

**A Qualitative Study of Local Obesity Policy Processes across South Yorkshire**

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# Abstract

**Introduction**

Obesity is a serious public health problem facing England, the UK, and other high-income countries. In South Yorkshire, childhood and adult obesity prevalence is consistently reported amongst the highest in England. Local authorities have a responsibility for population health with numerous levers available to influence obesity. Currently there is limited evidence on how local obesity policy processes operate in England. This research explores local obesity policy processes in practice, through a set of case studies in South Yorkshire. It draws on Bacchi’s (2009) WPR (what the problem represented to be) approach, in order to understand how obesity is framed as a policy issue and how this shapes local policy practices.

**Methods**

An interpretative qualitative approach was taken. Documentary analysis of local policies was completed (n=52) using a Framing Matrix (Jenkin et al. 2011). Semi structured interviews were completed with a purposive sample of local authority and Clinical Commissioning Group leaders, public health commissioners and weight management service providers (n=40), using thematic analysis.

**Results**

Despite nuances,obesity was dominantly represented across South Yorkshire as an individual health issue related to choices about diet and physical activity. This representation was operationalised in the context of: a lack of clarity on responsibilities for effectively addressing obesity; reducing resources; challenges of public health leadership in local authorities; and a lack of effective local leadership and governance for obesity. Combined, these factors influence local (in)action, prioritisation and resource allocation for approaches or interventions, and subsequent outcomes and impacts on local obesity prevalence.

**Conclusion**

Local obesity policy is developed and implemented within a complex, socio-political local public health system. The changes from the Health and Social Care Act (2012) led to local obesity policy ‘inertia’, set in the context of challenges of local views of obesity, evidence of effectiveness, financial constraints, and a lack of clarity regarding local responsibility for action. Whole systems approaches have been advocated as having potential to address these complex issues in a system, however, without any evidence of impact to date.

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Thank you is just not enough for Royce, Jemima and Tabitha. I would never have been able to find the motivation and strength needed without you three. This is for all of you.

# Declaration

I certify that this thesis submitted for the degree of Doctor of Philosophy is the result of my own research, except where otherwise acknowledged. No portion of the work presented in this thesis has been submitted for another degree or qualification to this, or any other, university or institution.

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# List of Abbreviations

ADPH Association of Directors of Public Health

ALSPAC Avon Longitudinal Study of Parents and Children

BMBC Barnsley Metropolitan Borough Council

BMI Body Mass Index

CCG Clinical Commissioning Group

CLAHRC Collaboration for Leadership in Applied Health Research and Care

CVD Cardiovascular Disease

DCMS Department for Culture, Media and Sport

DEFRA Department of the Environment, Farming and Rural Affairs

DfES Department for Education and Skills

DH Department of Health

DMBC Doncaster Metropolitan Borough Council

DPH Director of Public Health

DsPH Directors of Public Health

DPHAR Director of Public Health Annual Report

DTLR Department for Transport, Local Government and the Regions

FOI Freedom of Information Request

HAZ Health Action Zone

HOOP Helping Overcome Obesity Problems

HOSC Health Overview and Scrutiny Committee

HWBB Health and Wellbeing Board

HWBS Health and Wellbeing Strategies

HWF Healthy Weight Framework

HSCA Health and Social Care Act (DH 2012)

ITT Invitation to Tender

JHWS Joint Health and Wellbeing Strategy

JSNA Joint Strategic Needs Assessments

KPIs Key Performance Indicators

LA Local Authority

LBU Leeds Beckett University

LTC Long Term Conditions

MECC Making Every Contact Count

NAFLD Non Alcohol Fatty Liver Disease

NAO National Audit Office

NCMP National Child Measurement Programme

NDC New Deal for Communities Fund

NHS National Health Service

NICE National Institute for Health and Care Excellence

NRES National Research Ethics Service

OCN Open College Network

OECD Organisation for Economic Cooperation and Development

ONS Office for National Statistics

PCT Primary Care Trust

PH Public Health

PHE Public Health England

PHOENIX: Public Health and Obesity in England– the New Infrastructure Examined

QoF Quality Outcomes Framework

RCP Royal College of Physicians

RMBC Rotherham Metropolitan Borough Council

SCC Sheffield City Council

ScHARR School of Health and Related Research

SDH Social Determinants of Health

SDS Standard Deviation Score

SHU Sheffield Hallam University

Si Shared Intelligence

SLC4L Sheffield – Let’s Change4Life

STP Sustainability and Transformation Plans, now Partnerships

WPR What’s The Problem Represented to Be Approach (Carol Bacchi 2009)

WSA Whole Systems Approaches

# Chapter 1: An Introduction to the Thesis

# 1.0 Introduction

This thesis examines how local obesity policy processes operate in England. The research presented has sought to address the following question:

***‘How is national obesity policy translated, formulated and implemented locally by senior leaders, commissioners and service providers,***

***and additionally,***

***what implications do these policy approaches have in terms of successfully addressing obesity locally?’***

This first chapter introduces the research, explaining why focusing on local obesity policy processes in England is an important topic for academic inquiry and discusses how the research question has been answered.

Firstly, ‘the problem’ or issue of obesity is explored in broad terms and then in more detail, moving from the global to national to the local level. This is to not only set out the need for the research at a local level, but also to highlight that having an understanding of how obesity is represented in national policy and subsequently interpreted and implemented at a local level is *crucial* if there is to be progress in addressing the issue of obesity in England.

Secondly, the chapter explains how the research has been carried out. It describes the interpretative approach and qualitative methods that were used, as well as the conceptual framework that was employed which guided the research design. The applied nature of the study is explained, the four local authority areas that were ‘sites’ in the research are introduced, as well as the overall strategy for data collection and analysis.

Thirdly, the personal reasons for carrying out this research are outlined, in order to give the reader some insight into how my positionality has shaped the motivations for this study, as well as the way the research has been designed and carried out. Finally, the chapter concludes with an outline of how the thesis is organised, along with a short summary of each chapter.

## Introducing obesity and the need for policy action

Obesity isabnormal or excessive fat accumulation that presents a risk to health(WHO 2018). Obesity is commonly understood in relation to a person’s weight and height and is measured using a person’s body mass index (BMI), which is calculated by taking a person’s weight in kilograms and dividing this by the square of their height in metres (NHS 2016; NHS Digital 2018). For most adults, a BMI (kg/m2) of:

* 18.5 to 24.9 is a healthy weight
* 25 to 29.9 is classified as overweight
* 30 to 39.9 is categorised as obese
* >40 indicates severe obesity (NHS Digital 2018; WHO 2018).

The prevalence of obesity varies across countries of the world, but has generally increased in the last 40 years, with global rates tripling since 1975 (Sassi 2009; OECD 2017). World Obesity provides statistics and maps on the global obesity prevalence, and the latest maps illustrate that at least 25% of the adult population in many countries were classified as obese, with approximately 20% of children in countries where data was available also classified as obese (World Obesity 2019). As a result, obesity has been recognised as a priority global health policy priority (OECD 2017; WHO 2018).

Obesity is also a priority policy issue and challenge across Europe. Despite significant variation across countries, in 2017 it was estimated that there was an obesity prevalence of 25% for adults and 20% for children (OECD 2017; World Obesity 2019). Obesity is a significant issue in the UK given that its prevalence is amongst the highest in Europe (OECD 2017). In England, the UK Government has formally recognised this high prevalence, with recent policy documents highlighting, for example, that nearly a third of all children aged 2 to 15 years were estimated to be overweight or obese in 2016 (DH 2016; NHS Digital 2018). There are also concerning rates of obesity in the adult population in England. The 2016 Health Survey for England found that 27% of adults were obese and a further 35% overweight; equating to 62% of the adult population classified as overweight or obese (NHS Digital 2018).

Within England, there is spatial variation in obesity prevalence in both children and adults. A recent parliamentary briefing highlighted, for example, that across South Yorkshire, Barnsley, Doncaster and Rotherham were in the top 5 English local authority areas for adult overweight and obesity (Baker 2018). The most recent data from the National Child Measurement Programme (NCMP) also shows that across South Yorkshire local authority areas approximately 1 in 4 4-5-year olds and more than 1 in 3 10-11-year olds were classified as overweight or obese in 2016/17; which is higher that the England average (NHS Digital 2017) (see Table 1.1). This programme, which was introduced in 2005, requires all Primary Care Trusts (PCTs) (now local authorities) to weigh, measure and report on the weight status of all children in Reception Year and Year 6 (ages 4 and 5 and 10 and 11 respectively) (DH 2005; NHS Digital 2017).

Table 1.1 NCMP data (NHS Digital 2017)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Indicator** | **England** | **Yorkshire and the Humber region** | **Barnsley** | **Bradford** | **Calderdale** | **Doncaster** | **East Riding of Yorkshire** | **Kingston Upon Hull** | **Kirklees** | **Leeds** | **North East Lincolnshire** | **North Lincolnshire** | **North Yorkshire** | **Rotherham** | **Sheffield** | **Wakefield** | **York** |
| Reception Prevalence of overweight (including obese) | 22.6 | 22.2 | 16.8 | 22.5 | 21.3 | 23.0 | 18.2 | 27.9 | 22.1 | 21.1 | 23.8 | 24.3 | 21.2 | 23.9 | 22.3 | 25.2 | 20.8 |
| Year 6: Prevalence of overweight (including obese) | 34.2 | 34.6 | 31.2 | 37.9 | 34.3 | 35.8 | 32.0 | 36.1 | 35.3 | 33.7 | 37.8 | 34.7 | 30.6 | 37.0 | 35.6 | 35.9 | 29.0 |
| Obese children (4-5 years) | 9.6 | 9.7 | 7.9 | 10.4 | 8.9 | 9.9 | 7.9 | 13.0 | 9.9 | 8.5 | 11.1 | 10.1 | 8.9 | 11.5 | 9.6 | 11.1 | 8.5 |
| Obese children (10-11 years) | 20.0 | 20.4 | 19.0 | 23.7 | 20.3 | 21.1 | 18.1 | 22.7 | 21.1 | 19.3 | 22.4 | 20.7 | 16.2 | 22.2 | 21.2 | 21.3 | 16.1 |

Such is the extent of the obesity problem in England that some health commentators have called this a childhood and adult obesity ‘epidemic’ (RSPH 2015; Academy of Medical Royal Colleges 2016). In 2017, the then Health Secretary, Jeremy Hunt, also described the rise in childhood obesity as a “national emergency” (BBC 2016). The Foresight Report on Tackling Obesities (hereafter ‘Foresight Report’) (Butland et al. 2007), widely recognised as a seminal work on obesity, predicted that unless there is clear policy action in England - at both national and local level - to tackle this obesity epidemic, then obesity will continue to rise to almost 9 in 10 adults and 2 in 3 children by 2050. For South Yorkshire, this would mean that, by 2050, 70% of the total population would be classed as obese; making this area one of the most obese regions in England (Butland et al. 2007).

Addressing obesity in England and in regions such as South Yorkshire through coherent policy action is critical for public health given the impacts that obesity has for individual health and wellbeing and for wider society (Butland et al. 2007; NICE 2014). It is estimated, for example, that life expectancy is reduced by an average of 2 to 4 years for those with a BMI of 30 to 35 kg/m2, and 8 to 10 years for those with a BMI of 40 to 50 kg/m2 (NICE 2014). This is partly because unhealthy excess weight can lead to several health conditions, such as: type 2 diabetes; coronary heart disease; stroke; and some types of cancer (such as breast and bowel) (NICE 2014).

Obesity can also affect an individual’s quality of life, leading to psychological problems, such as depression and low self-esteem; with bi-directional associations between mental health conditions and obesity (Gatineau and Dent 2011). Those who are obese may also experience stigma, bullying and discrimination (Puhl and Latner 2007; Puhl and Heuer 2009). Whilst there is strong evidence of the impact of social stigma, some research and indeed public opinion, believe that weight stigma will encourage people to change their behaviours (Puhl and Heuer 2009). However, most research shows that weight stigma and discrimination decrease the likelihood that people with obesity will engage in health promoting behaviours (Puhl and Heuer 2009). Not only do these issues have a direct influence on a child and young person’s development, but they also have a long-lasting impact into adulthood. Research evidence shows that children who are overweight and obese are likely to face a range of social consequences in important aspects of life including education, the workplace, healthcare and social relationships (Puhl and Heuer 2009).

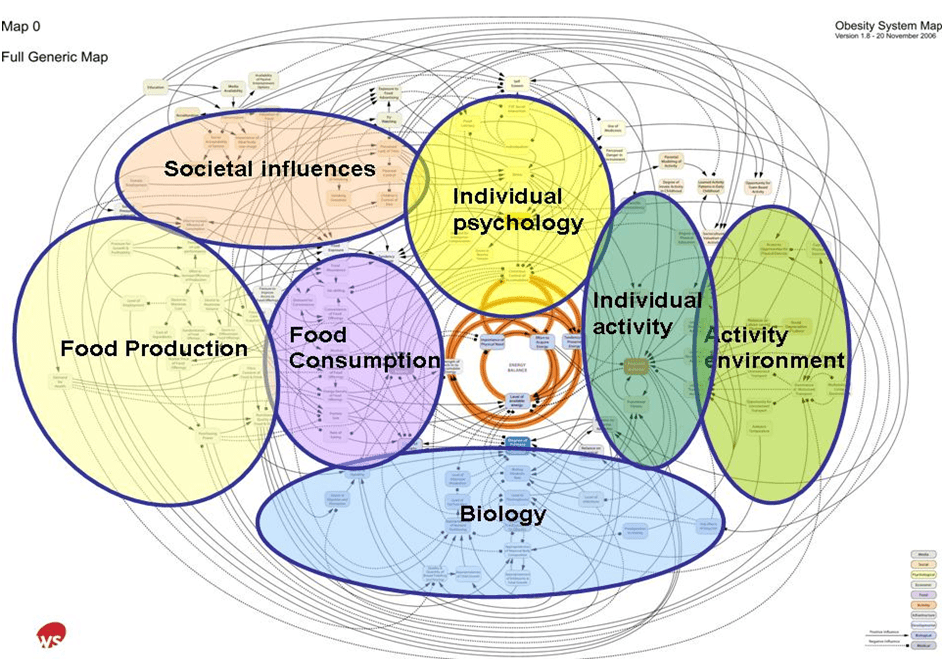
In terms of impacts on wider society, it is estimated that the wider economic cost of unhealthy weight to society and the UK economy is in the region of £27 billion annually (PHE 2017), and could rise to just under £50 billion in 2050 if obesity rates continue to increase (DH 2011). These wider economic costs are related to the educational, employment, economic and social wellbeing impacts of obesity. For example, childhood obesity is inversely associated with educational attainment (Carey et al. 2015); people who are obese are approximately 25% less likely to be in employment than people who are a healthy BMI (Flint et al. 2016); and, severely obese people are over 3 times more likely to need social care than those who are a healthy weight in England (LGA 2017).

Importantly, although there are people in all population groups who are overweight or obese, some groups are disproportionately affected. There is, for example, a clear relationship between obesity and socio-economic status, with a clear social gradient in obesity within the UK across both children and adults (Marmot 2010); obesity is thus related to social disadvantage. Indeed, national monitoring data provided by NHS Digital in 2018 shows that children living in the most deprived areas of England had more than double the obesity prevalence than those living in the least deprived areas, with the gap widening over time (NHS Digital 2018). There are also recognised associations identified between gender, deprivation and obesity prevalence in children in England (NHS Digital 2018). For adults in England, there is no association with household income and BMI in men, however women with lower household incomes have a higher BMI than those who are more affluent (NHS Digital 2018).

## 1.2 Taking action on obesity at national and local level

Taking policy action to address obesity is challenging for a number of reasons (Lang and Rayner 2007). One reason is because the drivers (causes) of obesity are complex and inter-related. This complexity provides a challenge as to know where best to intervene, and because taking action on one variable may affect other variables in unexpected ways or not lead to the desired effect, which may not lead to the desired outcome. The Foresight Report (mentioned above) highlighted the complexity of obesity in some detail; producing a detailed Obesity Systems Map that illustrates 108 different causatory variables and 304 causal links that contribute to the issue (Butland et al. 2007, see Figure 1.1 below). These variables and causal links, together, illustrate the determinants of population level energy balance (or imbalance), which together lead to weight gain and obesity (Butland et al. 2007).

Figure 1.1 Foresight Obesity Systems Map (Butland et al. 2007)



Although the Foresight Report identified multiple and inter-connected causes of obesity it did not propose solutions (Butland et al. 2007). However, significantly, the Report recognised that although individual weight is a consequence of individual decisions about diet and activity (shown at the centre of Figure 1.1, above), it also identified that the environment (which Foresight termed ‘obesogenic’) makes it difficult for individuals to maintain healthy lifestyles and thus healthy weight (Butland et al. 2007). The Foresight Report and then the widely-cited Marmot Review (2010) identified that a complex range of biological, social and environmental factors across the lifecourse contribute to the issue of obesity.

For some, the issue of obesity, and its complexity, is typical of a ‘wicked’ public health problem (Hunter 2009; Hendriks et al. 2013). Hunter (2009: 202) describes these problems as those that have *‘complex causes and require complex solutions’* and as having the following characteristics:

* difficult to define clearly;
* many interdependencies and multi-causal;
* may give rise to solutions which have unforeseen and/or unintended consequences;
* often not stable;
* usually no clear solutions;
* socially complex;
* rarely sit within the boundaries or responsibilities of any single organisation;
* involve changing behaviour.

It is this complexity of obesity that is recognised as posing a challenge for policy makers and subsequent action (Lang and Rayner 2007). More recently, this has led to arguments for systems-led national and local policy approaches to address obesity, wherein action is needed at multiple levels (individual, organisational, community, society, cultural and policy level) and across policy sectors (e.g. health, education, planning, economy) to ensure that the multiple influences that shape choices across the lifecourse are addressed (Swinburn et al. 2011; Ulijaszek 2017).

These issues of complexity reflect core policy challenges in addressing obesity, and thus make it problematic to find clear solutions. Current policy solutions in England are not yet reflective of this complexity, nor more recent systems thinking, and to date, neither national nor local policy in England has reflected this understanding in clear policy action, as illustrated below.

### 1.2.1 Recent examples of national obesity policy

A number of national policies have been introduced in England over the past 20 years, which have focused on addressing obesity, as summarised in Table 1.2 (WHO 2000; Health Committee of the House of Commons 2004; Butland et al. 2007; DH 2016; DH 2018).

**Table 1.2 Key national obesity policy and related documents published 1997-2018 (adapted from Ulijaszek and McLennan 2016: 400-401).**

|  |  |  |
| --- | --- | --- |
| **Document** | **Year** | **Agency** |
| Saving lives: our healthier nation | 1999 | Department of Health |
| Tackling obesity in England | 2001 | National Audit Ofﬁce |
| Annual Report of the Chief Medical Ofﬁcer | 2002 | Department of Health |
| At least ﬁve a week: evidence on the impact of physical activity and its relationship to health | 2004 | Department of Health |
| Obesity: third report of session 2003-04 | 2004 | House of Commons Health Committee |
| Securing good health for the whole population | 2004 | Wanless, HM Treasury |
| Choosing health: making healthy choices easier | 2004 | Department of Health |
| Choosing a better diet: a food and health action plan | 2005a | Department of Health |
| Tackling child obesity: ﬁrst steps | 2006 | National Audit Ofﬁce |
| Tackling obesities: future choices | 2007 | Foresight (Butland et al.) |
| Healthy weight, healthy lives: a cross-government strategy for England | 2008 | Cross-Government  Obesity Unit |
| Healthy lives, healthy people: our strategy for Public Health in England | 2010 | HM Government  White Paper |
| Fair society, healthy lives: strategic review of health inequalities in England post-2010 | 2010 | Marmot, Institute of Health Equity |
| Equality analysis: a call to action on obesity in England | 2011 | Department of Health |
| Strategic high impact changes: childhood obesity | 2011 | Childhood Obesity National Support Team, Hastie & Yates |
| Public Health outcomes framework 2013 to 2016 | 2012 | Department of Health |
| Living well for longer: a call to action to reduce avoidable premature mortality | 2013 | Department of Health |
| From evidence into action: opportunities to protect and improve the nation’s health | 2014 | Public Health England |
| Moving more, living more: the physical activity olympic and paralympic games legacy for the nation | 2014 | HM Government Cabinet Ofﬁce |
| Chief medical ofﬁcer annual report 2012: surveillance volume | 2014 | Department of Health |
| Living well for longer: progress 1 year on | 2015 | Department of Health |
| 2010 to 2015 Government policy: obesity and healthy eating | 2015a | Department of Health |
| 2016 Childhood Obesity Plan: A plan for Action (part one) | 2016 | Department of Health |
| 2018 Childhood Obesity Plan: A Plan for Action (part two) | 2018 | Department of Health & Social Care |

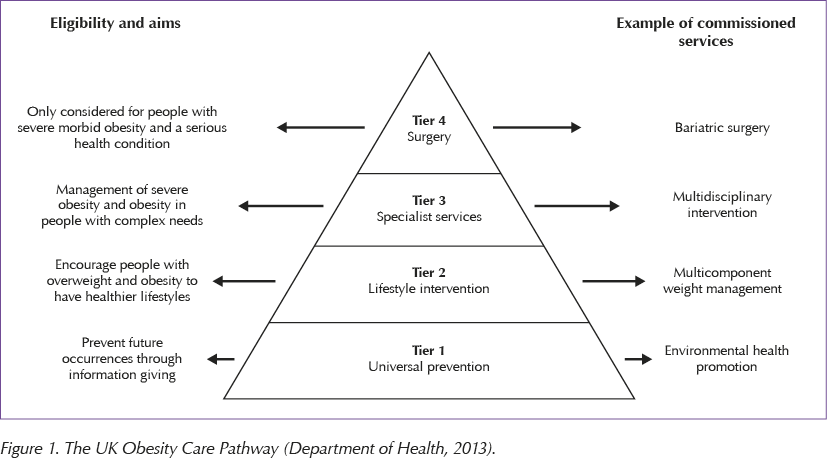
These national policies have put forward a diverse range of interventions to both prevent and treat obesity at an individual and wider societal level including, for example: the introduction of healthy start vitamins; promoting breastfeeding initiatives; introduced the NCMP (as mentioned above); promoting 5 fruit and vegetables a day; promote the funding of health trainers; introduced Change4Life social marketing approaches; promoted voluntary amendments to food labelling (e.g. traffic light labelling system); encouraged the reformulation of high sugar foods; promoted workplace and school health initiatives and weight management programmes (DH 2004; 2005a; 2008; 2010; 2016; 2018).

National government policy on obesity in the UK has been subject to numerous analyses and has been relatively well-researched, especially since the publication of the Foresight Report in 2007. There has been considerable discussion of what interventions have been undertaken, what does and might work well in what circumstances, as well as criticism of the interventions recommended and what remains unaddressed (Butland et al. 2007; Finegood et al. 2010; Jebb et al. 2013; Hawkes et al. 2013; Lobstein and McPherson 2016; Ulijaszek and McLennan 2016; Lancet 2017). For example, the appropriateness of the interventions outlined in national policy in England has been the subject of considerable academic debate, with a key focus of discussion being on the adequacy of the overall model or approach to addressing obesity that the interventions are embedded in. The issue here is essentially about how the drivers (causes) of obesity are understood and the types of policy intervention that ensue from this (Kersh 2009; Ulijaszek and McLennan 2016; Ulijaszek 2017). As Kersh comments (2009: 295): ‘*Much of the political discussion regarding obesity is centered on two [argumentative] “frames”, personal-responsibility and environmental, yielding very different sets of policy responses.’* An argumentative frame can be defined as a way of making sense of an issue; a way of constructing that issue socially. As Entman explains (1993: 51):

*‘Framing essentially involves selection and salience. To frame is to select some aspects of a perceived reality and make them more salient in a communicating text, in such a way as to promote a particular problem definition, causal interpretation, moral evaluation, and/or treatment recommendation for the item described.’*

In relation to national policy, Vallgarda et al. (2015) argue that obesity policy in the UK has focussed on the ‘personal-responsibility’ frame: which foregrounds individual behaviours and personal choice as the causes and solutions to obesity and results in interventions that tend to focus on treatment. A view supported by Ulijaszek and McLennan (2016: 397) who also recognise a ‘persistence of individualistic approaches’albeit with, some subtle shifts over time. The subtle shifts refer to the particular ways in which a personal-responsibility or individualistic approach has been defined. It has been argued that the last UK Labour government (1997-2010) focused on ‘informed choice’; defined as: *‘one that is based on relevant knowledge, consistent with the decision-maker's values and behaviourally implemented’ (*Marteau et al. 2001: 99). For example, the 2004 Wanless Report recognised the *‘right of individuals to have their own lifestyles must be balanced against the adverse effect that choice has on the rights and behaviours of others’* (Wanless, 2004 p. 149). Essentially, recommending individual diet and physical activity informed choice as an approach. In contrast, the Conservative-Liberal Democrat Coalition Government and subsequent Conservative Governments have only supported ‘personal responsibility’ with regards to health and obesity policy (DH 2012; 2016), where, as already mentioned above, personal responsibility is seen as just that: individuals responsible for their own choices and taking responsibility for those and the subsequent impacts. To a certain extent, this is about intervening on the basis of ‘doing it for yourself’ – making healthy food choices, cooking well, and thus eating more healthily, as well as being active – and focuses primarily on interventions relating to individual diet and physical activity choices leading to obesity (Kersh 2009; Barry et al. 2009; Jenkin et al. 2011; Ulijaszek and McLennan 2016; Ulijaszek 2017). Importance is also placed on attending weight management services/courses which may be self-funded or commissioned by public health (as described in Healthy Weight, Healthy Lives (DH 2008)). These types of individualised weight management services are those that generally follow the guidance and care pathway produced by the Department of Health in 2013 (DH 2013a). This is a four-tiered approach to addressing both child and adult overweight and obesity. It is a stepped model from universal prevention at the bottom, tier 1, working up to tier 2 lifestyle services, to tier 3 specialist services, to surgery at tier 4 does not have agreed cut offs or referral criteria. However, in general, as the severity of overweight and obesity increases, a higher tier of intervention is required and advocated, both in children and adults.

**Figure 1.2 Department of Health Obesity Care Pathway (DH 2013a)**



There have, however, been subtle shifts. For example, The House of Commons Select Committee Report on Obesity (House of Commons 2004) identified both the health implications of obesity and the social and economic costs, and made recommendations for government strategy based on the Wanless (2004) recommendations of informed choice and the rights of individuals to information, which should be acted upon for the good of the population and this balancing of the population good and the rights of individuals. It highlighted issues of food labelling and food advertising and suggested a health promotion campaign to raise individual awareness to tackle obesity. In this document, for the first time, obesity appears to have become also recognised a social problem (Martin 2008), with the report describing the culture and environment of Britain as ‘obesogenic’. Its recommendations reflected the previous policies’ ethos of informed choice, but in a supportive environment, created by government, and therefore positioning the state as an enabler of healthy choices. However, this recognition did not lead to policy responses reflective of this stance.

Supporting this point, Ulijaszek and McLennan (2016) reviewed the above-mentioned approach taken in England between 1997-2015, arguing that individual framing persisted despite evidence that wider approaches were also required. Ulijaszek and McLennan (2016: 17) stated that:

*‘Despite a changing political landscape in the UK between 2000 and 2015, there is surprising continuity in the framing of obesity across this time….Political values of individualism and market liberalism,…are continuous and have infused policy documents with recommendations based on individualist behaviour and practice, even when the rhetoric of obesity policy veered towards collective action with Foresight Obesities. The framing of obesity is consistent, …..There is also considerable continuity of key advisors involved in informing and developing policy across the period, and little research has been carried out to understand how their own views and values may affect the advice they give. This has implications for the framing of obesity, and for any possibilities for its reframing.*’

The second of Kersh’s (2009) frames, the ‘environmental’ frame, is more focused on prevention of obesity at a population level and the wider environmental influences on obesity (Kersh 2009; Barry et al. 2009; Jenkin et al. 2011; Ulijaszek and McLennan 2016; Ulijaszek 2017). This framing focuses on obesity being a normal reaction to an environment which encourages obesity. The environmental frame seeks to balance individual choice, autonomy, protection of vulnerable groups, targeting of those at-risk, and reducing inequalities, alongside interventions which are more focussed on preventing unhealthy weight. The environmental frame has led to a policy response in terms of interventions that are focussed on population prevention measures which are less individually focussed and more at population or system level, such as: reformulation of food in terms of reducing sugar, fat and salt; labelling of food; social marketing programmes e.g Change4Life, as described in the current guidance outlined in the most recent Childhood Obesity Plans, 1 and 2 (DH 2016; 2018).

Despite the existence of the two main argumentative frames identified by Kersh (2009: 295) as ‘*personal-responsibility and environmental’,* national obesity policy in England has been recognised as dominated by a personal-responsibility frame (Vallgarda et al. 2015; Ulijaszek and McLennan 2016: 401):

*‘Most policy interventions…overwhelmingly frame obesity as a problem of individual consumption and behaviour and propose individual consumer decision-making as the key targets for interventions. Less attention is paid to the role of civil society more broadly (including organizations and businesses) or to society-wide structural drivers.’*

The more ‘personal-responsibility’ frame and associated approach to obesity that has been adopted within national policy has been subject to various criticisms. Adler and Stewart (2009), for example, acknowledge a tension between providing information and/or services to empower individuals to take responsibility and the potential for ‘victim-blaming’ when people fail to make healthier choices about eating and physical activity, this is supported by others such as Puhl and Heuer (2009). Also, as demonstrated from the data presented above, to date this type of approach does not appear to have been effective in addressing obesity, with prevalence data continuing to rise (as already discussed above). The Foresight Report argued that there needs to be a shift away from a sole focus on the individual and personal responsibility, and towards a policy approach that recognises individual responsibility but *within* an environment that supports healthy choices (Butland et al. 2007).

More recently, acclaimed obesity researchers such as David Hunter, Boyd Swinburn, Diane Finegood and others, argue that there needs to be a continuum of public policy approaches, which address both individual and wider determinants of obesity (i.e. both personal-responsibility and environmental approaches), i.e. a systems frame, as part of what they call a ‘Whole Systems Approach’ to obesity (Hunter 2009; Frood et al 2013; Swinburn et al 2015; Swinburn 2016). This type of frame would lead to a multi-level and multi-agency policy response characterised by action at both the individual level for those who are already overweight and obese, and those more vulnerable to unhealthy weight (e.g. weight management services), alongside efforts to address the ‘obesogenic’ environment to support the whole population to achieve and maintain a healthy weight (e.g. food reformulation, labelling, campaigns etc). However, currently there seems to be a focus on one or the other i.e. personal responsibility versus wider environmental framing, and associated response in terms of prevention versus treatment, and not this systems frame with a continuum of interventions approach (Swinburn 2016).

It is important to understand the argumentative frames in relation to obesity, as described above, because the persuasiveness of policy arguments and thus subsequent policy processes of formulation and implementation can be affected by the frame (Kingdon 1984; Bacchi 2009). However, as Koon, Hawkins and Mayhew (2016) noted in their scoping review of ‘Framing and the Health Policy Process’, little is known about the ways that frames influence the health policy process – at national or local levels. Indeed, we know relatively little about what happens in practice because obesity policy is implemented locally. While national policy provides guidance and a framework for action on obesity, setting the goals for action and identifying possible effective interventions, it does not specifically detail how to achieve the desired outcomes; nor does it prescribe all forms of action that have to be taken at a local level. Although, NCMP is a statutory requirement and is prescribed. It is recognised in the literature that many well‐intentioned national obesity strategies may fail because of poor implementation (Jebb et al. 2013). Although national policies are often supported by guidance, toolkits and training (e.g. Healthy Weight, Healthy Lives: A Toolkit, DH 2008), what is enacted and implemented is largely up to local decision-makers in local authorities and/or the NHS given the local area decision-making powers brought about through the Localism Act (2011). This Act introduced a series of measures to shift or decentralise power and decision-making from central to local government levels. In 2012, a new Health and Social Care Act (2012) was also introduced. This transferred certain public health professional roles (e.g. Directors of Public Health) and certain public health functions that had been located in the NHS to local authorities (e.g. sexual health services, school nursing and health visiting) and also established Health and Wellbeing Boards (HWBBs) whose role is to ensure joined up action on issues across local partners to improve health and wellbeing and reduce health inequalities. HWBBs are the responsible body for ensuring health and social care issues are integrated in the interests of the local population. The localism agenda has thus became a key consideration for local public health teams involved in enacting national policy, including obesity policy, at a local level (for more detail about this context and public health see the background Chapter 2).

Little is known about the frames that are embedded in local strategies that lead to or support local interventions; the factors which drive local obesity strategies; and what shapes the subsequent interventions that are implemented. This is despite repeated calls for local obesity policy to be examined in more detail, both in the UK and in other countries across the world (Brennan et al. 2011; NICE 2014). Further understanding of framing within local policy processes would support recognition of potential policy outcomes of framing on policy process, especially where there is controversy or differing argumentative frames – as is the case with obesity policy. As Fischer comments (2002), the way that stakeholders and policy makers discuss policy issues “*does more than reflect a social or political ‘reality’; it actually constitutes much of the reality that has to be explained*.” (Fischer, 2002: vii-viii). Building on this, a number of other policy academics argue that the way policy issues are framed affect the policy process. They argue that the majority of policy problems are presented using narrative devices, and that framing influences how issues are received and discussed, prioritised (or not); policy formulated and the solutions that can be offered to the issue; and subsequent implementation (Kaplan 1986; Stone 2001; Bacchi 2009; Barry et al. 2009; Kersh 2009; Beeken and Wardle 2013; Ulijaszek and McLennan 2016; Ulijaszek 2017).

Seminal recent work has considered local obesity policy; for example, the UK Government commissioned PHOENIX (Public Health and Obesity in England– the New Infrastructure Examined) which examined the impact of the transition of certain public health staff and public health responsibilities from the NHS to local authorities in England as a result of the Health and Social Care Act 2012 (Peckham et al. 2016). This was the first study of its kind to look at obesity policy at a local level in England. Yet The PHOENIX Report’s focus was the transition of public health from the NHS to local authority. Obesity was the topic to examine transition and thus offered some insight into how obesity policy was being operationalised at a local level; focusing, for example, in terms of the impact of transition on public health staff, issues and processes (Peckham et al. 2016). The Report highlighted the impact of the Health and Social Care Act (2012) in general on public health in terms of the: ongoing transition and adjustment of structures, relationships and position of public health teams; system coordination; clarity of roles and responsibilities; functioning of Health and Wellbeing Boards (HWBBs); financial challenges of the time, new organisational structures and impact on decision making; and, independence of public health professionals. In relation to obesity, PHOENIX found: gaps in obesity pathway and tiers of service provision, resource reduction; and, a lack of partnership working (Peckham et al 2016). However, this Report did not explore, in any significant detail, the drivers and underpinning accounts of obesity from the perspective of local stakeholders, how the two frames noted above (as identified by Kersh 2009) featured in local obesity policy processes in terms of policy making, nor did it discuss the implications of what was learnt about local policy processes for addressing obesity. There is thus a significant gap in our understanding about how local obesity policy process works in England, which is what this research seeks to address.

## 1.3 The research question and approach in this thesis

As noted in the foregoing arguments above, obesity-related public policy at the national level in the UK has been dominated by a frame that suggests individual personal responsibility and choice-based causes and interventions to address obesity (Vallgarda et al. 2015). However, there is little existing literature as to how national obesity policy is translated into local action. More specifically, there is little about how obesity is framed at a local level and how this subsequently impacts on local obesity policy processes in terms of how local obesity policy is developed, interventions formulated and implemented. Therefore, this is what this research has sought to address, through answering the following research question:

***‘How is national obesity policy translated, formulated and implemented locally by senior leaders, commissioners and service providers,***

***and additionally,***

***what implications do these policy approaches have in terms of successfully addressing obesity locally’***

The central concern of the research was to start to fill the identified gap in policy literature and, specifically obesity policy literature, by exploring how local policy process operates in detail. In this way, this study has sought to go further than describing the causes, consequences and prevalence of obesity. Rather, it has sought to explore the experiences of understanding and enacting national policy locally, examining the local policy process through the perspectives of local stakeholders. More specifically, the research has sought to understand how local obesity policy process operates by questioning how obesity is framed or represented as an issue/problem locally and understood by local stakeholders; and how these representations and understandings influence local decisions about the prioritisation of obesity, content of strategies and obesity-related interventions, and thus ultimately action on obesity.

### 1.3.1 The research approach

This thesis has sought to help fill the above-mentioned gap in knowledge about local obesity policy in practice through a qualitative case study of local obesity policy in of each local area of the Yorkshire and Humber sub-region of South Yorkshire (Barnsley, Doncaster, Rotherham, Sheffield). The reasons for focusing on South Yorkshire are considered in more detail in the next section below (1.4). Detailed research was carried out in this region with local area senior leaders, commissioners and service providers to explore local obesity policy processes in terms of translation, formulation and implementation of national obesity policy at a local level, using an interpretive approach and employing qualitative methods.

In order to study the aforementioned local policy processes, this research used a case study approach, employing Yin’s understanding of case study (2009). Yin (2009) proposes that the 'case' can be, for example, a process, such as decision-making, as opposed to a more usual version of ‘the case’ being a geographical area. For the purposes of this study, ‘the case’ under research is obesity policy process at a local level (understood as the interaction between local perspectives, context and influences on obesity policy decision-making with respect to agenda setting/prioritisation, policy formulation, implementation, and what impact this has). In order for the case to be studied at a local level, areas, or sites, needed to be identified in which to study ‘the case’, as research on, and accounts of, obesity from a variety of perspectives and disciplines (medicine, epidemiology, physiology, anthropology and sociology), have not often focused on upon specific place-based examples or case studies (Herrick 2007). In this study, the ‘case’ is obesity policy process at a local level and it is examined in South Yorkshire in four areas (Barnsley, Doncaster, Rotherham, Sheffield). Rather than the geographical sites being the unit of analysis, obesity policy process at a local level is the ‘case’.

As we will go on to explore in more detail in Chapter 3 (literature review), obesity policy analysis to date has mostly provided insight about the content (the ‘what’) of obesity policy; that is to say, on what interventions are introduced/undertaken and what outcome measures or targeted reductions are, or, are to be, achieved. By concentrating on the ‘what’ of policy, key questions about who makes or influences policy, ‘how’ and ‘why’ have been somewhat unanswered (Clarke et al. 2016).

The current body of literature does not explore the issues of who is involved and how decisions are made in local obesity policy, nor does it seek to understand the frames in use locally, the perspectives of those involved and how their stance influences policy formulation and actions/approaches and interventions, implementation, and resultant impact.

As noted above, this research has explicitly sought to understand frames in use in local obesity policy process. Carol Bacchi’s What’s The Problem Represented to Be Approach (WPR) (2009) to policy analysis is presented as one approach used in order to address the identified gaps in understanding the frames in use. As will be discussed in Chapter 3, the literature review chapter, Bacchi’s WPR focuses on the way policies represent policy ʻproblemsʼ, and the effects of these ‘problematisations’, arguing that this allows a better understanding of an issue. The starting point is that problems are social constructions, i.e. issues are viewed in a particular way, using certain sets of data, perspectives, or particular lenses, to package and present the issue. However, it is important to point out here that, in order to answer the research question of this thesis, and to address the gaps identified in the obesity and policy literature as set out above, the WPR has been used as a guiding framework, rather than adhering to Bacchi’s (2009) order of questions.

The research draws on qualitative methods, with data collection and analysis driven by four research objectives, answering the following sub-questions; which embed Bacchi’s WPR approach (2009):

1. How has national obesity policy developed over recent decades and how is the issue of obesity understood in such policy?
2. How has the local obesity policy in the four areas of South Yorkshire developed over the decade 2006/7 to 2016/17 and how is the issue of obesity understood in such policy?
3. How do obesity policy processes operate locally? Including,

3i. How do the stakeholders involved understand the issue of obesity (what are their understandings, perspectives, etc)?

1. In what ways do these local understandings shape the way obesity policy is translated and implemented into practical realities?

In order to undertake this study, there had to be an understanding of the different elements outlined above. Therefore, this study explored:

* obesity policy, and obesity framing or representation in policy both nationally and locally,
* how the national political and legislative context within which public health issues (including obesity) are addressed fundamentally shapes the way that local obesity policy processes operate, and,
* the ways in which the national and subsequent associated local policy, affect experiences and perceptions about the more ‘day to day’ obesity policy processes and activity being undertaken locally.

These issues have been briefly introduced here to fully outline the basis for this research and the approach taken.

The qualitative methods employed in this research include undertaking content analysis of local obesity policy and supporting relevant documents; followed by, semi structured interviews with local obesity leads, commissioners and providers of obesity services, as well as senior leaders and key decision makers across the NHS and local authorities in South Yorkshire.

The documentary content analysis employed a framing matrix developed by Jenkin (et al. 2011), as, to date, this appears to be the only tool that has been used successfully in analysing frames in use in obesity policy through documentary analysis. This matrix was felt to resonate with the aims of this research as it embeds some of the ideas and questions that Bacchi suggests (2009). It also brings together the key issues of understanding models of obesity in use – understanding how obesity is framed by policy makers, and, the values underpinning this (Ulijaszek 2017). To date, the Jenkin (et al. 2011) framing matrix has not been employed to understand frames in use in the UK by obesity stakeholders at a local level, such as commissioners, key decision makers and providers of obesity services. The research therefore makes a novel contribution in this regard.

These methods have been undertaken to gain deeper understanding of the process and experiences of the local policy processes, as well as stakeholders’ understanding of obesity, the frames or representations in use, and how actors, process, context and content (i.e. the policy triangle framework, Walt and Gilson 1994) interact to influence local obesity policy.

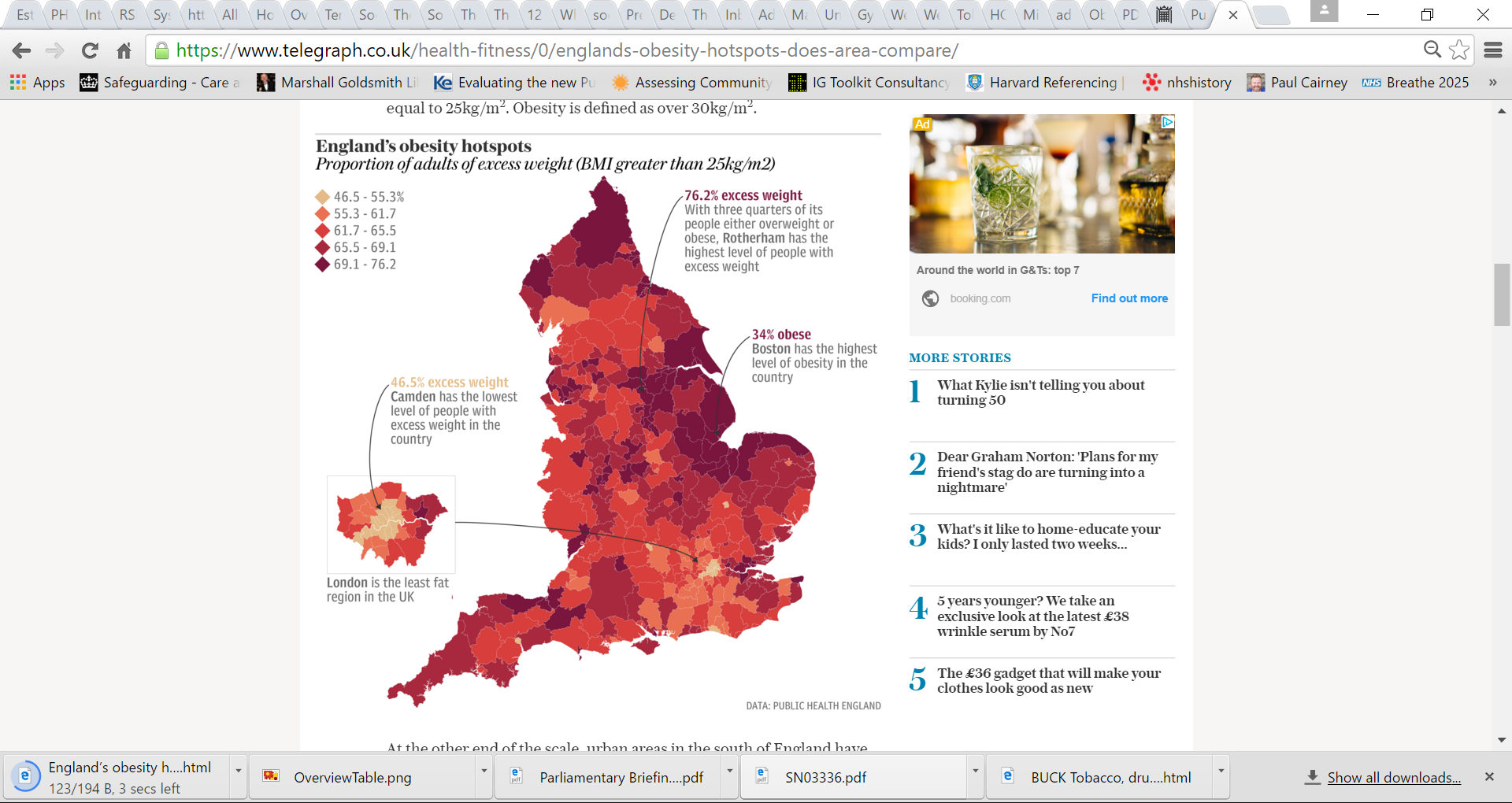
The qualitative data collection and subsequent synthesised analysis undertaken then forms the basis of the discussions of how local obesity policy processes operate. A detailed account of the documents, stakeholder groups from which potential participants were invited, sampling methods, the characteristics of participants, the organisation of the semi-structured interviews, and a consideration of limitations in the methods employed is provided in the methodology section (Chapter 4).

## 1.4 The rationale for undertaking this research in South Yorkshire

The research focused on South Yorkshire for a number of reasons. Firstly, in terms of prevalence, all four areas recognise that, although similar to the national average, both adult and childhood obesity prevalence is high, with Foresight (Butland et al. 2007) predicting that Yorkshire and Humber would see the highest levels of obesity in 2050 if the current trend continues (as discussed above).The issue of obesity has received considerable media attention related to obesity prevalence in these areas, greater than other England local authority areas, for example, The Daily Telegraph (Kirk, September, 2017), provided the following graphic, below in figure 1.3, and reported that:

‘*between January 2013 and January 2016, the fattest areas in England were Rotherham, Doncaster and Halton, where three in four people were overweight or obese. In Rotherham - the area with the most people of excess weight in England - some 43.5 per cent of people were overweight, while 32.6 per cent were obese.’*

Figure 1.3 Daily Telegraph: England’s Obesity Hotspots (Kirk 2017)



Secondly, the local areas that make up the South Yorkshire sub-region (Barnsley, Doncaster, Rotherham and Sheffield) have been working to tackle obesity and have all made investments in activity.

Thirdly, this research and PhD is funded through the obesity theme of the South Yorkshire CLAHRC (Collaboration for Leadership in Applied Health Research and Care). Lastly, as a dietitian, public health practitioner, and provider of healthy lifestyle services I have worked in three of these four areas, as a public health dietitian in Doncaster (2000-2004), and in Rotherham and Sheffield leading and managing the obesity activity (2007-2012), and latterly providing services in Rotherham as Clinical and Operations Director of MoreLife (2015-2018).

The chosen sites therefore present an interesting and important opportunity to observe and analyse policy process and, as appropriate, present interesting points of comparison across the four areas. However, it is important to note that comparison was not the focus of the work. The policy process – understood in terms of the interaction between local perspectives, context and influences on decision-making, and what impact this has - is the main interest; rather than comparing across sites.

## 1.5 Personal catalyst for this research

Lincoln and Guba (1985) suggest that the values of the researcher in any study reflect the problem chosen to study, the choice of the underpinning theoretical framework guiding the data collection, analysis and interpretation. They argue that it is the responsibility of the researcher to demonstrate integrity of method through providing a clear and reflexive account of the research process, recognising how their own perspective influences the research. Denzin and Lincoln (2000) recommend researchers consider how their own past and present experiences may influence data collection and interpretation. In addition to the academic justification for the research, as discussed above, several personal and professional beliefs and experiences provided the impetus to embark on this study.

My roles and studies in nutrition, dietetics and public health have allowed me to access many health areas and provided me with the insight and experience of working in a number of roles clinically and in public health as both a provider and a commissioner across the NHS and local authority. From 2005-2007 I pursued a part-time Masters in Public Health, which raised my political and philosophical awareness about the principles of public health and the changes in NHS orientation at this time.

Over the last 20 years I have worked as a dietitian and in public health, often in obesity, in Doncaster, Rotherham, and, Sheffield, more recently as a Director of a company delivering weight management and health improvement programmes nationally and internationally, and as a consultant on the Leeds Beckett University (LBU) led Whole Systems Obesity Project funded by Public Health England (PHE). I decided to pursue this interest further in the form of doctoral studies. The catalyst for this study was a combination of reactive elements over time involving my professional roles and experiences; interaction and empathy with the issues experienced by those translating, formulating, and implementing policy locally; a change in national Government policy driving radical changes in the NHS and public health, and an awareness that the issues in which I was interested were part of a wider political context.

## 1.6 Structure of the Thesis

This section is included in order to guide the reader through this thesis. The next chapter provides further background information about national policy and public health in England; providing further information about the national policy change that was significant during this research in the form of the Health and Social Care Act 2012, about how local government is organised and functions relevant to how responsibility for addressing obesity is structured in England.

Chapter 3 moves on to a more detailed literature review. It starts by considering what we understand by policy and the different approaches in policy analysis literature and, in particular, health policy analysis literature with respect to obesity. This chapter reviews what is known and still to be explored in relation to obesity policy processes at national and local level. The chapter details the approaches used in existing academic literature with respect to obesity policy analysis, and the insights of these different bodies of literature and what these may offer to support answering the research question. The chapter concludes with the conceptual framework used, alongside the research questions and themes outlined in this introduction, linking the two and developing the conceptual framework from the relevant policy literature to form the theoretical foundation for this research.

Chapter 4 justifies the methodological approach and methods chosen; outlining the process of study design, discussing the case study approach taken, methods of data collection and analysis, emphasising the importance of reflexivity in the research process. Chapter 4 also explores underlying assumptions and limitations in the methods.

Chapters 5, 6 and 7 are three findings chapters, which examine and present the collective findings from both data sources for the four sites for studying the case in South Yorkshire (Barnsley, Doncaster, Rotherham, Sheffield), drawing out area similarities and differences where appropriate. In so doing, the findings chapters consider the elements of the Walt and Gilson Policy Analysis Framework (1994), in order, the content, context and process (aligned to the stages model (Sabatier and Jenkins-Smith 1993) of local obesity policy, examining perspectives of obesity policy stakeholder groups or actors (Elected Members and senior leaders in local authorities, public health/obesity commissioning leads, clinical commissioning group (CCG) representatives, and providers of weight management services).

The first findings chapter, Chapter 5, combines the findings of both documentation and interview data sources to discuss the content of local obesity policies. Chapter 6 highlights how the data sources (documents and interviews) revealed the national political and legislative context within which public health issues (including obesity) are addressed fundamentally shapes the way that local obesity policy processes operate. Chapter 7 moves on to consider the policy processes aligned to the stages model (Sabatier and Jenkins-Smith 1993) and considers the ways in which the national changes and subsequent associated local shifts, alongside the representations in use affect the more ‘day to day’ obesity policy activity being undertaken locally, from both a stakeholder perspective and documentary sources. The three findings chapters, together, seek to address the overall research question. Each findings chapter contributes towards understanding the local content, context, and processes, the perspectives of those involved locally, and how these collectively influence obesity policy processes locally, drawing on similarities and differences across the sites.

Chapter 8, the discussion and conclusion chapter of the thesis, discusses what these findings may mean. The discussion starts by exploring what ‘the problem’ of obesity is represented to be locally in the four areas of South Yorkshire and what assumptions underlie these representations. Following Bacchi’s WPR approach (2009), it then moves on to examine what is left unproblematic in the problem representations. The chapter then reviews how local representations of the problem have come about, and what effects are produced. Finally, the discussion explores how the dominant ‘problematisation’ could be questioned, disrupted and replaced in order to address the issue of obesity more effectively. The chapter considers the implications of the research for policy makers at both national and local levels in England, as well as recommendations for further academic research. The chapter details the strengths and limitations of the research, considering the extent to which the research question has been answered. The chapter concludes with the key conclusions of the research and outlines dissemination undertaken to date and planned.

# Chapter 2: Background

The introductory chapter has set out the rationale for this research into obesity policy process at a local level. In order for the research to be set in context, this chapter presents more background information about the national and local obesity policy context, including the changes to local public sector and public health roles and responsibilities that have ensued since 2010 that were introduced in Chapter 1. Key relevant national policy changes that occurred during this research that influence the local policy landscape are briefly presented, alongside a discussion regarding the implications of these policies and the local context that influences public health and, in particular, obesity policy process at a local level. The chapter then discusses how the public health functions within local government structures have changed, with what potential implications for addressing obesity at a local level.

## 2.1 The Localism Act (2011), Health and Social Care Act (2012) and the public health function

Chapter 1 has introduced that although national policy in England can set the framework for local action and may provide guidance, on issues like obesity, it does not detail which action or interventions must be undertaken or how to achieve the desired outcomes. Local authorities can interpret and implement national policy given the policy powers that they have under the Localism Act (2011). The Localism Act was introduced in 2011 as part of reforms introduced by the then Conservative-Liberal Democrat Government The Localism Act 2011 brought about a series of measures to shift or decentralise power and decision-making from central to local government, such as increasing local decision making and community accountability, allowing different ways of local authority working and structure, removing aspects of central oversight, increasing local budgetary control, allowing local areas more freedom over planning decisions and housing (Localism Act 2011). One exception in relation to local obesity policy is duties relating to the National Child Measurement Programme (NCMP), which is a statutory requirement.

The Localism Act (2011) was followed, in 2012, by the Conservative-Liberal Democrat Coalition Government’s Health and Social Care Act (DH 2012). The Act (2012) was brought about as a result of the Coalition Government’s aspiration to modernise the NHS to meet the rising demand and costs of providing treatment. The Act reformed the public health system by giving new duties and powers to local authorities and the Secretary of State for Health. Relevant changes from the Health and Social Care Act (2012) involved the dissolution of Primary Care Trusts (PCTs) and the formation of GP-led Clinical Commissioning Groups (CCGs), as well as the creation of local Health and Wellbeing Boards (HWBB). The roles and responsibilities of these ‘new’ local bodies are described below.

## 2.2 Roles and responsibilities within the ‘new’ public health system

Before the introduction of the Health and Social Care Act (2012), public health professionals were located in the NHS in the form of Primary Care Groups or Primary Care Trusts (PCTs). The responsibility for certain public health roles and functions (e.g Directors of Public Health (DPH), health protection and DPH reporting) was within this NHS system. The Health and Social Care Act 2012 sought to: increase the emphasis on public health and disease prevention; create a more joined-up system with clearer leadership; and have a greater impact on the wider determinants of health at local level by transferring public health responsibilities to local authorities. This created new roles, responsibilities and arrangements.

Under the Act, The Secretary of State for Health and Social Care is responsible for public health in England, and leads on health protection, with national functions and governance undertaken by a newly created central body: Public Health England (PHE). At a national level, PHE’s role is to bring together different elements of the system to deliver services to: protect the public’s health through a nationwide integrated health protection service; provide information and intelligence to support local public health services; and, support the public in making healthier choices (Health and Social Care Act 2012).

The Health and Social Care Act (2012) led to statutory responsibility for certain public health functions transferring to local authorities and with that key public health professional staff. Since 1st April 2013, all upper-tier and unitary local authorities in England have had statutory responsibility for improving the health of their local population and for public health services, focusing on achieving positive health outcomes for the population and reducing inequalities in health. While local authorities are largely free to determine their own priorities and services to achieve these broad aims, they are required to have regard to a national Public Health Outcomes Framework (PHOF) in terms of what they should be seeking to achieve locally (DH 2012; PHE 2013). The Public Health Outcomes Framework sets the context for the system, from local to national level, setting out the range of opportunities to improve and protect health across the life course. However, as aforementioned, despite the localised focus and freedoms, there are some statutory requirements for interventions that local authorities are mandated to provide locally, these are:

• ensuring appropriate access to sexual health services;

• ensuring NHS Health Check assessments are provided

• ensuring plans are in place to protect the health of the population;

• ensuring weighing and measuring children for the National Child Measurement Programme (NCMP) takes place; and

• providing public health advice to NHS commissioners.

The Health and Social Care Act (2012) sought to embed public health and public health personnel within all LA departments and activities with the aim to more fully address the wider determinants of health at a local level. To enable LAs to deliver these new public health functions, LAs and PHE are required to jointly appoint Directors of Public Health to occupy key leadership positions within the local authority and be statutory members of the Health and Wellbeing Board (HWBB). The DPH is the lead officer for health, with elected members and other senior officers expected to consult the DPH on all local health issues and services (DH 2012). DPHs have a public health team who works with them to execute public health functions. The organisation of these teams can differ across local authorities, with some having a centralised team model, and others having a more ‘distributed’ model across other sections of the LA (ADPH 2014).

As a direct outcome of the Act (2012) local authorities were funded (at the time of this research) for these public health roles and to carry out their public health functions through access to a ringfenced grant. Since the research has been completed, the ringfence has been removed and there is an intention to eventually fund public health through local business rates, but as yet this has not been implemented.

HWBBs were created as part of the Act and set up to be a forum to bring local public sector partner leaders together to improve health and wellbeing and reduce health inequalities; through an increasingly joined-up offer. HWBBs are the responsible body for ensuring health and social care issues are integrated in the interests of improving the health and wellbeing and reducing the health inequalities in the local population.

As aforementioned, the Act also led to other changes such as the dissolution of Primary Care Trusts (PCTs) and the formation of GP-led Clinical Commissioning Groups (CCGs), which hold the budget for NHS services at a local level and ensure clinical decision making. The NHS continues to play a critical role in securing good population health and works closely with local authorities to achieve the best possible outcomes for local people. The NHS also delivers specific public health services, such as childhood immunisations and national screening programmes, and is expected to make every contact count by using all opportunities to promote healthier living.

## 2.3 How local government works: structure and functioning

Having set out the roles and responsibilities of different stakeholders within the new public health system that was set up following the introduction of the Health and Social Care Act (2012), it is necessary to present how local government is structured and functioned, some of the challenges it faces and what this may mean for public health transitioning in and now subsequently within local authorities, and with specific reference to obesity.

All upper-tier, unitary and district local authorities, also known as local councils, are run by councillors, who are democratically elected by the local community. Councillors are responsible for making decisions on behalf of the local community about local services and budgets. Local council decision making is undertaken by both the executive and the non-executive (Local Government Act 2000). As the changes affecting public health are the responsibility of upper-tier and unitary local authorities, this section focuses on these organisations, and not district councils who do have public health responsibility and function differently, with differing responsibility to upper-tier and unitary local authorities (DH 2012).

The executive, made up of democratically elected councillors or elected members, includes the Leader and a Cabinet or Board. The executive is responsible for budget and policy development and implementation (Local Government and Public Involvement in Health Act 2007). The Leader is an elected member or councillor and is appointed for a four year term and determines the executive arrangements of the council, including delegation to Cabinet/Board Members, Committees and Officers. Members of the Cabinet/Board have responsibility for overseeing particular areas of the council’s activities known as portfolios. These are determined by the Leader of the council, and as a result of the Health and Social Care Act (2012), each portfolio holder is responsible for leadership of both the public and officers for the promotion and improvement of the health of the local community. The Cabinet/Board Members report to the full council on developments in their areas of responsibility and answer questions from other councillors. Councillors’ roles and responsibilities include: representing the area/ward for which they are elected; decision-making; developing and reviewing policy; scrutinising decisions; regulatory and statutory duties; community leadership and engagement.

The non-executive focuses on regulatory, constitutional and personnel-related matters. This role is undertaken by various committees appointed by the council and by officers in accordance with terms of reference and delegations. Council officers are paid, non-elected employees of the organisation. In general terms, council officers implement policy decisions made by councillors.

The Chief Executive is the council's chief officer and policy adviser and the link between council officers and elected members. The Chief Executive has authority over all council officers and is responsible for co-ordinating and planning council services and objectives; ensuring a corporate approach; implementing policy efficiently and effectively; and maintaining the council's relationships with other organisations (LGA 2017). Senior council officers within the council make up the corporate leadership team which oversees the development and delivery of all council services and is the main decision-making body which works alongside the councillors.

All Councillors, i.e. the full council, determine the annual budget, set council tax, and outline the policy framework. Proposals or recommendations are prepared by councillor portfolio holders in liaison with the appropriate supporting council officer(s). These proposals are submitted to the Cabinet for debate, approval or as the basis for consultation, including with the relevant Overview and Scrutiny Committee and, where appropriate, other Committees; and with the public and partner agencies as appropriate. Having received the feedback through consultation processes, the Cabinet finalises proposals and presents them to full council for approval and adoption. Once various policies have been approved, they are implemented in accordance within the framework of executive arrangements as determined by the Leader of the council through Cabinet, individual Cabinet members and by council officers (LGA 2017).

Although the above is a very generalised depiction of the decision-making structure and functioning of local authorities, in large and complex organisations such as a local council, it is not always practical for elected members/councillors to make all the necessary decisions. Employees of the council therefore have certain powers to make decisions delegated to them by the council or by the Leader of the council, and these matters are listed in a scheme of delegation. Other, more specific or ad hoc matters, may be delegated by the Cabinet or a committee, and agreement of the delegation will be recorded in the minutes of that meeting.

As introduced above, officers are non-elected members who support the elected members. The senior leadership of Chief Executive and directors are responsible for managing the activities of the council staff and for advising councillors on the potential implications of political decisions. Whilst the elected councillors receive advice and then approve the policies, officers then put them into practice.

These structures and functions are now considered with relevance to public health roles and responsibilities within the local authority.

## 2.4 Structures within local authorities relating to public health decision-making

### 2.4.1 The statutory lead role of the DPH

In terms of public health, as noted above, the DPH and team of public health officers are now within the local authority, with differing arrangements in terms of structure across LAs. The Health and Social Care Act (2012) detailed the intention that DPHs would be in a senior position reporting directly to the LA Chief Executive, however recognised that this could not be mandated. There were differing arrangements for DPHs and public health teams across the four LAs in this research. However, in summary, in Barnsley and Doncaster the DPH is part of the senior team reporting to the Chief Executive with a public health team still working as a standalone public health directorate. In Rotherham the DPH and team report into the Director of Adult Social Care now with all public health within that directorate. In Sheffield although the DPH does report to the Chief Executive the team is distributed throughout the other directorates. These differences reflect the diversity seen across England since transition. The Association of Directors of Public Health Survey (ADPH 2014) presented a varied picture, with many DPHs responding to say they were part of a people and communities’ team or equivalent (as seen in Rotherham), or in some cases part of a corporate directorate (eg in CEO’s office). The same survey also indicated that for public health teams there were many variations on a distributed or integrated model, such as the one seen in Sheffield. At the time of this research, and to date, there is little evidence as to the impact of the models on public health issues and outcomes, such as the PHOF.

### 2.4.2 The Public Health Outcomes Framework (PHOF)

As mentioned above, the Health and Social Care Act (2012) established the Public Health Outcomes Framework as a way to measure and benchmark public health focusing on outcomes not processes (PHE 2013). The framework guides the actions of the public health team and LA without removing the local focus of the Localism Act (2011) and Health and Social Care Act (2012), as described above. The framework focuses on the two high level outcomes across the public health system and beyond:

1. Increased healthy life expectancy

2. Reduced differences in life expectancy and healthy life expectancy between communities

These two overarching indicators are then represented by four underpinning domains which within each have a set of supporting indicators (grouped into the four domains) that help focus local activity and understanding of how the overarching aims are being achieved. Each LA reports on these quarterly, these are measured and monitored within LAs, published and can be benchmarked. The four domains are:

1. Wider Determinants
2. Health Improvement (these obesity indicators are within this domain)
3. Health Protection
4. Healthcare and Premature Mortality

### 2.4.3 Governance & Accountability

As above, the Act (2012) also created Health and Wellbeing Boards (HWBBs) as a statutory executive committee of the council (LGA 2019). HWBBs role and responsibilities include: ensuring resources to support health improvement and quality of life are used efficiently; to produce a Joint Strategic Needs Assessment of the health and wellbeing needs of the local population; and develop a joint health and wellbeing strategy to provide a framework and priorities for commissioning plans for the NHS, social care, public health and other related services. The HWBB also brings together the commissioning activities of local health bodies and the local authority where this aligns with delivery of the joint strategy, seeking value for money and equity of access and outcomes.

The statutory membership comprises at least one councillor of the local authority nominated by the Leader of the council; the Directors of Adult Social Services, Children's Services and Public Health of the local authority; a representative of the local Healthwatch; a representative of the Clinical Commissioning Group(s) (CCG), the NHS Commissioning Board (for specific purposes) and such other persons as the Board, or the local authority after consulting the Board, thinks appropriate.

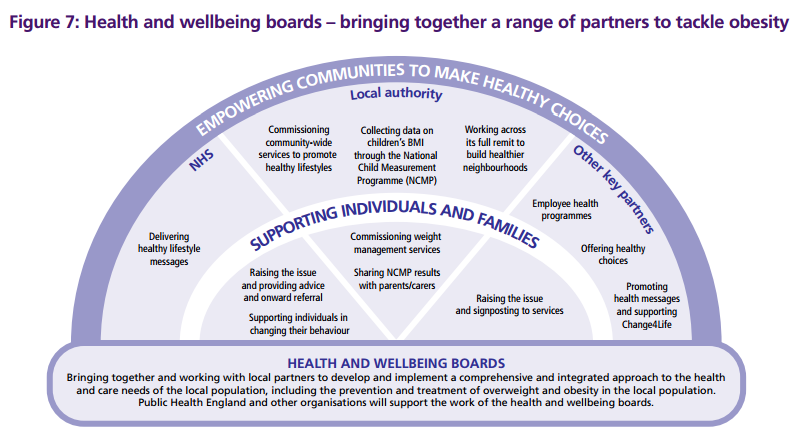
The Health Overview and Scrutiny Committee (HOSC) has a key governance and accountability role, discharging the statutory health scrutiny functions of the council. The Committee scrutinises local health services (partners, key contractors and service performance), oversees the Health and Wellbeing Board, and also the services provided by the council’s Adult Services and Children’s Services Directorates. This Committee and the HWBB are supposed to ensure decisions are made in the best interests of the local population and with appropriate scrutiny, governance and accountability to deliver effective and efficient outcomes, taking regard of the PHOF.

## 2.5 Local structures relating specifically to obesity

The above background information has focused on general public health changes and roles and responsibilities. It is also important to understand local structures and roles relating specifically to obesity. Under the changes brought about by the Health and Social Care Act (2012), public health in LAs is now responsible for addressing unhealthy weight in the population in both children and adults. Although obesity prevention and/or treatment (other than the NCMP) are not mandated or ‘prescribed’ public health functions for LAs to undertake since the transition of public health from the NHS, obesity is listed in the non-prescribed activities, on which the ‘ring-fenced’ public health financial allocation may be spent (Health and Social Care Act 2012). LA areas can choose to prioritise obesity locally and act accordingly. However, as aforementioned, the weighing and measuring of children through the National Child Measurement Programme (NCMP) is a mandated activity.

Figure 2.1, from Healthy Lives, Healthy people (DH 2011), presented potential roles for various bodies’ in the management of obesity at a local level as a result of the Health and Social Care Act (2012). For example, suggesting that local authorities should be responsible for commissioning local programmes to prevent and address overweight and obesity, such as weight management services and undertaking the NCMP. However, the guidance also referenced that the local NHS would provide advice and support referral to programmes, as would other partners, all supported by the HWBBs ensuring a joined up local approach.

Figure 2.1 Health and wellbeing boards – bringing together a range of partners to tackle obesity (DH 2011: 30)



Although different roles and responsibilities at a local level are put forward for obesity, the detail was required to be worked out locally (excepting responsibility for NCMP).

### 2.5.1 General Public Health Challenges

As mentioned in the Introduction to this thesis, limited research has been conducted on local obesity policy in England. However, the seminal PHOENIX Report (Peckham et al. 2016) focused on the new structures, roles and responsibilities for public health set out above, with specific reference to obesity. This Report identified some key issues relating to the transition of public health into LAs as a result of the Health and Social Care Act (2012): transition and adjustment; the role of HWBBs; financial challenges; and, decision making in local authorities. These are discussed below in turn, with reference to wider literature, in order to provide further background information of relevance to this research.

As aforementioned, the Health and Social Care Act (2012) led to transition of the majority of public health roles and staff to the LA from the NHS. A RSPH workforce survey (2014) identified the impacts of transition both positively in terms of the opportunities to influence across the wider determinants of health, and negatively, in terms of a concern over loss of specialist public health skills; the value of public health in local authorities and concerns over the use of the public health ring fenced grant. A survey of DPHs (Jenkins et al. 2016) revealed that some DPHs perceived that they had greater influence in LAs since transition, but that many DPHs equally perceived they have limited influence, with ongoing concerns that further public health restructuring may hinder influence. The experiences of transition of staff and adjustment into new structures is explored in this research.

As described above, Health and Wellbeing Boards were created through the Health and Social Care Act (2012). At the time of this research, Health and Wellbeing Boards were nationally recognised as still in their relative infancy in terms of development, and therefore variable in their activities. The Local Government Association (LGA) commissioned Shared Intelligence (Si) to review HWBBs, with four reports produced to date: *The Power of Place* (published April 2017), which recognised the journey Health and Wellbeing Boards have been on since their first report, *Great Expectations* (April 2014); followed by *Stick With It!* (February 2015); and, *The Force Begins to Awaken* (March 2016). The LGA’s conclusion in their fourth report (2017) was that more effective boards have continued to develop, but that some boards are still struggling. The picture of the less effective boards was one of ‘ticking a box’ and enabling locally rather than leading change, as intended from their role and function. This is explored as part of the research across the LAs involved.

In 2008 there was a much publicised national recession with associated public sector budget cuts, relevant to this research these included cuts across the NHS and LAs (ONS 2018). The 2010-15 Conservative-led government’s post-2008 financial crisis austerity programme was accompanied by a discourse that embraced a neo-liberal desire to reduce the state sector and further associated budget cuts. The impact of cuts in growth, cuts in public sector spending, a reduction in services at a time of increasing demand, lead to choices about prioritisation in a financially challenged sector (NHS confederation 2009; CLES 2011). The impacts of this on LAs prioritisation for addressing obesity is explored in this research.

Kneale et al. (2017) and Atkins et al. (2017) have reviewed what the transition of public health from the NHS to local authorities may mean in terms of public health decision making in these new organisational structures, systems and processes. Kneale et al. (2017), in their systematic review, examined research evidence use in decision-making and what impact working in a new political environment may have on public health decision-making. Kneale et al. (2017) identified: the value LAs place on local evidence and local evaluation evidence, and, the key role of local experts, despite potential issues with rigour in this evidence. Barriers included issues of access and availability of applicable research evidence, and an understanding that evidence could be perceived as a bureaucratic process. Kneale et al. (2017) also identified that since transition to local authorities, public health practitioners were keen to emphasise the uniqueness of their area and structures, and, various challenges as a consequence of higher levels of local political accountability.

The Atkins et al (2017) paper, on influences on implementing public health evidence-based guidelines in English Local Government, supports the Kneale (et al. 2017) systematic review findings, as Atkins (et al. 2017: 4) found the key influences to be:

*‘1. Role of context in implementation—budget, capacity and political influence were important influences on implementation.*

*2. Limitations of research evidence—the concerns expressed about guidelines included that recommendations are presented in the abstract, lack specificity and do not address complexity or local variation.*

*3. Using local evidence—local evidence was seen as very important, being used to provide context for recommendations and sometimes being used instead of recommendations when they conflicted with local evidence.’*

Adding that, ‘*In order to make guidance more relevant to local government, a demonstration in guidance of costs saved to local government budgets may support implementation of* [public health] *recommendations.’* (Atkins et al. 2017). This use of evidence in LAs is explored as part of this research into understanding local obesity policy process.

### 2.5.2 Resource reduction, gaps in pathways and partnership working

In relation to obesity specifically, the PHOENIX Report identified particular issues relating to obesity policy processes: resource reduction; gaps in pathways; and, partnership working (Peckham et al. 2016). Since the transition of public health responsibility to local authorities, concern has been raised about the reductions in public health allocation and spending (Kings Fund 2019) and specifically public health spending on obesity (HOOP 2014; 2015). The literature raises concerns over the use of this ring fenced grant on public health issues, or whether it is used more widely across LA issues; and concerns about what interventions are implemented locally, including their reach within local populations (Iacobucci 2014; 2014a; RSPH 2014).

Gaps have also been highlighted in the Obesity Care Pathway (see Figure 1.2) (DH 2013a), as the original guidance (Healthy Lives, Healthy People) did not make clear who should be responsible for commissioning and providing each tier of service (DH, 2011). There was some suggestion that local authorities should be responsible for commissioning local programmes to prevent and address overweight and obesity, such as weight management services. However, the guidance also referenced that the local NHS would provide advice, prescribe anti-obesity medicines and obesity treatment, with bariatric surgery commissioning devolved to CCGs. HWBBs were identified by DH in Healthy Lives, Healthy People (Figure 2.1) as crucial to ensuring joined-up investment and commissioning; with little known currently about this in practice. This issue was highlighted in the Joined Up Clinical Pathways for Obesity consultation document (NHS England and Public Health England Working Group 2014); emphasising the lack of clarity and need to establish who should fund the various tiers of the Obesity Care Pathway: NHS England, Clinical Commissioning Groups (CCGs) or Local Authorities. During the timing of this research, it was concluded that the provision of Tier 1 and Tier 2 services for children and adults should be LA responsibility, with Tier 3 services for adults the remit of CCGs. The responsibility for Tier 3 services for children remained unspecified. Tier 4 bariatric services for adults were to remain the responsibility of NHS at a local CCG level.

The lack of clarity in funding and responsibility remains. A Local Government Association report (LGA 2018) found that of the 85 out of 152 LAs that responded (56%), 65 of the 85 areas had LA commissioned tier 2 adult weight management services. For tier 3 adult weight management services, 6 of these were LA commissioned and 45 CCG (NHS) funded (the others had unclear responses). This is an interpretation of the responsibility as outlined in Healthy Lives Healthy People (DH 2011), that outlined that LAs were responsible for all weight management except bariatric surgery, clearly demonstrating the NHS seeing their role in tier 3 services.

Building on the issues of financial challenge and clarity of roles and responsibility, partnership working has been identified as an issue across public sector bodies involved in tackling obesity such as the local NHS and LA (RCP 2013; LGA 2015). Partnership working has been a persistent issue within the public health system since the early 2000s. The last major shift was the introduction of the Provider/Commissioner split, which led to a division of roles in the NHS to either a commissioner or provider of services. Providers can be NHS or independent private or third sector, and are responsible for delivering the services that commissioners design through specifications, and awarded through a tender process, with monitoring to the outcomes required within a financial envelope. LAs in England can be both a provider and a commissioner. However, in terms of public health specifically, public health is a commissioner of weight management services from provider organisations. This Provider/Commissioner split role in the NHS had led to issues for sharing and working together between providers and commissioners (NHS Providers 2017).

## 2.6 Different Perspectives in Public Health

As a final section in this background chapter, it is perhaps useful to consider different perspectives in public health that identify different priorities and assign causality in different ways; these relate to the frames introduced as part of the rationale for this research in Chapter 1 and which are expanded upon further in the next chapter (Chapter 3). Here, it is useful to recognize that public health has evolved as a discipline with differing perspectives often informed by people’s values, experiences and ideologies, and by their sets of assumptions about the social world - rather than there being one shared understanding.

Societal changes and improved knowledge have led to evolution in public health as a field. Initially a largely technocratic discipline focusing on housing, sanitation, clean water and adequate food, famous historical public health activities include identifying water carries infectious agents and responding by removing the ability to use the infected water and providing clean water. This was followed by a focus on individual approaches to prevention; including the introduction of immunisation and vaccination. Later, public health focus was on identifying that some ‘risky’ health behaviours (smoking, alcohol consumption, lack of physical activity, unhealthy diets) cause ill health and informing people that their behaviour is causing harm assuming this leads to a change in behaviour. The emphasis in these activities was on providing information and support to enable individuals to take responsibility for their health.

However, the "new public health" (Baum and Fischer 2014) recognises that there are wider influences on behaviour than the behaviour itself and that informing people does not often likely lead to health behaviour change. A wider sociological and ecological perspective on what leads to health behaviours may provide a greater understanding of the complexity of public health as an endeavour that is informed by people’s values, experiences and ideologies.

Health and wellbeing of both individuals and populations across all age groups is influenced by a range of factors both within and outside our own influence. Figure 2.2 presents the Dahlgren and Whitehead (1991) 'Policy Rainbow' depicting the contributions and interactions of all the recognised determinants of health, i.e. individual behaviour and wider social, environmental and economic determinants to health. There are fixed factors, such as age, sex and genetics and potentially modifiable factors presented in the diagram as a series of layers of influence including: lifestyle, the physical and social environment and wider socio-economic, cultural and environment conditions.

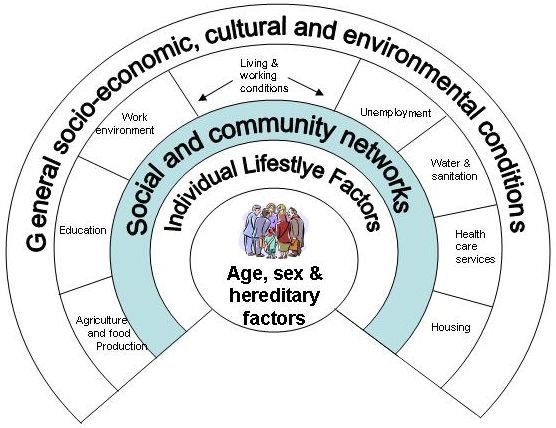


Figure 2.2 The ‘Policy Rainbow’ A Social Model of Health (Dahlgren & Whitehead 1991)

Baum and Fisher (2014) argue that public health policy has two dominant perspectives on prevention of ill-health. A focus on individualised unhealthy behaviour, and/or, a focus the wider social and economic factors that underpin behaviour. They argue that health policy is dominated by interventions at the individual behaviour level, with fewer addressing the wider determinants.

When specifically focusing on the topic of interest in this research, i.e. obesity and unhealthy weight, Ewert (in Ewert and Loer 2019) argues that policymakers have perspectives or theories about both the causes and solutions that they draw on to create policy. Ewert (in Ewert and Loer 2019) reflects Kersh’s perspective (2009) that there are two dominant underlying assumptions in obesity causation – the individual diet and physical activity choices, and, the wider environmental influences, termed "obesogenic environment" by Egger and Swinburn in 1997. Ewert (2019) goes on to support Barry (et al. 2009) and Swinburn’s (2016) view that there needs to be a continuum of perspectives and subsequent policy approaches to address change and both the individual and structural level (as has been seen with smoking, for example). However, identifies that there are significantly more interventions at the individual level addressing behaviour than wider determinants addressing structural and contextual factors.

Bacchi (2009), Barry (et al. 2009) and Ulijaszek (2018) all argue that what is done about an issue can reflect how the issue is thought of and vice versa. This research is interested in how obesity is thought of as an issue at a local level, recognising the frames in use in the literature and seeking to understand these at a local level across South Yorkshire to achieve the aim of this research, to better understand the local obesity policy process. Understood in terms of the interaction between local perspectives, context and influences on obesity policy decision-making with respect to agenda setting/prioritisation, policy formulation, implementation, and what impact this has.

# Chapter 3: Local Obesity Policy in Practice: A review of existing literature

## 3.0 Introduction

As introduced in the previous chapters, the purpose of this research is to explore how national obesity policy is translated, formulated and implemented at a local level by senior leaders, public health teams and commissioners and service providers, and, what implications this has in terms of successfully addressing obesity locally. More specifically, examining how obesity policy has been translated, formulated and implemented in one sub-regional area of England – South Yorkshire (i.e. Barnsley, Doncaster, Rotherham, and Sheffield).

The overall aim of the research is to better understand local obesity policy processes ‘at work’ and the key factors that are influencing these. The academic starting point is policy analysis literature and, in particular, health policy analysis literature with respect to obesity. This chapter narratively reviews policy analysis literature in relation to the following key questions:

1. How does existing policy analysis literature approach policy processes?
2. What theories about the policy process are present in this literature?
3. What does existing policy analysis literature tell us about the factors that may be important within local obesity policy processes?

As alluded to in the introductory chapter, this chapter presents an argument that existing, ‘mainstream’ health policy analysis literature, and specifically the literature focusing on obesity, tends to focus on specific issues and outcomes, not policy *processes*. It concentrates on the ‘what’ of policy, leaving key questions about the ‘how’ and the ‘why’ of policy unanswered (Brennan et al. 2011; Clarke et al. 2016). The chapter identifies a body of more critical and interpretive policy analysis literature, as well as ‘systems-thinking’ approaches that offer important insights about the drivers and contextual factors shaping policy processes which are of relevance to this thesis. The former literature specifically draws attention to the framing of obesity in policy processes and to issues such as the representation of obesity in policy; the context in which representations of obesity are operationalised, and, what this operationalising of a representation in context means for how issues like obesity are addressed. The latter ‘systems thinking' literature highlights the wider approaches that are currently being examined to support understanding of obesity and key drivers and levers for change across the whole ‘system’.

The chapter starts by presenting the method for the literature review before discussing definitions of policy and policy processes. It then reviews the contributions of different policy analysis literature, to explore what insight it offers to understanding how national obesity policy is translated, formulated and implemented locally by senior leaders, commissioners and service providers, as well as gaps.

## 3.1 The methods used in the narrative literature review

The aim of this review was to provide a broad overview of relevant policy analysis literature. A preliminary scoping search of the literature was carried out (in PubMed, ASSIA, google scholar, web of science) which searched terms of initial interest, in order to identify seminal policy analysis texts and key authors. This initial search supported clarification of key search terms and inclusion/exclusion criteria. A more detailed search was subsequently completed, and undertaken repeatedly at frequent intervals, which took an iterative approach throughout the time span of the thesis. As above, the review sought to answer the following questions:

1. How does existing policy analysis literature approach policy processes?
2. What theories about the policy process are present in this literature?
3. What does existing policy analysis literature tell us about the factors that may be important within local obesity policy processes

A search strategy was developed from the SPICE (Booth 2006) framework and search undertaken, via extensive use of electronic databases (such as CINAHL, Cochrane, ProQuest, Web of Knowledge, White Rose e-theses and Research) including those utilised for identifying grey literature. There was also extensive, and in fact primarily hand searching of citations and references of potentially eligible studies, alongside recommendations from key contacts such as supervisors and those working in the field known to the researcher professionally, as well as references that were identified in the course of the researcher’s professional roles outside of the PhD studies.

All results, irrespective of source, were screened to ensure eligibility against the set inclusion and exclusion criteria (see below). A quality assessment of each included study using the CASP tool (Critical Appraisal Skills Programme 2014) for qualitative studies was undertaken. Data was extracted and thematic synthesis performed in order to integrate the findings of multiple qualitative empirical and non-empirical studies, i.e. editorials, non-peer reviewed literature i.e. theses. This process was repeated at least monthly over the period of this research (more than 8 years), as this is an iterative narrative review of the literature aligned to the length of time this research has been undertaken. An iterative approach, using the terms in the table (below) was employed and a database of the relevant papers maintained throughout the thesis. This was repeated periodically, with searches redone to update the literature as new sources emerged. The findings from the searches were synthesised, employing thematic synthesis based on guidance from Thomas and Harden (2008), across the full length of the thesis undertaking, 2011 – 2019.

The criteria, firstly for the policy analysis literature was as Table 3.1 below, focusing on the three questions above:

1. How does existing policy analysis literature approach policy processes?
2. What theories about the policy process are present in this literature?
3. What does existing policy analysis literature tell us about the factors that may be important within local obesity policy processes?

**Table 3.1 - Search terms derived from the developed SPICE framework (Booth 2006) for Policy Analysis Literature Review Search**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Setting (S) | **AND** | Perspectives (P) – explicit reference to & inclusion of | **AND** | Interest, Phenomenon of (I) – explicit reference to & inclusion of | **AND** | Evaluation (E) | Comparisons (C) |
| Health  Community  Healthcare  Public Health  Government  Local Government  UK  Non UK | Actors  Stakeholders  Policy makers  Local  National  Public Health | Policy,  health policy,  Policy Processes, policy analysis,  Decision making  Policy making  Rational policy  Interpretative policy  Policy analysis methodology  Policy implementation  Policy framework  Systems thinking | Perspective  View  Attitude  Framing  Understanding  Experience  Problematised  Representation | N/A |

**Inclusion**

Study types: Empirical qualitative studies and mixed-methods studies (inclusive of qualitative findings that can be extracted), non-empirical studies, i.e. editorials, non-peer reviewed literature i.e. theses

Language: English language studies

**Exclusion -**

Setting: non healthcare/public health

Perspective: Other stakeholders’ perspectives without reference to public sector bodies ie local government, healthcare

Phenomenon of interest: non health/ public health

Study types: Quantitative studies

Language: Non-English language studies

Secondly, existing literature about how national and local obesity policy processes work was reviewed – more specifically: how is obesity represented in national and local policy, what the literature offers in terms of analysis of operationalising this representation of obesity in context, and what this context may be, as well as, what it means for how issues like obesity are addressed. The search strategy is presented below in table 3.2.

**Table 3.2 - Search terms derived from the developed SPICE framework (Booth 2006) for Obesity Policy Analysis Literature Review Search**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Setting (S) | **AND** | Perspectives (P) – explicit reference to & inclusion of | **AND** | Interest, Phenomenon of (I) – explicit reference to & inclusion of | **AND** | Evaluation (E) | Comparisons (C) |
| Health  Community  Healthcare  Public Health  Government  Local Government  UK  Non UK | Actors  Stakeholders  Policy makers  Local  National  Public Health | Obesity,  Healthy Weight,  Overweight,  Childhood,  Adult,  Prevention,  Treatment,  Policy,  health policy,  Policy Processes,  Framing, policy analysis,  Decision making,  Policy making,  Rational policy,  Interpretative policy,  Policy analysis methodology, Agenda Setting,  Policy formulation, Policy implementation,  Policy framework,  Systems thinking | Perspective  View  Attitude  Framing  Understanding  Experience  Problematised  Representation | N/A |

**Inclusion**

Study types: Empirical quantitative, qualitative studies and mixed-methods studies (inclusive of qualitative findings that can be extracted), non-empirical studies, i.e. editorials, non-peer reviewed literature i.e. theses

Language: English language studies

**Exclusion -**

Setting: non healthcare/public health

Perspective: Other stakeholders’ perspectives without reference to public sector bodies ie local government, healthcare

Phenomenon of interest: non obesity related, dietary or physical activity behaviours only (without explicit reference to obesity or obesity prevention, treatment)

Language: Non-English language studies.

The synthesis of the literature review is presented in the remainder of this chapter.

## 3.2 Understanding policy and policy analysis

This section discusses what is meant by the terms policy and policy processes. ‘Policy’ can be understood in many ways (Hogwood and Gunn 1984). There is no single accepted definition. Generally, however, there is agreement in existing literature that policy pertains, in some way, to government, choosing which problems to solve, and choosing how to solve them, and, utilises knowledge and values as a basis for policy-making (Milio 2001; Colebatch 2002; Tones and Green 2004; Smith 1976).

Cairney (2012) recommends that instead of pursuing a definition, when seeking to understand policy, addressing a series of questions will help researchers make sense of policy; for example, asking what do policymakers do and also *not* do; what do policymakers say they will do as well as what they actually decide to do; what are the effects of decisions as well as the decisions themselves and, within this, considers what ‘the government’ is, i.e. whether or not it includes elected and unelected policymakers? These are useful guiding questions for this research.

Just as a definition of policy is a contested issue, so is an understanding of policy analysis, discussed below.

## 3.3 Analysis of and for policy

Policy analysis is often understood as comprising two different approaches (Gilson, Orgill and Shroff 2018). Either as the analysis **of** policy processes: how problems are defined, agendas set, policy formulated, decisions made and policy evaluated and implemented or as the analysis **in** and **for** the policy process, which involves the use of analytical techniques, research and advocacy in problem definition, decision-making, evaluation and implementation.

Analysis **of** policy is retrospective and descriptive, examining a particular policy – why and how it got on the agenda, the decision-making processes, the content of the policy and whether or not and why it achieved its goals, including with what effects. Analysis **for** policy is prospective and used to inform future policy making. This research focuses on the first – analysis of policy - examining obesity policy in order that this analysis may lead to better understanding for future policy in this area.

Overall, the health policy analysis in this research is concerned with what influences local obesity policy processes – who, when, why and how, and with what consequences.

## 3.4 Policy Analysis Framework (Walt and Gilson 1994)

In the field of health policy analysis, the Policy Analysis Framework or ‘Policy Triangle’ developed by Walt and Gilson (1994) is a widely cited way to assist the understanding of policy and processes, at local, national or global levels. The Triangle consists of four core elements: Content, Context, and Process, with Actors (Walt and Gilson 1994; Figure 3.1).

Figure 3.1 Policy Analysis Framework (Walt and Gilson 1994)

Context

Actors

Process

Content

**Content** is the ‘what’ of policy, i.e. what is in policy documents and also what policy actors say is being done about an issue.

**Actors** in policy can be a number of things, such as, who sets the agenda, and once set, who influences the path taken (Colebatch 2002; Walt 1994; Tones and Green 2004; Buse et al. 2005). In policy-making there may be many participants with varied agendas, one of the tasks of policy making is pulling these together. Policies develop through the actions of identifiable players, groups who are affected by the policy and who believe they can make a difference in the policy choices that affect them. The literature (Colebatch 2002; Walt 1994; Tones and Green 2004) is inclined to suspend judgement about who ‘makes’ policy and focuses on identifying participants in the policy process. The participants (or those not included) affect how the issue is framed, and, how the issue is shaped affects results or policy outcomes.

**Context** focuses on the wider situational and structural factors that affect the policy - political, economic and socio-cultural factors that have been identified as affecting policy (Buse et al. 2005).

The **Process** of policy-making examines agenda setting (including how ‘the problem’ is defined); what and how decisions about the issue are made and implemented; and policy evaluation. The ‘stages model’ of policy as a heuristic device (Sabatier and Jenkins-Smith 1993) is one way to understand policy ‘processes’. These are:

* Problem identification or agenda setting, including problem definition;
* Policy formulation;
* Policy implementation; and,
* Evaluation.

Walt and Gilson (1994) highlight that these four elements interact in complex ways, but put forward the framework as a useful heuristic device to help simplify complex realities. Given its wide use and value in this way, the framework has been used in this research to help analyse and structure the findings about local obesity policy processes across South Yorkshire.

However, other literature is also relevant. Perhaps unsurprisingly, given that there are different ways to understanding policy, there is also a broad policy analysis literature, which provides different theories and insights into policy processes. Key examples of these are discussed below and the relevance of each to this research are considered, before moving on to outline and discuss more specific obesity policy analysis literature of relevance to this study.

## 3.5 Understanding policy analysis literature

There are the more traditional or ‘rational’ policy stages approaches to understanding policy processes (Sabatier and Jenkins-Smith 1993; Jimenez et al. 2014), as well as more interpretative approaches to understanding policy (Stone 2001; Bacchi 2009). However, this is not an either or approach and the extensive field of policy analysis and literature includes a full range of approaches and perspectives (Gilson, Orgill and Shroff 2018).

Early policy analysis focussed on understanding policy-making as a rational and linear process, with issues identified, policy goals established and alternative policy options considered and compared, with policy-makers choosing the alternative that maximizes the achievement of their goals (Hogwood and Gunn 1984). This is known as the “policy stages” model or “the stages heuristic” (Sabatier and Jenkins-Smith 1993).

Over time, there has been recognition that policy-making is a complex socio-political process and that different ways of analysing policy support this understanding (Gilson, Orgill and Shroff 2018). Some of these are presented below in order to outline what the different approaches or understandings of policy analysis literature may offer to this research into local obesity policy processes.

### 3.5.1 Policy Stages or Stages Heuristic (Sabatier and Jenkins-Smith 1993)

Sabatier and Jenkins-Smith (1993) developed the theoretical ‘Stages Heuristic’ model, to help our understanding of the policy process. The stages they defined are:

1. Problem Identification
2. Policy Formulation
3. Policy Implementation, and,
4. Policy Evaluation.

This model views the policy process as a series of interconnected stages, each with particular activities and products or outputs. Although, this is an over-simplification of how policy is made and implemented in the ‘real world’, it is considered useful framework through which to structure an examination of policy (Cairney 2012).

The rational approach is exemplified in literature that refers to the ‘policy cycle’, or the ‘Stages Heuristic’ model (Figure 3.2, Sabatier and Jenkins-Smith 1993), which presents policy making as an organised process, with specific steps (listed in Figure 3.2 below) and specific goals. This rational model of policy making starts with problem identification, where a problem (such as obesity) has received attention and gets on the ‘policy agenda’. Agenda setting as a policy process is generally understood to be about identifying problems that require attention, prioritising issues for action and also defining the issue or problem (Buse et al. 2005; Cairney 2012). A number of factors are generally recognised in policy literature as influencing whether or not issues get onto an ‘agenda’ of a body such as national or local government. Generally, these are related to changes in context that enable (in)action on an issue (Buse et al. 2005; Cairney 2012). The way in which issues are framed by stakeholders is also critically important within agenda setting processes – the chapter will discuss framing in more detail in section 3.13.

Agenda setting is followed in the Stages Heuristic model by policy formulation: those involved i.e. actors; and the activities involved in formulating realistic policy proposals or the content i.e. policy actions. The subsequent implementation stage is about translating the policy into action to resolve the initial problem. The last stage is evaluation, which determines the extent to which the implementation of the policy has resolved the underlying policy problem.

Figure 3.2 The Stages Heuristic (Sabatier and Jenkins-Smith 1993)

However, this is not the only model, there have been a number of Policy Cycles developed to assist in the analysis of policy. Hogwood and Gunn (1984) have developed one such model in which they outline the following stages:

* Deciding to decide
* Deciding how to decide
* Issue definition
* Forecasting
* Setting objectives and priorities
* Options analysis
* Policy implementation, monitoring and control
* Evaluation and review
* Policy maintenance, succession and termination.

Furthermore, Cairney (2012) synthesises the stages models work for the UK into the stages presented in Figure 3.3 below, adding in the steps of legitimation and maintenance, succession or termination.

Figure 3.3 The Generic Policy Cycle (Cairney 2012)

Like Walt and Gilson’s (1994) Framework above, these stages models are useful as they are organising approaches that help policy researchers to disaggregate policy processes and facilitate analysis in a more in-depth way (Hill 2009).

Nevertheless, stages models have been criticised for reflecting a normative approach to how ‘should’ proceed rather than focusing on how it does occur in practice; which has been highlighted as unrealistic (Cairney 2012). Indeed, it has been argued that policy cycles does not adequately reflect the complexity of the policy process, nor offer explanations about what happens and why – such as how issues get on the agenda, how problems are defined, the actors and content of the policy and why decision are made (Cairney 2012), as is the focus of this research. Despite this, it does provide a means of structure the analysis of policy (Cairney 2012). Whichever framework or structure is employed to analyse policy, it is important to acknowledge that analysis of policy is difficult due to the fact that the analyst must interpret and draw inferences from the data they are permitted access to and therefore; the analysis is only as good as the sources accessed. The analyst’s own interpretation and perspective is also an important factor to consider in policy analysis. Whether we see policy as a rational process or not, and if not, how the policy process is viewed, is important in terms of how we analyse policy.

### 3.5.2 Criticisms of the policy cycle

As discussed above, whilst some authors view policy making as a rational process, organised, with specific goals (Simon 1945; Parsons 1995; Bochel and Bochel 2004), others argue that although it may be desirable for policy making to be seen like this, whether it actually is or not is an area for debate (Hill 2009; Cairney 2012). Those who see policy making as rational understand the process generally as follows, as presented above (Cairney 2012):

1. Identification of policy-maker aims
2. Formulation of policies to achieve those aims
3. Selection and legitimation of policy measures
4. Implementation
5. Evaluation

However, this model is recognised as a theoretical model rather than real world example, it has been criticised as a difficult model to apply in the public sector because social problems tend to be complex, ill-defined and interdependent in nature (Cairney 2012). Equally, critics (such as Cairney 2012) argue that the world is more political and complex than this approach understands, offering other policy analysis literature that seeks to deal with and understanding this complexity. Alongside this, the model does not allow for self-interest or political pressure to influence the decisions taken, nor to really understand the how’s and why’s of policy processes (Cairney 2012). Therefore, out of this rational process, bounded rationality has emerged for policy making in the real world, in so far as it is a rational process but within the constraints of time, information, and ability to recognise and explore the consequences of every solution.

Lindbolm (1959) is another critic of the rational model approach and instead sees the process as a series of small incremental steps favouring the status quo. Small changes from what currently exists occur, enabling support to be gained from the majority, as the change is not too radical in its approach, and for alterations to be made quickly where the changes have been found to be unsuccessful. Although this is a more real example of the policy making process, a criticism of this model is that it is too conservative in its approach and therefore does not account for the process that allows for radical reforms in policy (Hill 2009).

Rational approaches to policy analysis appear to present that there are knowns which are empirically understood and measurable. These approaches often focus on the content or the ‘what’ of policy in analysis, understanding knowledge used in policy as scientifically based, offering insights into causes, effects, the nature of the relationship, and, scale, and that it is this knowledge that is important in the analysis – i.e. the ‘what’ (Buse et al. 2005; Cariney 2012). Many examples of national obesity policy evaluations reflect this more rational perspective, such as Jebb et al. (2013). Although this more rational obesity literature offers important insights into what is being done or proposed, such as Jebb et al. (2013), a key criticism of this type of ‘rational’ approach is that it does not account, nor allow for, contextual, political, and, social factors to be considered as influencing policy processes, including the decisions that are taken (Lindbolm 1959; Cairney 2012). Equally, there is little consideration of the environment in which policy choices are made, which might constrain and/or facilitate choice, and which might mean that there is a level of uncertainty and ambiguity about the issue itself (Cairney 2012).

This research seeks to understand some of these wider contextual, political, and, social factors that may influence policy (Buse et al. 2005). It is important to understand the context in which policies are made and implemented as it is important to understand the process, content and actors involved, as all elements affect and influence each other, and in turn influence the policy formed and how it is subsequently implemented, therefore worthy of investigation (Walt and Gilson 1994).

The rational model does however, underpin the notion of stages in policy making, no discussion of policy theories would be complete without it, and therefore is the basis to the structure of this chapter. However, this type of stage approach and associated analysis of policy process literature offers only a partial insight into the ‘how’ of policy making and the context that shapes the policy making process (Cairney 2018). As discussed above in the critiques offered, some policy analysis literature reflects that the world as more political and complex than the stages model supports and it is this literature that seeks to deal with and understand this complexity (Cairney 2012). Before moving on to discuss the different approaches to policy analysis, using the stages model or Stage Heurist (Sabatier and Jenkins-Smith 1999) for structure, the chapter first address the issues of power or for the purposes of this research, influence in policy processes.

## 3.6 Power in the policy process

Hill (2009) and others (Cairney 2012) recommend, that any study of the policy process should consider the nature of power, as examining the policy process is a study of politics, and the study of politics is about power – how it is acquired and used (Walt 1994; Hill 2009; Cairney 2012). There are full texts on this and therefore this is only briefly presented here within this literature review, with relevance to the research topic of this thesis.

### 3.6.1 Power

*‘Health policy is about process and power…it is concerned with who influences whom in the making of policy and how that happens’* (Walt 1994: 1). Often how issues get on the agenda and/or decision making is not a rational process but the outcome of a variety of power struggles between different interests or actors in the policy process (Cairney 2012). In any policy process there are influences on the actions taken (or not taken) (Bacchi 2009; Cairney 2012). Studies of policy processes are seen by some authors as more often studies of power struggles in the making of policy (Walt 1994; Buse, Mays and Walt 2005; Cariney 2012, WHO 2018).

Buse, Mays and Walt (2005) highlight three dimensions of power:

* Power as decision making – direct influence of individuals or groups whose importance or role differs depending on the specific policy.
* Power as non-decision making – keeping issues off the agenda.
* Power as thought control – shaping preferences.

Policy, on the whole, seeks to bring about some change, where the system or structure influences action or agency and in so doing the actions subsequently alter the structure. This structure-agency relationship is important in understanding the power in decision making and the determinants of that power, be they class oriented, economic considerations, professional and bureaucratic elites, or other influences specific to the policy under analysis.

There is a large amount of literature devoted to understanding power which focuses on pluralism, elitism and variations or further developments of these power theories (such as Buse, Mays and Walt 2005; Cariney 2012, WHO 2018 who provide useful summaries). Essentially, understanding that power is either distributed fairly equally or the preserve of the few and also examining the role the various determinants of power exert in the policy process is seen by the authors above as key to understanding the influences on the policy process. These different literatures are presented to support the theories employed in this research.

### 3.6.2 Pluralism and Elitism

Pluralist theory suggests that rather than power being equally distributed in a pluralist society, power is fragmented, however, no one is completely powerless and no one is dominant. The ability to have a voice and have your voice heard is open to all and those who are more often heard are representatives of the population and groups rather than elites (Buse, Mays and Walt 2005). Most pluralists acknowledge that the policy making playing field is not even and that the privileged position of some individuals and groups do take precedence over others. However, depending on the specific policy under study, the views of different individuals and groups may take precedence, which may differ between situations and policies.

Some, see the State and Government as neutral whereas others, dispute the State’s neutrality and see the State as an actor in its own right (Buse, Mays and Walt 2005). Some recognise power in both decision making and non-decision making, therefore in analysing decision making, researchers must determine both what issues are discussed and policies made and those which do not get discussed, as well as those issues which are discussed and then decisions taken not to act upon them (Buse, Mays and Walt 2005; Cairney 2012). This resonates with Bacchi’s approach (2009) to understanding policy which will be discussed later in the chapter, with a key insight here being to be aware of policy ‘silences’ (see section 3.13).

To some, such as Cairney (2012), agenda setting is in fact about power. Agenda setting is recognised in the stages model as a useful starting point for problem identification – it is to this the chapter now turns.

## 3.7 Problem identification and agenda setting

Agenda setting is also known as problem identification. It may also include those issues which are kept from coming to discussion or discussed and not taken further, otherwise known as non-decision making. However, as already discussed in considering the criticisms of the stages model, agenda setting itself is not as distinct nor a neutral a process as the stages model might imply.

The Hall Model (Hall et al. 1975) identifies three criteria which must be met for an issue to get onto the agenda: legitimacy (where it is right for Government to intervene), feasibility (the potential for successful implementation in terms of resources, personnel, infrastructure), and, support (public support for Government intervention). Hall (et al. 1975) states that only when these three criteria are met will an issue get onto the agenda.

The Kingdon model (1984) offers a different approach, depicting the policy process as disorganised, and coins the term ‘policy windows’. This model describes three streams of the policy process – problem (perception of problem as a public matter requiring Government intervention), politics (analysis of problem, proposed solutions and debate) and, policy (events, national mood, changes in Government etc.), when these three streams meet there is a policy window, or window of opportunity to get an issue onto the agenda.

As presented in the preceding two chapters, interest in obesity, obesity as a priority area and obesity policy has grown over the last 40 years, with the rising prevalence and costs mostly heralded as responsible for the increased focus, causing obesity to be a key issue (see chapter 2). However, as often noted, models are ideal in nature and real world processes often do not fit with theoretical models. Equally, using a theoretical approach, agenda setting as a stage implies issues arrive new or fresh onto the agenda, in practice this rarely happens, and as detailed obesity has at least been on the agenda, in some form, for over 40 years.

Additionally, as presented above, power issues may determine what gets prioritised and action taken or not acted upon (Cairney 2012). Therefore, it may be useful to consider using Colebatch’s key questions for analysis of public policy processes (2002) as a framework, which are:

* How do issues come onto the agenda, which issues do not and why not?
* Who is and who is not involved?
* How are issues defined and by whom?
* Who has influence and how transparent is this process?
* How successful is implementation?
* Is the vision translated into reality?

These are explored in this research.

## 3.8 Policy Formulation

The next stage in the policy process, once a problem has been identified, is policy formulation. This is the actors and process by which the ideas around how to solve a policy problem are identified and agreed to develop the ‘content’ and then translated into action, for implementation. This may be quite a complex process, which Knoepfel and Weidner (1982) call ‘policy programming’ which, once an issue has come onto the agenda, then involves defining policy objectives, operational activities to ensure the policy is effective (including choice of policy instrument), and responsibility and process arrangements regarding implementation.

The literature on policy formulation examines who was involved and how the content of the policy was developed and decided upon. Within this stage, relevant to this research, is who is involved and the use of evidence in policy making and the content of policy, explored below.

### **3.8.1** Actors and stakeholders

Policy is seen as based on scientific knowledge and ‘done’ by the government (Colebatch 2002) although policy making is no longer a sole activity undertaken by the state. Private organisations, such as commercial interests, are often invited to make policy. Private actors no longer simply influence policy, but often have power devolved to them in the policy process.

As presented above, policy actors are varied and have a range of influences over the policy process. Who sets the agenda, is one issue, and, once set who influences the path taken is another (Colebatch 2002; Walt 1994; Tones and Green 2004; Buse et al. 2005). Policy is not made in a vacuum, actors’ beliefs, attitudes, perceptions and professional roles influence how they behave and influence the policy (Ham 1981). Policy making is a complex process involving many different actors, with all policy actors competing for power in the decision making that shapes public policy, which is also true for some involved in obesity policy (Alvaro et al. 2011).

Colebatch (2002) suggests that in order to identify the ‘players’ the three key elements of policy should be examined as these act as gatekeepers, allowing participants a rationale for inclusion in the process. Colebatch (2002) describes these three elements as:

* Authority, that is, authorised decision makers, government, legislature, authorities.
* Expertise, in other words, those capable of problem solving and providing knowledge. Policy may not exist without experts to identify problems and propose solutions.
* Order, i.e. the structure.

Using Colebatch’s model (2002) policy participants fall into these three categories and their role can be analysed as such. However, this is merely a description of their place at the policy making table and not an analysis of actors or stakeholders influence or perspectives nor their interactions and effects on the policy as this research seeks to address.

Stakeholders are those with an interest or those affected by, or those with a role in making or implementing policy. Roberts et al. (2004) suggest that in order to better understand actors and stakeholders in policy one should identify them, asses their political resources, and understand their position or interests. However, this may still not offer full understanding of the who, why and how questions this research is interested in.

Organisations play dual roles both in terms of the society within which organisations exist and the individuals within organisations and their own beliefs. Organisations have a culture but also have within them individuals who may hold their own, perhaps very different beliefs to that of the organisation they represent, and therefore, in any analysis of policy, stakeholders and actors should be analysed to ascertain if they represent their own views or that of an organisation or body, relevant in this research.

### 3.8.2 Network theory

Network theory is essentially the bringing together of interests, whereby different groups, acting in policy, who have shared values, and a relatively equal balance of power, share resources in order to achieve shared goals in policy making. Within this idea of policy networks or communities is the idea of an advocacy coalition (Sabatier and Jenkins-Smith (1999) (cited in Sabatier 1999)). These authors believe that throughout the whole policy process there is, what they have termed, an advocacy coalition, that is, different groups and organisations working together in policy making (Sabatier and Jenkins-Smith 1999 (cited in Sabatier 1999)). However, again, this merely describes rather than explains the policy making process any better for our understanding, it’s critics argue that this still fails to explain the interactions between actors and the influence or their position within the wider environment/society (Hill 2009), which is what this research is seeking to understand at a local level.

### 3.8.3 The role of the State

As presented above, pluralism views the state as a neutral player or referee in the policy process, elitist theory sees the state as its own entity working for its own interests, network theory sees the state as part of the networks involved in the policy process with different parts in conflict, and institutionalist theory views the state as a structured system which controls action either through influence or constraint (Hill 2009). However it is viewed, the State is crucial when discussing public policy. The Government of the day is driven by its own ideological assumptions and their policies reflect this, therefore the role of the State and the ideology of the governing party needs to be discussed and recognised in any policy analysis.

As has already been discussed, with respect to obesity policy, the more recent changes in Government has led to shifts in obesity policy, reflecting a change in ideological stance, from one of informed choice to personal responsibility (Ulijaszek and McLennan 2016). Despite evidence viewing the wider determinants of health and the obesogenic environment as key to influencing individual behaviour and suitable for state intervention (Butland et al. 2007), there remains a more individualised focus with a shift to that of personal responsibility and individual choice in health, away from the informed choice perspective. With the advent of the Localism Act (2011) and Health and Social Care Act (2012) this research is interested in how the actors, stakeholders and institutions formulate and implement policy locally.

### 3.8.4 Use of Evidence in Policy Formulation

Evidence informed policy is perhaps a more accurate description of the realist’s perspective on the use of evidence in policy. Policy based evidence may also be a relevant term for the purposes of this thesis, as Pawson comments (2006: viii) that this implies what many believe that the only evidence that is used in policy making is ‘*cherry picked and rose tinted’.*

Hawkins and Parkhurst commented that, *‘Calls for evidence-based policy often fail to recognise the fundamentally political nature of policy making. Policy makers must identify, evaluate and utilise evidence to solve policy problems in the face of competing priorities and political agendas.’* (Hawkins and Parkhurst 2016: 575)

There is a recognised lack of evidence of effective obesity treatment and prevention interventions, mostly due to the complexity of the determinants of obesity (Butland et al. 2007), yet there is a need to act given the high prevalence rates. This has led to action based on the best evidence available rather than evidence-based practice as perhaps would be understood and expected if applied in the case of a clinical intervention.

Evidence based action in an area such as obesity must consider not only evidence of effective interventions but also the issues of context, implementation, and sustainability (Swinburn et al. 2005). This is discussed below with specific reference to obesity policy in section 3.13.5 (What is the role of evidence base policy in obesity).

Therefore, the process of policy formulation could be seen as crucial, engaging decision-makers from the start of the process in order to increase opportunities for success, as Swinburn and colleagues’ (2005) study recognises that decisions on policies and resource/funding allocations are determined by political, economic, and historical forces rather than purely the evidence base. In some cases, evidence points to actions that are politically unacceptable, and therefore the evidence itself becomes contested (King et al. 2011; Ulijaszek 2017).

As Hannes et al. (2010) have recognised in their work on the role of evidence in policy (albeit in psychiatry) there are differences in the use and understanding of evidence. In their study three main issues were identified, that could equally be applicable to the use of evidence in obesity: characteristics of evidence, including the lack of (use of) evidence and the applicability of evidence; characteristics of other partners, including government, patients and drug companies and discipline-related barriers, including the complexity of diagnoses, the importance of the therapeutic relationship and personal experience, and the different schools of thoughts.

There is a large body of literature exploring the role and use of evidence in policy, which is outside the scope of this chapter, however, this study recognises the difficulty the lack of evidence in obesity places upon the policy making process, as Brennan et al. (2011: 199) comment,

‘*The childhood obesity epidemic has stimulated the emergence of many policy and environmental strategies to increase healthy eating and active living, with relatively few research recommendations identifying the most effective and generalizable strategies. Yet, local, state, and national decision makers have an urgent need to take action*’.

Evidence use with specific reference to obesity policy is further discussed in section 3.13.5 (What is the role of evidence based policy in obesity).

## 3.9 Policy Implementation

The implementation stage is about translating policy decisions into actions to address problems. However, again the literature points to issues of the roles of actors in implementation, such as Lipsky (1980) and the role of street-level bureaucrats i.e. that it is what people actually do on the ground that ‘makes’ policy rather than policy being implemented in a linear way. Cairney (2012) also identifies that implementation may not be carried out successfully by those involved, and Jebb (et al. 2013), and Lang and Rayner (2007), particularly point to the role of implementation in the success of obesity policy.

There a number of models in the literature which policy analysts can employ to study policy implementation. Harrison (2001) and Hogwood and Gunn (1984) offer models against which policy implementation can be measured. Hogwood and Gunn (1984) called their model the ‘Preconditions for Perfect Implementation.’ They also detailed why these are 10 ‘ideal’ conditions and why they are unlikely to be achieved, demonstrating how unrealistic the ‘top-down’ method of implementation is. The issues of policy implementation are examined below.

### 3.9.1 Issues of Implementation

As presented above, the policy itself is only one part of the policy process, what is crucial is how it is implemented, and implementation is an equal part of the policy making process (Hill et al. 1993).

DeLeon (1999) defined policy implementation as *‘what happens between policy expectations and (perceived) policy results’*. It is therefore common or expected even to observe an ‘implementation gap’ between what is planned and what actually occurs. As Van den Bergh and Gatherer (2010: 640) state, ‘*Knowing what is best practice in a certain health area and what needs to be done to achieve this, does not necessarily bring along knowledge about how best to achieve this.’*

Policy implementation is not automatically carried through as a result of policy formation (Younis 1990). Whether policies are implemented or not depends on a range of factors. Bunton (1992: 137) states these to be: *‘How the policies are conceived, how they are introduced, the group’s commitment to them, the local resources available for implementation and a range of other socio-economic factors’*.

There is a large body of literature which argues that the ‘implementation gap’ emerges for a host of reasons. The top down flow from policy is imperfect - poor communication, inadequate resource allocation, and poor policy specification. In one study of obesity policy in the UK (Poobalan et al. 2010), the results show that although most recommendations on obesity are evidence based, the majority fail to meet the implementation standards set in the study, and recommends that obesity policy recommendations need to be framed so as to facilitate their implementation. The implementation framework used in Poobalan study (2010) was based on the six criteria of: Target population; Responsible agency; Monitoring and Evaluation; Time-frame for the Implementation; Prioritisation; and, Cost and Resources (Poobalan et al. 2010). However, the authors noted that when examining implementation of obesity policies this was far from the case as, ‘*They tend to be non-specific in identifying who is responsible for implementation and monitoring, and often no timescale is indicated. The costs of implementation are rarely estimated and those responsible for such funding are not specified.’* (Poobalaln et al. 2010: 17).

Colebatch (2002) also offers an overview of implementation: the vertical perspective is a top-down approach, focusing on policy goals and compliance, where implementation requires authority and compliance, i.e. ‘what ought to be’. The horizontal perspective recognises individuals have their own agenda and perspectives on implementation, focusing on people and processes, i.e. ‘what is’ rather than ‘what ought to be’. Very little has been done comparing the ‘what is’ to the ‘what ought to be’ in obesity policy in England.

The implementation gap may also occur, however, because there is a separate implementation culture which derives from the bottom-up (Lipsky 1980). This is a function of the inevitable freedom of action and scope for discretion which lies with those who implement policy and who are beyond the reach of those who formulated the policy. Thus implementation structures, policy interpretation (Ripley 1996), street level bureaucracy (Lipsky 1980), and the discretion open to front line staff, may all distort policy intention and vision.

This discretion between the principal (decision makers) and agent (implementers) often arises in policy implementation in England as the principal (Government) has no direct management control over the agents, therefore implementation is under their control and this may be one of the crucial factors leading to the implementation gap. This gap or discretion is affected by the nature of the problem/issue, the context in which it is being addressed and the organisation required to implement the policy. In the case of obesity, it is the complex nature of the problem, set in the context of localism, which may make implementation difficult. One way to overcome this is to use policy instruments such as targets to control discretion, however, very little progress on targets has been made in obesity policy in England (DH 2016; 2018; 2019).

To overcome policy implementation failure Buse and colleagues (2005) suggest developing an implementation strategy that accounts for the capacity to implement in terms of finance, technology and management, as well as the anticipated support or resistance to a policy from all those involved. In obesity policy in England this has rarely been the case (Poobalan et al. 2010; Jebb et al. 2013).

## 3.10 Policy Evaluation

The last stage of the ‘policy cycle’ is evaluation. Evaluation activities determine the extent to which policy decisions or intervention activity has resolved the initial policy problem, which is then ‘in the stages model’ designed to be fed back into processes to ensure subsequent policy improvement and learning lessons. This stage however, is recognised to be an ideal, which rarely happens as set in the stages model in practice (Buse et al. 2005). Many obesity policies are either not evaluated or the expectations of the evaluation are too great in the timescales given, as it is recognised that for many public health interventions a change in behaviour that will lead to an improvement in a lifestyle factor, such as reduction in obesity, will take many years to observe (OECD 2010).

However, where obesity policy evaluation has tended to be focussed is on ‘what works’ rather than anything wider (such as the questions that this study seeks to address) (Butland et al. in Foresight 2007; Jebb et al. 2013; McKinsey 2014; National Obesity Forum 2015; RCPCH 2017; Centre for Social Justice 2017; Knai et al. 2018). This will be discussed in further detail in section 3.12.

As in this study of the policy process, case studies can be used to allow for a deeper understanding of a policy or programme, particularly a complex, multi-agency and multi-faceted policy such as in this obesity example. Case studies are generally used to examine real-life situations, allowing deeper understanding and analysis in order to answer the ‘why’ questions that are often not fully addressed in a purely quantitative evaluation.

The rational style is shaped to a large degree by assumptions about knowledge and

reality, and by a relatively large distance between the object and subject of study: it is

assumed that the world is to a large extent empirically knowable and often measurable.

Knowledge used for policy must be capable of withstanding scientific scrutiny. The role

of knowledge in policy is a positive one, i.e. a greater insight into causes, effects, nature,

and scale produces better policy [54]. Policy should come about – preferably – in neat

phases, from preparation to execution, with support through research in each phase.

An example of this policy analysis approach is the systems analysis method

developed by the RAND Corporation [24,55]. The advice on policy regarding the Eastern

Scheldt storm surge barrier in The Netherlands was obtained using this method [27]. This

style is discussed in many general textbooks on methods of policy analysis [10,12,25].

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## 3.11 Alternative approaches to policy analysis

The sections above have covered a broad range of policy literature of potential relevance in this study. However, it is argued that the analyst’s own interpretation and perspective is an important factor to consider in policy analysis, as well as a key part of reflexive research. Whether we see policy as a rational process or not, and if not, how the policy process is viewed, is important in terms of how we analyse policy (Cairney 2012). Recognising this, there is other literature not yet examined which is relevant to this study and analysing policy. Some of these more ‘interpretative’ approaches, which recognise and seek to understand the key role of contextual factors in policy processes, are presented below.

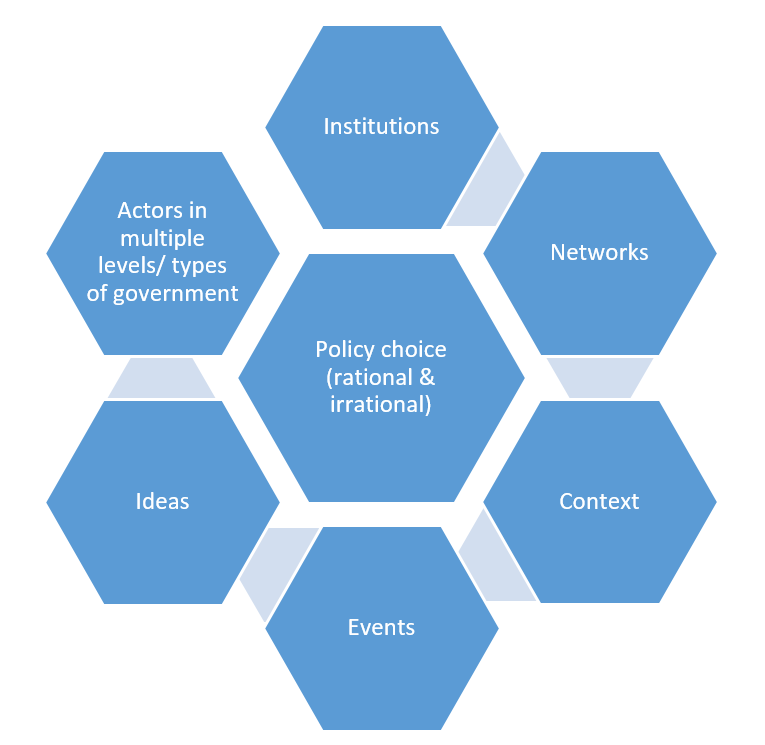
Colebatch (2002) identifies key ‘who’ and ‘how’ questions to ask in policy analysis, including the following:

* How do issues come onto the agenda, which issues do not and why not?
* Who is and who is not involved in what?
* How are issues defined and by whom?
* Who has influence and how transparent is this process?
* How successful is implementation?
* Is the vision translated into reality?

Cairney (2018) identifies an approach which considers the policy environment, i.e. the environment in which policy making is undertaken and policy is operationalised. He suggests this policy environment is made up of an important range of different factors that can shape policy processes, namely:

1. Actors
2. Institutions*: the (formal and informal) rules and norms followed by different levels or types of government*
3. Networks*: relationships between policymakers and influencers*
4. Ideas*: a tendency for certain beliefs or ‘paradigms’ to dominate discussion*
5. Context and events*: economic, social, demographic, and technological conditions provide the context for policy choice, and routine/ unpredictable events can prompt policymaker attention to lurch at short notice.*

Cairney (2018) proposes another alternative to the more rational models to analyse policy. This alternative approach is presented in Figure 3.4 below, and accounts for these diverse influences described above. However, Cairney (2018) notes that this model also has flaws: it is just a visual representation and does not indicate the interaction between elements nor the external world; nor does detail cause and effect relationships. This is partly because, to understand these interactions requires *interpretation* and therefore some element of skill and embedded understanding on the part of any policy analyst.

Figure 3.4 The Policy Environment (Cairney 2018)

As mentioned in the introductory chapter one, framing is a significant issue to consider within policy processes, and particularly with respect to obesity policy (Ulijaszek 2017). Koon et al. (2016) in their review argue that little work has so far been undertaken on frames and framing in health policy processes. This body of work on framing is further explored in section 3.13.2 below. However, before we go on to explore that in more detail, the chapter now moves to explore to the obesity-specific policy literature; examining what different approaches to obesity policy analysis offer in terms of insight about the way national and local obesity policy works.

## What do we know about the way national and local obesity policy works in the UK?

Having considered the contributions of a broad range of ‘general’ policy analysis literature above, in this section of the chapter, obesity-specific policy analysis literature will now be considered in terms of what insights are provided about the way national and local obesity policy works in the UK and England.

Literature of what could be described as a more rational perspective provides information about the multifactorial causes of obesity and offers a wealth of material about the prevalence, projections, causes and consequences of obesity and is exemplified in national reports that are commissioned by the UK Government. These describe and give accounts of the causes, consequences, and prevalence of obesity, and evaluate progress against obesity plans and targets that have been set. This obesity literature also includes some of the evaluation and review literature of these reports and strategies (Butland et al. in Foresight 2007; Jebb et al. 2013; McKinsey 2014; National Obesity Forum 2015; RCPCH 2017; Centre for Social Justice 2017; Knai et al. 2018). These reports and reviews are consistent in their reporting of obesity causes, consequences, prevalence and progress on obesity, however, fall short of understanding what more interpretative literature seeks to do – they fail to analyse obesity frames (how obesity is represented) and the political context. More rational approaches are also apparent in the evidence of effectiveness of obesity-related interventions, as discussed in the evaluation section above. These mostly focus at an individual level, using evidence of effectiveness based on evidence from a rational perspective (such as RCTs). This knowledge of evidence is then predominately used to inform Government policy and strategy on obesity, for example in Cochrane reviews and National Institute for Health and Care Excellence (NICE) reviews of evidence to produce obesity guidance (NICE 2014).

Whilst this literature offers crucial insights into what is being done or recommended and why, progress made, importance of this progress, and, what may be effective, it is limited in a number of ways. Firstly, the learning from this type of literature appears limited in terms of impact. Despite the wealth of rational policy analysis literature reporting cause, consequence, and prevalence, this has not led to any demonstrable impact, just further reporting, without questioning nor exploring this lack of progress from a different analytical lens.

Secondly, and leading on from the previous point, evidence for the predominantly individual personal responsibility approach taken in much of this literature and the effectiveness of individual approaches to tackle obesity, is similarly limited, the majority of national policy and the analysis literature associated with this, continues to focus on individual personal responsibility without questioning or exploring alternative approaches, just focusing on ‘success’ of individual actions.

Thirdly, the national policy analysis literature does not examine how people’s understandings of obesity influence their views on causation, responsibility for cure/prevention and support for policy initiatives, (Ulijaszek 2017), which this study seeks to understand. The literature examined seems to present an individual versus wider environmental approach to cause, and a prevention versus treatment approach to address obesity, based on ‘facts’, whereas Swinburn and colleagues (2015), and others (Frood et al. 2013) argue that support services – similarly to smoking cessation services – must be available as part of a whole systems approach to confront obesity, not single individual approaches, nor prevention or treatment, but a continuum of both to prevent obesity as well as support those already overweight and obese. However, this is not reflected in the national policy analysis literature to date.

Fourthly, and as already mentioned above, the more rational policy analysis literature does not account for context, nor the factors Cairney outlines as the ‘policy environment’ (2018). In the current economic and political climate of the Public Sector (NHS and LAs in particular) and the changes and challenges facing the NHS, LAs and public health, obesity faces a new challenge – maintaining priority status, receiving continued commitment of resource and investment in both prevention and treatment services, given the obesity related issues of lack of evidence base, long term invest to save nature of the return on the investment and the relapsing remitting nature of the condition. Set this alongside the wider implications of the Health and Social Care Act (2012) and the change in organisation for public health and obesity, there may be consequences for prioritisation for an issue predominantly represented as a matter of individual choice about diet and physical activity that can lead to health consequences. This is discussed in the PHOENIX Report (Peckham et al. 2016) but is not referred to, nor the understanding the PHOENIX Report (Peckham et al. 2016) provides reflected in more recent policy nor associated analysis.

Lastly, and important for this research, the current more rational policy analysis literature does not support understanding about the complexities and intricacies of *local* policy, such as who makes decisions, why decisions are made and the drivers for these, how obesity is framed or represented, and, how local policy operates within specific contexts.

What could be described as more interpretative approaches to policy analysis literature focusing on understanding context, framing, and more recent systems-thinking literature offer insight into some of these critical obesity policy processes and addresses limitations presented above. It is to this obesity literature that this chapter now turns.

## 3.13 What could wider obesity literature add to this research?

The previous section reviewed the literature on obesity and analysis of obesity policy, discussing causes, consequences, prevalence and impact of interventions, as mostly presented by analyses of national policy on obesity. However, this chapter also recognises the limitations of this approach, such as gaps in understanding the context, and processes in which the policy is operationalised, i.e. the policy environment, especially at a local level. The section that follows seeks to discuss what wider obesity policy analysis literature may offer in terms of addressing the key questions of this research and the limitations listed above, about the who and the how of *local* obesity policy, and not just the ‘what’ of mostly national policy.

There are some more interpretative approaches to obesity policy analysis, but they mostly focus on national policy not local, as this study seeks to do. However, they do provide different insights into how obesity policy works. One such insight is how issues are framed, and this is explored below. Additionally, more recent literature offers a ‘systems’ approach to addressing obesity and this is also discussed as an approach to addressing the critique of the more rational and mostly national policy analysis literature that currently exists.

One high level insight from this literature is the work of Lang and Rayner (2007). They describe the obesity policy environment as a ‘policy cacophony’ in which the ‘noise is drowning out the symphony of effort’ (Lang and Rayner 2007), which they propose may explain policy failure to date. In their 2007 paper, Lang and Rayner present their views on why obesity policy fails. Policy may fail either due to policy making or policy implementation or both. However, although policy cacophony is cited as one reason, by Lang and Rayner (2007) there may be others that are not explored, and especially at the local level which have not yet been identified, this study seeks to understand this. Given the apparent poor progress, despite policy ‘cacophony’ (Lang and Rayner 2007), one can only offer ideas as to why progress was not as envisaged by these policies (Lang and Rayner 2007: 166):

‘*This crisis is as a result of years of public policy failure. Obesity policy is already weighed down by complexity, accentuated by the multi-level (global, European, national, regional and local) nature of modern systems of governance. It is also shrouded by ideological fears such as interventions being interpreted as ‘nanny-ish’ or restricting ‘personal’ choices in food and lifestyle’.*

The National Government approach to obesity and obesity policy has been subject to multiple policy analyses (Butland et al. Foresight 2007; Jebb et al. 2013; McKinsey 2014; National Obesity Forum 2015; Vallgarda et al. 2015; Vallgarda 2015a; Kelly and Barker 2016; Ulijaszek and McLennan 2016; RCPCH 2017; Centre for Social Justice 2017; Knai et al. 2018), some of which has also identified a persistence of an individual approach despite evidence supporting the need for other approaches, especially addressing the social determinants of health (Vallgarda 2015a; Vallgarda et al. 2015; Ulijaszek and McLennan 2016).

The framing of obesity within UK policy has remained one of individual focus in the last 40 years, with individual responsibility, seen in the Conservative Government at the time, The Health of the Nation (DH 1992) to the Labour-led policies (1997-2010), Our Healthier Nation (DH 1999), and, Choosing Health (DH 2004) and then the seminal work of Foresight (Butland et al. 2007) (commissioned by the Labour Government) which drew attention to the many causal factors in obesity and system-wide responsibility, for the first and possibly only time. However, there was little policy change at the time to reflect this, despite Foresight (Butland et al. 2007). Returning to an individual responsibility focus with the advent of the Conservative-led Liberal Democrat Coalition and subsequent Conservative Governments from 2010 onwards, to the present at time of writing (Jebb et al. 2013; Vallgarda et al. 2015; Vallgarda 2015a; Kelly and Barker 2016; Ulijaszek and McLennan 2016).

The current national representations of obesity, as a health issue, related to individual diet and physical activity choices, seem to have shifted little and therefore persisted over time, since the pre-2012 transition of public health when in the NHS, before moving to LAs. Jebb (et al. 2013) Kelly and Barker (2016), Ulijaszek and McLennan, (2016) and Barth (2015) for example, all suggest that the NHS held a similar view about obesity, as to the one now held in policies that pertain to obesity under the management of Local Authorities.

The factors which drive local obesity strategies in England, and the subsequent approaches taken, have not been evaluated in any detail to date, despite repeated calls for this to happen (Brennan et al. 2011; NICE 2014). In their study of strategies for the prevention of childhood obesity (in the U.S), Brennan et al. (2011) identified several limitations in the existing evidence to inform practice and policy change in this area, which are still relevant in 2019 and pertinent to this research. Among the nine drawbacks listed were:

1. That existing literature generally had a lack of information about the policy-making process, including the challenges facing policy makers and implementers at all levels;
2. That there was little about issues associated with implementation; and,
3. That there was little demonstration of an understanding of the context in which the policy is being formulated and implemented.

This chapter has so far discussed the value and drawbacks of more rational policy analysis approaches. Brennan et al.’s critique (2011) seems to suggest that more interpretative literature would add value, however, it should similarly be noted, that there is no evidence of interpretative policy literature leading to effectiveness in addressing obesity, and moreover there is little literature that is UK focussed.

Clarke et al.’s (2016) published a systematic review and meta-synthesis of the key influences on obesity prevention policy decision-making. This is one of the few studies to have taken this type of approach to the topic, however, mostly focussing on US national level policy, but worthy of inclusion here. Clarke (et al. 2016) discuss studies that have identified some of the potential policy determinants that influence the policy processes related to obesity prevention at a national level. These include:

• individual skills, knowledge and capabilities of policy actors,

• processes within political institutions that shape policy adoption,

• power dynamics of networks and groups involved in policy development,

• socio-political and economic factors that shape individual policy maker’s ideas related to policy issues, which include macroeconomic conditions, influential groups, and changes in the governing political party.

The themes identified from the systematic review and meta-synthesis by Clarke (et al. 2016), examining the key influences on obesity prevention policy processes, were:

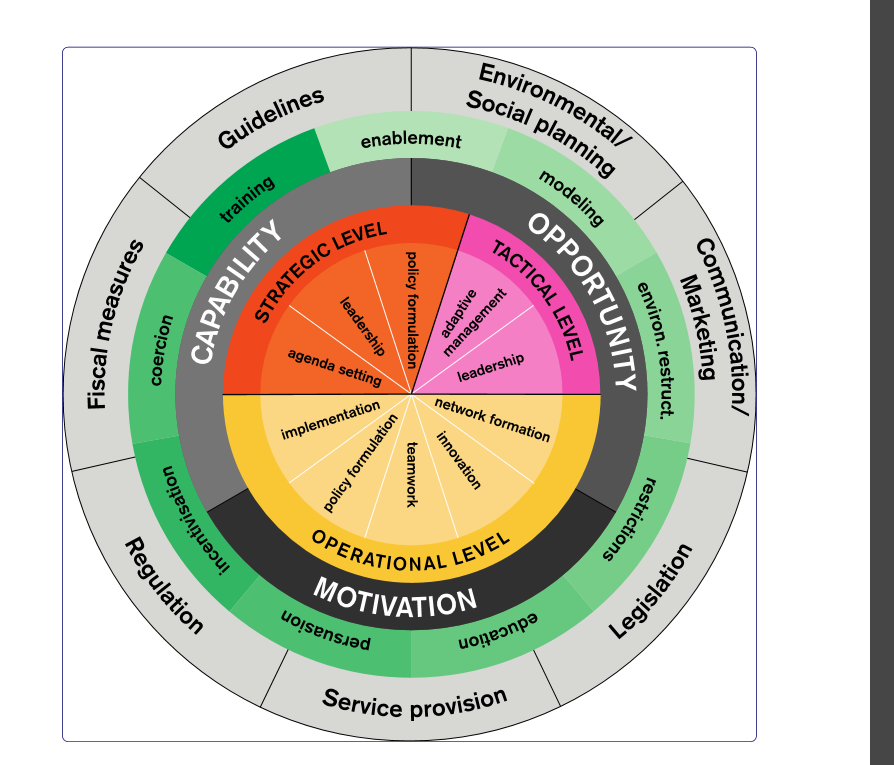
* industry and stakeholder group and coalition influences;
* institutional factors, including feasibility of policy options;
* leadership of key individuals;
* narratives and framing;
* political ideology;
* personal values, beliefs and experiences;
* use of evidence;
* timing; and,
* exogenous factors, such as crises and excessive budget deficits.

The findings from this work are more context and policy environment related, as Cairney (2018) suggests. Therefore, this supports the stance taken in this research that the more interpretative approaches to policy analysis might help identify the key influences on policy processes and decision making at a local level in England.

Additionally, Hendriks et al. (2013) proposed a framework for integrated public health policy – applied to childhood obesity – which considered the factors influencing development and implementation of integrated and effective obesity policy. It aligns with, if in more detail, the Clarke et al. (2016) findings, see figure 3.5 below. Hendriks et al. (2013) identified key organisational behaviours at the strategic, tactical and operational levels, as well as the determinants (motivation, capability and opportunity) required for these behaviours that encourage integrated local health policies. These were identified as follows. At the strategic level as agenda setting and leadership. At the tactical level as: policy formulation; adaptive management; leadership; and, network formation. Finally, at the operational level important behaviours were identified as: innovation; teamwork; policy formulation; and, implementation.

Hendriks et al. (2013) also identified content and process-related barriers to implementing integrated local obesity policy. These included: understanding of the issue and complexity; political support and context; relationships and the ability to collaborate; effective and clear engagement; resources; governance; vision and leadership; and, issues of implementation.

Figure 3.5 Hendriks et al. 2013 A conceptual framework for integrated local Public Health policy applied to childhood obesity – the behaviour change ball.



Hendriks (et al. 2013) findings support that a more interpretative approach to policy analysis may help to identify these influencing factors and context at a local level. However, the majority of studies to date do not provide understanding of how these determinants influence policy processes, nor do they explore the policy determinants or how these influence policy processes at a local level in the UK. The chapter now moves on to discuss the few examples of interpretive work focusing on the UK.

### 3.13.1 UK specific literature using more interpretative approaches to obesity policy analysis

The Government commissioned PHOENIX Report (Peckham et al. 2016) examined the impact on public health of the transition from the NHS to Local Authority responsibility in England (since 2013), as a result of the structural changes from the Health and Social Care Act (2012). The PHOENIX Report (Peckham et al. 2016), used obesity as the tracer topic to examine the transition of public health into local authorities, highlighting the impacts of structural changes at all levels on obesity activity.

The PHOENIX Report (Peckham et al. 2016) highlighted the importance of the context in which local policy decisions are operationalised and influences on policy processes in terms of both opportunities and challenges. However, it did not explore locally employed constructions nor representations of obesity from the perspective of differing local stakeholders, neither did it discuss the implications of stakeholders’ perspectives on local obesity policy processes, nor the subsequent impact of these. The PHOENIX Report (Peckham et al. 2016) did examine how things had changed since the 2013 transition, as a result of the structural changes and context. The PHOENIX Report (Peckham et al. 2016) was, in some senses, unusual in that it examined the context, and more of the ‘who’ and ‘how’ questions about local policy, with a focus on obesity policy, in terms of how it is made and operationalised in England. However, it did not focus on some of the who and how questions this research seeks to address as these were not the key objectives of the report.

Yet, despite these notable exceptions of PHOENIX in England (Peckham et al. 2016) and the work of Hendriks (et al. 2013) and Clarke (et al. 2016, above, mostly from US studies), most obesity policy analysis has to date taken a more positivist or rational stance, in that it has focussed on the content or the ‘what’, and less on the ‘who’ and ‘how’ of obesity policy. This approach leaves key questions unanswered, such as:

* Who is involved in prioritising obesity, defining the issue and agenda setting?
* Who translates and formulates policy, how and why are decisions made about what action/interventions to undertake, and,
* What this tells us about how the issue of obesity is thought of?
* Who implements obesity interventions?
* How are these policies evaluated?

These are critical questions in examining policy, and in this case obesity policy at a local level in England, from a more interpretative stance, because, as Ulijaszek comments, *“Models of obesity are not neutral, nor are the facts that emerge from them”.* (2017: 1).

The current prevalence of obesity nationally suggests the need for a different approach to be taken to address obesity (LGA 2017). In order to understand more about how to change the current situation, and what alternative approaches may offer, the more interpretivist obesity policy analysis literature offers insight into the elements outlined above which may be important in understanding local obesity policy.

Another example of interpretative approaches to obesity policy analysis is that presented by Ulijaszek and McLennan (2016) in their paper *‘Framing obesity in UK policy from the Blair years, 1997–2015: the persistence of individualistic approaches despite overwhelming evidence of societal and economic factors, and the need for collective responsibility’.* As framing of obesity has been identified as a limitation in the more rational literature, seen as important as to what may get done/not done (Ulijaszek 2017), and, is evident in the more interpretative obesity literature, this issue of framing is explored in more detail below before being discussed with specific reference to obesity literature, and indeed relevance to this research.

### 3.13.2 Issue Framing, Causal Stories & Problem Representation in Obesity

This section discusses the key literature focusing on issue framing and its potential significance in obesity policy analysis, and for the purposes of this study, local obesity policy. The understanding of issue representation in this research is that any issue may be viewed from a variety of perspectives and be construed in different ways, this includes obesity (Ulijaszek 2017), with the process of framing helping people to understand or conceptualise an issue in a certain way. This was highlighted earlier in the policy process as an important element of agenda setting. As introduced in chapter one, and repeated here, as Entman states (1993: 51):

*‘Framing essentially involves selection and salience. To frame is to select some aspects of a perceived reality and make them more salient in a communicating text, in such a way as to promote a particular problem definition, causal interpretation, moral evaluation, and/or treatment recommendation for the item described.’*

The stance taken in this research is that of interpretivism, and a recognition of the need to explore the influence context, (i.e. social and political factors), has on policy processes, recognising that the policy process is not value free. The way policy issues are framed affects how they are received, and the solutions that can be offered to the issue (as well as potentially the evidence sought and/or used) (Bacchi 2009; Ulijaszek 2017), with most policy problems presented using narrative devices (Kaplan 1986). As Fischer sees it (2002: vii-viii), the way that stakeholders and policy makers discuss policy issues “*does more than reflect a social or political ‘reality’; it actually constitutes much of the reality that has to be explained*.”

Fischer (2002) recognises that the policy process is generally driven by narrative accounts of problems and their causes, acknowledging the need to understand the narrative and what influences it.

Through immersion in the policy literature during this research (as described in the initial section of this chapter), seven key works of interpretivist policy literature were identified as relevant to understanding the issue of framing and exploring it in relation to obesity in this research. These have been utilised to provide insight into issue framing and obesity framing/representation in this research.

These seven key literatures move from more general policy analysis and framing literature to obesity specific framing literature, and then to obesity specific framing literature in England. The general policy literature of Stone (2001) and Bacchi (2009), and with specific relevance to obesity, the work of Kersh (2009), Barry et al. (2009), and following on from Barry, the UK-based study undertaken by Beeken and Wardle (2013), and, the more recent UK Government focussed work of Ulijaszek and McLennan (2016) and the more extensive work of Ulijaszek (2017). These works are relevant to this research as these approaches recognise the two key dynamics that Cairney describes in his model (2018), which reflects influencers and contexts for policy processes. Cairney (2018) describes these, as follows:

1. *That policymakers use ‘rational’ and ‘irrational’ cognitive shortcuts to make decisions quickly, despite their limited knowledge of the world, and the possibility to understand policy problems from many perspectives.*
2. *A policy environment made up of:*
   1. *Actors (individuals and organisations)*
   2. *Institutions: rules and norms*
   3. *Networks*
   4. *Ideas: a tendency for certain beliefs or ‘paradigms’ to dominate*
   5. *Context and events*

Each of these more interpretative bodies of work used in this research will be discussed in turn below.

Firstly, Stone’s work on causal stories (2001). Deborah Stone’s approach to understanding policy making is that, at its core, policy is about a struggle over ideas and their meaning (2001). In ‘Causal Stories and the Formation of Policy Agendas’,Stone (2001) uses the distinction between action and consequence, and, purpose and lack of purpose, to create a framework for describing the causal stories used in policy making. Each quadrant of Stone’s framework (2001) represents one understanding of causality. Stone suggests that this framework could be used as a map to illustrate how political and policy actors could move an issue from one quadrant to another in order to support their position, with shifts audience and context dependant in order to gain support (2001).

Stone (2001) notes that in her typology of causes there are two clear extreme positions -accident and intent -and two weaker positions – mechanical and inadvertent cause. Stone’s work suggests that political and policy actors in the process of problem definition (or framing or representation) prefer the strong positions (accident and intent) but will alter their position into one of the two weaker positions (mechanical and inadvertent) as a default option to gain support (2001).

Secondly, is Carol Bacchi’s (2009) work on problem representation. Bacchi (2009) offers another complementary interpretative way to think about public policy and a methodology for analysing policy. Bacchi (2009) contends that traditional policy analysis accepts that policy is an attempt by a government to deal with a problem; that is, a problem exists and therefore a policy is required to fix it. However, Bacchi (2009) suggests that another approach is to recognise that policies are social constructions, and a policy represents a problem in a particular way. Bacchi (2009) proffers therefore, that the policy itself helps create the accepted understanding of the issue or problem, i.e. it constitutes the problem, and governments are key players in the creation of these policy problems and how they are understood. This position is supported by the other works described here (Stone 2001 and Barry et al. 2009), as well as by more recent work by Ulijaszek (2017).

Bacchi (2009) suggests the use of six key questions to help analyse and understand how problems are represented, terming the process, ‘What’s the Problem Represented to be?’ (abbreviated to WPR approach). The questions are:

1. What is the problem represented to be in a specific policy?

2. What presuppositions or assumptions underlie this representation of the problem?

3. How has this representation of the problem come about?

4. What is left unproblematic in this problem representation? Where are the silences? Can the problem be thought about differently?

5. What effects are produced by this representation of the problem?

6. How/where has this representation of the problem been produced, disseminated and defended? How could it be questioned, disrupted and replaced?

These questions are important because they offer a specific and clear, yet more interpretative, way to understand the problem representation and contextual influences in which policy is formed and operationalised.

Thirdly, and with specific reference to obesity, is the work of Kersh (2009). Kersh (2009) identified that there are currently two main argumentative frames employed in obesity, that of individual responsibility and ‘informed choice’, and the wider social determinants of obesity and the ‘obesogenic environment’ and that obesity policy debates are mostly focused around these two main argumentative frames. There are a range of other obesity models which can be seen as different framing and rationalities proposed by other authors such as Barry et al. (2009), Beeken and Wardle (2013), and more recently and extensively by Ulijaszek (2017) who proposed several different models, explored below. However, this study will focus on the two main frames proposed by Kersh (2009) and most commonly referred to, by probing the meaning of the word obesity, how the concept is socially constructed, and how the different understandings of obesity are expressed, all at a local level.

Fourthly, the US study by Barry and colleagues (2009), who draw attention to the obesity metaphors that are used to understand causes of obesity, and the influence these have on support for certain policy approaches (2009). When considering causes of obesity, Barry et al.(2009), outlined the importance of understanding an individual’s ideological standpoint, on a continuum of causes of obesity, from individual responsibility to societal causes. In their study they outlined seven obesity metaphors, not just the two main arguments most in use, reflecting Kersh’s criticism (2009) of obesity as an ‘issue regime’, simply using the two main frames. Barry et al.(2009), examined how individuals’ demographic, health and political characteristics, and attitudes about the causes of obesity, may influence their support for 16 obesity policies, identified by ‘elite responders’ (experts in obesity). Barry et al. (2009) proposed that depending on how causes and responsibility/solutions are ‘framed’ this can lead to support or a blocking of policy action. The causes and obesity metaphors discussed by Barry et al. (2009) reaffirm the need to explore the issue of obesity framing as individual versus social responsibility (and the continuum in-between) when examining individuals’ views on the causes of obesity and their support for policy/action to address obesity.

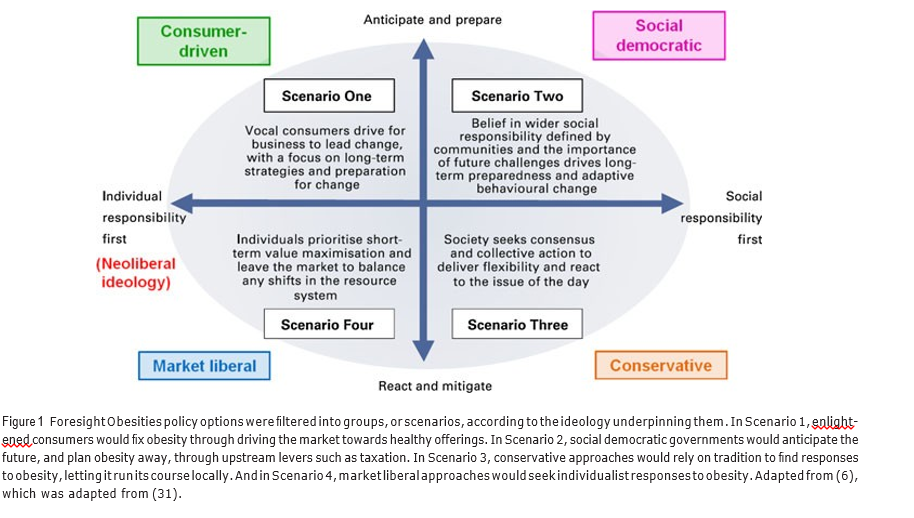
Fifthly, is the research undertaken by Beeken and Wardle (2013). They looked at attributions for overweight and support for policies. The attributions used were: genes; willpower; own fault; and abundance of unhealthy foods. These general framing expands the personal responsibility versus wider food environment slightly, not as widely as Barry (et al. 2009) but expands, nevertheless. This UK study found that 57% of respondents attributed overweight to lack of willpower, (‘people are overweight because they lack willpower’) and similarly 57% believed that ‘being overweight is mainly the person’s own fault’, reflecting an individual and personal responsibility stance. However, 61% also believed that availability of unhealthy food is a cause of overweight. There was a high level of support for most of the suggested policy approaches (campaigns (71%), restrictions on advertising and marketing (57%), labelling of foods including takeaways and menus (66%), and free NHS weight-loss treatment (48%)) with only taxation of unhealthy food scoring lowly (32%). Beeken and Wardle (2013) found that if overweight was viewed as outside individual control there was greater support for policies to prevent and treat obesity. They suggested that by ‘*improving awareness of the multiple causes of obesity could facilitate acceptance of policy action to reduce obesity prevalence’* (Beeken and Wardle 2013: 2132). Again, this work demonstrates that the frames or representations in use to attribute cause, do affect policy and action support to address overweight and obesity.

Sixthly, the paper, briefly identified above, by Ulijaszek and McLennan (2016) ‘Framing obesity in UK policy from the Blair years, 1997–2015: the persistence of individualistic approaches despite overwhelming evidence of societal and economic factors, and the need for collective responsibility’. In this paper, Ulijaszek and McLennan (2016) reviewed the approach taken during this time period and Labour Government at the time. They identified that individual personal responsibility framing dominated and persisted despite evidence that wider approaches were also required. Ulijaszek and McLennan (2016: 17) state the following:

‘*Despite a changing political landscape in the UK between 2000 and 2015, there is surprising continuity in the framing of obesity across this time…Political values of individualism and market liberalism,…are continuous and have infused policy documents with recommendations based on individualist behaviour and practice, even when the rhetoric of obesity policy veered towards collective action with Foresight Obesities. The framing of obesity is consistent,…There is also considerable continuity of key advisors involved in informing and developing policy across the period, and little research has been carried out to understand how their own views and values may affect the advice they give. This has implications for the framing of obesity, and for any possibilities for its reframing.*

Ulijaszek and McLennan (2016) developed the figure below (Figure 3.6) to describe the shift in policy options observed in their analysis when the government changed from Labour to the Conservative-led coalition, with an observed shift from scenario one to scenario four, but that values of individualism, individual choice and neoliberalism persisted even with this government change, this understanding has also been supported by Vallgarda (2015a; et al. 2015).

Figure 3.6 The shift in policy options observed by Ulijaszek and McLennan (2016) when the government changed from Labour to the Conservative-led coalition



Lastly, is the considerable work of Ulijaszek in the 2017 publication, ‘Models of Obesity’. Stanley Ulijaszek contends that the framing of obesity is central to the different policy models and approaches proposed, as discussed in his book. As Ulijaszek comments, *“Models of obesity are not neutral, nor are the facts that emerge from them”.* (2017: 1), as well as going on to state, *‘The way in which obesity is framed by any research discipline influences what is important to know about it….’* (2017: 169). Ulijaszek (2017) examines how obesity is framed, exploring the models that have been employed to understand and examine obesity from a range of perspectives. Ulijaszek (2017) argues that different groups understand and use different framings for what is important in obesity, as well as who/what has responsibility for both rise and reduction of obesity. Additionally, Ulijaszek presents that these different understandings lead to different actions. For example, Ulijaszek presents two sets of ‘facts’ about obesity. One set of facts is from the World Health Organisation (2014, in Ulijaszek 2017) and another from a group of US obesity researchers (Casazza et al., 2013, in Ulijaszek 2017). Ulijaszek presents that the WHO ‘facts’ are largely epidemiological, scientific and prevention focused, reflecting the WHO’s prevention purpose and perspective, whereas, Ulijaszek argues, that the commercial and funding interests of the other group are reflected in the Casazza (et al. 2013 in Ulijaszek 2017) facts, focusing on weight management treatment, pharmaceuticals and surgery.

These works fit well with the policy process literature from Kingdon (1984) and his work on agenda setting, as he notes that how issues are framed, or presented in public discussion, is important as to which policy approaches are adopted as well as to whether a topic reaches the legislative agenda in the first place (Kingdon 1984). This understanding is more recently supported in general policy analysis by the works presented above (Stone 2001; Bacchi 2009), and with specific reference to obesity policy analysis, by Barry et al. (2009), Beeken and Wardle (2013), Ulijaszek and McLennan (2016), Clarke (et al. 2016), and Ulijaszek (2017).

To date the only tool that the researcher could find that had been used successfully in analysing frames in use in obesity was the Jenkin (et al. 2011) framing matrix that had been based on an original matrix by Kwan (2009). Examining Kwan’s Framing Matrix (2009), which although employed in an American documentary analysis study, examined the competing frames employed in ‘fatness’ of: the medical model, social justice, and, market choice, this tool did outline a framework that was identified as suitable to assist in the analysis in this research. The Kwan matrix (2009) classifies documents into two main components, rhetorical and framing devices. Kwan’s rhetorical devices of a frame include: its overall position, the causal roots, the policy solutions and the core values underpinning the frame. The framing devices included are metaphors, exemplars, catchphrases and depictions [of allies and opponents], and visual images.

Kwan’s (2009) matrix was adapted by Jenkin (et al. 2011) and utilised to understand Australian and New Zealand obesity policy through documentary analysis. This adapted matrix was felt to resonate better with the aims of this research as it embeds some of the ideas in Stone’s work (2001) and ideas and questions that Bacchi suggests (2009). It also brings together the key issues Ulijaszek (2017) identifies to understanding models of obesity in use – understanding how obesity is framed by policy makers, and, the values underpinning this.

To date the Jenkin (et al. 2011) framing matrix has not been employed to understand frames in use in the UK by obesity stakeholders at a local level, such as commissioners, key decision makers and providers of obesity services. However, as described above, Ulijaszek and McLennan (2016) did study the framing of obesity in UK policy from 1997–2015 but using an analysis of framing of individual responsibility and collective action. (This is further expanded on in the methodology chapter that follows, chapter 4. See Table 3.3 below for the matrix employed in the study by Jenkin et al. 2011, adapted from Kwan’s 2009 study, which was utilised in this research.)

Table 3.3 The Framing Matrix developed by Jenkin et al. 2011

|  |  |  |
| --- | --- | --- |
| **Rhetorical Device** | **Key Aspect** | **Prompt** |
|  |  |  |
| **Position** | Overall description | How is the issue (obesity) described? |
|  |  | What is the emphasis? |
|  | Type of problem | Why is the issue (obesity) a problem? |
|  |  | What type of problem is it (health, social economic, moral)? |
|  | Affected groups | Who is the issue (obesity) a problem for? |
|  |  | Is it an individual, specific community, or whole population problem? |
|  |  | Are age, gender, ethnicity and socio-economic dimensions mentioned (i.e. demographics)? |
|  |  | Who is excluded from or not affected by the problem (obesity)? |
|  |  | How are subjects (those with the problem, of obesity) described? |
|  |  |  |
|  |  |  |
| **Causal Roots** | Main cause (of obesity) | What is identified as the main cause (of obesity)? |
|  |  | Is the cause environmental or individual? |
|  |  | Is there any additional focus or emphasis in the discussion of causes? |
|  |  | Who/what is to blame for the problem (of obesity)? |
|  | Non-causes (of obesity) | What are dismissed or explicitly identified as non-causes? |
|  |  |  |
|  |  |  |
| **Solutions** | Existing policy | What are the views on current policy? |
|  | Policy prescriptions | What solutions are proposed/emphasised? |
|  |  | What issues are included and excluded? |
|  |  | Are the solutions targeted or universal? |
|  |  | Who is responsible? |
|  | Non-solutions | Which solutions are opposed? |
|  |  |  |
|  |  |  |
| **Core Values** | Appeals to principle | What values or principles are evident in the problem representation (of obesity)? |
|  |  |  |
|  |  |  |

### 3.13.3 The current framing in use in obesity policy in England

As discussed previously, Kersh (2009) identified that there are currently two main argumentative frames employed in obesity, that of individual responsibility and ‘informed choice’, and the wider social determinants of obesity and the ‘obesogenic environment’ (Kersh 2009). Bacchi (2009) suggests that it is useful to consider how else an issue could be represented.

One representation of an approach to address obesity, is that obesity policies should support social equity, and take a truly healthy public policy approach to effectively tackle obesity (Nestle and Jacobson 2000; Allender et al. 2009; Gortmaker et al. 2011), one could represent this as a wider environmental or obesogenic environments approach. However, as discussed above, this approach is not reflected in the national strategies, with an individual focus persisting (Vallgarda et al. 2015; Ulijaszek and McLennan 2016).

Evidence from the Foresight Report (Butland et al. 2007) which has been further explored by academics such as Swinburn (et al. 2015; 2016 Frood et al. 2013) was clear about the role of the ‘obesogenic environment’ yet there remains a focus on obesity prevention and treatment at the individual behavioural level in England (Vallagrda 2015a; Vallgarda et al. 2015). This focus on individual behaviour change in the face of overwhelming evidence on wider structural and social determinants is also explored by Alvaro and colleagues (2011) in Canada. They state that this continued focus in Canada on the individual level despite evidence of the need to address the environmental (as identified by Foresight (Butland et al. 2007), is as a result of neo-liberal governmental approaches. They assert that the dominance government departments that support the free market economy have over other government departments, and policies supported by history and positive reinforcement from previous ‘successful’ policy that support the neo-liberal approach, continue to allow policies that support the free market economy to dominate over health (Alvaro et al. 2011).

This is similar to the stance taken by Herrick in her research, arguing that neo-liberal governmental policy approaches in England have,

*‘fundamentally altered the means and ends of Public Health, favouring a more individualist, localised and personalised approach to health, justified as being needs-based and efficient’* (Herrick 2007: 25).

This position is more recently recognised in the work by Vallgarda (2015a), Vallgarda et al. (2015) and Ulijaszek and McLennan (2016) which identifies that there remains a focus on obesity prevention and treatment at the individual behavioural level in England.

There is a tension between government activity and the autonomous individual, as defining health as being dependent on the behaviour of individuals it therefore becomes the responsibility of individuals not to participate in behaviours likely to result in ill-health and therefore add to the societal cost of ill-health, disease and healthcare provision. In the case of obesity, where food is ubiquitous, using this approach of individual responsibility can lead to victim-blaming (Puhl and Heuer 2009), as we are all at risk of over-eating and not being active enough, especially if the wider environmental forces, which Foresight (Butland et al. 2007) have recognised as central to obesity causation, are not considered.

The personal responsibility and informed choice approach sits uncomfortably alongside the seminal work of the Foresight Report (Butland et al. 2007) which demanded attention to the role of the environment in obesity and lead to the widespread use of the term ‘obesogenic environment’. Equally, personal responsibility and informed choice, without the means to make choices and the consideration of the environment, can create a tension when obesity prevalence is increasing, there is an observed widening and increasing health inequalities, and the issues of social and behavioural justice remain unaddressed (Adler and Stewart 2009; Ulijaszek 2017).

The public health model/approach seeks to balance individual choice, autonomy, protection of vulnerable groups, targeting at-risk, and reducing inequalities. The current public health model focuses on these wider social and environmental determinants, however, more from a preventative focus rather than treating obesity, and to a certain extent not focussing on the individual, solely on wider prevention, and with little evidence of effectiveness to date (DH 2016).

Some obesity academics have recognised that there needs to be continuum of approaches addressing both individual and wider determinants as part of a Whole Systems Approach (Swinburn et al. 2015; 2016; Frood et al. 2013), and a focus on health inequalities, despite the fact that the recent government strategies (for example the Childhood Obesity Plans one and two DH 2016; 2018) remain silent on these issues (Ulijaszek 2017).

The current interest nationally and internationally in this variant of a wider environmental or obesogenic environment approach, reflecting the complexity first widely identified by Foresight (Butland et al. 2007), through Whole Systems Approaches (WSA) is the type of approach renowned obesity academics such as Steven Allender, Boyd Swinburn, Diane Finegood and others have more recently acknowledged. That there needs to be a wider understanding of obesity policy approaches (Clarke et al. 2016) and that there should be an approach that considers the complex and adaptive nature of obesity as an issue, addressing both individual and wider determinants, as part of a system (Swinburn 2015; Frood et al 2013; Peckham et al. 2016). Further still, others have identified a wide range of representations that then influence differing views and actions, such as Barry (et al. 2009), Beeken and Wardle (2013), and Ulijaszek, as quoted above (2017).

Alongside these alternative representations of obesity in the literature, the role of evidence is also considered here to reflect how evidence influences representations of obesity, obesity policy and action.

### 3.13.4 What is the role of Evidence Based Policy in framing the issue of obesity?

This chapter has discussed approaches to obesity policy analysis literature relevant to this research, however, as identified in the critique offered by Clarke (et al. 2016) one key omission not yet discussed is the role of evidence. This is an area that Ulijaszek’s statement (2017: 169) about framing of obesity (quoted previously), also emphasises as important,

*‘The way in which obesity is framed by any research discipline influences what is important to know about it, how the research is done and types of evidence that are deemed important’*.

Some of the literature relating to policy formulation and evidence use has already been presented in section 3.8.4 (use of evidence). Leading on from his work in 2005 Swinburn collaborates again to develop the Obesity Policy Action (OPA) framework, based on the World Health Organization framework for the implementation of the Global Strategy on Diet, Physical Activity and Health (WHO 2004), to provide guidance for governments to identify areas for obesity policy action. Sacks and colleagues’ framework (2009) incorporate the recognised public health approaches of ‘upstream’, ‘midstream’, ‘downstream’, to address obesity. Their framework incorporates not only the processes, but also the approaches and perspectives driving the approaches, which resonates closely with the approach taken in this research study and the literature reviewed in this chapter. Sacks and colleagues (2009) outline their approach using a series of diagrams. Firstly, examining the process of the framework, then the approaches linking to the process and finally a table linking perspective to approach, which is where this study focuses in line with its interest in how an issue is framed and how this influences action.

Figure 3.7 Obesity Policy Action framework: high-level schema for policy development, implementation and evaluation (from Sacks et al. 2009)

Strategic policy and leadership

Process

Policy instruments

* Service delivery
* Government spending and taxing
* Advocacy
* Laws and regulations

Output

Supportive environment

Impact

Behaviour change

* Reduce energy intake
* increase physical activity

Health services

Outcome

Health

Economic

Social

Environmental

Monitoring, evaluation and research

Figure 3.8 Obesity Policy Action Framework – upsteam, midsteam and downstream policy targets (from Sacks et al. 2009)

Strategic policy and leadership

Process

Policy instruments

* Service delivery
* Government spending and taxing
* Advocacy
* Laws and regulations

Output

Supportive environment

Impact

Behaviour change

* Reduce energy intake
* increase physical activity

Health services

Outcome

Health

Economic

Social

Environmental

Monitoring, evaluation and research

Policy actions that shape the economic, social and physical (built and natural) environments

Policy actions that directly influence behaviour (reducing energy intake and increasing physical activity)

Policy actions that support health services and clinical interventions

Policy actions that influence underlying determinants of health in society

Policy actions that influence the food system

Policy actions that influence physical activity environments

**Socio-ecological**

**(upstream) approach**

**Lifestyle**

**(midstream) approach**

**Health services**

**(downstream) approach**

Table 3.4 Public Health Approaches to Obesity Action – upsteam, midsteam and downstream (from Sacks et al. 2009)

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Socio-ecological (upstream) approach** | **Behavioural (midstream) approach** | **Health services (downstream) approach** |
| **Perspective of the obesity epidemic** | The economic, social and physical environments are major determinants of population eating and physical activity behaviour patterns. | Population eating and physical activity behaviour patterns are major determinants of obesity prevalence. | Individual behaviours, motivations, genes and metabolism are major determinants of the presence of obesity in patients. |
| **Obesity prevention intervention targets** | Policy interventions shape the circumstances and conditions which are the underlying determinants of health and social equity in society. Policy actions target the food environments, the physical activity environments and the broader socio-economic environments (including taxation, employment, education, housing and welfare), thus indirectly influencing population behaviours. | Policy interventions target population or subpopulation behaviour change, aiming to improve eating or physical activity behaviours by using policy instruments such as social marketing and programmes. | Policy interventions support health services and clinical interventions. The focus is on managing and reducing existing weight problems in individuals and working with families to prevent overweight or obese children becoming overweight or obese adults. This includes medically managed, individually-based behaviour change. |
| **Responsibility for action** | Primarily governments, with the private sector responsible to some extent (corporate social responsibility). | Governments, civil society and the private sector. | Governments, health professionals and the non-government health services. |
| **Primary policy outcome measures** | Improved property, social equity and environmental sustainability, together with improved health outcomes. | Improved population eating and physical activity behaviour patterns and obesity prevalence. | Improved anthropometry and disease risk for individuals. |

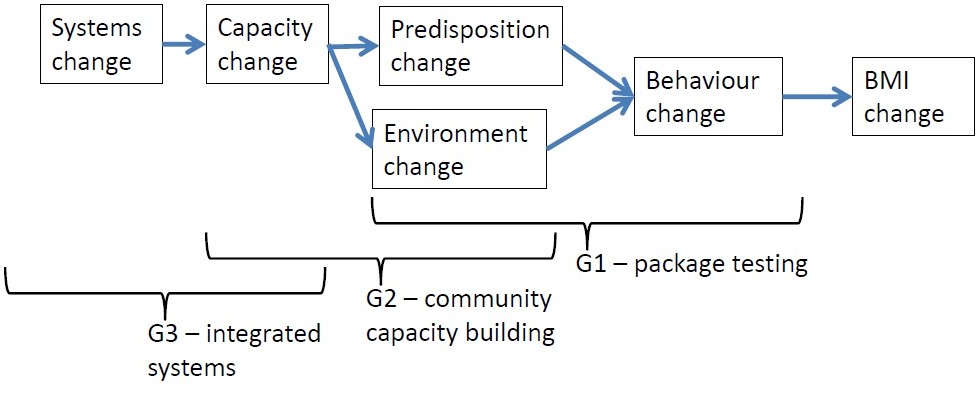
This table (table 3.4), as part of the OPA framework (Sacks et al. 2009) represents the paper authors’ views of differing perspectives linked to action. This supports the work of Barry (et al. 2009) in discussing differing obesity representations and support for policy action, and the more recent review by Ulijaszek (2017). However, Barry’s study (et al. 2009) noted that support was more based on personal narratives than political ideology. This research study seeks to explore the representations in use at a local level, understanding what informs local obesity policy processes. Evidence from the Foresight Report (Butland et al. 2007) was clear about the role of the ‘obesogenic environment’ yet there remains a focus on obesity prevention and treatment at the individual behavioural level in England (Vallgarda et al. 2015). This focus on individual behaviour change in the face of overwhelming evidence on wider structural and social determinants is also explored by Alvaro and colleagues (2011) in Canada, as previously described. The use of evidence and framing are two possible elements that were explored in this research at a local level.

### 3.13.5 Whole Systems Approaches to understanding policy processes

This section reviews Whole Systems Approach literature as a more recent approach to understanding policy processes. The Foresight Report (Butland et al. 2007) articulated the complex aetiology of obesity, stemming from an interconnected and interdependent web of 108 causal factors. The models developed for the Obesity Systems Maps produced by Foresight (Butland et al. 2007, Figure 1.1) contained causal loops to demonstrate that obesity is a problem, in a complex system. Foresight, in taking this approach, framed obesity as an issue of complexity (Ulijaszek 2017). Whilst this report intended to reflect the factors driving obesity, it also overwhelmed many policy makers because it did not outline a clear starting point, nor a mechanism, for action (Lang and Rayner 2007). However, one potential approach offered is to understand obesity in the context of a system. A complex systems model recognises ‘…*a multitude of interdependent elements within a connected whole’* (Rutter et al. 2017: 31267).

A systems approach recognises these interdependencies of causal factors and, in viewing them as a connected whole, will also see that a range of agencies could work together to address these causes by identifying key levers for change (PHE 2015). Recognised obesity academics such as Boyd Swinburn, Diane Finegood and others have recognised that there needs to be continuum of approaches addressing both individual and wider determinants as part of a Whole Systems Approach (Swinburn et al. 2015; Frood et al. 2013). For example, Swinburn (2016) presents a model to support action at all levels, across a range of agencies, addressing action for those who are already or at risk of overweight/obesity, as well as more population-level preventative action at the wider environmental level. This model, in what Swinburn refers to as his ‘three generations of thinking’, is also presented to support Swinburn’s call for action at a systems level i.e. downstream interventions, moving to capability and capacity building, to more upstream interventions (Figure 3.9).

Figure 3.9 Swinburn’s ‘three generations of thinking’ (2016)



In 2015, Public Health England (PHE) commissioned Leeds Beckett University (LBU) to create a toolkit that enables Local Authorities (LAs) to understand their local system which drives obesity and collectively work towards a shared aspiration for changing this system - A Whole Systems Approach (WSA). This was published in 2019 (PHE 2019). Examples are starting to emerge for how WSAs can benefit the health of the population by addressing obesity, with one recent case study coming from Amsterdam (Centre for Social Justice 2018). These approaches are recognised in the literature as requiring strong political will and support, persistent commitment, drive, and passion, and lastly, sufficient resource and prioritisation (Health Select Committee on Obesity 2018). It is still unclear if this systems thinking or whole systems approach may be likely to be any more successful than current approaches to obesity as there is no published evidence of the impact of systems approaches to obesity to date in the UK or internationally. However, as Bacchi suggests (2009) it is another way to frame the issue of obesity, differently to the dominant representation currently in use in the English national obesity policy (Vallgarda et al. 2015).

## 3.14 Literature Review Conclusion

The review of the literature presented in this chapter has considered different approaches to policy analysis, and specifically obesity policy analysis and what these may offer to answer the research question. Some of the literature reviewed focuses on understanding and measuring the causes, consequences and prevalence of obesity. This study seeks to go further by focusing instead on filling the gaps identified above; particularly by drawing on insights from the interpretivist policy analysis literature discussed, which suggests that framing or representation of an issue is of critical importance within obesity policy processes (Stone 2001; Bacchi 2009; Barry et al. 2009; Kersh 2009; Beeken and Wardle 2013; Clarke et al. 2016; Ulijaszek 2017; Cairney 2018). The chapter has shown that existing literature emphasises that how an issue is ‘problematised’ determines what does and does not get done, the way in which an issue is discussed, the evidence sought, produced and used, and how particular individuals and groups are viewed and treated (Bacchi 2009; Ulijaszek, 2017). However, current literature does not reveal how framing obesity intersects and works in a local policy environment – hence the need for this study.

### 3.14.1 Conceptual Framework

A conceptual framework for this study synthesises the insights from this literature review chapter in relation to the research questions of this thesis; illustrating the overall research design. This conceptual framework is illustrated in Table 3.5 and Figure 3.10 below. The elements in the framework provide a way of presenting the obesity and policy-related literature reviewed in this chapter, linking across to the methods for data gathering and analysis process used on this research. The research methods are described and justified in the next chapter. The framework was used to not only guide the research, ensuring that data collection tools had a sound theoretical basis, but also to structure the discussion of the findings of this research, relating them back to the wider literature and policy theory.

Table 3.5: Research Question, Aims, Methods and Sample Size

| **Expansion of Aim** | **Objectives** | **Theoretical Propositions within the Framework** | **Method & Justification** | **Sample & Justification** |
| --- | --- | --- | --- | --- |
| 1.How has national obesity policy developed over recent decades and how is the issue of obesity understood in such policy?  2. How has the local obesity policy in the four areas of South Yorkshire developed over the decade 2006/7 to 2016/17 and how is the issue of obesity understood in such policy? | 1)To understand national obesity policy documentation: both content and in relation to how obesity is represented as an issue.  2) To understand how local obesity policy has developed, both documentation and participant interviews, reviewing content or the ‘what’ as well as identifying any shifts in focus over 2006/7 to 2016/17  . | Aims 1, 2, 3, 3i & 4 link to the Conceptual Framework, through Walt & Gilson’s Policy Analysis Triangle (1994), Colebatch’s Key Questions (2002) and Cairney’s Policy Environment model (2018) by exploring:  a. How issues get on the agenda (Kingdon 1984).  b.Policy processes (Stages Heuristic – Sabatier & Jenkins-Smith 1993).  c.Actors involved (Walt and Gilson 1994; Colebatch 2002; Cairney 2018)  d.Policy Formulation, translation from national to local, exploring if ambiguity is locally negotiated (Hannes et al. 2010)  e.Policy Implementation (Hogwood and Gunn 1984) possible conflict between values and priorities required to formulate & implement policies (Stone 2001; Barry et al.2009; Hannes et al. 2010)  f.Differing desired outcomes from the policy depending on role and ideological position (Stone 2001; Barry et al. 2009; Cairney 2018).  g. Role of evidence in policy processes and decision making (Hannes et al. 2010; Kneale (et al. 2017) , Atkins (et al. 2017)  h. Influences on policy processes and decision making (Stone 2001; Barry et al. 2009; Cairney 2018) | 1. Literature review to gain understanding of the content of the national obesity strategies and policies and how obesity is represented.  2. Documentary Analysis and semi structured interview data analysing the ‘what’ ie the activities discussed by participants and the content of local policy and obesity policy documentation. Also using Jenkins (et al. 2011) framing matrix to gain understanding of the content of the local obesity strategies and policies and how obesity is presented.  Using documentation and interviews to explore key elements of the policy documentation and participant discussions to understand activity (in the broadest sense ie partnerships, work within teams, across teams and with partners), interventions commissioned, key actions, evidence used, actors and stakeholders, elements of the process and required outcomes from the policies.  . | 1.Narrative literature review.  2, 3, 3i & 4. Documentary analysis & semi structured interviews.  Documentary Analysis – Local policy documents. All local level standard/mandated strategy documents publicly available such as Director of Public Health Annual Reports (DPH Report), Health and Wellbeing Strategies (HWS), Joint Strategic Needs Assessments (JSNA), CCG strategy documents, Obesity/Healthy Weight Strategies, and service specifications - included from 2006/07 – 2016/17.  Semi structured interviews - Purposive sample of senior leaders, obesity leads, commissioners, stakeholders and providers of obesity services, and other strategy group members across sectors, in each area to be studied, until saturation achieved. Sampling based on job title/role.  Senior Leaders will include: PCT & LA Chief Exec, Directors of: Public Health; Children & Young People’s Services; Neighbourhood and Adult Services; Community/ Place/ Leisure, lead Councillors/elected members etc.  Sample size: difficult to predict due to different activities/stages of development of services (& transition) in each area. Est. 4-6 senior leaders & commissioners, 1-4 providers, approx.5-10/area, 25-40 total. |
| 3. How do obesity policy processes operate locally? | 3) To identify how local obesity policy processes operate. i.e. the broader umbrella and interlinked understanding of processes - To study how local obesity policy operates in South Yorkshire, using Walt & Gilson’s Policy Analysis Triangle (1994) - process; actors; content and context.  Exploring the national and local drivers and context for local obesity policy decisions and processes | As above | 3.Documentary analysis and semi structured interviews (one-to-one or groups) in each locality to explore the ‘who’ and the ‘how’ of local obesity policy, exploring the context and process elements of the Walt & Gilson Policy Analysis Triangle (1994). To gain deeper understanding of the local actors’ experiences and process of forming and implementing obesity policy in each area to be studied. Using documentary analysis insights to explore further in semi structured interviews | 3. Documentation and semi structured interviews as above. |
| 3i.Representation & Perspectives -  To explore how local stakeholders (senior leaders, commissioners and service providers) understand the issue of obesity. | 3i. To understand how local stakeholders understand and represent the issue of obesity, foregrounding framing as an issue (Bacchi 2009), within the Policy Analysis Framework (Walt & Gilson 1994).  Explore whether and how the two main argumentative frames in obesity (individual responsibility and obesogenic environment) (Kersh 2009) are used locally by senior leadership, decision makers, providers and commissioners, drawing on Bacchi’s What’s The Problem Represented to Be Approach (2009). | Aim 3i links to the Conceptual Framework through exploring framing or representation of issues using the general policy literature of Stone (2001) and Bacchi (2009), and with specific relevance to obesity, the work of Kersh (2009), Barry et al. (2009), and following on from Barry, the UK-based study undertaken by Beeken and Wardle (2013), and, the more recent UK Government focussed work of Ulijaszek and McLennan (2016) and the more extensive work of Ulijaszek (2017). | 3i. Documentary analysis using traditional content analysis to identify the ‘what’ as Bacchi (2009) argues that what gets done about an issue is indicative as to how it is represented or framed. The Jenkin (et al. 2011) framework and semi structured interviews to gain deeper understanding of senior managers, leaders and stakeholders perspectives and the frames in use about obesity. | 3i. Documentation and semi structured interviews as above. |
| 4.In what ways do these local understandings shape the way obesity policy is translated and implemented into practical realities? | 4. To appraise whether and how local understandings of obesity and locally employed representations of obesity influence obesity policy processes and day-to-day operationalising of policy. | 4. Aim 4 links to the Conceptual Framework through exploring Policy process literature  Exploring how decision makers formulate their own representations/causal stories of obesity, and how these causal stories, perspectives, and framing of obesity as an issue influences obesity policy decisions locally | 4. Documentary analysis using traditional content analysis to identify the ‘what’ as Bacchi (2009) argues that what gets done about an issue is indicative as to how it is represented or framed. The Jenkin (et al. 2011) framework and semi structured interviews to gain deeper understanding of senior managers, leaders and stakeholders process and experience of forming and implementing obesity policy, as well as participants causal stories of obesity, and how these causal stories, perspectives, and ideology influence decisions (about priority, funding, interventions etc) locally in each area of study. Exploration of the participants’ personal views on the local policy activity around obesity, and, their views on who should assume responsibility for delivering solutions. | 4. Documentation and semi structured interviews as above. |

Figure 3.10 Conceptual Model of the Case, its Development & Relationship between the Case, Research Question & Conceptual Framework

Interest & Preliminary Questions

Experiences & a priori knowledge

Refining Perspective

Further Experience & Review of Literature

**The Case**

Local Obesity Policy Decision Making Processes

National Policy

Local Policy

Local Impact

Context

Overall Issues (Research Question)

Senior Managers

Commissioners of Obesity Services

Providers of Obesity Services

***Integration of Theory***

**Conceptual Framework**

**Policy Processes -** Walt & Gilson’s Framework (1994), Colebatch (2002) Key Questions for Policy Analysis, Cairney’s Policy Environment (2018) inc Kingdon (1984), use of Evidence Kneale (et al. 2017), Atkins (et al. 2017), Causal Stories (Stone 2001), WPR2BA (Bacchi 2009)

**Issue Framing -** Causal Stories (Stone 2001), WPR2BA (Bacchi 2009), Obesity Metaphors (Barry et al. 2009), Framing matrices Kwan (2009), Jenkin et al. (2011), Beeken & Wardle (2013), Ulijaszek & McLennan (2016), Ulijaszek (2017)

**Elements to be explored *within the conceptual framework***

1. Translation of policy from National to Local and Local Policy to Local Impact
2. Policy ambiguities are left for managers at local level to negotiate
3. Actors involved in policy decisions, policy making and impact.
4. Local obesity policy content
5. How obesity is framed as an issue influences policy decision making about obesity
6. Local actors’ perspectives/representations of obesity and how these align with evidence
7. What is evidence, how evidence is used and to what effect locally
8. Contextual factors influence decision making eg policy history, national policy, finance, local priorities and focus

Undertaken Throughout the active research period 24 months: Documentary analysis – Processes, Aims, Evidence, Activities and Interventions, Outcomes, Prioritisation, Actors & Stakeholders. Using content analysis and framing matrix first developed by Kwan (2009), and expanded upon by Jenkin et al (2011) as a framework for the analysis of local policies.

 Undertaken in a 12 month period in the ‘middle’: Semi structured interviews with senior leaders, obesity leads, commissioners, stakeholders, providers and members of strategy groups etc involved in obesity policy processes locally.

**Locating the Research Question & Methods within the Domains of the Conceptual Framework**

# Chapter 4: Methodology

## 4.0 Introduction

This chapter presents and explains the research methodology employed in this thesis in order to answer the research question:

***‘How is national obesity policy translated, formulated and implemented locally by senior leaders, commissioners and service providers,***

***and additionally,***

***what implications do these policy approaches have in terms of successfully addressing obesity locally?’***

The chapter discusses the overall methodological approach; commencing with a review of the research paradigm employed in terms of ontology and epistemology. The chapter moves on to present the rationale for the case study approach used and the justification for the cases. The conceptual framework employed which has been presented above is discussed. The research design and specific methods used to generate data and insights are detailed, including the strategies for identifying potential participants. There is also a discussion of the data analysis and synthesis process. Ethical issues associated with the study are also considered.

The chapter is organised to ensure reliability of the research, addressing each of the steps LeCompte and Goetz (1982) outline as important in this respect; thus, assuring the reader of the reliability of the research. This includes: reporting the position of the researcher; reporting fully the data offered; reporting the setting; providing a full description of the theory used; and, providing a detailed description of the method.

The next section sets out the perspective from which this research was undertaken in terms of ontology (the science or study of being) and epistemology (the ways of understanding and explaining how we know what we know). It builds on the arguments of the literature review, chapter 3, which demonstrated the value of an interpretivist approach to policy analysis.

## 4.1 Research Paradigm – Ontology and Epistemology

There are a variety of different research paradigms, which shape the way research is approached, designed and carried out. According to Guba (1990), research paradigms can be characterised through their: ontology (what reality is); epistemology (how you know something); and, methodology (how to go about finding out).

Together, these are a holistic way of characterising how the world is understood, how knowledge is viewed, how we see ourselves in relation to this knowledge, and the methodological strategies proposed to understand it.

As mentioned in the previous chapters, this study embedded an interpretivist approach. This means that the study was shaped by the view that there is no single reality or truth (for example, of obesity policy processes) and, in turn, that reality needs to be interpreted in some way (Myers 2009). Interpretivist studies tend to focus on generating knowledge about meaning and understanding, focusing on comprehending different facets of the issues under study; recognising that this is relative (in terms of time, context, culture, values). Research embedding this approach tends to focus on what different people think and do when confronted with certain kinds of problems or issues, and how they deal with them. It also tends to involve the researcher in the process, where the relationship between the researcher and the participants is interactive, cooperative, and participative.

Given this understanding of an interpretivist research paradigm, the research was oriented from the perspective that there might be multiple interpretations of events or phenomena related to obesity (although recognising that certain interpretations might be dominant) and reflecting that there is no single reality of obesity policy locally. In following this approach, it was clear that the local obesity policy processes under study needed to be interpreted, in order to discover how the policy environment was shaped by context influencers - as Paul Cairney suggests in his policy approach (2018). In terms of methodology, this led to an embedded and qualitative methodological approach which supported the uncovering of meaning, and specific qualitative research methods that facilitated this (through qualitative analysis of policy texts and semi-structured interviews) (Yin 2009).

## 4.2 Qualitative Case Study Design

Given that the research embedded an interpretative stance and sought to understand the key areas of the Walt and Gilson Policy Analysis Triangle (1994) i.e content, context, process and actors’ perspectives and experiences of local obesity policy across the four areas of South Yorkshire, foregrounding framing (as previously discussed) a methodological approach which allowed the uncovering of meaning and the use of specific methods was needed. As a result, a qualitative case study methodology was used. Renowned case study researcher, Robert K. Yin (2009: 18) defines the case study research method as:

*‘empirical inquiry that investigates a contemporary phenomenon in-depth and within its real-life context; especially when the boundaries between phenomenon and context are not clearly evident’.*

Yin’s definition (2009) suggests that the 'case' can be any contemporary phenomenon, which includes things such as decisions or implementation processes. Following Yin’s approach (2009), it is important to note that, in this study, the case was defined as a contemporary process; i.e. local obesity policy processes, where policy process is an umbrella term encompassing all involved in the policy framework i.e. key areas of the Walt and Gilson Policy Analysis Triangle (1994) - content, context, process and actors. The focus of the case study was therefore on identifying and describing the relationships between policy content, processes, actors and local contexts, foregrounding framing (as previously discussed as important for policy understanding (Bacchi 2009) and a gap in the local obesity policy literature).

## 4.3 Applying the case study method in this research

Following the steps outlined by Yin (2009) for undertaking case study research the key elements of this research have been understood in the following ways. Firstly, this research defined the ‘case’ as ‘local obesity policy processes’, where, as aforementioned, this is an umbrella term for all in the Policy Analysis Triangle (Walt and Gilson 1994). Secondly, this research used multiple case study sites in the South Yorkshire area, examining the ‘case’ as defined, in Barnsley, Doncaster, Rotherham and Sheffield. Thirdly, the units of analysis were the sources of information, i.e. the documents, and, semi structured interviews. Finally, the boundaries of the case were defined, for the purposes of this study, as the commissioning bodies in which most policy activity took place and the activities undertaken (in the broadest sense of what activities are carried out, i.e. commissioned activities, work across the council, and work with others outside the council, partnerships etc) as well as but not just the services/activities commissioned.

The literature states that it is important to understand time boundaries, especially relevant for data collection processes, and therefore for the purposes of this research the timeframe binding the case was 2006/7-2016/17 financial years. This is from around the time of the publication of the NICE Guidance CG43, (Obesity: guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children) published in Dec 2006, which was important as it was the first of its kind, up until the data collection ended in early 2017 (due to participant availability).

### 4.3.1. Selecting the Case

As above, the ‘case’ under research is obesity policy *processes* at a local level. For the case to be studied at a local level, areas or sites needed to be identified in which to study ‘the case’. In this study the ‘case’ of obesity policy decision making at a local level was examined in the locality areas of South Yorkshire as case study sites.

### 4.3.2 Selecting the Settings

The research focused on South Yorkshire for several reasons, as detailed in Chapter 1 and expanded upon in Chapter 2. All the local areas that make up the South Yorkshire sub-region (Barnsley, Doncaster, Rotherham and Sheffield) have made investments in obesity-related activity; and have high prevalence of both adult and childhood obesity, with Foresight predicting in 2007 that Yorkshire and Humber would see the highest levels of obesity in 2050 if the current trend continues (with 3 of the 4 are regularly in the top 5 in England for prevalence. Finally, this research and PhD was funded through the obesity theme of the South Yorkshire CLAHRC, and, the researcher has worked in 3 of the 4 areas (and so South Yorkshire was therefore a useful area for pragmatic reasons).

The full extent of obesity prevalence, policies, activities and interventions to address obesity, across all 4 areas of the sub-region, is examined and detailed in this thesis in chapters five and six. The chosen case study sites presented an interesting opportunity to observe and analyse the policy process and present interesting points of comparison across the four areas. The comparative element, however, this is not the focus of the work. The policy process - local actors’ perspectives, content, context and influences on the obesity policy, including what impact this has - is the main interest.

However Table 4.1 below details some of the characteristics and priorities of the case study sites, in order to set the local context for the research. The demographic, health, obesity, and public health structure information regarding each of the sites at the time of the active period of the research is presented below. The data for each is from the PHE community health profile data set for 2014. What is notable are the key similarities rather than obvious differences across areas.

Table 4.1 Summary of key public health profile for each case study site (Community Health Profile Data (PHE 2014)

| **Area** | **Popn**  **000** | **Overall summary** | **Priorities** | **Deprivation** | **Public Health Structure** | **Council Control** |
| --- | --- | --- | --- | --- | --- | --- |
| Barnsley | 234 | Health in Barnsley is varied compared with the England average.  Deprivation is higher than average and about 24.4% (10,500) children live in poverty.  Life expectancy for both men and women is lower than the England average. 8.5 years lower for men and 5.9 years lower for women in the most deprived areas of Barnsley than in the least deprived areas.  In Year 6, 21.7% (458) of children are classified as obese, worse than the England average. The rate of alcohol specific hospital stays among those under 18, levels of teenage pregnancy, GCSE attainment, breastfeeding and smoking at time of delivery are worse than the England average.  In 2012, 34.4% of adults were classified as obese, worse than England average. The rate of alcohol related harm hospital stays, self-harm hospital stays, smoking related deaths, levels of adult excess weight, smoking and physical activity are worse than the England average. Rates of sexually transmitted infections, people killed and seriously injured on roads and TB are better than average. | -ensuring every child in Barnsley has the best start in life;  -facilitating large scale and voluntary behavioural changes among residents encouraging them to make healthy lifestyle choices;  -reducing the gap in life expectancy between the most and least deprived parts of the Borough,  -improving health of our most vulnerable groups and,  -protecting local residents from preventable threats to their health. | Barnsley is ranked as the 47th most deprived Borough of 326 English Boroughs. | Public Health is one of 5 Directorates, with the Director of Public Health part of the Senior Management Team (SMT) but not an Executive Director as all other 4 DIrectorate leads are. | Labour |
| Doncaster | 303 | Health in Doncaster is generally worse than the England average. Deprivation is higher than average and about 24.8% (14,000) children live in poverty.  Life expectancy for both men and women is lower than the England average, 9.4 years lower for men and 6.3 years lower for women in the most deprived areas than in the least deprived areas.  In Year 6, 19.1% (541) of children are classified as obese, England average (18.9%). The rate of alcohol-specific hospital stays among those under 18, levels of teenage pregnancy, GCSE attainment, breastfeeding and smoking at time of delivery are worse than the England average.  In 2012, 30.4% of adults are classified as obese, worse than the average for England. The rate of alcohol related harm hospital stays, rate of self-harm hospital stays, rate of smoking related deaths, estimated levels of adult excess weight and smoking are worse than the England average.  The rate of people killed and seriously injured on roads is worse than average. The rate of TB is better than average. | -alcohol misuse,  -obesity and,  -working with families. | Doncaster is ranked as the 39th most deprived Borough of 326 English Boroughs. | Public Health is one of 5 Directorates, with the Director of Public Health part of the Senior Management Team (SMT). | Labour |
| Rotherham | 258 | Health is varied compared with the England average. Deprivation is higher than average and about 23.2% (11,500) children live in poverty.  Life expectancy for both men and women is lower than the England average, 8.9 years lower for men and 6.4 years lower for women in the most than in the least deprived areas.  In Year 6, 21.2% (595) of children are classified as obese, worse than the England average. The rate of alcohol specific hospital stays among those under 18, levels of breastfeeding and smoking at time of delivery are worse than the England average.  Levels of GCSE attainment are better than the England average.  In 2012, 28.5% of adults are classified as obese, worse than the England average. The rate of alcohol related harm hospital stays, smoking related deaths, est. levels of adult smoking, and rates of sexually transmitted infections are worse than average.  Rates of people killed and seriously injured on roads and TB are better than average. | -giving everyone the opportunity to start well, develop and age well,  -tackling the root causes of ill health and,  -identify issues early and prevent premature mortality | Rotherham is ranked as the 53rd most deprived Borough of 326 English Boroughs. | Public Health is not a directorate in it’s own right but as part of the Adult Social Care & Housing Directorate reporting to that Strategic Director. There are 4 Directorates, with Strategic Directors and the Director of Public Health reports into a Strategic Director. | Labour |
| Sheffield | 557 | Health in Sheffield is varied compared with the England average. Deprivation is higher than average and about 24.4% (23,100) children live in poverty.  Life expectancy for both men and women is lower than the England average, 10.0 years lower for men and 7.2 years lower for women in the most than in the least deprived areas.  In Year 6, 18.7% (943) of children are classified as obese, England average (18.9%). The rate of alcohol-specific hospital stays among those under 18 and levels of breastfeeding are better than the England average. Levels of GCSE attainment and smoking at time of delivery are worse than the England average.  In 2012, 24.9% of adults are classified as obese, England average (23%). The rate of alcohol related harm hospital stays, smoking related deaths, and estimated levels of adult smoking are worse than the England average. The rate of people killed and seriously injured on roads is better than average. | -giving every child the best start in life and,  -reducing health inequalities. | Sheffield is ranked as the 56th most deprived Borough of 326 English Boroughs. | A distributed model working across & within other directorates and teams. Executive Management Team (EMT) is: Chief Executive, 3 Executive Directors (People, Place & Resources) , the Director of Public Health, the Directors of Policy, Performance & Communications. DPH reports to the Chief Executive, part of EMT & the PH team is distributed. | Labour |

## 4.4 Conceptual Framework

A conceptual framework for the study was developed and was presented in section 3.14.1, table 3.5 and figure 3.10. These sections indicate the links between the methodology, methods, and sampling strategy, with the literature review and theoretical framework,.

## 4.5 Research Design and Methods used in this Qualitative Case Study

This section details the methods employed to undertake the research, building on the conceptual components discussed in section 3.14.1. This section seeks to sufficiently describe the ‘how’ of the research.

Qualitative data collection and analysis was employed in order to collect descriptive information and provide an in-depth understanding of policy from the perspective of those who were involved. These were methods that support learning about: policy maker’s social and material circumstances; their experiences and perspectives; and, how local obesity policy works in particular contexts (O’Kane 1998; Ritchie and Lewis 2003; Pavis et al. 1997; Kalnins et al. 2002; Mason 2002).

As recognised by Denzin and Lincoln (1994), experiences are multidimensional and interpretative. Therefore, the approach needed to be able to capture the relationships between understanding about obesity and decisions or action taken, mediated through contextual factors such as issues and socio-political contexts, organisational structures, and the relationships between the actors and stakeholders involved in each area (such as in the approaches recommended by Cairney 2018).

### 4.5.1 Data Collection

Nutbeam (1998) outlines that, in qualitative research, the precise method is influenced by the aims of the research and the questions to be answered. This study was concerned with individual, shared and dissonant understandings and interpretations of obesity and their relationship to contextual issues and obesity policy processes locally. To answer the research question, documentary analysis and semi structured interviews were needed to adequately understand the ‘case’ of local obesity policy processes; to help understand both the representation of obesity in local policy documents and in use by local stakeholders. From the literature, these were deemed to be appropriate ways to understand all the factors involved in obesity policy at a local level and gain insight into the complex nature of the relationships between context and actors and processes (Sim 1998; Amaratunga et al. 2002).

### 4.5.2 Documentary Analysis

As above, in order to answer this thesis’ research question, and thus understand how national obesity public policy is translated, formulated and implemented locally by senior leaders, commissioners and service providers, it is important to understand how key stakeholders within Local Authorities (LA), Clinical Commissioning Groups (CCG), and those working in health and wellbeing and/or obesity across local areas, understand obesity, rationalise how to act on the issue of obesity, and what is actually implemented or ‘done’ about obesity at a local level. One way to do this is to analyse local obesity policy documentation, which can be considered as ‘authorised’ representations of local policy makers’ views. A deductive, textual analysis of publicly available policy documentation from the four areas was undertaken (which is referred to in this thesis as ‘documentary analysis’). This was conducted over the 24 months of active research, both before, during and after the semi-structured interviews to ensure the documentary analysis was contemporary (see below).

***4.5.2.1 Sample for Documentary Analysis***

The sample for the documentary analysis initially included all publicly available local obesity policy documents. These documents were wide-ranging (including data sets, Strategic Intentions, Service Plans, Reports and Health Profiles, essentially, whatever was publicly available or made available over the time of the active period of this PhD research 2011-2016/17 and included from a start date of 2006/07, (as above, when NICE Guidance (CG43) on Obesity was produced). However, as not all local documents were publicly available, and, there is no mandated requirement to have a local obesity policy or group, nor strategy, the suite of documents analysed was limited to documents that were publicly available and common across local areas that related to health/public health, and/or those that were relevant to obesity and willing to be shared by obesity leads.

The researcher located and verified all documents, with five local area document types being searched for (for example, on LA and CCG websites): Director of Public Health Annual Reports (DPH Report), Health and Wellbeing Strategies (HWS), Joint Strategic Needs Assessments (JSNA), CCG strategy documents, and Obesity/Healthy Weight Strategies (Table 4.2). From professional knowledge, and through consultation with a senior LA representative and my supervisors, these five document types were identified as being the most likely to include information pertaining to the local approach on obesity; and as providing a common documentary basis across the 4 areas.

The inclusion criteria were as follows. Firstly, documents were included 2006/07 to align with the publication of the NICE Guidance (CG43) on tackling obesity, the first guidance of its kind for obesity, and the increased national activity from this time onwards, up until the end of the active part of this research in 2016/17. This time frame also meant that current versions and previous versions of documents were eligible for analysis. Secondly, all documents were publicly available online and in the final published format.

In using this inclusion criteria, there were some documents that were excluded from the empirical analysis. These were mostly documents produced earlier than the inclusion criteria. Some areas had available documentation from the late 1990s and early 2000s which were outside the scope.

As above, in order to have an element of consistency across the four sites, six categories/types of document were used. These were: 1) Health and Wellbeing Strategies [HWBS], 2) Joint Strategic Needs Assessments [JSNA], 3) Director of Public Health Reports/ Public Health Annual Reports and Strategies [PH], 4) Obesity/Healthy Weight Strategies [Obesity], 5) CCG Strategies [CCG], and a sixth group was created for relevant other e.g. Obesity Specifications, Obesity Scrutiny reports etc [Obesity Other]. The documents identified and analysed are summarised in Table 4.2 below.

Table 4.2: Documentary Analysis Sample

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Documents** | **BARNSLEY** | **DONCASTER** | **ROTHERHAM** | **SHEFFIELD** | **TOTAL** |
| **Total** | 13 | 11 | 14 | 14 | 52 |
| **HWBS** (mainly external audience) | 2 | 2 | 2 | 1 | 7 |
| **JSNA** (mainly external audience) | 1 | 3 | 2 | 1 | 7 |
| **DPH/PH Annual Report/Strategy** (mainly external audience) | 4 | 4 | 2 | 7 | 17 |
| **Obesity Plan/ Healthy Weight Strategy** (mainly internal audience) | 0 | 0 | 0 | 0 | 0 |
| **CCG Strategy** (mainly external audience) | 1 | 1 | 2 | 1 | 5 |
| **Provider Strategy** (mainly external audience) | 1 | 0 | 1 | 0 | 2 |
| **Other including service specifications, scrutiny reports etc**  (mixed audience - (mainly external) | 3 - Scrutiny & specification document | 1 - specification | 6 - Obesity Scrutiny, Obesity Papers to Board, Professional Executive, specification | 4 – Move More Plan, Sheffield–Let’s Change4Life evaluation, City Strategy 2010-2020, specification | 14 |

This analysis therefore drew on a suite of 52 policy documents that were identified across each of the 4 geographical areas that were part of the study (Table 4.2). As will now be explained below, these documents were analysed by using the framing matrix of Jenkin et al. (2011).

***4.5.2.2 Documentary Analysis using the framing matrix of Jenkin et al. (2011)***

The framing matrix developed by Kwan (2009) in the United States and adapted for the New Zealand study (Jenkin et al. 2011) was used in this research, because it offers a systematic analytical framework (see Table 4.3 below). The work of Kwan (2009) and Jenkin et al (2011) was discussed in Chapter 3. The original matrix of Kwan (2009) analysed fatness using both reasoning (i.e., the positioning, causal roots, underlying core values, and solutions to obesity) and framing (i.e., terminology used to describe and articulate obesity) devices. This study focused on the reasoning devices of obesity, given the research aims, with the framing devices (as described by Jenkin et al. 2011) a lesser focus. Following the obesity policy matrix of Jenkin et al. (2011), the aims of the documentary analysis were to understand the following within the context of the local area and wider priorities locally:

1. Why obesity is an issue locally;
2. How the issue of obesity is discussed or framed locally (i.e. what is presented as the main cause, what type of problem it is, who does it affect);
3. What actions are outlined as being taken or planned, and by whom; and
4. How is obesity embedded in key local strategies?

The researcher read each of the documents numerous times (in a process of familiarisation) and then read again in alignment to the framing matrix (Table 4.3). Data from each of the local documents were captured in a data extraction form, which was aligned to the framing matrix (Table 4.3). The extracted data was then analysed further using the Jenkin et al. (2011) framing matrix, which assesses four key domains in obesity documentation:

1. *Position* (i.e. for this research focus - what type of problem is obesity, who does it affect?);
2. *Causal* *Roots* (i.e. for this research focus - what is stated to be the main cause of obesity?);
3. *Solutions* (i.e. for this research focus - what solutions to obesity are proposed and/or actioned?), and;
4. *Core Values* (i.e. for this research focus - what are the core principles of the document e.g. addressing obesity, addressing Health Inequalities, individual approaches, wider socio-environmental approaches etc?).

Table 4.3: The Framing Matrix developed by Jenkin et al. (2011).

|  |  |  |
| --- | --- | --- |
| **Rhetorical Device** | **Key Aspect** | **Prompt** |
|  |  |  |
| **Position** | Overall description | How is the issue (obesity) described? |
|  |  | What is the emphasis? |
|  | Type of problem | Why is the issue (obesity) a problem? |
|  |  | What type of problem is it (health, social economic, moral)? |
|  | Affected groups | Who is the issue (obesity) a problem for? |
|  |  | Is it an individual, specific community, or whole population problem? |
|  |  | Are age, gender, ethnicity and socio-economic dimensions mentioned (i.e. demographics)? |
|  |  | Who is excluded from or not affected by the problem (obesity)? |
|  |  | How are subjects (those with the problem, of obesity) described? |
| **Causal Roots** | Main cause (of obesity) | What is identified as the main cause (of obesity)? |
|  |  | Is the cause environmental or individual? |
|  |  | Is there any additional focus or emphasis in the discussion of causes? |
|  |  | Who/what is to blame for the problem (of obesity)? |
|  | Non-causes (of obesity) | What are dismissed or explicitly identified as non-causes? |
| **Solutions** | Existing policy | What are the views on current policy? |
|  | Policy prescriptions | What solutions are proposed/emphasised? |
|  |  | What issues are included and excluded? |
|  |  | Are the solutions targeted or universal? |
|  |  | Who is responsible? |
|  | Non-solutions | Which solutions are opposed? |
| **Core Values** | Appeals to principle | What values or principles are evident in the problem representation (of obesity)? |

**4.5.3 Semi-Structured interviews**

To investigate the research objectives about stakeholders’ representations, understandings and perspectives around obesity and whether these representations influence obesity policy processes and how, this research undertook 40 semi-structured interviews. These semi structured interviews were mostly one-to-one, with some *via* groups at the request of those in the group for their convenience and resource efficiency. These interviews were with senior managers (from the LA and CCG including public health leads), leaders (such as elected members and LA directors), local senior stakeholders and weight management service providers. Semi structured interviews were used as these were the most appropriate method to meet the aim of understanding experiences, perspectives and achieving in-depth knowledge around the issue from the participants’ point of view. The aim of employing semi-structured interviews in this research was to discover the interviewee’s understanding of obesity and context to help understand their perspective, ideal for meeting the objectives of this research.

The semi-structured interviews, as defined in the literature, were ‘guided conversations’ (Lofland and Lofland 1994); informal and relaxed discussions based around a predetermined topic, that contained broad questions enabling conversation and which allowed the opportunity to lead to new ideas and questions as a result (Wageningen 2004). A semi structured interview schedule and guide was used rather than set questions (see Appendix B) as good practice suggests the interviewer remain open to changing the interview; moving away from the predicted questions, combining a highly structured agenda with flexibility to move as the interview progresses (Milton 2004; Britten 1995: 252) ideal for exploring issues in depth.

*‘Semi structured interviews are conducted on the basis of a loose structure consisting of open-ended questions that define the area to be explored, at least initially, and from which the interviewer or interviewee may diverge in order to pursue an idea in more detail.’*

It was also felt that keeping the structure flexible would help to develop rapport with interviewees, which the literature suggests may lead to sharing more detailed or sensitive information, or issues not previously thought of (Britten 1995). The use of flexible interviews also allowed for checking, probing and clarification, which improves validity (considered in more detail later).

***4.5.3.1 Semi Structured Interview Study Population - Inclusion and Exclusion criteria***

The target study population were those who were involved in obesity policy processes at a local level across the 4 geographical sites across South Yorkshire (Barnsley, Doncaster, Rotherham, Sheffield), as the understandings of these participants were important to address the research question, in relation to local obesity policy processes. Sampling was based on job title/role. This included those who were identified by job title and/or role as local public sector (i.e. NHS or LA) senior leaders (i.e. PCT/CCG & LA Chief Executives, Directors of: Public Health; Children & Young People’s Services; Neighbourhood and Adult Services; Community/ Place/ Regeneration/ Leisure/ Resources/ Strategy, as well as lead Councillors etc.), LA/public health obesity leads, LA/public health commissioners, other identified senior local obesity stakeholders and providers of weight management services in each area to be studied, until saturation achieved. An inclusion and exclusion criteria was applied so that the target study population could be clearly defined, and the eligibility of the participants could be ensured.

Inclusion criteria

PCT/CCG & LA Chief Executives, Directors of: Public Health; Children & Young People’s Services; Neighbourhood and Adult Services; Community/ Place/ Regeneration/ Leisure/ Resources/ Strategy, as well as lead Councillors etc.), LA/public health obesity leads, LA/public health commissioners, other identified senior local obesity stakeholders and providers of weight management services *actively employed or serving* during the data collection period in one of the four geographical areas of South Yorkshire (Barnsley, Doncaster, Rotherham, Sheffield).

Exclusion criteria

PCT/CCG & LA Chief Executives, Directors of: Public Health; Children & Young People’s Services; Neighbourhood and Adult Services; Community/ Place/ Regeneration/ Leisure/ Resources/ Strategy, as well as lead Councillors etc.), LA/public health obesity leads, LA/public health commissioners, other identified senior local obesity stakeholders and providers of weight management services *not actively employed* or serving during the data collection period in one of the four geographical areas of South Yorkshire (Barnsley, Doncaster, Rotherham, Sheffield).

***4.5.3.2 Semi Structured Interview Sampling Strategy***

As the study involved in-depth qualitative semi-structured interviews, interviewees were selected purposefully and invited to participate in order to give as many different stakeholders a chance to express their views. Purposive sampling was employed in this study as it is the choice of a case because it illustrates a feature or process one is interested in (Denzin and Lincoln 2000: 370):

“*many qualitative researchers employ…purposive, and not random, sampling methods. They seek out groups, settings and individuals where…the processes being studied are most likely to occur*”

However, the numbers did not need to be large as the aim is to understand experiences and views as opposed to generalisability (Patton 1990: 184):

*‘There are no rules for sample size in qualitative enquiry. Sample size depends on what you want to know, the purpose of the inquiry, what’s at stake, what will be useful, what will have credibility, and what can be done with available time and resources’.*

Qualitative research does not require the inclusion of all potential participants from a target study population (Bryman 2016). However, the sampling strategy is described, in order to support methodological robustness and credibility in the process and findings, as well as to maximise the quality and range of responses and obtain a deep understanding (Ritchie et al. 2003).

South Yorkshire was chosen as the geographical area of focus for the reasons outlined in earlier chapters. This was also a practical decision, given the researcher’s location, knowledge of each geographical area in South Yorkshire and the limited time and resources available for conducting face to face interviews. The purposive sample, in each area under study across South Yorkshire, based on job title/role, included:

* senior leaders across NHS and Local Authority (LA) - this included: PCT/CCG & LA Chief Executives, Directors of: Children & Young People’s Services; Neighbourhood and Adult Services; Community/ Place/ Regeneration/ Leisure/ Resources/ Strategy, as well as, lead Councillors etc.
* Public Health Directors, obesity leads and commissioners,
* providers of weight management/obesity services, and,
* other senior local obesity strategy group members across sectors.

All LA Directors in each area were invited to participate without exception nor exclusion as it was recognised from the literature that wider socio economic environment is crucial in obesity (Butland et al. 2007) and therefore cuts across all LA directorates in terms of a systems approach to address obesity (Swinburn et al. 2015; 2016; Frood et al. 2013). The participants are summarised in the table, table 4.4 below.

Table 4.4: Participant Sample

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Participants** | **BARNSLEY** | **DONCASTER** | **ROTHERHAM** | **SHEFFIELD** | **TOTAL** |
| **Total** | **8** | **6** | **11** | **15** | **40** |
| **Public Health Directorate Staff ‘Public Health Commissioners’** (Public Health/Health Improvement Lead roles) | 3 | 2 | 1 | 2 | 8 |
| **Director of Public Health** | 1 | 1 | 1 | 1 | 4 |
| **(Other non public health) Local Authority Senior Leaders ‘Senior Leaders’** (at Director and/or Assistant Director Level - Chief Executives, Directors of: Children & Young People’s Services; Neighbourhood and Adult Services; Community/ Place/ Regeneration/ Leisure/ Resources/ Strategy. | 2 | 0 | 1 | 2 | 5 |
| **Elected Members/Councillors** | 1 | 0 | 1 | 3 | 5 |
| **CCG Senior Leaders, ‘CCG Participants’** (at Director and/or Assistant Director Level) | 0 | 1 | 1 | 3 | 5 |
| **‘Weight Management Service Providers’** (Leadership Roles) | 1 | 2 | 6 | 3 | 12 |
| **Other local Senior Leadership represented in ‘Senior Leaders’** | 0 | 0 | 0 | 1 | 1 |

There are a few gaps in the participant list but despite many attempts over the active period of research and data collection, (i.e. a two-year data collection period) including from Directors of Public Health and approval and advocacy locally for the study, no Doncaster LA Senior Leaders nor elected members, nor Barnsley CCG staff responded to my requests to participate in interviews. The recruitment and engagement of the participants is given in more detail below.

***4.5.3.3 Recruitment and engagement of the participants***

As described above, the participants referred to in this research were mostly the Public Sector Senior Management and Leadership Team (across NHS, Local Authority and the Clinical Commissioning Groups). Many of these participants were already known to the researcher in her professional role. Public health teams and weight management service providers were also crucial. Again, many were known to the researcher and therefore public health and/or obesity leads from each area were contacted to help identify relevant participants. There was an obesity strategy group and sub-groups for other stakeholders such as providers and commissioners already in existence in each of the local areas. Most obesity stakeholders and research participants were Public Sector (NHS and Local Authority) employees or contracted provider organisations who attended these meetings. After initial email and telephone contact with the Public Health leads for obesity in each area, and agreement from the relevant obesity strategy group meeting chair, these meetings were attended in each area by the researcher to explain the study and share information. These were followed up by the information being sent out electronically to the meeting attendees with meeting minutes.

The initial approach for recruiting senior leaders in the NHS and LA locally to become participants was via email after the initial attendance at the local weight management strategy group meeting. Each individual email included a summary of the intended research, a participant information sheet and a consent form (Appendix B). Where publicly available, direct email addresses were used, which assisted in making the email invitation to participate personalised. As outlined in the ethics application, an initial and follow up email were sent, after that, if no response either agreeing or declining to participate was received, no further contact was made.

Participants were approached in phases based on geography due to the part-time nature of the PhD researcher’s availability and ability to coordinate full time employed participant face to face interviews with time off from full time employment. Emails were sent between May 2014 and May 2015 to invite for participation, with approximately two to three months allocated to each site to approach, recruit and undertake participant interviews, with breaks between when recognised holiday periods meant recruitment and interviews were less likely to occur (e.g. August, December, April holiday times). All interviews were completed by July 2015.

A total of 192 emails were sent to secure the interviews with 40 participants. This was out of an initial and follow up approach to 69 identified potential participants in the sample.

Snowball sampling was also employed during the data collection process with some participants identifying and naming others who they thought should be approached and who met the inclusion criteria as described by Atkinson and Flint (2001). However, this did not prove effective, with none of the additional 6 participants identified responding to initial, nor follow up, approaches to participate in the research.

Saturation

This sampling approach and recruitment process resulted in 40 people agreeing to participate (as described in Table 4.4 above). As data was being collected the data from the critical listening and transcription of interviews was read and re-read by the researcher to identify the emergent themes. After initial analysis of the data, at a certain point in the interviews few new themes were appearing. At this point, it was felt that data saturation had been reached. At this point, and through discussion with supervisors (Baker and Edwards 2012), no further recruitment was undertaken. It is recognised this is a somewhat imperfect approach and that, given the interpretative nature of the research, new information may always be gleaned through interviews (Baker and Edwards 2012). As this PhD was undertaken part-time and all participants at a senior level but working in or with the Public Sector in South Yorkshire, the overall data collection period for the semi structured interviews was around 12 months.

A point of note, relevant to the sample, were the issues some of the LAs were dealing with at the time of the research. Aside from the national changes described in Chapter 2, there were local issues. As a result of an unsatisfactory inspection Doncaster Council Children’s Services were under external government ordered independent trust control (BBC 2014). The whole of Rotherham Council was under Government appointed Commissioner control for the duration of the research, after the Child Sexual Exploitation issues that have been well publicised nationally (RMBC 2019). This may have led to some recruitment issues. In Rotherham the whole council cabinet resigned leading to significant delay in engaging elected members to participate and changes may have been a factor in the lower interest in Doncaster from elected members and LA senior leadership. The Elected Members have therefore been presented as part of the ‘Senior Leaders’ group to avoid identification due to low numbers involved in any area.

### 4.5.4 Ethical considerations (and how these were addressed)

Research ethical approval was obtained from the School of Health and Related Research, University of Sheffield (Approval Number CSP125807) and is provided in Appendix A. Participant information sheets were given to explain the study to all potential participants and signed informed consent was taken from all participants (Appendix B).

Once ethical approval was gained from Sheffield University and National Research Ethics Service (NRES) as well as local NHS and LA panels the research proceeded. Each organisation to be studied was initially contacted to gain their cooperation, explaining the purpose of the study, and assembling key contact information. All data (documents and interview data with participants) was collected over a period of 24 months as a part time PhD.

Ritchie and Lewis (2003) provide guidance for researchers to consider the following:

* Research should be worthwhile
* Research should not make unreasonable demands on participants
* Participation in research should be based on informed consent
* Participation should be voluntary and free from coercion
* Participants and researchers should be protected from harm
* Confidentiality and anonymity should be respected

In order to address these ethical principles, I undertook the following elements. Firstly, in order to ensure that the research was worthwhile and not making unreasonable demands on participants, I developed a protocol that was given ScHARR ethical approval, recognizing that the research could contribute to the evidence base, and did not make unreasonable demands on participants. However, the time and resource commitment to participation was recognized and acknowledged in the information shared and in the approaches to participants. Interviews were conducted at the participants chosen location (all at a work base or convenient office space) and at a date and time convenient to each. An email was sent to participants thanking them for their contribution after each interview.

Secondly, to ensure participation was based on informed consent, all participants were fully informed and consented. As the researcher, I openly and honestly explained what, how and why information was to be collected and how it was to be shared, and always considered participant safety and welfare when making decisions. Consent was always sought and ensured, as this should always be respected and the personal information not shared, unless there was sufficient need to over-ride the lack of consent, such as, if justified in the public interest or where there is significant risk of harm to another. These were not required in this research process.

The emails inviting participation attached a Participant Information Sheet and Consent Form, which was re-provided and discussed at the semi structured interview before signing. All participants were offered opportunity to discuss the research before and after participation. The ability to be removed from the study was reiterated after data collection also (Appendix B). As per ScHARR recommended ethics procedures, the study information sheet provided:

• An introduction and overview of the research

• A description of the expectation of participants including potential risks and benefits

• Confirmation of voluntary participation, including both the right and how to withdraw at any point, without consequence

• Data collection, data protection and data management processes

• The researcher, supervisor and ScHARR contact information, including complaint procedures

Only one participant objected to the use of audio recording but continued to participate with the researcher having to make detailed notes.

Thirdly, and as already addressed through information and consent processes, Ritchie and Lewis (2003) support that research participation should be voluntary and free from coercion or pressure. In order to ensure this, the right to withdraw was made clear in the information and consent process and written materials and reiterated at all interaction points as consent is a continual process not given once without requiring to be revisited (Pope and Mays 2006).

Fourthly, Ritchie and Lewis (2003) explain that adverse consequences of participation should be avoided, and risks of harm known. Risk to the participants and the researcher was considered, also discussed in the completed ethics proforma, and approved (Appendix A). However, these were non-vulnerable adult participants in a non-invasive study and therefore risk was minimal. The ethics panel agreed that risk of participation was minimal. The only potential issues that were identified and explained to participants were:

1. The time to participate
2. Participants may feel uncomfortable about sharing or answering certain questions related to their views or experiences
3. Participants may feel concerned about the use and storage of personal information i.e. contact details
4. Participants may feel uncomfortable about how their answers, views or experiences may be presented and if they can be identified from the written thesis and any subsequent publications.

The following were undertaken to address these issues:

1. Interviews were arranged around participant work schedules at a time and location convenient to them and quite often rearranged at short notice to accommodate pressing work issues. This rearranging of interviews happened with six of the 40 participants at their request.
2. Participants were assured that they were free to decline answering any question posed without penalty or consequence.
3. A detailed description was provided in both the Information Sheet and verbally about the robust approach to managing data, data protection, and, information governance processes. All electronic data (audio files, transcripts, emails, signed scanned consent forms) were saved and backed up in password-protected folders on a secure server approved by The University of Sheffield or deleted as appropriate (i.e. audio recordings). The paper copies of consent, once signed and emailed, were shredded and securely disposed of.

All interviews were transcribed verbatim without personal identifiable information, a code was used to identify participants, known only to the researcher.

I ensured information was accurate, up-to-date and necessary, shared with the appropriate people only on a need-to-know basis (in supervisory sessions to develop themes and discussion), and, stored safely (encrypted on a hard drive).

1. This element was addressed, as outlined below, discussing Ritchie and Lewis’ (2003) last point.

Lastly, Ritchie and Lewis (2003) recommend that confidentiality and anonymity should be respected. Participants were assured that they would not be able to be identified in how the data was shared and presented. Data was only shared with the appropriate people, on a need-to-know basis (in supervisory sessions to develop themes and discussion). The findings have been presented in such a way to respect confidentiality and anonymity. For example, as all numbers of groups of participants are less than six no identifiable data has been included with roles grouped and gender, age etc. not referred to. Equally, as this study is looking at South Yorkshire as a whole, with obesity policy processes as the case, the findings as quotes are not presented with geographical identifiable labels throughout. This is only done where the specific area is being referred to and done with caution. This is twofold. One as it was not felt relevant in this research, with presenting in this way discussed and regarded in supervision as having minimal impact/value to the overall findings. Secondly, and aforementioned, this study seeks to understand obesity policy processes as the case, using South Yorkshire as a whole and the four areas (Barnsley, Doncaster, Rotherham and Sheffield as sites in which to study the case, not geographical case studies in themselves. Where quotes are referenced geographically as well as by role, this is only undertaken to highlight the critical similarities and differences in the four sites in section 7.2. This was also only undertaken where there were at least three or more participants from a role that was being referenced, to try to reduce the risk of identification, therefore the categories and ability to clearly understand different roles and areas perspectives may be limited by the presentation of quotes as a result of small numbers.

In addition to the Ritchie and Lewis (2003) recommendations there was an additional element addressed in this research. 25 of the 40 participants were known to the researcher in some way. Some were very well known professionally having been colleagues, others known from working relationships and networks, as well as others in passing in a professional capacity. Only 15 of the 40 participants were completely unknown to the researcher before commencing the research. At the time of the data collection the researcher was no longer working in the area of obesity and was also working out of South Yorkshire (as Children’s Services Manager in Leeds at a NHS Trust). At the time of data collection, the researcher had no influence nor involvement with either obesity locally or at any level anywhere. Therefore, some of the ethical issues and risks associated were mitigated by making this clear. However, it was recognised that participants may feel unable to answer completely honestly and openly due to previous/current professional working relationships. The Participant Information Sheet and Consent Information addressed some of this for participants. It may be that in some cases this relationship was of benefit and not an inhibitor to research. It was stressed to all verbally that this research had no relationship to previous work undertaken by the participant locally nor would anything be shared that could be personally identifiable (as discussed above). The purpose of the research (for PhD, sharing locally, and possible publication) was made clear to all.

### 4.5.5 Semi Structured Interviews Data Collection

To undertake the semi structured interview data collection an interview schedule was developed (Appendix B) to ensure both a systematic approach and consistency, which included a mixture of open and closed questions (Pope and Mays 2006). The literature recommends questions should be open-ended (to stimulate discussion), neutral (to avoid bias), clear, and, starting with easy questions and then moving into a designed and tested interview schedule with core questions that broadly define the areas to be covered, with the option to reword or reframe the question to suit the individual interviewee (Patton 1987). This recommendation by Patton (1987) was undertaken in this research.

Piloting of draft interview schedules was also undertaken with a range of individuals in similar roles to the participants but not working in the study area. This was a benefit of the researcher working in this field but now out of the research geographical area. Achieving breadth and depth was key to meeting the needs of this research (Ritchie and Lewis 2003), however, it was discussed at supervisory, from the pilot interviews, that not all questions suited all interviewees and although they may pilot well and be used to good effect in the study they mean nothing to some respondents, which demonstrates the skill and time required to develop good questions and the benefit of the flexibility to change questions that semi structured interviewing as a method provides (Pope et al. 2000). As a result of undertaking the pilot interviews there was a reduction in the number of questions, limiting to those of relevance to the study, and therefore, allowing more opportunity to probe and clarify. Overall, there were no significant alterations to the structure and content of the interview guide or the practical arrangements for conducting the interviews.

The first few questions were about participant thoughts on national and local obesity prevalence and then local obesity related activity. This information was felt (in the pilot) to be well known to this group of participants, non-contentious and simple to answer, to build rapport. These led into open questions, more closely aligned to the research aims and more focussed on the participants’ opinion.

As presented in background chapter the key national policy changes relevant to and affecting this research were: the Localism Act (2011); the Health and Social Care Act (2012); and specifically for obesity, Healthy Lives Healthy People (DH 2011). As previously presented, these national changes, which occurred during the active period of this research, led to a change in the structure of public health, alterations to ways of working at a local level and changes in roles and responsibilities for addressing obesity. It was critical to the aims of this research that the impact of these changes at a local level were understood without leading the participant.

As briefly presented in the background chapter, Chapter 2, there are different perspectives recognised in public health, reflecting differing schools of thought that identify different priorities and assign causality in different ways (Baum and Fisher 2014). These differing perspectives are often informed by people’s values, experiences and ideologies, and by their sets of assumptions about the social world - rather than there being one shared understanding.

As presented in chapter 2 in figure 2.2 Dahlgren and Whitehead’s (1991) 'Policy Rainbow' depicts the contributions and interactions of all the recognised determinants of health, i.e. individual behaviour and wider social, environmental and economic determinants to health.

Baum and Fisher (2014) argue that public health policy has two dominant perspectives on prevention of ill-health. A focus on individualised unhealthy behaviour, and/or, a focus the wider social and economic factors that underpin behaviour. They argue that health policy is dominated by interventions at the individual behaviour level, with fewer addressing the wider determinants.

Equally, Ewert (in Ewert and Loer 2019) reflects Kersh’s perspective (2009) that there are two dominant underlying assumptions in obesity causation – the individual diet and physical activity choices, and, the wider environmental influences, termed "obesogenic environment" by Egger and Swinburn in 1997. However, Ewert (2019), similarly to Baum and Fisher (2014) identifies that there are significantly more interventions at the individual level addressing behaviour than wider determinants addressing structural and contextual factors.

It was important in this research to ensure that the broad range of ‘activities’ to address obesity were able to be understood and discussed by participants i.e. and not just what might be more traditionally recognised as activity i.e. commissioned services. The researcher piloted the questions to ensure that information on all activity related to tackling obesity was presented by participants in the pilot, recognising the wider determinants model (Dahlgren and Whitehead 1991; Swinburn and Egger 1997; Butland et al. 2007), and not just activity explicitly ‘tagged’ as obesity activity, and not just commissioned activity, but activity in the broadest sense i.e. partnerships, work within teams, across teams and with partners, as well as more specifically obesity related interventions commissioned. It was also recognised by the researcher that all the participants were professionals working in or with the public sector, working in the field of public health or with public health, or specifically in obesity, therefore had good knowledge of the topic. This was supported by the pilot of the interview schedule and therefore, in conversation with supervisors, felt to be addressed.

As presented in the background chapter and then further expanded upon in the literature review (Chapters 2 and 3), one of the key issues foregrounded in this research is the issue of framing of obesity, as some researchers have argued is important to understand in policy in order to understand the policy actions taken and possible consequences, which as yet is unexplored in local obesity policy in England.

Bacchi (2009), Barry (et al. 2009) and Ulijaszek (2018) all argue that what is done about an issue can reflect how the issue is thought of and vice versa. This research is interested in how obesity is thought of as an issue at a local level, recognising the frames in use in the literature and seeking to understand these at a local level across South Yorkshire. Therefore, the questions were developed and piloted to allow actions to be described in their broadest sense (as discussed above) and to support greater understanding of the participant perspective on obesity and any frames that may be in use.

As above, good practice suggests the interviewer remain open to changing the interview; moving away from the predicted questions, combining a highly structured agenda with flexibility to move as the interview progresses (Milton 2004) ideal for exploring issues in depth. Additionally, interviewing whilst also analysing initial data allows further exploration of themes with new participants. In this research, a benefit of undertaking the interviews was the ability to include information from the content and documentary analysis to support the interviews as initial themes of interest were uncovered from the documentation. For example, a lack of clarity on what was actually being done in the documentation was able to be uncovered from the interviews, There was little information in the documentation about causation, responsibility, and the impact of national changes, therefore this was able to be explored in interviews in depth.

The interviews took approximately 12 months to complete, requiring detailed, careful planning and piloting, interviewing and analytical skills, were time and resource intensive, and, due to their personal one-to-one nature, may have suffered from issues of confidentiality, anonymity and, interviewer bias (Pavis et al. 1997; Kalnins et al. 2002; Scottish Executive 2000). This is addressed further in limitations below.

***4.5.5.1 The interview process***

As presented in Appendix B, in order to achieve a successful interview, the researcher undertook the following to support interviewing outcomes. Firstly, all interviews were conducted at a time and place of the participants’ choosing. These were all their work environments, but in areas that were confidential. Secondly the researcher conducted all correspondence and meetings professionally, dressing appropriately and addressing participants correctly and professionally, befitting from more than 20 years of professional employment in this sector. Thirdly, at the start of the interviews, the researcher thanked the participant for agreeing to take part and provided a brief overview of the research, the interview procedure and how their contributions would be used in and as part of the overall study.  Fourthly, the participant information sheet and consent forms (Appendix B) were then also discussed, whilst ensuring that the participant had both received and read a copy of each prior to the interview and agreed to the interview being recorded. This information was sent via email in advance and then again 24 hours before with a confirmation email. Fifthly, consent was signed at the interview after discussion and copies retained by both participant and researcher.  Assurances were given regarding confidentiality and data management and the participant was then given the opportunity to ask any questions before recording and the interview commenced.  Finally, once the interview was completed, the researcher thanked participants and reiterated consent, anonymity and sharing of results information discussed at the outset and included in the information sheet (Appendix B).  This was followed up with a thank you email.

***4.5.5.2 Recording of Interviews***

Having sought participant permission to audio record the semi-structured interview, I positioned the recording device close to them. In all but one interview, where recording was not agreed to, I took minimal notes as in practice I felt it hindered the interaction. Instead, notes were limited to prompts or ideas to follow up within the interview. As soon as possible after the interview, recordings were transferred to the secure server and stored as password protected files. For the interview where no recording was permitted, I took detailed notes and added to these immediately after the interview ceased.

### 4.5.6 Description and Justification of the Analytical Approach for Semi Structured Interviews - Thematic Analysis using the Analytic Hierarchy

The aim of qualitative analysis is to achieve meaningful understanding from raw data. The approach to analysis chosen in this research sought to understand things from people’s points of view (the subjective experience is their reality). Figure 4.1 below, is a depiction of the stages and processes involved in the qualitative analysis utilised in this research, employing the Analytic Hierarchy (Ritchie and Lewis 2003: 212).

The analysis process to support understanding in this research was through a process of uncovering and discovering themes and interpreting their implications for the research questions, in other words, using inductive and/or deductive reasoning (O’Leary 2004). Inductive, insofar as categories are derived gradually from the emerging data, and deductively in terms of what was already known (Pope, Ziebland and Mays 2000), as described in table 3.5 and figure 3.10.

The data from the 52 documents and 40 interviews was voluminous and rich in detail but unordered in content. Unlike quantitative analysis, there is no agreed method to qualitative analysis (O’Leary 2004), the approaches vary according to the research approach taken, epistemology, and, focus and aims (Kwale 1996), however, there is a great deal of discourse regarding how qualitative data is analysed to generate themes, findings and meaningful understanding (Tesch 1990; Bryman and Burgess 1994; Hammersley and Atkinson 1995; Mason 2002; Ritchie and Lewis 2003). Ritchie and Lewis (2003) list the features of tools used to interrogate data as: remaining grounded in the data; not losing the original thoughts; facilitating order; permitting patterns to be identified; systematic; comprehensive; flexible and transparent. For these reasons, the process of analysis of the semi structured interviews undertaken in this research was the analytic hierarchy approach to achieving thematic analysis (Ritchie and Lewis 2003).

This thematic analysis using the analytic hierarchy approach to analysis has been identified in the literature as suitable to support this level of understanding from interviews (Ritchie and Lewis 2003), as noted that transcripts of interviews provide a descriptive record, but they cannot provide explanations (Pope and Mays 2000). The analytic hierarchy framework approach is relevant when the objectives of the investigation are set in advance, as in this study (Pope and Mays 2000; Ritchie and Lewis 2003).This approach is heavily based in the original accounts of the people studied (that is grounded and inductive), and starts deductively (from what is already known) from the aims and objectives already set for the study. Again, these explanations and justifications of this approach from the literature fit well with this study.

Figure 4.1 The Analytic Hierarchy (Ritchie and Lewis 2003: 212)

Seeking applications to

wider theory/ policy strategies

Developing explanations **EXPLANATORY** **Iterative process**

**ACCOUNTS throughout analysis**

Detecting patterns Assigning data to refined concepts to portray meaning

Establishing typologies

Refining and distilling

more abstract concepts

Identifying elements and

dimensions, refining categories, **DESCRIPTIVE**

classifying data **ACCOUNTS**

Summarising or synthesizing data Assigning data to themes/concepts to

portray meaning

Sorting data by theme/concept

Assigning meaning

Labelling or tagging data by

concept/theme

**DATA**

**MANAGEMENT**

Identifying initial themes/concepts Generating themes/concept

RAW DATA

In using the analytic hierarchy approach, which is non-linear, the first stage is data management, sorting and synthesising the data. In this study, data was managed, involving the researcher first undertaking critical listening, and then transcribing the interviews. While part of the organisation and management of data, transcription is also a stage of analysis. I transcribed all 40 interviews (over 40 hours of recording). However, I also used the university transcription service to support my time, understanding, and as a check of my own transcription. Some interviews were transcribed by the university service before I had time to undertake my own transcription and therefore supported my critical listening, understanding and the identification of themes in a timely fashion. A brief example section of a transcript is outlined in Appendix C. This transcribing within a week of interview allowed the data collection and analysis process to be undertaken concurrently.

This transcribing was followed by reading the transcripts and identifying initial themes, becoming familiar with the data, whilst keeping in mind the research objectives (O’Leary 2004). The data was managed by reading, rereading, then labelling and sorting the data. Labelling or coding/indexing was crucial to allow data to be retrieved later, for further analysis or to present findings through quotes, as has been done (Miles and Hubermans 1994) (see Findings Chapters 5, 6 and 7). The manual coding process used a mixture of lines of text, paragraphs and phrases, colour coded for ease. Themes were looked for, based on some of the identified preconceived ideas in the conceptual framework (Figure 3.10), from having carried out detailed research and practice prior to the interviews. Therefore, a mix of deductive and inductive approaches were employed. For example, the researcher, using a deductive approach, was aware of the two main argumentative frames employed in obesity discourse of personal responsibility and choice, and wider environmental influences (Kersh 2009), therefore this was looked for. However, categories and themes also emerged from the data inductively, as they came from the data generated and were not be expected or known about beforehand. In using the analytic hierarchy this allowed movement between themes and back to the raw data, to check, clarify and search for detail, moving backwards and forwards.

Within these initial stages, collected data was sorted and synthesised before moving onto initial interpretation and subsequent explanation. Patterns and connections were identified by reading, rereading, underlining and highlighting relevant text, and then discussing these themes with supervisors to support a novice PhD researcher’s approach. These discussions led to more descriptive accounts formulated using quotes as representative of themes identified from further familiarisation and noted in the margin and grouped together under major headings/categories using colours for themes for ease of identification later (Miles and Hubermans 1994). These themes were ‘lived with’ by the researcher on a white board and refined over time through further data analysis, reading of the transcripts to ensure themes correctly identified and supported in quotes, as well as reading the literature and discussion with supervisors. These were then further developed or abstracted into models and/or concepts which were interpreted, bringing all the data together into a theory, presented in the subsequent chapters and as a diagram to depict themes and sub themes, as identified. This process involved moving from descriptive accounts to more explanatory accounts using the literature to support accounts and moving to this level of analysis, as well as employing the Bacchi (2009) framework, although more as guide rather than adhered to.

The analytic hierarchy process utilised was cyclical, as qualitative analysis is cyclical, therefore, there was a constant need to revisit and check data and move between analysis and data to ensure all themes were accounted for and meanings and original ‘voice’ not lost. This was found to be an extremely time-consuming method, never-the-less, as the data was collected and transcribed over a 12-month period this allowed for this level of familiarisation and analysis, as well as academic reading and supervisory discussion.

### 4.5.7 Semi Structured Interview Limitations

There were some specific limitations to the interviews already discussed in section 4.5.3 relevant to the time and place this research was undertaken. In addition to these very specific limitations, the literature lists numerous limitations to semi structured interviews which need to be recognised. Using interviews in qualitative research has been criticised by some as ‘blinkered’ (Silverman 2007), as the interview asks for the respondents telling of a story in a way which they will, due to human nature, highlight certain aspects and neglect others. Silverman (2007) advocates opting for forms of naturally occurring data rather than generated, however, this method has been chosen in this research as the most appropriate method to answer the question, as described above, and using piloting of the tool and process to try to mitigate some of these criticisms. This method also sits within a qualitative case study design, and findings can be triangulated by the documentary analysis, previously described.

Reflecting on the limitations of semi structured interviews, as Sparkes and Smith (2014) state in qualitative research, the person and their communicative abilities are the main instrument of data collection, because of this, a neutral role cannot be achieved, the subjectivity of the researcher is also influential, and therefore there is need for researchers to be reflexive about their practice. For Etherington (2004) reflexivity is the capacity of the researcher to acknowledge how their own experiences and contexts (which might be fluid and changing) inform the process and outcomes of inquiry. This reflexivity can be addressed by keeping a log or memoing, as, Etherington states (2004: 32):

*‘if we can be aware of how our own thoughts, feelings, culture, environment and social and personal history inform us as we dialogue with participants, transcribe their conversations with us and write our representations of the work, then perhaps we can come close to the rigour that is required of good qualitative research’*.

This reflexivity is further discussed in section 4.7 below.

### 4.5.8 Synthesis of the findings from documentary analysis and semi structured interviews

The findings from the documentary analysis and the semi structured interviews were brought together in the findings chapters and discussion through thematic analysis and synthesis (Thomas and Harden 2008). Analysing qualitative research and synthesising findings is recognised as a complex and contested process (Thomas and Harden 2008).   Thomas and Harden (2008) recommend thematic analysis and synthesis as particularly suitable for use in interpreting people’s perspectives and experiences as in this research. Thematic synthesis, based on thematic analysis (Ritchie and Lewis 2003) is essentially looking for recurring themes across the different research elements and was employed in this research using a similar process to analysis of the semi structured interview findings to synthesis all findings into themes. Thomas and Harden (2008) recommended: coding the text; then organising the codes into descriptive themes; and subsequently developing the descriptive themes into analytical themes.

In this research, after familiarisation with the findings from content and documentary analysis (using the Jenkin et al. 2011 framework) and semi structured interviews, the initial themes identified were lived with, revisited, triangulated across data sources, and then abstracted into more analytical themes, using the analytic hierarchy (Ritchie and Lewis 2003) previously described. The synthesis of data sources was undertaken by revising the descriptive themes through this process to allow analysis beyond the original separate data sources and initial findings into key themes and subthemes.

All themes were then checked for by revisiting the different data sources to support and challenge the identified themes. Theme identification was also challenged through discussion with supervisors and numerous iterations of themes over the not inconsiderable length of this research.

### 4.5.9 Overall Analytical Limitations

The analytical approaches to qualitative data vary according to the research approach taken, epistemology, and, focus and aims (Kvale 1996), however, the end result should be an analysis which represents reality for the participants, not an absolute truth (Pope and Mays 2000). This was achieved in this research through a process of uncovering and discovering themes and interpreting their implications for the research question.

There are various tools to facilitate analysis, however, these do not negate the need for the analyst to read, categorise and interpret the data, as the analyst, and how they think and operate, is the most important factor in analysis (Bowling 2005).

Given the different methods employed in this study of documentary analysis and semi-structured interviews, different analytical approaches were used to be appropriate to the data generated. These were explained and approaches justified above. Whichever framework or structure was employed to analyse policy, it is important to acknowledge that analysis of policy has limitations. The two main limitations are the data sources and the analyst’s own perspective, explored further below.

Policy analysis can be limited since the analyst must interpret and draw inferences from the data they are permitted access to. Therefore, the analysis is only as good as the sources accessed, which can be influenced by those approached for materials from which to undertake the analysis, also the views of those involved in the study, as well as the researcher’s views on what ‘ought’ to happen, can distort what ‘does’ happen in policy analysis.

The analyst’s own perspective can also influence both the research question chosen, the approach, the methods and findings. These have been considered and reflected upon throughout the research process, employing reflexivity and addressed below. Interpretivist analysis allows a researcher to explore the meaning ascribed by a participant to a particular event, but as with all such qualitative research it is possible that the researcher’s own views, conflicts and prejudices influence the themes that are subsequently identified from the transcripts. However, good thematic analysis describes the whole picture not just what supports one’s own argument selectively, and, out of context (Bowling 2005). The findings in qualitative analysis of this type are direct quotations, allowing the reader to hear the voice of the participants (Bowling 2005). Care was taken to avoid anecdotalism (Silverman 2007) or simply displaying findings that support the research argument, or findings displayed out of context. The findings chapters have addressed some of these limitations through numerous iterations and checking the data. Quotes used are the empirical research findings and not the researcher’s prior knowledge or assumptions. These elements are addressed below in considering reliability and validity in this research and further expanded upon in the final chapter (section 8.8).

## 4.6 Qualitative Reliability, Validity & Reflexivity

Reliability and validity in qualitative work is about ensuring rigour and transparency, openly describing what is being done and why, being systematic, and constructing an audit trail (a diary/log of what was done and why, detailing methods, decisions, rationale, describing settings and events (Bowling 2005). Reliability here, is about how accurate methods are, and, the extent to which findings are able to be replicated (Cano undated). This is difficult in qualitative work, as no two researchers and their thought processes, are alike.

Validity is about truth, whether the method explains what it set out to, and therefore the extent to which the findings are true and accurately reflect reality (Bowling 2005), reflected in the appropriateness of the method and data interpretation. Validity can be increased by respondent checking, which was undertaken in this study during the interviews as part of the process but not after using transcripts, as Mason (2002) notes this is inherent with difficulties as researchers are expecting interviewees to understand the transcript or interpretation and may also have to deal with respondents changing their mind about giving a response (Seale 1999). Validity may also be increased through triangulation, which was undertaken, to a certain extent, (Webb et al. 1996 cited in Bowling 1997), by examining the same phenomena in a different way as opposed to different methods producing the same results.

This research met these requirements for reliability and validity in a number of different ways. Firstly, the researcher used an audit trail to record what was done and why at various decision points during the research process, including data collection as well as during analysis through the long process of identifying themes. This includes records the whole process of the PhD, including but not limited to:

* All communication regarding the research process from initial meetings to final thesis
* Academic supervision meeting write ups and notes regarding decisions and processes
* Communication with participants both before and after data collection
* Notes of key decisions I made regarding data collection and analysis
* Verbatim (anonymised) interview transcripts

Secondly, the researcher has given a thorough description and justification of method and approach (in this chapter); and, thirdly the researcher, in being a reflexive practitioner, recognises that the researcher is inevitably part of the research and has sought methods to try to address impacts and bias from this – see below.

Lincoln and Guba (1985) describe validity in qualitative work as ‘trustworthiness’, ensuring: credibility (internal validity, ensuring conclusions accurately portray data, aided by a log, and member checking, which was undertaken in this study); transferability (applicability, external validity or the extent to which findings can be transferred to a similar group, through providing a rich description of setting); dependability (consistency, reliability, increased through an audit trail with well documented accounts of methods and decisions); and; confirmability (objectivity, findings are the consequences of research not as a result of biases, requiring neutrality and reflexivity). This research has sought to achieve validity as described through meeting the Lincoln and Guba criteria (1985) as outlined above and throughout this chapter, and also recognises Guba and Lincoln’s fifth criterion of authenticity (1989; 1994).

Authenticity is a measure of the quality of the data and data collection methods. To ensure authenticity this research has detailed the sampling approach and participant selection (above). Other processes that support authenticity are: ensuring that the appropriate method to answer the research question is employed; and, the justification for the approach is well detailed (above). Equally, using interview guides that are not biased, i.e., that do not ask closed or leading questions, is another means of authenticating the research. The schedules are provided in appendix B and were piloted to ensure they used open and non-leading questions allowing conversation to develop, as discussed above.

Triangulation is another means of addressing authenticity. In this instance triangulation refers to using multiple data sources to produce a more comprehensive view of the phenomenon being studied, e.g., in this case interviewing participants across a range of study sites, and/or organisations, as well as across professional disciplines, which is brought together in the discussion chapter (chapter seven).

The researcher's relationships to the issue, setting and participants needs to be explicit, and this was addressed in the information sheet to participants and has been detailed in the introductory chapter (Chapter 1). Additionally, the researcher's own biases and beliefs relative to the issue must be made explicit, and, again, this has been addressed in this thesis.

Alongside authenticity of the data collection, Lincoln and Guba (1985), Bowling (2005), and, Silverman (1997) to name a few, also recommend elements that ensure the analysis can be described as trustworthy. Trustworthiness was addressed by ensuring the analysis process was clearly described, and, that the potential influence of the researcher is reflected upon and made explicit. This is further expanded upon below.

## 4.7 Reflexivity

Reflexivity has been briefly introduced above and is further detailed for this research process below.

### 4.7.1 Reflexivity on the Researcher Role

As indicated above, reflexivity is one way to enhance the validity or credibility of qualitative research (Lincoln and Guba 1985). Reflexivity means sensitivity to the ways in which the researcher, research process and researcher-participant relationship have shaped the data collected and analysis undertaken, including prior assumptions and experience (Bowling 2005). The effect of the researcher’s professional status and the distance between the researcher and those researched are also factors for discussion on the issue of reflexivity in this study. As data collection and analysis is a reciprocal process between the interviewer and interviewee, which needs to be acknowledged and accounted for (Bowling 2005). O’Rourke (2005) emphasises the importance of questioning this relationship, and if this has introduced any biases. It is crucial researchers critically examine their role, potential bias or influence, which comes from face-to-face contact, the way questions are framed, results presented, analytical method chosen and process by which it is carried out (Morse 1996).

### 4.7.2 Researcher – Participant Relationship in this Qualitative Research Study

Ritchie and Lewis (2003) outline that the role of the interviewer cannot be underestimated: being, him/herself, a research instrument; and whether or not they are known to respondents or their occupation is known, as often the respondents are keen to ‘please’ and say what they think the interviewer wants to hear (acquiescence), which may be a limitation of this study as the researcher and researcher’s role as previous obesity lead was known to most of the participants, however, the researcher ensured that interviews were well understood by the participants as not a role of local professional obesity work or assessment or monitoring, but a research role for fulfilment of a PhD. Recognising that many of the participants were known to the researcher from previous working and professional colleague/peer and subordinate relationship, the researcher sought to stand aside from the data and reflect the participant voice questioning interpretations to ensure reflexivity. In reflecting on the researcher-participant relationship, this also gives rise to reflecting on the participants themselves.

### 4.7.3 Reflexivity on the Research Participants

Silverman (1997) notes the importance of recognising that the generated data from the questions posed may not be a true account of events but how the participant wishes to be perceived or remembers events – highlighting some aspects and downplaying others. As indicated by Ham and Hill (1993: xi):

*"It is rarely possible to agree on one version of events: the most that can be achieved is a plausible interpretation"*.

However, this is recognised in qualitative research, and as previously stated, triangulation was undertaken in this research by studying the same phenomena in different ways i.e. through documentary analysis and interviews, as opposed to triangulation which seeks to replicate findings.

The role of the participants in qualitative research is further complicated in interpretive analysis as the participants interpret their situation and the researcher interprets these interpretations. These are based on all sorts of previously held assumptions hence the need for a log, methodological description and justification, as well as understanding of reflexivity and how to improve reliability, validity and minimise bias.

Silverman (2007) also notes the need to recognise the impact the research setting has on participant’s behaviour, this may be relevant in this research, as all interviews took place in the participants’ place of work.

## 4.8 Bias

Bias, can come in many forms, from the research method (documentary analysis and semi structured interviews), instrument (tool used, questions asked, or not asked, how the question is framed, what is recorded), researcher as an instrument (how they are perceived), researcher/interviewer/analyst (attitudes, opinions and beliefs), and, from the subject themselves (how they wish to be perceived, truthfulness, ability to respond, and response to checking meanings) (Silverman 1997).

It must be recognised and acknowledged that the researcher’s philosophical stance, personal beliefs, attitudes and opinions ultimately determine the method chosen which then influences findings and the process by which they are generated, therefore the researcher’s stance and interests were detailed in the introductory chapter, and as part of the participant information sheet.

In qualitative analysis, the researcher or analyst is the most significant feature, as their perspective influences interpretation and understanding (Morse and Richards 2002). The main method of examining reflexivity and reducing bias in qualitative research is by memoing, as this log can be referred to, to give the rationale for doing something, helping with transparency. This was undertaken by the researcher in this study to help to overcome some of the limitations encountered as a result of the ‘relationship’ between the researcher and some of the potential participants in this study. Addressing the other areas of bias as proposed by Silverman (1997) and how these have been mitigated against in this research, is summarised in table 4.5, as follows:

Table 4.5: Addressing Bias

|  |  |
| --- | --- |
| **Source of Bias** | **Mitigation Employed in this Research** |
| The research method - documentary analysis and semi structured interviews | Description and justification wrt research question to support appropriateness |
| Instrument (tool used, questions asked, or not asked, how the question is framed, what is recorded) | Piloting the questions to ensure they were open, training in interviewing, clarity and transparency of researcher background and study provided in thesis and to participants in the info sheet, reflexivity |
| Researcher/interviewer/analyst - attitudes, opinions and beliefs, as well as how I was perceived by participants | Memoing/log could be referred to, this recorded the rationale for doing something, supporting transparency |
| Participants (how they wish to be perceived, truthfulness, ability to respond) | Clarity and transparency of researcher background and study purpose was provided to participants in the info sheet, Triangulation. |

## 4.9 Rigour

The findings of qualitative research are produced and constructed by the research process, therefore, issues of reliability, validity and generalisation are worthy of discussion. Reliability and validity in qualitative work is about ensuring rigour and transparency, openly describing what was done and why, being systematic, and constructing an audit trail (a diary/log of what was done and why, detailing methods, decisions, rationale, describing settings and events). This was done in this research process to support rigour.

LeCompte and Goetz (1982) outline five steps to improve internal and external reliability which was employed in this study and has been described in this chapter to support reliability of the findings:

1. Report the position of the researcher
2. Report fully the data offered
3. Report the setting
4. Provide a full description of the theory used
5. Provide a detailed description of the method.

## 4.10 Potential for Generalisability or Transferability

The outcomes of qualitative research should be rigorous: plausible and reliable, but they are not intended to be, nor designed to be, generalisable. Although the sample may not be representative of the population, this is not required, nor, the researcher’s aim as generalisability is not the intended outcome of this research, but instead to understand the ‘case’ of local obesity policy processes in South Yorkshire (Ritchie and Lewis 2003; O’Leary 2004; Bowling 2005).

The researcher hoped to ensure this study has good validity, as the methodology provided here has been described in detail to provide reliability and validity. The results presented in the subsequent chapters are ‘true’ for the people in the research, and, the study details that it has addressed all that it set out to in the objectives and thereby ensures good internal validity. External validity may be questionable as the sample mainly involved participants in South Yorkshire, English speaking and reading, and, with the self-motivation to attend semi-structured interviews. However, as previously stated, generalisability is not the aim.

For the purposes of this research, the researcher tried to address issues in advance of the research being undertaken, as well as during, in the hope that the strength of the evidence presented by the data collection and analysis is recognised, with questions and threats to validity and reliability addressed well, and therefore, ensuring a valid, reliable and potentially transferable study, but not empirically generalisable. The results may be transferable to a group, but not empirically generalisable as is often the case with qualitative research (O’Leary 2004).

Nevertheless, obesity is an issue all local areas in the UK are trying to tackle and therefore, it may be the case that some of the insights provided in this study can be of use and value in other areas; particularly areas which some of the contextual characteristics are similar. In this respect then, the findings may be useful in terms of ‘sensitising’ people in other LA areas to the types of issues that can arise, and types of factors that may be important in operationalising obesity policy at a local level, as the discussion goes on to examine.

Furthermore, while the research might not be directly generalizable, the themes identified in the following chapters and discussed in chapter eight resonate with wider literature. Therefore, this research contributes to a wider body of evidence on factors that are important to local policy processes; and, as we shall soon see, provide insight into the complexity of the public health system as it relates to local obesity policy.

## 4.11 Methodology Conclusion

This chapter has explained how an interpretative qualitative case study approach was employed to explore different elements of obesity policy process, including the policy context, content, processes and how the issue is framed in documents and by actors at a local level. It has shown how a qualitative research strategy is consistent with the ontological and epistemological basis of an interpretivist approach, the overall goals of the research, and how this approach has assisted in answering the research question. In order to address some of the criticisms of qualitative research, the chapter has described the methods used in detail and explored bias, rigour and reflexivity, to ensure that those who are interested in this research have sufficient detail to make judgements on the credibility of the research undertaken and the findings presented in the following chapters. The next three chapters present the findings of the research examined through the lens of content, context and process of local obesity policy processes and decision making in turn, employing Walt and Gilson’s Policy Analysis Triangle (1994) as a framework.

# Chapter 5: Findings – The ‘Content’ of local obesity policy

## 5.1 Introduction

This first findings chapter is focused on local obesity policy *content*, one element of the Walt and Gilson (1994) Policy Analysis Triangle. In examining content, this chapter focuses on the ‘what’ of local obesity policy, i.e. what is in local policy documents and also what participants said they were ‘doing’ (i.e. the solutions / actions / interventions being taken) to address obesity at a local level. In this way, the chapter presents findings from the synthesised analysis of: 1) how the 52 local policy documents identified in this study (see Chapter 4) described obesity, based on documentary analysis using the Jenkin et al. (2011) framework); and 2) how both documents and the 40 participants who were interviewed detailed local interventions to address obesity in each local area. The findings presented in this chapter are structured in relation to the key thematic areas of the Jenkin et al. (2011) framing matrix; focusing on position, causal roots, solutions and core values.

It should be noted that, while the focus on the chapter is the content (the ‘what’) of obesity policy, issues of context and process are also touched upon, given that, as presented in the literature review Chapter 3, these elements are all inter-related (Walt and Gilson 1994).

## 5.2 Position

The first key dimension of policy content is ‘Position’. This domain comprises a number of elements that help understand how obesity is described in local policy documents, in order to determine:

1. why obesity is an issue or problem locally,
2. what type of problem obesity is described as in local documents,
3. who obesity is described as affecting, and,
4. how those affected are described.

The problem of obesity was described in a number of different ways within and across different policy documents in each local area. For example, in different documents it was described as: a health risk factor for long term conditions (LTC); a lifestyle choice; a problem for children; and an issue of inequality. There did not appear to be any particular pattern to how the problem of obesity was described. These different framings of the problem are now examined systematically below.

### 5.2.1 Obesity as a lifestyle risk factor for long term health conditions

One way in which obesity was positioned as a problem in local policy texts was as a health issue, often related to long-term health conditions. In different policy texts from all areas (e.g. JSNAs, HWBS, DPH annual reports) obesity was, for example, presented as a medical condition, caused by lifestyle choices, and as a risk factor for longer term health conditions (LTC) such as diabetes, cardiovascular disease, and some cancers; as illustrated by the following excerpts:

*‘Obesity is a significant risk factor for poor health in later life’*

(Barnsley Health and Wellbeing Strategy 2013-2016, BMBC 2012).

*‘Excess weight is a risk factor for a range of cardiovascular diseases, including diabetes, and some cancers.’*

(Doncaster JSNA, DMBC 2014).

*‘Obesity is a key risk factor for high blood pressure and diabetes, both of which can lead to coronary heart disease and stroke; obesity is therefore a key factor fuelling premature deaths from circulatory disease..*’

(Rotherham DPH Report, RMBC 2013).

*‘Overweight and obesity increase the risk of a wide range of diseases and illnesses, including coronary heart disease and stroke, type 2 diabetes, high blood pressure, metabolic syndrome, osteoarthritis and cancer.’*

(Rotherham JSNA, RMBC 2011)

*‘Obesity is a medical condition in which excess body fat accumulates to the extent that it may have an adverse effect on health, leading to increased health problems and reduced life expectancy. A number of health conditions are associated with being overweight and obese including: type 2 diabetes, hypertension, coronary heart disease and stroke, osteoarthritis and cancer.’*

(Sheffield Director of Public Health Annual Report, SCC 2015)

In this description, obesity is primarily presented as affecting health, and not a wider issue impacting on or shaped by economic, social or wider wellbeing; and as a risk factor in terms of future disease burden for obesity-related illness, such as CVD, diabetes and cancer.

Linked to this positioning of obesity as a risk factor for long-term conditions, across all the four geographical areas, obesity was commonly positioned and referred to as a ‘*lifestyle risk factor’* for future disease development, such as cardiovascular disease, diabetes, some cancers, and as such a potential contributing factor to locally observed health inequalities gap. For example:

*‘Our JSNA has told us that the main determinants of health inequalities include deprivation and worklessness, attainment and skills, low birth-weight, infant mortality and mental health, as well as lifestyle factors such as poor diet, obesity, smoking and alcohol use, teenage pregnancy and low levels of physical activity.’*

(Rotherham Health and Wellbeing Strategy 2012-2015)

*‘Obesity, poor diet and increasingly sedentary behaviour are associated with higher risk of hypertension, heart disease, diabetes and certain cancers…. Sheffield’s rising trend in both adult and childhood obesity is worrying and poses a major risk to health.’*

(Sheffield JSNA, SCC 2013)

This was a very particular understanding of inequality – one that was grounded in differences in individual lifestyle behaviours, rather than stemming from wider inequalities in social or economic determinants (such as income, social status and poverty). This point is returned to in section 5.2.3 below.

### 5.2.2 Obesity as a problem for children

Another way in which obesity was positioned as a problem in the content of policy texts (as analysed using Jenkin et al. (2011), was as a as a problem for children; with particular focus on the mandated National Child Measurement Programme (NCMP) prevalence reporting by local authorities. All documents analysed that included reference to obesity emphasised the local significance and scale of obesity through childhood obesity prevalence and trend statistics. All documents that mentioned obesity also included the latest NCMP figure (a mandated LA function as mentioned in chapter 2) and some comparison to local and national trends over time. The focus on children is illustrated by the following excerpts:

*‘Childhood obesity is one of the biggest Public Health challenges for the 21st century. Obese children have an increased risk of developing health problems and are more likely to become obese adults.’*

(Director of Public Health Annual Report for Barnsley, BMBC 2016)

*‘Overweight and obesity have been similar to or better than the England average in recent years. In Year 6 (Y6) the percentage of overweight and obese children has remained steady in recent years even though nationally the levels have been increasing…….Obesity rates are higher in the more deprived areas of the borough, in both YR and Y6.’*

(Barnsley Director of Public Health Annual Report, BMBC 2016)

*‘Childhood represents a unique opportunity to improve population health; however it is imperative that people maintain a healthy lifestyle in adulthood. Doncaster was in the news in early February 2014 when data published by Public Health England revealed that Doncaster was the area second highest rates of obesity in England. Seventy four per cent of the adult population were found to overweight or obese. Excess weight is a risk factor for a range of cardiovascular diseases, including diabetes, and some cancers.’*

(Doncaster Joint Strategic Needs Assessment, DMBC 2014)

*‘Obesity was chosen as a priority area because it is widespread, prevalence is rising and the consequences are costly. The prevalence of overweight and obesity across Doncaster is considerably higher than the England average. Although there is a marginal decrease in recent National Child Measurement Programme (NCMP) results, this may be more to do with a fluctuation in data, rather than a levelling off or part of a long term downward trend.’*

(Doncaster Health and Wellbeing Strategy 2016-2021, DMBC 2016)

*‘In terms of childhood obesity, in 2010/11, 22.7% of 4-5 year olds and 34.7% of 10-11 year olds were classed as overweight or obese. Overweight and obesity levels for both of these age groups have increased over the last four years, in line with most other areas of the country. In terms of people aged 16 years and over in Sheffield 23.7% are estimated to be overweight or obese. This is slightly lower than the national average of 24.2% but the 4th highest out of the eight Core Cities.’*

(Sheffield JSNA, SCC 2013)

All documents that presented information about obesity across all four sites identified children as a group particularly at risk of obesity linked to NCMP data. The NCMP prevalence data in some instances appeared to be presented as one of the main drivers for policy activity locally. However, obesity was discussed in these documents as a whole population issue, affecting everyone and all ages, but with a focus in the documents on children, and some reference to deprivation, as is discussed below.

### 5.2.3 Obesity as an issue of inequality

A third way in which obesity was positioned as a problem in the content of policy was as an issue of inequality. Across the four areas, obesity appeared to be acknowledged in policy texts as connected to inequality, but mainly through people’s lifestyles and behaviours. For example, Doncaster documentation described different groups as being affected differently by obesity; with Rotherham and Sheffield having more documentation identified in the study discussing inequality than Barnsley and Doncaster. Inequalities appeared to be understood in a particular ‘individualised’ way. That is to say, that obesity was presented as a contributing lifestyle factor to health inequalities; with the health inequality gap observed locally across many documents as down to individual lifestyles, as opposed to inequalities in, for example, social status, material wealth and wider resources. In this way, obesity was not generally described as being influenced by underlying socioeconomic factors rather that obesity is more prevalent in those of lower socio-economic status. As presented by the following quote:

*‘[Our action will be] specifically targeting groups where we know obesity is more common, such as people from deprived communities, people with disabilities, older age groups and some black and minority ethnic groups.’* (Doncaster Health and Wellbeing Strategy 2016-2021, DMBC 2016)

In Sheffield there seemed to be more direct linking of obesity to social inequalities. For example:

*‘When there are inequalities in society, we all suffer. “For each of eleven different health and social problems; physical health, mental health, drug abuse, education, imprisonment, obesity, social mobility, trust and community life, violence, teenage pregnancy and child wellbeing, outcomes are significantly worse in more unequal rich countries” (Picket and Wilkinson, 2010). In other words, nobody benefits from inequality and it is therefore in all our interests to tackle the inequalities that exist in Sheffield.’*

(Sheffield Director of Public Health Annual Report, SCC 2015)

*‘For those aged 4-5 years (2009-10 and 2011-12), there is an inequalities gap of 9.5% in overweight and obesity prevalence between the most (25.8%) and least (16.2%) deprived children in Sheffield. The Slope Index of Inequality pooled over three years shows that approximately 82.1% of variation in overweight and obesity prevalence may be explained by the level of deprivation. For children aged 10-11 years (2009-10 and 2011-12), there is an inequalities gap of 15.1% overweight and obesity prevalence between the most (41.4%) and least (26.3%) deprived in Sheffield. The Slope Index of Inequality for Year 6 data pooled over three years shows that approximately 84.9% of variation in overweight and obesity prevalence may be explained by deprivation. Interventions focused on reducing childhood obesity must recognise the clear and significant relationship between deprivation and obesity.’*

(Sheffield JSNA, SCC 2013)

*‘If it’s…about poverty, it is starting to become noticeably statistically significant in sort of the lowest 20% in terms of deprivation, so it’s starting to congregate, which tends to reinforce the point about poverty which has been pretty universal for some time and probably just like every other public health challenge, doesn’t that always happen?……the figures prove that that’s happening because every middle class person is wising up and saying ‘no you’re not having an ice cream every morning for your breakfast’ and the lowest 20-30% is not that inclined really’.*

(Public Health Commissioner)

*‘And recognising it’s actually not just tackling health inequalities it’s about tackling inequalities in general and really sort of putting your weight behind things that might make a difference and I suppose ultimately it’s down to work and income really, largely it’s a key thing in obesity.’*

(CCG participant)

However, at times this health inequalities focus in participant interviews and documents in Sheffield is more in general terms and not specifically focussed on obesity. Additionally, this was not supported by action in terms of what is being done locally around obesity from the documentary analysis. Furthermore, although obesity was presented as an issue of inequality, this was not the dominant position. The dominant positioning of obesity in local policy documents was as an individualised, lifestyle and health issue, and as a risk factor for long term conditions (LTC), and primarily with a focus on children. This point is supported by the finding that where inequality was discussed, it tended to be connected to addressing inequality gaps locally that were associated with addressing LTCs, for which lifestyle choices are seen as risk factors (of which obesity is recognised). There was limited consideration of inequalities in wider determinants of obesity.

## 5.3 Causal Roots

A second key area to consider following Jenkin et al (2011) when considering policy content is the causal root(s) of obesity that are presented in policy documentation, defined as:

* the main cause of the issue,
* how the cause is described (i.e. is it an environmental or individual issue, or other),
* if there is any emphasis on other causes,
* whether anyone is ‘blamed’ for the problem, and if so, who is blamed, and,
* if anything is omitted.

Focusing on causal roots involves a closer consideration of the positions introduced above in relation to these key areas.

### 5.3.1 Lack of clear articulation of causes

The overall causes of obesity were not well articulated in the documents analysed across all areas. Where causes were identifiable, there appeared to be more consistencies across the four areas in terms of how the causes of obesity were described than differences, with a consistent focus on individual lifestyle choice in terms of diet and physical activity.

In Barnsley, the only causal links that were identifiable in terms of how obesity was described was that it is seen as a lifestyle choice leading to avoidable long-term conditions and related co-morbidities:

*‘Too many people have avoidable disabilities caused by lifestyle choices such as: smoking, obesity, poor diet, low levels of physical activity and excess alcohol consumption.’*

(Barnsley Director of Public Health Annual Report, BMBC 2016)

In Doncaster, again causation was not easily identifiable in the documentation. However, it was also described as an issue of individual lifestyle choice regarding diet and physical activity, within a complex environment. The following well illustrates the more recent Doncaster document discussion on causation:

*‘Unhealthy diets, inactivity and the availability of high energy foods are major factors in the rise of obesity across the UK. Obesity is a complex issue and we know it is not solely affected by individual behaviours, but influenced by a number of social and environmental issues.’*

(Doncaster Health and Wellbeing Strategy 2016-2021, DMBC 2016)

In Rotherham, obesity was again, as in the other areas, also described as an issue of individual lifestyle diet and physical activity choices. Greater reference appeared to be made to other wider contributory or causatory factors, but these were inconsistently addressed, appearing in one document and then no further mention. The HWBS outlined:

*‘There will be many contributing factors to this increase [in childhood obesity]: lifestyle and diet choices of the children, their parents, their school, and the local environment.’*

(Rotherham Health and Wellbeing Strategy 2015-2018, RMBC)

In Rotherham, there was a noted link between increased prevalence of obesity in Learning Disability groups, with a specific section of the 2011 JSNA devoted to this. This was not replicated in other areas, however, and this link was not mentioned in subsequent documents nor the issue highlighted again. Rotherham was also the only area to focus on obesity and Non Alcohol Fatty Liver Disease (NAFLD). However, similarly this was not followed up or repeated.

In Sheffield, there was also a lack of consistency across documents in terms of whether the main cause was articulated as individual and/or wider socio-environmental. In some documents there were clear statements about individual choice and lifestyle and, in others, more attention on wider socio-environmental factors. However these did not seem to track consistently in terms of chronology, authorship or suites of documents. In 2013, the JSNA included, for example, statements focusing on lifestyle - *‘Obesity is typically caused by unhealthy food choices and sedentary behaviour.’* (JSNA 2013) - with similar statements in the DPH report of 2015:

*‘Obesity is a medical condition in which excess body fat accumulates to the extent that it may have an adverse effect on health, leading to increased health problems and reduced life expectancy. A number of health conditions are associated with being overweight and obese including: type 2 diabetes, hypertension, coronary heart disease and stroke, osteoarthritis and cancer.’* (Sheffield Director of Public Health Annual Report, SCC 2015)

However, in the same Sheffield documents, there was also some recognition of wider environmental related factors:

*‘Weight gain occurs when you regularly eat more calories than you use through normal bodily functions and physical activity. There are complex behavioural and societal factors that combine to contribute to the causes of this weight gain and that can explain the increasing prevalence of overweight and obesity that has been seen in recent decades. The Foresight Report (2007) referred to a “complex web of societal and biological factors that have, in recent decades, exposed our inherent human vulnerability to weight gain”. The report presented an obesity system map with energy balance at its centre.’* (Sheffield Director of Public Health Annual Report, SCC 2015)

Maternal obesity was heavily focussed on in the 2013 Sheffield JSNA, alongside links to infant mortality, but this was not followed through in any documents; nor reflected in any other published document. Overall then, although there was some focus in Sheffield documentation on a wider determinants of health, in terms of obesity causation, the causative links between determinants and obesity were unclear in Sheffield.

### 5.3.2 Consistent, individual diet and physical activity approach

Although there was a lack of clear articulation of causes, as hinted at above, the causal roots of obesity were consistently described as related to diet and physical activity choices of individuals which lead to energy imbalance; albeit with some recognition that obesity causation is more complicated than individual energy balance, but no more in any document than a statement reflecting its complexity. This is exemplified in the following quote which illustrates this dominant focus on individual diet and physical activity, despite a recognition of wider influences and complexity:

*‘Unhealthy diets, inactivity and the availability of high energy foods are major factors in the rise of obesity across the UK. Obesity is a complex issue and we know it is not solely affected by individual behaviours, but influenced by a number of social and environmental issues.’* (Doncaster Health and Wellbeing Strategy 2016-2021, DMBC 2016)

This view was reflected in all four geographical areas, for example, across all the Rotherham documents analysed, there was recognition of the many contributing factors to obesity, but again the dominant narrative kept referencing wider factors but focusing on individual behaviours, taking a very simple, individual approach, listing as causatory: ‘*lifestyle and diet choices of children, their parents, their school, and the local environment*.’ (Joint Health & Wellbeing Strategy 2015-2018, RMBC 2015)

Very few of the strategic documents analysed seemed to utilise the seminal work of the Foresight Tackling Obesities Report (Butland et al. 2007), which extensively explores the causes of obesity, their linkages and complexity. Where Foresight was mentioned there was no wider discussion of the causal factors cited by Foresight, namely: biology, societal influences, individual psychology, food production, food consumption, individual activity, activity environment, merely a reference to the document.

Overall, the documents did not seem to adequately reflect the causes of obesity more widely than individual diet and physical activity choices, despite references to wider complexity. Obesity was dominantly and consistently described in a rather simplistic and reductionist way as a result of individual choices about diet and physical activity leading to an energy imbalance leading to unhealthy weight.

## 5.4 Solutions

The third aspect to consider when analysing local obesity policy content is solutions, also understood as interventions to address obesity. Interventions are what more traditional approaches to analysing policy content have tended to focus on. As explained at the start of this chapter, this thesis understands policy content as the content of ‘texts’ as well as ‘what’ interventions are proposed or being implemented within obesity policy processes. As such, this section therefore focuses on what interventions were mentioned in policy texts, as well as those mentioned in participant interviews .

A mix of interventions were identified across policy documents and participant interviews in each area. These were all aligned, to some extent, to the Department of Health’s tiered model of obesity solutions (DH 2013a, figure 1.2). Although the interventions within each tier are not clearly defined by Department of Health nor NICE, in the policy documents reviewed, and participant interviews, the interventions undertaken were found to be:

1. primary prevention partnership working (Tier 1);
2. primary prevention tier 1 interventions related to: physical activity, breastfeeding promotion, food plans and fast food takeaway restriction work with planning departments (Tier 1), and,
3. secondary prevention, mostly through commissioning of specialist weight management interventions – such as group 12 week courses focussed on diet and physical activity (Tiers 2 and 3).

### 5.4.1 Tier 1: Primary Prevention Partnership Working

The local documentation analysed identified the LA as the local obesity leads but with other partner organisations having a role or responsibility over certain interventions or a contribution as a partner, that may benefit the healthy weight of the local population. However, very few of these partners were listed in documentation or interviews, nor anything explicitly outlining their contribution. Instead, just general statements about working in partnership to tackle public health issues were presented. In interviews this was the case even when specifically probed about partnership. The findings in terms of documentation and participant interviews are presented below.

*Barnsley Partnerships*

Obesity is not the main focus in Barnsley documentation. There is discussion of partnership prevention approaches to public health issues but not specifically obesity. The majority of focus in general across the Barnsley documents is on the three public health priorities of oral health, smokefree, and; physical activity, with a recognition that the focus on increasing physical activity will also, in the view of Barnsley Council, contribute to tackling obesity (BMBC 2016). The main thrust of how any action on oral health, smokefree, and physical activity will be delivered was described a through utilising local pre-existing community assets, local people making changes themselves, not creating dependency. An example of this narrative is given below from the Barnsley Health and Wellbeing Strategy 2014-19 (BMBC 2014):

*‘The Health and Wellbeing Board has developed a series of principles to shape its work and underpin its intentions of co-producing a safe and sustainable health and care system. These principles will ensure all agencies are working together to deliver the best possible health and care outcomes for local people and communities throughout the Borough. The principles are:*

*Shared responsibility:*

* *Enables partnership working across the public, private, voluntary and community sectors,*
* *Maximises everyone’s contribution to build communities and environments conducive to good health and wellbeing choices,*
* *Encourages local people and communities to take responsibility and positive action to improve their health and wellbeing,*
* *Recognises local assets and strengthens the ability of local people and communities to develop local solutions to local issues, and*
* *Provides targeted support where necessary to increase community resilience and self-reliance, enabling people to help themselves, their families and communities, and targets resources to those in the most need.’*

However, as illustrated by the quote, this partnership and community asset focus was not specifically linked to obesity in the documents analysed. There was however, specific reference in one document analysed to a partnership prevention approach to obesity:

*‘Through working together with our partners, we hope to address population-level challenges that no single agency can address on its own, such as joint approaches to preventing and managing childhood obesity and increasing physical activity’*

(Barnsley Director of Public Health Annual Report 2016, BMBC 2016)

However, a public health commissioner did give more detail in their interview, which could not be substantiated in documentation. They also recognised that perhaps this partnership approach, described as in place in Barnsley, was not achieving as the documentation described, despite recognising all was in place, they commented:

*‘Overall we’ve got what you think is a good service there. We’ve got healthy settings, we’ve got breastfeeding peer support, we’ve got erm midwifes, we’ve got health visitors, school nursing, we’ve got integrated weight management service, we’ve got health trainers. Erm so overall we’ve got a really good service. All of the services work independently. Nobody know what’s going on so they’re all working in silos, erm yet public health is supposed to have this umbrella so that’s what we’re trying to achieve at the moment.’*

Despite a number of attempts there was no CCG representative from Barnsley willing to take part in the research, therefore little in terms of triangulation of partnership approaches from other agencies.

*Doncaster Partnerships*

In Doncaster partnership working was especially prevalent in and a feature of Doncaster’s documentation:*‘….over the next year, the aim is to strengthen partnership and collaborative work to tackle issues which influence excess weight.’* (Doncaster Health and Wellbeing Strategy 2016-2021, DMBC 2016). It was equally a feature of public health participants’ discussions, however, it seemed that partnership prevention approaches were in the planning rather than actually in place, with one Public Health Commissioner best describing the planned approach that others in Doncaster also referred to,

*‘To get all partners involved erm because we can’t do it in public health on our own…actually get commitment from Team Doncaster if you like which is all the sort of strategic partners in Doncaster that have a role to play in reducing obesity. Is to actually sign up to erm a health improvement plan, and that’s not just about obesity, its other erm areas of health. Erm and hopefully what that will mean is that we can get a partnership approach to the whole issues of health in the borough.’*

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However, despite this recognition within public health that partnership working was necessary, there was also a recognition that working in partnership across the obesity pathway was challenging, with another Doncaster Public Health Commissioner stating:

*‘Erm I think that’s, well, I’d say that the majority of our sort of investment appear limited and I think we’ve got ourselves into a situation where err we are now commissioning specialist services for the whole obesity pathway …and I think what we’re seeing is a sort of deskilling of people front lines or professionals who should be doing more so some of the work we’ve done around with midwives in terms of talking in pregnancy the sort of relative inability of midwives to even raise the issue of weight in pregnancy is erm quite stark and so so I think our impact really has been sort of limited to those so some base specific commissioning approach so particularly things like tier three weight management and probably what we’ve ended up doing is focussing on those areas because we know the evidence is effective but actually forgetting the rest of the pathways’*

The Doncaster CCG had limited recognition regarding partnership in their documents (where there was no reference to it nor obesity), and in interviews, as stated by one CCG representative:

‘*Erm it’s a limited, my knowledge is limited rather than what’s going on is limited erm because we don’t specifically commission any obesity prevention or treatment services erm so the local authority commissions tiers one to three of weight management and then NHS England commission tier four which is bariatric surgery as you know erm but I think the link, we’re trying to make stronger links with the local authority in terms of the prevention agenda per se and that’s sort of falling out a little bit of the five year forward view so we’ve got a kind of memorandum of understanding with the local authority about where we’ve got joint pieces of work and who’s doing what in which ones.’*

*Rotherham Partnerships*

In terms of Rotherham partnerships, the LA documents and participants discussed obesity partnerships locally, such as those with the providers of the weight management services, leisure services, cook and eat opportunities, and the healthy child pathway. Rotherham CCG also mentioned obesity in their documentation, however, were keen to stress that responsibility is with public health in the LA and that the CCG will have a supporting role only and not a commissioning one:

*‘Partnership working is essential to reduce health inequalities across Rotherham. Through working closely with Public Health, RMBC and voluntary sector we can support: ……reductions in childhood obesity……….The CCG is not responsible for the commissioning of: ….. Public Health initiatives e.g. Obesity, Smoking, Breast feeding – transferred from NHS Rotherham to Rotherham Public Health April 2013 Whilst the CCG will not be commissioning the services above, it will work in partnership to enable our partners to meet their objectives.’* (Rotherham CCG Annual Commissioning Plan 2013-14, Rotherham CCG 2013)

These statements reflecting the Rotherham CCG position are different to other areas as none of the other CCGs mentioned obesity in the documentation included in this research.

*Sheffield Partnerships*

Some Sheffield documents provided a comprehensive, detailed narrative around obesity and clear partnership commitment. For example, a plan in the Joint Health and Wellbeing Strategy (SCC 2012) noted plans to:

*‘Commission a joint plan and integrated pathway across the city including schools and the commercial sector to act preventatively and with lower-tier interventions to tackle obesity, providing accessible information.’* (Sheffield Joint Health and Wellbeing Strategy 2012, SCC 2012).

Sheffield City Council appeared to have a more comprehensive partnership offer detailed than any other of the areas in their documentation. However, this was again related to aspirations rather than evidence of existing partnership activity:

*‘Whilst [the above] services have a role to play in tackling obesity and are of benefit to those who use them, the evidence on obesity is clear that such services will not be enough to address the scale of the problem. Significant effective action to prevent obesity at a population level is required and evidence shows that a ‘whole system’ approach is critical – from production and promotion of healthy diets, to redesigning the built environment to promote walking, together with wider cultural changes to shift societal values around food and activity. This will require action by many partners including national and local government and by industry.*

*It is important that if we are to reverse the trend in excess weight gain and encourage healthy behaviour change, particularly amongst children and young people, the environment in which we live needs to change to make being physically active the easiest option. By making 20mph the default speed limit wherever individuals and families live, work or play; encouraging playing out schemes in local neighbourhoods; investing in more sustainable safe walking and cycling routes to school; and creating parking and drop off exclusion zones within the school areas can all contribute to reversing obesity.’* (SCC 2015)

This does reflect a different focus that the other areas with more attention on the need for partnership, prevention, ‘whole system approaches’, and wider environmental activities. However, there was no subsequent mention of obesity in any of the documents after this 2015 report. A focus on the lifecourse, early intervention and prevention does appear to have a policy history in Sheffield because, in 2009, it was reported that NHS Sheffield and Sheffield City Council match funded a £5million award from the Department of Health to be one of nine areas nationally to pilot work around obesity prevention and the obesogenic environment, implementing the Healthy Towns approach (DH 2008; SHU 2011). This occurred alongside the local existing NHS Sheffield commissioned treatment activities. NHS Sheffield was the accountable body for the delivery of this programme, however, delivery was through partnership of all sectors. The programme had 8 key areas: breastfeeding, healthy urban planning, green space usage, early years initiatives, school activity and cross sector innovation to ensure that by 2012 the obesity rates in Sheffield would be falling. The independent evaluation, undertaken by Sheffield Hallam University (SHU), found that overwhelmingly all KPIs and targets were met, if not exceeded (SHU 2011). However, Sheffield – Let’s Change4Life (SLC4L) has not been supported in the subsequent documentation, in fact not mentioned after its funding ended and the subsequent structural changes that occurred across Public Health, the NHS and LAs from the Health & Social Care Act (DH 2012).

At the time of this research in Sheffield, the main partnership activity to addressing obesity was through physical activity and the Move More Strategy. As one Public Health Commissioner commented:

*‘Yeah, I think the move more thing is an amazing idea that I’ve not seen in all my….when there’s so many organisations with a shared idea about there’s something not right and we need to contribute to putting it right, I’ve never seen that before in anything I don’t think’*

(Public Health Commissioner)

Other participants in Sheffield supported this focus on prevention via the ‘Move More’ strategy. In fact, this was the main focus of discussion in terms of local solutions to obesity in Sheffield, as demonstrated by the following quote from one Sheffield CCG representative:

*‘Erm well I know there’s a lot of work going on around activity, Activity Sheffield erm the miracle cure so the various initiatives to try and enable people to be more active, there’s move more and all of that so that’s very positive, that’s one side of the equation isn’t it? Erm I think there are some services available for weight management, I refer people to Weigh Ahead and other things like that.’*

Additionally, a local public health participant added*:*

*‘We’ve got the National Centre for Sports and Exercise Medicine with the links that that brings into the medical establishment in the city and the links to academia nationally and with the employers in the city and they’re all through the Chamber of Commerce signed up to that so the idea that through that we can promote the physical activity agenda through that organisation. So, I think there’s quite a lot going on on the physical activity side…..On the food side we’ve got a new food strategy that (name) has pulled together and is being signed up to. Erm again we don’t have any great amount of resource to throw at that but nevertheless I think establishing the food agenda more broadly is really something we need to be thinking about …. and I think to be honest I’m less assured that we’re doing as much as we should be doing around the food side of things as around the physical activity side of things.’*

In 2012, the Sheffield Joint Health and Wellbeing Board reported Food, Physical Activity and Active Lifestyles as one of the five programmes of work in the City’s Health and Wellbeing Strategy (Joint Health & Wellbeing Board Strategy, SCC 2012), demonstrating partnership working. This agenda is overseen by the Food and Physical Activity Board, a single overarching group responsible for physical activity and food (and healthy weight) in the City, leading the implementation of the ‘food and physical activity’ work programme of the City’s Health and Wellbeing Strategy. There is now a single strategy for physical activity “Move More” and a single strategy for food “Sheffield Food Strategy” that are detailed as intended to complement one another and together contribute to the wider healthy weight agenda. The Food and Physical Activity Board is directly accountable to the Sheffield Health and Wellbeing Board and the Children’s Health and Wellbeing Partnership Board. However, in both the 55 page Move More and the 23 page Food Strategy (SCC 2014), the terms weight, unhealthy weight, overweight, and/or obesity are in total mentioned less than 20 times and only to describe prevalence data or the current offer, not what these strategies are or will do to tackle obesity locally, yet these strategies are regularly detailed in the documents (and quoted by nearly all stakeholders) locally as the partnership solution to obesity in Sheffield.

### 5.4.2 Tier 1: Other Primary Prevention Interventions

The section above considered partnership working as a Tier 1 intervention to address obesity. Other Tier 1 primary prevention interventions generally include: focusing on awareness-raising and information/knowledge, promoting breastfeeding, healthy eating sessions such as growing and cooking; school food and local food plans, school stay on site policies; takeaway restriction activity; physical activity promotion such as active travel pans, walking, cycling and green space usage. These interventions are examined below across policy documents and interviews as a component of local obesity policy processes.

*Barnsley Tier 1 Activities*

There was limited evidence of Tier 1 interventions being implemented in Barnsley in policy documents. The only evidence that was identified was some mention of Tier 1 activity in the ‘integrated healthy lifestyle’ specification tender documents, but there was no detail of what these interventions were. There was a similar lack of detail provided by participants, despite probing on this topic. A Public Health Commissioner, for example, described the ‘overall offer’ in Barnsley, but without mentioning specifics:

*‘A new integrated model which is a tiered model approach; tier one being all the prevention or the intervention, website all those sorts of things. So tier two would be that face to face telephone, text, social media, and that’s where that actual behavioural change intervention comes in place for the people that need more support. Tier three would be MDT for weight management. But what we’re trying to do away with is that silo working…Well the other side of it is that to compliment that, so we will have the service and this is this tiered model, but around that we want to wrap around another lot of services. And those are cookery classes. Those are breastfeeding peer support. Health champions. So that it builds community capacity. Erm we want there to be community health and development courses. We want there to be a lot about, erm particularity in schools, about social norms about growing, about cooking, about distribution. About all those types of things about parenting skills. So it’s not just a service that can that will concentrate and do the behaviour change. That’s great, but if they’re going back to the environment that they’ve come from and nothing has changed there then they’ll go back to default and they’ll eat the unhealthy things and they won’t do the physical activity and won’t do any of those things.’*

Other participants also struggled to describe the local offer, including Senior Leaders who, when probed about what was being undertaken locally, commented: *‘Change4Life and things like that,…tooth brushing for kids’.* Similarly, another Public Health Commissioner responded,

*‘Well, I’m just not sure….Well we won’t do treatment so the treatment side will be NHS so anything that we do is more preventative, the Council does prevention so actually we do tier one and tier two so as long as there’s strong pathways …. I think most of our funds go into prevention.’*

This lack of clarity and lack of consistent understanding on the offer, either partnerships or other Tier 1 primary prevention interventions was not uncommon across areas.

*Doncaster Tier 1 Activities*

Doncaster policy documentation gave more information than Barnsley in terms of wider, more universal prevention Tier 1 activities. For example, from the Health and Wellbeing Strategy 2016-2021 (DMBC):

*‘The top priorities for 2015/16 are: The development of a plan to address access to healthier food (to incorporate Doncaster food plan, food procurement, school meals, workplace health award environmental health plan). Work with academic partners to explore the feasibility of a toolkit to improve the food environment in Doncaster communities. Active promotion of physical activity opportunities. Development and rollout of a Making Every Contact Count (MECC) training package. Continued work with planning teams to ensure access to healthier food and physical activity opportunities are incorporated into the Local Development Plan’.* (Doncaster’s Health and Wellbeing Strategy 2016-2021, DMBC).

However, interestingly, despite this being articulated in the 2016-21 Health & Wellbeing Strategy (DMBC 2016), the latest Director of Public Health Report (DMBC 2017) does not mention overweight/obesity. Equally beyond partnership working participants did not mention any of these approaches in any interviews therefore it was difficult to triangulate and to understand if these were actually happening.

*Rotherham Tier 1 Activities*

In Rotherham there were few tier 1 primary prevention interventions mentioned in the policy documents. Most documents focused on high level strategy, discussing wider issues locally not solely obesity, nor did they mention obesity. Where obesity was mentioned the focus on interventions appeared to be on tier 2 commissioned services in the pre-transition period of public health (commissioned pre-2012). These are discussed below. The Rotherham Healthy Weight Framework (HWF) developed in 2008/9 was referenced in documents. This is a tiered model reflecting the DH guidance (2013a), including tier 1 interventions. The Rotherham HWF was repeatedly mentioned as an area of nationally recognised best practice, with detail of the model given in the 2011 JSNA, for example:

*‘Rotherham’s healthy weight framework to address overweight and obesity is recognised nationally as an example of best practice.* (Rotherham Health and Wellbeing Strategy 2015-2018, RMBC 2015)

From 2012 onwards there was more included in documentation about the need for tier 1 activities such as school interventions, school meals and, work with planning, however it should be noted there was still little detail about what was being implemented in practice. For example, the 2011 JSNA highlighted,

‘*Tier one services include primary care, health visiting, school nursing, leisure services, cook and eat and their contribution to the HWF is as part of their general service provision (some of these services are not commissioned as part of the HWF).’*

In the Rotherham Joint Health & Wellbeing Strategy 2015-2018 (RMBC 2015) there was reference to school stay-on-site policies, and the potential impact of planning decisions to enable physical activity, or *‘using planning levers to limit the growth of fast food takeaways’,* which the authority states *‘can contribute to the broader effort to reduce growing levels of overweight and obesity.* However, these were brief mentions without further reference to the detail of any of the local tier 1 prevention activities in any other policy documents. The HWF was discussed by participants in the interviews, but the detail of these preventative approaches was not articulated by any of the Rotherham interviewees.

*Sheffield Tier 1 Activities*

The on-going obesity work in Sheffield does not seem to have a core strategy document although obesity is described by the local authority as a priority, across a range of documents reviewed (Sheffield DPH Annual Report 2009; 2010; 2011; 2012. 2013; 2014; 2015)*.* In these documents,the approach to tackling obesity in Sheffield consistently references taking a prevention approach, however mostly lacking in the detail of what this is.

Obesity services in Sheffield were re-procured in 2014, post transition to the LA, with the reported ‘new’ approach *– ‘to offer an integrated pathway for weight management in Sheffield following a lifecourse approach, with a focus on prevention and early intervention’*. This approach is detailed in the local DPH Annual Report of 2014, which is highlighted as ‘*the key to halting the rise in obesity locally*’ (Director of Public Health Annual Report, SCC 2014). Participants in Sheffield were able to describe different elements of the prevention and tier 1 approach in differing amounts of detail. No one from the CCG nor the Weight Management Service Providers could describe anything further than their own delivered interventions and name the Move More strategy (without any supporting detail). However senior leaders and public health participants could give more detail. All senior leaders and public health participants mentioned Move More but did not provide detail. For example, one Senior Leader’s comment is typical of others, ‘*I think that you know the food plan and the move more strategy’.* Another senior leader, who gave the most in terms of detail in the interviews, described a need to focus on tier 1 interventions, given this did not appear to be currently happening:

*‘we made a decision to take some money off the treatment services and invest in early intervention and prevention so create a tier one and two services …we need to give them the skills and the tools to help themselves so if we focus around food, active, being active err so we’ve got our food strategy as well you know cook for life those sorts of things all the things that we did in move more in a way but you know making sure so its linked if we can do that and also if we can focus on some of our I don’t like the word parenting classes, giving the parents the tools to know what they have to do. Again, if we work on preconception and pregnancy, mothers through pregnancy, breastfeeding and then weaning the more we get people breastfeeding the more we get weaning on to food that they’ve prepared themselves the less likely we are to have obese children.’*

However, the detail was still lacking, but prevention/tier 1 focus and some activities could be named by the majority of Sheffield public health and senior leader participants. Other participants could also describe this need for tier 1 prevention interventions, however, seemed unable to give further detail about local implementation. For example, a public health participant noted:

*‘we’ve just re-tendered for our weight management programmes and we’re trying to get them to be a bit more upstream, pro-active in more preventive work rather than downstream’.*

### 5.4.3 Tier 2: Secondary Prevention Interventions

The diagram from DH (2013a) in Figure 1.2, outlines tier 2 interventions as including: child and family 12 week group sessions; as well as similar for adults at different levels of intervention (based on BMI, intensity of offer and staff qualification required to deliver in a range of settings). There was significantly more information in the documents regarding commissioned weight management activities than wider tier 1 preventative approaches. The commissioned treatment activities were well described by the participants in all areas, although some participants more than others. For example, the leads for obesity, as well as the providers of services in each area could clearly describe services commissioned/provided, as may have been expected. The tender documents were clear on what was to be commissioned in terms of treatment activities, (these did not exist for prevention activities).

*Barnsley Secondary Prevention Commissioned Activities*

In Barnsley, tender documents (as expected) clearly detailed the requirements and KPIs of the weight management Tier 2 interventions (as below). In other documents, delivery of obesity services was only briefly mentioned in terms of single lines in the DPH Annual Report 2016 (BMBC 2016) mentioning: delivery of NCMP, a referral pathway to a dietitian, and a fit family’s pilot, as well as ‘Be Well Barnsley’ (an integrated adult healthy lifestyle service delivering services for: Smoking, Weight Management, Mental Health, and, Alcohol). However, little further was given. ‘Be Well Barnsley’ was relatively newly commissioned (1-year with respect to this DPH Annual Report). It was noted that this Integrated Healthy Lifestyle Service was commissioned by BMBC to achieve a range of KPIs:

‘*a reduction in excess weight in adults by 1% (Using GP Smoking/Obesity Dataset), by supporting overweight and obese individuals and families to lose weight and maintain their weight loss post intervention – 1000 adults, 550 children and 200 families.’* (BMBC 2015).

The obesity activities and services in Barnsley before 2015 were not detailed in any NHS or LA documents nor plans analysed.

*Doncaster Secondary Prevention Commissioned Activities*

Local documents analysed infrequently mentioned obesity interventions that might relate to Tier 2 secondary prevention. There did appear to be ongoing investment in tackling obesity in Doncaster as evidenced by the most recent service specification (DMC 2014). The specification indicated a clear aim around ill health prevention through the delivery of these services, with

*‘Key Performance Indicators (KPIs), to achieve a minimum of 250 people trained in healthier lifestyles per annum, minimum 500 people reporting healthier lifestyle changes per annum, minimum 250 adults and 250 children per annum through Tier 2 weight management services achieving a successful minimum 3% weight loss outcome or reduction in BMI SDS respectively. In Tier 3 the aim is for a minimum of 200 Children (4-17) and 300 adults to complete a tailored 6-month programme*.’

This activity was undertaken by the PCT prior to and including the time of transition to the Local Authority (2012/13), with identified similarities in investment by the LA with services recommissioned in 2014 to continue for a further up to 5 years and then subsequently re-procured in 2015. Doncaster LA (DMBC) sought to continue to commission all ‘Tiers’ of obesity activity except Tier 4, (as described in the introductory chapter and recommended by DH in their obesity care pathway (DH 2013a) and depicted in figure 1.2). As this information is from the service specification and there was, as aforementioned, no recent discussion of obesity in any of the documents analysed, there is no information as to the progress of these services in Doncaster.

There was little participant discussion of the services other than from the public health commissioner lead and service providers who were able to articulate what the offer was in Doncaster. As previously presented in quotes above, some participants reflected that perhaps the focus of the services and associated investment was no longer in the correct place and should be redirected to Tier 1 intervention (see Doncaster tier 1 sections above).

*Rotherham Secondary Prevention Commissioned Activities*

In Rotherham documents and participants identified a significant focus on tier 2 interventions. From example, in documentation from 2007/08, the local PCT reported that it chose to invest in a range of obesity services including community weight management programmes, a Multi-Disciplinary Team of health professionals and Bariatric surgery to support 2000 adults over 3 years (2009-2012) (Rotherham PCT 2007). The £1.5m investment in 2007/08 was reported as based on the evidence from published papers on successful weight management interventions (Rotherham PCT 2007), with a focus on ill health prevention, with the JSNA reporting that:

*‘a 5% weight loss can be expected and that this would lead to a reduced incidence of Type 2 diabetes in the population of 58% compared to a control group (NOO 2009).’* (DMBC JSNA 2011).

These services were continued and then re-procured in 2013/14 to continue delivery of all adult and children’s tiers of weight management services until at least 2018 (RMBC Obesity Services Specification 2014).

The local JSNA, DPH Annual Reports, Health & Wellbeing Board Strategies (HWBS) and CCG documents all cite Rotherham’s nationally recognised approach (HWBS 2012-15; H&WBS 2015-18; JSNA 2011; JSNA 2013; DPH Annual Report 2011; DPH Annual Report 2014; CCG Commissioning Plan 2013-4; CCG Commissioning Plan 2014-19). However, despite this widespread recognition there is little detail given as to what this activity entails, nor achievements to date. The one document where there is some of this detail provided is in the 2011 JSNA. The Rotherham Healthy Weight Framework (HWF) is described in the 2011 JSNA as,

‘*evidence based, driven by local need and incorporates best practice, both for preventative and treatment interventions through four tiers of services’*

(Rotherham, JSNA 2011).

All four tiers are detailed in the JSNA (2011), the tier 2 services are detailed as follows:

* *Tier two services include multi-component weight management lifestyle services for children aged 4-17years on or above the 85th centile and their families, and similarly for adults.*

All public health participants and weight management service providers were able to well articulate the treatment services offered in Rotherham in interviews. Most other (i.e. senior leader and CCG) Rotherham participants were able to describe nearly all of these services and did so in interviews, to some extent, recognising the different tiers and citing some such as the Rotherham Institute of Obesity and ‘fat camps’, which were more frequently than any other offer in Rotherham. For example, in Rotherham a CCG representative commented on the services, demonstrating the sort of level of recognition of services that most Rotherham participants articulated:

*‘I think the contract is coming up very shortly so I think are strategic directive has been strong and probably will have been ahead of the game since 2009/10 but I think the game’s caught up with us and Rotherham’s obesity strategy’s in need of a refresh and a decision about how its resourced. Obviously we’d have to get the appraisal of the existing schemes but assuming that was positive then maintaining a Rotherham Institute of Obesity and targeted focussed, work on the top of the pyramid individuals then if the evidence shows that then that’s what it showed in 2010 I would obviously have to see the evidence beyond that.’*

*Sheffield Secondary Prevention Commissioned Activities*

Turning now to Sheffield, policy documents illustrated that NHS Sheffield has invested in obesity policy activity since at least 2009, with £3million invested between 2009-2013 in a range of treatment services (Sheffield City Council 2009). Obesity services were then re-procured in 2014, post transition to the LA, with the reported ‘new’ approach - to offer an integrated pathway for weight management in Sheffield following a lifecourse approach, with a focus on prevention and early intervention. This preventative approach is detailed above, with additional information provided below.

The commissioning plan that was put out to tender in 2014 in Sheffield has the most detail about what was intended locally, alongside the Director of Public Health Annual Report (2014). The following were proposed by public health now in the Local Authority in the Director of Public Health Annual Report (SCC 2014):

*‘1. Tier 1 and 2 Early Years Healthy Weight Service for children aged 0-4 years who are at risk of becoming above healthy weight or above healthy weight*

*2. Tier 1 and 2 Children and Family Healthy Weight Service for those aged 5-17 years who are above healthy weight, funded for £200K pa for 3 years.*

*3. Tier 1 and 2 Adult Healthy Weight Service to include the general population aged 15 years and over (including pre-conception and maternity services) funded for £260K pa for 3 years.*

*4. Tier 3 Adult Weight Management Service for clients aged 15 years and upwards with Body Mass Index (BMI) greater than 35kg/m2 with co-morbidities; clients of South Asian origin with a BMI greater than 32kg/m2 with or without comorbidities; clients with BMI greater than 40kg/m2 with or without comorbidities; registered with a Sheffield General Practitioner (GP). This was tendered for £400K pa for 3 years with 910 referrals per annum, with further KPIs for 80% losing weight, 60% completion losing 3% at 12 weeks and then 5% at 6 months and maintained at 9 and 12 months.’*

Except for the provider and lead commissioner, the only information that participants were able to discuss in terms of services was to name, ‘Weight Ahead’ the adult weight management service. CCG participants discussed referring patients to it, for example one CCG representative stated the same as the others in so far as, *‘I’ve referred patients to Weigh Ahead service’* and senior leaders were able to state that there was a service and name it. Other than that the discussion was more focussed on diverting funding from services to prevention as presented in the previous section above.

## 5.5 Core Values: obesity explicitly as an issue of personal responsibility and implicitly an issue of inequality

The final section of the Jenkin et al. (2011) framework explores the values or principles evident in how the policy issues are described in the documents. There are overlaps with the material already described, therefore given all the above, the findings in terms of what is suggested as ‘Core Values’ in the documents are described below.

The core value that was predominantly articulated in the documents across all areas was that public health activity supports tackling the (mostly lifestyle) issues that may contribute to the health inequality gap that exists, mostly as a result of LTCs. Therefore, it was implicit rather than explicit in the documents, that promotion and support of a healthy weight is a public health (and therefore LA) concern and responsibility as part of a general public health approach to tackling health inequalities (and the associated lifestyle risk factors and LTCs). This general public health focus on health inequalities was reflected in the focus on obesity affecting the whole population, and links made between higher deprivation and increased obesity contributing to local health inequalities, especially in Sheffield documentation, as described by the quote below. Alongside a general public health focus on health inequalities, obesity prevalence was the main interest or commonality across all documents, recognising that the persistent high prevalence of obesity leads it to be viewed locally as an issue that needs to be addressed. This common approach and view across the sites is best illustrated in the following from the 2015 Director of Public Health Annual Report in Sheffield (SCC 2015):

*‘In 2013/2014 just under a fifth of children aged 4-5 years (YR) were overweight or obese (19%), rising to around one third (33.4%) of children aged 10-11 years. Prevalence of overweight in 4-5 year olds in Sheffield is significantly better than the England average. At 10-11 years (Y6) the figures are not significantly different. In general the rate of childhood overweight and obesity combined in Sheffield is improving. However, the relationship between deprivation and overweight and obesity in both YR and Y6 is significant, with higher rates of combined overweight and obesity correlated with greater deprivation. The inequality between the most and least deprived in the City is widening in Y6. (NCMP 2013/2014 academic year).’*

Although a general public health focus on tackling health inequality runs throughout all the Barnsley documents, recognising the local health inequality gap between the most and least deprived, none of this is specifically linked to obesity in the documents analysed. There are multiple statements about seeking to reduce obesity locally to deliver health improvement, but no reference made as to how or what success looks like in terms of activity and achievements, except for a tracking of NCMP target, but this is not related to addressing inequality. There is information about targeting in the specification documents reviewed but nothing explicitly about obesity in the high level strategy documents locally.

All Doncaster documents refer to addressing health inequalities with a focus on those who are most deprived and narrowing the gap between those most and least deprived. However, obesity is not specifically mentioned in relation to this, only that all public health activity locally is to address health inequalities. Obesity service specifications analysed do indicate key target groups but do not explain why these groups have been identified nor link any of this back to inequality.

All Rotherham documents refer to addressing health inequalities and the local gap that exists. Although all activity is for the whole population, commissioned obesity service specifications list target groups and areas, seeking to reduce the inequalities gap through targeted work alongside universal activity. This is not detailed in the strategic documents only in the specifications for obesity services. A focus in some Rotherham documentation appears to be on reducing the levels of obesity locally due to the impact on other LTC that are increasing as a result of the increasing obesity prevalence, and the resultant impact this reduction in LTCs will have on the Health Inequalities locally.

All Sheffield documents refer to addressing health inequalities and the health inequalities gap locally. The focus of all activity in the documents analysed is for the whole population, with only the commissioned obesity service specifications listing target groups and areas, seeking to reduce the inequalities gap through targeted work alongside universal activity. Like Rotherham, this is detailed in the tender documents but not in any of the policy or strategy documents analysed, except for one Director of Public Health Annual report, as quoted above. Health inequalities appear to be more of a focus in Sheffield than elsewhere, across all areas of public health, which comes out more strongly in their documents in terms of consistency of message than in the other localities.

Although this focus on inequality is stated as underpinning all public health work and documents across all the four areas, there are only clear references to obesity and inequality in the service specifications in Rotherham and Sheffield. Inferences could be made to health inequality and obesity, as outlined above but there were few clear commitments or comments made. There were inconsistencies when it comes to health inequalities and obesity in the documentation, as despite the statements of commitment to addressing health inequalities across all public health activity, the individual approach does still dominate in the documents, for example: *‘Obesity is primarily caused by excessive food energy intake and lack of physical activity.’* (Rotherham Public Health Annual Report 2014, RMBC 2014), and, *‘Parenting styles and eating habits have a big impact on risks of obesity’* (Sheffield Director of Public Health Annual Report 2016, SCC 2016), as well as:

*‘[NCMP prevalence figure] This is a startling finding; why does it happen? It must be as a consequence of the lifestyle and diet choices of the children, their parents, their school and local environment.’* (Rotherham Public Health Annual Report 2014, RMBC 2014)

## 5.6 Overall content analysis summary

Overall, this chapter argues that there are clear similarities across all the four geographical areas in terms of the way that obesity is represented in policy documentation. The dominant terminology used in the local documents analysed points towards an individualised, personal choice, and health-focused perspective on obesity, and moreover, one which can be quantified in terms of prevalence. Indeed, common to all areas and documents was the regular stating and comparison of obesity prevalence statistics, and a recognition that obesity impacts on long term health conditions, and subsequently (but less clearly) that these LTCs impact on health inequalities locally. Interestingly, the suggestion here appeared to be that obesity ‘causes’ inequalities, rather than vice versa. In this respect then, obesity appeared to be pre-dominantly represented across South Yorkshire as a health issue, with a significant focus on individual choice and personal responsibility as a key cause of obesity itself locally, in terms of poor dietary choices and inactivity.

There was some nuance to this dominant representation, and it is important to emphasise this here. A partial exception to this dominant representation was in some of the Rotherham and Sheffield documents, where there was some emphasis on obesity being a product of, or affected by, health inequalities, and with obesity situated in the context of the wider determinants of health (e.g. society, housing, transport, employment). This aligns with, and the documents indeed made reference to, national reports and documents on obesity and health more broadly (Butland et al. in Foresight 2007; Marmot Review 2010; Healthy Weight, Healthy Lives DH 2008). However, it is argued that this representation of obesity was not consistent in either Rotherham or Sheffield, and, in fact, these inconsistencies allowed the individual choice narrative to dominate.

Overall then, obesity seemed to be presented as an issue of individual responsibility, or in the case of children, as an issue of parental responsibility, and there appeared to be a very simple, view of causation in the form of unhealthy diet and physical activity choices. This view was compounded by the way in which solutions were represented. The solutions to obesity were briefly discussed in terms of prevention and partnership approaches but lacked detail in terms of any description of what was actually being implemented and achieved (including who was part of any partnerships). Despite any subtle differences in the documents, and a distinctly different narrative about prevention and physical activity focus in Sheffield, ultimately all the four areas appeared to be undertaking similar things in relation to obesity in terms of action, from the procurement and tender documentation (as opposed to policy documentation) and this remained common over time both with public health and obesity in the NHS and now in the LA despite structural changes. There is little in terms of detail around achievements or progress to date except for the year on year analysis of NCMP prevalence trends. However, as aforementioned, it was difficult to be clear on what is actually being done. As stated, there may be an argument that the inequality work being undertaken is activity to address obesity and therefore should be presented, however, where these activities were not aligned in any way to obesity in documents or participant interviews these have not been included.

The next findings chapter focuses more on the context element of the Walt and Gilson (1994) policy triangle, recognising the aforementioned overlap between policy content, context and process. Each findings chapter makes a contribution towards understanding the local obesity policy processes, the perspectives of those involved locally, and how these processes and perspectives influence decision-making locally, drawing on similarities and differences across the case study sites.

# Chapter 6: Findings - The ‘Context’ for local obesity policy processes

## 6.1 Introduction

This second of the three findings chapters focuses on the local obesity policy *context*, another element of the Walt and Gilson (1994) Policy Analysis Triangle. It considers contextual factors that affect local obesity policy, as described in both policy documents and by the research participants; focusing therefore on the wider situational and structural - political, economic and socio-cultural - factors were identified as affecting local obesity policy processes (Buse et al. 2005). While this chapter presents findings from both the documentary review and interviews, the chapter relies more on the interview data because there was limited information in the documentary sources on contextual factors – despite extension searching and a further review of material to uncover any documentary contextual factors. As with the previous findings chapter (Chapter 5), although this chapter focuses on context, elements of content and process also feature, given that there are inter-relations between these different elements of local obesity policy (Walt and Gilson 1994).

The chapter starts by discussing national contextual, and mostly situational, factors that were found to be shaping local obesity policy at the time of the research. The chapter describes how policy documents and how interviewees in South Yorkshire discussed the political and legislative context within which public health issues such as obesity are addressed (focusing particularly on the Localism Act (2011) and the impact of the Health and Social Care Act (2012)); and how that context shapes the way that local obesity policy processes operate.

## 6.2 A significant national legislative change - the Health & Social Care Act (2012) - affecting the environment for policy processes

As mentioned earlier in the thesis (chapters 1 and 2), the Health & Social Care Act (2012) came into force following the 2010 White Paper ‘Liberating the NHS’ (DH 2010). The 2012 Act led to several changes in the structure and functioning of the NHS and, of significance for obesity, was the resultant change to public health as a professional field of activity. A key change was the transfer of public health responsibility, including resource (both people and finance) from the NHS (in the form of Primary Care Trusts (PCTs)) to local government (in the form of Local Authorities (LA)) (DH 2012). However, other relevant changes involved the dissolution of PCTs, and the formation of GP led Clinical Commissioning Groups (CCGs), which hold the budget for NHS services at a local level. The changes from the Act (DH 2012) started to come into effect from 2010 with the Conservative-Liberal Democrat Coalition Government, and the resultant shifts in National NHS policy and obesity responsibility and structures from then, brought about by the Conservative-Liberal Democrat Coalition Government’s Health & Social Care Act (DH 2012).

These key legislative changes were highlighted by all participants, across all four areas of South Yorkshire and all groups involved in the research (i.e. Elected Members, Senior Leaders, Public Health Leads/Commissioners, CCG Representatives, Weight Management Service Providers) as the main contextual factors impacting obesity policy locally at the time of this research. A number of other local contextual factors were highlighted – such as perceptions of public health in their ‘new’ organisation; the experiences of transition, the financial context in which policy processes are undertaken, which are all discussed later in this chapter, as well as some factors that have been presented in the process chapter, such as the governance arrangements. It is recognised that there is overlap and felt to be better presented in the process chapter, but does influence context. However, the dominant issue discussed by participants at the time this research was undertaken were changes as a result of the Health & Social Care Act (2012). As one Public Health Commissioner participant put it: *‘The disruptive effect of the changes to NHS and Public Health can’t be overstated’.*

Participants reported on and discussed the impacts of the change at a local level on obesity policy in a number of ways. The key issue related to structural reorganisation: with ‘public health’ people, issues and resource moving from the PCTs in the NHS to local government and the dissolution of PCTs and formation of Clinical Commissioning Groups (CCGs). The issue was how this reorganisation subsequently impacted on public health and policy making.

To emphasise, across all four geographical areas and all groupings of participants, it was commonly mentioned that the national changes had been disruptive for public health as a profession and, as a consequence, within local obesity policy-making processes. Some participants noted that the structural changes resulting from the Health and Social Care Act 2012 had brought about positives for the NHS and social care; for example, some public health commissioners mentioned that this period of transition and adjustment would ultimately prove worthwhile in terms of community engagement and taking account of wider determinants in policy processes, as their views on public health in LA were positive:

*‘Erm there are chances that we can work better into the communities now that we’re in local authority so I think that’s a positive step.’*

(Public Health Commissioner)

*‘local authority is the right place for public health but it will take a while to make it work’*

(Public Health Commissioner)

‘*[Local authorities] are kind of more in control, very much in control of sort of wider determinants. So it makes a lot of sense in terms of that’s where it should be managed. I mean, but today I wouldn’t say it’s been a positive move.’*

(Public Health Commissioner)

Although many participants commented, mostly negatively, on the changes in the position, influence and value afforded to public health roles and skills as this chapter will go on to evidence below, some participants did suggest that the move was an (as yet) unrealised *‘opportunity to influence’*. As one senior leader explained:

*‘This is where it’s really useful having the public health are based in the local authority…There are health implications across all directorates within a local authority which is why they ring-fence budget. Erm so we’re now much better placed to influence that work in whatever way we need to influence it. All these things sit within local authority that we’ve never had any influence over in the past.’*

(Senior Leader)

However, many more negative points were voiced for public health as a profession as reflected in the following quotes:

*‘I think bringing together of health and social care has probably been the best thing that dare I say it that Andrew Lansley and his chums have done. The rest of it has been done in a cack handed sort of way but erm and its upset a lot of people’*

(CCG participant)

*‘Well I think there’s erm I think it’s been disappointing really the change for Public Health into local authorities ……..’*

(CCG participant)

*I think it’s been a disaster Public Health going into councils.’*

(Senior Leader)

Participants’ negativity was connected to a number of different issues, including the impacts on people’s roles, resources for public health interventions, including for obesity, and thus public health’s ability to address issues like obesity locally. These issues will be explored further in later sections of this context chapter. At this point, the chapter will consider how the restructure of public health from the NHS into LAs was reshaping local obesity policy processes, including how it was affecting the positioning and ability of public health personnel to exert influence within policy processes, including about obesity, within their ‘new’ LA organisational context.

## 6.3 The value and visibility of public health in policy processes in its new organisational position with Local Authorities

A key theme from the interviews across all case study sites was that public health as a profession and professional public health roles were not well understood in LAs. A number of participants who were working within an identified public health professional role expressed that the LA did not fully understand, nor did they think that the LA necessarily wanted to understand, the role that public health could offer to Local Authorities and this was preventing them from being utilised, accepted and ‘valued’ in the new structures and therefore in policy-making. As one public health participant put it succinctly: *‘PH is not valued’* (Public Health Commissioner). Indeed, a key feeling from those both inside (identified public health participants) and outside the public health profession (i.e elected Member, Senior Leader, CCG and weight management service provider representatives in this research) was that there were unclear understandings and expectations around the value of public health roles in LAs:

*‘I don’t know what they [Public Health] do’* (Senior Leader)

*‘And that’s the thing. So I think we’ve lost. I don’t think, I think there are opportunities there to work closely with the council in the areas of alliances, but I don’t think they understand Public Health.’*

(Public Health Commissioner)

Linked to this view of an unclear understanding of public health was the view that public health professionals were less influential or important organisationally in local government than they had been in the NHS within policy processes. This view was shared across all the areas and was raised mostly by CCG participants, but also by public health participants themselves, as demonstrated by the quotes below:

*‘The Public Health voice has been diminished and side-lined in Local Authorities’*

(CCG participant)

*‘Erm I think in some ways it’s a pity to lose the Public Health influence on the medical model cause it has been lost. Erm I’m prepared to have an open mind about whether Public Health influence on the social model through influence of the council couldn’t be as powerful. Maybe it could but it doesn’t seem to me to be having that impact yet.’*

(CCG participant)

*‘We’re not valued, I don’t think public health is valued. I think we’ve landed either at a wrong time and I think that, not only here in public health, I think public health could unravel quite quickly over the next couple of years. And really once it’s gone what do you do to get that back? We’ll have lost that we’ll have lost that momentum that ground that cohesion and everything that we had within the NHS..’*

(Public Health Commissioner)

This lack of perceived value placed on the role and function of public health post- implementation of the Health and Social Care Act (2012) was well-summed up by one public health commissioner and so it is worth reproducing in full here:

*‘‘Local government needs to understand how to use public health expertise to best effect… there is still a deal of mistrust or lack of understanding about how best to use specialist expertise in the field of public health…I think Elected Members need to understand much better what it is that specialists in public health can offer to them when they come to trying to do their jobs ……they don’t think that there’s a level of specialist expertise that has got something to….they can see it if you don’t know how to do surgery you’ll make a mess of it. They don’t think of public health in the same way…I think there’s a learning curve for local authorities to understand what it is that specialist public health skills can contribute to help them to achieve their goals and their aims and you see it’s not even like they’re lawyers in this organisation and the Elected Members think well you know if it’s a legal question we’ll ask the lawyers but somehow with public health they think because they engage with the public all the time and what politics is about, changing society and changing people’s behaviour, they think they can do it and they don’t need necessarily public health specialists.’*

(Public Health Commissioner)

The lack of value placed in public health roles and skills seemed, in part, to be related to prevailing understandings of public health within the LA contexts in South Yorkshire and, in particular, understandings about public health commissioning and what commissioners versus providers do. Public health and weight management service provider participants in all areas discussed the way that the Provider/Commissioner split role in the NHS in the early 2000s (see background Chapter 2) had led to issues for public health now within new structures in LAs, and for commissioned obesity service providers. To explain, an LA can be both a provider and a commissioner of services for the local community; for example, bin collections, school meals, housing. Public health practitioners however, in the NHS and therefore upon transition into LAs, were commissioners of services in specialist areas; for example, commissioning weight management services based on outcomes (such as weight loss), working with providers and managing contract performance rather than designing and/or delivering local services, i.e. not directly delivering public health or obesity interventions. Some participants suggested that senior leaders within the LA and colleagues from other directorates in the LA did not necessarily understand this commissioner role and there seemed to be a view that any wider *‘influencing, data and advising’* (Senior Leader) role of public health practitioners within policy processes was not valued within a LA context. As one public health commissioner who had transitioned from the NHS to LA put it; public health are viewed as *‘driving a desk’* and would be more valued if we were *‘doing or delivering services.*’ (Public Health Commissioner).

Reflecting on this contextual challenge for being involved in policy-making, a number of public health participants discussed whether there should be plans to move some public health services, particularly lifestyle and obesity provision, back to in-house public health delivery, or LA delivery of public health services. As one participant suggested:

*‘…I think we need to move back to being a provider that we have more control over what’s done in the communities and within services.’*

(Public Health Commissioner)

The rationale offered by participants seemed to relate not only to perceptions about the value and visibility of public health, but also economic reasons in the challenging financial situation in the public sector and overall reducing resource for investment (rather than, say, evidence of effectiveness). These financial contextual influences are discussed in later sections of this chapter.

Another participant, from a different area, was more explicit about what public health in LA needs to be doing to, in their opinion, be more valued: they needed to be visible. There was a sense expressed by participants that they could not ‘evidence’ the value of what they do as commissioners because it was hard to visibly show what they had produced. Their policy work was reduced down to a technical specification, with limited understanding of ‘other’ things they might do to develop the specification. Managing or delivering services directly would be more visible and tangible:

*‘They [LA leaders] don’t understand what we [public health] do. And I think even now erm they don’t understand what public health does because public health needs to change…I had a meeting yesterday and they said our achievements and outcomes would define public health. Because they need us to be out to be visible to be in the areas to be in church halls, to be in schools, to be doing food boxes, to be doing mental health, to be doing the stop smoking, to be doing debts. That’s what they know that’s what they understand.’*

(Public Health Commissioner)

This view of public health and its value to LA as a commissioner and/or provider links to the issues of public health influence and positioning, as one Public Health Commissioner commented:

*‘I don’t think they understand public health …members say what do you do? I would say I commission services. And they’d say right so what do you do all day. And I’d say well that’s what I do I commission it. And how long’s the contract? It’s a 3 year contract. So you only work for 2 weeks of the year…And then for the other three years you don’t do anything you just manage them. So you go out and see people? No I manage the services. If I’d got a team that are out in the community helping people change lives, do all that sort of stuff. They’d understand it. They understand the out in the community helping people touching people’s lives. What’s a commissioner? You only work for 2 weeks out of 3 years when you’re putting this service spec together’*

(Public Health Commissioner)

Other participants emphasised the issue of lack of visible or tangible work:

*‘…I think over the last sort of four or five years public health professionals have morphed into commissioners and commissioning seems to be the tool in the box that we use so when we’ve got a problem we’ll commission something to address the problem and actually erm I think we need to think about what or reinvent that sort of public health sort of practitioner type role you know so trying to you know suppose make sure that people have got more tools in the box than just the commissioning tool’*

(Public Health Commissioner)

This perception by public health participants about a lack of clarity of LA understanding of their role and value was not only felt by those who had ‘transitioned’ but by those ‘receiving’ public health into Local Authorities, including those in senior roles. As two Senior Leaders commented:

*‘PH are not delivering, they should be doing something not just commissioning’,* (Senior Leader)

*‘At the moment it feels like we’ve got like a team of thirty odd but they don’t really add a lot of value because they don’t they can’t do anything. They’ll influence of design or research something, but actually we need people, because the resource is so stretched, to actually come in and just advise us and then actually implement it.’*

(Senior Leader)

And another reflected in more detail:

*‘I think the public health coming into local authority is maybe helping us to have better information and evidence to do some of the stuff. So we could inform the public a bit better. Erm not scare tactics but I think it is getting people to understand, and there is an element of err actually shocking people about some of this because they should be shocked. So I think erm that connection to understanding what that data means is probably the one thing the public health can help with. I think the other bit is changing the public health model so that, we’ve often had public health delivered by public health professionals; I actually think the people to deliver public health are the public.’*

(Senior Leader)

Some participants working in public health in LAs felt that a move back to public health providing not just commissioning services and advising on public health evidence and need was a change that needed to happen to ensure public health was valued again within LA policy processes.

## 6.4 Transition as a contextual factor in obesity policy processes

The context of transition itself and the organisational changes to public health roles and responsibilities that were associated with the implementation of the Health and Social Act (2012) were described by participants as having a significant influence on the context for local obesity policy-making, particularly the pace with which obesity policy was formulated and implemented. Some participants spoke about how transition of public health from the NHS to LAs was leading to *‘limbo, standstill’* (Weight Management Service Provider) and ‘*inertia,’* (Weight Management Service Provider). There were some positive views as quoted in the previous section of how working practice may support improved addressing of public health issues such as obesity, this was shared by others in public health, however, this was a minority view, and recognised as such by those voicing it. It should be noted that the active period of this research was during, what was still considered to be, ‘transition’ therefore feelings may have been heightened by this timing.

This situation described by participants effectively meant that very little was happening at the time of the research in terms of local obesity policy process – due to the wider context of transition. Participants described that this inertia had occurred partly because of the way transition had been managed and the lack of national obesity policy clarity i.e. that the process was ‘a mess’ because there was little clarity about what structures / roles should be in place for dealing with obesity. One local Public Health Commissioner’s comments best summarise the general consensus across the majority of participants as all recognised the lack of clarity and subsequent current confusion within the new local structures for obesity:

*‘…But, well it is a mess isn’t it, pretty obviously it’s a mess, I mean, even here when we try to figure out who’s paying for what we ended up in an argument within minutes! And that’s in here, where we’re pretty good, imagine what it’s like in places that don’t get on…I know quite a few areas that aren’t like that and if that’s like that in every single one, imagine the amount of senior officer time that’s been spent across the UK, just going ‘it is’, ‘it isn’t’, ‘it is’, ‘it isn’t’ about 4 different ways, just on obesity, so it’s pretty obvious is the answer to that is that it’s made a right mess’*

(Public Health Commissioner)

Another reason put forward by participants for inertia in local obesity policy-making was because transition had resulted in the loss of expert staff. One CCG participant noted:

*‘Well I think there’s erm I think it’s been disappointing really the change for public health into local authorities … the reported experience of colleagues well former colleagues now, people resigning etc. etc. now I know there will be a certain amount of that anyway with such a fundamental shift and some people just don’t want that degree of change in their life but even those that were kind of prepared to go along with it seem to be disappointed by the way that its happened and the effects of it.’*

(CCG participant)

A Public Health Commissioner said:

*‘there’s that erm the disruptive effect of the changes in the NHS and public health can’t be overstated I mean it has just been the most tumultuous reorganisation and the planning blight and the loss of institutional memory and the loss of staff and so on and so forth so that’s had a huge impact. ‘*

(Public Health Commissioner)

This issue particularly exercised Weight Management Service Providers in the main with all those in that group of participants across the four research site areas commenting on the loss of expert public health staff who could commission something that was feasible and evidence based, suggesting that moving to obesity decision making based on the views of Elected Members’ was concerning, and that Elected Members’ views take priority over anything else in terms of what is focused on and actioned. However, caution should be applied to this stance as that is the nature of the democratic process in England, and as previously discussed, it was more the ability of public health to advise and influence with expertise that was the participants’ concern than democracy:

*‘Well that’s the worry. How long can someone that’s very motivated, passionate continue doing that when what their vision is, and they know it’s working, is constantly being stopped by people that don’t understand and are not clinically trained and don’t have the expertise and it’s very much about a financial budget line… But that’s what worries me, … suddenly everything about obesity is going to be commissioned by these people that are pulling the purse strings that don’t understand and it will all be about the cheapest possible service and whether it’s effective or not is irrelevant.’*

(Weight Management Service Provider)

Finally, the inertia in local obesity policy making processes was also shaped by the wider financial context of LAs at the time of the research. As mentioned in the background Chapter 2, LAs at the time were experiencing cuts related to the national financial challenges, the changes as a result of the Localism Act (2011) and Health and Social Care Act (2012). One Public Health Commissioner observed:

*‘Erm I think I think moving Public Health away from the NHS has erm weakened our position. Erm and I think we’ve lost some of the direction that that transition year or two years moving in. We’ve lost direction erm and I think it’s diluted what we can do. Erm finances as well now that we’re in a political environment so we’re being slashed so we can’t do what we want to do anyway.’*

(Public Health Commissioner)

Weight management service providers across the four areas described their experiences of the impact of the changes, which has led to difficulties in terms of commercial insecurity, a stoppage in terms of commissioning relationships, and challenges of working together during a period of adjustment and ambiguity. This was best illustrated by one provider’s comments:

*‘I personally I feel that we’ve been in a state of limbo. And [obesity] services have lost a lot of because of all the uncertainty and the changes, there hasn’t been a focus on moving forward really in delivering. It’s been difficult to work in partnership with people and organisations.’*

(Weight Management Service Provider)

## 6.5 Financial context for local obesity policy processes

A number of participants suggested that the financial challenges that LAs were facing were also compounding the above-mentioned ‘inertia’ in local obesity policy-making. One vocal weight management services provider stated the following, which best sums up the views of others in public health and provider sectors about the impact of transition, the financial context and responsibility, as well as austerity on the loss of momentum and prioritisation of obesity as a result of the changes in the Health and Social Care Act (2012). Their point, also made by others was that financial challenge was the main driver in decision making around obesity within LAs.

*‘We started the recommissioning process and we’ve just recently been told it’s going to be put on hold for another three months while the authority look at how much money they’ve got in the bank. Well, we’ve been told by again very clever people that the obesity epidemic is our number one public health* *priority and it’s going to bankrupt the NHS, now that the responsibility for it lies predominantly, not entirely, with local authority, why are we now messing about saying that we need to look at the amount of funding?’*

(Weight Management Services Provider)

Participants also articulated that, connected to a reduction in resources, were the issues about the ability of public health professionals to influence obesity policy processes – including prioritisation of obesity as a policy area requiring resource allocation. Indeed, this issue was raised by a range of participants, with a number raising the concern that public health resource (ring fenced grant) had been or could be ‘raided’ for other purposes, for example, for libraries, or any LA issue that could be linked to broader health impact. One Public Health Commissioner commented, for example, about how they had heard things had happened with the transfer elsewhere, in terms of impact on public health:

*‘instead of the situation we have and we hear of in lots of places about you know the public health grant shoring up other Local Authority services you know there may have been more freedom to spend the public health grant in kind of slightly more daring ways and so I think the time it happened and has kind of compromised what it might achieve erm I mean some of the ideas have just been just terrible in terms of the fragmentation of how things work.’*

(Public Health Commissioner)

Another Public Health Commissioner reiterated the perspectives of other participants in terms of the financial implications for this transfer into local government and the ability to use the ring fenced public health budget on public health issues:

*‘All they say is we can’t we can’t set an unbalanced budget. So when I’m looking at that one million [funding in healthy lifestyles] going forward,...that money will go over into the new community’s directorate. We will physically put a million pound in his bank. The LA has £180,000 to save; he is saying he wants to use some of that million pounds to write some of that debt off… He wants the money; we don’t want him to have the money. That’s the politicisation of it.’*

(Public Health Commissioner)

A Senior Leader in another area stated how the public health finances were being used and linked this with the limited ability of public health to influence policy decisions alongside the financial challenges LAs face:

*‘Erm I think an example of this is when the libraries got in a mess in [area] financially and they reduced the budget to the point where libraries were going to close to alleviating the political fallout. Who actually got the err who actually bailed out the council? Public Health. So Public Health money err was taken from the Public Health budget err to prop up libraries. Now you could argue you could argue that there is an indirect benefit from people going to libraries, but the link is quite a tenuous link….they’re saying every single department of the council affects health. Housing. Transport. Lighting. Roads. Everything. Ok? So that gives them carte blanche to raid the public health budget. Ok?’*

(Senior Leader)

The issues of financial challenge faced by the participants were not specific to the case study sites, nor as a result of the Health & Social Care Act (2012). However, the impact of the financial challenges was felt by participants in this research to be exacerbated by the contextual influences presented in this chapter.

*‘Erm those aren’t being recognised at the moment within local authority. So we go on about the evidence base erm and the cost, and money and all those sorts of things but it’s not being recognised and because of that public health isn’t being valued.’*

(Public Health Commissioner)

## 6.7 Conclusion

This chapter has examined the most prominent contextual influences that participants highlighted as influencing obesity policy processes locally across the South Yorkshire case study sites in this research. Although the documents were specifically searched many times they did not make reference to contextual factors other than to refer to the Health and Social Care Act (2012) and public health transferring to the LA. The main influencing factor identified was the situational influencing factor of the Health & Social Care Act (2012), and the subsequent impacts of this at a local level on policy process. The chapter shows how there have been resultant impacts on public health professionals from these legislative changes, in terms of position, influence, view, value and visibility within local public health and obesity policy processes. The impacts identified were felt mostly negatively by those who were most directly impacted and therefore their voice is most dominantly represented. However, other participants’ views and perceptions of the contextual influences and subsequent impacts/consequences for public health, public health issues and functions, such as obesity, are also presented.

This chapter has illustrated how within all the ‘messiness’ and change brought about by the Act, the roles and functions of public health teams, which are central to identifying issues, priorities, actions, and making a case for investment and/or action, were also affected. The findings from this chapter identify that the organisational setting for the translation, formulation and implementation of obesity policy at a local level is changing. It also presents that the people who are seen to be making policy is also perceived to be shifting, with a reduced direct role for those in public health and an enhanced role for Elected Members. This is as a result of the changes from the Health and Social Care Act leading to public health transferring to LAs, where Elected Members are the decision makers but also the impact of the way public health role appears to be understood and valued in LAs. This is discussed further in the policy process chapter that follows.

This chapter has also outlined how participants viewed the impact of the transition period, that during this period, many of the local obesity leads, and public health team left. This loss of organisational knowledge and topic/issue expertise was identified by participants as having had an impact on the identification, prioritisation and ‘case’ for public health, and in this case, obesity, action and investment. As a result of transition from the Health and Social Care Act (2012) obesity policy making has, in some sense, not been translated and implemented locally, because of the policy ‘inertia’ that has resulted from the transition and the ‘mess’ that this has caused, perhaps compounded by the context of austerity at the time of transition (and ongoing).

The next chapter will now move on to present the findings of the element of process in the Walt and Gilson framework (1994), examining local obesity policy processes in more detail, linking with the more general issues previously highlighted and discussed, and examining these experiences more closely. It focuses mostly on the stakeholders’ experiences of the impact on obesity policy processes and decision making at a local level on a day to day basis, in the context of the higher-level issues identified in this chapter, triangulating where possible with the documentary analysis.

# Chapter 7: Findings – The ‘Process’ of local obesity policy

## 7.1 Introduction

This final findings chapter moves to consider more specific processes of policy-making at a local level; including how contextual influences affect process in terms of how ‘the problem’ of obesity is defined and agenda setting; what and how decisions about obesity are made and implemented; and obesity policy evaluation. The chapter draws primarily on stakeholder interviews, but findings from the documentary analysis are also drawn upon where relevant, and in particular searched for to ensure the two data sources were synthesised in the findings. Cross referencing is made to Chapter 5 as there is much relating to policy process (agenda setting, formulation and implementation) in the content analysis, therefore not repeated here but signposted where appropriate. There is much more from the participant interview data despite specific focus in seeking to synthesise data sources in the findings chapters. This has been included where possible and relevant.

The chapter uses the ‘stages model’ of policy as a heuristic device to structure the findings (see Sabatier and Jenkins-Smith 1993). The policy ‘processes’ examined are therefore:

* Problem identification or agenda setting, including problem definition;
* Policy formulation;
* Policy implementation; and,
* Evaluation.

The chapter starts its examination of process by considering how obesity issues are understood by key obesity stakeholders and thus how they form part of the policy-making agenda within LAs in South Yorkshire.

## 7.2 Agenda Setting

Agenda setting as a policy process is generally understood to be about identifying problems that require attention, prioritising issues for action and also, underlying both of these aspects, defining or framing the issue or problem (Buse et al. 2005; Cairney 2012). Issue definition in documentary sources was considered as part of the policy ‘content’ Chapter 5. Here, the focus is on how interviewees defined the issue of obesity and how this related to agenda setting and prioritisation in each LA area. A number of factors are generally recognised in policy literature as influencing whether or not issues get onto an ‘agenda’ of a body such as national or local government. Generally, these are related to changes in context that enable (in)action on an issue (Buse et al. 2005; Cairney 2012), such as has been presented in the previous findings chapter: national obesity policy; perceptions of public health, organisational structure of LAs and the financial context for LAs. The way in which issues are framed by stakeholders is also critically important within agenda setting processes. These issues are examined below.

### 7.2.1 Problem definition (framing) as a component of agenda setting

Across the four geographical areas and four participant groups involved in this research there were some interesting differences as well as significant similarities in terms of how obesity is represented or understood as an issue locally and acted upon. Some of these similarities and differences have been presented in Chapter 5 (the first findings chapter) focusing on the Jenkin (et al. 2011) framework analysis of the content of the documents. This section builds on this documentary analysis from the semi structured interview findings. The main differences described seemed to be related to the national socio-political context influencing local views and action in each locality separately in a number of different ways, discussed below. What is more interesting than the differences, are the similarities, in obesity representation, action, and agreements in terms of roles and responsibility described by the participant groups involved. This section outlines the different representations of obesity that exist across the areas first and then the similarities that were evident. As discussed in the methods section (4.5.4), participant quotes are assigned to a geographical area in this section, this was only done where there was belief that participants could not be identified (i.e. a number of participants with that role in that area etc.). Where quotes are referenced geographically as well as by role, this is only undertaken to highlight the critical similarities and differences in the four sites in this findings section. This has also only been undertaken where there were at least three or more participants from a role that was being referenced, to try to reduce the risk of identification.

Bacchi (2009) identifies in her research that was is proposed or actions undertaken often are useful to reveal how an issue is framed, defined or ‘problematised’. In order to avoid issues of repetition and to support Bacchi’s point (2009) what is undertaken or proposed, as well as views on causation are examined here to support the research’s position on identifying a dominant understanding of obesity. The documentary analysis in Chapter 5, focusing on the Jenkin (et al. 2011) domains of position, cause and solutions (reflecting Bacchi 2009) are synthesised in this section to give an overall dominant understanding of obesity used in the case study sites in this research. This is cross referenced to avoid repetition.

There appeared to be four distinct narratives about obesity in each of the four geographical areas (these were: community assets; partnerships; prevention and treatment; inequality and physical activity). However, the areas or case study sites across South Yorkshire are, in the main, from what was analysed and understood in this research, to be essentially doing the same thing. That appears to be mostly investing in weight management service treatment interventions, as it is these that have the most clarity in the research findings analysed across documents and interviews. Given Bacchi’s understanding (2009) this would suggest an individual responsibility focus. The findings related to agenda setting as problem definition are presented below for each area in turn.

### 7.2.1.1 Framing of obesity in Barnsley

In **Barnsley**, there was a dominant view that obesity is an issue of individual responsibility, where excess food consumption was understood as the main causatory factor and physical activity the main solution, causing long term health conditions. This simplistic reductionist view was held by all participants, with physical activity predominating discussions, perhaps as it is a positive message, that already has local currency and many free local assets exist to support physical activity, such as green space, cycle lanes and active travel promotion etc. However, as can be seen in Chapter 5 this narrative was not supported by policy documentation as there was a lack of consistent understanding on the offer, either primary or secondary prevention activities reflecting the lack of clear articulation of solutions. Interestingly, the dominant view represented was about individual responsibility, across all participants including by Public Health Commissioners, best presented in the following quote:

*‘There’s no doubt there is individual responsibility; people do need to take responsibility for their own health. We know that. But there’s no getting away from the fact that when people don’t take responsibility for their own health it costs money. If that wasn’t the case we wouldn’t be bothered. We wouldn’t care. You know that’s the bottom line.*’

(Public Health Commissioner)

Senior Leaders in Barnsley supported this individual responsibility view, although it is unclear as to whether this is an organisational position or just individually held views that have now become the local narrative, as one local Senior Leader commented:

*‘Erm I think in very simple terms and I’ve fed this back into public health team, is that I look at any child, person or individual, and it’s actually about what they eat and what their levels of activity are or levels of fitness in school or outside of work….t broadly we overcomplicate it. It feels like when we look at obesity we look at you know, whether it’s you know my own weight or my own kid’s weight etc, you know it is about whether they’re drinking fizzy pop or not or whether they’re you nice eating nice healthy food and fruit and vegetables etc. And actually how active are they….So it frustrates me at times that we do overcomplicate it, but actually it seems bloody obvious what you need to do to tackle obesity.’*

(Senior Leader)

As presented in Chapter 5, the overwhelming interview position in Barnsley appeared to be that obesity prevention should be the priority, not treatment, and people taking individual personal responsibility and utilising community assets as the answer to address obesity. However, the interpretation of community assets in Barnsley did appear to be individuals, supporting the personal responsibility view. A number of Senior Leaders voiced this view, described by the three different quotes below, which are from three different Barnsley Senior Leaders:

*‘It always feels like we’re trying to do it for someone else. So you have to go on a cooking and eating session or referral or whatever. Whereas actually you want that encouragement for those individuals and communities to take it upon themselves. We try and impose on it too much..’*

(Senior Leader)

*‘We’ve often had public health delivered by public health professionals; I actually think the people to deliver public health are the public.’*

(Senior Leader)

*‘Erm you may obviously see that as quite a key theme for me. I am very much a champion and believer that the community and public have the capacity to deliver the things the community needs, it is the community that need to facilitate that in the main, and the Local Authority be very targeted about our other interventions because otherwise we just create another dependency.’*

(Senior Leader)

Again, this was the widely held view in Barnsley, with at least three leaders (as above) articulating this, but there was no clarity about how this has become the local narrative across the LA, with public health also holding this view, as two Barnsley Public Health Commissioners also identified:

*‘the solution is community asset based approach and work with local communities and it’s not about services per se it’s looking at what we’ve got and what people want and what they need and plugging them into those things.’*

(Public Health Commissioner)

*‘what can we make sustainable without any money because that’s where we’re going and that’s really where you come back to that community assets, building from grass roots’*

(Public Health Commissioner)

The dominant Barnsley view of obesity from documentary analysis and interviews, appeared to be one of individual responsibility in terms of diet and physical activity, with people needing to be (or become) more responsible for their own health, perhaps, as quoted above, due to lack of finances in the Public Sector to invest in obesity. However, the documents analysed did not offer the same level of clarity as the interviews, as previously discussed in Chapter 5, but did triangulate with the interview position in terms of definition of obesity, in that it is seen as an issue of personal responsibility. This is discussed further in the discussion chapter.

### 7.2.1.2 Framing of obesity in Doncaster

The **Doncaster** definition of obesity or problematisation of obesity was challenging to understand, partly because there was less engagement than the other areas in the research, with no senior leader representatives from the LA. Overall, the representation of obesity in Doncaster appeared to be one of individual responsibility.

*‘Individuals have a responsibility to themselves for their own health to take advise erm to be helped I guess if they need help. Be it educational skills or knowledge. Confidence even. So people do definitely have an individual responsibility.’*

(Weight Management Services Provider)

However, there were one off exceptions to this, as obesity was described as an issue of individual lifestyle choice regarding diet and physical activity, within a complex environment:

*‘Unhealthy diets, inactivity and the availability of high energy foods are major factors in the rise of obesity across the UK. Obesity is a complex issue and we know it is not solely affected by individual behaviours, but influenced by a number of social and environmental issues.’*

(Doncaster Health and Wellbeing Strategy 2016-2021, DMBC 2016).

However, in Doncaster, without exception, all participants mentioned genetics as the first cause of obesity and for over half the participants this was seen as the major cause. This is different to the other areas. Barry et al.’s work (2009) would suggest that recognising genetics as the cause points towards defining the problem at an individual level but not one that individuals can be seen as responsible for. It is interesting as to why this is the main view of participants in Doncaster. Despite this, the view was not mentioned in any documentation locally. The following is one example of genetics being recognised as a key contributing causatory factor, repeated by other participants in Doncaster but not elsewhere:

*‘There’s obviously some genetic reasons for some people, erm and for those that isn’t genetic it’s to do with everything else really in life.’*

(Public Health Commissioner)

As Bacchi (2009) recommends reviewing solutions to better understand problem definition, Doncaster policy documentation gave some of the most information in terms of wider, more universal prevention or Tier 1 activities. For example, from the Health and Wellbeing Strategy 2016-2021 (DMBC):

*‘The top priorities for 2015/16 are: The development of a plan to address access to healthier food (to incorporate Doncaster food plan, food procurement, school meals, workplace health award environmental health plan). Work with academic partners to explore the feasibility of a toolkit to improve the food environment in Doncaster communities. Active promotion of physical activity opportunities. Development and rollout of a Making Every Contact Count (MECC) training package. Continued work with planning teams to ensure access to healthier food and physical activity opportunities are incorporated into the Local Development Plan’.* (Doncaster’s Health and Wellbeing Strategy 2016-2021, DMBC).

However, interestingly, despite this being articulated in the 2016-21 Health & Wellbeing Strategy (DMBC 2016), the latest Public Health/Director of Public Health Report (DMBC 2017) does not mention overweight/obesity. Equally beyond partnership working participants did not mention any of these approaches in any interviews.

Overall, the combined documentation and interview definition of obesity was despite nuances, as with the other areas, predominantly around individual responsibility.

### 7.2.1.3 Framing of obesity in Rotherham

In **Rotherham**, the issue of obesity was viewed differently to Doncaster and Barnsley described above. It was discussed by most participants as being complex, more than food and physical activity by most, with participants citing Foresight (Butland et al. 2007) and with reference to both the individual and wider social determinants of obesity. For example:

*‘Well the problem is we’ve known ever since 2007’s Foresight report where much cleverer people than us sat round a table for 4 years and thought about the cause of obesity, there’s over 100 different factors why we as an individual or a society are getting bigger. So you can’t really answer that with ‘oh it’s because of this’ or ‘because of that’ which is why solving the problem of obesity is so difficult, because unless we address all of those different issues, we’ll never be able to prevent it or sufficiently manage the epidemic.’*

(Weight Management Service Provider)

However, there was still an overriding individual focus, even within this wider understanding:

*‘lifestyle and diet choices of children, their parents, their school, and the local environment.’*

(Joint Health & Wellbeing Strategy 2015-2018, RMBC 2015)

Despite participants sharing a recognition of wider and individual cause and responsibility, and both prevention and treatment, there was a distinctly local focus on treating obesity that was expressed by all interviewed. This was also found in the documentary analysis (see Chapter 5). This was best summarised by one of the local Weight Management Service Providers:

*‘Now, in my opinion there’s not enough evidence to suggest that any preventative treatment works, whereas we’ve got evidence to suggest that the management of obesity works, with various different levels of effectiveness depending on the intervention. Now if we also take the argument that treating the obese prevents morbid obesity and treating the morbidly obese prevents super obesity and even treating the overweight prevents obesity, then you could take the attitude that treatment interventions are a form of prevention, so why we’ve got this artificial black and white situation with preventions here and treatments there and far more attention and money is going to be given to prevention when there’s no evidence that it works I do not know.’*

(Weight Management Service Provider)

Overall, the Rotherham definition of obesity either through description of position, causation or solutions proposed/undertaken (as recommended by Bacchi’s approach 2009) across all the Rotherham documents analysed and participant interviews was a dominant narrative that despite participants talking about obesity being complex, when probed and in more detailed discussion, there was a prevailing focus on treatment rather than prevention, and therefore a foregrounding of medical approaches to obesity.

### 7.2.1.4 Framing of obesity in Sheffield

Different to the other areas discussed above, a common **Sheffield** view was that health inequalities are the major contributing factor and therefore the solution to all public health issues was to focus all efforts here. Here, people spoke about inequality. As illustrated in the following quote:

*‘If it’s…about poverty, it is starting to become noticeably statistically significant in sort of the lowest 20% in terms of deprivation, so it’s starting to congregate, which tends to reinforce the point about poverty which has been pretty universal for some time and probably just like every other public health challenge, doesn’t that always happen?’*

(Public Health Commissioner)

Many, across all staff groups, voiced inequalities as the major factor that needed to be addressed, for all public health issues, and that by addressing health inequalities health issues would be positively affected. However, this focus was not clearly articulated for obesity, specifically but more in general. This was reiterated by a local CCG participant, here with some reference to obesity:

*‘And recognising it’s actually not just tackling health inequalities it’s about tackling inequalities in general and really sort of putting your weight behind things that might make a difference and I suppose ultimately it’s down to work and income really, largely it’s a key thing in obesity.’*

(CCG participant)

This general health inequality position was not supported by action in terms of what is being done locally around obesity from the documentary analysis in chapter 5. All analysed obesity documents and plans point to a similar approach to what is being done elsewhere, some prevention focus across the lifecourse and then some weight management service type interventions. The overwhelming discussion regarding obesity was not that it is directly linked to inequality but that it is directly linked to physical activity. In Sheffield, addressing physical activity through the Move More Strategy appears to be the answer, with barely a mention of anything else from all staff groups, despite the reported focus on inequalities, and the weight management interventions that the documentary analysis identified as being delivered locally (see chapter 5).

Across Sheffield participants’ prevention was the main answer, for both the Local Authority and CCG participants, with some limited services, but scaling those back to focus on the prevention agenda. However, this was not what was revealed as actually being undertaken as described in chapter 5, as there was similar activity to the other areas in terms of interventions. Equally, there was no discussion nor evidence reported or discussed in terms of what works in the prevention area and no sustained learning or even recollection from the large-scale prevention programme that was delivered in Sheffield 2009-2011, Sheffield – Let’s Change 4 Life (SLC4L). Again, this links with the lack of reporting, monitoring and evaluation from the learning of previous obesity activity, noted in Chapter 5. Also, this potentially links with the general comments about loss of organisational memory through the changes nationally that led to many staffing and programme changes and affected the learning, people and expertise in this area in Chapter 6.

The view from Elected Members and Senior Leaders in Sheffield was that there needs to be a shift in obesity investment locally away from treatment to prevention of obesity with more upstream investment require, as previously presented in Chapter 5. This would support a view of obesity being as a result of wider socio-economic factors and less of an individual personal responsibility issue in Sheffield, if using Barry’s (et al 2009) approach.

However, despite nuances as described, and a clear concern for inequality there was a particular individual responsibility narrative for those inequalities – as already presented in Chapter 5.

Overall, across the South Yorkshire sites, presented above and in Chapter 5, the dominant problem definition of obesity was an individual responsibility related to diet and physical activity choices, leading to health related impact. As previously discussed, this research argues that this problem definition is crucial to policy processes such as whether or not obesity gets on the agenda and is seen as a priority, this is further examined below.

### 7.2.2 Prioritisation as a component of agenda setting

The interviews with key obesity stakeholders across the South Yorkshire sites revealed that obesity was inconsistently framed as a priority across the sites. Although all interviewees recognised obesity as a priority, how this was described by interviewees and especially in documents was inconsistent. Obesity would, for example, be mentioned as a priority in some local documents then not others, even in the same year and in similar, consecutive documents year on year; suggesting a lack of clarity about obesity’s priority status in policy-making.

In Barnsley, for example, local documentation mentioned obesity but this was inconsistently referenced as a priority; with other issues sometimes taking priority (such as smoking, oral health, physical activity. In Doncaster obesity was discussed inconsistently as a priority in documentation and by participants. In terms of documentation, the 2013 Director of Public Health Report (DMBC 2013) and the Doncaster Joint Health & Wellbeing Strategy (2013-16) clearly identified obesity as one of Doncaster’s 5 key priority areas. However, more recent Doncaster public health policy documentation – such as the 2016 PH annual report (DMBC, 2016) - did not mention obesity. Furthermore, where obesity was identified or briefly mentioned, for example in the Health & Wellbeing Strategy 2016-2021 (DMBC 2015), no information was given on progress or priorities, with only NCMP prevalence stated, and not specifically discussed as a local priority. In terms of the Doncaster stakeholder interviews, whilst most participants spoke about obesity as a priority issue locally they were frequently unable to articulate clear causes or local solutions being undertaken, suggesting, following Bacchi (2009) that this may not be a clearly understood local priority.

In Rotherham, there was a clearer priority narrative across documents and participants about obesity, with all mentioning local activity aligned to the Rotherham Health Weight Framework as a type of core strategy document (as mentioned in Chapter 5). In contrast none of the other areas appeared to have a similar type of document.

In Sheffield, obesity was consistently described by the Local Authority as a priority across a range of local policy texts, including DPH reports from 2009-2015 (see Sheffield DPH Annual Report 2009; 2010; 2011; 2012. 2013; 2014; 2015). Similarly, participants also identified obesity as a priority in their interviews. Interestingly however, more recent local Sheffield documents from 2016 onwards did not mention obesity.

These inconsistencies in the prioritisation of obesity across the case study sites appear to be recognised by stakeholders as a result of lack of national leadership on obesity as they discussed issues relating to a lack of leadership and clarity at a national level in terms of how this undermined local-level prioritisation and agenda setting. Participants spoke about how there was no one to drive forward/advocate and ensure obesity is on the agenda in LAs and how thewider national context of transition was also affecting agenda setting locally. Stakeholders called in their interviews, for example, for national action to address the lack of local prioritisation. One weight management service provider discussed this passionately and at length, as exemplified in the following quote:

*‘fundamentally the big problem we have is there is absolutely no leadership on this [obesity] agenda. It’s not a priority agenda, more people die from obesity than terrorism and yet the big agenda of our age if you like is terrorism and yet more people die on a day to day basis from obesity than they do terrorism. Now these are difficult things to balance out but we really need some serious level leadership because at the moment the system is in such a complete mess that actually there’s two things. I think the system’s in such a mess and it’s so unclear what to do or how to address obesity at that intervention level, that local level, that regional level, that national level there’s absolutely no blueprint for doing that effectively therefore somebody at the top needs to start to try and organise those different elements to look at how do we do this differently and more effectively.’*

(Weight Management Service Provider)

Other participants also expressed some desire for clearer national action, as three different Public Health Commissioners and one Senior Leader reflected:

*‘It’s got to come nationally for me it’s got to come nationally. And this is quite controversial but you know we’ve only got to look at the smoking ban to know the difference that that’s made.’*

(Public Health Commissioner)

*‘I think responsibility in the future lies with government to provide a legislative framework...’*

(Public Health Commissioner)

*‘The whole and you can’t just do it on your own. And we [the Local Authority] can’t probably do. Some of it has got to be national as well; it’s not just local.’*

(Public Health Commissioner)

*‘The government ought to be erm perhaps doing more. Erm investing more.’*

(Senior Leader)

## 7.3 Policy Formulation

Policy formulation is about how strategies and decisions about solutions (actions) happen in local authorities; a key consideration is who is involved in these processes and how.

### 7.3.1 Policy Formulation: actors

Firstly, it was found that the role of Elected Members in policy formulation was seen as challenging by others involved, secondly but relatedly, the ability of public health officers to influence Elected Members, and, lastly the loss of expertise.

As introduced in the previous chapter focusing on context, participants discussed how public health functions within the new local authority environment. This included the resultant changes to positioning and influence of public health personnel within these new structures in local government. Additionally, within the changes to position and influence of public health personnel, participants gave accounts of how public health policy formulation works in local government, with specific reference to obesity. They discussed how public health people and issues, including obesity, operate within this new context, structure and culture, in terms of position and influence. Indeed, the issue of public health positioning and influencing, and ability to influence obesity policy processes was discussed at length by participants, both participants within and external to public health, who identified a number of issues within this theme.

Firstly, participants discussed that Local Authority decision making is undertaken by Elected Members (i.e. elected officials or Local Councillors). Participants discussed this decision-making set up and there were mixed views about it across participant groups. Interestingly, participants who were mostly from the weight management service providers and CCGs (who are external to the Local Authority processes), seemed to raise most concern over this process; in terms of questioning how Elected Members’ knowledge is shaped and influenced to enable them to make decisions. This was best summarised in the concern voiced by a weight management service provider:

*‘the problem is we’ve got non-medically trained elected local individuals who are in charge [of obesity]’.*

(Weight Management Service Provider)

Those working in public health within the Local Authorities across the South Yorkshire sites also raised this issue of local influences on obesity policy decision making processes; identifying a range of issues or influences on local authority obesity policy decision making. For example, participants discussed the influences on decisions about: how issues get on the agenda; how issues such as obesity are prioritised; the local narrative about obesity causation and solutions, and how obesity policy is interpreted, formulated and enacted locally.

In terms of how issues get on the agenda and are prioritised, some participants expressed concerns about how locally Elected Members made decisions about this and on what basis these decisions were made; for example, questioning how decisions were influenced by personal knowledge, public acceptability and votes, rather than scientific evidence. As one Public Health Commissioner explained:

*‘…firstly about support for exclusion zones around school, so erm, so parents can’t park within half a mile of their children’s school. An elected member said to me although I agree with it and I think it’s a great idea there’s no way I’d support you because I’ll lose votes. And that’s ultimately what their aim is. They’ve got to gain votes. And [they’re] there to represent the electorate so you know that’s right.’*

(Public Health Commissioner)

Another Public Health Commissioner noted this challenge more succinctly:

*‘the difficulty is because it’s a political organisation it depends upon the personal agendas of the politicians.’*

(Public Health Commissioner)

Secondly, another factor relating to local obesity policy formulation, was about the ability of public health officers, now within LA structures, to influence the decisions of Elected Members on the issue of obesity. The recognition of the leading position and role of Elected Members in LA decision-making, led to participants discussing how they could exert influence. In other words, in this new political environment and given how public health was now positioned, they discussed what this meant or may mean for local obesity policy decision making and subsequent impacts on tackling obesity. On this topic, and as already mentioned above, weight management service providers and public health participants voiced frustration that the views of Elected Members were now central to what gets done or invested in; and, moreover, that the influence of those who, in theory, should be providing the evidence to inform these decisions (i.e. public health staff) was not impactful. As one weight management service provider participant explained:

*‘it feels like people are now in this council culture where they’ve got to try and sell the value of this investment to members. We’ve almost stepped back in terms of Public Health. Because all we get is well members are not going to understand these difficult arguments,…they definitely want to see a thousand people with 5% weight loss; that’s what. That does it for them. That’s what we are told…things are being challenged and you’ve got certain councils that are making big decisions about cuts and things. It feels like under more pressure to give them some tangible stuff. ‘*

(Weight Management Service Provider)

*‘The problem there seems to be with that is evidence and outcomes are another thing members aren’t swayed by, because it’s the nature, is are the things that they can see locally.’*

(Public Health Commissioner)

Interestingly, this aligns with the findings from the first findings chapter about the lack of evidence provided in the documents about the success or otherwise of the local obesity activities that have been undertaken, and, therefore what evidence is used, or available, to make decisions.

Across all geographical areas, public health participants frequently articulated issues pertaining to the challenges of working with Elected Members. As suggested from some of the material included above, the main one raised by participants seemed to be that the knowledge, background and views of Elected Members influenced action; rather than the experience, qualifications or scientific evidence presented to them in relation to public health or obesity. Indeed, to emphasise, this concern about Elected Members’ knowledge, background and views rather than public health specific evidence was repeated frequently by the commissioners in public health now in Local Authorities across all of the geographical research site areas (Barnsley, Doncaster, Rotherham and Sheffield). Significantly, the perceived inability to really influence action on obesity appeared to be revealed as frustration by some and annoyance by others. All in public health roles in LAs voiced concerns about their ability to influence, as well as the majority of CCG colleagues commenting on public health colleagues’ roles and influence, and, by all the weight management service provider participants. The frustration and annoyance are illustrated by these comments below. Firstly, from a Weight Management Service Provider:

*‘Well that’s the worry. How long can someone that’s very motivated, passionate continue doing that when what their vision is, and they know it’s working, is constantly being stopped by people that don’t understand and are not clinically trained and don’t have the expertise and it’s very much about a financial budget line… But that’s what worries me, … suddenly everything about obesity is going to be commissioned by these people that are pulling the purse strings that don’t understand and it will all be about the cheapest possible service and whether it’s effective or not is irrelevant.’*

(Weight Management Service Provider)

*‘The Public Health voice has been diminished and side-lined in Local Authorities’* (CCG Participant)

These main issues are perhaps best illustrated by the following quote from one local leader/key decision maker who noted the difficulties of public health having influence in LAs and the position and impact of the Director of Public Health (DPH) within this new organisation and hierarchy, and what this means for whether or not obesity is acted upon:

*‘Yes I’ve a lot of respect for [the DPH]. But they’re no street fighter! Erm and you know you’re in a, you know you’ve got to be a lion tamer if you’re you know arguing with councillors. I mean there is appalling lack of support for [the DPH] and Public Health.’*

(Senior Leader)

However, all local providers of weight management services across all areas described that they felt that, as a result of the national changes and transition, there was a risk to the expertise, pathways, processes, services and funding, with reductions in LA budgets, best summarised by the following quote from a Weight Management Service Provider:

*‘what worries me about it is that you’ve got to understand obesity and that it’s a long term problem…If I think about the last 5 years that we’ve been looking to be part of the partnership and the talented and passionate people that we’ve worked with that are no longer part of the process because of the funding cuts…we can’t have people leading on obesity that don’t understand what obesity is about and that it’s a long term problem and that’s what worries me, that it’s going to come down to people commissioning based on a budget and we’re not going to have people that understand.’*

(Weight Management Service Provider)

Interestingly, all these issues above about decision-making, the limits of public health influence and the role of Elected Members are reflected in recent research commissioned by Public Health England examining the impact of transition of public health to LAs. There not only seems therefore to be a common pattern across the LAs involved in this research, but also other LAs in England (in the PHOENIX Report, Peckham et al. 2016). This is discussed further in chapter 8.

As well as the role of different actors in policy formulation, and relatedly, is the content of the policy itself. This is presented below.

### 7.3.2 Policy Formulation: policy content

Despite nuanced differences discussed in section 7.2 in terms of the local views held about obesity, it was found that in all four areas there was a dominant narrative around personal responsibility. Referring back to Chapter 5, all four local areas have decided to focus on obesity, detailing: work as a partnership approach locally; some tier 1 prevention activity (such as physical activity promotion, dietary education, work in schools) and are investing in a range of treatment options for adults and children (for example 12 week weight management interventions).

It was found challenging to understand the partnership and prevention work from documents and interviews. Although there was a focus on partnership responsibility by those currently working in and commissioning services, especially seen in Doncaster, there was no real detail nor examples in either interviews or documentation (see Chapter 5) in any area about what this partnership working was, and/or if it was a reality or just a proposal:

*‘I think what I’d like to do is to actually get all partners involved erm because we can’t do it in public health on our own…Erm and hopefully what that will mean is that we can get a partnership approach to the whole issues of health in the borough. And commitment to that and staff committed to that and resources committed to that..’*

(Public Health Commissioner)

However, what was clearer was that all areas were commissioning the same type of weight management service treatment interventions, and have done for a number of years, pre and post public health transition from NHS into LA. However, despite this being clearer in the research, there was still little detail given about what exactly is commissioned. There are service specifications that were put out to tender but these were plans about outcomes rather than what is actually now being delivered in detail. Additionally, as will be discussed in section 7.5 below, there is no detail presented about what any of these services are achieving to support this investment in these interventions.

As presented above, participant interviews and documentation presented in Chapter 5 revealed some misalignment between what local policy stakeholders say they wanted to do around obesity and what is reported to be invested in from the procurement/tender documentation. This was discussed by one Public Health Commissioner in terms of trying to explain some of this misalignment between what is said and what is done related to the lack of clarity about what may be effective:

*‘it feels very much that we’re still at the stage of problem identification, analysing more about the problem. We have got some evidence about what works and that’s why we’ve ended up focusing on two or three key areas like morbid obese surgery because NICE have got evidence around that whereas the evidence around the whole of obesity pathway just feels too difficult or too complex to really decide what are the two or three things to do so we have conversations about licensing and takeaways and things like that, we also have conversations about active travel and planning but actually that doesn’t sort of coalesce now, it doesn’t seem to coalesce into a programme of works.’*

(Public Health Commissioner)

Differently to the other areas, although still not a dominant feature, there was a view from Elected Members and Senior Leaders in Sheffield was that there needs to be a shift in obesity investment locally away from treatment to prevention of obesity with more upstream investment required, *‘a shift in obesity investment locally away from treatment to prevention of obesity’* with *‘more upstream investment required*’ (Senior Leader).

Why the areas seem to document some things related to obesity, state a different focus in the research interviews and yet deliver something that may not align to the stated focus is unclear. It may well be that this is historical and/or as a result of transition, or perhaps the complexity of obesity constraining action (as previously presented and discussed in the work of Lang and Rayner 2007). This may be because of issues of evidence of effectiveness, or some other reason. These will be explored further in the discussion chapter that follows. In order to understand the potential reasons for the local similarities and differences in the stated obesity focus and action undertaken across the areas, the following section presents the findings from the participant responses and documentary analysis about the next stage in the policy process – implementation, examining the views or representations of obesity locally and what is then operationalised.

## 7.4 Policy Implementation

As aforementioned, the perception regarding national lack of clarity impacting on local level clarity regarding responsibility to act on obesity, in the context of the national changes such as transition and public sector finances were all found to be having an impact on local level obesity policy processes. All four areas are implementing some obesity activity and investing some resource, as demonstrated by the table below. However, it was difficult to be clear on the exact level of resource and what actions it was actually invested in as discussed in Chapter 5.

Table 7.1: Weight Management Activities and Spend per Area

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Commissioned Service & Local Authority Area | Children & Family Prevention/ Tier 1 | Children & Family Tier 2 | Children & Family Tier 3 | Children & Family Tier 4 | Adult Prevention/ Tier 1 | Adult Tier 2 | Adult Tier 3 | Obesity Spend/ Popn (£) 2015/16 |
| Barnsley | Y | Y | N | N | Y | Y | N | 2.63 |
| Doncaster | Y | Y | Y | N | Y | Y | Y | 2.04 |
| Rotherham | Y | Y | Y | Y | Y | Y | Y | 3.28 |
| Sheffield | Y | Y | N | N | Y | Y | Y | 1.81 |

Despite the stated focus on prevention, and nuanced local narratives discussed in the previous section on problem definition, the areas did not necessarily appear to undertake actions specifically aligned to what they discussed was their stated aim(s), as presented in chapter 5. More specifically, the point to note is that despite local area differences in views about causation and what to do to tackle obesity, what was done locally across the areas with differing views appears similar: some partnership, prevention and tier 1 activity as well as commissioning of very similar treatment interventions, as presented in chapter 5 and demonstrated in the table above.

This next section goes on to try to understand why some of this has arisen, firstly by exploring how the lack of clarity on roles and responsibilities was viewed and then how the roles and responsibility issues identified may lead to implementation gaps.

### 7.4.1 Local level implementation of obesity policy in the current national context

The lack of national obesity policy clarity in terms of who should be responsible for what, as well as a reported lack of leadership from central government on obesity, was seen by many participants across the four areas who were directly working in obesity (such as public health commissioners and weight management service providers) to be central to the local experience in terms of a reported ‘mess’ of, obesity policy processes locally, and who should and could do what to address obesity. Participants recognised the issues associated with this lack of clarity at a national level and how this is translated locally, for example the following comment supported the views of others who had similar comments*‘…at the moment there is a disconnect between the national [obesity] policy and how it’s delivered locally.’ (*Public Health Commissioner).

Although obesity was stated as a priority overall in this research across Local Authorities and the NHS, views, action and investment locally differed, as discussed in the previous findings chapters. Much of the challenge of addressing obesity locally is seen by participants to be because of the transfer of this issue of obesity into the context of Local Authorities, and, the way in which public health issues now need to be raised and addressed, as discussed in the previous findings chapter. This contextual complexity, the fact that obesity is a non-prescribed activity, in the context of the way public health appears to be viewed and valued in LAs, and, the financial climate in the public sector, whereby all areas need strong arguments to warrant investment, leads to a series of challenges for obesity policy locally. The lack of clarity nationally about responsibility for tackling obesity further complicates this for obesity prioritisation and investment at a local level. All these issues are discussed by one Public Health Commissioner, with a quote that best exemplifies the issues that others also discussed:

*‘…But, well it is a mess isn’t it, pretty obviously it’s a mess, I mean, even here when we try to figure out who’s paying for what we ended up in an argument within minutes! And that’s in here, where we’re pretty good, imagine what it’s like in places that don’t get on…I know quite a few areas that aren’t like that and if that’s like that in every single one, imagine the amount of senior officer time that’s been spent across the UK, just going ‘it is’, ‘it isn’t’, ‘it is’, ‘it isn’t’ about 4 different ways, just on obesity, so it’s pretty obvious is the answer to that is that it’s made a right mess’*

(Public Health Commissioner)

*‘it will take a few years won’t it, so in 5 years’ time everybody will know who’s paying for what, so I don’t think that stacks up. It might be interesting to see how much investment comparative and collective investment is there in 5 years compared to what there is now, but in actual fact whether because of all the cuts we’ll actually end up investing less in this issue than we did before collectively.’*

(Public Health Commissioner)

All areas and all groups identified and acknowledged obesity was a priority to some extent in documentation and interviews. However, this was not necessarily supported in the findings of this research by clear action nor investment in neither interview nor documentation analysis (discussed in Chapter 5). Although there was ongoing investment in obesity, it has been shown to be reducing (Chapter 5) and participants raised their concerns around obesity’s prioritisation for action and investment in the new LA environment. There was agreement across Weight Management Service Providers that transition of public health into LAs had led to inaction, ‘*inertia’* and inactivity during transition and adjustment, loss of organisational memory, staff and with them knowledge/expertise in public health but also in obesity, which has been seen to have had a serious detrimental impact and was noted by many in the Weight Management Service Provider sector as still causing significant problems, as this process of change was not one to have been ‘through’ but still ongoing (Chapter 6). One vocal weight management services provider stated the following, which best sums up the views of others in public health and provider sectors about the impact of public health transition, the financial context and responsibility, as well as austerity on the loss of momentum for obesity as a result of the changes from the Health and Social Care Act (2012):

*‘We started the recommissioning process and we’ve just recently been told it’s going to be put on hold for another three months while the authority look at how much money they’ve got in the bank. Well, we’ve been told by again very clever people that the obesity epidemic is our number one public health priority and it’s going to bankrupt the NHS, now that the responsibility for it lies predominantly, not entirely, with local authority, why are we now messing about saying that we need to look at the amount of funding?’*

(Weight Management Services Provider)

As the quotes above have already introduced there were equally important issues raised by participants across all four sites and participant groups of the (in)ability that they felt to act on obesity, based on tensions of working in local government, which were identified as increasingly competing priorities for investment of resource, especially around areas of local economic growth and how health agendas can be in conflict with this. A Public Health Commissioner summed up this struggle locally, illustrating the similar comments of many across all areas and participants:

*‘we have local areas where there’s a real conflict between kind of business and generation and providing a more healthy environment so erm you know you now an example of you know working in Public Health and local government and wanting to do some things around reducing the amount of takeaways, conflicts around that economic agenda so one of the things we need to do is think about how we instead of conflicting we kind of work towards the same agendas oh you know things like having a health high street, those kind of things.’*

(Public Health Commissioner)

### 7.4.2 Policy Implementation: NHS or LA Responsibility for local obesity policy leading to implementation gaps?

Due to unclear national strategy of responsibility for obesity, implementing obesity action is open to local interpretation. Participants identified a lack of clarity between the NHS and LAs in terms of responsibility for treatment in particular, which was leading to implementation gaps for specific groups with obesity. These implementation gaps in service provision, especially for those already identified as overweight and obese may arise because LAs see themselves as doing ‘population’ prevention and the NHS as ‘doing treatment’ (which LAs don’t seem themselves as responsible for), yet the local NHS position is that the LAs received the resource (public health people and ring fenced grant) and therefore are locally responsible as the NHS received no resource for treatment.

The generally held view that appeared to be common across the four geographical areas, and particularly by Elected Member and LA senior leader participants, was that public health’s role was more aligned to population prevention and the NHS’ role is more suited to individual medical treatment type approaches.

*‘Well we won’t do treatment so the treatment side will be NHS so anything that we do is more preventative, the Council does prevention so actually we do tier one and tier two…but I think most of our funds should go into prevention.’*

(Public Health Commissioner)

As the previous chapters have presented, although the local discussion was about obesity prevention, the action being taken (by LAs) was that of a more individualised treatment type approach to obesity locally. This therefore may pose challenges for action on obesity which the discussion chapter will go on to explore.

The key issue identified here is however actually about financing implementation processes. There is an overall issue in relation to lack of resource generally locally as the previous chapter presented, and also an issue about who specifically has the resource. To explain, as there was a locally acknowledged lack of clarity nationally in terms of responsibility in the obesity pathway between Local Authority and Clinical Commissioning Group responsibility, with recognised fragmentation in the pathway (Barth 2015), participant discussions were mostly focussed on the central dominating issue of funding i.e. financial responsibility and control. The public sector, either CCG or LA participants in this research, commented in general that they were all happy to be leading work around obesity if they had the adequate funding to support this activity locally. There were a number of CCG comments that summarise this position, one CCG participant stated the following about fragmentation in the pathway and funding:

‘*My personal view is that the CCG should commission all four of the levels, the only thing is we just need to work out the funding…there’s two areas that have split commissioners, one is CAMHS and one is obesity and neither of them work for that very reason so I’d have all four tiers commissioned by the same commissioner. It doesn’t matter whether that was the CCG or the Council but as long as it was the same commissioner and the funding streams were clear’.*

(CCG participant)

In general, the dominant CCG view and weight management service provider views were closely aligned, in terms of discussing having one integrated obesity pathway, not a fragmented commissioning structure (with responsibility for some elements the LA and other parts of the obesity pathway a NHS responsibility), as the previous quote exemplifies. However, the general public health and LA view appeared more financially driven, recognising they currently hold the public health budget, and therefore obesity budget. A Senior Leader crystallised this issue:

*‘I wouldn’t stop anything we’re doing as long as we’ve got the funding to do it but like all Council’s we’re going to have to take some very hard decisions this current year err and we’ve lost in terms of our budget erm and I know there are some members who will say why do we need to fund an obesity programme? Isn’t that to do with health? Yes but we have sections responsible for health? No that’s the hospitals and the NHS and I know, well I suspect that I’ll get that from some of the members you know when we come to look at budget cuts’*

(Senior Leader)

The majority of participants who discussed this issue of responsibility between the LA and NHS, felt that one integrated pathway across all tiers of obesity activity would be the best pathway for commissioners (currently the LA), and therefore service users. There was widespread recognition that the national and local shifts in commissioning pathways for obesity (as a result of the Health and Social Care Act 2012) had not been positive in terms of supporting understanding of local roles and responsibilities and structures to tackle obesity and leading to ‘silo’ working not joined up integrated action on obesity.

*‘We need an integrated approach, a whole system approach would be better’.*

(Public Health Commissioner)

*‘The different commissioning organisations need bringing together but it’s not happening’.*

(Public Health Commissioner)

*‘LA & NHS have been planning separately, this needs to be integrated’.*

(Public Health Commissioner)

This is a resounding theme as many of the participants discussed this issue in some form:

*‘We have disparate responsibility’.*

(Public Health Commissioner)

*‘We need integrated prevention and treatment services’.*

(Weight Management Services Provider)

*‘We need a whole systems approach’.*

(Weight Management Services Provider)

*‘We have fragmented responsibility in commissioning of these services.’*

(Weight Management Services Provider)

Overall the view seemed to be that whoever had the resource for the different elements of treatment and prevention needed to address it, but that national clarity was required on what was prevention and treatment, who was responsible for what and then that be nationally mandated. One Senior Leader commented on the roles and responsibilities and the impact on the public sector, with an interesting view on the issue of LA resource being invested in areas that were predominantly seen as health and then the savings to be reinvested in LA work rather than absorbed by the NHS:

*‘We ought to talk these days about prevention and about the cost of obesity to the health service. Erm now we can put a lot of erm we can put resources into obesity but we don’t see any of the savings that the health service make. They don’t come back to the local authority. You know say we do loads of stuff that saves them money. We don’t see that money.’*

(Senior Leaders)

There was a feeling that there was a general lack of leadership, clarity and direction nationally to act, best summarised in the following comment from one CCG participant:

*‘Well the fundamental problem really I mean many problems in this, but the pathway is fragmented in its commissioning and then of course its fragmented in its provision……so my take on its just a mess really and there are people in central government, local government, NHS providers and commissioners all over the place who all claim to be interested in it and yet it’s this lack of organisation like so many things.’*

(CCG participant)

### 7.4.3 Policy Implementation: local obesity policy financial responsibility & control

For participants in this obesity research, finances, financial control and responsibility for obesity was a key influencing factor in terms of policy processes and particularly policy implementation, i.e. what resource there is, who controls it, and, how it can and is to be used. To explain, public health transferred to local authorities with a ring-fenced grant, which in the new financial climate and nationally austere times, seemed to be reported as the only interest local government had in public health, and how this resource could be used in the Local Authority, not necessarily for what public health teams would traditionally see as public health issues, as discussed in the previous section. As one weight management service provider stated, that public health moving into LAs is seen as a *‘cash cow’.* (Weight Management Service Provider)

Although participants recognised that many of the challenges, including financial, were national and not necessarily local authority specific, working in a time of austerity with a difficult national and public sector financial climate, there was still competition for issues to be prioritised in local government in the context of reducing resource. This was felt two-fold in terms of both trying to get public health issues on the agenda and prioritised and then for resource to be allocated, or indeed, not have the ring-fenced public health grant used for issues other than what public health practitioners would deem as public health priorities locally – as previously presented. A Weight Management Service Provider expressed concern that there is *‘reducing investment in obesity locally’ .* This prioritisation of resource for obesity, was played out in the context discussed in the previous chapter.

CCG participants commented on the financial pressures facing LAs and therefore responsibility for obesity may be better placed within the NHS:

*‘there is greater pressure on council budgets than there is health budgets so obesity services would be better protected in the health commissioner one.’*

(CCG participant)

A CCG participant from another areas, stated:

*…I think [GPs] would make better informed decisions than possibly councillors from that background…Yes I think what I could say confidently is if the obesity budget came through to a clinical commissioning group we wouldn’t be looking for efficiencies out of it… we’d probably invest in it actually than take money out of it. I think we would however need a national directive. I think there’s nothing to stop you doing it legally locally but say there’s one commissioner for obesity service, things would happen a lot quicker if it’s done at a national level’*

(CCG participant)

Within this theme of financial challenge in the public sector, and especially LAs, there was an expressed view from the public health and also weight management service provider participants that local authorities were able to spend the public health resource however they saw fit – *‘cash cow’.* This appeared to align and be further compounded as an issue for concern by how public health people and issues were viewed within local government and whether or not they had influence to effectively challenge policy processes, as discussed in the previous chapter. This was discussed by many participants in some way/form, but perhaps best reflected in the comments from the different sectors below:

*‘I think the negative is it has gone into an environment that’s very financially challenged and there’s no doubt that although public health is in theory ring-fenced, the councils are you know doing their damdist to find ways of shifting some of that spend around in ways that bails other areas of the service out. Because almost whenever we’ve been involved in discussions around contracts we’ve been talking about significant reduced financial envelopes. So there’s obviously the money that’s being kind of erm, I don’t know, being used creatively. But it’s certainly not going into obesity’’*

(Weight Management Services Provider)

*‘Erm finances as well now that we’re in a political environment so we’re being slashed.’*

(Public Health Commissioner)

*‘Ring-fence grant; what’s a ring-fenced grant about? It’s not been ring-fenced so we’ve just been slashed and we can’t do what we wanted to do without funding.’*

(Public Health Commissioner)

These views about the use of the public health resource for efficiency savings or activity not traditionally public health were expressed across all public health and weight management service providers, possibly as they were the groups experiencing first-hand the real impact of such changes. This was seen to be as a direct result of the financial challenges facing LAs, and therefore spend and prioritising issues for investment was a concern, this, naturally included obesity prioritisation and resourcing.

However, public health moving into Local Authorities was also seen as a real opportunity, for public health by some public health staff, illustrated by two public health participants’ quotes:

*‘Public health could offer a real contribution and an opportunity with other LA directorates’*

(Public Health Commissioner)

And,

*‘I don’t know what it’s meant for obesity but for I think for general lifestyle what’s happened [moving PH into LA] is good that we can being in Public Health in the NHS it was very clinical focused. And very service led. Being in the local authority I think give us the breadth to do the wider determinants of health more, so we’re in you know consultation of planners, housing, transport, green space. It’s the wider determinants, whereas in the NHS we were driven down the clinical route.’*

(Public Health Commissioner)

Public health moving into LA was seen by some Elected Members and senior leaders as *‘an opportunity which has not yet delivered’*, with a large focus on the *‘resource that PH brings into the LA to tackle things more upstream.’* And that public health moving into LA *‘unlocks a bigger budget’*, where LA leaders think this resource can be better used.

This raises the question as to how obesity can be acknowledged, and in fact is universally stated to be a local priority yet may not be invested in and/or acted upon successfully. The difficulty seems to be understood by the participants in this research as – who is responsible for what? This issue of who should do what, links back to the unclear national strategy around obesity roles, responsibility and resource allocation. This is not only felt by public health in LAs but also by CCGs. Once again, the main issue for most participants about who should act and what they should do was ultimately about financial control and responsibility for obesity, and allocation during the transition. Although there are many inter-related factors (such as national clarity and evidence of effectiveness) this lack of clarity on local action predominantly came down to money. This was most significantly discussed by those who were asked to provide services within these financial constraints, and observing and operationally delivering the efficiencies felt by the financial impacts at the sharp end, i.e. Weight Management Service Providers across the four areas:

*‘And I guess just the financial constraints as well. The fact that erm when you look at how much money has been assigned to obesity compared to say drugs and alcohol and smoking, it is relatively small. And I’m not sure that that’s right, but then not my erm decision. And then given that I don’t know that people actually appreciate how complex it is. And the fact that you do need specialists like psychologists and dietitians, and are expensive so we’re trying to do everything on a shoe string.’*

(Weight Management Service Provider)

Another Weight Management Service Provider summed up their frustrations as follows, reiterating the views of others in the same sector:

*‘Now in the sense of obesity there is no power. There’s no systems, there’s no process, no capabilities, no workforces, no nothing so why are we surprised that obesity gets 2.5% of the public health allocation erm when it costs twice as much as most other public health issues. Why are we surprised at that? Why are we surprised that we continue to invest loads in cardiovascular disease and cancer which are effectively impacted on by obesity significantly, why are we surprised. So for me at a big level yes potentially right outcome but execution of it complete disaster, complete disaster’*

(Weight Management Service Provider)

Another area CCG participant made similar remarks that due to the national position CCGs were restricted in terms of involvement but that was not to say they were not interested in obesity as an issue:

*‘we haven’t got any influence or impact on either of those obesity commissioners, we haven’t got any jurisdiction over either of them whereas if we were commissioning…you’re not going to get the input and the focus that you need and that’s, that’s the benefit you would get by bringing it back to the CCG but you would also create a hornet’s nest if there wasn’t absolute clarity and actually if there wasn’t clarity the CCG I think we would just revert back to the constitution which is that we can commission as we you know as we see fit for our population health need and we wouldn’t be dictated to by a national commissioning policy that wasn’t mandated through you know the relevant type of routes.’*

(CCG participant)

Predominantly, those in CCGs felt that obesity responsibility (and associated budget) would be well placed within the NHS structure, i.e. in CCGs. The reasons given for this included: the financial pressures LAs face; the local view of obesity (as a result of individual diet and physical activity choices); and, the reported NHS understanding of the consequences of obesity and significant NHS and health impact of obesity. Those in CCGs felt they may be a better fit for this issue.

This view was also shared by some outside the CCG, with a Weight Management Service Provider noting many of the issues presented here, therefore the lengthy quote is given in full to provide this opportunity to hear the participant:

*‘I mean the problem we’ve got is now we’ve got non medically trained elected local individuals who are in charge of the budget so they could turn round and think ‘oh well it’s an easy win with the taxpayer if I cut the budget and save some money and they’ll think I’m great and re-elect me and why should we be saving money for the NHS, that’s their problem’, it totally neglects the argument that treating obesity saves money in the long term because you know, you reduce the co-morbidities, you reduce the direct and indirect healthcare costs and social impact. But they might think ‘somebody else’s problem’. Now the only way we could have got round that would be if we’d have maintained an integrated framework for commissioning and given all the responsibilities to that one organisation because then when they didn’t address obesity in that local area, they could have been the one and only people held to account. There’s no accountability in a fragmented system because somebody can say ‘it’s not my problem, it’s somebody else’s problem’, CCG could turn round and say ‘it’s not our problem that we haven’t addressed obesity, we’ve got a great tier 3, the local authority have let us down with tier 1 and tier 2’ and vice versa. You know, if it had all been done by the same people, it would be one person, one organisation that were held accountable, they would have had full responsibility and they wouldn’t have wanted to be held to account and therefore provided good services. ‘*

(Weight Management Service Provider)

The widely held CCG view is that the resource may be better sat in one place, that it really doesn’t matter who has the resource as long as it is with one commissioner, as it was before the Act (2012), with the NHS. The CCG view was that obesity may be better understood by clinicians, in terms of wider impacts as a result of obesity, and therefore the budget for obesity better protected and in fact further invested in if sat in CCGs. One CCG lead was keen for CCGs to take this responsibility on, commenting on the fact that if all four tiers were commissioned by one body, that would be best placed to be the CCG due to less pressure on NHS budgets than LA and that GPs can see the consequences and know the people, however, the current structures prevented this:

*‘I think the GP’s would be more than happy at having a greater role in it. It’s just the way we’re currently structured its Public Health and the council sort of self-style themselves as the obesity accountable body.’*

(CCG participant)

All CCG participants were keen to take on the responsibility for obesity, if the budget came with the responsibility.

### 7.4.4 Policy Implementation: service providers operationalising obesity policy locally

Issues with financing the implementation of obesity policy action were leading to cascading problems for service providers locally partly due to the financial ‘cuts’ were operationalised in commissioning processes.

Weight management service providers are key implementers of local obesity policy: they interpret local service specifications , bod for these through the tender process, and then deliver to specified outcomes set by commissioners (i.e public health). There was agreement in interviewees that were conducted with weight management service providers that the transition of public health into LAs created commissioning changes which had had a *‘negative impact on services’ and* meant that their work on obesity was stalled. As one weight management provider indicated: ‘[we are in a ] *state of limbo, uncertainty and changes’.*

The implementation of weight management services had been perceived to have stalled mainly because of the Health and Social Care Act (2012). As previously presented, the Act led to: transition of staff (including loss of staff and expertise); time to establish new working relationships; a new organisational structure to influence regarding prioritisation of issues such as obesity; and, a shift in the financial climate nationally, affecting the public sector, known as austerity (with associated measures and cuts to services, such as obesity).

The loss of expert staff was seen as a key issue, set in the context of the new organisational structures of LAs and how decisions are made in local government, as one weight management service provider commented:

*‘passionate, talented staff and those people who understand obesity are no longer part of the process. The people leading on obesity don’t understand obesity’, ‘the problem is we’ve got non-medically trained elected local individuals who are in charge’.*

(Weight Management Service Provider)

with this potentially leading to:

*‘people not working in an integrated pathway but being protective due to money’.* (Weight Management Service Provider)

This was well summed up by one weight management service provider, previously quoted by reiterated here to demonstrate the points:

*‘We started the recommissioning process and we’ve just recently been told it’s going to be put on hold for another three months while the authority look at how much money they’ve got in the bank. Well, we’ve been told by again very clever people that the obesity epidemic is our number one public health priority and it’s going to bankrupt the NHS, now that the responsibility for it lies predominantly, not entirely, with local authority, why are we now messing about saying that we need to look at the amount of funding?’*

(Weight Management Services Provider)

Related to this, there was agreement in terms of Weight Management Service Provider concern over provider/commissioner split (as described in chapter 2) that competition has made working together difficult and that this split had led to a lack of integration and less working in a client centered way, as now work was more about a business than health improvement. Although this had been the case for sometime, given the reduction in finances this issue seemed to be more prevalent in this context.

*‘Competition has made working together difficult…competition prevents sharing….before we used to work together much more seamlessly, sharing and working together…There was a whole climate of working together, now it is much more fragmented. I think the competitive element has led to more barriers. Even when you want to work together there is someone looking for the business opportunity’*

(Weight Management Service Provider)

The picture presented is one of an unclear national strategy, leading to a fractured obesity pathway, which leaves responsibility to act open to local interpretation, which can then be interpreted by local decision makers how best they see fit, and in this case usually informed primarily by financial challenges rather than evidence or imperative to act. This raises the issue of governance of these decisions and how those responsible are accountable for policy implementation and ensuring policy aims are achieved. This will be addressed in the discussion chapter that follows.

### 7.4.5 Policy implementation - leadership, governance and accountability for local obesity policy processes and the role of Health and Wellbeing Boards

The changing context for public health people and issues arising from the Health and Social Care Act (2012) was also found to be impacting on obesity policy processes. In particular, the changes meant that there were new leadership, governance and accountability structures for public health issues such as obesity – in the form of Health and Wellbeing Boards (HWBBs), to oversee joined up local level action on issues – but participants felt that (at the time of this research) to date these Boards were not yet living up to what their stated role was. The new local level roles and responsibilities for obesity were defined nationally in 2011, however these were felt to still be unclear at a local level in this research. Interviewees in this research found a lack of clarity about who is responsible for leading action to address obesity. More specifically, people raised two key issues:

* 1. It was unclear who was responsible for taking action on obesity at different levels locally, (this has been addressed in this policy implementation section), and,
  2. It was unclear what the role of HWBBs was in addressing issues that require local level joined up action, such as obesity. This is discussed further immediately below.

To explain, as presented in Chapter 2, and discussed in more detail in this chapter in the previous section, roles and responsibility for obesity at a local level remain unclear. The Obesity Care Pathway (Department of Health 2013a), did not make clear who was responsible for providing and commissioning each tier of service described, nor did it clearly describe what the tiers were or what outcomes should be expected. The lack of clarity had stemmed from the Health Lives Healthy People Strategy (DH 2011) which suggested that from 2013, local authorities would be responsible for commissioning local programmes to prevent and address overweight and obesity, such as weight management services. This strategy (DH 2011) also referenced that the local NHS would provide advice, prescribe anti-obesity medicines and obesity treatment, with bariatric surgery commissioning devolved to CCGs. The Health and Wellbeing boards (HWBBs) formed as a result of the Health and Social Care Act (2012) were identified as crucial to ensuring joined-up investment and commissioning.

At a national level the obesity commissioning and responsibility pathway was described as at worst, fractured and at best, unclear, in terms of who is responsible and for what (Barth 2015). Participants, across all groups and areas, discussed a lack of joint working as a result of the current and previous national strategies around health i.e. provider/commissioner split and the Health and Social Care Act (2012) and, for obesity, Healthy Lives Healthy People (DH 2011). As discussed in Chapter 2, HWBBs were set up to be a forum to bring local public sector partner leaders together to improve health and wellbeing and reduce health inequalities, through an increasingly joined up offer. Some of the local documents analysed (post 2012) mentioned the existence of HWBBs generally, but not specifically in relation to obesity policy. HWBBs are understood nationally as the responsible body for ensuring health and social care issues are locally integrated in the interests of the population, however, participants in this research largely reported that this was not the case. As yet but did not really seem to know or discuss why HWBBs were not fulfilling their remit, other than they were ‘new’. This view was held by all different groups of participants across all the four geographical areas, as illustrated by the comments from one Public Health Commissioner who is a member of a HWBB:

*‘The principle of health and wellbeing boards is a good one but I’ve yet to find an area that says this is working really well erm but you know in theory it should work well.’*

(Public Health Commissioner)

A CCG participant, from a different geographical area, also on a HWBB commented similarly:

*‘we’ve reviewed our health and wellbeing arrangements and found that they’re not fit for purpose so we’ve currently rewritten or are in the process of rewriting the priorities with the commissioners which undoubtedly obesity will be one of them.’*

(CCG participant)

Yet another Public Health Commissioner from a third area, who was also a HWBB member gave a more thorough opinion of their local HWBB, suggesting reasons as to why they were not functioning at the level that had been desired:

*‘I have to say I think the health and wellbeing board has spectacularly failed to live up to it’s potential…. Now I think the danger and the difficulty with that…is what’s come about is it feels to me as though it’s not much more than a talking shop and it doesn’t really shape the agenda and I maybe just being a bit too simple about that but it doesn’t feel to me as though I can’t think of anything that the health and wellbeing board has done’’*

(Public Health Commissioner)

The role of the HWBBs, generally accepted to be overseeing joined up action on area-wide issues, did not seem to be perceived by participants as well enacted in any of the areas in this research. A key part of their role is leadership and accountability on these joined up issues. One element of this role, as well as a key part of the generic policy stages cycle is evaluation, which is discussed below.

## 7.5 Evaluation

The last stage in the ‘stages heuristic’ policy process model is evaluation. Overall, of the documents analysed, no strategic document commented or reflected on the learning from implemented obesity activity. There was no reflection on monitoring, no identified evaluation or progress report, or examples of ‘successes’ from previous action. . Rather, the documents focused on emphasising *commitments* to action and addressing obesity challenges. Similarly, none of the identified documents reported progress on obesity locally as aligned to action, even where NCMP prevalence was reported as a mandated activity. This is not necessarily the purpose of these documents. However, the lack of information, reflection and documented learning is important because it makes understanding activity, impact and outcomes difficult for any wider stakeholders at a local level and thus difficult to hold those in policy-making positions to external account for obesity-related action. Additionally, there are no targets set, other than to state the all four areas are keen to halt the rise or reduce the local obesity prevalence. The exception is Barnsley who had set published targets, reported in a performance management table presented in the Barnsley Health and Wellbeing Strategy 2014-2019 (BMBC), however they have not reported on these.

In 2013, the Director of Public Health Report (DMBC 2013) and the Doncaster Joint Health & Wellbeing Strategy (2013-16) identified obesity as one of Doncaster’s 5 key priority areas alongside: Alcohol; Mental Health and Dementia; Family; and Personal Responsibility. More recent Doncaster Public Health policy documentation has not discussed obesity, and where obesity is identified or briefly mentioned i.e. Health & Wellbeing Strategy 2016-2021 (DMBC 2015), no information was given on progress or priorities, with only NCMP prevalence stated, up until the most recent PH annual report which does not mention obesity (DMBC 2016). This is interesting given the previous priority focus, yet lack of documentation regarding progress on this priority, therefore there appears to be a lack of ‘holding to account’.

It is interesting that the only difference between areas is noted in Sheffield, where, when obesity is mentioned there is detail given of how groups and activities report and are held accountable and governed locally. Yet, even with this level of detail, there is no analysis of progress on outcomes/activity presented. The one exception is the Department of Health funded SLC4L programme, where there are reports which indicate success at a number of levels, however, as aforementioned there is no sustained activity around this programme locally (SHU 2011; Cummins et al. 2016). SLC4L has not been supported in the subsequent documentation, in fact not mentioned after its funding ended and the subsequent structural changes that occurred across Public Health, the NHS and LAs from the Health & Social Care Act (2012).

Overall, what is common, and perhaps surprising, is that none of the documents report progress on obesity locally aligned to action, even where NCMP prevalence is reported as a mandated activity. Perhaps this is not the purpose of these documents, but it does not make understanding activity, impact and outcomes easy for the reader at a local level. Even where programmes have been heralded as leading (e.g. Sheffield Let’s Change4Life and Rotherham Healthy Weight Framework) the documents analysed do not provide detail nor progress reports to support these claims. One could assume that as NCMP is mandated and data monitoring is a feature of procurement that all this information is known, i.e. impact of interventions commissioned to address obesity prevalence locally. However, the evaluation data regarding commissioned work is not publicly available and was not shared during this research. Equally it is not in the public domain in terms of detailing obesity prevalence, against local activity and outcomes, as one might expect on a priority issue locally. This raises the issue of where would someone who wanted to understand what was being done and achieved locally on this agenda find this information. From the documents and information reviewed for this research the following table (table 7.2) could be one type of this analysis to help set the empirical findings in context.

Table 7.2 Obesity Prevalence (NCMP) & Overall Investment

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | BARNSLEY | DONCASTER | ROTHERHAM | SHEFFIELD |
| NCMP Obesity Prevalence Yr. R 5-year data 2012/13-2016/17 | 8.7% | 9.8% | 10.2% | 8.9% |
| NCMP Obesity Prevalence Yr. 6 5-year data 2012/13-2016/17 | 20.1% | 19.5% | 22.0% | 20.0% |
| Yr. R & Yr. 6 Obesity trend |  |  |  |  |
| Investment £/pop 2014/15 | 2.72 | 2.22 | 3.73 | 1.94 |
| Investment £/pop 2015/16 | 2.63 | 2.04 | 3.28 | 1.81 |
| Investment trend |  |  |  |  |

Interestingly, the lack of evaluation was supported in part in the interview data, with a number of public health commissioners recognising this as an issue. As two different Public Heath Commissioners, stated:

*‘Evaluation of the service should be pivotal for every contract. And actually even the largest percentage of the costs should be attached to the evaluation and at the moment it’s not…So at the end of the three years we’ve had an intervention but we’ve absolutely no idea whether it works or not because we haven’t the evaluation we haven’t done. If we’ve done any it’s been really piecemeal and just a token gesture.’*

‘*We still don’t know what works’([Public Health Commissioner]*

As previously discussed, Health and Wellbeing Boards (HWBBs) are seen to be the responsible body, as a result of the Health and Social Care Act (2012) for joining up local action and holding local activity to account, although as presented in section 7.2.3 at the time of this research this was not felt to have yet demonstrated effectiveness. This is further developed in the discussion chapter that follows.

## 7.6 Findings Conclusion

This last chapter has reviewed how the issue is obesity is prioritised for action at a local level including how obesity as an issue is defined or ‘problematised’ arguing that in the absence of a clear national strategy action on obesity is left open to local interpretation. That interpretation is undertaken by those in leadership positions i.e. Senior Leaders, and that this representation of obesity is critical to how the local obesity is then formulated, in the local context – a political environment which is experiencing significant resource cuts across all areas, with a governance body in the form of HWBBs not yet living up to expectation. The view expressed by all involved in this research was that in these times of financial challenge, responsibility must rest with the individual and that although the public sector has a role to play that they cannot be responsible, individuals must be responsible for their own solutions. These issues of lack of national clarity regarding roles and responsibility, alongside financial challenge were the key influences on implementation. The final element of the stages model discussed was evaluation. The learning and evaluation from the services and activities undertaken locally was recognised as lacking in the documents analysed and by participants involved in interviews, suggesting a lack of learning locally, and again highlighting a possible role of HWBBs.

These three findings chapters (5, 6, and 7) have described in some detail the empirical elements of the research. Detailing the local health, public health and obesity documentary analysis synthesised and triangulated in part by the interview participant views across senior leaders, elected members, CCG representatives, public health commissioners and weight management service providers. The three chapters have employed the Walt and Gilson Policy Analysis triangle (1994) as a framework, recognising the obvious overlap between elements.

The first chapter focussed on content of local obesity policy both in terms of the content of documentation i.e. local policy documents, and the ‘what’ of local policy in terms of what participants said was being undertaken to address obesity locally. The second chapter focussed more on the policy context and the key factor affecting local policy processes at the time of this research – the Health and Social Care Act (2012). The third findings chapter focussed on the policy processes (as described by the stages model of Sabatier and Jenkins-Smith 1993). This last findings chapter acknowledged that day to day obesity policy processes are occurring within the national socio-political context outlined in the second findings chapter and detailed to a certain extent in the documents and interviews presented in the first findings chapter, including how the national changes outlined have impacted on obesity policy processes at local level, with the last findings chapter examining how the local action on obesity policy is enacted within this context. The significance of these findings is now examined in the discussion chapter, Chapter 8.

# Chapter 8: Discussion & Conclusion

## 8.1 Introduction

As set out in the introduction to this thesis, this research has sought to address the following research question:

***‘How is national obesity policy translated, formulated and implemented locally by senior leaders, commissioners and service providers,***

***and additionally,***

***what implications do these policy approaches have in terms of successfully addressing obesity locally?’***

The chapter briefly revisits the key findings across the four case study sites of South Yorkshire (Barnsley, Doncaster, Rotherham and Sheffield), as outlined in the previous Chapters (5, 6, and 7), and then moves on to discuss the significance of these, in terms of what they tell us about local obesity policy processes. To do this effectively, the chapter is structured around Carol Bacchi’s What’s The Problem Represented to Be Approach (WPR) (2009), which was introduced in the literature review chapter (Chapter 3) as an approach that foregrounds the role of problem definition / framing as core to understanding policy; and therefore core to understanding local obesity policy translation, formulation and implementation. The chapter draws broadly on the questions that Bacchi (2009) suggests should be asked about policy. It is therefore structured around the following questions:

* What is the ‘problem’ of obesity represented to be locally in the four areas and what assumptions underlie this representation?
* What is left unproblematic in this problem representation? Where are the silences?
* How has this local representation of the problem come about? How/where has this representation of the problem been produced, disseminated and defended?
* What effects are produced by this representation of the problem at a local level?
* How could this ‘problematisation’ be questioned, disrupted and replaced?

Throughout this discussion chapter, key literature is drawn upon in order to link the findings of this thesis to a broader body of academic work focusing on obesity. This includes literature from the background and literature review chapters, as well as other literature, for example: Barry and colleagues’ (2009) work on ‘Obesity Metaphors’; and Beeken and Wardle’s similar UK-based study (2013), amongst many others. The chapter also utilises more recent work on models and approaches to addressing obesity (as outlined by Jebb et al. 2013; Frood et al. 2013; Hendriks et al. 2013; Swinburn et al. 2015; Rutter et al. 2017); and Ulijaszek’s (2017) work on models of obesity. The work of Peckham et al. (2016) – the PHOENIX Report – which examined the impact of the Health and Social Care Act (2012) in England on the functioning of the public health system, and on the approaches taken to improving the public’s health, using obesity as the factor to discuss these changes, is also drawn on as being unique, as well as having key areas of reference to this thesis.

Overall, this thesis contends that, although the local representation of obesity is crucial, the context in which this local representation is operationalised is also of critical and equal importance if we are to understand local obesity policy process. Therefore, the chapter focuses on both how the representations of obesity in use and the local context influence the policy process to better understand the local obesity policy process, or more specifically, ‘*how national obesity policy is translated, formulated and implemented locally by senior leaders, commissioners and service providers, and additionally, what implications these policy approaches have in terms of successfully addressing obesity locally?’*

The chapter highlights the central role of prevailing framings of obesity in the translation of local obesity policy, which have persisted over time. The chapter argues that these prevailing framings, which shape agenda setting and subsequent policy formulation and implementation, are not simply a factor of the wider current context. Rather, recent structural changes associated with the Health and Social Care Act (2012), as well as other contextual factors such as the value placed on and perceived ‘visibility’ of public health professionals, and the financial context (as presented in Chapter 6), are significant in terms of how representations of obesity are operationalised in practice within local obesity policy processes.

The discussion highlights how many of the factors Paul Cairney (2018) identifies as influencing the policy process are relevant to how obesity policy works locally. Cairney (2018) describes the influences on the policy process are two-fol. Firstly, that policymakers use ‘rational’ and ‘irrational’ cognitive shortcuts to make decisions quickly, and, secondly he suggests the policy environment is made up of an important range of different factors that can shape policy processes, namely: actors*;* institutions*;* networks; ideas*;* context and events*.* Aligning with Cairney (2018), the chapter highlights how policy choices appear to be made locally, and how the wider policy environment (the national socio political context, financial context etc for example) fundamentally shapes local decision-making (Cairney 2018). Perhaps most significantly, the chapter shows how, despite some level of local variation in representations of obesity across South Yorkshire, common wider contextual influencing factors seem to result in local obesity policy processes which are relatively similar: such as decisions about the solutions that are available. The chapter discusses what the findings may mean for addressing obesity at a local level longer-term and finishes by providing a final conclusion; setting out the contribution of this research to the evidence base on local obesity policy and wider policy literature, whilst recognising its limitations.

## 8.2 What is the ‘problem’ of obesity represented to be locally in the four areas and what assumptions underlie this representation?

Bacchi (2009) argues that how an actor understands and discusses an issue is of critical importance to understanding policy process because it shapes the range of possible decisions about policy actions. Equally, actions proposed or undertaken reveal how an issue is understood. As presented in the literature review (Chapter 3), Barry et al. (2009), Beeken and Wardle (2013), Stone (2001) and Ulijaszek (2017) also support this view; arguing also that the views of different actors affect the level of support that they might show for different policy actions. In this way, understanding how obesity and people with obesity are represented in policy documents and by policy makers is important, because it can shape agenda setting, and subsequent policy formulation and implementation, by virtue of the degree of support that different ways of addressing obesity may receive (Barry et al. 2009; Beeken and Wardle 2013; Ulijaszek 2017).

The empirical findings chapters discussed how obesity was represented in local documentation and by the research participants in the four LAs involved in the research. Together, they showed that obesity is framed as a problem in a number of different ways locally. These were: obesity as a lifestyle risk factor for Long Term health Conditions (LTC); obesity as a problem for children – as indicated by NCMP prevalence reporting by local authorities, (a prescribed/mandated public health activity); and, obesity as an issue of inequality. A number of interesting differences as well as significant similarities were observed.

In **Barnsley**, there was a clear view that obesity is an issue of individual responsibility, where excess food consumption was understood as the main causatory factor and physical activity the main solution. This view was expressed in discussions with all participants and was also reflected in the documents analysed; with physical activity predominating discussions as it described as a positive message that already has local currency and, moreover, that many ‘free’ community assets existed to support physical activity locally. Prevention of obesity was described as the sole focus of the LA, supporting communities and community assets to lead the change, not professionals delivering interventions. As described in the findings chapters, in Barnsley, local policy documents and participants’ dominant representation of obesity appeared to be one of individual responsibility in the sense that obesity is caused by personal choices relating to diet and physical activity: people need to be (or become) more responsible for their own health due to lack of finances in the public sector to invest in obesity. However, despite the narrative of prevention focus, there was little detail, other than communities taking responsibility, as to what prevention meant in Barnsley, with Barnsley LA continuing to invest in obesity treatment services aimed at individuals, suggesting a personal responsibility view (if following Bacchi 2009). As one Public Health Commissioner participant described this representation, *‘There’s no doubt there is individual responsibility; people do need to take responsibility for their own health.’*

The **Doncaster** view was challenging to understand, partly because there was less engagement with participants and fewer documents from this LA area than the other areas in the research. For example, there was no engagement with Elected Members or representatives of the senior leadership of the LA, and there were fewer publicly available documents to review. Overall however, and as described in the findings chapters, it appeared from documents and interviews that the Local Authority in Doncaster were leading an individualised and ‘treatment-focussed’ intervention approach. In Doncaster, without exception, and different to the other areas, all the research participants mentioned genetics as the first cause of obesity. Moreover, for over half the participants, this was described as the major cause. A position that was not, however, reflected in the documentation reviewed. Despite this reference to genetics, as mentioned in findings, which the literature would suggest reflects a view that is less about personal responsibility (Barry et al. 2009; Beeken and Wardle 2013), the prevailing representation across documents and participants based in Doncaster appeared to be on individual responsibility as a cause of obesity and treating obesity. For example, as presented in findings, the LA in Doncaster was continuing to invest in obesity treatment services which are focused on individuals, and despite discussion and documentation statements to prevention, there was no clarity in discussion nor documents as to what prevention activity actually was. Only discussion and documentation to reflect individual treatment interventions. Although all the areas made reference to partnerships and partnership working to tackle obesity, this was particularly clear in Doncaster, however without detail as to who or what these were.

In **Rotherham**, the issue of obesity was discussed and represented by most participants as a complex issue. As detailed in the findings chapters, some participants, spoke about how obesity was both an issue of individual choice and the wider environment requiring prevention and treatment to address, with some citing the Foresight (Butland et al. 2007) report. Different to the focus in the other areas, there was discussion by participants in Rotherham about treatment *and* prevention. However, despite references to wider causes and prevention, across documents and participant interviews the dominant representation remained that of an individual treatment focus with diet and physical activity as causatory and individual treatment interventions the main actions undertaken, suggesting a personal responsibility representation. The wider factors and prevention elements were lost in terms of detail with most participants and documents referencing these but focussing on individual personal responsibility and treatment.

In **Sheffield** research participants and documents had a clear focus that health inequalities were the major contributing factor and therefore the solution to all public health issues was to focus all efforts here. This was different to the narrative in the other three areas, however obesity was not explicitly mentioned alongside the inequality narrative, as this was more about health and public health in general. As discussed in Chapter 7, in the section on the views of obesity causation and responsibility across the geographical areas and participant groups, the over-riding Sheffield narrative was one of health inequalities and prevention rather than treatment across all public health activity, this was more implicit than explicit with respect to obesity. Despite this pervading general discourse, there was little documented action nor progress discussed on prevention or health inequalities. In addressing obesity in Sheffield, public health were still procuring treatment services in line with the other areas, resulting in the same activity as other areas. Despite a general narrative of prevention and health inequalities in Sheffield this did not translate to clear action on obesity. All analysed obesity documents and plans point to a similar approach to what is being done elsewhere, some prevention focus across the lifecourse and then some weight management service type individual treatment interventions. The dominant discussion from participants in Sheffield regarding obesity was not that it is directly linked to inequality but that it is directly linked to diet as causatory and physical activity as the solution. In Sheffield, addressing physical activity through the Move More Strategy and increasing the population levels of activity through active travel, cycling and social marketing, appeared to be the answer to tackling obesity, with barely a mention of anything else from all staff groups, despite the reported focus on inequalities. This focus on some of the wider environmental causes and solutions to addressing obesity was different to the other areas however, a particularly individualised way of discussing obesity – both cause and solution remained dominant in Sheffield.

The existence of these different understandings reflects what has been found and presented in other literature on the topic, recognising that there are a complex set of causal factors for obesity beyond individual food and physical activity choices (e.g. Butland et al. in Foresight 2007; Barry et al. 2009; Ulijaszek and McLennan 2016; Ulijaszek 2017). However, the wider environmental understandings were found to be the exception rather than the dominant representation, with inconsistent discussion and a lack of aligned action.

Despite the nuances of obesity causation presented above, the dominant representation discussed by most participants and presented in documents consistently was that obesity was an issue of personal responsibility and the choices that are taken in relation to diet and physical activity by people across South Yorkshire. Even in areas like Sheffield, this dominant representation was apparent in and through the activities that were being undertaken/commissioned locally. For example, mostly the same specification for obesity treatment interventions for children and adults (one-to-one and group based NICE-compliant interventions) were commissioned in all four areas; all of which have of an individualised and treatment-focus (see Tables 7.1 and 7.2). Yet, despite some reference to partnerships and prevention there was an absence of clearly articulated or documented wider action that was related explicitly to addressing obesity (e.g. breastfeeding promotion, food plans and fast food takeaway restriction work with planning departments).

The overall emphasis on obesity being an issue of individual cause and personal responsibility, treated by individual treatment interventions, as discussed above, resonates with other literature on the issue of obesity. For example, the work of Barry et al. (2009) (already presented in the literature review chapter, Chapter 3), examined participants’ views (a sample of the American public) of the causes of obesity and how these views aligned to support for interventions. When considering causes of obesity, Barry et al. (2009), outlined the importance of considering an individual’s ideological standpoint, on a continuum of causes of obesity, from individual responsibility to societal causes (see Figure 8.1 below). In their study they outlined seven obesity metaphors and examined how (a sample of the American public) individuals’ demographic, health and political characteristics, and attitudes about the causes of obesity, influenced their support for 16 obesity policies, identified by ‘elite responders’ (experts in obesity).

Figure 8.1 The continuum of causes of obesity (Barry et al. 2009)

*Responsibility Individual Individual & Societal Societal*

**Metaphors**  Sinful Disability, Eating, Addiction, Time Commercial Toxic Food

**Re causes** Behaviour Disorder Pressures Manipulation Environment

Barry et al., (2009) proposed that depending on how causes and responsibility are ‘framed’ this can lead to support or a blocking of policy action. Barry et al., (2009) found that individual responsibility views led to individual action support, through a continuum, to wider environmental policy support from those who saw obesity more as a consequence of an obesogenic environment. Similarly Babbel et al (2017), who examined GPs’ conceptualisations of health inequalities, found that GPs who were more likely to view individuals as responsible for choosing an unhealthy lifestyle, had a focus on individual interventions, yet those who took a more ‘Social Determinants of Health’ approach were more likely to discuss wider environmental interventions to addressing inequalities. This also resonates with wider obesity literature such as Stanley Ulijaszek’s (2017) book on models of obesity which identifies seven different ways of representing obesity and therefore different approaches aligned to addressing obesity based on representation.

The work of Barry et al. (2009) and Beeken and Wardle (2013) outlines that framing leads to action on and support for action on (or inversely, lack of support for and even blocking of action on) obesity. The findings of this research accord with the literature about framing supporting action. The main actions undertaken across the four areas were understood from tender documents, publicly available through procurement exercises in each area (discussed in Chapter 5), and from interviews with providers. The research found that all areas had sought to provide or externally commission some level of Tier 1, 2 and 3 adult weight management interventions in line with NICE and DH guidance and Tier 1 and 2 children’s weight management interventions. From the reading and understanding of the tender documentation made available, across the four LAs, mostly the same tier 1, 2 and 3 adult and tier 1 and 2 children’s weight management individual treatment interventions were offered, often repeating plans that have persisted for approximately the last 10 years or so, with little indication of what was being done or achieved from these actions. Reference was made in documents and interviews to wider integrated activity, such as partnership prevention work. However, it was unclear what this involved and how, despite interviews probing on this topic.

Authors such as Frood et al. (2013) and Swinburn et al. (2015) criticise an individualised representation of obesity and for associated action coming from this framing for being narrow and simplistic. They emphasise that there are many ‘silences’ in this perspective, given that there are many more complex, environmental, social and political, factors that lead to obesity (see Foresight for example, Butland et al. 2007). These points are considered in more detail in the next section, which focuses on ‘silences’ in the way obesity is framed; that is to say, the way that wider causes are mostly silenced in local representations, as well as in particular the way that forms of evidence are ‘silenced’ in local obesity policy process.

## 8.3 What is left unproblematic in this problem representation? Where are the silences?

Bacchi (2009) argues another key element of her approach is to identify and reflect on issues that are *not* discussed (i.e. are silenced) in policy processes and what impacts this may have. It is argued that from the findings, there were three types of silence:

1) a limited discussion of wider causes of obesity beyond individual diet and physical activity choices,

2) limited use of evidence and particular forms of evidence, and

3) a lack of reporting on progress in implementation or learning from monitoring and/or evaluation within local obesity policy process.

These are now discussed in turn.

Firstly, and as already suggested above, there was limited discussion of wider causes of obesity in policy documents or by the participants in the research, beyond those causes that are directly under an individual’s control (such as diet and physical activity choices). In other words, wider causes, or the wider social determinants (of obesity) and/or structural factors (including living and working conditions, inequalities, and the wider environment locally (Dahlgren and Whitehead 1990) were rarely, identified or mentioned by research participants. The exception to this was in Rotherham where participants did mention the Foresight Report (Butland et al. 2007), in Sheffield, where participants and policy texts mentioned inequalities, (however, not specifically linked to obesity), and, the list of other factors that were inconsistently mentioned across differing participants and texts (as presented above). However, there was little elaboration on these causes, other than a brief mention; nor any evidence of action, with no action discussed nor documented to address wider determinants of obesity directly (for example through policies addressing food availability, affordability or knowledge etc). This silencing of the wider causes or any other representation of obesity other than one of personal responsibility, such as the different models of obesity described by Ulijaszek (2017), are therefore a key ‘silence’. However, it could be argued that the linkages between these wider more upstream activities and obesity was unclear to participants and therefore perhaps a limitation of this research that these were not identified. This research argues that if documents and participants did not explicitly link the activities that were perhaps being undertaken to addressing obesity then they were not being seen as related to obesity locally and therefore not presented in this research. This is discussed later in this chapter in section 8.8 presenting the limitations.

Secondly, and linked to the above, there were silences about particular forms of evidence. What is meant by this is that there was a lack of consideration of wider causes of obesity in local representations of obesity *despite* the fact that there is evidence to illustrate that obesity is the product of social, economic, environmental and political determinants. Most notably perhaps is the Foresight Report, which was published in 2007 (Butland et al.) and received widespread academic, practical and media recognition for the first time outlining the complexity of obesity in the Obesity Systems Map (Figure 1.1). However, this key document was not discussed nor documented in two of the four areas. It was mentioned, more in Sheffield and Rotherham than elsewhere, but without detail in any area as to what Foresight presented. Where Foresight (Butland et al. 2007) was referenced there was no wider discussion of the causal factors cited by Foresight, namely: biology, societal influences, individual psychology, food production, food consumption, individual activity, activity environment, therefore, the dominant representation of individual choice persisted. Overall, the documents and interviews did not seem to adequately reflect the causes of obesity more widely than individual diet and physical activity choices, despite statements, particularly in Rotherham and Sheffield, to wider complexity.

In fact, a key ‘silence’ overall in terms of the way that obesity was discussed by participants, and in the local policy documents, was in the use of evidence. There was limited reference to evidence in describing both causes and evidence for and of the local solutions to obesity (such as partnership working/approaches, preventative or commissioned treatment services described), either in the interviews with participants, or in policy documents.

Thirdly, and similarly, as presented in Chapter 7, solutions were repeated in local documents but with little indication of evidence, achievements, clarity of impact required; nor ongoing plans i.e. monitoring and evaluation of the policy. This was true for both primary prevention and secondary interventions. All that was consistently cited was a statement that all these solutions would contribute to a reduction in local obesity prevalence but with no indication of how, how much or by when. The exception was in Barnsley, where prevalence targets and a timeline for addressing obesity was clearly stated in the Barnsley Health and Wellbeing Strategy 2014-2019 (although this was not updated against in terms of recent progress towards said aims) (see Chapter 5). There was also no detail provided to accompany the targets in terms of action to support achieving these locally.

Furthermore, there was no evidence presented nor discussed as to what outcomes commissioners would expect to achieve from these actions – either the partnership working, the described preventative solutions or commissioned treatment interventions- or what outcomes were actually being achieved locally. There was little presented in terms of progress, monitoring or evaluation nor any learning from previous activity locally (as discussed in Chapter 7, examining the documents and interviews, and reporting on the lack of progress or learning from monitoring and/or evaluation). Indeed, none of the documents nor interviews reported monitoring data in relation to obesity nor progress on obesity locally, nor can any activity nor outcomes be aligned to action. Perhaps that was not the purpose of the documents analysed but what is apparent is that it does not make understanding obesity-related activity, and obesity-related impact and outcomes, easy for the wider public or interested wider stakeholders at a local level.

Also, as detailed in the documentary analysis, even where programmes were heralded locally or nationally as ‘leading’ the documents analysed do not provide detail nor progress reports to support these claims, for example: Sheffield Let’s Change4Life and the Rotherham Healthy Weight Framework, which have both been cited elsewhere as exemplars.

One could assume that as NCMP is mandated, and also that data monitoring is a feature of any procurement, that the impact of any interventions commissioned to address obesity prevalence locally is known by who those commissioning it through local monitoring arrangements. However, the evaluation data regarding commissioned work is not publicly available and was not shared during this research.

So far, this chapter has presented how obesity is dominantly represented in the four areas of South Yorkshire, what assumptions about causality of obesity appear to underlie this representation, and a consideration of what is left apparently unproblematic or as a ‘silence’ in this dominant representation. This is relevant to this research as it is argued that this representation informs the local policy agenda-setting and subsequent policy formulation and the decisions that are made about solutions. This chapter now moves on to consider two other of Bacchi’s other core WPR questions (2009); namely: How has this local representation of the problem come about? And how / where has this representation of the problem been produced, disseminated and defended? This next section (section 8.4) examines some of the contextual factors found to be influencing local obesity policy process.

## 8.4 How has this local representation of the problem come about? How/where has this representation of the problem been produced, disseminated and defended? What effects are produced by this representation of the problem?

It is difficult to definitively answer Bacchi’s question about how the dominant local representation of obesity – about personal choice and individual responsibility - has come about (2009). In the findings chapters (Chapters 5, 6, and 7), at least 6 key factors were identified as influencing the local context for obesity policy processes, these were:

* History or ‘path dependency’
* National obesity policy shaping the local representation
* The implications of the Health & Social Care Act (2012), creating a fragmented commissioning and responsibility pathway
* The views of Elected Members and senior leaders
* The governance role of the Health and Wellbeing Board
* Responsibility and financial control of obesity in the context of the changes and challenges of austerity.

It is argued that, together, these six factors shaped the local obesity policy-making processes in South Yorkshire. All were therefore found to contributing to how the dominant local representation of obesity (about personal choice and individual responsibility) had come about and, crucially, what policy actions were being implemented locally to address obesity, i.e. the ‘effects’. The apparent significance of each of these factors will now be discussed in turn.

### 8.4.1 History or ‘Path dependency’

Firstly, and as presented in the literature review chapter (Chapter 3), and final findings chapter (Chapter 7, section 7 on agenda setting: national obesity policy translated at a local level) there is the significance of history or ‘path dependency’, in that current local representations of obesity seem to have persisted over time; including since the pre-2012 transition of public health professionals from the NHS into to LAs, with the advent of the Health and Social Care Act (2012). Jebb (et al., 2013), Vallgarda (et al., 2015), Barth (2015), Kelly and Barker (2016), and, Ulijaszek and McLennan, (2016) for example, all suggest that this current dominant representation of obesity has persisted over time, i.e. public health in the NHS had a similar representation of obesity, as to the one now held in Local Authorities. In fact, Ulijaszek and McLennan in their paper *‘examining shifts in the framing of obesity from a problem of individual responsibility, towards collective responsibility, and back to the individual in UK government reports, policies and interventions between 1997 and 2015’*, stated that (Ulijaszek and McLennan 2016: 397):

‘*Since 1997, and despite several political changes, obesity policy in the UK has overwhelmingly framed obesity as a problem of individual responsibility. Reports, policies and interventions have emphasized that it is the responsibility of individual consumers to make personal changes to reduce obesity.’*

Their paper supports the findings of this research that this representation has persisted since before transition to LAs, when the context for obesity policy action has changed, from the NHS to a new organisational context of Local Authorities. Within this new LA structure there is also a ‘new’ wider context for public health working in this environment, with the direct ability to influence the wider more social determinants of health than perhaps pre-transition within the NHS, as reflected upon by Jenkins et al. in their 2016 survey of Directors of Public Health.

How obesity is thought of locally, and how this view is operationalised in the local context, and the impacts on the local obesity policy processes (of translation, formulation and implementation) is what is under study. What has been presented in this research is that how obesity is represented is not new but rather the context is new. In the new context of public health in local government, what is important to discuss is how this view is persisting and affecting processes in this new context, which is what is discussed below.

### 8.4.2 National obesity policy shaping the local representation

Secondly, another key factor shaping how the local representation of obesity has come about, persists, and is operationalised, influencing the local obesity policy processes appears to be the national obesity policy context within which the local is interpreted and formulated. The four local authorities’ approaches appear to mirror the approach advocated by, and the framing of, current national government obesity policy (Jebb et al. 2013; Ulijaszek and McLennan 2016). National policy has framed obesity in a personal responsibility way (Vallgarda et al. 2015; Ulijaszek and McLennan 2016), with mirroring at a local level serving to maintain a diet and physical activity individual choice and responsibility representation of obesity, as a health issue requiring treatment. For example, the Healthy Weight, Healthy Lives strategy *“Halting the obesity epidemic is about individual behaviour and responsibility: how people choose to live their lives, what they eat and how much physical activity they do”* (DH 2007: xi) and the Healthy People, Healthy Lives Strategy, regarded obesity as everybody’s business and that it is the responsibility of individuals to change their behaviour to lose weight (DH 2011). Although these national strategies acknowledge some of the complexity, as illustrated in the Foresight Report (Butland et al. 2007), there is little focus wider than individual choice.

If local areas are simply reflecting the national policy, it is therefore unsurprising that LAs primarily frame obesity as an individual issue and the product of poor lifestyle behaviour choices, as is seen across all the authorities in this study (see final findings Chapter 7), and that these LAs opt to undertake individual treatment focussed interventions (see Tables 7.1 and 7.2).

### 8.4.3 The implications of the Health & Social Care Act (2012), creating a fragmented commissioning and responsibility pathway.

Thirdly, another key factor shaping how the local representation of obesity has come about and is operationalised within obesity policy processes appears to be the fragmentation of the commissioning and responsibility pathway for obesity locally, as a result of the implementation of the Health and Social Care Act (2012). This was cited by participants in this research as an issue (see final findings Chapter 7). There was recognition from many participants that the national and local shifts in commissioning pathways alongside the current financial context, had not been positive in supporting the local understanding of responsibilities to tackle obesity, leading to ‘silo’ working not joined-up integrated action on obesity. As indicated in Chapter 7, under roles and responsibilities to act on obesity, this was a resounding theme with many participants talking about disparate responsibilities, fragmentation and the need for integration of prevention and treatment.

National government, through the ‘localism’ agenda (Localism Act 2011), and the Health and Social Care Act (2012), devolved responsibility for tackling obesity to local authorities, whilst retaining responsibility for specialist treatment in the NHS, leading to a recognised fragmented pathway in terms of responsibility, with the response in the form of the following guidance *‘Joined Up Clinical Pathways for Obesity’,* (NHS England and Public Health England Working Group, 2014). However, this report has not led to any changes to support integration.

As discussed by participants in the final findings chapter, local authorities in this study were clear that they were now responsible for obesity, in line with the requirements of the Health and Social Care Act (2012). However, all local authorities in this study were also keen to state that partners, and primarily the local NHS, in the form of CCGs, also had a responsibility. Many CCG participants noted that LAs were now responsible. CCG participants recounted that public health had received the staffing and resource when public health transferred to LAs. However, many CCG participants were clear that the fragmentation in commissioning was unhelpful and that one commissioner would be better, and that if national policy changed to make CCGs responsible (with the supporting resource) they would accept their role. Until such a time obesity was an issue that sat with public health in LAs.

This fractured commissioning pathway, leading to a split in responsibility between LAs and the NHS, but without national obesity policy clarity, seems to contribute (along with the other factors presented in this section) to the apparent dominant representation of obesity in this research persisting.

While LA participants in this research seem to view obesity as an individual health issue, they feel justified to outline that although they recognise they are responsible, they are only mandated to undertake NCMP, and are not solely responsible for addressing overweight and obesity. Individuals, and the health sector, i.e. the NHS, also have a responsibility based on this representation of the issue.

The findings of this research were that LA participants saw themselves as acting at the population and prevention level, but that individual treatment was the responsibility of the NHS, as this was a health issue and outside the LA and public health remit, as presented in the final findings Chapter. However, the NHS, represented by CCG participants, saw that obesity was now the remit of LAs. This lack of clarity on roles and responsibility as a result of the Health and Social Care Act (2012) appeared to be perpetuating the individual personal responsibility framing of obesity at a local level.

### 8.4.4 The role and views of Elected Members & Senior Leaders.

The fourth key factor contributing to how the local representation of obesity has come about and is operationalised within obesity policy processes relates to the role and views of Elected Members and senior leaders in relation to obesity and public health in general. It is argued that the views of these groups in LAs have also served to maintain the representation of obesity as an individual diet and physical activity choice and responsibility health-related issue. To explain the point, these actors are the leads for decision-making in the LA and their views, although informed by public health officers, are important, as they are the locally democratically elected officials. As McLennan and Ulijaszek (2016: 397) state,

‘*UK obesity policies reﬂect the landscape of policymakers, advisors, political pressures and values, as much as, if not more than, the landscape of evidence. The view that the individual should be the central site for obesity prevention and intervention has remained central to the political framing of population-level obesity, despite strong evidence contrary to this.’*

One of the key changes with the Health and Social Care Act (2012) was that public health transitioned to local authority control and is now operating within local authority organisational structures, functions and culture. As presented in the second findings chapter, Chapter 6, in this new organisational structure, Elected Members are the decision-makers, supported by local authority officers. This research found that the views of these Elected Members influenced obesity policy processes and therefore subsequent obesity (in)action, but also served to maintain the dominant representation of obesity locally.

The findings from the semi-structured interviews of both Elected Members and officers, as well as those outside the LA, as presented in the second findings Chapters 5, 6, and 7 identified that the local and dominant representation of obesity was presented by participants to be:

* politically driven, rather than evidence-based;
* misaligned with previously held definitions of evidence (as when Public Health was in the NHS), reflecting more of a personal understanding (see above);
* significantly influential in local health decision-making;
* variable in the extent to which the Elected Members’ representation was able to be influenced by the officers in Public Health (see findings Chapter 6, regarding the value and visibility of public health).

These influencing factors and concerns identified in the empirical findings in this research were also echoed in: the PHOENIX Report (Peckham et al 2016); the Directors of Public Health survey undertaken by Jenkins et al. (2016) as part of the PHOENIX work; and also, the RSPH workforce survey (2014). Indeed, these works all highlight the challenges of the transition of public health into local authorities, and the ability of public health (and Directors of Public Health) to influence decision-making in these new organisational structures. The issues outlined in these published reports included the following:

* concerns raised by the public health workforce about the perceived role of politics in LA health-related decision-making,
* gaps in elected member knowledge and understanding of health-related issues (RSPH 2014), and,
* the ability of public health to influence and speak out independently, where views may not align with that of the LA (Peckham et al. 2016).

The PHOENIX Report (Peckham et al. 2016), as well as the Atkins et al (2017) paper, on influences on implementing public health evidence-based guidelines in English Local Government, found the key influences to be as follows, which resonates with this study (Atkins et al. 2017: 4):

*‘1. Role of context in implementation—budget, capacity and political influence were important influences on implementation.*

*2. Limitations of research evidence—the concerns expressed about guidelines included that recommendations are presented in the abstract, lack specificity and do not address complexity or local variation.*

*3. Using local evidence—local evidence was seen as very important, being used to provide context for recommendations and sometimes being used instead of recommendations when they conflicted with local evidence.’*

However, this research’s finding, about public health officers’ ability to influence Elected Member obesity policy decision-making, is both shared and rebuked in the same literature, perhaps reflecting that each LA situation is unique (RSPH 2014). The situation in these four LAs (from the research undertaken and presented in the second findings chapter, section on impact of structural organisation on public health staff and the issue of obesity) seemed to support the issues of influence presented in these papers.

Relatedly, the survey of DPHs (Jenkins et al. 2016) revealed that DPHs perceived that they had greater influence in LAs since transition, with greatest influence when transition was positive, collaborative working relationships had developed, and HWBBs were seen as effective. However, Jenkins’ (et al. 2016) findings also highlighted that many DPHs equally perceived they have limited influence, with ongoing concerns that further public health restructuring may hinder influence.

It must be noted that the views of Elected Members and their influence works both positively and negatively and that the PHOENIX Report (Peckham et al. 2016: 8) recognised the decision-making and influence of Elected Members positively: *‘having councillor and senior officer support could have a significant impact in terms of programmes being protected or commissioned’.*

Given this understanding of the influence of Elected Member and Senior Leader views on local obesity policy processes and decision making, leads to the question of how local areas are structured and function to support governance, and how this governance structure and functioning influences the dominant local representation of obesity in this research.

### 8.4.5 The governance role of the Health and Wellbeing Board

The fifth factor contributing to how the dominant local representation of obesity has come about and is operationalised within obesity policy processes relates to local governance. Governance is understood in this research as how actions are structured, regulated and held accountable.

In the challenging local context that has been described and is recognised to exist (Peckham et al. 2016), there are, systems and processes to support accountability and governance for local population health as a result of the Health and Social Care Act (2012). There is the mandated role of the Director of Public Health (DPH) in LAs. However, the DPH used to be responsible for public health in an area, but now the DPH gives advice to Elected Members who are responsible. The final findings chapter reviewing local policy processes, considered the impacts of transition, and identified that in some areas this change in both position, organisation and role was impacting on public health’s ability to influence, as supported by other surveys (Jenkins et al. 2016).

With the Health and Social Care Act (2012) came the formation of an accountable body in the form of the Health and Wellbeing Boards (HWBB), whose role is to ensure joined up approaches to local area issues. However, it was felt by the majority of participants, in this research, who discussed its role, that Health and Wellbeing Boards in the four areas under study, at the time of this study, were still in development andhad not yet lived up to their potential and were not examining areas like obesity and public health as a priority (as discussed in the final finding Chapter 7, section regarding the governance and accountability role of health and wellbeing boards). This lack of ‘teeth’ or ability to serve as a governing body may lead to the maintenance of the locally held view of obesity as an individual diet and physical activity choice and responsibility health-related issue and not lead to wider challenge or allow alternative views. David Buck, Senior Fellow, The King’s Fund, in Maintaining the Momentum (2017, online), summed this up by the following quote:

*‘As Public Health becomes more embedded in local government’s everyday workings there needs to be a fundamental look at accountability. How do we define failure, as well as improvement and success, in a system that is more about outcomes than about specific services? Who gets to make those decisions, and who is accountable to who? These are questions I was left asking at the tail-end of my essay two years ago and I am no nearer to knowing the answers. On that score, at least, we still have a long way to go to a mature Public Health system.’*

This is reflective of the findings of the four reports to date in a longitudinal review of Health and Wellbeing Boards (HWBBs) for the Local Government Association (LGA) undertaken by Shared Intelligence (Si): *The Power of Place* (published April 2017), which recognised the journey Health and Wellbeing Boards have been on since their first report, *Great Expectations* (April 2014); followed by *Stick With It!* (February 2015); and, *The Force Begins to Awaken* (March 2016). The LGA’s conclusion in their fourth report (2017) was that more effective boards have continued to develop, but that some boards are still struggling. The picture of the less effective boards was one of ‘ticking a box’ and enabling locally rather than leading change, as intended from their role and function.

It was felt by participants in this study that the HWBB is where this joining up of pathways, accountability and responsibility, and, wider challenge or discussion of obesity (especially in light of the fragmentation of responsibility) should happen, but that, to date, this had not been the case. With this model of local governance, the dominant representation of obesity is left unchallenged and therefore unchanged.

### 8.4.6 Local Authority responsibility and financial control of resource allocation to obesity in the context of the changes and challenges of austerity

The sixth and final factor that seems to shape how the local representation of obesity dominates and is operationalised locally in South Yorkshire, is that of local authority responsibility and financial control of resource allocation to obesity; in the context of the changes and challenges of austerity in the UK. This was discussed in both the second and final findings Chapters (6 and 7). As explained in Chapter 6, the national changes and transition outlined as a result of the Health and Social Care Act (2012) have driven reorganisation of public health. With the issues of public health reorganisation and austerity challenges (as presented in Chapter 6), a number of impacts have been observed, which may have sustained the dominant representation of obesity.

Firstly, one factor that this research proffers as having sustained the local representation is the available budget. The dominant local representation of personal responsibility in the current context identified in this research had still led to all the local authorities continuing to commission individual treatment interventions, however, with reducing investment. This reducing offer of treatment interventions and reducing obesity resource as a whole (as described in Tables 7.1 and 7.2), is reflective of the findings of the PHOENIX Report (Peckham et al. 2016), and more recently the Local Government Association (LGA) research that found that barriers to investment in obesity were related to: financial issues; evidence of impact (linked to financial pressures and therefore cost effectiveness); engagement (also linked to finance and competing priorities for investment); and, competing organisational priorities (from a 56% response rate) (LGA 2018).

This dominance of local individual treatment activity, even if reducing, was despite the narrative about an obesity population prevention focus, as previously identified in the findings chapters. This focus on individual treatment investment, even if reducing, supported the view of obesity as an individual issue, if using Bacchi’s approach (2009) and both Barry (et al. 2009) and Ulijaszek’s examples (2017), which outline that actions relating to an issue often identifies the view held of that issue.

Secondly, a key issue identified by participants in this research, (in Chapter 7)) was about who had responsibility for obesity, and, who in the public sector was seen as responsible for what, given the fragmented commissioning pathway. In this way, responsibility for obesity and financial control of obesity resource allocation were interlinked by participants. One key element, which was to a certain extent silenced, was about financial control and responsibility for obesity in the context of austerity. Participants did discuss financial control of the resource for obesity linked to responsibility to act at a local level, but did not focus on the national austerity measures across the public sector. The focus was more on local authority budgetary cuts and public health’s ring-fenced grant. A BMJ investigation (Iacobucci 2014), reported that local authorities across England were utilising ring-fenced public health money for other LA services, due to the ‘cuts’ faced by austerity measures, just as the RSPH survey (2014) had also identified. This was supported by the findings of this research where concerns about the use of the public health ring-fenced funding for other local authority services were articulated by participants across public health, CCGs and service providers (see findings Chapter 7 section on prioritisation, investment, resource allocation and use of the ring-fenced budget). However, it is worth noting that in the NHS the public health budget was not ring-fenced and could be spent on other priority NHS issues, recognised in the BMJ report (Iacobucci 2014). A BMA survey, also by Iacobucci (2014a), of public health professionals working in local authorities and at Public Health England, found that only 45% believed that the public health grant was being used appropriately in their area, while almost half (49.6%) believed that the grant was seen “as a resource to be raided” by local government.

Some of the reasons for the representations of obesity observed in this research have been suggested in the section above, recognising how these differing contextual influences may shape local obesity policy processes. As previously outlined, the dominant representation has persisted over time, and may be as a result of national policy, personal views, moral judgements, or indeed perhaps ‘convenience’, in a time of ‘cuts’ or austerity measures. In the climate of the current financial challenges, with this framing of obesity, LAs may be able to deflect responsibility for treatment interventions to the NHS (local CCGs) by using this representation of obesity. It could be suggested that framing obesity in this way is suited to the context, therefore context and process become one, however further research would be required to examine this and other reasons for why obesity is framed in this way.

## 8.5 What effects are produced by this representation of the problem? i.e. *‘What implications do these policy approaches have in terms of successfully addressing obesity locally?’*

Bacchi’s (2009) question, ‘What effects are produced by this representation of the problem?’, has been addressed in the previous section, in terms of considering how the representation of the issue has come about and persisted and what the ‘effects’ of this are. This section extends Bacchi’s question and addresses the second key part of the question of this research, i.e. *‘What implications do these policy approaches have in terms of successfully addressing obesity locally?*’

There may well be numerous effects and impacts of the representation and operationalising of obesity that dominates this research, however, this section discusses two interdependent main impacts or implications identified through this research, and one implication that, to use Bacchi’s approach (2009), was ‘silent’ but from literature may well be an impact not discussed.

The first impact to be examined is how this representation, operationalised in this context, may well lead to an unclear rationale for local authority action to address obesity, as a result of what this research has identified as a ‘False Dichotomy’ in approaches to solutions to obesity (Roberto et al. 2015; Kleinert and Horton 2015; Frenk and Gomez-Dantes 2016). The discussion then argues that one of the potential impacts of this representation is the stigmatising and ‘victim blaming’ of those who are overweight and/or obese, as discussed by Puhl and Heuer (2010), among others (Johnson 2012; Flint et al. 2015; Lobstein 2018). However, this was not identified by participants in this research, but is a ‘silence’ that is examined here. The final section offers a potential implication of these policy approaches in terms of questioning if this may result in an uncertain future for successfully addressing obesity locally.

### 8.5.1 A ‘False Dichotomy’ resulting in an unclear rationale for local authority action to address obesity.

The first potential implication of this approach to be discussed is that this dominant representation, in this context, may lead to an unclear rationale for local authority action to address obesity. As presented in Tables 7.1 and 7.2, the four LAs in this research appear to have implemented or plan to implement similar solutions to each other and those outlined in national strategies rather than specific and local approaches. However, as there is little national evidence to suggest what works best to support addressing obesity at a local level, what is planned and/or actioned by these four LAs is not outwith the current evidence base (NICE 2014).

One issue of this representation operationalised in this context is that it may only serve to perpetuate an intervention only type of approach to treating obesity. This does seem to be the current focus of action across these four LAs, although with reducing resource over time as evidenced by the FOI regarding spend on obesity locally (see tables 7.1 and 7.2) and supported by other reports nationally (Peckham et al. 2016; LGA 2018).

As presented in the first findings chapter, there is mention of prevention activities in all the four LAs as a priority focus, but it is unclear if any of these are actually being undertaken. Action on both prevention and treatment does reflect a ‘Foresight’ type (Butland et al. 2007) approach, or that advocated by others such as Swinburn to undertake a Whole Systems Approach (et al. 2015). However, it was not discussed in this joined up way in any of the LAs. Activity was just described as a list of actions (planned and/or current). This lack of purposive approach to prevention and treatment of obesity is not reflective of the work of Foresight (Butland et al. 2007), nor more recent research by Swinburn (2016), among others, reflecting the need for a continuum of approaches. This leads to a question about impact, i.e. if LAs in this study recognise they are responsible for obesity, are undertaking action at both prevention and treatment levels, even with an unclear national position and evidence base, then what potential impact is there?

The issue that this research argues, is that this dominant representation of obesity, as an individual diet and physical activity choice and responsibility health-related issue may not resonate with local authorities, who see themselves as responsible for population prevention, not individual treatment for health issues, which is what they deem the NHS responsible for.

This leads onto a discussion about a dichotomising of action to address obesity into prevention versus treatment, i.e. LA responsibility versus NHS (local CCGs). An issue that is described in the literature as a ‘false dichotomy’ (Roberto et al. 2015; and, Kleinert and Horton 2015). As Roberto (et al. 2015: 2) commented:

‘*Divergent beliefs exist about what drives and sustains obesity. The way the problem is framed underlies many of the existing barriers. In this paper, we examine the false dichotomy that obesity is driven by either personal choice or the environment and suggest that these two competing perspectives be merged to show the reciprocal relationship between the individual person and the environment.’*

The resultant effect is that local authorities and the NHS also appear to become dichotomised in their approach in terms of responsibility to act, with the LAs arguing that prevention is a LA role and treatment the responsibility of the NHS, whereas the NHS argue that LAs have been given the responsibility and the resource for obesity.

This was in evidence in Chapter 7, the final findings Chapter, where the prevailing view was that if LAs are to invest in action to address obesity, it should be in prevention not treatment. Treatment was seen as a CCG role. The CCG view was that LAs had the resources for obesity due to their transfer out of PCTs into LAs, and it was suggested that these resources had not been used wisely. Indeed, as suggested in Chapter 7, CCGs commented if they had the resource they would do things differently, recognising obesity’s priority status and health impacts, but would still need the LAs to invest in prevention.

The views held appeared to suggest that LAs don’t identify with, nor are they set up to deal with individual health issues, as their function is different or at least they view it to be. This is also supported by the Local Government Association (LGA) publication in 2013 ‘Tackling Obesity Local Government’s New Public Health Role.’ This document only outlines NCMP as a responsibility of LAs and the rest of the document gives ideas, suggestions and case studies on cooking skills, access to leisure opportunities and schools work on healthy eating. Indeed, the document starts with a clear statement about individual responsibility.

The current dominant representation of individual cause and responsibility for obesity, in the context of a fragmented pathway and financial challenges, may be leading to a dichotomy of prevention versus treatment, Local Authority versus NHS, one or the other, not a spectrum of interacting activities, noted by Kleinert and Horton (2015: 2326) who examine these competing ideas:

*‘the debate is becoming increasingly polarised with false and unhelpful dichotomies: individual blame versus an obesogenic society; obesity as a disease versus sequelae of unrestrained gluttony; obesity as a disability versus the new normal; lack of physical activity as a cause versus overconsumption of unhealthy food and beverages; prevention versus treatment; overnutrition versus undernutrition.’*

As has already been discussed there is a reducing offer for those already overweight and obese, and this may continue given this dominant representation of obesity, operationalised in the current context of financial challenge and austerity measures. This was supported by the findings of the 2018 LGA survey, that found that barriers to investment in obesity were related to: financial issues; evidence of impact (linked to financial pressures and therefore cost effectiveness); engagement (also linked to finance and competing priorities for investment); and, competing organisational priorities, as evidenced in the findings of this research.

### 8.5.2 Stigmatising and ‘Victim Blaming’?

Bacchi’s approach (2009) encourages analysis of impacts - both identified and ‘silent’. One of the potential implications of focusing on an individual cause and responsibility narrative is that it may lead to stigmatisation and victim blaming of those who are overweight and obese (Puhl and Heuer 2010; Lobstein 2018), this is also supported more widely (i.e. not simply obesity narratives) by the Babbel et al. (2017) study of GPs views and health inequalities.

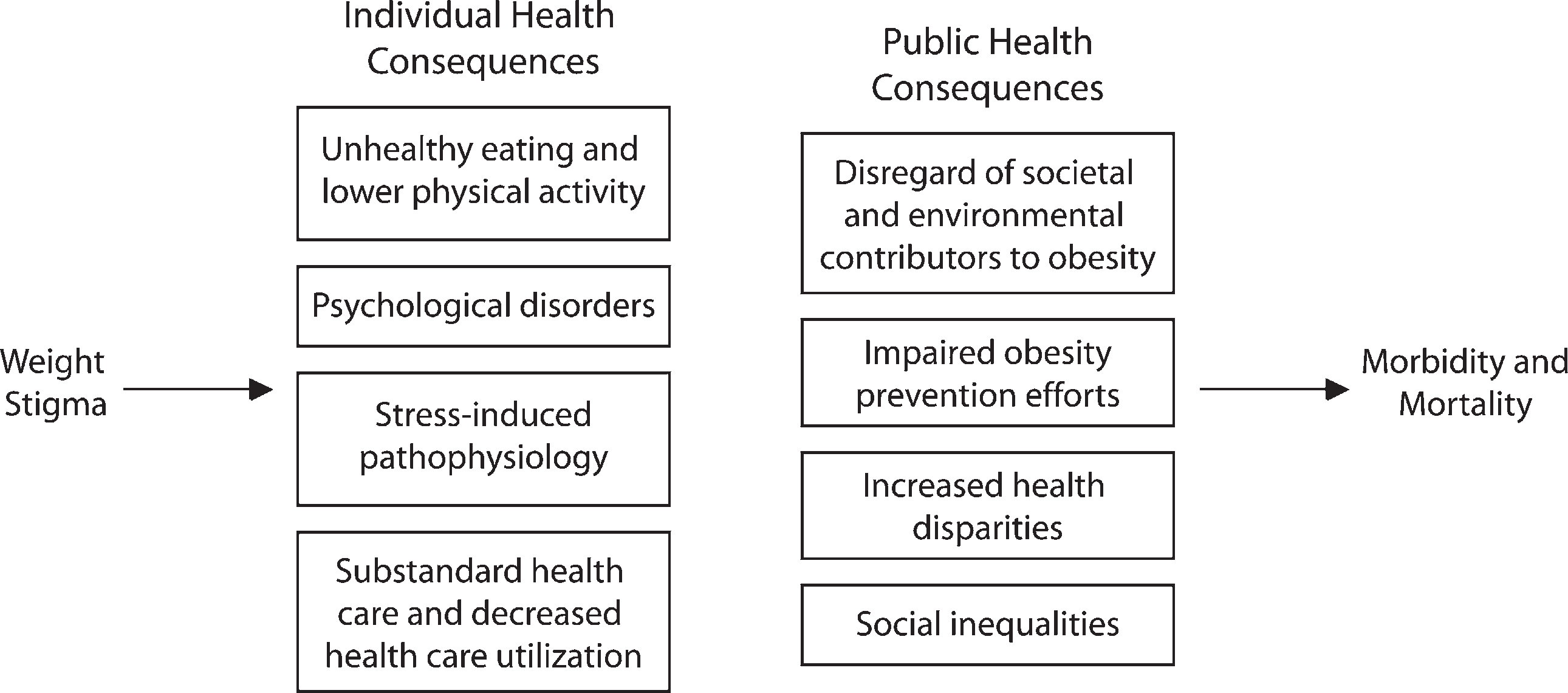
Both Lobstein (2018) and Puhl and Heuer (2010) suggest that people who are overweight and obese are stigmatised as they are deemed responsible for their weight status. Unlike protected characteristics which are subject to anti-discrimination legislation, overweight and obesity discrimination is not legislated against. One effect may be that this framing leads to overweight and obese people viewed as deserving of discrimination because of their apparent lack of self-control (Puhl and Heuer 2010; Johnson 2012).

There is increasing evidence that anti-obesity attitudes are evident within society, with obese individuals facing stigmatisation and discrimination in employment, education, interpersonal relationships, as well as healthcare and the media etc. (Puhl and Heuer 2010; Johnson 2012; Flint et al. 2015; Lobstein 2018), with overweight children and adults stereotyped as lazy, unmotivated and lacking in self-discipline (Puhl and Heuer 2009; Puhl and Latner 2007; Lobstein 2018). In other words, overweight people are often blamed for their condition, and as a consequence, some believe the solution to the obesity epidemic is one of personal responsibility and choice, which resonates with the view found to be held in this research.

Stigmatizing people in this way has been shown to be counterproductive, without any evidence that this motivates people to make healthier choices and in fact it may have the opposite effect (Puhl and Heuer 2009; Puhl and Latner 2007; Lobstein 2018).These anti-obesity attitudes accord with the well documented views held by authors such as Lupton (2013) who discuss how health promotion in today’s society supports self-regulation and ‘responsibilisation’ with those who fail to self-regulate victimised and blamed for their lack of self-control (Lupton 1995) The effects of weight stigmatisation were well-documented by Puhl and Heuer (2010: 1019) outlining that:

*‘stigmatization of obese individuals threatens health, generates health disparities, and interferes with effective obesity intervention efforts’…. Identifying ‘weight stigma as both a social justice issue and a priority for Public Health’.*

Figure 8.2 Individual and Public Health Consequences of Weight Stigma (from Puhl and Heuer 2010: 1024



As shown in Figure 8.2, above, from Puhl and Heuer 2010: 1024, the individual and Public Health consequences of weight stigma.

Another potential implication of this approach, which may lead to stigmatising and victim blaming is that, as a consequence of a focus on the individual, other causes, such as the wider environmental causes identified by Foresight (Butland et al. 2007), may be ignored, and therefore not more widely recognised and addressed, i.e. individual cause = individual action (Lobstein 2018), which comes full circle with the discussion of implications, in terms of how framing influences action.

If the potential implications of an individual responsibility and health view of obesity are that obesity action is falsely dichotomised into prevention versus treatment, LA versus NHS responsibility, with individuals held increasingly responsible and potentially ‘blamed’, then what are the potential impacts of this on decision-making about obesity at a local level? Although this was not studied as part of the research as the public/people with obesity were not participants this could be an area for future research at a local level.

### 8.5.3 An uncertain future for obesity action at a local level?

In the absence of a clear national strategy and action plan on obesity, local action is left open to the local interpretation of Elected Members and senior leaders receiving advice from public health teams, based on national obesity policy. It is recognised that national obesity policy making has moved to policy more driven by political ideology than evidence base (Atkins et al. 2017; Masters et al. 2017; Peeters and Backholer 2017; Ulijaszek and McLennan 2016), and that local interpretation is undertaken by Elected Members and senior leaders, with the PHOENIX Report (Peckham et al. 2016) recognising the decision-making and influence of these Elected Members.

One potential impact of the dominant representation of obesity used in this research, is that in the local context, and specifically, these times of financial challenge, responsibility for obesity must rest with the individual and that although the Public Sector has a role to play that they cannot be totally responsible, individuals must be responsible for their own solutions, and the LA must not create dependency. Alongside this, the local view held by the LAs in this research suggested that, as a result of the ‘false dichotomy’, individuals requiring support (i.e. those already overweight and obese) are now seen by LAs to be the responsibility of the NHS, see the final findings chapter, section about roles and responsibilities (7.4.2).

With this view, there is a risk that action on obesity in terms of treatment for the over 60% population already overweight and/or obese is uncertain, as the NHS recognise that LAs have the mandated responsibility and resource. This has the potential to lead to LAs reducing and/or stopping these obesity treatment activities (as is already being enacted, see tables 7.1 and 7.2), in favour of more prevention and population approaches, as is already the narrative. However, as discussed there was little found in this research as to what LAs were undertaking regarding prevention, nor reference to evidence of impact or outcome on obesity from any prevention or treatment activities. Therefore, the potential risk of viewing obesity in this falsely dichotomised way, in the absence of a clear national strategy to support local action, with the mandated lead organisation (LAs) seeing themselves as responsible for prevention and not treatment, is that activity for the more than 60% of the population already classified as overweight and obese may reduce or even cease. This may also lead to a dichotomised view of obesity activity that is either prevention or treatment to address obesity and not, as Swinburn (et al. 2015; 2016) recognises, a combination/continuum of both.

The NHS i.e. CCG view, is that LAs have the resource and national mandate to act on obesity through public health, not the NHS. As public health in LAs are the leads for local obesity work, this view may lead to a risk, that short term judgements on service cost in the current financial climate, come at the expense of understanding wider system savings in the longer term. This was articulated by some participants who noted that LA investment in obesity benefitted the NHS not the LA therefore the NHS should invest or return resource to the LA as a result.

This is supported by the findings of the PHOENIX Report (Peckham et al. 2016), which indicated some concern that the reforms and restructure from the Health and Social Care Act (DH 2012) may not encourage the right behaviours between the NHS and local government, and these may be driven by financial challenges and considerations, both claiming the other is funded for the work.

The Iacobucci survey in 2014 quoted Duncan Selbie, the chief executive of Public Health England, accountable for monitoring Public Health spend as follows:

*“We’ve had a shed load of money gone into the NHS. And today we have gaps in life expectancy and quality of life as wide as they were 40 years ago. ... It’s not about maintaining a direct line from where we’ve been before. Where we’ve been before was a shameful [low] level of investment in prevention and early intervention. Local government will not be taking lessons from the NHS on this. The duty is to improve the public’s health, not to provide a Public Health service…..If you ask Public Health professionals what’s going to improve the health of people of Sheffield, it’s job creation, decent neighbourhoods, a good start to life, children being ready for school, companionship, [and] not being isolated. The biggest single contributor to good health at population level is economic prosperity.”*

This view appears to support LAs using the public health ring-fenced grant for things other than traditional public health and to support wider council objectives which can be seen to improve health, as Selbie is quoted, for example jobs, education etc. This is supported as a wider determinants of health approach, as first advocated by Dahlgren and Whitehead (1990), but also queried by the research of Alvaro et al. (2011) who contend that the economy will always win over a health issue in local government where the main concerns are jobs, economy and growth.

This position raises a question about how more traditional public health work around topics such as obesity are to be addressed and funded, and what the impact of a reduction of the public health funds may be, and indeed whether the SDH approach, as outlined by Selbie, should be challenged.

If the current representation, operationalised in this context, could lead to the effects outlined above, then one of Bacchi’s key questions (2009) is, how could this ‘problematisation’ be questioned, disrupted and replaced? Following this approach includes how the issue could be represented differently, and then what this may mean in terms of who is affected, how, and, what actions may be taken for any alternative representation.

## 8.6 How could this ‘problematisation’ be questioned, disrupted and replaced? The policy implications of this research in terms of what this means for successfully addressing obesity locally?’

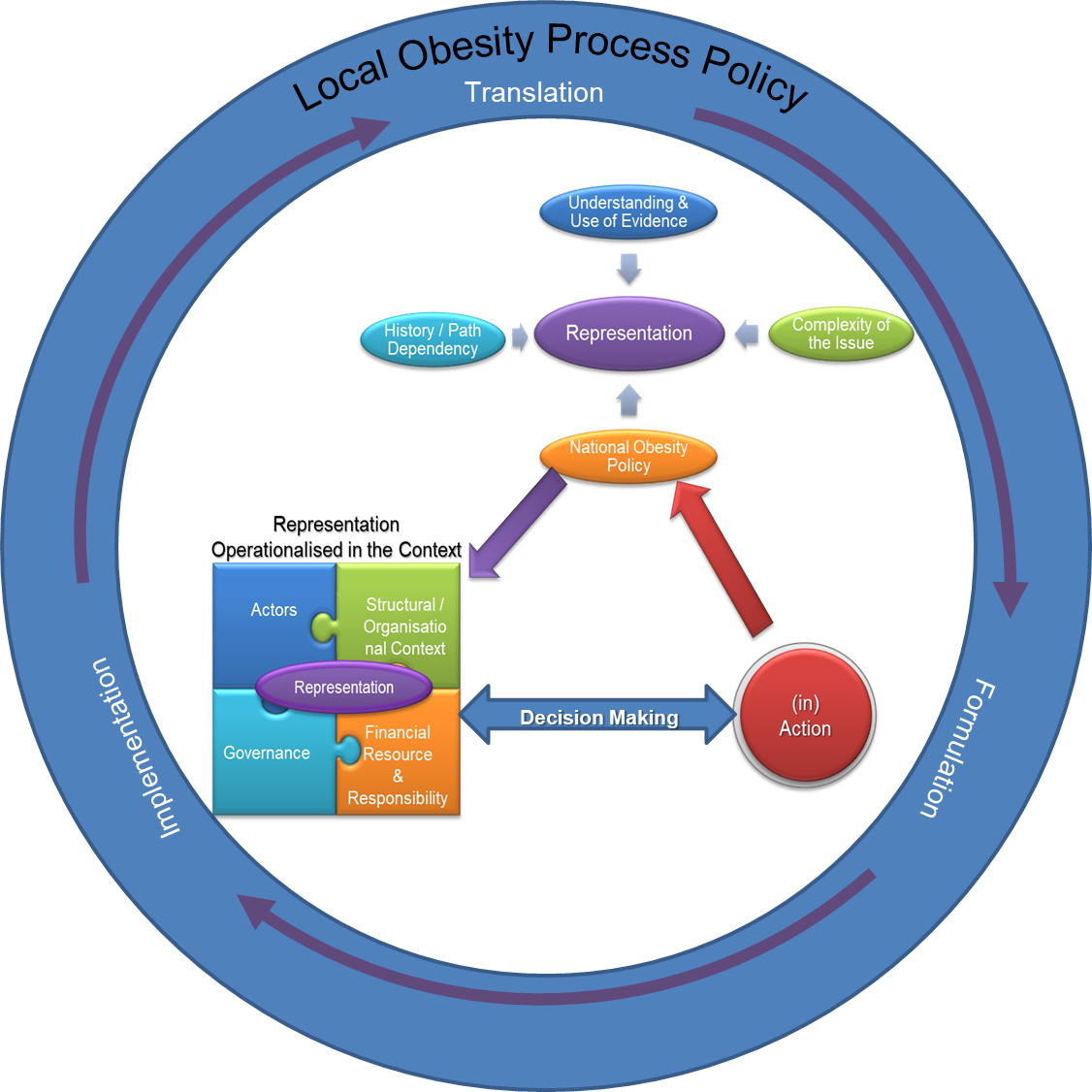
Bacchi’s (2009) final question asks: How could this ‘problematisation’ be questioned, disrupted and replaced? This question is essentially asking for reflection on how this representation could be presented differently and therefore, for the purposes of this thesis, it is about what the implications are for future research and practice in terms of ‘*what this means for successfully addressing obesity locally?’* i.e. addressing the second part of the research question. This is discussed below, focusing on the factors that this research has identified as influential in the representation and operational context of obesity at a local policy level.

The diagram below, figure 8.3, presents the different factors or influences that have been identified from the empirical findings of this research, which shape obesity policy processes at a local level (translation, formulation and implementation). The diagram below shows the policy process ‘system’ that this research has identified. Figure 8.3 explains that local obesity policy process is influenced by the dominant representation of obesity that exists and has persisted (i.e. path dependency) locally. This local dominant representation is influenced by the factors depicted, such as: the complexity of the issue of obesity; the local usage and understanding of evidence; and, the National Obesity Policy and how this is translated and understood locally.

However, although these factors influence the representation, the context in which this representation is being operationalised is crucial as to how this representation continues to be produced, disseminated and defended, and therefore equally crucial as to how it could be questioned, disrupted and replaced. The local context in which the representation of obesity is operationalised is presented in the diagram as the square ‘jigsaw’ recognising the interconnectedness/overlap of the contextual issues. These contextual influences were found in this research to be: the implications of the Health and Social Care Act (2012) creating a fragmented commissioning and responsibility pathway; the views of Elected Members and senior leaders; the governance role of the Health and Wellbeing Board; and, responsibility and financial control of obesity in the context of the changes and challenges of austerity.

The diagram illustrates how the local context and dominant representation of the issue are key influencing factors on the local obesity policy processes i.e. policy translation, formulation and implementation. Therefore, when these factors are considered as a local obesity policy process ‘system’, lead to subsequent outcomes and impacts of how the view of obesity is operationalised locally.

Figure 8.3 Factors identified as influencing obesity policy processes at a local level – the local obesity policy process ‘system’



This system, identified in this research and the factors identified within it, resonate with the issues Prof Jane Anderson raised in Maintaining the Momentum (LGA 2017). In this document Prof Anderson discussed sexual health, a similarly complex issue to obesity, in the post 2012 Health and Social Care Act context, highlighting many parallels to the issues discussed in this thesis relating to obesity. For example, issues of the transition of responsibility to local government, the impact of a period of organisational change, a fragmented commissioning pathway, issues of accountability, responsibility, and a financially-driven market, with one part of the public sector investing to deliver savings elsewhere. The issues outlined by Anderson (LGA 2017), resonate with the findings of this research, and significantly for answering Bacchi’s final question, Prof Anderson indicates the potential value in taking a whole system approach, with potential value for disrupting the status quo. As Prof Anderson argues (in Maintaining the Momentum, LGA 2017: 16):

*‘Success requires whole system approaches in which commissioners, providers and service users work together develop joined up, strategically aligned plans to meet population needs. This could be a good fit with STPs as potential vehicles for joining up the system. However so far there is little evidence that sexual health and HIV are being included in plans. Sharing learning of what works across the country is immensely helpful for commissioners and service providers alike.’*

The local obesity policy process ‘system’ depicted in the diagram (figure 8.3), above, shows the factors influencing the representation and context in which obesity decision making is operationalised leading to (in)action. The factors identified from the empirical research, depicted in the local obesity policy process system figure 8.3 and the parallels with the Anderson quote are discussed here in turn to examine how the problematisation could be questioned, disrupted and replaced, i.e. how the local obesity policy process ‘system’ can be changed. Firstly, discussing what systems thinking/approaches may offer local obesity policy. Secondly, applying systems thinking requires examination of the different ‘parts’ of the system that could be leverage points for change. Although all factors identified are potential leverage points, a key leverage point (and potentially a powerful one) is in how the issue is represented. A second key leverage point is, examining the role of central government, national leadership on obesity and therefore also national obesity policy in challenging this current dominant representation.

In recognising the contextual factors identified in this research as key, this section examines how understanding the policy environment (Cairney, 2018) may support a different ‘problematisation’. Finally, focusing on the findings of this research, leads to a discussion on how the public health workforce can be supported and trained to work in these environments and contexts, in local authorities, and what this may mean for addressing obesity as a local level.

### 8.6.1 A possible role for Whole Systems Approaches?

A systems approach is advocated in the 2007 Foresight Report Tackling Obesities – Future Choices (Butland et al. 2007), which underlined that there is no single solution to tackle obesity and that a broad range of interventions are required using a systems-wide approach. Despite this now being over 10 years old very little has happened on the whole systems recommendation in England. Indeed, so far, no country has been successful in reversing obesity trends, and evidence for the effectiveness of individual measures to tackle obesity, at a population level, is limited. This suggests a different approach to tackling obesity is required – a systems approach could be an important way forward here, as supported by the PHOENIX Report (Peckham et al. 2016), Swinburn (et al. 2015; 2016) and others (Jebb et al. 2013; Frood et al. 2013; Rutter et al. 2017; PHE 2019) in calling for a ‘whole systems’ approach, and with emerging evidence from Amsterdam (Sheldon 2018).

Systems thinking and whole systems approaches offer a different view of obesity than the one dominating this research (Ulijaszek 2017). That obesity is not a simple individual cause and responsibility relating to diet and physical activity choices but that the current system is fuelling obesity. The outcome of the current system is a product of the combination of causes, not the result of an individual cause. Whole systems approaches recognise that obesity exists in a complex adaptive system i.e. a system made up of many inter-connecting forces and influences, which organises itself according to the strongest forces within it. Currently, the collective impact of drivers is more towards excess weight than healthy weight, therefore the current system produces obesity. If obesity is understood in the context of a system, then obesity and local obesity policy, in the context of the influencing factors discussed in this research, are all part of that wider system (Ulijaszek, 2017).

Swinburn’s (et al. 2015; 2016) model for a whole systems approach to obesity is not a prevention versus treatment focus but a Social Determinants of Health approach focusing on the wider environment and prevention but alongside support for those already vulnerable (i.e. those already overweight and obese).

It is still unclear if this systems thinking or whole systems approach may be likely to be any more successful than current approaches to obesity as there is no published peer reviewed evidence of the impact of systems approaches to obesity to date in the UK or internationally. However, one of the leads of the Public Health England (PHE) funded Whole Systems Approach Steering Group, Professor Jim McManus, Director of Public Health, Hertfordshire, is quoted as saying (2016, online):

*“We have built a culture where being healthy is not the default option for many. Only acting as a system will turn it round. And it will take phases of work across time, and work at different levels. If focusing on individuals really worked then well, why are we still in this mess?”*

However, although the findings of this thesis’ research would suggest that taking a whole systems approach may address some of the issues identified, this research also proposes that those involved in obesity at a local level may also need to consider or focus specifically on the influencing factors identified.

### 8.6.2 Issue Representation

In answering Bacchi’s (2009) question about representation questioning, disruption and replacement, here this research is essentially asking, what the implications are for future research and practice. Another way to challenge the current representation, reflecting one of the main findings and influencing factors of this research, is to offer alternative frames or models of obesity used, as it is recognised the representation leads to issues getting onto the agenda and then crucially certain actions and support for actions i.e. policy formulation. This is discussed in the literature review chapter, such as the work by Stone (2001), Bacchi (2009), Barry et al. (2009), Beeken and Wardle (2013), McLennan and Ulijaszek (2016), Ulijaszek (2017) and more widely by Babbel (et al. 2017).

This reflection and awareness of how issues are framed and the potential implications of such could offer a wider challenge to currently held views of obesity causation and awareness of alternative and more evidence-based views. These findings may have important implications for our understanding of narratives as mechanisms for social constructions in public policy processes. Barry et al (2009), Husmann (2015), and Ulijaszek (2017) all support the position that narratives can affect individual perceptions of policy target populations and solutions to an issue or policy problem. As narratives are used to make meaning of complex political and social environments, we should try to better understand what this might mean for complex issues such as obesity and how policy narratives may be better used to communicate and influence, based on evidence. The issues and impact associated with these narratives has been recently highlighted by Lobstein (2018) in terms of potential negative impacts.

### 8.6.3 The role of central government and national leadership on obesity

If recognising the model presented as a local obesity policy process ‘system’, this leads to applying systems thinking, which in turn suggests identifying key leverage points for change, as aforementioned. One key leverage point may be the role of central government and national leadership on obesity. Although national government outlined in Healthy Weight, Healthy Lives (DH 2011), that LAs are well placed to make decisions and develop strategies which are driven by local needs and context, the four LAs in this research appear to have simply reflected the solutions outlined in national strategies, and are offering the same or very similar solutions to the national strategy and therefore also each other.

National leadership on obesity could be potentially responded to as PHE’s role, however this research suggests that this leadership needs to go further than government department offering guidance and may need to include a National Statutory Framework, reflecting that a nationally mandated NCMP leads to a certain level of interest and action locally. A national framework could include strategic recommendations, such as Health in All Policies (WHO 2012), clarity about local obesity roles and responsibility, and an oversight of governance at a local level through Health & Wellbeing Boards, as well as other newer opportunities such as Integrated Care System (ICS) (as was Sustainability and Transformation Plan (STP)) work.

This national leadership could address the articulated challenges locally from this study, in terms of:

* confusion about what to do (in terms of use of evidence in local government, supported by Atkins (et al. 2017),
* clarity over who is responsible for doing it (i.e. a ‘false dichotomy’, prevention vs treatment, LA vs NHS as supported by Roberto et al. 2015), and,
* a level of governance to support systems thinking on a complex local issue such as obesity, as supported by the reported role of the Health and Wellbeing Boards locally but recognising these are still developing (Shared Intelligence (Si) 2017).

### **8.6.4 Support and/or training of the PH workforce in LA**

As already outlined, and as Atkins et al. (2017) offer, context is what seems to be important in local government, with less interest in traditional more medical forms of evidence and more importance given to local contextual evidence influencing views and action, recognised as a feature of local government decision-making. Atkins et al (2017) discuss that this must now be considered in public health training, identifying actions and understanding ways of working in this new organisational context for public health.

This may include training for public health roles regarding working in LAs in terms of position and ability to influence; opportunities to act, the business case to prioritise obesity in local government; advocacy for obesity as well as other public health issues; and commissioning (not just procurement and/or contracting). Reflecting the findings of this research about some of the challenges to influence in local government around obesity, as well as the recommendations of other reports such as PHOENIX (Peckham et al. 2016) and the RSPH workforce survey (2014), that public health practitioners may be moving away from public health specialist skills to more business and contracting roles in local government.

Reviewing what support and training the public health workforce may require to work and influence in these policy environments and contexts, in local authorities, reflecting on the factors identified in this research, could support ability to lead and influence the views of Elected Members and senior leaders, as well as understanding the organisational contexts, and governance processes. This issue may be a factor of NHS to LA transition of public health staff at the time of this research. This may well be addressed over time as public health staff in LAs become LA natives rather than LA immigrants, and what a workforce with these understandings and skills may mean for disrupting the current problematisation and addressing obesity as a local level.

## 8.7 Implications for future research

Reflecting the findings and policy implications discussed above, this research suggests further work would be beneficial in the following areas:

* Understanding how the issue of obesity is represented in other local authority areas and, how framing of obesity influences local action there
* Understanding the impact of whole systems approaches to obesity (Swinburn et al. 2015; 2016), as these are so far untested. This work is already being progressed by Public Health England.
* Understanding of Elected Members views on obesity and if these are linked to political ideology or individual view. As obesity is already recognised in the literature as an issue that is linked to many influences on perspective e.g. own body weight, weight history, stigma, victimisation, therefore, political view is another potential influencer ripe for future academic interest.
* The impact of the austerity climate and if and/or how framing of obesity related to this context may be a strategic response to the financial challenges.
* Another area for further research building on from Atkins and colleagues work (2017) is to examine use of evidence in local government and how this needs to be relevant and useful in this context, reflecting their findings that local context is more relevant than traditional evidence.
* The actual decision making processes in policy formulation through ethnography (which may have been lacking in this research – see below)
* The views of Elected Members, as the Elected Members were poorly represented in the research and therefore not able to be presented separately as a group due to risk of identification, therefore presented as part of the ‘Senior Leaders’ group. It would be useful to engage sufficient numbers to be able to review these participants and present the findings from this group to allow points of interest to be explored in research.

## 8.8 Limitations

A detailed consideration of the strengths and limitations of this research is discussed in detail in the methodology chapter (sections 4.5-4.9), where the methods used were described in detail to support the credibility of the research. The methodology chapter also explored bias, rigour and reflexivity, to ensure that those who are interested in this research have sufficient detail to make judgements on the credibility of the research undertaken and the findings presented. As for many studies with a qualitative interview design, the main limitations of this investigation are:

* the research method itself - documentary analysis and semi structured interviews,
* the self-selection of a modest sample size of interview participants,
* the data sources made available for documentary analysis,
* the semi structured interview schedule i.e. questions asked, or not asked, how the question is framed, what is recorded
* the analyst’s own perspective, as well as how I was perceived by participants, and indeed how participants wish to be perceived, truthfulness, ability to respond.

However, because the researcher was aware of and took steps to prevent, reduce, control and mitigate these limitations and sources of bias (as detailed in Chapter 4, sections 4.5-4.9 and Table 4.5) it is unlikely these significantly compromise the integrity of the study.

The outcomes of qualitative research should be rigorous: plausible and reliable, but they are not intended to be, nor designed to be, generalisable due to the non-probabilistic basis of sampling. Although the sample may not be representative of the population, this is not required, nor, the researcher’s aim as generalisability is not the intended outcome of this research, but instead to understand the ‘case’ in South Yorkshire (Ritchie and Lewis 2003; O’Leary 2004; Bowling 2005). However, obesity is an issue all local areas in the UK are trying to tackle and therefore in terms of theoretical generalizability there may be a case to argue for some generalizability as the sample and processes will be similar elsewhere. However, the relevance of the findings to other areas would require to be established by further study, or by the readers’ understanding of the context to which the findings from this study would be applied.

The findings may also be useful in terms of ‘sensitising’ people in other areas to the types of issues that can arise, and types of factors that may be important in operationalising obesity policy at a local level, as the discussion goes on to examine.

It should also be noted that this research was undertaken at a particularly challenging time for both public health and undertaking research with public health teams. This research was undertaken during the process of enacting the main transformation and changes brought about by the Health and Social Care Act (2012), which is recognised as having profound implications for the organisation and delivery of the public health (Peckham et al. 2016 in the PHOENIX Final Report).

The researcher recognises that there are some significant limitations in terms of the extent to which the research question was able to be answered through this research process. These limitations are discussed below. Firstly, as a result of the stance taken in this research, and the position and professional background of the researcher, as discussed in the introduction and methodology chapters, there may have been an inherent bias. The researcher has clearly stated her position in this research, hence the rationale and impetus for the study. The researcher undertook reflexive practice ensuring that all findings were discussed with supervisors and challenged to be based on the empirical evidence.

Secondly, the participants themselves, as previously discussed will have led to the findings presented. These participants were selected by the researcher and are also self-selected to consent to participate but this is true for much research of this nature and is recognised in the methodology chapter. There were additional complications in terms of recruitment to this research. At the time of the active period of interviews Doncaster Council Childrens’ services were under review and managed outside of the Council by a Trust. This may have led to the reluctance of Elected Members and senior leaders at DMBC to participate as they were not represented. Rotherham Council had full Cabinet resignation and a change in Chief Executive and Director positions related to the Child Sexual Exploitation (CSE) review by Baroness Jay that resulted in Government Commissioners taking control of the Council. All booked interviews were cancelled, and time elapsed before new participants were identified and agreed to participate. This may have resulted in lower participation here, and especially from Elected Members, than in some other areas. This may have impacted on Elected Member participation and therefore Elected Members were not able to be presented and analysed as a distinct group as due to low numbers there was risk of identification.

It is clear that there were some groups of participants in some areas who were not represented, and this is presented in the methodology. As the study was looking at ‘obesity policy processes’ as the case, across South Yorkshire, there were sufficient representation across the participants to give some level of understanding. As acknowledged previously with qualitative research, numbers of participants are not required as results are not designed to be generalisable but true for the participants of the research, which this methodological approach has sought to ensure.

Thirdly, due to the questions asked or way questions were asked during interviews, they may have not allowed or encouraged participants to fully answer with details about more ‘upstream’ activities that focus on wider determinants of health. The nature of the questions, although successfully piloted, may have led to participants focussing only on activities directly linked to ‘obesity’ and thus may have led to a focus on commissioned service-type activities rather than participants truly reflecting wider work. It may be that the participants did not recognise some of the work as relevant due to the nature of the questioning. However, it could also be argued that participants in this research working in the sector and field in professional positions would be aware of ‘upstream’ activities and therefore would have been able to make the connections themselves and articulate these in their answers. However, it was not evident from documentation that there were more upstream, wider determinant-type interventions linked to obesity, thus supporting the findings about a pre-dominant focus on more individualised interventions. These are all issues that could be explored in further research.

Fourthly, as the researcher has acknowledged in the methodology chapter, as a novice PhD researcher, perhaps the answers given by participants were accepted without sufficient probing that would enable fuller understanding and address the point above seeking clarity on all local obesity related activities. The questions and process were piloted and findings were discussed with supervisors as the research progressed and therefore hopefully this was addressed. Equally, to have specifically probed about more wider social determinant activities may have been seen as ‘leading’ the participant and equally a limitation.

Fifthly, as is true for much qualitative research of this nature with one researcher, the interpretation of the findings by the researcher is another limiting factor. The researcher has clearly stated her position in this research. The researcher undertook reflexive practice ensuring that all findings were discussed with supervisors and challenged to be based on the empirical evidence, not unsupported interpretations, however, it is recognised that no two researchers will interpret findings in the same way, hence discussions with supervisors about interpretations.

Overall, due to this being a qualitative PhD research project, with a novice researcher, at a particular time and place there will always be limitation as to the extent the research question is answered. This is acknowledged. It is also recognised that these findings have been arrived at through a documented, evidence based research process, over a considerable period of time of ‘living’ with the data, discussions with a supervisory team of more experienced researchers, challenged by them, and numerous iterations of the interpretations. Therefore, this research does make a contribution to knowledge, which is presented below.

Given the limitations of the methods discussed above there are aspects of the local obesity policy processes, and therefore this research question, that have not been fully explored. For example, there are gaps in understanding parts of policy formulation such as how actors are involved in decision making and why. Other research approaches could have been employed to better understand policy formulation and decision making in practice. For example, ethnography may have allowed observation of the decision making processes. It is suggested that observational ethnographic work is a priority for further research to better understand the local obesity policy process, and in particular how actors are involved in policy decision making. This means that aspects of the research question about local obesity policy processes remain to be explored.

## 8.9 Strengths and contribution of this research study

The research adds to the general policy literature and more specifically health policy literature, providing new theoretical insights and an in-depth understanding into the processes of local policy, specifically obesity policy. This study, as far as I am aware, is the first in-depth exploration of local obesity policy processes, incorporating a focus on framing as central within local obesity policy, across local authorities and the NHS (as local leaders and potential commissioners), and with weight management service providers. The factors identified as influencing obesity policy processes at a local level – the local obesity policy process ‘system’ (Figure 8.3) developed, for example, provides a starting point and output that can be tested in further research.

The issues, challenges and factors shaping local obesity policy processes highlighted in this study are relevant as obesity remains a key public health issue and NHS focus (DH 2016; 2018; NHS 2019). Local Authorities are CCGs are explicitly referenced as the organisations to drive this action, in partnership, locally (DH 2016; 2018; NHS 2019), yet Local Authority ring-fenced public health budgets are being removed and the latest public health funding allocations have been shown to be significantly reduced for the fourth year in a row (Buck 2018). This local level responsibility, without any improvements in national policy clarity, alongside continued budgetary pressures, have the potential to contribute to a reduction in prioritised resource available for non-prescribed functions, such as obesity.

Despite the calls for research to be undertaken to support better understanding about local level obesity policy processes (NICE 2014), as evidenced in this thesis, no research to date has been undertaken to explore LA, CCG, local leader and weight management service providers’ perspectives on obesity, and experiences of local obesity policy processes. This study starts to fill this gap.

Furthermore, this research adds to debates in academic literature about how obesity is represented as an issue in policy and what influence and impact this has on how obesity is addressed. As mentioned, this research is novel as it is one of the first to use the Bacchi (2009) framework in a local setting in England. This study therefore addresses an identified gap in the literature and provides a unique and valuable contribution to the understanding of how local obesity policy processes operate.

Whilst it is not the intention nor is it possible to generalise from the findings, obesity is an issue all local areas in the UK are trying to tackle and therefore in terms of theoretical generalisability there may be a case to argue for some generalisability as the sample and processes will be similar elsewhere. However, the relevance of the findings to other areas would require to be established by further study, or by the readers’ understanding of the context to which the findings from this study would be applied. Where these findings may also be useful is in ‘sensitising’ people in other areas to the types of issues that can arise, and types of factors that may be important in operationalising obesity policy at a local level, as the discussion has presented.

## 8.10 Conclusions

The research findings have emphasised that, as identified by Hunter (2009), obesity is a ‘wicked’ public health issue. Local obesity policy is translated, formulated and implemented within a complex, socio-political local system; with the system, at the time of this research, characterised by ‘inertia’ as a result of the Health and Social Care Act (2012). Alongside the impact of the Act (2012), the wider contextual influences on, and complexity of, the local system, all may suggest an uncertain future for obesity policy and for the prospects for addressing obesity at a local level.

1. Obesity is dominantly represented as about individual choice and personal responsibility

There is a dominant representation of obesity that exists and has persisted (i.e. path dependency) in South Yorkshire. This research found that**,** despite nuances,obesity was dominantly represented as an individual choice and personal responsibility health issue by those in local leadership and decision-making roles, despite evidence to support a wider view, initially from Foresight (Butland et al. 2007) and subsequently supported by others (Jebb et al. 2013; Swinburn et al. 2015; 2016; Ulijaszek 2017). As discussed, the reasons for the representations of obesity observed in this research remain unclear, although as previously outlined, some explanations have been offered through this research (presented above). However, the dominant representation has persisted over time, and may be as a result of national policy, personal views, moral judgements, or indeed perhaps ‘convenience’, in a time of ‘cuts’ or austerity measures.

As the observed dominant representation or view of obesity is not new, an important question in this research therefore is: what the implications of this view might be in this local context, recognising that this research argues that context is crucial, and that the literature of certain more interpretative approaches, such as Cairney (2018) identify that the ‘policy environment’ is key. In other words, to answer one of Bacchi’s key questions (2009), what effects are produced by this representation of the problem (in this context or policy environment)? These are presented in the conclusions of the research that follow.

1. Framing influences action

Obesity’s causal story, being seen as an individual health issue related to choices about diet and physical activity, appears to influence action locally (Bacchi 2009; Ulijaszek 2017). A focus on individual treatment actions, in the context of LAs who see their role as population prevention, and, reducing finance has led to a reduction in funding for interventions, as these are seen as a NHS responsibility, with a plan to undertake actions that align to areas of LA control and influence. This representation, operationalised in this context, has led to this position on (in)action/reducing interventions and resource. This is supported by a local narrative about who is responsible for what action on obesity at a local level, in the absence of clarity nationally, a fragmented commissioning pathway, and a recognised limited level of obesity governance and leadership at a local level (as presented in Chapter 7 and discussed above).

In the climate of the current financial challenges, with this local and dominant framing of obesity, LAs may be able to deflect responsibility for treatment interventions to the NHS (local CCGs) by using this representation of obesity. It could be suggested that framing obesity in this way is suited to the context, therefore context and process become one, however further research would be required to examine this and other reasons for why obesity is framed in this way.

1. Responsibility for local action on obesity is dichotomised

The dichotomised approach to obesity responsibility is in two parts. Firstly, prevention versus treatment. Secondly, prevention being seen as a public health responsibility, and treatment as a NHS responsibility, as discussed above. Despite LAs having responsibility for all obesity work across prevention and treatment (excluding surgery), as mandated in the national strategy, the view of responsibility for action at a local level remains unclear (presented above). With obesity viewed or ‘framed’ as an individual responsibility and health issue requiring treatment, this aligns to the LA view of the NHS’ role, as LAs don’t necessarily identify with individual health issues nor treatment, as obesity is currently framed.

This view of obesity as an individual issue requiring treatment, in the context of public health struggling to influence about obesity in the structures of LAs, may lead to a lack of LA action on obesity.

1. An uncertain future for policy action relating to obesity

This research found that a complex range of factors shape local obesity policy and processes and that these resonate with and overlap with existing wider literature on policy (for example, Cairney 2018). In the context of these factors of reducing resource and prioritisation of activity for that resource, the prevailing narrative held about obesity, and lack of obesity leadership and governance, non-existent positive media pressure and absence of national or local advocacy or lobby groups, leaves obesity action to local decision making based on these aforementioned views. Alongside, the lack of national directive on obesity action, either nationally or locally, with the localism agenda, and a lack of effective local governance through the designated system and structures of the Health & Wellbeing Boards, one wonders how the prevalence of obesity may be effectively tackled. This was demonstrated in this research through reducing resource and activity on treatment interventions, with mention of prevention activities that are mainly under LA control, with little clarity on evidence for these activities, nor if they are planned or current, as there was little clarity given in documents or interviews. A focus on individual treatment actions, in the context of LAs who see their role as population prevention, and, reducing finance has led to a reduction in funding for interventions, as these are seen as a NHS responsibility, with a plan to undertake actions that align to areas of LA control and influence. This representation, operationalised in this context, has led to this position on (in)action/reducing interventions and resource. This is supported by a local narrative about who is responsible for what action on obesity at a local level, in the absence of clarity nationally, a fragmented commissioning pathway, and a recognised limited level of obesity governance and leadership at a local level (as presented in Chapter 6 and discussed in Chapter 7). These factors collectively may mean an uncertain future for action to address obesity at a local level.

1. A possible role for systems thinking?

Systems thinking and whole system approaches are one possible way to overcome challenges identified in this research. By applying systems thinking to obesity, it might be possible to better understand the local context and drivers from the perspectives of all involved in the system, as well as identify key leverage points for change (PHE 2019). However, issues such as obesity framing, use of evidence, public health influence and, the financial challenges will all remain and will need to be effectively challenged, using systems thinking, to enable an effective whole systems approach to obesity. Whole Systems Approaches have been advocated as having potential to address these complex issues in a system (PHE 2015; 2019) however, without any evidence of impact to date, and this will surely take time to become clear.

The public health system remains in flux due to ongoing finance and policy changes, alongside the context of the embedding of changes from the Health and Social Care Act (2012) (Peckham et al. 2016). There are still many challenges and many opportunities yet to be realised fully from the national changes, it will be important to continue to examine how public health adapts, evolves and responds to the changes and to continue to study the implications for issues such as obesity.

## 8.11 Dissemination

This research adds new understanding to policy and/or practice related to obesity activity, therefore, effective dissemination is crucial to achieve impact both within and beyond academia (Bryman 2016).

The research recommendations also provide opportunity to develop and expand the evidence base in this area, particularly with reference to issue representation, Whole Systems Approaches, and training for public health professionals working in LAs.

Recognising the interest and potential benefit of dissemination to the following groups, (the participants; the academic research community; local, regional and national public health, obesity policy and obesity practice professionals), several actions are planned and are in process of being undertaken at the point of thesis submission in order to effectively disseminate the research:

* A summary of the study findings will be available to all those who took part.
* At least one academic paper resulting from this research will be written for submission to peer reviewed journals.  The first proposed paper relates to the key influences on local obesity policy decision making identified by this research and is proposed for submission to Perspectives in Public Health, and/or Journal of Public Health.
* The researcher has already presented elements of this research at various conferences:

1. British Dietetic Association Research Conference, Manchester 2015; 2016; 2017, with abstract published in Journal of Nutrition and Dietetics 2016
2. European Congress on Obesity, Liverpool 2013
3. International Congress on Obesity, Vancouver 2016
4. UK Congress on Obesity, Nottingham 2016

* Further abstract submissions planned for conferences throughout 2020, those identified to date include:
* The 22nd International Conference on Obesity (May 2020 tbc – abstract submission Dec 2019)
* The European Association for the Study of Obesity (May 2020 in Dublin - abstract submission Dec 2019)
* The UK Congress on Obesity (Sept 2020 – abstract submission deadline date to be confirmed)
* Public Health England Annual Conference (Sept 2020 in Warwick – abstract submission deadline date to be confirmed).

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# Appendix A: Confirmation of ethical approval from the ScHARR Research Ethics Committee

Kirsty Woodhead

Ethics Committee Administrator

Our ref: 0622/KW 4 April 2013

Carol Weir, ScHARR

Dear Carol

**A qualitative case study of obesity policy translation, formulation and implementation in South Yorkshire. A set of case studies in South Yorkshire.**

Thank you for submitting the above research project for approval by the ScHARR Research Ethics Committee. On behalf of the University Chair of Ethics who reviewed your project, I am pleased to inform you that on 04 April 2013 the project was approved on ethics grounds, on the basis that you will adhere to the documents that you submitted for ethics review.

The research must be conducted within the requirements of the hosting/employing organisation or the organisation where the research is being undertaken. You are also required to ensure that you meet any research ethics and governance requirements in the country in which you are researching. It is your responsibility to find out what these are.

If during the course of the project you need to deviate significantly from the documents you submitted for review, please inform me since written approval will be required. Please also inform me should you decide to terminate the project prematurely.

Yours sincerely

**Kirsty Woodhead**

**Ethics Committee Administrator**

# Appendix B: Semi structured interview participant information sheet and interview schedule

**A qualitative study of obesity policy translation, formulation and implementation: A set of case studies in South Yorkshire** - Carol Weir, PhD study –ScHARR, University of Sheffield.

I have spent 15 years working in obesity across Yorkshire and nationally with the National Obesity Forum, National Obesity Observatory, and recently with NICE developing Adult Weight Management guidance. These roles, as well as my own personal interest in obesity, have led to my desire to pursue a PhD exploring how to better tackle obesity.

The **Research Question** I wish to explore is: *How is national obesity policy translated, formulated and implemented locally by senior leaders, commissioners and service providers, and what implications does this approach have in terms of successfully addressing obesity locally?*

This research is funded by the National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care, South Yorkshire (CLAHRC SY). CLAHRC SY aims to translate health research into practice to improve outcomes. I am writing to ask you to help me undertake this study, to further mine and others’ knowledge, and to help me complete my PhD.

This project has been ethically approved via ScHARR ethics procedure, Integrated Research Application System, National Research Ethics Service, and local research offices.

**Why do I want to talk to you?**

*I am interested in what local areas are doing to tackle obesity and what these activities aim to achieve.* This project is about the process and experiences of those translating, formulating and implementing obesity policy locally. It is hoped, that this research will provide insight into how we can better tackle obesity. I am interested in your views on the subject. Your views can help me communicate what works, what doesn’t, what facilitates successful policy translation, formulation and implementation and what hinders it, and the barriers and challenges faced. It is hoped that this study will improve the formulation and implementation of obesity policies and strategies.

**What will you be asked to do?**

*If you agree to take part, you will participate in a confidential one-to-one interview to discuss your views in more detail.* This should take approximately 45 minutes to one hour, will be audio recorded, and can be undertaken at your convenience, including over the phone, if preferred. All data presented will be anonymous and you will not be able to be identified in the report.

**What will the information collected be used for?**

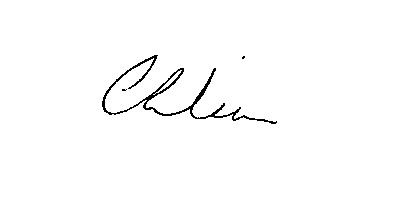
*The information collected will be used in my PhD for Sheffield University*. The final report may include a list of recommendations on how the Public Sector may better tackle obesity and devise and implement policy, which will be shared with Public Health teams in South Yorkshire, and wider, in the form of publications, if deemed appropriate.

Thank you for taking the time to read this and consider if you would be willing to take part in this study to further my knowledge, inform practice in obesity at a local level, and to help me complete my PhD qualification at Sheffield University.

I hope that you feel you can contribute to this project. If you have any questions or would be willing to participate please contact me on 07876351976 or email [carol.weir@sheffield.ac.uk](mailto:carol.weir@sheffield.ac.uk)

I look forward to hearing from you.

Yours sincerely,



Carol Weir

Draft Semi Structured Interview Schedule

**Points to note:** Thank participants. Reiterate issues of confidentiality and the right to withdraw at any time.

**Text re Objective:** *We have all been involved in obesity services locally and are all working to prevent or treat obesity and tackle the high prevalence of unhealthy weight locally. This one-one interview is about your views on obesity.*

*This one-to-one discussion asks you to consider the following questions:*

1. **Lead Question: *Why do you think we have such high levels of obesity and why is it continuing to increase despite investment and interventions?***

**Probe:** *Can you tell me more about……..*

**Probe:** *Can you give an example of……*

**Probe:** *Why do you think interventions often do not work?*

**Probe:** *Is there a difference between obesity policy vision and implementation? What differences exist?*

1. **Lead Question: *What do the obesity services locally want to achieve?***

**Probe:** *In terms of the activities locally to tackle unhealthy weight do you think they will achieve what they set out to?*

**Probe:** *What does success look like?*

**Probe:** *Is success achievable?*

1. **Lead Question:*****What or who do you think causes obesity?***

**Probe:** *Can you tell me more about……..*

**Probe:** *Can you give an example of……*

**Probe:** *What/which factor do you think is the most important?*

1. **Lead Question: *Who or what is responsible for the prevention/treatment of obesity?***

**Probe:** *Can you tell me more about……..*

**Probe:** *Can you give an example of……*

**Probe:** *What role do you think the Government and Public Sector have (National Government, PCTs, NHS, LAs)? (Nanny State or Personal Responsibility and respect for autonomy?)*

**Probe:** *What role do you think the Food Industry has?(Choice and Informed Choice)*

**Probe:** *What role do individuals have (active or passive?)*

**Probe:** *Who or what else is responsible/ has a role?*

1. **Lead Question:*****Should those responsible for overweight and obesity be held to account? If yes, who and how? If not, why not?***

**Probe:** *Can you tell me more about……..*

**Probe:** *Can you give an example of……*

**Probe:** *Personal responsibility? To what extent do you think people should be held personally responsible for their own weight?*

1. **Lead Question: *How do you think we can better tackle obesity?***

**Probe:** *Can you tell me more about……..*

**Probe:** *Can you give an example of……*

**Probe:** *Partnership working?*

1. **Lead Question: *How do you think the recent changes to the NHS and Public Health will affect our ability to tackle obesity?***

**Probe:** *Can you tell me more about……..*

**Probe:** *Can you give an example of……*

**Probe:** *How might changes to Public Health structures and funding affect prevention of obesity. How might the new funding arrangements and GPs as commissioners affect treatment options (community weight management, drugs/prescribing, specialist services, surgery)?*

***END OF SEMI STRUCTURED INTERVIEW\****

# Appendix C: Transcript Excerpt Example

I = Interviewer

P = Participant

|  |  |
| --- | --- |
| I | Right. So that’s it on now. Ok so I’ll start off. Erm just every briefly just to get us in that way of thinking, tell me a little bit about what you think are the main causes of obesity? I know you could go on forever! It’s just to get your brain into obesity mode because I know your job can be all over the place ha-ha! |
|  |  |
| P | There’s allsorts! Erm I don’t think there’s one reason whatsoever that causes it. There’s obviously some genetic reasons for some people, erm and for those that isn’t genetic it’s to do with everything else really in life. |
|  |  |
| I | Yes. Ok. And why do you think we’ve got such high levels of obesity? Given that over the last say half a dozen years we’ve had loads of interest, loads of investment in certain areas. Why do you think that levels are continuing to be high? |
|  |  |
| P | Because I just erm I think people are people and their individuals and some of the things that we try to put into practice probably don’t really reach those individuals. Erm and it’s also to do with choice and people choose the way they live. |
|  |  |
| I | Hmm. |
|  |  |
| P | For lots of different reasons. Erm you could link it to lots of other things such as erm inclement. I don’t know. Err just general lifestyle. People not really think that they’re obese when they are. |
|  |  |
| I | Hmm. |
|  |  |
| P | And perceptions. There’s all yes lots of different reasons. |
|  |  |
| I | There’s a long list isn’t there? |
|  |  |
| P | Yes. |
|  |  |
| I | So what would you want to achieve locally with what you’re trying to do around obesity? What’s the vision? What’s the aim? |
|  |  |
| P | Erm it’s not going to be an overnight thing so it’s you know we’ve got to be in there for the long-term. I think what I’d like to do is to actually get all partners involved erm because we can’t do it in public health on our own. |