Welsh Parliament
Health and Social Care Committee

Prevention of ill health - focus on obesity

Engagement findings

October 2024

As part of the **Health and Social Care Committee's** inquiry into prevention of ill health, with a focus on obesity, the Citizen Engagement Team proposed a qualitative approach to engagement, comprising a series of interviews and focus groups with people across Wales with lived experience of obesity and those who support them. This paper communicates the findings of those interviews and focus groups.

Contents

1. Background

1. The promotion of healthy lifestyles and prevention is one of the priority issues identified in the Committee's strategy for the Sixth Senedd.

2. The Health and Social Care Committee are holding an inquiry into the prevention of ill health, with a focus on obesity.

3. The Committee wanted to hear from people, across Wales, who have lived/are living with obesity, and the people who support them.

Engagement

4. Between 2 August 2024 and 30 August 2024, the Citizen Engagement Team facilitated 8 individual interviews and 3 focus groups with a total of 22 people (11 female and 11 male) either living with obesity or supporting people living with obesity, in a professional capacity. A further 6 participants chose to respond in writing.

5. The terms of reference considered during the engagement programme included:

- the stigma and discrimination experienced by people who are overweight/obese;
- people's ability to access appropriate support and treatment services for obesity;

- the relationship between obesity and mental health.

Participants

6. Participants were sourced via a screening survey shared with over 15 organisations and groups supporting people living with obesity.

7. The Citizen Engagement Team worked in collaboration with organisations and groups, for example, Slimming World and Man v Fat to identify some participants.

8. All participants either have lived/are living with obesity, or support people living with obesity, in a professional capacity, including physiotherapist, occupational therapist, bariatric surgery dietician, clinical psychologists, *Slimming World* consultants, a personal trainer and *Man v Fat* coach.

9. The ages of the participants ranged from early thirties to late sixties.

10. All seven health boards were represented in the programme of engagement, so were many of the disadvantaged communities where obesity rates are much higher.

11. Thank you to everyone who contributed to the programme of engagement, especially the participants, who shared their experiences.

Methodology

12. Engagement was conducted both online and face-to-face, according to the preference of the participants.

13. The following discussion points were addressed during the programme of engagement:

a. What barriers do people living with obesity in Wales face in their daily lives? (for example, use of gym/sport facilities)

b. What type of stigma and/or discrimination do people living with obesity face on a day-to-day basis?

c. What are the links between obesity, mental health and emotional well-being?

d. To what extent are people living with obesity able to access appropriate support and treatment services?

e. How can people living with obesity be better supported? (for example, mental health support, talking groups, use of positive language)

f. What are the main reasons why people become obese in Wales today?

g. Can you give examples of ways to improve prevention of ill health? (for example, promoting good nutrition in early childhood programmes, school campaigns.)

2. Setting the scene

How did we get here?

14. All participants spoke about the obesogenic society we live in today.

> *"Whether we are happy or unhappy about life, we turn to food."*

Lifestyle

15. The impact of technology on people's lifestyle today, including home food deliveries like *Deliveroo* and *Just Eat*.

> *"Everything's so easy.....At the press of a button you can slump on the sofa, and do everything from there.....it's a bit scary and there's no easy fix."*

16. The challenge of work life balance. There is no time to cook because of work pressures and there is no incentive to cook when unemployed.

17. Working patterns impact family life. For example, parents who work full time are not able to give their children the time to be active. Also, working from home, especially on the weekends, means that children have to stay in and entertain themselves.

18. The change in food shopping patterns. One participant, who has lost nine stone this year said,

> *"Although companies like Hello Fresh encourage people to use fresh produce to cook, an important part of a healthy lifestyle is going out to shop and choose produce to cook."*

19. The 'sweets reward system' for children, has led to nomalising junk food as a reward in adulthood.

20. Lack of encouragement to increase activity levels, largely due to poor facilities.

Convenience food v 'real' food

21. Easy access to high-calorie, high-processed foods in comparison to healthier options.

> *"How did we get here? Easy, it's easier to buy a kebab than a salad."*

22. Cultural factors have made eating convenience foods, like takeaways and fast food chains, commonplace.

Education

23. Lack of basic nutritional knowledge, especially among children, young people and parents, about the long-term impact of diet on health. This results in people making ill-informed choices about their dietary needs.

24. Lack of dissemination of dietary information - where to seek support and how to access it.

25. People consider culinary skills *"a thing of the past"*, as convenience foods are so readily available.

Poverty

26. Increasing someone's awareness about healthier options, sometimes isn't achievable in practice, because of the expense during a cost-of-living crisis.

27. Low socio-economic status has a huge impact on eating habits.

> *"Meal prep and food choice is all about planning ahead, but this is more challenging when using a food bank; people don't know what food they will be given week to week."*

Mental health matters

28. The number of people living with mental health challenges is increasing in numbers and severity. If parents' mental health challenges are not well-managed, this can impact the children and the parenting ability in that family.

3. Key themes

Following each of the three key themes below, a collection of ideas and proposals suggested by participants during engagement sessions are presented. These ideas represent diverse perspectives aimed at improving the current situation. It is important to note that while these suggestions reflect the creativity and concerns of participants, they have not been unanimously agreed upon. Rather, they were brought forward during discussions as potential pathways for positive change and are shared here to inspire further dialogue and consideration.

Barriers in daily life

29. Participants spoke at length about a whole range of barriers, in all areas of everyday life, faced by people living with obesity.

> *"Name me anything you do normally, and I can tell you how that is a barrier for me……it's absolutely everything."*

> *"Engaging in life is the greatest barrier."*

Physical and mobility barriers

30. Participants noted the impact of physical restrictions, for example, not being able to go to the dentist, as the dentist chair would not be suitable or safe for the individual living with obesity.

31. Parallel examples were given by other participants, including getting a seat on the bus or train, going to the theatre or cinema or going through the turnstiles at a football ground. Using gym equipment at leisure centres was also mentioned. (Gym equipment are usually deemed safe for people up to 150Kg in weight.)

> *"When I go to a restaurant, I always look through the window first, to see if I'll be able to sit in the seats."*

32. One participant runs psychological therapy groups for people with a BMI of 40+. There is only one venue across the health board who is able to supply bariatric chairs to enable them to meet face-to-face.

33. An occupational therapist described some people who are "trapped in their own homes" and not able to do anything to help themselves.

> *"I went out to see one lady who was really bariatric. She was actually trapped in her own room because the ceiling hoist needed to be serviced and the service company wouldn't service the hoist without the lady being in the room. But we couldn't get the lady out of the room because she couldn't leave her bed. I found it really distressing because she was completely stuck and there was nothing I could do."*

34. The participant also noted her frustration when trying to order special equipment for the patients, for example a bariatric toilet frame or commode. The equipment is larger in size but not necessarily suitable for the individual and in some cases is unusable.

Environmental barriers

35. Many participants commented that our built environment is not designed for people living with obesity and facilities don't provide adequate space, seating and equipment.

> *"Equipment in society isn't built for people in bigger bodies, even though so many people are now living with obesity and quite significant obesity."*

36. Few participants mentioned the lack of public transport services and suggested the active travel policy should focus on improving public transport rather than cycle paths.

37. Some participants spoke about geographical restrictions, especially in some socio-economic deprived and rural areas.

Social barriers

38. All participants described how hostile society has become towards people living with obesity.

39. Many participants referred to the lack of understanding about the complexity of obesity within society today and a tendency to over-address the risk factors of diet and exercise, without considering the more complex roots of obesity, namely the social, psychological and biological, polygenic factors.

> *"There is controversy whether we call it a disease or not, depending on what group of people you ask. So, I think it's understandable, then, that the layperson is probably led by what they see on social media."*

40. A participant who works with children and young people commented how the hostility is engrained in society from childhood.

> *"Among young people you see it in its rawness, you see the bullying….they will comment on what each other is eating. Others will say nothing or they'll allow it, they'll join in. So you've got a whole societal issue before you even get to adulthood."*

41. All participants spoke about people living with obesity being judged and blamed for being overweight and how people assume they make poor food choices and are lazy.

> *"Research has shown that social attitudes towards obesity is that people assume people living obesity to be more likely to be lazy and lack willpower."*

42. One participant noted that there is a lack of understanding about the barriers faced by people living with obesity and morbid obesity, even among people who are overweight.

Health barriers

43. Some participants spoke about the challenges of everyday routines, for example, taking a shower can be exhausting.

44. Participants noted how self-cleaning challenges can lead to further health issues like skin problems, ulcers and pressure sores.

45. Many participants spoke about not being able to exercise because of their obesity; this exacerbates the situation.

Employment barriers

46. Some participants said that they are unable to work because of their obesity.

47. Other employed participants spoke about bullying at work and explained how people living with obesity become "easy targets" in the workplace.

> *"I feel personally in my job that I've been passed over for other people. I'm very capable, I'm very, very qualified, but I felt it was because of my size. They saw the size not the person inside."*

> *"You get bullied and targeted for every pound you're overweight. It's a cruel world."*

48. Many employed participants discussed lack of work life balance, work pressures and how their employment impacts their eating habits.

Financial barriers

49. Some participants noted financial barriers due to their inability to do income generating work.

50. Many participants spoke about the cost of leisure and sport centre memberships, leading to their inability to access sport and leisure facilities.

51. Many participants spoke about the cost of healthy foods and their inability to buy them. They compared the cost of healthy foods to '10 meals for £10' in *Iceland* shops, for example, or the 'buy one get one free' promotion on ready meals.

Education barriers

52. Most participants speaking in a professional capacity commented on the general lack of knowledge about food and nutrition and how diet impacts health.

> *"Patients coming through assessment with me…plenty of them still don't know what you'd think would be common sensical because they just haven't learnt it."*

53. Many participants noted a general lack of culinary skills and lack of confidence in using foods, among all ages.

54. Some participants also commented on the mixed messages around unhealthy foods, for example *Subway* 'eat fresh'.

55. One participant suggested that *"simplistic health messaging"* for example, 'eat less, move more' impacts or affects people living with obesity, as this is not always true and could be very challenging to hear for some people.

Psychological barriers

56. All participants spoke about psychological barriers faced by people living with obesity, primarily because of the stigma and discrimination they face in their daily lives.

> *"If you're large, people feel uncomfortable around you and that has a massive psychological impact on you."*

"I think that people respect me less when I am this way, I really do feel that."

57. Psychological barriers include lack of confidence and self-esteem, often resulting in isolation, anxiety and depression, preventing people living with obesity to seek support and treatment.

"People are quick to judge without knowing what's going on with that person.....I felt like I didn't belong to the world."

"People think I'm lazy and stupid. And after a while, you start believing it yourself."

Ways forward

58. Develop healthy hubs for information sharing, to educate about portion sizes, hold emotional eating workshops and courses for individuals and families and increase confidence in using food.

"We need to be back in touch with real ingredients...and reconnect with food to build people's confidence so people can actually look at a bean, that isn't a Heinz baked bean, and think, 'do you know what? This isn't going to kill me and I might actually eat it.'"

"I actually think it's not about what supermarkets are selling. It's about helping people to make informed choices. If people like Coca-Cola, they will pay the extra 50p. But, if they realised there are nine teaspoons of sugar in a can of Coca-Cola they might think twice. I used to drink Coke...now I don't touch it."

59. Education, on all levels, needs to make food interesting, so that children and adults are not "afraid" of food, but rather well-informed and knowledgeable about where food comes from. For example, having gardens or allotments in schools.

60. Promote locally produced foods at easily accessible places, at affordable prices.

61. Focus on normalising healthy options in public places, for example cinemas and leisure centres. This should be applied to meal deals and the way food is displayed in shops and supermarkets too.

62. Redefine what is meant by 'exercise'; getting children and young people involved in exercise and making it enjoyable within and beyond the school environment.

> *"Families of the future need healthier lifestyles, including exercise. It hasn't got to be all gym and lycra, just going to the park or going for a walk."*

63. Create a network of personal trainers to work locally, outside of the gym environment, to promote the benefit of outdoor exercise, provide an opportunity for people to socialise, through exercise, and develop a local support network.

Obesity and mental health

64. All participants spoke about the correlation between obesity and mental health and its impact on the struggle to make positive changes about their weight.

> *"As a physiotherapist I find the child/parent mental ill health one of the main barriers to them being able to be ready to make changes to their physical activity."*
>
> *"The bigger I was getting the bigger it impacted my mental health. Every time I was upset, I would eat, and then I'd be upset because I'd eaten more.....You can't get out of it until you get the right support."*

65. Many other participants shared their experiences about how obesity impacts their mental health and visa versa.

> *"When I was heavier, I wore the same three things and I wouldn't go and buy anything. So that would then depress me even more so you get into that downward spiral.....You actually do self-destruct."*

> *"The links are huge. I know when I was at my lightest, I was feeling great, I was on top of the world….My anxiety and depression is far more pronounced now that I'm at my heaviest. I really struggle with it."*

Childhood adverse experiences

66. Drawing on their professional experience, some of the participants explained the well-established link between adverse childhood trauma and weight gain. This in part is related to overeating being used as a way of regulating emotions which are experienced as overwhelming.

> *"For people living with a complex obesity, there's often a link between trauma, adversity, socioeconomic deprivation in childhood, and later developing obesity difficulties."*

67. One psychologist said that people living with obesity accessing the level 3[1] weight management services in her health board, are three times more likely to have experienced adverse childhood events than the general population in Wales and twice as likely to have experienced sexual abuse.

> *"There is a bi-directional relationship with mental health problems and obesity; when people are experiencing low mood and emotional dysregulation they are more likely to eat for emotional comfort."*

Emotional eating

68. Emotional eating is an eating behaviour that's prompted by a strong emotional experience, for example, happiness, sadness, anger, anxiety, despair, loneliness. rather than being prompted by the bodies physiological hunger signals.

[1] Level 2: BMI = 30+ Level 3: BMI = 40+ / 35+ with comorbidity / 32.5 ethnic minority groups

> *"Eating is soothing, rewarding, distracting in terms of the kind of stress hormones and the neurotransmitters that are released from eating. From infancy we associate food and emotion and relationships."*

69. One participant explained how parents who have experienced trauma often find it difficult to set boundaries for their children around food, as food is linked with so many emotions.

70. Eating is one of the more socially acceptable coping strategies in response to emotional dysregulation.

> *"You can have an absolutely huge take away that isn't good for your health and go to work the next day and be an amazing employee or carer for your family member who's sick or parent. You can't do that so much with alcohol and drugs."*

71. Many participants living with obesity, including those receiving treatment for their obesity, noted that they have not been offered mental health support during their treatment.

72. Many professionals working with people living with obesity referenced the lack of funding available for mental health and psychological support for patients.

Ways forward

73. Earlier intervention, especially with families who have a higher number of adverse childhood experiences, who potentially have an increased risk of obesity.

74. A multi-disciplinary holistic approach to supporting and treating people living with obesity; physical, mental health and well-being all impact by each other and contribute to overall health.

> *"Unsurprisingly, being in a position to make weight changes comes when they [patients] get help with their trauma."*

75. Improved resourcing of health professional staff to deliver early psychological and mental health interventions.

76. Further funding and research into the links between obesity and mental health.

Accessing support and treatment services

Availability of support and treatment

77. Not all health boards offer a weight management service and there is only one bariatric surgery service in Wales.

78. Weight management services vary greatly within each health board, as do the waiting lists for the services. The demand is far beyond capacity. For example, one weight management service is commissioned to support 200 Level 3 patients annually. As the demand is way beyond the limit, many Level 3 patients are enrolled for the Level 2 so that they at least are able to access *"some really good quality dietetic intervention."*

79. Some participants noted the lack of services available to high weight eating disorders in comparison with low weight eating disorders.

> *"I'm a psychologist at a weight management service, but we aren't a mental health service.....There is a big gap in terms of the mental health provision for people with what we call high weight eating disorders.....We've got inpatient care for low weight eating disorders across the whole of the UK. We don't have any inpatient care or rehabilitation for people who have got high weight, eating disorders and those poor people end up becoming house bound and we don't know what to do for them."*

80. Weight management services can be difficult to access, especially for people with limited access to transport and the difficulties with accessing public transport.

81. Mental health services can be difficult to access, especially if patients don't have a diagnosis or their mental health is not 'severe enough'. This is challenging when working with children, because their underlying mental health plays such a

large part in their physical ability, sleep, social skills and uptake of opportunities to make changes.

82. Some participants spoke about specific treatments. One participant commented how she is grateful to have been offered wegovy[2] but lives with the fear of what will happen after the 2 years she has been prescribed.

Timing of support and treatment

83. Most participants spoke about the impact of long waiting lists for weight management services.

84. When a person living with obesity decides to self-refer to the clinic, they are ready to seek help and support at that time. Having waited possibly 12-18 months or more, to access the service, they probably have gained more weight and are possibly in a very different mindset.

> *"Support for people living with obesity needs to be holistic, accessible and in good time."*

Impact of support and treatment

85. Many participants living with obesity spoke about the positive impact of various types of support and treatment.

86. One participant, who has lost seven stone, described the impact of counselling on her mental health.

> *"I've had counselling and it really has helped me to identify my own triggers. I've lost a lot of weight as a result and feel far more comfortable in my own body, no matter what size it is."*

87. Some of the *Man v Fat* group members – who had found the group by chance – spoke about the impact the group has had on their weight and mental health.

> *"My mental health is so much better since joining a team sport. I can't speak highly enough about what it's done to me. It's probably saved*

[2] Wegovy is an injectable prescription medicine, to help lose excess body weight.

> *me…..The weight loss has been brilliant, I've lost nearly six stone, but the mental health has been the biggest improvement."*

88. Some *Slimming World* members spoke about the impact attending their local group.

> *"I have lost 4 stone in weight since January this year……..I was on two lots of medication for High Blood Pressure for 20 years, I'm now off both. I was diagnosed as a Type 2 diabetic…..I am now in remission. I joined my local gym at 62 years old….and I love going. I'm the lightest I've been for years and it feels good."*

- One participant who was referred to *Slimming World* via her health board, spoke about the benefits of the scheme for her.[3]

> *"Seeing my fellow members [Slimming World] every week has brought me out of my shell. I wouldn't leave the house before."*

Support and sensitivity

89. Many participants spoke about the lack of dignity they have experienced whilst trying to access support and treatment for health matters outside of their weight management concerns. These are often denied, until they lose weight.

> *"In my first appointment[for fertility treatment] – without asking why I might be overweight or what could be impacting my weight – the doctor said, 'you need to go away and lose weight. Then, when you come back, we'll look at you.'…..It was one of the worst experiences of my life and it will always be with me."*
>
> *"When I go to see the GP, everything boils down to 'lose weight and you'll be fine'. That's not true, for a lot of people that isn't true."*

[3] The referral allows for 12 weeks free membership with *Slimming World*, with a possible additional 12 weeks, in some cases.

90. This results in poor medical outcomes for people living with obesity, as they delay seeking treatment or advice.

91. One participant mentioned that people report weight gain following healthcare consultations which are not handled sensitively.

92. Sometimes people cannot access support to lose weight, and the causes of obesity may be complex and cannot be managed alone.

93. One participant described her response to the empathy she experienced during her first appointment at the weight management clinic.

> *I was expecting the whole 'how much do you weigh? But she[the doctor] said, 'So, tell me what's going on in your life right now.' I was just like, oh, my God, nobody's ever asked me that question. Nobody.....[Later the doctor said] 'You've got a lot on your plate, no wonder you're struggling with your weight. How can you think about losing weight when you've got all of that going on in your life?'.....I'm 34 years of age and it's taken 34 years for a doctor to speak to me as a person....I am a person, I'm not just my size, I'm not just how many stones come up on that number. I remember leaving that appointment and I said to her, 'Thank you so much for treating me like a human being.' It meant the world to me."*

Ways forward

94. Developing a primary care weight management service "*where the holistic factors are considered, designed and supervised by specialists but it doesn't have to be delivered by specialists.".*

95. A focus on weight inclusive care rather than weight focused care, *"to improve health even when the number on the scale is not changing."*

96. Where needed, a co-ordinated 'family approach' within weight management services, which would support all members of the family and their individual, different needs.

97. A focus on parenting support to allow parents to feel more confident to make changes in the home, for example, around diet, sleep and screen time.

98. A focus on promoting positive language and appropriate choice of words, including within the healthcare profession.

99. Community talking groups to support individuals on their weight loss journey; the onus doesn't need to be on professional people always.

100. Community activities where people living with obesity feel they can take part, as individuals.

101. More funding and further research into obesity, including causes and treatment.

> *"There are very few charities supporting the illness.....You don't see people running marathons for Obesity UK, do you?"*

102. Improved and earlier access to weight loss medication and treatment, across Wales.

103. A focus on monitoring and supporting healthy lifestyle choices following medication and/or treatment, to mitigate further issues.

> *"I think we need to recognise both in politics and health that it is a complex disease, so we need that recognition and we need to have people available to help these individuals....People should not be trying to do this on their own."*