Health Equalities Group

Why weight to talk?

beyond

“Why weight to talk?”

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

Summary report 2023-25

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About HEG 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.

Acknowledgements

- We would like to thank the team at NHS Cheshire and Merseyside's Children and Young People's Transformation Programme (*Beyond*) for their support in scaling up delivery of *"Why weight to talk?"* across Cheshire and Merseyside and to all local authority partners for helping embed the training in their wider systems.

Background and rationale

- **Obesity and weight stigma are deeply rooted in structural inequalities:** Overweight and obesity affect two-thirds of adults and one-third of children in England, with prevalence highest in areas of deprivation due to systemic drivers like poverty, trauma, food insecurity, and commercial determinants of health.
- **Narratives of personal responsibility are harmful and inaccurate**, contributing to weight stigma and ignoring the complex, intersecting biological, social, and environmental factors that influence body weight. Stigma worsens health outcomes and is a barrier to accessing support.
- **Practitioners face multifaceted barriers to discussing weight**, including limited confidence, fear of damaging trust, stigma, and systemic issues like time pressures and unclear referral pathways. These challenges are exacerbated when organisational cultures don't support relational, reflective practice.
- ***"Why weight to talk?"* promotes a compassionate, stigma-informed model**, training practitioners to deliver brief interventions that are context-sensitive, non-judgemental, and trauma-aware; embedding trust, dignity, and discretion into weight-related conversations.
- **System change is essential:** Effective delivery of compassionate care requires more than practitioner skills, it demands organisational conditions that enable reflective practice, discretion, and continuity of care, addressing both stigma and health inequalities.

Programme development

"Why weight to talk?" was developed and delivered through strong local partnerships across Cheshire and Merseyside and tailored to support local priorities.

- **Expression of interest (EOI):** All nine local authority public health teams in Cheshire and Merseyside were invited to submit an EOI to help assess their readiness to receive the training. In Phase 3 we worked with six local authorities. We worked with a further two in Phase 4.
- **Local expertise:** Working groups were formed in each area, comprising key stakeholders to help map local provision of weight management services, physical activity opportunities and support around food insecurity. These groups also helped to identify priority staff cohorts and helped socialise the training to aid recruitment.
- **Bespoke training:** Eight individual training packages were developed alongside supplementary materials detailing local service provision.

Partnerships

Cheshire West and Chester

Cheshire East Council

HALTON BOROUGH COUNCIL

Knowsley Council

Liverpool City Council

Sefton Council

ST HELENS BOROUGH COUNCIL

WARRINGTON Borough Council

beyond

Why weight to talk?

Delivery model

- **Two core formats:** Training was offered as a 90-minute online session and a 2-hour in-person session to accommodate varying staff availability and learning preferences.
- **Online delivery:** Conducted via Microsoft Teams, the virtual format increased accessibility for geographically dispersed teams and time-constrained professionals.
- **In-person sessions:** Delivered in local venues, these sessions enabled richer discussion, contextual relevance, and stronger peer interaction.
- **Local trainer development:** HEG trained Halton Health Improvement Team to deliver sessions, expanding delivery capacity and fostering local ownership.
- **Scalable and sustainable model:** The dual-format approach, combined with place-based trainer development, helped to increase capacity and demand for the training.

Target audience

- **Focus on 0–19 services:** School nurses, health visitors, and early years practitioners were key targets due to volume of contact time with children and families.
- **Inclusion of social prescribers and education staff:** Recognising their roles in addressing wider determinants and providing early intervention, social prescribers, teachers, and pastoral staff were actively engaged.
- **Broader workforce engagement:** A diverse range of professionals, including lifestyle advisors, speech and language therapists to library outreach officers, participated, reflecting a whole-systems approach.
- **Tailored local implementation:** Each local authority identified priority staff groups based on their own strategies, service plans, and readiness, ensuring alignment with local needs and structures.

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Why weight to talk?

Training content

1. Public health framing

- Reframes obesity as a complex condition driven by structural and social inequalities.
- Aligns with whole systems approaches and wider determinants/upstream prevention.

2. Stigma and trauma-informed practice

- Addresses how stigma and bias undermine care, motivation, and service uptake.
- Promotes trauma-informed, compassionate practice that supports psychological safety.

3. Behavioural techniques & communication

- Introduces evidence-based tools to guide respectful, strengths-focused conversations.
- Encourages person-first, culturally competent language to build trust and reduce resistance.

4. Practical application and local integration

- 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.

Supplementary materials

- **Support pack:** Participants received summary slides reinforcing weight-inclusive, trauma-informed principles and practical guidance for conversations about weight. The pack also included models such as Ask–Provide–Ask (APA), reflective listening strategies, and a conversation checklist to support compassionate practice.
- **Support services:** Documents were created to showcase the range of support available in each locality and included contact information and referral criteria.
- **Whole systems support directory:** Information on support services were hosted on the Why Weight Hub, a digital platform supporting frontline practitioners to address healthier weight.
- **Safeguarding:** Information concerning multi-agency safeguarding hubs (MASH) were shared with practitioners as a guardrail in the event there were concerns for a child's welfare associated with healthier weight.

Evaluation design and methods

- **Theory-informed, mixed-methods evaluation:** Guided by a logic model (see Appendix 1), the approach enabled triangulation of data across individual and system levels, supporting assessment of both learning and longer-term application.
- **Structured, multi-point survey design:** Participants completed surveys at three time points (pre-, post-, and 3-month follow-up) to assess knowledge, beliefs, and confidence related to the training.
- **Quantitative and qualitative measures:** Surveys included Likert-scale items to assess beliefs, knowledge, and confidence, alongside open-text questions to capture reflective feedback on practice relevance.
- **Analytical approach:** Quantitative data were analysed using Friedman tests for repeated ordinal measures; qualitative responses underwent reflexive thematic analysis based on compassionate care theory.
- **Dual-level qualitative analysis:** Practitioner reflections and local authority stakeholder feedback were analysed thematically and mapped against the programme's logic model for strategic insight.

Sample size

- **Wide reach:** 616 practitioners attended 48 sessions (online and in-person) across eight local authority areas in Cheshire and Merseyside.
- **Robust participation in evaluation:** 276 pre-training and 236 post-training surveys were completed, with 206 matched responses enabling paired analysis.
- **Sustained follow-up:** 67 follow-up surveys were returned, including 35 fully matched responses, allowing assessment of lasting change across varied professional groups.

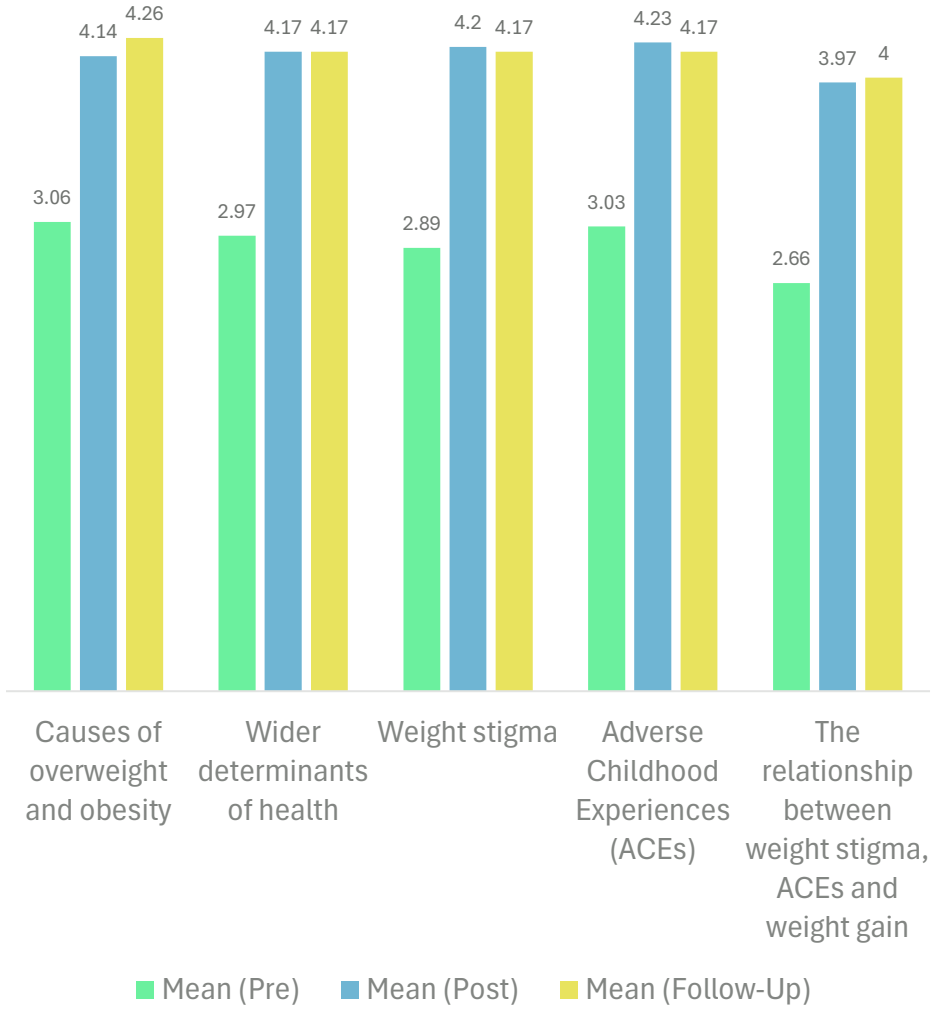
Sessions and participants per local authority

Local authority	Sessions			Number registered	Number attended	Mean attendance
	Online	In person	Total			
Cheshire East	6	4	10	130	93	9.3
Cheshire West and Chester	3	4	7	127	78	11.1
Halton	0	1	1	3	3	3.0
Knowsley	3	0	3*	57	50	16.6
Liverpool	3	2	5	91	77	15.4
Sefton	4	4	8	68	48	6.0
St Helens	5	2	7	126	129†	18.4
Warrington	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.

Analysis 1: Participants' self-reported knowledge scores

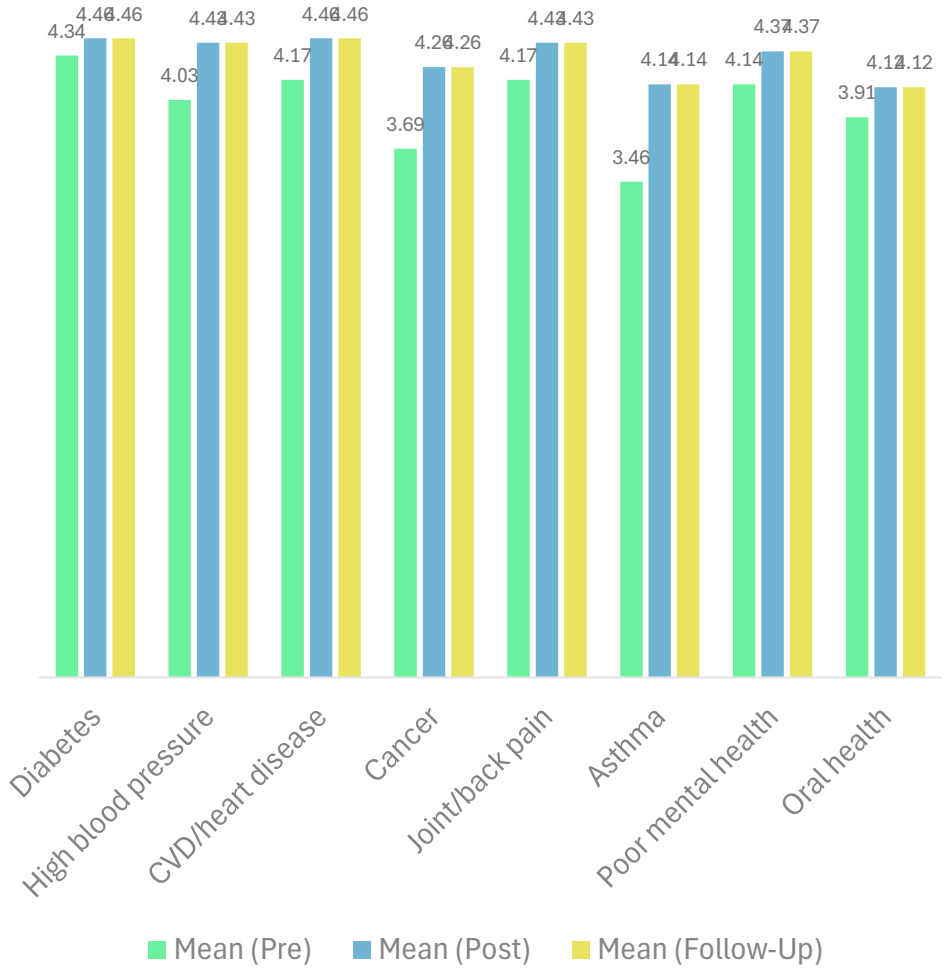
- **Significant knowledge gains were observed across five key domains**, including wider determinants, trauma, and stigma, with mean scores increasing from 2.66–3.06 at baseline to 3.97–4.23 post-training.
- Knowledge retention was sustained at three-month follow-up, **indicating strong consolidation of learning** and effective use of supplementary materials.
- Training enhanced system-level understanding, **equipping practitioners with deeper insight into the complex, structural drivers of obesity** and the implications of stigma for equitable service delivery.



Sample sizes | **Pre:** 206 | Post: 206 | Follow-up: 35

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

- Practitioner knowledge of health conditions linked to overweight was already high for commonly recognised comorbidities such as diabetes and cardiovascular disease.
- Substantial gains were observed in less commonly acknowledged associations, including cancer, asthma, and oral health; **areas often overlooked in public and professional discourse**.
- Knowledge was retained at follow-up, supporting more holistic, informed conversations about the wide-ranging physical and mental health impacts of excess weight.



Sample sizes | **Pre:** 206 | Post: 206 | Follow-up: 35

Analysis 3: Practitioner beliefs on responsibility and causation

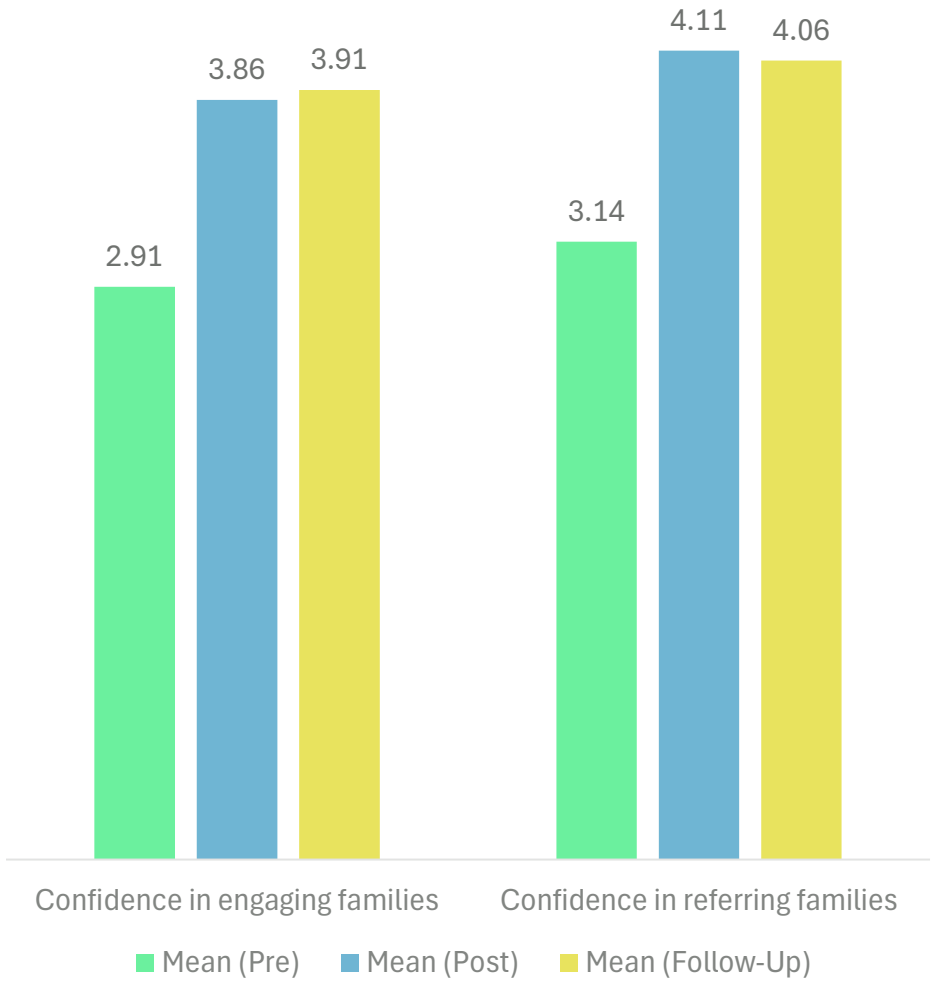
- Practitioners showed statistically significant **shifts away from blame-oriented beliefs**, with declining agreement that overweight is caused by poor self-control or lack of motivation.
- **Stigma-rejecting attitudes strengthened**, including reduced belief in the effectiveness of shame and a clearer understanding that weight is shaped by systemic and psychosocial factors.
- **Confidence in brief interventions increased**, with practitioners more strongly endorsing the health benefits of small weight changes and the value of brief advice as a support tool.

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*

Sample sizes | **Pre:** 206 | Post: 206 | Follow-up: 35

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

- **Confidence in discussing weight with families** rose significantly, increasing from a mean of 2.91 pre-training to 3.91 at follow-up.
- **Confidence in making appropriate referrals** also improved markedly, rising from 3.14 to 4.06, with especially strong gains post-training.
- Improvements were sustained over time, indicating the training's lasting impact and the practical value of the referral toolkit and local pathway guidance.



Sample sizes | **Pre:** 206 | Post: 206 | Follow-up: 35

Analysis 5: Qualitative insights from practitioners

The thematic analysis summarised below draws on open-text responses from practitioners who completed the post-training, and three-month follow-up surveys:

- **Structural barriers persist:** Time pressures, fragmented services, and unclear referral pathways often limited practitioners' ability to apply the training effectively.
- **Trust is fragile:** Emotional risks and fear of offending families made conversations about weight difficult, despite the training providing helpful strategies.
- **Confidence improved:** The training was widely praised for its practical tools and respectful tone, helping practitioners feel more capable and supported.
- **Blame was reframed:** Many participants shifted their understanding of obesity from individual responsibility to broader structural and psychological causes.
- **Sustained impact requires support:** For compassion-led approaches to take root, practitioners need flexible systems, reflective space, and organisational backing.

Analysis 6: Reflections from local authority public health

This analysis draws on qualitative feedback from local authority public health leads who supported delivery:

- **Catalyst for systems thinking:** The training was viewed as a valuable tool for promoting compassionate, upstream approaches to obesity and challenging individual responsibility narratives.
- **Strategic alignment:** The programme was seen as timely and well-aligned with local priorities (e.g. early years, trauma-informed care), helping to build skills, visibility, and consistency across frontline services.
- **Structural challenges remain:** While the training addressed knowledge and confidence gaps, stakeholders emphasised that systemic barriers such as limited service provision and unclear pathways must be addressed to sustain impact.
- **Appetite for scaling:** There was strong support for delivery through a train-the-trainer model to sustain impact in the medium term.
- **Sustainability depends on leadership:** Long-term impact was seen to depend on senior buy-in, investment in local infrastructure, and alignment with wider public health system architecture.

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Why weight to talk?

Discussion

- **Strategic system enabler:** *"Why weight to talk?"* goes beyond training, acting as a catalyst for system-wide cultural change by aligning with trauma-informed care, safeguarding, early years reform, and upstream prevention priorities.
- **Builds confident, compassionate workforces:** The programme significantly improved practitioner confidence in engaging families and making referrals, while fostering stigma-informed, non-blaming attitudes to weight; key for sustainable, compassionate practice.
- **Strengthens local pathways and partnership working:** Local tailoring uncovered service gaps, mapped referral infrastructure, and facilitated new cross-sector connections between statutory, community, and VCFSE partners, enhancing service integration.
- **Supports safeguarding and professional curiosity:** The training increased awareness of how weight can intersect with unmet needs, trauma, or neglect, positioning practitioners to identify and respond to potential safeguarding concerns with care and sensitivity.
- **Offers scalable, value-for-money delivery:** With a per-participant cost of ~£99, and proven demand for train-the-trainer models, *"Why weight to talk?"* presents a cost-efficient, adaptable model with the potential for strategic embedding in local workforce development and prevention strategies.

Reflections and recommendations

- **Adaptable delivery model with local nuance:** While digital formats increase accessibility, in-person training is more effective for fostering discussion and cross-sector relationships, especially for 0–19 teams. Future delivery should flexibly blend formats based on geography and workforce.
- **Build sustainable capacity through local champions:** A train-the-trainer model, as piloted in Halton, offers a viable route to scale delivery, embed learning, and tailor content to local systems. Future projects should invest in developing champions to support ongoing cultural change.
- **Improve integration with health and community sectors:** Commissioners should actively engage NHS partners (e.g. GPs, paediatrics, social prescribers) and address disconnects between statutory and VCFSE sectors by embedding integrative models and scenario-based learning into training.
- **Align with system transformation and policy reform:** Embedding *"Why weight to talk?"* within wider strategies (e.g. family hubs, safeguarding, mental health, physical activity) ensures strategic coherence. Requiring local pathway mapping and cross-sector coordination pre-delivery will enhance impact.
- **Support long-term system change:** Commissioners are encouraged to invest in digital infrastructure for referrals, prioritise high-need areas, and commission academic partners for longitudinal evaluation. The programme can also inform local commissioning specifications to embed dignity, discretion, and upstream approaches into weight management services.

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