More Than Weight:

Exploring the human, social and economic cost of obesity

Humber and North Yorkshire Centre for Excellence

West Yorkshire Health and Care Partnership

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Foreword

Obesity is one of the most complex public health challenges we face today - shaped by biology, environment, mental health, trauma, and the human, social and economic inequalities people live with every day. It's about far more than weight, and for many, it's a deeply personal and emotional experience that deserves care, compassion, and understanding.

In West Yorkshire, we know that if we want to make a difference, we need to change how we work. That means giving people more choice, control, and support on their own terms—and designing services that reflect the reality of people's lives. This review looks at the scale and impact of obesity across West Yorkshire, Humber and North Yorkshire. It doesn't just focus on costs to the health system—it highlights the emotional toll, the stigma and isolation people face, and the strong links between trauma and weight. These stories and statistics together build a powerful case for doing things differently.

Obesity is a chronic, relapsing medical condition and we need our systems to treat it as such. We also need to recognise that obesity and mental health are closely connected, often feeding into one another. That's why compassion must be at the heart of how we respond.

A huge part of this project has been about listening—truly listening—to people with lived experience of obesity, as well as to the health professionals working alongside them. If we're serious about creating services that work, we have to keep doing that.

People are the experts in their own lives—and they are telling us what needs to change. We'd like to thank everyone who has contributed to shaping this report—including those with lived experience who generously shared their stories, healthcare professionals across our system, public health colleagues, and voluntary and community sector partners. Your insights, honesty, and commitment to change have been invaluable.

Our colleagues in the Humber and North Yorkshire Centre for Excellence - a regional prevention programme funded by the Humber and North Yorkshire ICB to tackle the three biggest killers: tobacco, alcohol and unhealthy food and drink - also deserve a special mention for the support they have given us in extending the reach of the project.

Finally, a special thank you to the Public Health Team at City of Doncaster Council for their support and for sharing their knowledge and practice around compassionate, trauma-informed approaches. Their input has helped us shape a more inclusive and hopeful narrative that puts people at the centre.

Emmerline Irving,
Head of Improving Population Health,
West Yorkshire Integrated Care Board (ICB)

Executive summary

Obesity is one of the most pressing and complex public health challenges in the UK today. Obesity presents a significant global health issue that hinders both social progress and economic growth across nations (World Health Organization, 2023). This insights report, commissioned by West Yorkshire ICB and conducted by Brightsparks Agency, explores the human, social and economic costs of obesity, drawing on lived experience, workforce insights, policy and economic evidence.

What lived experience tells us
People described obesity not as a cause, but as a consequence—of trauma, bereavement, poverty, neurodivergence, and emotional distress.

66% of survey respondents reported frequent emotional eating

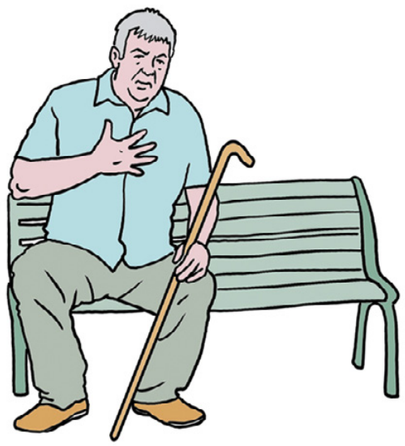
78% reported at least one mental health or neurodevelopmental condition

Over 70% said they experienced social isolation

Focus groups became therapeutic spaces where people felt listened to and validated—often for the first time. Being heard, without judgement, was described as transformative.

The cost of inaction
Current estimates place the cost of obesity across the region at over £6.1 billion each year, comprising:

£683 million in NHS treatment
£2.84 billion in lost productivity
£1.58 billion in social care
£1.05 billion in wider economic impacts.



Rising levels of obesity are already putting pressure on health and care systems, unpaid carers, and local economies. Without intervention, both financial and human costs are likely to grow.

Key system failures:
Stigma continues to shape experiences, including within healthcare

- Support is inconsistent and often difficult to navigate
- Only 35% of healthcare professionals feel equipped to deliver effective obesity care
- Carers remain unsupported, despite bearing a significant emotional and financial pressure
- Gaps in training, continuity and service access are leaving both individuals and professionals without the tools they need to succeed.

Strategic opportunities for change
People living with obesity and the workforce emphasised the need to shift the focus—from weight to wellbeing, from blame to belonging. Compassionate, coordinated care should:

- Address trauma and inequality as core drivers of obesity
- Centre lived experience in service design and delivery
- Provide professionals with time, tools and psychological support
- Ensure equitable access to care across all parts of the region.

A trauma-informed and responsive, person-centred approach has the potential to improve outcomes, reduce pressure on services, and restore trust across the system.

Five actions for immediate implementation

- Embed trauma-informed and trauma-responsive care across all obesity pathways
- Strengthen access to behavioural and specialist weight management services
- Implement anti-stigma training and culture change within health and care
- Support peer-led, community-based models rooted in lived experience
- Prioritise prevention and early intervention in areas of greatest need

Lived experience: what's at stake

Obesity is not just about numbers or BMI charts. It shapes how people are treated, how they navigate public spaces, and how they see themselves. Behind every data point is a person who may have experienced challenges, encountered stigma, or felt overlooked by the very systems designed to support them.

For many people, obesity is not simply a medical condition. It is something they live with in every interaction—on the bus, in the GP's waiting room, at the school gates. It can mean being overlooked, disrespected, or blamed for things beyond their control. It can mean being denied dignity.

As one participant told us:

"It's not just about weight. It's about being seen. Being believed. Being treated like a whole person."

For others, weight gain is directly linked to survival. One participant described how eating was a way to cope with distress:

"This body saved my life."

Another told us:

"I ate instead of drinking or doing drugs or slicing my skin… I'd rather be here and be fat than dead."

These lived experiences reveal the human cost of inaction. Focusing solely on the economic burden or health outcomes risks missing what really matters: people's lives, identities, and futures.

Introduction and rationale

Obesity is one of the most pressing public health challenges in the UK today. Living with obesity significantly increases the risk of developing long-term conditions such as diabetes, cardiovascular disease, kidney disease, and musculoskeletal disorders. However, the impact extends far beyond physical health - obesity is deeply interwoven with issues of mental health, trauma, social stigma and widening health inequalities. In West Yorkshire, North Yorkshire, and the Humber, adult obesity rates exceed the national average. Despite this, the localised social and economic implications of obesity remain poorly understood, and current weight management provision falls short of meeting population needs.

In response, West Yorkshire ICB is leading the way by taking decisive and compassionate action to transform how obesity is understood and addressed across its whole system and beyond. This transformation starts with a paradigm shift: reframing obesity as a long-term, relapsing medical condition rather than a consequence of individual lifestyle choices. The goal is to challenge stigma and replace blame with compassion, embedding trauma-informed, person-centred approaches into all aspects of obesity care.

To support evidence-based policymaking and service redesign, West Yorkshire ICB commissioned Brightsparks Agency in September 2024 to conduct an in-depth insights project. This work aimed to explore and quantify the human, social and economic costs of obesity in adults across West Yorkshire, North Yorkshire, and the Humber. The overarching goal was to provide robust, actionable recommendations to inform the development of effective, financially sustainable and integrated obesity and weight management care pathways which deliver long-term benefits for individuals and communities.

Justification for the study

At the heart of West Yorkshire ICB's obesity care transformation programme is a commitment to co-production—working closely with people who have lived experience of obesity to design care that truly meets their needs. However, to do this effectively, West Yorkshire ICB needed a clearer picture of the full scope and impact of obesity on individuals, communities, and public services. This insights project aim was to address a vital knowledge gap by examining:

- The human and social implications of obesity, including impacts on quality of life, mental health, stigma and family dynamics
- The relationship between trauma and obesity, including how these factors intersect with long-term conditions and health inequalities
- The direct and indirect economic impacts, from healthcare expenditures to productivity losses and effects on sectors such as employment, education, and social care
- The "cost of doing nothing" compared to the benefits of intervention—both financially and in terms of population health and wellbeing.
- This vital project aimed to equip policymakers and commissioners with a deeper understanding of obesity—not only its symptoms, but also the underlying contributory factors and its wide-ranging financial, human, social and emotional impacts.

Sensitive content notice

This report contains detailed discussions and personal testimonies relating to obesity, weight stigma, trauma, mental health, emotional eating and experiences of discrimination. These topics can be emotionally challenging for readers, not least those with lived experience and the professionals working alongside them in health and care settings.

We have adopted a trauma-informed and person-centred approach throughout this work. While the report aims to elevate voices and deepen understanding, some of the content may evoke strong emotional responses.

We encourage all readers to engage with these findings with sensitivity, reflection and empathy. The personal narratives shared in this report reflect deep and often painful experiences, and we honour and are humbled by the courage of the participants who shared them.

If you find any content distressing, we encourage you to take breaks and seek support to debrief and reflect if needed. Support services include:

Samaritans – 116 123 (24/7, confidential support).

Mind – 0300 123 3393 www.mind.org.uk.

BEAT Eating Disorders – www.beateatingdisorders.org.uk.

Occupational Health or Staff Support Services (for NHS and local authority professionals).

NHS 111 for urgent mental health support.

Methodology and approach

The insights project was carefully designed to meet the specification set by West Yorkshire ICB. It followed best practice research methodology, adhered to ethical standards, and ensured the validity and reliability of the findings.

The study comprised two primary components:

Lived experience insights:
An online survey and four focus groups with individuals living with obesity to capture first-hand experiences of stigma, trauma, and barriers to care.

Participants shared how obesity affects their physical and mental health, access to services, and interactions with health professionals.

Sector-focused analysis:
An online survey and focus group engaged the health and care workforce, particularly in primary and community care, in West Yorkshire and Humber and North Yorkshire.

This component explored how obesity impacts care delivery and the ability of the workforce to provide trauma-informed, person-centred care.

It also sought suggestions for system-level changes and interventions that could improve care outcomes and reduce burdens on services.

The methodology section offers a more detailed explanation of the approach taken and outlines the study's ethical approach and limitations.

Conclusion

The findings from this project serve as a critical foundation for transforming obesity care in West Yorkshire, North Yorkshire, and the Humber. By combining lived experience with economic and social analysis, the insights generated are intended to support the design of compassionate, effective, and sustainable strategies that address the root causes of obesity. The commitment of both ICBs to deliver systemic changes in obesity care which is informed by evidence and co-production, represents bold and necessary steps towards tackling one of the region's most urgent public health challenges.

The human and social cost of obesity

Introduction

This section brings together insights from 119 e-survey responses and five focus groups with people living with obesity across Yorkshire and the Humber. Together, they reveal the often-invisible human, social, emotional and psychological costs of obesity—costs that extend far beyond physical health. The findings showed that trauma, stigma, social isolation, and systemic neglect profoundly shape the lives of people with obesity. While the survey offers quantitative reach, the focus groups enrich and deepen understanding, providing powerful first-person accounts that give life to the statistics.

Integrated themes and evidence

1. Social isolation, withdrawal, and loss of participation

Survey findings:

73.5% of people with lived experience of obesity reported avoiding social events due to their weight.

Over **70%** of participants experienced social isolation to some extent.

Excerpts from focus group participants:

"It's a vicious circle. You want to enjoy the outside but… it's so much easier staying in."

"I have had scenarios where seat belts haven't fit me—it stops me going out."

"I don't always go to social and work events because I feel ashamed of my size."

What we heard – Life gets smaller:

People described stepping back from friendships, family activities and social events—not because they wanted to, but because of shame, anxiety or practical barriers.

The impact wasn't just social—it affected how they parented, worked, travelled and showed up in the world.

"I miss doing things with my children over fear… rides at fairgrounds, slides on holiday."

"I've lost friendships because I avoid places where I feel like I won't fit—physically or emotionally."

2. Emotional eating, trauma, and mental health

Survey findings:

65.7% of participants reported frequent emotional eating.

51.5% experienced anxiety, and 48.5% reported depression.

78% of survey respondents reported experiencing at least one mental health or neurodevelopmental condition, such as anxiety, depression, an eating disorder or post-traumatic stress disorder (PTSD).

In open-text comments, respondents also spoke about conditions such as attention deficit hyperactivity disorder (ADHD), highlighting the complex and often overlapping emotional and cognitive challenges faced by people living with obesity.

Excerpts from focus group participants:

"Food is my therapy."

"I eat when I'm happy, sad, stressed, tired. It just seems to be my go-to activity."

"I had undiagnosed ADHD… food was a stimulant, a comfort."

"My fiancé was killed in a car accident three weeks before our wedding… I coped by eating to block out the pain."

"I kept a lot of the pain to myself… being judged, bullied or ignored really stayed with me."

What we heard – Life gets smaller:

Participants shared how food was often a coping mechanism—not a lifestyle choice. Many described deep links between trauma, mental health and eating behaviours.

"The reason I'm fat is because I ate instead of self-harming… this body saved my life."

"I have a trauma-responsive eating disorder, based around control."

3. Stigma, shame, and social judgement

Survey findings:

Many participants described being mocked, excluded or treated with hostility, attributing this to their weight.

11.8% reported experiencing eating disorders, frequently caused and driven by shame.

Excerpts from focus group participants:

"I am the thing that is in your nightmares – to be fat."

"I've always been the jolly fat friend… but that's a mask."

"I didn't want to go to a wedding dress shop… the trauma of going shopping is awful."

What we heard – Shame doesn't start in adulthood:

Experiences of being mocked, excluded or judged often began in childhood and continued through every life stage. Participants described how these moments shaped self-worth and belonging.

"My dad used to offer me money to lose weight… I remember thinking: why doesn't he love me as I am?"

"People say, 'you'd be pretty if you lost weight'. These things carry with you for life."

4. Intimacy, relationships and romantic isolation

Survey findings:

While no single closed-response question captured this theme, over a third (36%) of free-text survey respondents described how obesity negatively impacted their romantic relationships, intimacy, or confidence to date. Common themes included shame around physical intimacy, low self-esteem, and fear of rejection.

This theme was echoed frequently in open-text responses, with participants describing a reluctance to pursue or sustain intimate relationships due to self-consciousness, avoidance behaviours, or a belief they were undeserving of love

Excerpts from focus group participants:

"I do not feel attractive to my husband… I avoid sex despite him saying I am attractive."

"I haven't undressed in front of my partner in over eight years."

"I wouldn't want to date… I don't feel like I'm in a place to because I know I've let myself go."

What we heard – We feel undeserving of love:

Many participants spoke about shame, fear and self-consciousness in romantic relationships. Intimacy was often avoided—not due to lack of desire, but from a belief they wouldn't be accepted.

"I have never really had a relationship… I assumed that no one would be remotely interested in me."

"There's so much shame in being seen naked—it's easier to avoid."

5. Healthcare harm and missed opportunities

Survey findings:

Many participants reported weight-related bias from healthcare professionals.

Respondents cited barriers, such as a lack of proactive support, and dismissal of symptoms by healthcare professionals.

Excerpts from focus group participants:

"I want weight management specialists in GP surgeries—not just general advice."

"Unless I was purging, there is nothing… I cannot get any help."

"Trying to get menopause healthcare while being overweight is just a disaster… you're telling me to go and lose weight, it's not that easy."

"Tier 3 was the best, most helpful programme I've undertaken—particularly the psychological support."

What we heard – The care system let us down:

For many, healthcare interactions felt judgemental or dismissive. These experiences created long delays, worsened outcomes and left people feeling blamed rather than helped.

"Being judged for my weight by a medical professional caused a long delay—and worsening of my heart failure."

"Doctors just say 'lose weight'… there's no emotional intelligence."

6. Physical environment and accessibility

Survey findings:

Many reported difficulties with transport, seating and public space access.

Excerpts from focus group participants:

"I cannot fit in some chairs. Plane seats can be uncomfortable due to width."

"I had to ask an usher to find me a more comfortable seat… in some ways it was empowering and mortifying."

What we heard – The world isn't built for us:

Everyday environments—buses, cafés, waiting rooms—were described as hostile or excluding. This was about more than comfort; it was about visibility, anxiety and the pressure of being judged.

"Public transport is hard to access, especially when you feel stared at."

"I avoid theatres, buses, cafes—anywhere where I might not physically fit or be judged."

7. The power of peer support and being heard

Survey findings:

Despite hardship, participants expressed hope and empowerment through peer connection, validation and being involved in shaping services to meet their needs better.

Excerpts from focus group participants:

"Walking groups were really helpful… it was walking and talking with people who had similar experiences."

"The cooking group at the library has been a lifeline… nobody cares about my size."

"I want to be part of these discussions going forward. I want to have a voice."

"We've all lived in these bodies a long time. Listen to us. Believe us."

What we heard – When we feel heard, we feel hopeful:

Being truly listened to can be empowering. Peer support not only breaks the cycle of isolation but offers a space where individuals can reclaim their stories—rooted not in shame, but in shared understanding and solidarity. The focus group setting itself became a space of affirmation, where participants felt safe and that their voices mattered.

"Thank you for treating our time as valuable. That in itself means something."

Conclusions and recommendations from the surveys and focus groups

This integrated analysis reveals obesity as a profoundly human, social and emotional issue, shaped by trauma, stigma, shame and structural exclusion, not just lifestyle or biology. Participants called for services that are empathetic to their experiences, offer them real solutions and which restore dignity. In response to the findings the following recommendations are proposed:

1. **Embed trauma-informed and trauma-responsive care across all overweight and obesity management services**
   Trauma-informed care should be embedded across universal services (sometimes referred to as Tier 1), behavioural services (Tier 2), and specialist services (Tier 3 and Tier 4).

   Train professionals to recognise the emotional and psychological roots of obesity and give them the time to work with individuals.

   Build obesity services that meet psychological, emotional and physical health needs.

2. **Ensure equitable access to effective treatment**
   End postcode lotteries, the unequal access to healthcare services or treatments based on where a person lives. Make newer treatments like weight-loss medications accessible and distribute them fairly.

3. **Integrate mental health into all weight management pathways**
   Access to mental health care and support must be the standard within obesity care pathways, not be an optional extra. Treat the person holistically, including their trauma; care cannot just be about weight loss.

4. **Address weight stigma through policy and practice**
   Mandate anti-stigma training in healthcare. Actively challenge weight stigma in service design and delivery.

5. **Offer holistic, personalised support**
   Replace generic 12-week programmes with flexible, person-centred pathways that respond to individual histories and priorities.

   Peer support can help mitigate shame and loneliness.

6. **Design inclusive physical environments**
   Audit and adapt public and clinical spaces to be inclusive of larger bodies using trauma informed lenses —physically and culturally.

7. **Co-produce services with lived experience**
   Involve people living with obesity in developing, reviewing and delivering services. Let their insights drive change and continuous improvement in obesity care.

Summary

The stories shared through this research speak about pain, loss and trauma, but also power. Participants showed that living with obesity is not an internalised experience; rather it is a constant externally visible experience which requires frequent renegotiation of identity, sense of self-worth and social value.

The message is clear:

"You catch sideways glances from strangers… you become the punchline just for existing."

Trauma-informed and trauma responsive, compassionate care is not just good practice—it is a moral imperative.

Workforce perspectives on obesity care

Introduction

This section brings together insights from a regional survey of 190 health and care professionals and a focus group with frontline staff. Together, these insights shared by members of the workforce demonstrate efforts to deliver compassionate, effective care in the face of widespread stigma, systemic fragmentation and limited training. Professionals across primary and community care described both the barriers they face day to day in practice and their aspirations for more trauma-informed, integrated and person-centred obesity care.

Key themes and integrated findings

1. Stigma within healthcare culture and professional practice

Survey findings:

42.86% of professionals identified stigma as a key barrier to providing support. A further 74.24% of people living with obesity said they felt misunderstood by healthcare professionals, a view echoed by staff themselves.

Excerpts from focus group participants:

"Even as someone who doesn't consider themselves judgemental… I feel a sense of dread when someone with obesity enters the room, because I know I don't have the tools or time to help them well."

"The culture in primary care still leans towards 'weight = fault'. It's outdated, but we haven't really moved past it."

What we heard – Stigma isn't limited to wider society – it can be present in caring environments too:
Stigma doesn't only come from the public—it is present in clinical spaces too. Professionals spoke honestly about discomfort, lack of tools, and fear of causing harm.

They described how clinical culture can reinforce blame and silence difficult conversations.

"We're not trained to be curious about the reasons behind obesity—we're trained to measure it and refer on."

"It's difficult to talk about obesity without implying blame."

2. Fragmented pathways and systemic gaps

Survey insight:

Many reported inconsistent or absent behavioural and specialist overweight and obesity management services (sometimes referred to as Tier 2 and Tier 3), with unclear referral processes and long wait times.

Excerpts from focus group participants:

"We're left holding the risk when patients are waiting for services that are full or non-existent."

"It feels like we're fire-fighting—trying to meet targets rather than offering sustained support."

What we heard – The system doesn't join up:

When services lack coordination and clarity, professionals are often left to work across fragmented systems that can be challenging for both staff and patients. These gaps in care may contribute to misunderstandings, increase the risk of unequal access, and leave the workforce feeling vulnerable as they manage ongoing clinical uncertainties.

Professionals described working in disjointed systems with unclear pathways and little coordination.

"You end up referring people back and forth between services, and they lose faith in all of us."

"The pathway is patchy—some areas have Tier 3, others don't."

3. Lack of training, confidence, and time

Survey findings:

Only 35.42% of professionals felt adequately trained to support people with obesity, while over 20% reported no confidence in doing so.

Excerpts from focus group participants:

"We aren't trained in weight management in any meaningful way—it's mostly trial and error."

"There's no time, no funding, no clear route. It's not that we don't care—it's that we're stretched beyond belief."

What we heard – We want to help, but we're stretched:

Many professionals said they care deeply but don't feel equipped to offer meaningful support. Training is inconsistent, time is limited, and expectations are often unclear.

"You have 10 minutes. That's not enough to talk about trauma, food, movement, mental health, everything."

"I don't feel confident managing obesity. I end up falling back on generic advice that I know isn't helpful."

4. Calls for holistic, trauma-informed care

Survey insight:

80% of professionals supported holistic assessments and psychological support as part of effective obesity care.

Excerpts from focus group participants:

"We need to think beyond BMI. Ask better questions. Understand what's really going on for that person."

"A trauma-informed lens would change the way we talk about weight completely."

"The best conversations I've had about obesity were when I just listened. No agenda, just space."

"Kindness matters. If people feel safe, they'll come back. If they feel shamed, they won't."

What we heard – Kindness changes care:

There is strong support for shifting towards trauma-informed and responsive, relational care that addresses the unmet needs of people living with obesity, including the psychological and social roots of obesity. Staff want to offer compassionate care and feel they have something to contribute but need system-wide support to make that possible.

5. Structural change and investment

Survey findings:

Respondents consistently called for investment in services, better coordination and a national strategy that recognises obesity as a chronic, relapsing medical condition.

Excerpts from focus group participants:

"We need joined-up systems, not siloed referrals. Social care, mental health, primary care—working together."

"It's not just Tier 3 services that need funding—it's prevention, early intervention, everything upstream."

What we heard – The system can't run on goodwill:

Many professionals said they care deeply but don't feel equipped to offer meaningful support. Training is inconsistent, time is limited, and expectations are often unclear.

"Stop relying on individual goodwill. Fund it. Commission it. Make it part of core practice."

"We need national guidance that recognises obesity as a long-term condition, not a lifestyle issue."

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Recommendations from the Health and Care workforce

Grounded in both survey and focus group findings, the following recommendations represent a clear call for change from those delivering obesity care across the populations:

1. **Make trauma-informed and trauma responsive care standard practice**

   Provide compulsory training for all healthcare professionals in trauma-informed and trauma responsive communication and care.

   Embed relational approaches that recognise the emotional, psychological, and historical roots of obesity.

> ***"A trauma-informed lens would change everything—it would create safety, not shame."***

2. **Address stigma within clinical culture**

   Challenge blame-based narratives through reflective practice, CPD, and leadership modelling.

   Promote the use of respectful, person-first language across all services and materials.

> ***We don't need more judgement—we need understanding and space to listen."***

3. **Clarify and strengthen overweight and obesity management services**

   Ensure every ICB has accessible behavioural (sometimes referred to as Tier 2) and specialist (Tier 3) overweight and obesity management services. Ensure these have adequate capacity, and clear and well-communicated referral pathways.

   Integrate medical, psychological, and social support into a unified care model.

> ***"We need services that reflect the real lives of our patients—not just BMI cut-offs and barriers."***

4. **Build workforce confidence and capacity**

   Invest in ongoing professional development, including motivational interviewing, obesity medicine, and psychological literacy.

   Protect time within appointments for meaningful weight conversations.

> ***"It's not that we don't care. It's that we don't have the tools, or the time, to help in the way we want to."***

5. **Redesign care around relationships and trust**

   Shift away from transactional models to person-centred support that prioritises dignity and continuity.

   Recognise that healing begins with being heard and respected.

> ***If people feel safe, they'll come back. If they feel shamed, they won't."***

6. **Commission integrated, cross-sector services**

   Break down silos between physical, mental, and community care through shared commissioning.

   Include housing, employment, public health, and social care in a unified obesity strategy.

> ***"Obesity doesn't sit neatly in one service—it's a system issue and needs a system response."***

7. **Create national policy that reflects complexity**

   Develop guidance that treats obesity as a long-term, multifactorial condition.

   Provide ringfenced funding and accountability for implementation across regions.

> ***This isn't a lifestyle issue—it's a complex, chronic condition and needs to be treated as such."***
>
> ***"It's time we treat people living with obesity as human beings with histories—not just bodies with numbers."***

Healthcare professionals feel the need to do more for people living with obesity, but they cannot achieve this in isolation. Their voices reflect a clear mandate: shift the focus from blame to compassion, from fragmentation to integration, and from surface-level interventions to deep, sustained support.

The economic cost of obesity in West Yorkshire, Humber and North Yorkshire

Obesity is a growing public health emergency across West Yorkshire, Humber, and North Yorkshire. In West Yorkshire alone, around 27% of adults live with obesity (Public Health England, n.d.). These trends are most acute in communities experiencing high levels of deprivation impacting significantly on the wider determinants of health such as access to healthy food, active lifestyles, health literacy and equitable healthcare.

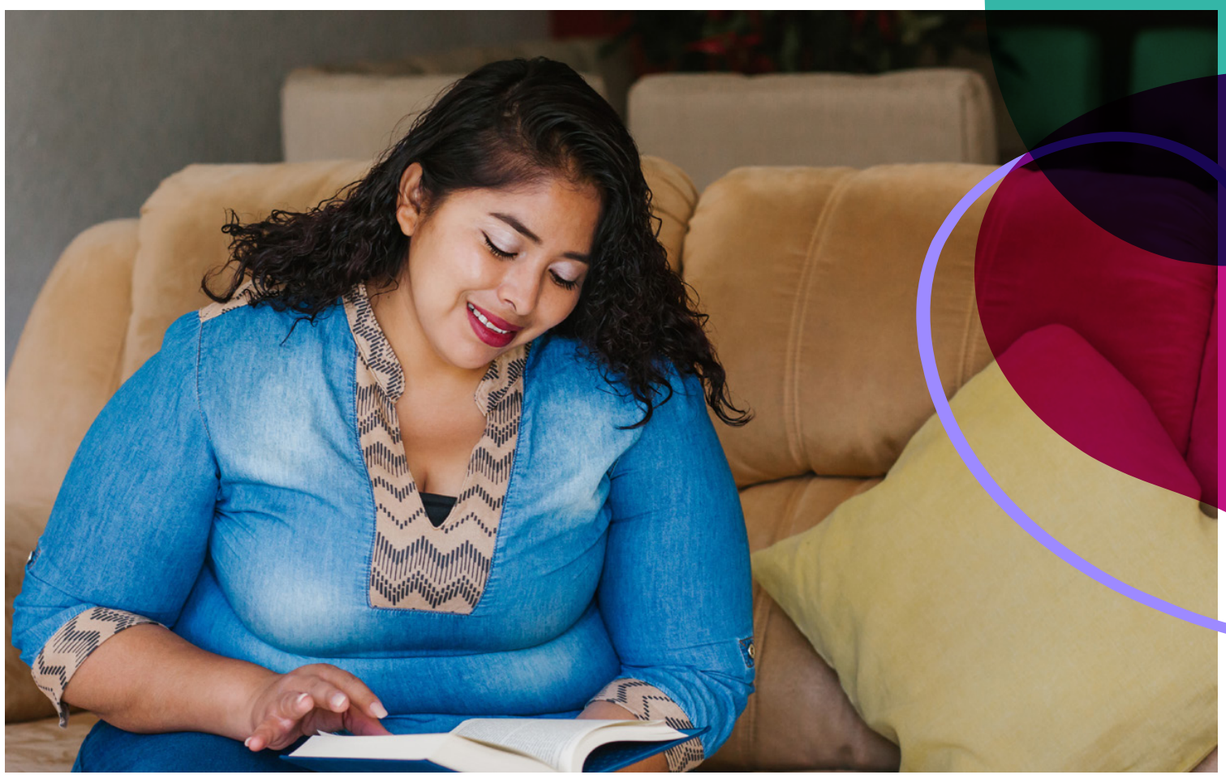
This is not simply a health issue. Obesity directly contributes to reduced workforce productivity, increased sickness absence, long-term disability, rising demand on health and social care services, and growing pressure on unpaid carers. Without meaningful intervention, the costs will continue to escalate. The following section provides an estimated economic cost related to obesity.

Limitations of the economic cost model

While the economic cost estimates presented offer a valuable indication of the scale and distribution of obesity-related burden across West Yorkshire, Humber, and North Yorkshire, they should be interpreted with caution.

The model used is based on publicly available national data which, although credible and widely used, is not specific to the subregional context and often has a significant reporting lag. For instance, figures from the NHS, Office for National Statistics (ONS), and Department of Health and Social Care (DHSC) typically reflect data that is one to three years out of date and may not fully capture post-pandemic shifts in healthcare utilisation, employment patterns, or social care demand.

In addition, the model assumes a proportional cost distribution based on population size, which does not account for local variations in obesity prevalence, service access, deprivation, or comorbidity rates. As such, these figures should be considered estimates rather than precise calculations, intended to support strategic planning and investment prioritisation rather than exact budgeting or forecasting.



The cost of doing nothing

While interventions to prevent and manage obesity require upfront investment, the long-term cost of doing nothing is significantly greater. Rising rates of obesity drive increasing demand on already stretched health and social care systems, reduce workforce productivity, and deepen health inequalities. The following section explores the known costs.

Nationally, obesity costs the UK economy over £58 billion annually, A breakdown of national spend on direct and indirect costs include:

- **£6.5 billion** in direct NHS treatment costs (UK Government, 2023).
- **£27 billion** in productivity losses through absenteeism and presenteeism (Department of Health and Social Care, 2022).
- **£15 billion** in social care and disability-related costs.
- **£10 billion** in wider societal and economic losses, including early retirement, welfare dependency, and unemployment linked to long-term conditions.

Applying national obesity cost estimates to the ICB populations

Based on population estimates (with West Yorkshire, Humber, and North Yorkshire accounting for approximately 10–11% of England's population), the annual cost burden is conservatively estimated at £6–6.5 billion.

Using publicly accessible national datasets, the table (right) outlines the estimated annual costs of obesity across key sectors. These figures highlight the extensive and multi-dimensional burden that obesity imposes—not only on the healthcare system, but also on the wider economy and society.

By applying population-based modelling to national estimates, we have generated a region-specific projection of annual obesity-related costs across the West Yorkshire, Humber and North Yorkshire ICB populations.

The combined population of West Yorkshire, Humber and North Yorkshire is approximately 5.9 million, which represents roughly 10.5% of England's population (based on ONS mid-year population estimates, 2023). Using this proportion, we can apply national cost estimates to produce a credible and conservative regional economic burden.

Cost area	National estimate	Regional estimate (10.5%)	Description
NHS Treatment Costs	£6.5 billion	£683 million	Direct medical treatment costs for obesity-related diseases like diabetes and heart disease.
Productivity Losses	£27 billion	£2.84 billion	Work absenteeism, presenteeism, and early retirement linked to obesity-related ill health.
Social Care Costs	£15 billion	£1.58 billion	Long-term care, disability, and adult social care linked to obesity-related conditions.
Wider Economic Costs	£10 billion	£1.05 billion	Welfare dependency, transport infrastructure, and informal caregiving burdens.
Total Estimated Cost	£58+ billion	£6.16 billion/year	Overall economic cost of obesity in West Yorkshire, Humber, and North Yorkshire.

Key assumptions

The calculations are based on the following key assumptions:

- **Population basis:** England ~56 million; Region ~5.9 million (~10.5%) (Office for National Statistics [ONS], 2024).
- **Proportional distribution:** Assumes regional prevalence and impact scale align with national trends. Note that local adult obesity rates in West Yorkshire and surrounding areas are slightly above the national average, so this estimate is conservative.
- **Data rounding:** Figures are rounded to two decimal places and should be interpreted as indicative, not exact.

Why economic cost matters

Understanding the regional cost of obesity allows ICBs to:

- Make the case for obesity prevention investment by demonstrating avoidable costs.
- Prioritise targeted interventions where health inequalities are greatest.
- Measure cost benefits of locally commissioned interventions, care pathways and policies over time.

Subregional analysis of obesity-related costs

A subregional breakdown of obesity-related economic costs across the West Yorkshire, and Humber and North Yorkshire Integrated Care Systems highlights the significant and varied financial burden faced at a system level rather than regionally.

Based on population-weighted estimates drawn from national data, West Yorkshire incurs costs of approximately £2.46 billion annually, while Humber and North Yorkshire spend on obesity accounts for around £3.69 billion. These costs include both direct healthcare spending, such as treatment for type 2 diabetes, heart disease and musculoskeletal disorders (UK Government, 2023); and the indirect costs which make up a substantial share of the total.

Indirect costs encompass reduced workforce productivity through absenteeism and presenteeism (Department of Health and Social Care [DHSC], 2022), long-term welfare dependency, social care provision (Institute for Fiscal Studies [IFS], 2023), and the economic impact of unpaid caregiving (Carers UK, 2023). West Yorkshire's higher obesity prevalence—particularly in areas of socioeconomic deprivation—suggest the true cost burden in West Yorkshire may be underestimated (West Yorkshire Health and Care Partnership, 2024). This analysis underscores the need for local place-based system-wide strategies that respond to clinical need and the broader economic and social determinants of obesity.

The hidden cost: unpaid carers and obesity

Unpaid carers, often family members, play a vital but frequently overlooked role in supporting individuals with obesity-related conditions. Although specific national data on obesity-focused caregiving is limited, broader research highlights the profound economic and personal toll of unpaid care. In the UK, unpaid carers contribute an estimated £184.3 billion annually—a figure that surpasses the entire NHS budget (Carers UK, 2023). Yet this contribution often comes at a personal cost. Those providing between 20 and 49 hours of care per week lose up to £153 per month in income (Centre for Care, 2024), and 1.2 million carers live in poverty, including 400,000 in deep poverty.

Caring responsibilities also take a significant toll on health. Nearly 49% of carers report negative physical and mental health effects, including fatigue, stress, and disrupted sleep (ONS, 2024), and those delivering over 50 hours of care per week are more than twice as likely to experience poor health compared to non-carers (NHS England, n.d.).

Local data further reinforces the connection between caregiving and health risk. In Wakefield (West Yorkshire), recent survey findings showed that 41.2% of unpaid carers are living with obesity, significantly higher than the 35.7% prevalence among non-carers. The disparity is even greater among women (45.7%) and adults aged 18 to 64 (44.7%) (Wakefield Adult Population Health Survey, 2023). Such findings suggest unpaid carers bear financial and emotional burden but may also experience more risk factors for poor health, including obesity risk factors.

As obesity increases the risk of long-term chronic illness and dependency, the unseen cost borne by carers is most likely on the increase, contributing to wider societal inequity and stress on families. Local data on obesity-related caregiving is sparse, limiting targeted support and resource allocation; and as such requires further research and analysis.

Prioritising early intervention

Investing in early intervention offers a credible and cost-effective alternative. International evidence suggests community-based, early-years and family interventions can yield positive returns on investment—reducing BMI, preventing weight gain, and improving long-term outcomes, including:

- **PRIMROSE Trial (Sweden)** A preschool obesity prevention programme offering parent-focused counselling through primary care. It used motivational interviewing to encourage healthy eating and activity in children. Results showed modest costs and effective BMI reduction. (Döring et al., 2018).
- **NICE Guidance (UK)** NICE considers obesity prevention programmes cost-effective if they cost £100–£400 per person per year, particularly when they prevent long-term illness and reduce dependency on health and social care (NICE, 2022).
- **INFANT Program (Australia)** A community-based early-years intervention helping low-income families build healthy eating and activity habits. It showed long-term behavioural change and reduced obesity risk in children. (Tan et al., 2019).

Early intervention is a critical and cost-effective component of obesity prevention and management. However, a comprehensive whole system response to obesity must also consider the needs of individuals already living with obesity. Economically viable and impactful strategies can reduce the long-term burden of obesity: including targeted support for high-risk populations, and improved system coordination and efficiency. The following recommendations highlight the broader actions, which if implemented, have the potential to contribute to improved health outcomes and economic sustainability.

Key recommendations

Reducing the long-term economic burden of obesity across West Yorkshire, Humber, and North Yorkshire requires an integrated, whole-system strategy. ICBs are uniquely positioned to commission prevention-first approaches across health and care. Key recommendations in relation to the economic cost of obesity include the following approaches:

- Scale up community-based prevention. Fund family and early-years healthy lifestyle programmes in areas with highest deprivation.
- Embed trauma-informed and trauma responsive, inclusive care. Tailor services to address psychological and emotional roots of obesity.
- Work towards improving access to behavioural and specialist overweight and obesity management services (sometimes referred to as Tier 2 and Tier 3) and promoting consistent use of evidence-based care and support across the obesity care pathways.
- Coordinate whole-system multiagency change. Align health, education, social care, and voluntary and community sector efforts.
- Track and evaluate cost impact and value for money. A consistent subregional approach would strengthen opportunities for collective commissioning.

Conclusion

Addressing obesity across West Yorkshire, and Humber and North Yorkshire is both a health and economic necessity. Current national data suggests that the combined annual cost of obesity to this region exceeds £6.1 billion - encompassing NHS treatment, productivity losses, social care demand, and wider economic impacts (UK Government, 2023; DHSC, 2022; IFS, 2023). While this figure is based on publicly available data and population modelling—and should be treated as a conservative estimate—it clearly illustrates the magnitude of the challenge.

The cost of inaction is not just a financial concern—it is an ethical and public health concern. Failing to act allows preventable diseases, rising inequalities and increasing demand on already stretched services to continue unchecked. In contrast, investing in early intervention, inclusive support, and integrated care pathways offers a sustainable, cost-effective solution that improves health and reduces long-term expenditure. The evidence points to a pressing need to act now and agree priorities. We need common alignment of the primary decision makers in what is a political environment. Obesity is not a future problem—it is a current crisis, and delaying action will only deepen its impact on individuals, communities and public systems. The time for decisive, coordinated intervention is now.

Regionally, this could include building on the Healthy Weight Healthy Lives strategy, supporting tailored, community-based programmes that empower individuals to achieve and maintain a healthy weight through inclusive, person-centred approaches (North Yorkshire Council, 2022).

Literature and policy review

This literature and policy review provides a comprehensive analysis of current evidence, national and local policy frameworks, and practice relating to obesity in the UK, with a particular focus on the West Yorkshire and Humber and North Yorkshire ICB populations. It explores the complex and interconnected factors contributing to adult obesity — including biological, behavioural, socio-economic, environmental, and trauma-related influences — and critically examines the economic, human, social, and emotional impacts of obesity on individuals, communities, services, and systems.

The sources for this review were drawn from a range of credible publications and organisations, including peer-reviewed journals (such as The Lancet and BMJ), global health authorities (WHO, CDC), UK policy bodies (DHSC, NICE, OHID), and academic think tanks (King's Fund, Health Foundation, OECD). The review presents a snapshot in time of the current understanding of obesity, drawing on the most relevant policy documents and research available at the time of writing. It is not intended to be exhaustive, but rather to synthesise key insights and evidence to inform local strategic thinking and action. Throughout, the review acknowledges the evolving nature of the evidence base — particularly the need for more region-specific research and highlights opportunities for further enquiry, innovation and learning.

The aim of this review is to inform the development of a more holistic, evidence-based system response to obesity, one that promotes better health outcomes, reduces health inequalities, and aligns with the integrated care priorities of both ICBs. This work may also be of interest to other regional and national partners.

Exclusion criteria

Children were excluded from the insights project due to ethical and practical constraints that would have delayed the delivery of this project significantly. Consequently, limited literature pertaining to childhood has been included. Brightsparks fully acknowledges the importance of studying childhood obesity and understanding the links between childhood and adult obesity. Brightsparks recommends that future insights projects that include children and young people are undertaken, and supported by appropriate funding, timescales, and robust ethical frameworks. No other groups were deliberately excluded from the review.

Key terms used in the review: Trauma, trauma-informed, and trauma-responsive

To provide clarity and consistency throughout this review, the following definitions are used when referring to trauma and related approaches. These terms form the foundation for understanding the principles and practices discussed in the context of trauma-aware systems and policy.

Trauma is understood as the lasting emotional, psychological, and physiological impact of distressing or harmful experiences—such as abuse, violence, neglect, loss, or exclusion. It is defined not only by the event itself but by how it is experienced and its enduring effects on an individual's sense of safety, emotional regulation, and trust in others. Trauma is often shaped by structural inequalities and systemic injustice (West Yorkshire Trauma Informed Education, n.d.).

Trauma-informed approaches acknowledge the widespread presence of trauma and seek to create environments that promote healing and avoid re-traumatisation. They are guided by principles such as safety, trust, peer support, collaboration, empowerment, and cultural responsiveness. This perspective encourages a shift from asking "What's wrong with you?" to "What has happened to you?"

Trauma-responsive approaches take this understanding further by embedding trauma-awareness into tangible action. They involve adapting policies, practices, and systems to meet the needs of those affected by trauma. This includes reducing harm, removing barriers to engagement, supporting both individuals and staff, and committing to ongoing learning and change. At its core, trauma-responsiveness is about doing things differently—through compassion, equity, and shared power (West Yorkshire Trauma Informed Education, n.d.).

Structure of the review

This literature and policy review is structured to provide a broad yet focused overview of obesity's multifaceted nature. It considers the impacts of obesity on individuals, communities, and systems, and examines emerging approaches to delivering more compassionate, trauma-informed and trauma responsive, effective care. In doing so, the review identifies strengths and gaps in current strategies, alongside risks of harm such as unintended stigma, inequitable access to services, and the potential reinforcement of health inequalities.

Overview

This section provides a comprehensive overview of obesity, examining its prevalence locally and nationally, and exploring the complex web of factors that contribute to it—including biological, behavioural, socio-economic, environmental, and trauma-related influences. It outlines the significant economic burden obesity places on healthcare systems, workplaces, and individuals, while also highlighting the social and emotional toll experienced by those affected. The relationship between trauma and obesity is explored in depth, emphasising the importance of trauma-informed approaches. Drawing on national and regional policy insights, the section offers evidence-based recommendations to guide inclusive, person-centred responses. It also identifies key gaps in the current literature, particularly around regional economic data. It concludes with practical recommendations tailored for West Yorkshire and Humber and North Yorkshire ICBs to support coordinated, equitable, and effective obesity care across the region.

Section 1: Understanding obesity in context

Obesity is a complex and multi-faceted public health challenge shaped by a wide range of biological, behavioural, social, and environmental factors. It is now the second leading preventable cause of cancer, highlighting the urgent need for intervention (UK Government, 2023). It is clear obesity presents profound human, social, emotional, and economic challenges on individuals living with obesity and on society. It has been described as “the biggest threat to public health today” (Public Health England, 2017). This section makes clear that there is a compelling, evidence-driven need for change.

The national context

Obesity presents a significant economic and public health challenge in the UK, costing approximately £74 billion annually, equating to 3% of GDP (Office for Health Improvement & Disparities [OHID], 2024). Nationally, the NHS spends an estimated £6.5 billion each year on obesity-related healthcare, a figure expected to rise due to increasing rates of associated conditions such as type 2 diabetes, cardiovascular disease, and cancer (Department of Health and Social Care [DHSC], 2024). Poor diet and excess weight contribute to 38% of preventable ill health and premature death, further intensifying pressures on healthcare services (OHID, 2024).

Current interventions and remaining gaps

Weight management services face several challenges including variation in provision, workforce shortages, and funding constraints. There is a growing demand for weight management services (sometimes referred to as Tier 2) and specialist overweight and obesity management services (sometimes referred to as Tier 3), yet accessibility remains limited (NHS England, 2024).

The introduction of new obesity medications, such as semaglutide (Wegovy) and Tirzepatide (also known as Mounjaro), represent a potentially transformative intervention for managing obesity and unhealthy weight. Early evidence suggests that pharmacological treatments offer a promising addition to the obesity management toolkit (Chartered Institute of Environmental Health, 2024). However, it is too early to assess their long-term effectiveness, safety, and cost-effectiveness. Moreover, the present reliance on private access, with its associated high costs, raises concerns about affordability for many individuals and the potential to exacerbate existing health inequalities. Policymakers and commissioners should therefore monitor emerging evidence closely and explore strategies to promote equitable access while minimising the risk of widening disparities (Contemporary Health, 2024; The Times, 2024). Ensuring fair access to these medications, alongside comprehensive long-term weight management support, is essential to help prevent weight regain and achieve sustainable outcomes (NHS England, 2024).

As access to pharmacological treatments continues to evolve, it remains essential to sustain and expand population-wide and community-based strategies aimed at reducing obesity and addressing health inequalities. In response to these challenges, the UK government has introduced several policy interventions, including a ban on junk food advertising of products high in fat, salt and sugar, before 9pm (effective from October 2025) and restrictions on the sale of high-caffeine energy drinks to under-16s (DHSC, 2024). Complementing these national efforts, local initiatives such as North Yorkshire's Adult Weight Management Service provide accessible community-based support, particularly in areas with high obesity prevalence (North Yorkshire Council, 2024). However, further investment in regional and local weight management services is required to effectively tackle the growing health inequalities linked to obesity (OHID, 2024).

The Government's Health Mission highlights the need for structural changes to the broader systems, policies, and environments that influence people's ability to live healthy lives, to reduce obesity rates and promote healthier lifestyles. Evidence suggests adherence to national dietary guidelines could increase life expectancy by up to eight years (OHID, 2024). Effective weight management interventions must also integrate trauma-informed and trauma-responsive care. This is in recognition of the role of adverse childhood and adult life experiences. Interventions therefore must include holistic care and support, which considers wellbeing and mental health (Public Health England, 2024).

Structural factors such as poverty, housing insecurity, limited access to education and healthcare, and systemic discrimination significantly influence the prevalence of both obesity and trauma. These conditions shape the environments in which individuals live, often restricting access to healthy food options, safe spaces for physical activity, and consistent healthcare services. For instance, economically disadvantaged neighbourhoods frequently lack supermarkets offering nutritious foods and are instead saturated with fast-food outlets, contributing to higher obesity rates (Williams et al., 2024).

Moreover, these structural inequities increase the likelihood of experiencing trauma, including adverse childhood experiences, community violence, and chronic stress, which have been linked to long-term health issues such as obesity (UK Trauma Council, 2023). Frameworks such as Core20PLUS5 emphasise the importance of understanding and addressing these root causes through multi-agency, trauma-informed and trauma responsive approaches that centre around the person's lived experience and prioritise equity across health and social care systems (Core20PLUS5, 2023). Addressing obesity and trauma necessitate comprehensive strategies that go beyond individual behaviour change; the focus should be on systemic interventions instead to mitigate social determinants of health and promote equitable access to resources.

Without further whole system intervention, obesity-related healthcare costs will continue to rise, reducing workforce productivity and worsening health inequalities across the population. A multi-faceted strategy, combining national policy measures, local authority engagement and NHS service improvements, is essential to reversing these trends and ensuring a healthier population (NHS England, 2024).

The local context: prevalence of adult obesity

Nationally, in 2021/22, approximately 26.3% of adults in England were classified as obese (NHS Digital, 2023). According to Public Health England (n.d.), 27% of adults in West Yorkshire are living with obesity, with 1 in 5 children affected at reception age and 1 in 3 by year six. In the Humber and North Yorkshire ICB population 28% of adults in Humber and North Yorkshire were reported to be living with obesity (Quality and Outcomes Framework 2024). This highlights the importance of continued efforts to address local health inequalities and improve access to healthy food, physical activity opportunities, and supportive community environments.

Section 2: Human, social and emotional impacts of obesity

Living with obesity and obesity-related health conditions adversely affects mental health and overall quality of life. Individuals living with obesity often experience stigma, discrimination, trauma and social isolation. The consequences of these experiences can contribute to psychological distress, depression, and anxiety. These psychological wellbeing and mental health challenges can further perpetuate the presence of factors which contribute to obesity and unhealthy weight – for example, disordered eating, social withdrawal and more sedentary lifestyles. This creates a vicious cycle that further intensifies obesity and its related health risks (Public Health England, 2017). For example, emotional eating is a notable consequence, where individuals consume food in response to negative emotions rather than hunger. Depression is a prominent mental health condition impacting emotional eating, often acting as a mediator between depression and obesity. Addressing the contributory factors in relation to emotional eating, such as improving emotion regulation, is crucial for effective intervention (Health Action Research Group, n.d.).

Obesity extends beyond physical health implications, significantly affecting social and emotional well-being. Individuals with obesity often face societal stigma, leading to discrimination in various settings, including employment and healthcare. This stigmatisation can cause social isolation, low self-esteem, and mental health issues such as depression and anxiety (Bupa UK, 2023). To break this cycle, interventions must adopt compassionate, trauma-informed and trauma responsive approaches that integrate emotional, psychological and mental health support within weight management services. In parallel, and not to be overlooked, there is a need to tackle the wider societal stigma that compounds the burden of living with obesity.

Section 3: Trauma and obesity: A critical relationship

Trauma-informed and trauma-responsive approaches acknowledge the widespread impact of trauma on individuals and communities, aiming to create services that prioritise safety, trust, choice, collaboration, and empowerment (NHS England, 2022). These principles align with national priorities around reducing health inequalities, improving mental health, and delivering person-centred care (Public Health England, 2021). Both Humber and North Yorkshire and West Yorkshire ICBs have embedded trauma-informed principles within their population health strategies, recognising that trauma—whether historical, intergenerational, or recent—can significantly shape health outcomes and engagement with services. Within this context, the West Yorkshire Adversity, Trauma and Resilience (ATR) Programme offers a well-established regional framework for operationalising trauma-responsive practice. Its emphasis on psychological safety, empowerment, and equity aligns with evidence linking trauma to emotional eating, distress, and social isolation—factors that contribute to obesity. Incorporating the ATR model into obesity care pathways can reduce re-traumatisation, improve service effectiveness, and support more compassionate and inclusive care that addresses root causes rather than symptoms (West Yorkshire Trauma Informed Education, n.d.).

In response to mental health issues, antidepressant and anti-anxiety medications are commonly prescribed. For some, the side effects of these medications may contribute to weight gain, – for example, through appetite stimulation, perpetuating weight management difficulties further (Serretti & Mandelli, 2010; Gafoor et al., 2018). This is particularly concerning given the bidirectional link between obesity and mental health. Poor mental health can drive weight gain, while obesity and related stigma can worsen depression and anxiety (Luppino et al., 2010). For individuals already living with obesity, this creates a cycle that can further harm both physical and mental health. Policymakers and commissioners have a responsibility to ensure that weight management and mental health services are integrated and include trauma-informed and trauma responsive approaches. Those delivering the services and interventions must understand the potential effects of medications on weight and ensure the care provided mitigates for the impact of the medications.

In summary, the relationship between trauma and obesity is both profound and complex. Trauma can alter biological, psychological, and social pathways that contribute to weight gain and difficulty in managing weight. Understanding this link is essential for developing compassionate, trauma-informed and trauma responsive approaches to obesity prevention and treatment.

Commissioning and delivering services which move away from recognising obesity not merely as an issue of willpower or lifestyle, to a health condition which has contributory factors which may be deeply rooted in an individual's life experiences, opens the door to more holistic and effective interventions.

As research continues to uncover the connections between trauma, obesity and stigma, it is increasingly clear that responding to trauma and lived experience is a critical component of supporting long-term health and well-being in those living with obesity. The evidence points to the value of combining trauma-informed and responsive, person-centred frameworks, which supports more ethical, inclusive, and effective practices for people living with obesity (Alberga et al., 2016). This integrated approach can enhance engagement, trust, and outcomes in both healthcare and research settings.

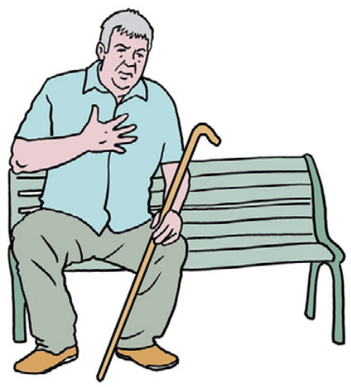
Trauma-informed and trauma responsive approaches to obesity: putting patient care and staff wellbeing first

In the UK, healthcare professionals are increasingly recognising the need for trauma-informed approaches when supporting individuals living with obesity. This population often encounters multiple forms of adversity, including weight stigma, social exclusion, and past trauma, all of which can shape their interactions with health services. Trauma-informed care (TIC) provides a compassionate framework that prioritises emotional safety, trust, empowerment, and collaborative relationships (Public Health England, 2021). For patients with lived experience of obesity, such approaches can reduce stigma, support autonomy, and improve engagement with care (Lewis, 2023).

However, the implementation of trauma-informed care must also account for the wellbeing of healthcare staff. Practitioners are at risk of vicarious trauma (or moral injury) and compassion fatigue, particularly when working with patients who disclose distressing experiences. Learning from delivering care during the Covid 19 pandemic, highlights the role of employee support services including an organisational culture which is compassionate and supportive. Staff should experience role modelling of compassionate leadership from executive management and access to support from peers is key. For those staff impacted by vicarious trauma, more targeted interventions may be required such as mental health first aid and/or referral to staff counselling and other wellbeing services.

Policy makers and commissioners must also consider employees' own trauma informed life experiences. A UK study found that up to 31% of healthcare professionals had themselves experienced domestic abuse, highlighting the prevalence of trauma among the workforce (Howard et al., 2022). Without adequate organisational support for the sources of trauma for employees, the workforce may struggle to consistently apply trauma-informed principles in their own practice.

To ensure trauma-informed systems benefit both patients and professionals, policies must address staff safety, offer regular restorative supervision, and foster psychologically safe workplaces. West Yorkshire is leading the way in embedding trauma-informed principles through regionally developed resources, most notably the Trauma Informed Organisational Toolkit, which brings together key elements such as leadership, culture, language, workforce wellbeing, and service design to support system-wide change.



Evidence suggests that organisational commitment, including protected time for training and inclusive service co-design, is essential for sustainable trauma-informed practices (Lewis, 2023). While regions such as Scotland and Wales have made significant progress, implementation in England remains fragmented, necessitating greater national coordination and resource investment (University of Bristol, 2023).

By embedding trauma-informed care and trauma responsive approaches as both a clinical and occupational priority, health systems can promote equity and resilience for patients living with obesity and the professionals who support them.

Adopting weight-neutral, trauma-informed and responsive, person-centred approaches to advance health equity

In recent years, the concept of a weight-neutral approach has gained prominence in public health and community wellbeing policies. Being weight-neutral involves shifting the focus from weight loss and body size to fostering behaviours that enhance overall health and wellbeing, regardless of body weight (Society of Behavioural Medicine, n.d.). This perspective promotes self-care practices, encourages body respect, and aims to reduce the stigma associated with weight.

Crucially, it supports individuals in engaging with health-promoting behaviours that are sustainable and meaningful, rather than being driven by externally imposed weight targets. This aligns with evidence suggesting that traditional weight-centric approaches can increase weight stigma and disordered eating, while weight-neutral interventions such as Health at Every Size® (HAES®) can improve psychological wellbeing and physical health outcomes (Bacon & Aphramor, 2011; Tylka et al., 2014).

In the Yorkshire and Humber region, (South Yorkshire ICB) the Doncaster model reflects these principles in practice, through its whole-systems approach to healthy weight that integrates weight-neutral principles into local policy and community services (City of Doncaster Council, 2022). The model shifts the narrative from "obesity prevention" to "health promotion," ensuring that interventions are inclusive and non-stigmatising. It embeds support for mental health, physical activity, and nutrition through a lens of empowerment and equity, rather than weight control. Such an approach resonates with the growing evidence that weight-centred health policies can inadvertently perpetuate harm, while weight-neutral frameworks encourage more positive and equitable health outcomes.

The Doncaster Talks about Weight and Health survey explored local perceptions of weight, health, wellbeing, and weight stigma among 417 residents. Findings revealed that health was most often defined as a good quality of life, mental wellbeing, and physical vitality, while improvements were linked to stress reduction, access to mental health services, and lifestyle factors such as diet and exercise. Despite 84% of participants believing that weight and health are related, responses indicated conflicting beliefs about weight causation; while many attributed weight challenges to individual motivation and self-control, psychological and environmental factors were also seen as highly influential. The majority reported difficulties with maintaining weight loss, citing barriers such as time constraints, accessibility of unhealthy foods, and broader life pressures. The survey also highlighted pervasive weight stigma, with 55% perceiving stigma in accessing weight management services and 78% believing that overweight individuals face discrimination. Importantly, 95% of respondents advocated for weight management services to prioritise holistic health and wellbeing rather than weight loss alone. The findings in this section demonstrate the need for compassionate, inclusive approaches to public health messaging and weight management interventions.

Section 4: Economic costs of obesity

This section draws on existing data regarding the economic costs of obesity, but it is important to recognise its limitations. While this project does not provide a comprehensive economic cost analysis of obesity, it aims to bridge the gap between national-level estimates and regional data. By linking available national statistics with regional insights, this project offers a valuable snapshot of the economic impact of obesity in the West Yorkshire and Humber and North Yorkshire ICB populations, using the best available evidence at the time. For a more detailed discussion of these limitations, please refer to the Economic costs section of this report.

The economic impact of obesity is substantial, encompassing direct healthcare costs and indirect costs such as lost productivity. At a national level, the NHS spends approximately £19 billion annually on obesity-related healthcare, while the broader economic impact, including productivity losses, is estimated at £16 billion (Frontier Economics, 2023).

There are significant constraints in assessing the economic impact of obesity within the West Yorkshire and Humber and North Yorkshire ICB populations. Estimating these costs is inherently challenging, particularly when it is difficult to determine whether obesity causes certain health problems or whether those health problems contribute to obesity.

Impact on public health initiatives and preventive care programmes

As stated earlier, the high prevalence of obesity puts a financial strain on public health initiatives and preventive care programmes. Resources allocated to managing obesity-related conditions could otherwise be invested in broader health promotion and disease prevention efforts, underscoring the opportunity cost associated with the obesity epidemic (Public Health England, 2017). Persistent funding cuts in real terms mean that budgets are already limited. For policymakers, this highlights the urgent need to prioritise investment in effective obesity prevention and management strategies, to reduce the demand of health and care resources and protect the sustainability of public health services.

Costs associated with absenteeism and reduced productivity

Obesity contributes to increased absenteeism, presenteeism and reduced workplace productivity. The wider societal costs of obesity, including loss of productivity, are estimated at £27 billion annually in the UK (National Audit Office, 2020). This economic impact highlights the urgent need for interventions that are equitable, inclusive, and sensitive to the diverse experiences of individuals, with the goal of reducing both health disparities and the broader economic impact of obesity.

Costs of obesity-related social care services

Obesity also imposes significant costs on social care services. Individuals with obesity may require additional support, including mobility aids, home modifications, and personal care assistance – such needs may be related to the complications of obesity and /or co-existing long-term conditions/multiple long-term conditions. The need for social care contributes to the overall economic impact of obesity on public services (Frontier Economics, 2020).

Medical treatment costs for obesity-related conditions

Obesity significantly increases the risk of various health conditions, including type 2 diabetes, cardiovascular disease, and cancer. The National Health Service (NHS) in England spends approximately £6.1 billion annually on overweight and obesity-related ill health (Public Health England, 2017). This figure is projected to rise to over £9.7 billion each year by 2050 (Department of Health and Social Care, 2022). For policymakers, these figures highlight the urgent need to prioritise prevention and early intervention strategies to reduce obesity-related health risks and healthcare demands. Investing in effective, equitable, and sustainable approaches to support healthy weight management can help alleviate long-term pressures on the NHS and improve population health outcomes.

Economic costs to the individual and current limitations in research on weight loss treatments

The economic impact of obesity on individuals is multifaceted, extending well beyond healthcare expenses to include a wide range of direct and indirect costs. Individuals often incur out-of-pocket expenses for weight management, including memberships to slimming groups, gyms, and commercial weight loss programmes. These costs can be substantial and may not be affordable for all, potentially limiting access to effective weight management support (Office for National Statistics, 2023).

Private sector costs for weight loss interventions such as medications and bariatric surgeries are also significant. For instance, weight loss injections can cost between £122 and £330 per month through private clinics, while annual costs for semaglutide (Wegovy) can exceed £2,700 (Contemporary Health, 2024; The Times, 2024). These expenses may be prohibitive for many individuals, reinforcing disparities in access to treatment and making long-term adherence financially challenging, both for individuals and for the NHS.

In addition to direct private spending, obesity is linked to significant indirect economic costs. These include workplace productivity losses due to increased absenteeism and presenteeism. In the UK, obesity-related absenteeism is estimated to contribute to £33 billion in lost productivity annually (The Times, 2023). Moreover, individuals living with obesity often face additional personal expenses such as transportation adjustments, specialised seating, and bariatric equipment for home or healthcare settings. The NHS has reported growing expenditures on bariatric equipment, including larger wheelchairs and beds (Independent, 2015), while local councils have documented a 47% increase in spending on bariatric home adaptations (THIIS, 2023). For policymakers, these costs highlight the need to adopt a whole-systems approach to obesity, one that not only addresses health outcomes but also considers the wider social and economic impacts.

Although newer pharmacological treatments such as Wegovy and Mounjaro have demonstrated efficacy in promoting short-term weight loss, their long-term safety and effectiveness remain under investigation. A five-year clinical trial is underway to assess the prolonged impacts of these treatments on obesity, diabetes incidence, and related complications (Chartered Institute of Environmental Health, 2024). In addition to clinical outcomes, the cost-benefit and cost-consequence profiles of these medications are key considerations.

For individuals, the ongoing expense of treatment can be substantial, particularly given that long-term use may be required to maintain weight loss. For organisations and health systems such as NHS England (NHSE), widespread adoption could have significant financial implications, balancing potential savings from reduced obesity-related complications against the high upfront costs of these therapies. Comprehensive economic evaluations are needed to determine whether these treatments deliver value for money and sustainable benefits at individual, organisational, and system levels.

Policymakers, commissioners, service providers, and people living with obesity need clear, robust evidence to guide future decisions about tackling obesity and investing in new interventions. They require a deeper understanding of the long-term impact of obesity, the safety and effectiveness of emerging therapies, and the cost-effectiveness of different approaches at both national and local levels. This evidence will be critical to shaping policy, designing sustainable services, and commissioning interventions that are equitable, clinically effective, and financially viable. Without such evidence, decisions risk being made on uncertain ground, potentially affecting the quality and outcomes of obesity care.

Limitations in available data on the regional economic impact of obesity

Several limitations currently hinder a comprehensive understanding of the economic costs of obesity, particularly at the regional level. Firstly, there is a lack of region-specific economic analyses; most studies focus on national or international costs, with limited data available at regional or sub-regional levels. The absence of localised economic intelligence for West Yorkshire and Humber and North Yorkshire ICB populations makes it difficult for policymakers to design targeted interventions that account for local socioeconomic and demographic contexts (Public Health England, 2017).

Secondly, methodological variability complicates efforts to compare and synthesise findings. A systematic review by Zhou et al. (2017) highlighted inconsistencies in approaches to estimating the economic burden of obesity — including differences in perspective (societal vs. healthcare system), timeframes, and inclusion of direct and indirect costs. This lack of standardisation hampers accurate regional cost estimation.

Thirdly, while initiatives such as the former weight management service in North Yorkshire, a community-based behavioural overweight and obesity management service (sometimes referred to as Tier 2), provide strategic frameworks for prevention, they often lack comprehensive local cost-consequence analyses, limiting policymakers' ability to make value-for-money decisions. It is worth noting that resourcing in locality areas is currently modelled on obesity prevalence.

Studies frequently focus on direct healthcare costs (e.g., hospital admissions, medication) while neglecting indirect costs such as productivity losses, absenteeism, and premature mortality (Scarborough et al., 2011). This results in an incomplete picture of obesity's wider financial impact on local economies. In addition, differences in which obesity-related diseases and health conditions are included make economic estimates less consistent (Dobbs et al., 2014; Krueger et al., 2017; OECD, 2019; Guh et al., 2023). A standardised, comprehensive approach to economic analyses is needed to ensure that all relevant obesity-related conditions are consistently captured and that policymakers across regions, including Yorkshire and the Humber, can make informed, data-driven decisions.

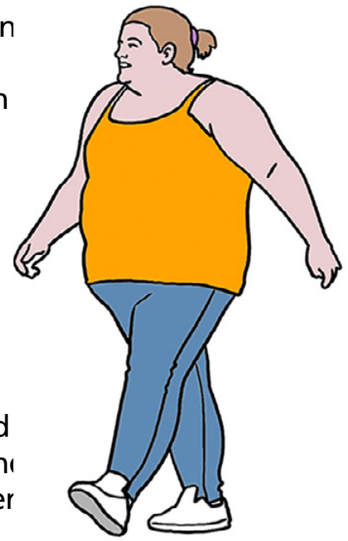
Summary of limitations and gaps in the literature related to economic costs

In summary, this section highlights significant gaps in understanding the economic costs of obesity at a regional level in West Yorkshire and Humber and North Yorkshire. Limited local data, inconsistent methodologies, and underrepresentation of indirect and private costs constrain effective policy and resource allocation. There is an urgent need for robust, region-specific economic evidence to guide equitable and cost-effective interventions.

Despite these challenges, the existing evidence base remains a valuable guide. It provides a starting point for regional stakeholders to understand the scale and components of obesity-related economic costs and to identify gaps in current data. Moving toward a standardised, comprehensive approach to economic analysis will strengthen the ability of regions, including West Yorkshire, North Yorkshire and the Humber, to make informed, data-driven decisions.

Section 5: Policy, interventions and recommendations from the literature

Several specific challenges facing the West Yorkshire and the Humber and North Yorkshire ICB populations in relation to obesity have been identified. Socioeconomic disparities remain a key concern, with higher obesity rates observed in areas of greater deprivation. In addition, rurality presents unique barriers to care. In parts of North Yorkshire, for example, geographic isolation and transport challenges limit access to healthcare services and structured weight management programmes. Cultural factors also play an influential role, with regional dietary habits, lifestyle patterns, and community norms shaping behaviours that may contribute to higher obesity rates. Addressing these interconnected challenges will require place-based, tailored interventions that reflect local contexts, prioritise equity, and engage communities meaningfully in the design and delivery of solutions.



The human, social and economic cost of obesity in the UK is substantial, encompassing not only direct healthcare spending and lost productivity but also broader impacts on wellbeing, community resilience, and public services. In shaping a regional response, both Humber and North Yorkshire and West Yorkshire ICBs have expressed a strong commitment to embedding trauma-informed and trauma responsive approaches. This reflects the integration of compassionate principles into obesity strategies and delivery models.

However, much of the national and international literature continues to use language that lacks empathy, inadvertently reinforcing stigma. It is crucial that HNY and WY ensure their policy frameworks adopt a strengths-based culture and approach, recognising that coping behaviours related to eating, activity, and body image are often shaped by complex personal and social experiences. Compassionate, trauma-informed, and trauma-responsive care is increasingly recognised as essential in this field (Lewis, 2023; Public Health England, 2021; West Yorkshire Trauma Informed Education, n.d.).

An effective regional obesity strategy that is co-produced must be central. Services should be designed by and for the ICB populations, ensuring they reflect lived experience, local needs, and shared ownership. The strategy must also explicitly address the structural determinants of health. Socioeconomic disadvantage, racism, discrimination and marginalisation contribute both to the development of obesity and to reduced access to appropriate support. Any whole-system response must therefore ensure that services are inclusive and designed to reach those most affected by health inequalities, aligning closely with Core20PLUS5 priorities and Inclusion Health principles.

This review highlights the need for a comprehensive policy approach to obesity prevention that supports healthier food environments and promotes innovation. This should include creating commercial food environments that make healthy options accessible and affordable, embedding healthier food standards across public sector entities, and adopting emerging research, technologies, and treatments to improve obesity prevention and management (Tony Blair Institute for Global Change, 2023). Regionally, this could include building on the Healthy Weight Healthy Lives strategy, supporting tailored, community-based programmes that empower individuals to achieve and maintain a healthy weight through inclusive, person-centred approaches (North Yorkshire Council, 2022).

In many cases the literature does not sufficiently address the complex social and emotional dimensions of obesity. While evidence from Felitti et al. (1998) suggests that adverse childhood experiences contribute to obesity in adulthood, there remains a need for more research into trauma-informed and trauma-responsive interventions that address these underlying factors and mitigate stigma, mental health challenges, and social isolation.

Future research should aim to develop standardised methodologies for assessing the direct and indirect costs of obesity at the local level, explore the long-term economic impact of weight loss interventions, and incorporate a broader understanding of obesity's psychological and social consequences. Addressing these gaps will enable more targeted, effective, and cost-efficient obesity prevention and management strategies in West Yorkshire and Humber and North Yorkshire ICB areas.

The evidence clearly highlights the need for intentional service design that enables compassionate, trauma-informed, and trauma-responsive care for people living with obesity—as well as for the professionals who support them. For individuals affected by obesity, this means creating safe, inclusive spaces, offering peer-led support, and providing flexible models of care that also recognise the needs of families and unpaid carers. This approach is consistent with co-produced guidance developed in collaboration with communities and the West Yorkshire ATR Programme. It draws on resources such as the Trauma-Informed Co-production Guidance and Trauma-Informed Language Guidance, which support respectful, inclusive, and psychologically safe practice (West Yorkshire Trauma Informed Education, n.d.-a; n.d.-b).

For the workforce there must be a strong focus on staff wellbeing. Healthcare and community professionals are also vulnerable to vicarious trauma and compassion fatigue (Howard et al., 2022). Trauma-informed practice should therefore encompass regular reflective supervision and mental health resources for staff. Equally, lived experience must be central to future service design and strategy in both West Yorkshire, Humber and North Yorkshire, through psychologically safe and inclusive engagement that addresses historic exclusion. This work aligns with the principles set out in the West Yorkshire Trauma-Informed Co-production Guidance and Trauma-Informed Language Guidance, which emphasise the importance of psychological safety, inclusive practice, and respectful communication in the design and delivery of health and care services (West Yorkshire Trauma Informed Education, n.d.-a; West Yorkshire Trauma Informed Education, n.d.-b).

Finally, there is evidence to suggest that embedding an integrated neighbourhood model of care is essential to deliver person-centred pathways that combine primary and community care with specialist services via an accessible, single point of entry, moving beyond a narrow, medicalised approach to support holistic wellbeing.

In summary

The current evidence reviewed highlights the breadth and seriousness of the human, social and economic impact of obesity on individuals, health and care service providers, commissioners, policymakers, NHS England, and government. It underscores the wide-ranging costs and consequences across society and the pressing need for coordinated, evidence-based responses at both national and local levels. Robust data and ongoing research will be critical to informing future decisions on prevention, treatment, and sustainable service models that can effectively address the challenges posed by obesity.

Reducing the human, social and economic impact of obesity requires a holistic, trauma-informed and trauma responsive, inclusive approach. This must be underpinned by clear policy commitments, compassionate practice, the meaningful involvement of people with lived experience, and the delivery of care through integrated models that address both structural and individual drivers of obesity.

Failing to provide personalised, trauma-informed and trauma responsive services and support for individuals living with obesity carries significant long-term costs. If current trends continue, the NHS's annual expenditure on obesity-related treatments is projected to exceed £9.7 billion by 2050 (Department of Health and Social Care, 2022), while wider societal costs—including those related to social care—are expected to reach £49.9 billion per year (Public Health England, 2017). Obesity-related absenteeism and reduced workforce productivity already contribute to an estimated £27 billion annually in lost productivity (National Audit Office, 2020), threatening future economic growth.

In contrast, investing in nationwide person-centred obesity and weight management programmes, which incorporate upfront costs related to programme development, training, and delivery, offers the potential for substantial long-term savings. Effective interventions can help reduce health and care demand, improve productivity, and transform care for people living with obesity.

The cost of doing something—targeted, compassionate intervention—must therefore be weighed against the escalating cost of doing nothing, which would result in continued harm to individuals and unsustainable financial pressure on health and care systems. To ensure a sustainable, equitable response to the growing challenge of obesity, robust data, adequate funding, and policy leadership are urgently needed.

Research methodology

This section outlines the approach used to deliver the insights aspect of the ICBs obesity insights commission and generate the findings presented in this report. A mixed-methods approach was adopted, combining quantitative and qualitative research to provide a rich understanding of the human, social and economic impacts of obesity and to capture real-world insights from both individuals with lived experience and the health and care workforce. Data collection and analysis were conducted with a strong emphasis on ethical integrity, trauma-informed practice and person-centred engagement.

Overview

This project employed a mixed-methods, collaborative approach to explore and quantify the human, social and economic costs of obesity across West Yorkshire, Humber, and North Yorkshire. The methodology was designed to meet the specification set by West Yorkshire NHS ICB and adhered to best practice research standards, ensuring validity, reliability and ethical integrity. A combination of quantitative and qualitative methods was used to generate insights from individuals living with obesity and from the health and care workforce, with particular attention paid to trauma-informed and person-centred approaches throughout all stages of the project.

Target demographics

The project engaged two primary target groups:

- Individuals with lived experience of obesity, recruited via community channels and networks.
- Health and care workforce members across West Yorkshire (WY) and Humber and North Yorkshire (HNY), focusing on the primary and community care workforce.

Key insight areas

The research explored the following key areas:

- Economic costs of obesity
- Human and social costs of obesity
- Trauma and obesity
- Long-term conditions and health inequalities
- Real-world ideas and solutions.

Foundational insights

Literature and policy review

A desk-based review of existing literature, national and regional policy relating to obesity and its individual and socioeconomic impact. The review was conducted to set the context, identify knowledge gaps and inform the development of data collection tools. A summary of the findings is in the literature review section of this report.

Survey design and implementation

Two tailored e-surveys were designed:

- One for individuals with lived experience of obesity.
- One for health and care professionals in primary and community healthcare settings.prior to participation. The principles of anonymity, confidentiality and the right to withdraw were strictly observed

Surveys were designed collaboratively with West Yorkshire ICB and tested prior to launch to ensure clarity and accessibility. They included a combination of closed and open-ended questions and integrated equality, diversity, and inclusion questions aligned with West Yorkshire ICB standards.

Informed consent and ethical considerations

All activities were conducted in accordance with best practice guidelines from the Market Research Society and the Social Research Association. Participants received an information sheet and consent form. Informed consent was obtained from all participants prior to participation. The principles of anonymity, confidentiality and the right to withdraw were strictly observed.

Accessibility and inclusivity

Efforts were made to ensure participation was accessible and inclusive of the diverse population groups across West Yorkshire and Humber and North Yorkshire. Surveys and focus group materials were written in plain, inclusive language and tested for screen readability.

Focus groups were held online. This approach was adopted in response to participant preferences, who indicated that remote engagement methods were suitable for their needs; while face-to-face engagement would have been accommodated if requested, it was not required during this project, ensuring inclusivity without excluding those less digitally active.

Incentivisation

To encourage participation and recognise the value of participants lived experience, focus group participants were offered a £20 voucher. The incentivisation process was developed in collaboration with West Yorkshire ICB. Members of the workforce who took part did not receive any incentives.

Quantitative and qualitative data collection

Surveys

Data collection included:

- An e-survey completed by individuals living with obesity exploring healthcare use, productivity, quality of life and lived experience.
- An e-survey completed by primary and community care professionals exploring the impact of obesity on care delivery, barriers to person-centred care and potential solutions.

Focus Groups

Five focus groups were conducted:

- **Four lived experience online focus groups** with up to eight participants in each, covering a broad geographic and demographic range. The focus groups explored barriers to accessing care, experiences of stigma and trauma and ideas for improving support.
- **One online focus group** with healthcare professionals exploring how obesity impacts care delivery and seeking professional insights into opportunities for integrated care and systemic improvement.

Focus group questions

The line of questioning for the lived experience groups explored the following key areas, using a compassionate, trauma-informed approach to encourage open discussion and generate rich, qualitative insights. Questions focused on:

- The barriers and challenges to accessing care and support
- Experiences of stigma and its impacts
- The relationship between trauma and weight management
- Effective support systems and opportunities for improvement.

The workforce focus group centred on:

- The impact of obesity on individuals and healthcare roles
- Barriers and challenges in providing care
- What good obesity care looks like
- Practical ideas for service improvement
- Workforce perspectives on barriers, solutions, and opportunities for more joined-up obesity care.

Data analysis

Thematic analysis was applied to qualitative data from focus groups and open-ended survey responses to systematically identify key themes and sub-themes. This method, following the approach outlined by Braun and Clarke (2006), enabled the research team to move beyond surface-level observations and capture the depth and complexity of participants' experiences and perspectives. The process involved familiarisation with the data, coding, theme development and iterative refinement to ensure analytical rigour.

Quantitative survey data were analysed and cross-tabulations to identify patterns, trends, and variations across demographic groups. Triangulation of qualitative and quantitative data was used to enhance the validity and robustness of the findings (Fetters et al., 2013), ensuring that emerging insights were supported by evidence from multiple sources and perspectives. This mixed-methods triangulation provided a richer, more nuanced understanding of the human, social and economic impacts of obesity, as well as actionable insights to inform policy and practice.

Focus group cohort sizes and scheduling

Each focus group consisted of up to eight individuals to allow for safe, open discussion. Groups lasted approximately 60–90 minutes and were facilitated by two experienced, trauma-informed moderators.

Ethical considerations

The research undertaken by Brightsparks into the lived experiences of individuals living with obesity and the healthcare staff who support them was designed and conducted in accordance with the British Educational Research Association (BERA) Ethical Guidelines for Educational Research (BERA, 2024). These guidelines provided the foundation for ensuring that all aspects of the research upheld the dignity, rights, and well-being of participants, while maintaining integrity and social responsibility throughout the project. The approach taken included safeguards against secondary trauma and supported all involved to maintain ethical integrity in engagement with sensitive narratives (West et al., 2017).

Participants

All participants were briefed on purpose, risks, and data handling. A Data Protection Information Sharing Agreement and data sharing protocols were in place. A key strength of this study was its co-produced approach, developed in partnership with West Yorkshire, Humber and North Yorkshire ICBs. These ICBs brought expert knowledge and deep understanding of the complexities of obesity as a health and social issue, and access to lived experience partners and healthcare professionals through

strong and trusted regional and local networks. Their collaboration in shaping the research methods ensured that the study reflected both current evidence and the nuanced realities faced by individuals and healthcare staff in these regions. By drawing on the ICB's regional insight, study design was both ethically robust and practically relevant to local contexts. The partnership played a vital role in encouraging participation from groups who might otherwise be marginalised or hesitant to engage, ensuring that a broad range of lived experiences were represented.

Central to our ethical approach was the recognition of the value of participants' time and expertise. Individuals living with obesity were offered appropriate incentives as a means of acknowledging the significant personal contributions they were making to the project. This practice aligned with BERA's (2024) guidance on valuing participant input with voluntary informed consent and prevention of coercion. Incentives were provided transparently and were framed as recognition of participants' lived experience and the critical insights they brought to the research.

Efforts were made to ensure accessibility for diverse population groups. Survey and focus group materials were written in plain, inclusive language and tested for screen readability. All focus groups were delivered online to accommodate participant needs, with safeguarding measures in place to ensure a safe and respectful environment for all participants. The study also sought to create an environment of respect, trust and psychological safety. Individuals living with obesity often face stigma and discrimination, including within healthcare settings (Puhl & Heuer, 2009). As such, every aspect of participant engagement — from recruitment to data collection and dissemination of findings — was designed to foster trust using inclusive, non-judgemental approaches. Informed consent processes were comprehensive, ensuring that

participants understood their rights, the purpose of the research, and the use of their data. Participation was entirely voluntary, and participants were free to withdraw at any stage without consequence.

Privacy and confidentiality were rigorously protected, particularly given the sensitive nature of the subject matter. All project data were stored on GDPR-compliant, EU-based cloud platforms. Survey responses, which captured special category health data but were collected anonymously, were held in Zoho Survey's encrypted data centres in Dublin and Amsterdam. Focus group recordings and registration details, which were anonymised during transcription and reporting, were stored in a secure, access-controlled Google Workspace environment hosted in Dublin. (van Geel et al., 2014).

Health and Care professionals

The approach to insight gathering recognised ethical responsibilities towards healthcare staff who participated. Health and care professionals often face emotional demands, moral distress, and the challenges of navigating complex healthcare systems in their support of individuals, including those living with obesity (Austin et al., 2005; Figley, 2002). The research design ensured staff participation was voluntary and confidential, and that opportunities for reflection and support were encouraged and made available. Interviews and focus group discussions were conducted sensitively, allowing staff to voice both their contributions to obesity care and the challenges encountered whilst fulfilling their roles.

The project also consciously addressed broader ethical considerations related to equity and social justice. Obesity is inextricably linked to structural and social determinants of health (Bailey et al., 2017). The study design reflected this understanding, avoiding reductionist or individualising

narratives; instead lived experiences were situated within broader systemic contexts. This framing was reinforced through the ICBs deep regional understanding of the interplay between personal experiences of obesity and wider social factors.

Finally, the ethical wellbeing of the insights team and ICB partners were actively considered throughout the project. Given the potential for exposure to emotionally challenging content, debriefing processes were embedded in the research workflow, and reflective practice was encouraged.

In conclusion, this project exemplified an ethically grounded, partnership-driven approach to research. By adhering to the principles of BERA (2024), co-producing methods with expert regional partners, and placing the dignity and wellbeing of participants and staff at the heart of the research process, Brightsparks has sought to contribute meaningfully and responsibly to understanding and addressing the lived experience of obesity in the context of health and social care.

Governance and collaboration

Brightsparks maintained close collaboration with West Yorkshire ICB throughout the project, ensuring transparency through regular check-ins and project progress updates. Project progress was tracked using project management tools, ensuring alignment with agreed objectives.

Limitations of the project

While it is important to acknowledge the limitations of this obesity insights project, these should be viewed in the context of its overall strengths and contributions. Due to budget constraints, the study did not include original economic modelling and instead relied on high-quality secondary data to estimate the economic costs of obesity across the two ICB regions. While this approach limited the ability to produce fully localised cost projections, it nonetheless provided a credible and evidence-based indication of regional economic impact. Similarly, although some of the literature reviewed drew from secondary sources, the analysis remained rigorous and relevant, synthesising the most up-to-date and applicable evidence available.

Participant incentivisation was also capped due to resource limitations, which may have affected engagement—particularly among groups less likely to access traditional services or participate in research. Nevertheless, the project achieved strong participation levels and captured meaningful insights from individuals with lived experience as well as health and care professionals. Recruitment was supported through established networks and stakeholder organisations, and while this approach may have resulted in underrepresentation from some inclusion health communities, considerable effort was made to ensure reach, diversity, and accessibility. Practical barriers such as digital exclusion and time constraints may have impacted focus group participation; however, thoughtful design, trauma-informed facilitation, and the use of remote methods helped mitigate some of these challenges.

As with any self-reported data, there is potential for response bias. However, the use of inclusive, carefully crafted surveys and safe, supportive engagement practices encouraged openness and depth of reflection.

Taken together, while the project had some methodological constraints, it remains a robust and valuable piece of work. The insights gathered are rich, nuanced, and grounded in real-world experiences, offering actionable recommendations that are directly informed by those living with obesity and the professionals who support them. The study has successfully laid a strong foundation for future research, service development, and system-wide change.

Overarching recommendations

Based on the literature, current policy guidance, and the findings articulated earlier in this report, the following recommendations are proposed to improve support and services for individuals living with obesity and to strengthen the healthcare workforce that serves them. These recommendations showed the need for more compassionate, effective, and equitable approaches to obesity prevention, treatment, and long-term management. They reflect the growing recognition of the need for trauma-informed, community-centred, and integrated care models, supported by ongoing research and policy innovation.

1. Adopt a trauma-informed and trauma responsive, whole-person approach

Both people living with obesity and healthcare professionals emphasised the need for services that recognise trauma, mental health, and complex life experiences—not just weight as a metric.

- Embed trauma-informed care across all overweight and obesity management services-including universal (Tier 1), behavioural (Tier 2), and specialist (Tier 3 and Tier 4) support-by integrating the West Yorkshire Adversity, Trauma and Resilience (ATR) Programme to ensure that services address the psychological and structural drivers of obesity through compassionate, inclusive, and system-wide trauma-responsive approaches (West Yorkshire Trauma Informed Education, n.d.)
- Prioritise emotional safety, non-judgemental engagement, and active listening in service design and delivery.
- Provide training to professionals on the psychological roots of disordered eating, such as bereavement, abuse, neurodiversity, and shame.

"We need to think beyond BMI. Ask better questions. Understand what's really going on for that person."

"The reason I'm fat is because I ate instead of self-harming or drugs. This body saved my life."

2. Address stigma through systemic culture change

Stigma operates at personal, institutional, and cultural levels. Participants called for a radical shift in how obesity is understood and discussed.

- Launch awareness campaigns to challenge weight stigma in society and healthcare
- Incorporate stigma-reduction strategies into all training for health and social care staff
- Develop reflective spaces for professionals to explore bias and shift internal narratives around weight.

"I feel a sense of dread when someone with obesity enters the room, because I don't have the tools or time to help them well."

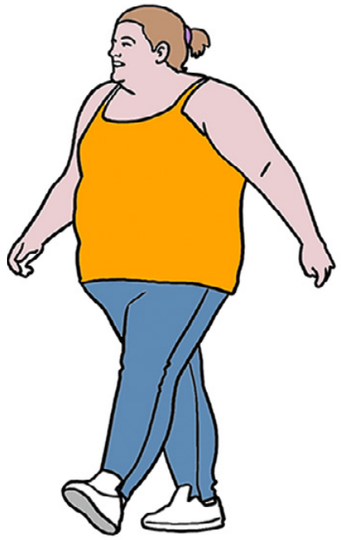
"Even my doctor blames everything on my weight - I avoid going unless it's urgent."

3. Reform access and continuity in obesity services

The current system is fragmented, gatekept, and inaccessible for many. Participants described long waits, confusing referral routes, and limited continuity.

- Standardise and strengthen overweight and obesity management pathways across the region, including universal services such as health promotion or primary care (sometimes referred to as Tier 1), behavioural management services (Tier 2), and specialist management services (Tier 3 and Tier 4)
- Integrate services across mental health, primary care, and social prescribing
- Provide earlier intervention options that don't require people to meet extreme thresholds for support.

"We're left holding the risk when patients are waiting for services that are full or non-existent."



"Unless I was purging, there is nothing… I cannot get any help."

4. Expand peer support and community-led interventions

Peer support was repeatedly described as validating, empowering, and essential for recovery.

- Commission peer-led programmes and walking groups rooted in lived experience
- Involve service users in co-design and delivery to ensure relevance and trust
- Provide funding for grassroots initiatives that focus on connection, not just weight loss.

"The support group made a big difference… it made me feel less alone."

"Please keep lived experience at the heart, we want to be part of these discussions going forward."

5. Develop compassionate, skilled, and confident workforce

Professionals want to offer better support, but often feel disempowered by time constraints, lack of training, and uncertainty.

- Provide structured CPD on trauma, neurodiversity, stigma, and holistic care
- Equip GPs and nurses with practical tools and protected time to hold meaningful conversations
- Recognise and invest in emotional labour, not just biomedical outcomes.

"You have 10 minutes. That's not enough to talk about trauma, food, movement, mental health, everything."

"We aren't trained in weight management in any meaningful way—it's mostly trial and error."

6. Invest in early intervention and prevention

The system must shift upstream, addressing the social determinants of health and offering support before crises occur.

- Tackle affordability of healthy food, safe exercise spaces, and access to mental health services
- Build holistic weight and wellbeing services into schools, workplaces, and community hubs
- Recognise obesity as a chronic medical condition requiring sustained, not episodic, investment.

"It's not just Tier 3 services that need funding—it's prevention, early intervention, everything upstream."

This research has powerfully demonstrated that obesity is not simply a matter of individual choice or willpower. Rather, it is the visible outcome of trauma, shame, inequality, disconnection, and systemic failure. People living with obesity—alongside the professionals supporting them—are calling for a paradigm shift: from a punitive, fragmented, and weight-centric model to a compassionate, trauma-informed, and holistic one.

The voices captured in this work reveal a landscape marked by pain, but also by resilience and hope. They show us what's possible when people are listened to, when services see beyond BMI, and when policy acknowledges that "weight is a symptom, not the cause."

The call to action is clear: rebuild obesity services through the lens of dignity, trust, and lived experience. Anything less will continue to fall short of the human need—and the moral responsibility—to do better.

Next steps

The ICBs will now need to review the recommendations in full and develop a detailed response plan. This plan should outline clear timescales and allocate the necessary resources to ensure that each recommendation is addressed effectively. The resulting actions must be specific, measurable, and designed to drive tangible improvements, enabling the organisation to track progress and demonstrate accountability.

Recommendations for further research

To build on these findings and address current evidence gaps, the following areas should be prioritised for future research. They are grouped below by suggested implementation timescales to support strategic planning and phased delivery.

Immediate priorities (within 12 months)

Trauma-informed practice in obesity care

- Explore the impact of embedding trauma-informed and trauma responsive approaches in obesity pathways, including outcomes on engagement, retention, and mental health.

Stigma reduction interventions

- Evaluate strategies for reducing weight stigma in healthcare settings, including training, reflective practice, and policy change.

Mid-term priorities (1–2 years)

Peer support models

- Assess the effectiveness and scalability of peer-led and community-based interventions in improving emotional wellbeing and health equity.

Neurodiversity and obesity

- Investigate how conditions like ADHD and autism intersect with eating behaviours, weight gain, and access to care.

Longer-term priorities (2–5 years)

Lived experiences in underrepresented areas

- Conduct targeted engagement in the Humber and North Yorkshire regions to ensure geographical equity in insight gathering.

Economic impact of delayed care

- Examine the long-term cost to the NHS of delayed or inaccessible obesity treatment—including impacts on co-morbidities, mental health, and service use.

Risks of inaction

Failure to act on these research priorities could lead to:

- Escalating healthcare costs driven by preventable illness and service demand.
- Worsening health inequalities among underrepresented and underserved groups.
- Continued stigma and disengagement from services among people living with obesity.
- Reduced workforce resilience due to unaddressed training and supervision needs.
- Missed opportunities to intervene earlier and more effectively across the system.

Opportunities

Investment in research across these areas offers the potential to:

- Improve outcomes by aligning care with lived experience and psychological needs.
- Reduce costs through earlier, more coordinated and responsive support.
- Build more inclusive services that reflect the complexity of obesity.
- Strengthen workforce capability, confidence and wellbeing.
- Inform long-term system change through robust economic and behavioural evidence.

Conclusion

This report presents a compelling call for transformation in how obesity is approached across health and care systems. The findings from individuals living with obesity and the professionals who support them reveal a shared reality: current services need reimagining. They are fragmented, under-resourced, and too often defined by stigma and surface-level interventions, rather than compassionate, joined-up care rooted in the complexity of people's lives.

The lived experience narratives in this report cut to the heart of the issue. They speak of trauma, grief, abuse, poverty, neurodiversity, shame, and lifelong exclusion. Obesity, for many, is not the root problem—it is the visible consequence of deeper wounds, shaped by adversity and often compounded by systems that fail to listen. One participant put it simply: "This body saved my life. I'd rather be fat than dead."

These stories are not outliers. They are reflective of a broader, well-documented pattern. A growing body of evidence in public health, psychology, and clinical research confirms the link between Adverse Childhood Experiences (ACEs), emotional dysregulation, and disordered eating. Trauma-informed approaches—those that recognise how trauma affects behaviour, physiology, trust, and engagement—are increasingly recognised as best practice in health and care. Yet as the professionals in this study confirmed, these approaches are rarely embedded, and even more rarely funded.

Moreover, the evidence from policy and national guidelines is unequivocal. Obesity is a chronic, relapsing medical condition, shaped by complex intersections of biology, environment, mental health, and social inequality. NICE guidelines call for integrated, multi-disciplinary care with clear, compassionate pathways. NHS England's Long Term Plan advocates for early intervention, mental health support, and holistic management. But these aspirations are not consistently realised in practice. Professionals report feeling ill-equipped, unsupported, and caught in a system where the dominant culture remains reactive, weight-centric, and underpinned by blame.

Economically, the urgency is just as stark. Obesity-related illness costs the NHS over £6.5 billion annually, with wider societal costs projected to exceed £27 billion. These costs will continue to rise without meaningful reform—not just because of increased treatment demand, but because current models fail to address the upstream drivers of poor health. Investment in trauma-informed, coordinated care is not only ethically right—it is economically essential.

The message from participants is clear: services must move beyond weight loss programmes and generic advice. What is needed is a shift to trauma-informed and trauma-responsive care—where practitioners are not just aware of trauma but trained and resourced to respond to it with curiosity, flexibility, and empathy. This means recognising the signs of trauma, avoiding re-traumatisation, and fostering safety and trust in every encounter. It means seeing the person behind the BMI and listening with respect to their story.

Reform must also be place-based and culturally relevant, recognising the unique challenges and assets of local communities. West Yorkshire, with its diversity, innovation, and strong integrated care partnerships, is well-placed to lead this shift.

Obesity cannot be treated in isolation. It demands coordinated, compassionate, trauma-informed and trauma-responsive strategies that are regionally tailored, co-designed with communities, and delivered through joined-up systems.

West Yorkshire and Humber and North Yorkshire ICBs now stand at a pivotal moment: with the insight, the evidence, and the lived experience needed to drive change. This is more than a policy challenge—it is a moral imperative. The time for trauma-informed and reform is now.

Why action cannot wait

The case for change is clear. People living with obesity are too often met with judgement instead of care, offered fragmented support rather than sustained help, and excluded from services shaped without their voices. The consequences are profound—avoidable distress, poor health outcomes, widening inequalities, and escalating costs to the NHS and wider system. But this is not inevitable. Investing in trauma-informed and trauma-responsive care, tackling stigma, and acting on lived experience is not only the right thing to do—it is also the most effective and economically sound.

The system cannot afford to wait. A shift towards compassionate, coordinated, and equitable support is both a moral obligation and a financial necessity. Without change, the cost will not only be measured in billions—but in lives diminished, trust eroded, and futures lost.

Humber and North Yorkshire Centre for Excellence

West Yorkshire Health and Care Partnership

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