.001*
Shaming people because of their size can help them to lose weight	Consistently low, but reduced further	1.46 → 1.23 ↓	0.0498*
Even small weight loss can produce health benefits	Belief strengthened and sustained	4.17 → 4.54 ↑	0.0008*
Engaging in brief advice is effective in supporting children and families to achieve and maintain a healthier weight	Strong and growing confidence in brief interventions	3.76 → 4.38 ↑	<0.001*

** Statistically significant at p < 0.05 using Friedman test.*

Analysis 4: Confidence to engage and refer children and families into services

Self-reported confidence among practitioners increased markedly following the training, with improvements sustained at three-month follow-up. Confidence in engaging families in conversations about weight improved from a mean score of 2.91 pre-training to 3.86 post-training, with a slight additional rise to 3.91 at follow-up. Similarly, confidence in referring families to appropriate services rose from 3.14 pre-training to 4.11 post-training, with a marginal retention at 4.06 at follow-up.

These findings suggest that the training not only enhanced practitioners' initial confidence but also supported its sustained integration into practice over time. Notably, gains in referral confidence were particularly pronounced, reflecting both increased familiarity with local pathways and the value of structured guidance provided through the training and supplementary toolkit.

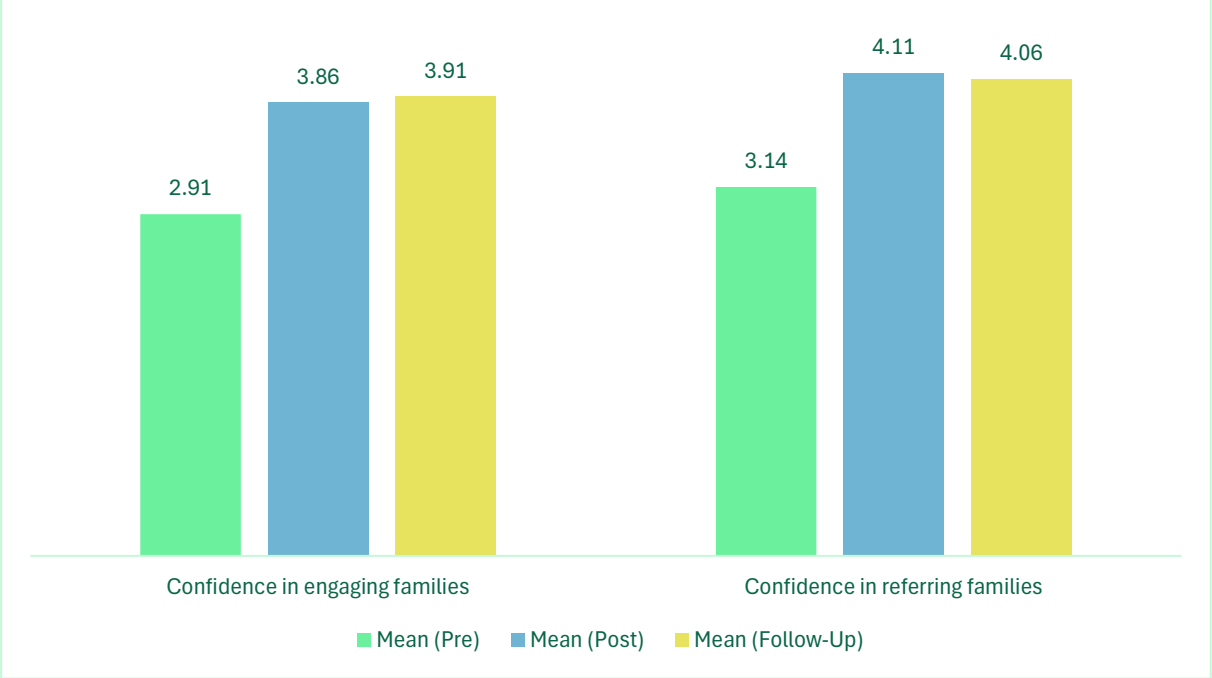


Figure 3: Changes in practitioner confidence to engage and refer families

Analysis 5: Qualitative insights from participants

This thematic analysis draws upon participants' qualitative feedback to elucidate the perceived value, challenges, and implications of the *"Why weight to talk?"* training. Conducted using Braun and Clarke's reflexive thematic analysis framework, the data was reviewed inductively before being mapped onto a predefined set of sensitising concepts derived from compassionate care principles, as set out by Singleton and Mee (2017), Mol (2008), and Tveit and Raustøl (2017) (16–18). The resulting themes are: (1) organisational friction and systemic constraints; (2) emotional risk and the fragility of trust; (3) training, tools, and confidence; and (4) reframing responsibility: from blame to understanding.

Theme 1: Organisational friction and systemic constraints

Practitioners frequently articulated structural barriers to delivering compassionate and effective care, including service fragmentation, lack of time, and unclear referral pathways. These constraints often undermined the application of training in practice.

> *"Referral pathways are not always clear or easy to access."*
>
> *"[I have a] lack of time in school environment to carry out in depth conversations with families."*

These reflections underscore the importance of discretion as a condition for compassion, as practitioners must navigate organisational boundaries and service demands. Despite increased knowledge, respondents reported that systemic inflexibility, being time poor, and unclear pathways remained significant barriers to acting on what they had learned.

Theme 2: Emotional risk and the fragility of trust

Engaging families on the topic of healthier weight was consistently described as emotionally fraught. Practitioners reported a persistent fear of offending or shaming families, especially those with complex needs or existing vulnerabilities.

> *"Not always being sure how the family will respond, not wanting to be seen as a 'nag' or patronising."*
>
> *"Lack of confidence and fear of offending."*

This emotional hesitancy reveals the fragility of trust in the practitioner–family relationship. Many found the training valuable in providing language and strategies that supported trust-building, yet the underlying fear of emotional harm persisted. Compassion, as articulated in the literature, must be relational and reflective, something practitioners are acutely aware of but not always institutionally supported to enact.

Theme 3: Training, tools, and confidence

A strong theme emerging across feedback was the positive impact of the training on practitioners' confidence to initiate conversations about weight. Participants described the sessions as practical, relatable, and respectful.

"A good reminder of what we already know, but delivered in a really engaging and interactive way."

"Excellent training - good pace, great information, delivered in a respectful way."

The training was widely perceived as enabling, helping participants reframe their role not as enforcers of behavioural change or to regurgitate health promotion advice, but as facilitators of supportive conversations. Interactive components and lived experience examples were frequently cited as highlights, reinforcing the importance of experiential learning in sensitive health topics.

Theme 4: Reframing responsibility: from blame to understanding

Participants described a clear shift in their conceptualisation of obesity – from a model of personal blame to one of social, psychological, and structural causation. This theme cuts across and reinforces the previous three, highlighting how compassion involves critical reflection on causality.

"Thinking more about the impact of trauma and stress on a person's life and how this can influence their weight."

"Reinforced the wider factors contributing to weight issues. I feel more confident having difficult conversations with parents now."

The training's focus on adversity, trauma, and stigma was especially powerful for many, challenging dominant narratives around motivation and responsibility. This shift was not merely cognitive but emotional, with several participants describing an enhanced sense of empathy and patience.

Synthesis

Together, these themes reflect both the strengths and limitations of the training. While the programme was successful in reshaping knowledge, improving confidence, and fostering more compassionate understandings of weight, its impact is contingent on systemic and relational conditions. Compassion, as participants make clear, cannot be reduced to knowledge transmission. It must be actively supported through flexible systems, protected time, and continued professional reflection.

As such, the training's longer-term impact relies on organisational cultures that value and enable reflective practice. Trust, empathy, and relational discretion are not incidental to this work; they are central to it. These findings point to the necessity of embedding weight-related public health training within broader institutional structures that empower practitioners to deliver care with integrity and understanding, rather than operating within compliance-driven or time-limited environments.

Analysis 6: Reflections from local authority public health colleagues

This analysis draws on written feedback from local authority public health leads and system stakeholders to better understand the strategic value and perceived impact of the *"Why weight to talk?"* training. Data were analysed using Braun and Clarke's reflexive thematic analysis approach. This thematic analysis aimed to identify how the training aligns with broader public health strategy to support sustainable structural change.

Theme 1: Training as a catalyst for systems thinking and compassionate framing

Feedback from local authority public health leads strongly endorsed the training as a foundational element in stimulating systems-level reflection on the social, psychological, and structural determinants of weight. Rather than reinforcing individualised framings of behaviour change, stakeholders viewed the programme as an opportunity to disrupt entrenched narratives and promote compassionate, upstream approaches.

> *"It's been fantastic to offer this training to so many people – this is vital if we want to shift attitudes on weight stigma across the system."*

> *"Great training to start the wider conversation and challenge people's beliefs."*

These responses suggest the training functioned as a platform for system-level change, offering a counter-narrative to entrenched biomedical or individualistic understandings of overweight and obesity. Importantly, the training was framed as an enabling tool that equips staff with the language, rationale, and confidence to apply more compassionate, upstream thinking across services. Many spoke of feeling "more confident having difficult conversations with parents now," a sentiment that suggests alignment between strategic vision and practitioner experience. Together, these accounts position the training as an important lever for collective reframing; one that enhances relational practice on the ground while driving broader ideological shifts across the public health system.

Theme 2: Alignment with local strategy and practice

Local authority stakeholders repeatedly noted that the training arrived at a strategically opportune moment, dovetailing with ongoing workstreams including early years priorities, workforce development, and trauma-informed practice. Several described the programme as filling a longstanding void in skills and confidence among frontline staff.

> *"It was timely for us… we have seen a number of referrals from staff groups such as school nurses who attended the training."*

> *"It's allowed us to link up with key frontline professionals and promote services that otherwise wouldn't have had visibility."*

The training was also described as filling knowledge gaps in key professional groups and helping to consolidate shared approaches across services. Its consistency with national prevention priorities was further noted, particularly in relation to tackling obesity through system-wide behaviour change support. This harmony between strategic direction and practitioner-level impact suggests the training was not experienced as a generic offer, but

rather as a tailored intervention that aligned with and enhanced local capacity-building goals.

Theme 3: Ending structural and service-level gaps

Some stakeholders viewed the training as part of a wider programme of work to address historical under-provision or fragmentation of services for children and families affected by obesity. However, they were also candid about the ongoing challenge of implementation, more specifically the difficulty in sustaining momentum without further structural support.

> *"While we now have a CYP offer the challenge is now to reach the children and families that need/want support."*

> *"The training has helped get us to this point, but we now need buy-in from the top to embed this across services."*

This reflects a broader theme in practitioner responses concerning organisational friction and systemic constraints. Numerous practitioners described unclear referral pathways and time limitations as barriers to embedding compassionate conversations in day-to-day practice. These intersecting accounts suggest that while training can support attitudinal and knowledge-based change, it requires parallel investment in system architecture to deliver on its full promise. Compassionate, trauma-informed care must be scaffolded by sustainable referral networks and service availability.

Theme 4: Embedding, tailoring, and scaling the model

A clear appetite was expressed for locally owned versions of the training that could be adapted and delivered by in-house teams, enabling greater sustainability and reach. Several local authorities requested resources to support ongoing capacity-building.

> *"Train the trainer model so local trainers can deliver sessions in [Local Authority]."*

> *"We'd like to explore how this can sit within our wider workforce development framework."*

This theme reinforces the importance of a scalable model that is responsive to local need and suggests future iterations of the programme should consider flexible commissioning arrangements, shared delivery mechanisms, and the creation of communities of practice.

Conclusion

This thematic analysis highlights the perceived value of the *"Why weight to talk?"* training in seeding long-term change in how systems conceptualise and respond to weight. Public health leads endorsed its capacity to challenge entrenched beliefs, complement existing strategies, and address service gaps. However, they also pointed to the need for clear next steps, including engagement with senior leadership. A train-the-trainer model and integration into workforce development pathways were seen as critical to long-term impact.

8. Discussion

Local delivery

The local delivery of *"Why weight to talk?"* proved both logistically viable and strategically insightful, uncovering a range of implementation benefits and challenges across Cheshire and Merseyside. The Expression of Interest (EOI) process was instrumental in identifying local authorities that were well positioned to benefit from the programme, while simultaneously highlighting readiness gaps in other areas. This transparent and competitive process fostered early engagement, encouraged internal reflection, and offered a degree of quality assurance by ensuring sites were committed and adequately prepared.

Mapping local healthier weight provision, encompassing statutory weight management services, food insecurity support, and physical activity opportunities, emerged as a key exercise. This mapping not only clarified local referral pathways for trainees but facilitated cross-sector dialogue between stakeholders who may otherwise operate in silos. The collaborative nature of this process allowed partners to share best practice, identify systemic barriers to brief advice, and begin shaping a more cohesive local infrastructure to support families.

Leadership buy-in was pivotal. Where senior local authority officials, including directors of public health and children's services leads, were engaged, the programme extended beyond public health teams into children's services, family hubs, and schools. This cross-departmental engagement was vital for sustainability and cultural reach. Furthermore, in several areas, staff from local weight management services themselves undertook the training, allowing for reciprocal referrals and shared understanding of stigma-sensitive language.

The hybrid delivery model demonstrated that both online and in-person formats hold value. While in-person sessions fostered greater discussion, attendance was sometimes hampered in geographically large or dispersed boroughs. Online sessions offered greater flexibility and higher overall attendance. Future delivery may benefit from a blended model tailored to geography, workforce structure, and digital inclusion.

System-level benefits and strategic alignment

The *"Why weight to talk?"* programme delivered clear system-level benefits across Cheshire and Merseyside, acting as both a strategic enabler and a catalyst for change. Stakeholder reflections, triangulated with practitioner survey data, highlight a marked alignment between the programme's core principles and wider public health system goals. Feedback from public health leads consistently framed the intervention as more than a standalone training; rather, as a foundational step in advancing whole systems thinking around weight, stigma, trauma, and care.

The evaluation demonstrated strong strategic synchrony: local leads viewed the training as timely and responsive to emerging priorities such as trauma-informed practice, early years reform, and upstream prevention. This coherence was reflected in quantitative outcomes, including significant gains in knowledge and confidence (+1.00 for engaging conversations and +0.92 for making referrals), and in qualitative accounts that described the training as

reframing practitioner assumptions and increasing service responsiveness. This embeddedness within system-level thinking strengthens the case for the programme's inclusion in regional workforce strategies and integrated care models.

Support for weight management services

A recurring theme across strategic and operational feedback was the programme's role in bolstering existing and emerging weight management pathways. Through its emphasis on local tailoring and the collation of area-specific service provision, the training offered practitioners not only the confidence to initiate conversations, but the knowledge to refer appropriately within their own locality.

Participants praised the visibility given to community- and VCFSE-led services, and many reflected on increased clarity around when and how to refer, particularly for children and families. This is supported by the rise in self-reported confidence in referral-making and by local authorities noting a tangible uplift in referrals from frontline teams following the training. However, the evaluation also surfaced structural limitations; most notably, gaps in local provision and inconsistencies in referral infrastructure. For areas without fully developed offers, the training risked highlighting needs without providing adequate means of response. To fully capitalise on the programme's benefits, concurrent investment in accessible, sustainable services is essential.

Cultural shifts in service delivery

The qualitative data revealed powerful narratives of cultural and attitudinal shift. Practitioner responses indicated a departure from deficit-based, blame-oriented models toward more compassionate, stigma-informed perspectives. Analysis of beliefs showed statistically significant movement away from individual blame (e.g., agreement with the statement "Losing weight is primarily an individual's responsibility" decreased from 3.17 to 2.63, $p<0.001$), suggesting the programme helped practitioners adopt a more contextual, systemic understanding of weight.

Local authority stakeholders echoed this shift, citing the training as a key mechanism for initiating conversations about weight stigma, and embedding a more respectful, trauma-aware culture of care. These cultural changes were reinforced by the programme's discursive framing, its reflective methodology, and its explicit alignment with contemporary compassionate care theory.

Crucially, the programme positioned practitioners not as passive recipients of policy directives but as active agents in reimagining care. This cultural repositioning, centred on reflection, discretion, and dignity, represents one of the most enduring outcomes of the intervention and offers a strong foundation for system-wide transformation.

Contribution to safeguarding children

While the primary focus of *"Why weight to talk?"* was stigma-informed conversations around healthier weight, the training also demonstrated clear utility in supporting wider

safeguarding efforts. The resource packs included safeguarding prompts and guidance on identifying when unhealthy weight may be symptomatic of unmet needs or wider neglect. Practitioners reported increased awareness of the complex, multifactorial origins of weight gain, particularly in relation to trauma, ACEs, and psychosocial stressors – all key safeguarding considerations.

Participants' qualitative reflections emphasised greater confidence in navigating difficult conversations, particularly with families experiencing complex needs. Several practitioners articulated how the training helped them to approach weight concerns with greater sensitivity, recognising potential indicators of emotional or social harm. When viewed through a safeguarding lens, the training thus functions as an upstream intervention, enhancing professional curiosity, promoting early identification, and encouraging supportive signposting rather than punitive or stigmatising action.

These findings suggest that compassionate weight conversations can serve as an important adjunct to safeguarding frameworks, particularly when embedded within broader trauma-informed and relational care approaches. Future iterations of the training could further strengthen this dimension by incorporating case studies, supervision tools, and stronger links with safeguarding leads.

Sustainability and legacy

The training's legacy is visible at both operational and strategic levels. Across the subregion, over 600 practitioners are now equipped to deliver stigma-informed, compassionate conversations around weight, many of whom work in schools, health visiting, early help, or safeguarding roles. A freely accessible digital referral pathways document was produced and hosted on the *Why Weight Hub*, offering an ongoing resource for signposting.

Moreover, the effectiveness of Halton's Health Improvement Team as a delivery partner exemplifies the viability of a 'train-the-trainer' model. This offers a sustainable model for future phases and suggests the potential for embedding the programme within routine workforce development.

The training's universal offer allowed adaptation to local strategic priorities: in some boroughs the focus was food insecurity and community nutrition; in others, it supported newly launched physical activity strategies. This adaptability adds considerable value, although gaps remain, particularly in NHS engagement. Primary and secondary care services had limited contact with the programme, representing a missed opportunity for fully integrated pathways.

Buy-in was high. Attendance data across phases 3 and 4 demonstrates significant reach, although travel barriers in larger geographies highlight the value of hybrid delivery. HEG maintained consistent communication with Beyond throughout delivery, providing a flexible and responsive approach to project management.

Value for money

At a total investment of £60,843, *“Why weight to talk?”* delivered more than just training sessions. It represented a strategic investment in public health infrastructure—mapping local provision, tailoring stigma-informed content for eight localities, training in-house teams, and producing sustained tools (e.g. the *Why Weight Hub*). While the cost-per-participant estimate of £98.77 offers a useful reference point, it masks the programme’s broader systemic value and capacity-building outcomes.

When evaluated through a multi-level framework, *“Why weight to talk?”* demonstrates strong alignment with value-for-money principles: targeted investment in workforce capability, operational efficiency through tailored delivery, and the potential to reduce long-term demand on high-cost services through improved early intervention and referral confidence. Future evaluations could strengthen this case further by adopting cost-effectiveness or SROI methodologies. Commissioners should therefore view *“Why weight to talk?”* not as a transactional cost but as an enabler of long-term savings, strategic alignment, and compassionate care integration across systems.

Forward outlook

Taken together, these insights highlight *"Why weight to talk?"* not simply as a training programme, but as a strategic mechanism to drive systemic, cultural, and operational change. With appropriate commissioning support the model is well placed to support a more compassionate, effective, and equitable response to childhood obesity and its determinants across the region.

9. Reflections and recommendations

Barriers and adaptations

While the *"Why weight to talk?"* programme achieved considerable success, several systemic and contextual barriers emerged during delivery. In larger geographic areas, logistical barriers, such as travel distances to in-person training, impacted attendance. Digital delivery offered a solution, yet practitioners noted the loss of interpersonal learning and peer exchange that face-to-face formats support. In-person delivery should remain the default, particularly for high-impact staff cohorts such as 0–19 teams, where group discussion, reflection, and cross-sector interaction add significant value.

The training also surfaced underlying philosophical differences in approach between statutory commissioned services and the VCFSE sector. Statutory services frequently continue to apply a traditional health promotion lens, focusing on behaviour change messaging and personal responsibility. By contrast, VCFSE partners often adopt a more structural approach, recognising the impact of affordability, stress, and trauma on health behaviours. Training should further develop these distinctions and encourage services to reframe provision and policy through a wider determinants of health lens.

In areas with less developed infrastructure for healthier weight services, the training raised practitioner awareness without a corresponding increase in system capacity to respond. While mapping exercises helped consolidate service knowledge, they also exposed disparities in provision, particularly for families experiencing food insecurity or requiring sustained support.

Improvements to training

Feedback from participants and stakeholders revealed several opportunities to strengthen future iterations of the training:

- **Train-the-trainer capacity:** Halton's success in delivering the programme internally indicates potential for scaling this model. Training 'local champions' to embed the approach more sustainably should be considered.
- **Stronger NHS engagement:** Future commissioning should explicitly involve primary care networks, general practice, and community paediatrics to ensure NHS alignment and improve cross-sector referrals and further empower social prescribers.
- **Addressing sectoral disconnects:** Future training should explicitly address the disconnect between statutory services and the VCFSE sector, embedding case studies and reflective activities to challenge deficit-based approaches and champion equity-informed models.
- **Enhanced localisation:** The collation of area-specific services was well received, and future programmes could build on this by undertaking a mapping exercise on a more routine basis to ensure contemporary information is shared.

- **Expanded safeguarding focus:** Participants valued the safeguarding elements but requested more case studies and scenario-based learning to build confidence in applying knowledge to real-world complexities.

Recommendations for future commissioning and implementation

1. **Strengthen system integration:** Commissioners should embed *"Why weight to talk?"* into broader workforce development strategies, including safeguarding, mental health, and public health training frameworks. Explicit links to early years, family hubs, and education should be formalised.
2. **Leverage strategic timing:** Align delivery with existing system changes (e.g. family hub rollouts, early years reforms, physical activity strategies) to maximise relevance, impact, and momentum.
3. **Ensure service readiness:** Require mapping of local pathways and cross-sector engagement before delivery begins, using the expression of interest process as a readiness tool.
4. **Embed digital infrastructure:** Develop and maintain the *Why Weight Hub* as a central repository for referral tools, best practice, and implementation support for any local authority or other funded commissioning *"Why weight to talk?"*.
5. **Prioritise equity:** Future delivery should prioritise areas with higher levels of deprivation and childhood obesity, ensuring reach into under-served populations.
6. **Evaluate for long-term impact:** Consider commissioning academic partners to lead longitudinal evaluations, examining sustained changes in referral activity, practitioner behaviours, and service uptake.
7. **Support leadership engagement:** Maintain high-level buy-in from local authorities, facilitating engagement beyond 0–19 teams to include education, safeguarding, SEND, and housing.
8. **Influence policy and commissioning specifications:** Use learning from this programme to inform service specifications and local commissioning policies; ensuring weight management and prevention services are framed around dignity, structural determinants, and long-term change and encourage practitioners to exercise their discretion where appropriate.

Conclusion

The *"Why weight to talk?"* programme is a credible and effective intervention for tackling childhood obesity through a compassionate, stigma-informed lens. It has demonstrated alignment with system priorities, strengthened referral pathways, and shifted practitioner cultures. With modest adaptation and sustained strategic commitment, it offers commissioners a scalable model for upstream prevention that addresses the wider determinants of health across Cheshire and Merseyside.

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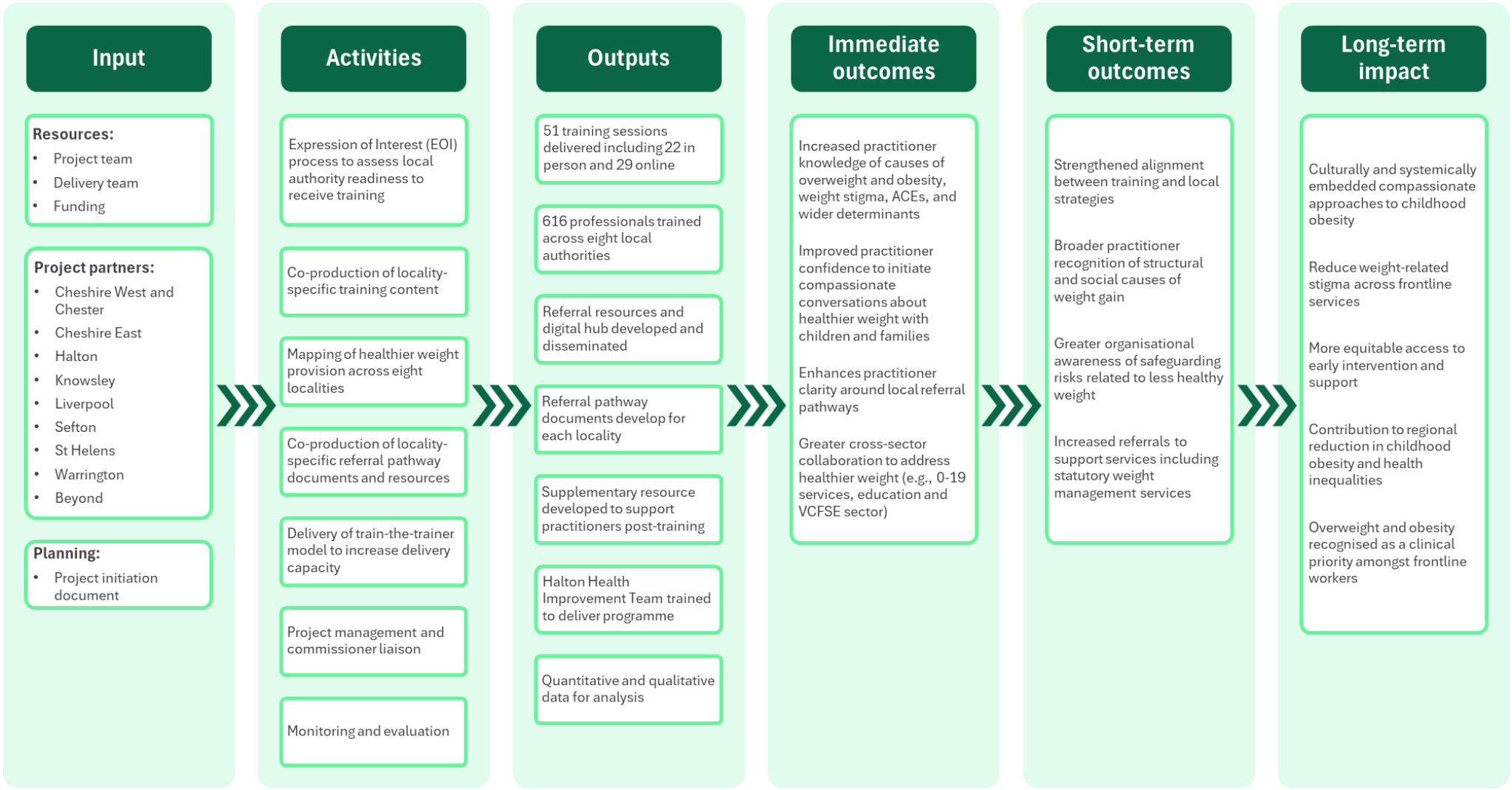
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Appendix 1: Logic Model



Why weight to talk?

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