Healthy Weight Management services in Hertfordshire and West Essex: barriers to engagement for primary school children and their families

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Executive Summary

Background

Childhood obesity in Hertfordshire and West Essex (HWE) is a growing public health concern, with children from disadvantaged and ethnic minority backgrounds disproportionately affected. This report presents the findings from work carried out by Health Innovation East to better understand the factors influencing engagement with healthy weight management services for children and young people (CYP), particularly in areas of high inequality.

Aim

To understand barriers and enablers to engagement with healthy weight management services for children and their families, and to identify opportunities for improvement.

Objectives

- To explore the evidence relating to families' experiences of primary school children healthy weight management services, including enablers and challenges to engagement
- To describe the current structure of service provision, specifically focusing on areas of inequality within HWE
- To understand barriers and enablers to service engagement, with a specific focus on inequality areas, from the perspectives of key informants from HWE

Methods

We conducted: i) a targeted literature review, ii) service mapping across Hertfordshire and Essex, and iii) stakeholder conversations with commissioners and providers of healthy weight services, and public health leads. Findings were combined to identify common themes relating to barriers and enablers to engagement and to develop recommendations.

Key Findings

- Families face stigma, fear of judgment, and practical constraints such as transport, time, and finances. Confusing referral routes and poor inter-professional communication further hinder access.

- There are uneven access points and some schools have opted out from the National Child Measurement Programme (NCMP) programme. Many Healthy Weight Management (HWM) programmes don't' have a follow up; and staffing, funding and digital exclusion reduce reach.

- Non-judgmental communication and trusted settings such as schools and family hubs increase access and engagement. Cultural tailoring and support for wider needs like food insecurity enhance relevance.

- Embedding weight management into broader family support reduces stigma. Flexible, hybrid, and modular formats improve accessibility and engagement. Stronger school and community links and Special Educational Needs and Disabilities (SEND) inclusion are key.

- Cross-sector collaboration is essential. Addressing poverty, food environments, and housing supports long-term impact.

Recommendations

1. Co-develop Culturally Appropriate Materials: create inclusive materials with community input, reflecting cultural values and language needs.

2. Reframe Programme Narratives: focus on holistic wellbeing rather than weight loss to reduce stigma and improve engagement.

3. Flexible, Accessible, and Localised Options: deliver shorter programmes locally, use mobile units, and offer taster sessions.

4. Community-Based Delivery: use trusted community spaces and leaders to build trust and improve relevance.

5. Family and Community Involvement: encourage family participation and peer support to strengthen engagement and continuity.

6. Personalised Goals and Incentives: use individual goals and small rewards to motivate and retain participants.

7. Embedding evidence-informed practices: using evidence, data and behaviour change models to inform programme design.

8. Improve Engagement with Schools: work with schools to improve NCMP participation and streamline referrals.

9. Evaluate and Refine: monitor engagement and outcomes to adapt services based on feedback and learning.

10. Sustainable and cross-sector collaboration: convene multi-agency partners to explore shared delivery models and address wider determinants of health; integrate programme design to embed weight management in broader support services.

Conclusion

This evaluation highlights that by addressing structural barriers and embedding services within trusted local systems, future programmes can better support children and families most at risk of becoming overweight. The recommendations outlined provide a set of key considerations for effective service design and delivery of equitable, sustainable, and impactful interventions that reflect the lived realities of the communities they aim to serve.

Contents

List of Abbreviations

ARC – Applied Research Collaboration

BMI – Body Max Index

COM-B – Capability, Opportunity, Motivation-Behaviour

CYP – Children and Young People

CEW – Complications from Excess Weight

ESNEFT - East Suffolk and North Essex NHS Foundation Trust

GP – General Practitioner

HCRG - Health, Community and Recruitment Group

HWE – Hertfordshire and West Essex

HWM – Healthy Weight Management

ICB – Integrated Care Board

IT - Information Technology

NCMP – National Child Measurement Programme

NHS – National Health Service

NHSE – NHS England

NICE – National Institute for Health and Care Excellence

NIHR – National Institute for Health and Care Research

SEND – Special Educational Needs and Disabilities

VCSFE – Voluntary, Community, Social Enterprise and Faith Sector

1. Introduction

1.1 The National Context

Childhood obesity is a major public health issue in the United Kingdom, with increasing prevalence and significant implications for long-term physical and mental health. According to NHS Digital, approximately one in four children in England begin primary school overweight or obese, and this figure rises to nearly 40% by the time they leave at age 11. The rise in childhood obesity has been particularly pronounced over the past three decades, exacerbated further by the COVID-19 pandemic and its associated restrictions on physical activity and access to healthy food (1).

Obesity is not evenly distributed. Children from socioeconomically disadvantaged backgrounds and certain ethnic minority groups, including Black African, Black Caribbean, and Bangladeshi communities, are disproportionately affected. These disparities reflect broader social determinants of health, including access to nutritious food, safe environments for physical activity, and health literacy (1, 2).

Efforts to address childhood obesity have included a range of school-based and community interventions. However, evidence suggests that engagement with weight management services remains a significant challenge, particularly in areas of high deprivation. A review of school-based obesity prevention programmes found that while some interventions can be effective their success often depends on factors such as length of programme, environmental changes, and integration with broader support systems. Educational approaches alone have shown limited impact, and interventions that fail to consider the complex social and environmental context may inadvertently widen health inequalities (3).

1.2 Child Obesity in Hertfordshire and West Essex

Obesity remains a significant and growing public health issue in Hertfordshire and West Essex (HWE), with long-term implications for health and wellbeing. Data from the National Child Measurement Programme (NCMP) and the April 2024 Healthy Weight Summary highlight a steady increase in obesity rates among children aged 4–11, particularly in areas of deprivation. In Hertfordshire, 31 % of 10–11-year-olds were classified as overweight or obese in the 2024 data, up from 27.8% in 2015. Children living in the most deprived areas were reported as more than twice as likely to be obese compared to those in more affluent communities. Ethnic disparities are also pronounced, with children from Black African, Black Caribbean, Bangladeshi, and Chinese backgrounds experiencing higher rates of obesity than their White, Indian, or mixed-heritage peers (4).

In response, Essex and Hertfordshire County Council have implemented a range of weight management strategies for children and young people (CYP), including food education, Healthy Schools initiatives, and lifestyle programmes delivered in partnership with the NHS and local

organisations. Programmes such as Beezee Bodies, Active Essex, and Healthcare Resolution Group (HCRG) provide direct support to families and training for professionals.

Despite these efforts, engagement with services remains a challenge, particularly in high-inequality areas. HWE Integrated Care Board (ICB) recognises the complexity of obesity and the need for a whole systems approach that brings together stakeholders and communities to address the root causes and support healthier outcomes for CYP.

1.3 Aims and Objectives

This project aimed to understand barriers and enablers to engagement with healthy weight management services for children and young people from Reception to Year 6 and their families, and to identify opportunities for improvement.

Our objectives were:

- To explore the evidence relating to families' experiences of primary school children healthy weight management services, including enablers and challenges to engagement
- To describe the current structure of service provision, specifically focusing on areas of inequality in HWE
- To understand barriers and enablers of service engagement, with a specific focus on inequality areas, from the perspectives of key stakeholders (e.g., commissioners and providers) from HWE

2. Methods

To explore barriers to engagement with healthy weight management services for CYP across HWE, particularly understanding families and children's experiences, this project consisted of three components:

1. A literature review of the evidence relating to the experience of CYP and families engaging with healthy weight management services
2. Mapping of healthy weight services within HWE
3. Stakeholders conversations

2.1 Literature review of evidence

A literature review was conducted between June and August 2025 to explore existing evidence to understand families' experiences, and barriers to engagement with weight management services for CYP. This was conducted in two steps:

2.1.1 Scoping existing national guidance and policy documents

To establish the national context surrounding healthy weight management and identify common barriers and solutions to engagement we searched relevant organisational websites,

e.g., Public Health England and National Institute for Health and Care Excellence (NICE) for eligible literature. We purposively selected national organisational documents, including guidelines which either described engagement to healthy weight services or management of childhood obesity. We included any document type. We excluded documents which were not published online and therefore not publicly available. We reviewed all of the documents included, and identified key themes from each.

2.1.2 A review of UK and international literature published in peer-reviewed journals

We explored the published journals that provided evidence of lived experiences of children and families engaging with weight management services to inform a more holistic understanding of effective practice. This focused on what had been effective or ineffective in terms of engagement with different types of intervention. Particular attention was given to insights from deprived communities to ensure equity and relevance in the findings.

Inclusion criteria required studies to address primary school-aged children, family or community-based interventions, and factors influencing service uptake or engagement (see table 1 below). A thematic synthesis approach was used to identify recurring patterns and contextual factors. We imported 224 citations into Covidence software which we used to manage this review. Covidence removed 8 duplicated citations. We screened 196 title and abstracts and excluded 184 citations which did not meet our inclusion criteria as outlined in the table below. We screened 15 full texts for eligibility, and excluded a further two documents.

Data was extracted from 13 peer-reviewed studies that examined childhood obesity interventions globally, in countries like Australia, New Zealand, the United Kingdom, Ireland, and the United States. The studies investigated diverse interventions including digital health tools, school-based programmes, peer-led group sessions, and community-wide, whole-system approaches. The populations targeted were predominantly school children living with overweight or obesity and their families, with a strong focus on underserved communities, including low-income households, ethnic minority groups, and Indigenous populations.

TABLE 1 Inclusion and exclusion criteria for scientific studies

Criteria	Inclusion	Exclusion
Population	Children aged 5–11 and their families/carers	Adolescents 12+ /non primary school children
Intervention	Healthy weight management services, programmes or interventions targeting childhood overweight & obesity	General health promotion without weight focus
Outcome	Barriers to engagement or participation	Only programme outcomes without engagement data
Literature Type	Peer-reviewed (including reviews) and grey literature	Editorials, opinion pieces

Language	English	Non-English
Time Frame	2015–present	Pre-2015

2.2 Mapping current service provision within HWE

A service mapping exercise was undertaken to provide an overview of the current weight management provision across HWE. This included identifying the types of services available (e.g., lifestyle programmes, school-based interventions), access points (e.g., self-referral, GP referral), and referral pathways. Information was gathered through consultation with key stakeholders. The mapping aimed to describe service availability and accessibility.

2.3 Stakeholder conversations to understand local experiences

2.3.1 Participant Recruitment and Engagement

Stakeholder conversations were conducted with key informants. Informants held leadership positions in commissioning, service provision and health improvement; three individuals worked across Hertfordshire and two across West Essex. These were selected based on their involvement in the design, delivery, or commissioning of CYP weight management services in the target areas. Interviews explored perceptions of service accessibility, cultural relevance, communication strategies, and perceived barriers to engagement among families. A list of interview questions is provided in Appendix 3.

In total, we held five stakeholder conversations. These were held via Microsoft Teams by one member of the evaluation team and lasted approximately 45 minutes. Following informed consent, conversations were recorded and then transcribed.

2.3.2 Stakeholder conversations analysis

Transcripts from stakeholder conversations were analysed using thematic analysis (5). Through familiarisation, relevant codes were identified based on the data collection topic guides and new themes emerging from the data. Coding and analysis were agreed through duplicate coding by evaluation team members, cross-checking for consistency of interpretation, and discussions and feedback meetings with the evaluation team and the stakeholder group. Table 2 provides a summary of the main themes and sub-themes used to identify common challenges, facilitators to engagement, opportunities for improvement and strategic vision.

TABLE 2 Summary of themes and subthemes from stakeholder conversations

Theme	Subtheme	Example
1. Barriers to Engagement	1.1 Emotional & Social Barriers	*Stigma and fear of judgment around weight discourage families from engaging.*
	1.2 Practical Constraints	*Time, transport, childcare, and financial pressures make attending programmes difficult.*
	1.3 Low Perceived Need	*Some families do not recognise weight as an issue.*
	1.4 System Challenges	*Fragmented systems and unclear referral routes confuse families.*
	1.5 Professional & Provider Gaps	*Missed referrals due to staff training gaps, poor communication, or service awareness issues.*
2. Service Gaps & Challenges	2.1 Inequitable Access	*Families in deprived or rural areas face limited or inconsistent service availability.*
	2.2 Limited Sustainability	*Short-term programme benefits often fade without follow-up or ongoing support.*
	2.3 Resource Pressure	*Staffing shortages and funding cuts restrict service reach and flexibility.*
	2.4 Digital Exclusion	*Families without internet access or digital skills struggle to engage with online services.*
3. Engagement Enablers	3.1 Supportive Communication	*Clear, non-judgmental messaging helps families feel safe.*
	3.2 Trusted Local Access Points	*Services offered through familiar settings: schools, family hubs, or health visitors.*
	3.3 Holistic & Inclusive Support	*Addressing food insecurity, mental health, and housing increases relevance.*
	3.4 Culturally Sensitive Delivery	*Tailoring services to family needs, culture, and language improves reach and retention.*
	3.5 Equity & Targeted Outreach	*Focusing efforts on underserved communities with inclusive, community-informed strategies.*
4. Opportunities for Improvement	4.1 Integrated Family-Centred Care	*Embedding weight management into broader family services improves continuity and helps reduce stigma.*
	4.2 Modular & Tailored Programmes	*Shorter, flexible formats including hybrid delivery help meet diverse family needs.*
	4.3 School & Community Partnerships	*Schools and peer networks help normalize healthy behaviours and increase retention.*
	4.4 SEND Inclusion	*Ensuring children with special educational needs have full access to programmes and support.*
5. Systemic Change & Strategic Vision	5.1 Cross-Sector Collaboration	*Coordinated planning across public health, education, and social care.*
	5.2 Social determinants	*Tackling food environments, poverty, and housing as underlying causes of obesity.*
	5.3 Science-Driven Design	Using behavioural science to tailor services to real-life family contexts.

3. Findings

3.1 Literature review of barriers and enablers to engagement

Twenty-one documents were included, eight from the review of organisational documents and 13 from published journal articles. Five themes were identified in the organisational documents and these are summarised in table 3 below and described in section 3.1.1. Five themes were also identified from the journal articles; these are summarised in table 4 and described in section 3.1.2.

3.1.1 Synthesis of organisational documents

1. Structural and Systemic Barriers

Children and families in deprived areas often encounter structural issues that limit access to weight management services. Geographic inequality results in services being less available in rural or underserved neighbourhoods (6, 7). Tier 2 services are typically overstretched, leading to long waits or limited programme options (8). Professionals, including school staff, report difficulties in navigating referral pathways, with some lacking direct referral mechanisms (8). In addition, while digital and hybrid delivery models have been introduced to increase access, families in low-income communities may experience digital exclusion due to lack of internet access or limited IT literacy (9).

2. Psychosocial and Cultural Barriers

Psychosocial barriers such as stigma, fear of judgment, and previous negative experiences are common among families in deprived communities. Communication about children's weight, particularly NCMP letters, are often perceived as blaming or distressing, discouraging families from engaging with services (8, 10). Cultural mismatch between programme content and community values or food practices further hinders uptake, especially among ethnic minority groups (11). Language barriers and a lack of culturally tailored content can also leave families feeling alienated or unsupported (10, 12). Many parents believe that programmes overlook the emotional and mental wellbeing of children, despite its centrality to health behaviour change (6, 9, 11).

3. Practical Constraints and Family Contexts

Practical and economic constraints significantly affect engagement. Families often juggle shift work, childcare, and financial pressures, which makes attending weekly, in-person sessions difficult (10). Transport costs and lack of accessible venues are common barriers, particularly in rural or peripheral communities (8). Healthy food may be unaffordable or unavailable, further complicating efforts to follow dietary advice (10). Programmes that are rigid in format, with limited scheduling flexibility or location options, are not well suited to families in precarious living conditions (12).

4. Communication and Messaging

How services are presented to families greatly influences their willingness to engage. Referrals that use formal or clinical language may not resonate with families and can come across as patronising or impersonal(13) (8). Families also express discomfort with communications that focus heavily on weight or BMI, which may evoke guilt or defensiveness (6, 9, 11, 13). The tone and delivery of these messages often fail to consider the broader context of poverty, family stress, or trauma. A more empowering approach centred on positive lifestyle changes, emotional wellbeing, and self-efficacy is preferred by families (9, 11). Awareness of services also remains low in many communities, with few families able to recall being offered or invited into support (8).

5. Lessons for Future Engagement

To address these barriers, engagement strategies must shift toward a holistic, person-centred model that reflects families' lived experiences. Co-design with target communities is critical to ensure services feel relevant and respectful (7). Programmes should take a whole-family approach and be sensitive to cultural and religious norms, language preferences, and literacy levels (12). Embedding services within trusted community settings, such as schools, family hubs, or places of worship, can make engagement more approachable and reduce perceived stigma (6, 7). Delivery formats should be flexible and modular, accommodating differing schedules and allowing for hybrid access (11). Finally, services must go beyond behaviour change to address underlying social determinants of health, such as housing, food insecurity, and emotional wellbeing (6, 11, 12).

TABLE 3 Summary of key themes from organisational documents

Structural and Systemic Barriers	Psychosocial and Cultural Barriers	Practical Constraints and Family Contexts	Communication and Messaging Failures	Lessons for future engagement
Limited service availability in deprived or rural areas	Stigma, fear of judgment, and previous negative experiences	Time pressures due to work and childcare	Overly formal or unclear language in referrals	Co-designed, culturally adapted programmes
Overstretched Tier 2 services	Cultural insensitivity and language barriers	Transport, cost of attendance, and food	Weight-focused messages can feel judgmental	Whole-family approaches
Weak referral pathways and digital exclusion	Overlooked mental health needs	Inflexible programme delivery formats	Low visibility and awareness of services	Holistic support addressing wider determinants
				Flexible delivery & community-based access

3.1.2 Synthesis of journal articles

1. Community and Family Engagement

Community and family engagement was essential, with programmes involving local networks and parent-led sessions achieving higher trust and participation. Programmes such as "Go-Golborne"(14) demonstrated the effectiveness of mobilising local networks through multi-sector partnerships that spanned education, healthcare, and community organisations. Similarly, the STEP IN programme (15), which employed parent-led group sessions, promoted trust and accessibility among predominantly Black, low-income families. Interventions

that incorporated stakeholder input from the outset, (16) (17), were better aligned with community values and achieved higher engagement.

Conversely, a lack of trust in the healthcare system, particularly among Māori families in New Zealand (17), emerged as a significant barrier to engagement. Families reported experiences of institutional racism and cultural alienation, which discouraged them from participating in traditional weight management services.

2. **Cultural Relevance and Programme Fit**

Interventions tailored to the cultural contexts of participating families were more successful than generic, one-size-fits-all programmes. Culturally tailored messaging and content enhanced programme relevance and acceptability; obesity programmes around holistic wellbeing, rather than weight alone, reduced stigma and improved family engagement (16, 17).

By contrast, cultural misalignment was frequently cited as a barrier. Interventions that failed to account for ethnic identity, language, or family structure were perceived as irrelevant or judgmental. For example, the use of weight-centric language and metrics often clashed with family values and discouraged participation, particularly among populations with histories of stigma or discrimination.

3. Accessibility, Flexibility, and Use of Technology

Several studies highlighted the importance of flexible, accessible delivery formats. E-Health platforms appealed to parents due to their convenience and capacity for personalisation (18). Similarly, integrated wearable fitness trackers and app-based surveys to enhance motivation and self-monitoring in both children and caregivers. These tools supported real-time feedback and individualised goal-setting, which participants reported as useful for sustaining behaviour change (15).

Nonetheless, logistical barriers such as transportation, time constraints, and lack of childcare were frequently cited obstacles to in-person attendance (19, 20). Additionally, in low-income settings, families often lacked digital literacy or access to devices, limiting the potential reach of technology-enhanced programmes (15, 17).

4. System-Level and Organisational Sustainability

System-level factors had a substantial influence on programme uptake, implementation, and sustainability. A case study of Irish school-based interventions emphasised the role of leadership, inter-agency coordination, and policy alignment in promoting successful adoption. Integration into existing institutional structures, such as school curriculums or health services, was cited as a key enabler of scale and continuity (21).

Numerous structural barriers impeded programme longevity. Many interventions struggled with short-term funding, overburdened school schedules, and insufficient staffing (14, 21). In some cases, efforts to adapt programmes to local contexts risked undermining fidelity to core components, making evaluation of effectiveness more difficult (16). Health system fragmentation, poor feedback loops, and provider discomfort in initiating conversations about weight also limited effective referrals and follow-through (19, 20).

5. Motivation and Support for Behaviour Change

Effective behaviour change strategies were those that incorporated motivational supports such as goal setting, incentives, feedback, and social reinforcement. Low-value non-cash incentives tied to goal achievement supported both parental and child engagement (22). Similarly, fitness tracking and session-based feedback loops kept families motivated (15).

Emotional and psychological factors such as shame, low self-efficacy, and stress often interfered with sustained participation, especially among families dealing with socioeconomic disadvantage (17, 22). Lack of follow-up or progress tracking also led some families to disengage over time (20).

TABLE 4: Summary of Barriers and Facilitators from Journal articles

Theme	Facilitators	Barriers
1. Community and Family Engagement	Involvement of parents and caregivers from the outset (16, 18) Use of peer-led, parent-led, or community-based delivery models (14, 15) Multi-agency collaboration within the community (14, 21)	Lack of trust in health services, especially among Indigenous and minority communities (17, 23) Limited community consultation during program design (16) Inconsistent provider communication and weak referral pathways (19, 20)
2. Cultural Relevance and Programme Fit	Culturally tailored materials and messaging (16, 17) Framing around holistic wellbeing, not just weight (13) Use of culturally safe settings and Indigenous staff where appropriate (12, 13)	Weight-centric language and content perceived as stigmatising (12, 7) Programmes not reflective of family structures or cultural practices (16) Lack of translation or adaptation for non-dominant cultures (11)
3. Accessibility, Flexibility, and Technology	e-Health and app-based delivery reduced logistical barriers (15, 18) Flexible session times and hybrid options increased reach (16) Wearables and mobile tracking tools promoted engagement (5)	Time constraints, transport issues, and scheduling conflicts (19, 22) Limited access to devices or digital literacy in low-income households (15, 17) Rigid, centralised services reduced participation (24)
4. System-Level and Organisational Sustainability	Alignment with school and health policies supported integration (14, 21) Strong local leadership and champions (21) Flexible adaptation without compromising fidelity (16)	Inadequate or short-term funding (14, 21) Overloaded school curricula and limited staff time (4) Difficulty maintaining programme fidelity during scaling (2)
5. Motivation and Behaviour Change Support	Use of incentives and goal-setting tools (15, 22) Real-time feedback (e.g., wearable data) to sustain engagement (5)	Emotional stress, shame, and low self-efficacy (3, 12) Lack of ongoing feedback or visible progress (20)

	Supportive social environments and coaching (16)	Families overwhelmed by competing life stressors (13)

3.2 Mapping of current provision in HWE

3.2.1 Essex CYP Weight Management Service Pathway and Commissioning Structure

The pathway for CYP Weight Management Services (WMS) and the associated delivery and commissioning framework across Essex and surrounding regions emphasises a tiered approach to weight management support, based on the level of need, and highlights the multiple entry points, support stages, and responsible commissioning bodies (Figure 1).

Table five summarises representation of service delivery agencies. Table 6 provides a comparative overview of types of services, access points, referral pathways, and variation in availability, accessibility, and alignment with local needs, comparing Essex and Hertfordshire

Pathway Overview

CYP may enter the weight management pathway through a range of routine referral sources. These include the NCMP, self-assessments, clinical observations by professionals such as school nurses, social workers, and paediatric consultants, or formal weight assessments conducted in primary care settings. These referral routes feed into the Healthy Lifestyles Team, a central coordinating body operated by HCRG.

Once referred, children are triaged to determine the appropriate level of intervention. The pathway follows a staged, evidence-based model of support. At the first level, children receive initial targeted interventions, followed by regular monitoring to track progress. If further support is required, they progress to Level 2, which may include more structured programmes and group-based services delivered within family hubs or local communities.

Continued lack of improvement or more complex cases lead to Level 3 support, the most intensive tier within the pathway. At this stage, children may be referred to specialist Child Excess Weight (CEW) clinics, which are part of a pilot initiative led by NHS England (NHSE).

Delivery and Commissioning Framework

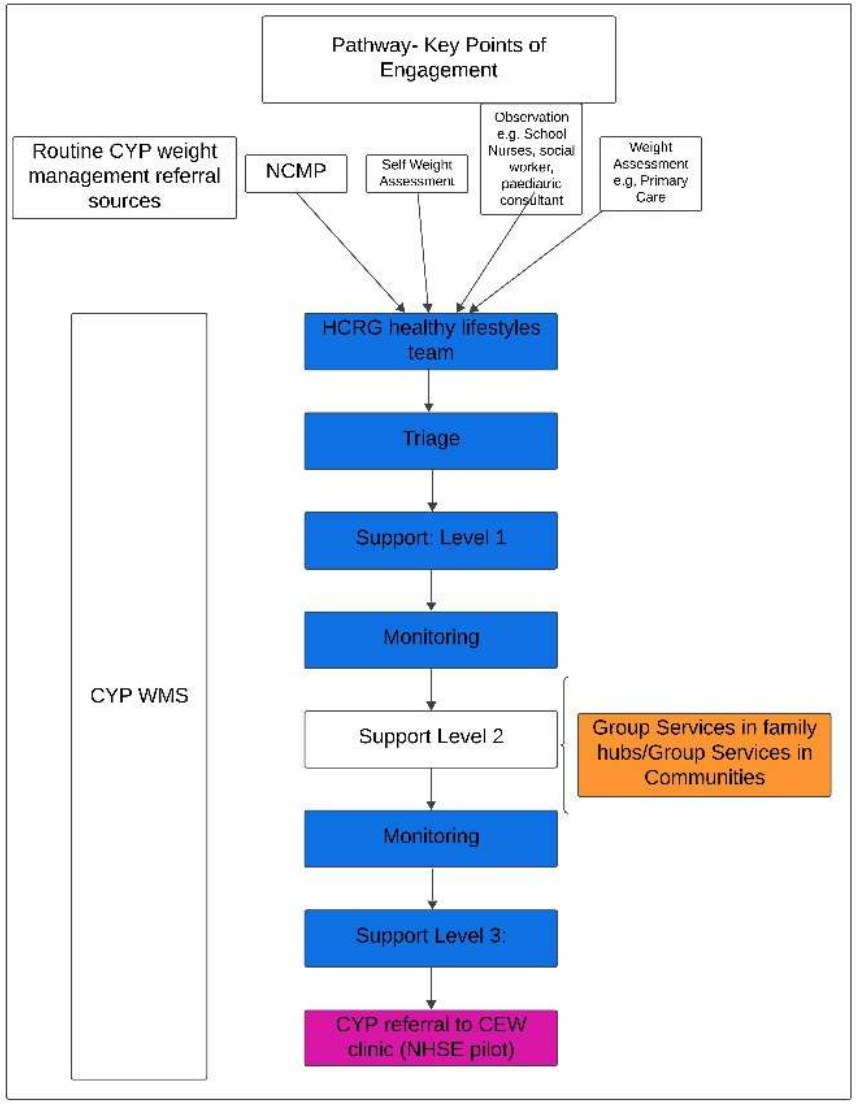
The delivery of services within this pathway is shared across different commissioning bodies, primarily Essex County Council (ECC) and NHSE.

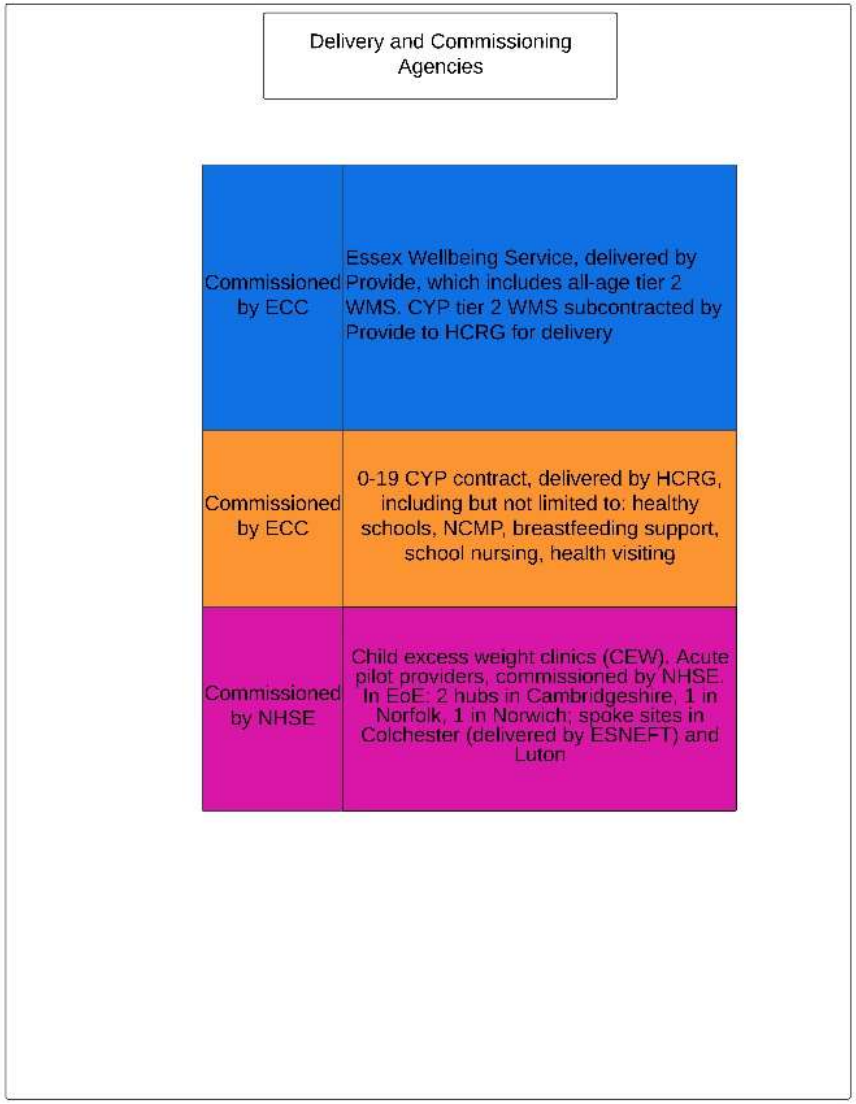
ECC commissions two core elements of this model. First, it funds the Essex Wellbeing Service, delivered Provide, which includes all-age Tier 2 weight management support. For CYP specifically, this Tier 2 delivery encompasses a wide range of child and family health services, including healthy schools programs, breastfeeding support, NCMP delivery, school nursing, and health visiting.

Separately, NHS England is responsible for commissioning specialist CEW clinics as part of a national pilot initiative. These acute intervention services are located in regional hubs: two in Cambridgeshire, one in Norfolk, and one in Norwich, with additional spoke sites in Colchester (delivered by East Suffolk and North Essex NHS Foundation Trust, ESNEFT) and Luton. This

model allows for specialist, multidisciplinary care to be accessed when local Tier 2 or community-based interventions are insufficient.

FIGURE 1 Essex child weight management pathway





3.2.2 Hertfordshire CYP Weight Management Pathway and Commissioning Structure

The Hertfordshire Child Weight Management Pathway outlines a multi-agency, tiered approach to supporting healthy weight in school-aged children and young people (Figure 2). This system aims to engage families, educational professionals, and healthcare providers in coordinated interventions, ranging from prevention and early support to clinical services. There is currently no local Tier 3 specialist child weight management service in place, though discussions are ongoing regarding regional service development under NHSE.

Pathway Overview

The pathway targets school-aged children and young people, starting from multiple access points including the NCMP, Public Health Nursing, school staff, education welfare officers, family support workers, and self-referral. Children identified as needing support can access various services depending on need and risk. Children with complex needs or requiring further evaluation may be referred back into the NCMP for monitoring or signposted to alternative support.

Interventions are both individual and family-based, with services tailored around public health and educational contexts. Parallel to direct interventions, the system also includes a training and awareness arm that provides education to professionals across multiple sectors (e.g., school staff, GPs, family centre teams, libraries, and community workers). These professionals play a role in identifying, supporting, and referring children to relevant services.

The service model includes three core levels:

1. Healthy Families Programme – Targeted at school-aged children with identified weight concerns, particularly those lacking underlying health or safeguarding risks.

2. Universal Services – Focused on awareness and prevention, providing general training and engagement opportunities for health and education professionals.

3. Brief Interventions – Delivered by various professionals including health visitors, school nurses, social workers, and others who may identify weight concerns and signpost families to appropriate services.

Commissioning and Delivery Structure

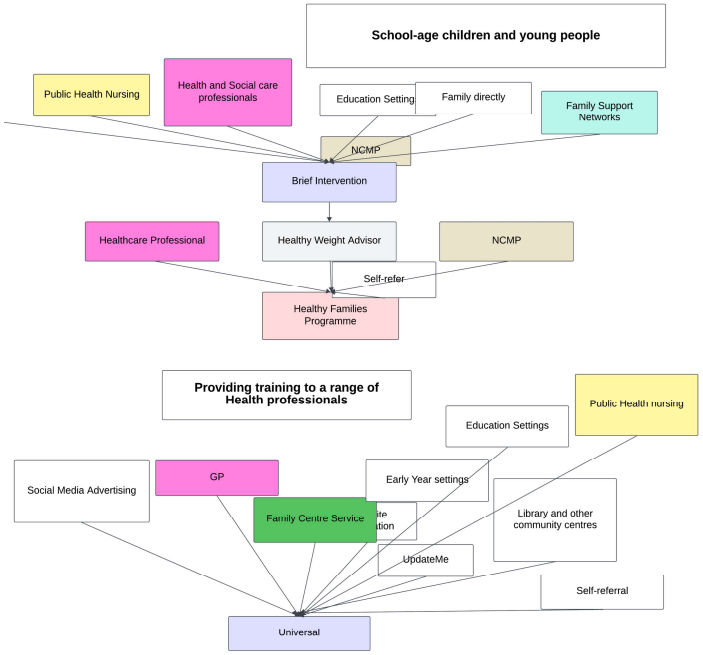
Services are commissioned and delivered through a partnership model involving Hertfordshire County Council, public health, children's services, Herts Sport and Physical Activity, and NHSE.

- Public Health commissions:
    - Healthy Families Programmes, Beezee Families, Beezee Youth, Henry 0-5 (Beezee Bodies delivered by Maximus)
    - Public Health Nursing Services (delivered by NHS providers)
    - Healthy Weight Advisors and Family Centre Services
- Children's Services fund:
    - Family Network services and local family/community-based support
- Herts Sport and Physical Activity supports:
    - Fit, Fed and Read schemes (run during school holidays)
- NHS England is responsible for:

- Local public health teams
- Tier 3 Clinical Weight Management Services, which are currently only available regionally and via restricted referral processes.

Although regional Tier 3 services for children are being piloted by NHSE, they remain inaccessible for most families due to eligibility constraints and complex referral mechanisms. There are plans to devolve these responsibilities to Integrated Care Boards (ICBs), but this remains pending further guidance. Figures 3 and Table 4 below represent the Hertfordshire child weight management pathway.

FIGURE 2 Hertfordshire child weight management pathway



Delivery Agencies

Commissioner	Commissioning Body	Service Name	Delivered By
Commissioned by Hertfordshire County Council	Public Health	BeeZee Bodies (contracted Provider)	Healthy Families Programmes, Beezee families, Beezee Youth and Henry (0-5) Family First Assessment
		Public Health Nursing Services	Public Health Nurses
		Healthy Weight Advisors	Public Health NHS Providers
	Children Services	Family Centre Services	Family Centres/Local Providers
		Family Networks	Family Centres/Community Providers
	Herts Sport Physical Activity	Daily Mile	In Schools
		Fit Fed and Read (commissioned by other charity partners	In schools and during school holidays
Commissioned by Hertfordshire County Council and NHS England		NCMP	Public Health/School Nurses
Commissioned by Hertfordshire County Council and HWE ICB		NHS Clinical Weight Management Service	NHS Providers: GPs Health and Social Care Professionals

Note: Currently no local Tier 3 child weight management service in both counties (which is recommended in NICE guidance). There is a regional service, piloted by NHS England, but this has restricted referral processes and criteria. There are plans to devolve the service to ICBs, currently waiting for further guidance.

TABLE 5 Representation of service delivery agencies

Service Area	Eligibility / Service Suitability	Referral Routes
Healthy Families Programme	School-age children and young people Living or attending school in Hertfordshire Direct referral possible where BMI >98th centile BMI >91st centile following Brief Intervention and review, and evidencing readiness to change	Healthy weight advisor following Brief Intervention if additional support required Families with children >98th centile can be referred by professionals working with them or following NCMP assessment, or self-refer, and automatically access this service
Universal	Providing training to a range of Health professionals Training for Families Digital offer	Website information UpdateMe Social media advertising GP Family Centres Early years settings Education settings Library and other community centres Public Health nursing Self-referral
Brief Intervention	School-age children and young people Living or attending school in Hertfordshire BMI >91st centile Not receiving support from Public Health Nursing service	NCMP, Public Health Nursing Health and social care professionals, education settings, Family support networks, family directly

TABLE 6 Child Weight Management Services – Comparative Overview

Category	Essex	Hertfordshire
Types of Services Available	Tiered weight management (Levels 1–3) Healthy Lifestyles Team interventions Tier 2: Group-based support in Family Hubs Tier 3: Specialist CEW clinics (regional) School nursing, NCMP, healthy schools	Healthy Families Programme (targeted) Brief interventions by professionals Fit, Fed and Read (holiday schemes) Universal prevention and awareness services No local Tier 3; regional access limited
Access Points	NCMP, GP and primary care School nurses, paediatricians, social workers Self-referral (via Healthy Lifestyles Team)	NCMP Public Health Nursing School staff, education officers, Family support workers Self-referral (e.g., via family centres, campaigns)
Referral Pathways	Central triage via Healthy Lifestyles Team (HCRG) Tiered progression from Level 1 → 2 → 3 Level 3 referrals to CEW clinics (NHSE pilot)	Multi-agency referral through schools, health, or family centres Risk-based triage into Healthy Families, Bold Interventions, etc. Complex cases referred back to NCMP or signposted elsewhere
Service Commissioning	ECC commissions: ▪ Essex Wellbeing Service (Provide) ▪ 0–19 contract (HCRG) NHS England: Tier 3 CEW clinics	Public Health commissions: ▪ Healthy Families, Beezee Bodies (Beezee Families, Beezee Youth, Henry 0-5); Nursing services, Healthy Weight Advisors - Children's Services: Family support - Sport & Activity partnerships - NHS England: NCMP, Tier 3 (regionally)
Tier 3 Access (Specialist Services)	Available regionally via CEW clinics (Cambridge, Norfolk, Colchester, Luton) Limited to severe/complex cases - Referral via NHSE pilot. Lacks local commissioned secondary care services	No local Tier 3 services Regional services exist but are inaccessible to most families - Access limited by eligibility and referral constraints. No clear route/escalation programme
Alignment with Local Needs	Coordinated, tiered access aligned with need Healthy Lifestyles Team streamlines triage - Regional gaps at Tier 3 level remain	Strong early and community support Tier 3 access not aligned with local need Professional training increases early identification
Workforce Training & Prevention	Included under 0–19 contract (e.g., school nurses, NCMP) - Some professional engagement	Dedicated training for school staff, GPs, community workers - Focus on early identification and prevention

3.3 The perspectives of key informants

This section provides a narrative overview of the key findings based on descriptions provided by the stakeholder conversations with key informants.

Key informants provided an initial overview of current healthy weight management services referral system. Referrals primarily come through the NCMP, where families receive letters informing them of their child's measurements and offering information about available services. Although families have the option to self-refer, this route is less commonly used. Professionals such as general practitioners, social workers, and school nurses also make referrals. Schools themselves can refer children, but this pathway is limited by a lack of confidence, training, or awareness among school staff, and further hindered when schools opt out of participating in the NCMP.

Families tend to prefer face-to-face services, finding them more engaging and effective, particularly for younger children. However, in-person sessions are not always feasible due to distance, timing, or transport barriers. To address this, services have incorporated online components, though these present their own issues, including digital access and lower engagement. The current programme offerings in Hertfordshire includes a range of programmes that last around 12-week and are delivered across six to eight venues simultaneously throughout the county. Areas identified as having higher levels of need receive more consistent provision, while other locations are served on a rotational basis to ensure equitable access over time. Families in some areas may experience a short delay if a course is not immediately available locally. Different delivery formats are intended to address different needs and age groups, though accessibility and retention remain ongoing challenges. The services operate across Essex with regionally assigned health coaches and a bank Special Education Needs specialist, providing tailored, one to one support to families with children significantly above the 91st centile in weight. Some key informants reported the potential to expand provision to include weekend sessions, which could further improve accessibility for families with weekday commitments.

Subsequent conversations focused on barriers, challenges, enablers and opportunities, and are presented within the following five themes:

3.3.1 Barriers to Engagement

Key informants described a number of barriers experienced by families and CYP, especially those who live in deprived areas. Families face a range of barriers to engaging with services, including emotional and social factors such as stigma and fear of judgment, as well as practical challenges like time constraints, transport, childcare, and financial pressures. Additional challenges include a low perceived need for support, fragmented systems with unclear referral pathways, and gaps in professional awareness or training that can lead to missed opportunities for referral and engagement.

One of the reported challenges in Hertfordshire related to the spread of services across the county, delivered in six different locations. Services reportedly try to maximise their spread, but also make sure that they are delivering in areas of health inequality.

> *Whether it's high levels of deprivation, but we can't be everywhere. Ideally you would deliver across many locations. But the funding isn't sufficient to deliver in more locations. That's partly why we try to rotate, but also offer that online service so that there is accessibility to the programmes for everyone. (P05)*

In more remote or underserved communities, transport access and distance to service locations create further obstacles. Additionally, providers suggested that some families do not perceive their child's weight as problematic, particularly in the context of more immediate life stressors, which reduce motivation to participate. Navigating the health system can be confusing, especially when services are fragmented across health, education, and housing sectors.

> *The most disadvantaged families, you know, it's the responsibilities and time constraints are even more stressful and to commit to something like that, even though there may be the intention to want to do it just in reality, it's just too difficult. So, so we and we do see that with some people that will attend partially attend so they won't. (P04)*

From the provider perspective, engagement is hindered when schools opt out of the NCMP or when school staff lack training and awareness of referral pathways.

> *Trying to get schools more on board with it so you don't have whole schools opting out because that really does make a difference. […] Parents won't be receiving any letters telling them about the weight management service or highlight if there's an issue with their child's weight. (P02)*

Key informants suggested some parents show resistance or misunderstanding around BMI and growth centiles, which can hinder engagement. Cultural perceptions may also play a role, with weight often normalised or BMI dismissed as irrelevant, particularly within some ethnic minority communities. Concerns are frequently downplayed. In some cases, families appear receptive during NCMP calls but later disengage. Additionally, discussing weight, especially with girls in Year 6, can be emotionally charged and sensitive, contributing to reluctance in addressing the issue. Interviewees suggested communication materials are often overly complex or formal, making them hard for families to relate to.

> *I think communication is boring[…] I think the whole messaging is wrong. There's a lot of finger wagging going on […] You've really got to hit at the right point and have proper conversations and research it thoroughly. It's not something where you just produce a leaflet with a lot of bullet points in it, saying don't do this. Don't do that. (P01)*

Commissioners' reliance on aggregate data may overlook individual family needs. The formal nature of weight management programmes, especially those tied to NCMP, can create negative perceptions that further deter participation.

3.3.2 Service Gaps and Challenges

Programmes access remains uneven, with deprived or rural families often required to travel significant distances to participate. Online programmes are offered to extend reach, but these are not always effective or accessible, particularly for families lacking digital devices or internet access. Standard 12-week programmes show some short-term improvements in weight management, but maintaining healthy behaviours beyond programme completion is a major challenge due to a lack of structured follow-up. A gradual transition following a 12-week programme could support families in managing weight more sustainably. While this approach may incur additional costs initially, it allows for a more measured adjustment that can enhance long-term outcomes.

Having a step down approach maybe after the 12 week, I mean it then it costs more money but gradually. (P02)

Limited resources, including budget cuts and workforce shortages, also impact programmes delivery. These constraints prevent the development of more flexible or personalised support options for families who may benefit most.

3.3.3 Engagement Enablers

Increased engagement requires programmes to be designed in ways that feel approachable, relevant, and supportive to families living in deprived areas. Programmes that use non-stigmatising language and emphasize healthy habits and wellbeing, rather than focusing on weight, are more successful in creating trust. Integration with trusted services, such as health visiting teams or family hubs, can help normalise participation and reduce the sense of judgment.

Health, education, employment, and housing, often work in silos. This disjointed approach makes it difficult for the public to engage with services effectively and understand how they interconnect. (P01)

Delivering programmes in familiar and accessible locations at times that suit families helps reduce logistical barriers, although providers suggested that they often struggle to find venues in the community for the whole length of a 12 week programme

On the provider side, simplifying referral materials and ensuring that communication is clear and personal helps make services more accessible.

Having nice nicer letters, having a welcoming website that that looks like it supports. It's something we're working on anyway, but it's not that user friendly, it's a bit stale. (P02)

Follow-up calls after referral can help ease concerns and build relationships. One of the most important factors is the initial contact and how families are first approached by the service**.**

Once a genuine conversation takes place, families often feel more connected and better understand what they're engaging with, which significantly increases the likelihood of them accessing support. (P04)

Programmes that consider mental health, food insecurity, and housing alongside physical health are more likely to meet families' real needs. Targeting services in deprived and ethnically diverse communities, while tailoring content to reflect their lived experiences, is essential for improving equity.

We need to have the data and the oversight across the county and we need to look at the particular small pockets, of areas of communities that we need to, you know, we need to aim to target and that is happening. (P04)

Uptake in most deprived areas can be low even though there is an identified need. Building networks with the professionals to promote services is important so that they are aware of the programmes and they are referring into them.

We do a lot of work trying to build those relationships but that can be quite a slow journey. (P05)

3.3.4 Opportunities for Improvemt

Improving uptake and outcomes requires services and the programmes they deliver to be promoted in ways that focus on family empowerment and avoid blame. Human-centred messaging that focuses on wellbeing and progress rather than appearance is more effective. Offering shorter, modular, or hybrid programmes helps engage families who cannot commit to long-term formats. Making content age-appropriate and relevant to younger children improves engagement and retention.

Embedding these programmes into broader family support systems, rather than keeping them as standalone interventions, helps families see them as part of everyday life.

Schools, in particular, are crucial partners in supporting health. Inclusive school-based initiatives like breakfast clubs, healthy lunch options, and after-school activities can help normalise positive habits. Children with special educational needs (SEND) should also be actively included to ensure equitable access. Community groups and local peer networks, including social platforms like WhatsApp, can also boost attendance and provide ongoing encouragement. When families feel supported by their communities, they are more likely to continue healthy behaviours over time. Sharing stories from other families in their community in similar circumstances also helps to motivate and inspire.

Once they [families] start and they meet other families in their community that are attending the programme, that is also a positive factor. You know that we normally in a lot of the programmes they'll sign, they'll have like their own little WhatsApp group and that we find that when they then make connections, maybe with new people in their community or other parents that are going through the same thing, they find that really beneficial and that keeps them attending.(P04)

3.3.5 Systemic Change and Strategic Vision

Long-term progress requires coordinated efforts across public health, education, primary care, and local government. A unified strategy must address more than individual behaviour, it must also consider the structural conditions in which families live.

Successful engagement often comes from integrating weight management services within broader family support systems, such as those provided by pre-birth to 19 services. Continuity of care, where families are already familiar with the service provider, increases engagement. The holistic approach, which looks at the overall needs of the family, rather than just focusing on weight, has proven effective in getting families to participate. (P03)

Obesogenic environments, where unhealthy food is more accessible than nutritious options, are particularly common in deprived areas. Programmes need to tackle root causes such as poverty, food insecurity, and housing instability, which directly impact a family's ability to make and maintain healthy choices.

By applying behavioural science to both programme design and delivery, services can be made more effective by aligning with how families actually live, decide, and cope. This means designing interventions that are practical, respectful, and relevant, using a place based approach to public health.

Staff also recognised the importance of using behaviour change science as part of the engagement process to influence attitudes and behaviours before individuals even consider seeking help.

> *Going in and saying to people, can we help you change your eating habits? That's not only ineffective, I mean, that's borderline offensive, actually, because it's such a poor reflection of what is really causing them to comfort eat. (P03)*

Furthermore, it is important to re-educate families on the purpose and value of the services, highlighting that support is available and designed to help, not judge. By clearly communicating the benefits, such as improved health outcomes, personalised guidance, and long-term positive change, families are more likely to engage and recognise the programmes as a meaningful opportunity for support.

3.4 Discussion

The weight management pathways for CYP in HWE are underpinned by a tiered, multi-agency model designed to meet varying levels of need. Both systems share common access points such as the NCMP, referrals by school nurses and GPs, and self-referral routes.

Themes identified from the evidence review aligned with findings from the stakeholders conversations. These findings suggested that families in deprived areas often face significant barriers to engaging with weight management services and the programmes they deliver. These include practical constraints, emotional stigma, and fragmented systems, which negatively impact accessibility to services and long-term effectiveness of services. Engagement with healthy weight management services is influenced by a complex interplay of cultural, social, economic, and geographical factors. For some groups, barriers extend beyond awareness and communication, requiring adaptations to programme content, delivery formats, and settings.

Addressing the issues requires a deep understanding of local systems, community contexts and the evidence that can inform programme design and delivery. A flexible, tailored offer that takes into account families' lived experiences, cultural contexts, and practical realities is critical to increasing engagement and improving outcomes. Engagement strategies must reflect the diversity of communities and address both direct and indirect barriers to access and participation.

Engagement can be strengthened by employing staff and facilitators who reflect the cultural and linguistic diversity of the target population. Taking into account language preferences and literacy levels when planning or redesigning programmes aligns with NICE guidelines (12). Facilitation of peer learning and feedback, where participants can shape session content are likely to be better aligned with community values, and to increase engagement. This approach also allows the exploration of underlying social determinants of health, such as housing, food insecurity, and emotional wellbeing, in line with NICE recommendations (11, 12).

Shifting the emphasis from weight loss to broader holistic wellbeing, including healthy eating, physical activity, mental health, and emotional resilience is recommended, in line with current offers such as some of the programmes run by Maximus in Hertfordshire. Evidence shows that positively framed messages that focus on overall health and wellbeing are more engaging, particularly in communities where weight-related conversations carry stigma. Co-design with target communities is critical to ensure services feel relevant and respectful (10). The findings also suggest that flexible and community based approaches can help to address systemic barriers, including a lack of trust in health and care services (8, 10, 17, 25).

Use of service data and population health intelligence to identify who is not engaging with current provisions, for example, by age, ethnicity, gender, geography, or socioeconomic status as well as by type of service can identify gaps in provision, reach and engagement. In line with embedding evidence-informed practices adopting and adapting from existing interventions delivered elsewhere and applying behaviour change models is suggested. One example is the use of evidence-informed interventions for healthy eating and/or physical activity (26) within a broader programme of support to ensure that individual initiatives are not delivered in isolation but form part of a coherent and sustainable approach to improving engagement and outcomes. Use of behaviour change models to guide service design is recommended, such as COM-B, a model that provides a framework to focus on peoples' Capability, Opportunity, and Motivation to change behaviour (26). Some examples of regional projects relevant to this are a study on the impact of takeaways near schools and homes on childhood obesity, conducted in collaboration with Hertfordshire County Council and a study on consultation with young people in Hertfordshire to address obesity.

This report has synthesised evidence from different sources and highlighted valuable information, direct input from service users, families and those who refer into these services would have added greater contextualisation and nuance to the findings. Prioritising the voices of service users in future evaluation to ensure that their perspectives are embedded in both design and delivery. By centring services around the real needs of families, and creating systems that are responsive, equitable, and inclusive, there is a significant opportunity to improve engagement, address inequalities, and achieve better health outcomes for children and families. Table seven provides an overview of the key findings.

TABLE 7 Integration of themes from interviews and the review

Theme	Summary
Barriers to Engagement	Families face stigma, fear of judgment, and practical constraints like transport, time, and finances. Some do not recognise weight as an issue. Confusing referral routes and poor inter-professional communication hinder access.
Service Gaps and Structural Challenges	Uneven access to Tier 2 and 3 services, with Hertfordshire lacking local Tier 3 provision. Many programmes lack a follow up at the end. Staffing and funding issues, plus digital exclusion, reduce reach.

Engagement Enablers	Non-judgmental communication and trusted settings (e.g., schools, family hubs) increase access. Reframing the narrative from weight loss to holistic wellbeing.
Cultural and Local Adaptations	Cultural tailoring and support for wider health needs enhance relevance. Co-design with target communities is critical to ensure services feel relevant and respectful (10).
Opportunities for Service Improvement	Embedding weight management into broader family support reduces stigma. Flexible, hybrid, and modular formats improve accessibility. Stronger school and community links and SEND inclusion are key.
Strategic System-Level Opportunities	A stronger focus on sustainability through Cross-sector collaboration is essential. Addressing poverty, food environments, and housing supports long-term impact.
Evidence-informed Programmes	Use of data to understand population needs, underserved groups; and embedding behaviour change science into service design, offers an opportunity to reshape engagement in a more empowering and effective way.

4. Recommendations

The evidence suggests that a single, standardised offer is unlikely to meet the needs of all communities. Drawing on the insights gained, the following recommendations address key barriers to engagement, uptake, and effectiveness of healthy weight programmes. These recommendations focus on practical, evidence-informed strategies that can be adapted to different local contexts and population needs.

1. **Co-develop culturally appropriate materials**
   Co-creating invitation letters, programme descriptions, promotional materials and programme content with community members and leaders from diverse backgrounds helps ensure language, imagery, and tone are culturally sensitive and non-stigmatising, and that content aligns with community concerns, values and food practices.

2. **Reframe programme narratives to promote holistic wellbeing**
   Shifting the emphasis from weight loss to broader holistic wellbeing, including healthy eating, physical activity, mental health, and emotional resilience. Evidence shows that positively framed messages that focus on health and wellbeing are more engaging, particularly where weight-related stigma exists

3. **Flexible, accessible and localised options**
   Offer shorter programmes in different local venues to reduce travel, with the option to expand commitment once participants are engaged. Explore use of mobile units or temporary satellite venues to bring services to communities. Taster sessions can be useful to generate interest and act as a "stepping stone" to engaging with services.

4. **Community-based delivery**
Evidence suggests that families prefer face-to-face sessions. Trusted community leaders and voluntary sector organisations could be actively engaged in delivering and promoting healthy weight messages, as information shared by familiar and respected figures is more likely to resonate.

5. **Family and community involvement**
Involve family members in sessions where possible. Providing a family-friendly environment or childcare to help reduce barriers to attendance. Opportunities for parents to share experiences, co-deliver sessions alongside staff, peer champions or buddy schemes could help boost engagement within communities and provide ongoing support, recognising the importance of family support in sustaining lifestyle changes.

6. **Personalised goals and incentives**
Incorporating personalised health and lifestyle goals, supported by motivational tools such as activity trackers can help increase engagement, particularly when progress is linked to tangible rewards.

7. **Embedding evidence-informed practice**
Using evidence to inform programme design and delivery, including evidence-informed interventions delivered and reported on in different settings, use of service data and population health intelligence to identify gaps in provision, reach and engagement; and use of behaviour change models to guide service design.

8. **Improving engagement with schools**
We recommend exploring opportunities to work collaboratively with schools to understand barriers and facilitators to promoting and supporting the delivery of healthy weight management programs, including enhancing engagement with NCMP for schools that opt out.

9. **Evaluate and refine**
We recommend continuing to monitor participation, outcomes, and satisfaction via surveys, focus groups and other methods to iteratively refine delivery models. In particular, we suggest focusing on what motivates people to initially engage with programmes and factors that contribute to people dis-engaging further into the programme.

10. **Sustainability and cross-sector collaboration**
Given current resource constraints and limitations around changes that can be feasibly implemented, we suggest convening multi-agency roundtables with schools, providers, local authorities, other ICBs, education, public health, primary care and VCSFE partners to explore sustainable resourcing, shared delivery models and cross-system learning.

Table eight is a visual framework that outlines the recommendations, how these could be applied as actions and anticipated impacts from these, providing a potential roadmap for action shaped by the evidence and insights reported.

Table 8 Roadmap for action

Recommendations to Activities	Outputs	Short-Term Outcomes	Medium to Long-Term Outcomes
Co-design Services with parents & communities to tailor culturally & locally relevant content (Schools, VCSEs, SEND advocates, youth centres, family hubs, community and religious leaders). Develop materials that are person-centred, non-stigmatizing, multilingual & language appropriate	No. of families engaged through outreach, schools, local champions No. of co-design activities, parent panels, feedback Resources developed e.g., Toolkits, WhatsApp guides, SMS reminders, story-based video	Increased awareness of weight-related health risks and services Families report feeling less judged, more supported	Increased family participation in support services Reduced childhood obesity prevalence, especially in deprived deciles
Training & Upskilling to build capacity to talk about weight sensitively, address social determinants, cultural awareness for health professionals in primary, secondary & community settings, school staff, community workers, cultural mediators	No. of staff trained Attendance at preventative approaches, equity workshops, behaviour change	Parents report greater understanding of healthy behaviours Increased confidence among staff to address weight and wellbeing	Families report programs feel relevant and non-judgmental Narrowed health inequalities, particularly in Core20PLUS5 populations
Holistic programmes to offer whole-family programmes with cooking, movement, healthy living and parenting support delivered together, helping to reframe the narrative	No. of integrated family sessions, age-appropriate and inclusive	Children and caregivers adopt shared routines (e.g., meals, sleep) Increased retention and trust in health services	Healthier family environments Sustained healthy behaviour change in families More resilient and health-literate families
Flexible Modes of Delivery offering hybrid (digital + in-person), evening/weekend sessions, drop-in models. Embed in family life, normalised in schools, community-owned, use of technology & wearables, apps, digital support platforms	No. of options delivered Group-based, 1:1, digital check-ins, maintenance phases Personalised support options, shorter modular programs, SEND adaptations	Improved reach among underserved groups, including ethnic minorities Reduced dropout and no-show rates, more families completing full programmes	Ongoing engagement beyond the program, digital follow-ups Ongoing maintenance of healthy behaviours
Community based & community involvement through delivering engagement events in familiar venues, peer-led delivery,	No. of programmes delivered School-based and community-based models No. of outreach events e.g., libraries, schools, church/community centre events	More positive peer narratives and visible role models	Stronger community trust in services and facilitators
Sustained cross-sector working to improve communication, improve referral pathways & strengthen streamlining between NCMP, GPs, schools, community care	No. of effective referrals, family hubs, health visitors, schools working together	Increased referrals into services from NCMP and primary care Improved understanding of services and what to expect	Stronger multi-agency coordination & integrated healthy weight pathways Better service navigation and fewer missed appointments
Sustainable, evidence-informed programmes through use of data, intelligence and behaviour change models	Programmes designed based on local data, needs & appropriate models e.g., COM-B	Embedded use of evidence	Long-term system resilience and prevention culture

5. Conclusion

Engagement by children and young people with healthy weight management services, particularly in under-served communities, is shaped by a range of complex and interconnected factors. Families face personal, structural, and systemic barriers that go far beyond simple awareness or willingness to engage. These include stigma and fear of judgment, practical limitations such as time, transport and finances, and a lack of trust in service providers. At the same time, variable service delivery, limited follow-up, digital exclusion, and staff or resource constraints can limit the effectiveness and accessibility of programmes.

Despite these challenges, the report has identified various enablers that can improve engagement. These include non-judgmental, culturally sensitive communication; delivery of programmes in trusted local settings; and integration of weight management into broader family and community support services. Effective partnerships with schools, voluntary organisations, and community leaders are key drivers in reaching underserved populations and increasing relevance. A one-size-fits-all approach is unlikely to succeed.

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Appendices

Appendix 1 **Policy and guidance documents included in the evidence review**

Title	Summary
Overweight and obesity management: Preventing overweight, obesity and central adiposity (NICE, 2025) (6)	This NICE guidelines on the prevention and management of overweight and obesity in CYP and adults. Section 1.6 in particular provides guidelines for schools and other childcare settings: emphasises the importance of making nutrition and physical activity a priority across all early-years settings including nurseries, childcare facilities, and schools. It recommends adopting a whole-whole approach to promote lifelong healthy habits, focusing not just on food and exercise but also on emotional wellbeing, self-esteem, and positive body image. Families and carers should be actively involved in these efforts, for example, by receiving information about lunch menus, after-school activities, or healthy practices through newsletters and other forms of communication. Schools are encouraged to reduce sedentary behaviour, increase opportunities for active play (especially inclusive of children with SEND), and follow national nutrition and education guidelines. Interventions should be evidence-based and sensitive to differences in culture, beliefs, sensory needs, and economic barriers. Headteachers and governors should work with families and pupils to create a school environment that supports healthy weight, diet, and physical activity. Interventions must be long-term, school-wide, and integrated into daily practice, not limited to short-term or one-off initiatives.
Overweight and obesity management: Identifying and assessing overweight, obesity and central adiposity (NICE, 2025) (9)	NICE provides specific recommendations for identifying and assessing overweight in CYP: processes be in place to identify overweight and obesity in all children and young people in addition to the NCMP and Healthy child Programme. Professionals are advised to seek consent before discussing or measuring weight, avoid attributing unrelated symptoms to weight (diagnostic overshadowing), and consider using waist-to-height ratio to assess health risks. It also stresses the importance of sensitive, non-judgmental communication and maintaining accurate, up-to-date records, especially for those who self-refer for support.
Overweight and obesity management: Discussing results and referral (NICE 2025) (13)	NICE advises healthcare professionals to approach discussions about overweight and obesity with children, young people, and families sensitively, always asking permission and using age-appropriate language. It recommends explaining health risks, setting realistic goals like weight maintenance during growth, and considering underlying factors such as mental wellbeing or social context. Interventions should be tailored, culturally appropriate, and involve families in decision-making, with clear information on costs, expectations, and long-term support. If a referral is declined, professionals should offer follow-up, share healthy lifestyle resources, and suggest community-based alternatives.

Evidence review for effectiveness and acceptability of weight management interventions in children and young people living with overweight and obesity (NICE, 2025) (11)	The NICE Evidence Review assessed the effectiveness and acceptability of weight management interventions for children and young people with overweight or obesity. BMI z-score was identified as the primary outcome due to its suitability across age and sex, with the most consistent findings seen in children aged 6–11 years. Multicomponent interventions combining behaviour change techniques (BCTs) and dietary changes showed modest improvements in BMI z-scores, but evidence quality was generally low, especially for adolescents and preschoolers. Interventions involving families and sustained beyond six months appeared most promising, though robust, long-term UK-based evidence remains limited. Qualitative findings highlighted the importance participants placed on psychological and social outcomes; such as self-esteem, stigma, and family relationships; which were often undervalued or absent from quantitative studies. Children and families preferred supportive, culturally sensitive interventions but faced barriers such as fear of stigma or logistical difficulties. In light of the limited long-term effectiveness shown in the evidence, the committee revised their recommendations to avoid suggesting weight management interventions alone are sufficient to address overweight and obesity. They emphasised the importance of referring children and young people to broader services that address underlying determinants of. They also added a consensus-based recommendation encouraging professional judgement and safeguarding action where needed, aligning with broader NICE guidance on children and young people's healthcare experiences (NG204).
Evidence reviews for increasing uptake of weight management services in children, young people and adults (NICE, 2025) (12)	The NICE Evidence Review explores how to increase the uptake of weight management services in children and young people, with particular attention to those from minority ethnic backgrounds. The review examined both quantitative and qualitative evidence to identify effective strategies and understand barriers and facilitators to engagement. Some promising findings included improved attendance through home-based motivational interviewing and contingency management incentives, as well as culturally adapted programmes and parental information letters, which modestly improved engagement among Pakistani and Bangladeshi subgroups. However, overall, the evidence base was limited in size and quality, and no interventions were recommended solely on this basis. Key facilitators of uptake included family motivation (particularly around social outcomes like bullying and self-esteem), peer support, flexible and culturally sensitive programming, good staff rapport, and practical access considerations (timing, location, cost). Barriers included stigma, distrust or denial of weight issues, conflicting parental views, competing priorities, lack of culturally appropriate dietary advice, and logistical challenges such as transport and scheduling. The committee concluded that while weight management interventions may have modest effects on BMI, the broader health and psychosocial benefits should be emphasised when offering referrals. They also highlighted the need for long-term support, tailored interventions, and referrals to other services (e.g. mental health, physiotherapy, social care) that may better address the underlying determinants of obesity. Recommendations were updated to focus on holistic and sustainable engagement approaches, acknowledging the complexity of factors influencing uptake and the diversity of family needs.

Barriers and facilitators to supporting families with children most at risk of developing excess weight (Public Health England 2020) (10)	A scoping review from Public Health England of qualitative evidence from the UK and Europe that aimed to examine the barriers, facilitators and practice implications for the development and delivery of weight management services for families with the highest risk of developing overweight or obesity. There is limited qualitative evidence on preventing excess weight in older children from low-income, ethnic minority, and disabled groups. However, key findings from this review suggests effective programmes should be culturally sensitive, tailored to families' needs, and co-developed with high-risk communities. Clear communication (i.e. use of a translator or visual aids to overcome language barriers), inclusive access, and consideration of economic and environmental barriers are essential. Places of worship may help reach some groups, and more evidence is needed, especially for children with disabilities. Reviewing papers focused on the treatment of overweight and obesity in CYP, 6 papers were extracted including studies conducted in Germany, France, Sweden and the UK. In summary. the evidence base for this review was limited, mostly focused on low socioeconomic and ethnic minority groups, with minimal data on children with physical disabilities and none on those with intellectual disabilities. Common barriers included poor communication, cultural insensitivity, language difficulties, stigma, and practical constraints like cost, transport, and childcare. Facilitators to engagement included culturally tailored content, flexible scheduling, visual materials, interpreters, and staff from target communities. These findings echo previous UK and US reports highlighting the importance of culturally appropriate, accessible, and inclusive approaches to reduce health inequalities.
Children and young people's new holistic, healthy lifestyle service NHS Nottingham and Nottinghamshire CCG (2021) (8)	NHS Nottingham and Nottinghamshire CCG sought to engage children and young people up to the age of 18, their parents and carers and frontline professionals with experience of weight management services to inform a new service offering. **Key findings from children and young people:** Survey and focus group findings from children and young people revealed that nearly half struggle to access weight management support, though those who do typically feel well-supported. Young people emphasized the importance of friendly, knowledgeable staff, flexible appointment times, and tailored, non-judgmental support that includes both mental and physical health components. Preferred service delivery includes a mix of in-person and online formats, access in community settings, and availability during evenings or weekends. Key motivators for engagement include relatable staff, fun and interactive activities, self-referral options, and holistic support that addresses emotional wellbeing, family dynamics, and healthy lifestyle education. To maintain long-term engagement and promote positive change, young people value practical tips, personalized support, and goal-focused encouragement. **Key findings from parents / carers:** Focus groups with parents and carers revealed key themes around experiences with weight management support, barriers to access, and suggestions for improvement. Many were unaware of available services or faced delays in referrals, with concerns that mental health needs and individual differences (like height or parental stature) were not adequately considered. Families reported stigma, fear of judgment, and previous negative experiences as major barriers, alongside cultural views, language difficulties, childcare challenges, and lack of tailored support for children with disabilities. Communications, particularly from the National Child Measurement Programme, were often seen as unhelpful and distressing. Participants stressed the need for more empathetic, culturally sensitive, and accessible services. **Key findings from professionals**: Current experiences highlight significant gaps in weight management services, leading to frustration among families and worsening health in children due to delayed or limited support. Access to Dietetic care is often restricted to those with specific conditions like diabetes, and professionals lack the ability to make direct referrals, creating further barriers. Tier 2 services are overstretched and unable to meet the complex needs of

	many children, with limited support available for those under 5. Additionally, societal norms and perceptions may cause some families to underestimate weight concerns, reducing engagement with existing services. Early intervention and more accessible referral pathways are urgently needed.
Uptake and retention in group-based weight-management services (7)	Public Health England Behavioural Insights commissioned Staffordshire University to conduct a review and behavioural analysis of the literature on group-based weight management. Uptake and retention in group-based weight management programmes are influenced by several behavioural factors. Motivation alone is not enough for uptake, participants also need capability (e.g., knowledge and psychological skills) and opportunity to change their behaviour, particularly social support. A lack of support from family or fear of stigma reduces enrolment to services. For retention, social opportunity is critical, with group dynamics, peer accountability, and supportive leaders playing key roles. Flexibility, relevance, and educational content also support continued engagement, while barriers include time constraints and insufficient external support. Effective retention strategies include fostering social support within and outside the group, offering educational components, incorporating self-monitoring and feedback, using graded behaviour change tasks, goal setting, and delivering enjoyable, accessible, and flexible sessions. Recruitment strategies remain poorly described, highlighting the need for clearer, behaviourally informed approaches to maximise participation.

Appendix 2 Documents included in the evidence review showing methodology and intervention type

Study (Author, Year)	Methodology	Type of Intervention / Program	Target Population
Burrows et al., 2015 (18)	Cross-sectional online survey; mixed-methods (quantitative + qualitative feedback)	Design preferences for a parent-focused eHealth obesity prevention program	Australian parents of children aged 4–18
Darling et al., 2023 (16)	Qualitative study using interviews and focus groups; FRAME framework used for adaptation	Adaptation of an evidence-based family healthy weight program for cultural and contextual fit	U.S. low-income families from diverse ethnic backgrounds
Enright et al., 2022 (22)	Mixed methods: demographic surveys, parental questionnaires, interviews with parents and stakeholders	Evaluation of a community-based behaviour change program focused on motivation and incentives	Parents and children in community settings in England
Gadsby et al., 2020(14)	Quasi-experimental study with NCMP data; annual surveys and qualitative process evaluation	Whole-system, multi-sector community pilot ("Go-Golborne") across schools, health, and leisure	Children and families in a deprived London borough
Gorecki et al., 2023 (15)	Feasibility study with pre-post design; wearables + interviews + behavioural tracking	Parent-led group sessions combined with Fitbit-based self-monitoring ("STEP IN")	Predominantly Black, low-income U.S. families with children aged 6–12
Hayes et al., 2019 (21)	Qualitative multiple case study using semi-structured interviews; RE-AIM framework	Evaluation of two school-based obesity prevention programs (Food Dudes, Green Schools)	School-aged children in Ireland
Johnson et al., 2018(20)	Qualitative evaluation using interviews and focus groups with health professionals	Service evaluation of family weight management referral system ("Eat Well Move More")	Health providers and referred families in England
Kelleher et al., 2017 (27)	Systematic review with thematic synthesis of qualitative studies	Review of barriers/facilitators to community-based lifestyle programs	Families of overweight/obese children (international)
Kulik et al., 2017 (19)	Qualitative study using focus groups and interviews; thematic analysis	Exploration of access barriers to primary care child weight management services	Urban, low-income U.S. parents
Wild et al., 2020 (28)	Cross-sectional survey with descriptive analysis	Evaluation of engagement in a multidisciplinary healthy lifestyles program	New Zealand families (diverse ethnic groups)

Wild et al., 2021a (23)	Qualitative study with interviews and thematic analysis	Examination of Māori family experiences in a lifestyle program	Māori families in New Zealand
Wild et al., 2021b (17)	Qualitative study with interviews	Exploration of barriers to healthy lifestyle change in families	Families across New Zealand
Wild et al., 2021c (29)	Qualitative study using semi-structured interviews	Examination of health system access barriers	Māori and non-Māori families in New Zealand

Appendix 3 Key informants topic areas

Background:

- The evaluation seeks to understand engagement with healthy weight management services for children and young people across Harlow, Waltham Cross and Waltham Abbey.
- We would like to interview key staff in the local authority, commissioners, healthy weight service managers, and public health experts across the ICB, to understand current gaps, what challenges and barriers they perceive for families with CYP in engaging with HWM services
- We expect the interview to last approximately 45 minutes and no longer than an hour.

Topic areas:

SECTION 1: Demographics and Background

- Role, where based, how long being in present position

SECTION 2: Current service provision

Interviewer shares provisional map of service pathway in [Hertfordshire/ West Essex] to facilitate discussion on:

1. **current provision** of healthy weight management services
2. **current gaps** in the distribution of services
3. **barriers** faced by service providers and/or commissioners of services

SECTION 3: Perceptions of barriers and enablers to engagement

4. **current barriers** to engaging with healthy weight management services
5. **enablers** to engagement with healthy weight management services

SECTION 4: Future service development

In what ways the healthy weight management programmes could be **improved**

6. What **other support** could be beneficial to help children and families to manage a healthy weight
7. Anything else