Getting RREAL about implementation of a Whole Systems Approach to obesity prevention in Northern Ireland: a longitudinal process evaluation

Detailed recommendations – May 2026

Laura Lamming, Imogen Freethy, Charis Bontoft, Gavin Breslin, Abi Dennington-Price, Kevin Eggert, Amander Wellings, Neil Howlett, Katherine E. Brown, and Katie Newby

The following recommendations should not be viewed as mandatory or for immediate enactment, but instead as a suite of flexible, practical suggestions that may help decision-making when faced with limited resources and capacity. Decision-makers should consider reviewing them at opportune moments (for example when a new site is about to begin implementation) or when the context or resource levels change to see if any recommendations could be enacted to further optimise the WSA implementation process.

Recommendations have been categorised into 'Regional' (intended for WSA stakeholders or oversight groups operating in departments or organisations at the regional level in NI) and 'Local' (intended for the EA sites, leadership groups, or WSA stakeholders operating at the local level in NI). Recommendations that either the PHA, ROPIG T&F group or the three EA sites think should be prioritised are labelled as 'PRIORTY'. Multiple examples of existing good practice were identified across the implementation of the WSA in NI and as such recommendations include suggestions for these practices to continue. Recommendations also include opportunities for good practice to be developed further.

Most of these recommendations relate to, facilitate or reiterate systems working behaviours outlined in the original PHE guidance[1] helping EA sites transition towards a WSA and emphasising their importance to the implementation process.

For example, recommendations 9a and 9b *relate* to the systems working behaviour 'Using systems thinking' as they suggest ways to help stakeholders to start thinking about how they as individuals or organisations relate to the wider obesity system, a starting point for engaging in more in-depth system thinking. Recommendations 5e and 6a will help to *facilitate* 'Employing strategic learning' by making space and resource available for learning to be shared among EA sites. Finally, recommendations 3a and 8a *reiterate* the statements made under 'Establishing effective communication mechanisms' around the need to 'design a communication strategy'.

Where a recommendation relates to the development of systems working behaviour (as defined by the Public Health England (PHE) guidance) this is noted under the recommendation heading. The following detailed recommendations will be most accessible when read in conjunction with the PHE guidance or by those who are already familiar with it.

Public health in NI

NI public health structures differ significantly from England's, yet the implementation framework (PHE guidance) was based on the English model, leading to misalignments that had to be addressed by PHA and participating EA sites and which have been outlined

[1] Public Health England, 2019. Whole systems approach to obesity: A guide to support local approaches to promoting healthy weight. Pp 22-26.

in the evaluation data, **(see document 1a. Getting RREAL Briefing). The recommendations in this document should be considered based on the key differences between public health structures and responsibilities outlined below.**

In NI, the Department of Health (DoH) sets public health policy. The Public Health Agency works closely with the Department of Health, local Health and Social Care (HSC Trusts) and other partners including Councils, to improve and protect the health of the population in Northern Ireland. NI councils do not commission public health services, unlike English local authorities which have a ringfenced public health grant for this function. NI's approach is therefore more centralised, compared with England's place-based model.

NI councils have a statutory duty for Community Planning (also known at the Community Planning Partnerships), involving partners such as but not limited to PHA, Health and Social Care Trusts, Education Authority, Housing Executive, Sport NI, Libraries, and the voluntary/community sector. Partners must *jointly* agree and commit to deliver plans; councils have no mandate over partner organisations. EA councils embedded the WSA within their existing Community Planning structures and plans.

Community Planning Partnerships (CPP) are the closest NI equivalent to English Health and Wellbeing Boards, and their CPP plans—supported by PHA/DoH intelligence—approximate to English Joint Strategic Needs Assessments (JSNAs), though NI data is generally less comprehensive.

Differences also extend across other sectors relevant to the WSA, such as children's services, adult social care, and transport.

Glossary of key terms

Co-design	A form of public involvement that goes beyond consultation into active partnership but is often limited to the design phase of a project/service/programme/piece of research.
Community Planning Partnership	A group of sector representatives that address issues in a local area
Department of Health (DoH)	Sets the policy agenda for public health in Northern Ireland
Early Adopter (EA)	One of the three first councils in NI to implement a WSA.
Leadership Group for the WSA, based at each Early Adopter site (LG)	A small group of key individuals who drive the WSA work forward and where necessary, they will direct appropriate actions towards appropriate partners as applicable (e.g. Education Authority, Health and Social Care Trusts).
People with lived experience of overweight or obesity (PLE)	At the time of writing, this would include 65% of the adult population currently living in NI.
Public	Members of the general public who don't necessarily have direct or indirect experience of living with overweight or obesity and may or may not have an interest in it.

Public involvement	Collaborating with members of the public or people with lived experience to enable them to actively shape a programme, service, or piece of research. Co-design is a form of public involvement.
Public Health Agency (PHA)	Acts in both an oversight role for the WSA and members also sit in each EA site leadership group. Lead body for improving and protecting public health, overseen by Department of Health.
Public Health England (PHE)	Author of the WSA guidance being used by EA sites.
Regional Obesity Prevention Implementation Group (ROPIG)	Group of experts who provide oversight on obesity prevention work.
ROPIG Task and finish group for the WSA (ROPIG T&F)	Subgroup of ROPIG which provides regional oversight of the WSA work.
Voluntary, Community and Social Enterprise (VCSE)	Independent, non-profit, non-governmental organisations including charities, trusts, foundations and social enterprises. This could include organisations that represent people with lived experience of overweight or obesity or who use relevant services.
Whole Systems Approach (WSA)	Obesity prevention approach being implemented in NI.

Contents

.... 4

Regional recommendations 4

R1. Optimally situate the WSA 4

R2. Take your time with induction 5

R3. Communicate and be transparent 7

R4. Optimise financial and human resources 9

R5. Prepare tools, materials and processes 11

R6. Capturing and sharing learning 13

Local recommendations 15

L1. Prepare for implementation 15

L2. Optimise communication 16

L3. Generate commitment 18

L4. Enable valuable stakeholder contributions 20

L5. Strategically recruit and involve people with lived experience and the public 22

L6. Help facilitate a mindset shift 25

Regional recommendations

Regional-level recommendations are targeted at WSA stakeholders from departments or organisations working across NI already involved in the WSA work. For example, the Public Health Agency, Department of Health, ROPIG, ROPIG task and finish group, Sport NI, and third-sector organisations. However, it is acknowledged that some of these individuals may have both regional and local level remits and therefore local-level recommendations (see page 15) may also be relevant to them. A simplified infographic of regional recommendations is also available.

R1. Optimally situate the WSA

R1a. Embedding in local strategies (PRIORITY)

Linked to following systems working behaviours: Implementing appropriate governance structures

PHA and the DoH should continue existing good practice by:

- requesting that the local WSA is embedded into existing local governance structures (rather than create new ones) to gain immediate commitment from accountable and relevant partners e.g. Community Planning, Area Integrated Partnership Board plans, Integrated Care Boards
- embedding the WSA into strategic documents at a local and regional level e.g. the Healthy Futures obesity strategic framework.

Also consider further developing good practice by considering whether it's possible to seek other long-term strategies to embed the WSA into, even if funding may not be available for the full length of the strategy.

R1b. High-level ownership (PRIORITY)

Linked to following systems working behaviours: Undertaking collective action

Department of Health as well as other relevant NI executive departments such as the Department of Communities could develop their good practice further by considering whether it's possible to place the WSA at the highest strategic and structural levels possible, to generate comprehensive buy-in and collective efforts, and reap benefits across the widest possible system. Consider:

- highlighting that some of the drivers of obesity are also drivers of other departments' challenges e.g. more active travel could simultaneously support decarbonisation, and air quality targets or making food systems more sustainable can be achieved alongside improving the quality of people's diets
- embedding the requirement to engage with the WSA into policies and strategies with the widest possible reach and relevance to the range of stakeholders that are needed. For example, embedding the WSA in strategic documents in multiple government departments, beyond the Department of Health, such as the Department for Communities' sport and physical activity strategy, the food strategy, transport planning, housing planning, workforce

wellbeing, business and economic growth planning, sustainability and decarbonisation planning
- asking the Health Minister to champion the WSA to help generate buy-in from the top-down.

This should reduce interdepartmental competition for limited resources, avoid diluting messaging around obesity by keeping it at only a local level, encourage regional organisations to prioritise the work/meetings, as well as encourage early adopter sites to invest in the approach even if it does not generate revenue.

R2. Take your time with induction

R2a. Expression of interest and site readiness

PHA should continue their existing good practice of allowing early adopter sites to come on board in a voluntary capacity, using an expression of interest (EOI) approach. This enables sites to generate senior-level commitment for the WSA before implementation begins, which leadership groups can then use as building blocks for gaining more senior support during implementation.

Through this process, take the opportunity to start assessing a site's readiness. The PHA should continue their existing good practice of allowing time pre-implementation to ensure that the site is in a good state of readiness to avoid later delays or misunderstanding and inviting new/upcoming sites to the shared learning network meetings.

PHA could also develop their good practice further by considering:

- adding to their existing list of essential resources, made available to sites to review and respond to as part of the EOI. This could include items such as access to local data, Arc GIS system mapping software, the PHA progress tracker tool, guidance on appointment of staff, guidance or training on, or in-house availability of leadership around public involvement, and so on
- inviting relevant staff from new/upcoming sites to other site training opportunities
- creating and sharing videos of past early adopter sites describing their experiences
- sharing ways in which other early adopter sites have ensured that they had appropriate resources before commencing implementation e.g. finding funding for coordination staff

R2b. WSA training (PRIORITY)

The PHA and ROPIG T&F group should continue their existing good practice of offering funded WSA training as standard to early adopter sites but could also develop their good practice further by considering:

- who needs WSA training and at what stages of the process, making it clear what the purpose of training is at the invitation stage
- 'top-up' WSA training, to capture new staff or stakeholders
- continuous WSA training to enable learning and shifts in mindset to grow alongside progress through the phases and to capture new staff or stakeholders. Considerations include:
    - where not already implemented, whether training before each new phase could be useful to outline specific expectations, tools/materials and how they should be

used. This could also allow for identification and problem-solving of potential issues before they arise, both in general and caused by differences between local councils, leadership groups and ways of working
    - regularly revisiting the wider determinants of health and causes of obesity to help with the slow shift towards a system-thinking mindset[2]
- broadening WSA training to incorporate:
    - further in-depth exploration and understanding of systems thinking beyond what is already covered, and system behaviours (although it is acknowledged that this will also occur as part of phase 3, it could be beneficial to explore it earlier too)
    - a more significant introduction to the PHE guidance and its tools/materials as well as any bespoke tracking tools teams may be expected to use
    - an explanation of short- and medium-term goals, as well as long-term goals, of the WSA
    - an introduction to patient and public involvement (also see recommendation R2d)
- adopting the following practices to increase efficiency and build capacity at a regional level for WSA training
    - a library of tools/materials including but not limited to:
        - bitesize lessons/information
        - generic training videos (probably requiring one-off financial support from the Department of Health)[3]
            - viewing videos in advance of training can allow more time within workshops
        - a suite of materials, preferably in different formats to accommodate different learning styles, that can be circulated
        - 'homework' for teams to complete before/between training sessions to facilitate understanding
    - a train the trainer model to help reach more team members/stakeholders
- in-person sessions with councils, tailored to the local context from the beginning (as this was not reported to have occurred for all sites)

- use of credible and known experts and real-world examples of WSA implementation; this is likely to increase uptake of WSA training
- WSA training and 'top-ups' offered to people with lived experience/the public as well as other local and regional partners, so they can learn alongside teams, start to build relationships and therefore enable their long-term contribution to the WSA work.

R2c. Time for familiarisation (PRIORITY)

PHA could develop their good practice further by considering whether key members of early adopter sites (and new staff in PHA, ROPIG T&F) have sufficient time to familiarise themselves thoroughly with the PHE guidance, the iterative and cyclical process it proposes, and the materials, before implementation begins in earnest. Consider using the WSA training opportunities to support this process.

[2] Following the data collection period PHA informed the research team that the wider determinants of health had been reviewed at each phase by sites.

[3] Following the end of the data collection period, PHA reported that they are now seeking to get WSA experts to record training presentations that can be shared with early adopter sites.

PHA could also continue their good practice of using their bespoke progress tracker tool to ensure all team members are clear on key phases, steps and associated materials. However, it is important to emphasise that the WSA requires an iterative implementation process and therefore steps/phases may not be able to be 'checked off' on the tool definitively but it can capture what has been enacted during a step/phase.

R2d. Training for local and regional teams involving the public or people with lived experience

Linked to following systems working behaviours: Engaging communities in a WSA

Training could help allay uncertainties around how and when to involve the public in the WSA and allow leadership groups to align more closely with the PHE guidance by including public members earlier in the process[4]. PHA should continue their existing good practice of encouraging EA site 2 to continue integrating and piloting a co-design framework, but could also develop their good practice further by considering:

- if they could emphasise further to early adopter sites the importance of involving people with lived experience/the public in the WSA work
- if they could check as part of site readiness whether an early adopter site has access to training or support and expertise in public involvement and financial resources to deliver it, as sites are likely to vary in knowledge and existing public engagement structures. PHA could also consider signposting sites to national or regional resources such as The UK Standards for Public Involvement or opportunities in Northern Ireland for example: https://research.hscni.net/personal-and-public-involvement-training. Different generic training is also offered by various Universities or institutions (check with Queens University, Belfast, that hosts themed training, and Ulster University), typically targeted at researchers, this could be an initial starting point for those new to involving and engaging the public e.g. NIHR Cambridge Biomedical Research Centre (https://cambridgebrc.nihr.ac.uk/training-professional-development/for-our-researchers/online-ppi-training-for-researchers/)
    - preferably, if financial support can be accessed, creating bespoke training for local leadership groups, partners and stakeholders that can count towards their Continual Professional Development.

R3. Communicate and be transparent

R3a. Communication

Linked to following systems working behaviours: Establishing effective communication mechanisms

[4] The PHE guidance suggests that 'a pragmatic approach [to community involvement] would be to include VCSE organisations from the beginning and to identify additional community members and organisations as work develops' (pp 34) and on pp 36 it suggests that community representatives are part of the system network and will include participants from workshop 1 (phase 3) and workshop 2 (phase 4), However, it still primarily advocates for community involvement throughout the entire implementation process (see the systems behaviour 'Engaging communities in a whole systems approach' described on pp 25). As such, there is scope for community representatives such as PLE or members of the public to be consulted, invited to get involved or contribute to the WSA work from as early as phase 1 without waiting for an in-depth co-design process to be put in place.

PHA should continue their existing good practice of communicating regularly with local early adopter sites but could also develop their good practice further by considering:

- whether ongoing two-way communication with early adopter sites is in place throughout implementation, on expectations, estimated timelines, resource needs and resource availability, as these are likely to continue to evolve (e.g. staff changes at early adopter and regional sites are common and frequent)
- whether it could be helpful to discuss with early adopter sites any expectations around communication and also:
    - preferably creating a regional-level internal communication strategy and setting expectations for EA sites for a local communication strategy, and which can be used by early adopter sites to inform their strategies (see recommendation L2a) and enable a degree of consistency across sites, outlining details such as but not necessarily limited to:
        - any agreed/shared language required around the WSA that early adopter sites could use, preferably consulting with people with lived experience and the PHA communications team as required (e.g. will the term 'obesity' be used? Will there be an agreed regional name/brand for the work showing a unified approach?[5] How will people with lived experience be referred to?)
        - explaining complex terminology for different audiences at the regional level (e.g. what is a whole systems approach? what is systems thinking?)
        - key groups/audiences that regional partners will communicate with and any expectations around what sorts of audience's early adopter sites may need to communicate with
        - frequency of communications with regional-level audiences and with early adopter sites
        - mode of communication with regional-level audiences and early adopter sites (e.g. regular meetings, emails, via the shared learning network)
- and whether they will review the communication strategy at regular intervals (e.g. as new early adopter sites come on board or annually) to adapt to any challenges that may have arisen. This will enable early adopter sites and PHA to continue to work in sync with each other and avoid missed opportunities and wasted resources.

R3b. Transparency

Linked to following systems working behaviours: Developing a shared aspiration and vision

PHA, the ROPIG T&F group, and other regional organisations/departments supporting the WSA, should continue their existing good practice of having transparent communication about:

- the early and often the steep learning curve that both regional and local partners will experience by taking on a WSA and as such a new way of working, no matter how well trained or prepared teams are
- the fact that detailed understanding of the WSA and a change in mindset takes time, not only for local leadership groups, but also for those who they bring into the work either as stakeholders, to provide senior support, or for accountability purposes, and as such they

[5] Following data collection, in consultation with people with lived experience, one EA site reported that as of October 2025 their WSA is now named: 'Healthier Systems 4 Healthier Weight'

may want to repeat information regularly for partners (training materials could help with this task).
- the potential need for work to pause, change tack, or to adapt, throughout the implementation process, and that while this is not unusual as part of a WSA, clear leadership and regular communication/updates will be essential to maintain commitment, motivation and trustworthy relationships
    - PHA could also acknowledge that they understand that this process can therefore be challenging for EA sites, as they will be trying to maintain effective relationships with stakeholders to progress non-WSA work in addition to the WSA work.

They could also develop their good practice further by considering:

- whether greater us of continuous training opportunities (as outlined in recommendation R2b), alongside the shared learning network, could help reinforce expectations around the gradual pace of mindset change, as well as potential workload implications and implementation delays as delivery progresses.
- whether sharing existing evidence could be helpful to further demonstrate the slow rate of change, steep learning curve, workloads, and delays that frequently occur in WSAs[6].

R4. Optimise financial and human resources

R4a. Resource and capacity (PRIORITY)

Linked to following systems working behaviours: Creating an environment for change; Developing a shared aspiration and vision

PHA and the ROPIG T&F group could develop their good practice further by considering whether they can do more to identify any required human resources at both a local and regional level as early as possible. Additional financial resources may be required to meet local and regional needs, but this support could help demonstrate regional level commitment to the WSA[7]. Consider:

- seeking support from strategic levels both locally and regionally (e.g. from Department of Health) to ensure human resources are made available for the WSA
- transparent, needs based, consistent and equitable allocation of any regional-level financial resources to support human resources at the local level
    - but preferably consider allocating a budget to each local site to facilitate implementation

[6] For example, reviews and evaluations of WSA's conducted by Bagnall et al 2019 (Whole systems approaches to obesity and other complex public health challenges: a systematic review), Safefood, 2021 (Whole systems approach to childhood obesity: A review of the evidence), Public Health Scotland, 2022 (Whole systems approach (WSA) to diet and healthy weight: early adopters programme process evaluation) and the PHE guidance learning report, 2019 (Whole systems approach to obesity programme: Learning from co-producing and testing the guide and resources) all emphasise that heavy time-demands exist for WSAs and that sufficient time is needed to build relationships, capacity, collaborations, build familiarity with interventions and so on.

[7] PHIRST Connect do not have sufficient insight or knowledge of the funding structures in NI to advise on the source of additional financial resources, but it is worth noting that promising WSA's have required considerable investment E.g. Hawkes et al., 2017. What can be learned from the Amsterdam Healthy Weight programme to inform the policy response to obesity in England? Obesity Policy Research Unit: Rapid response briefing paper.

- suggesting to early adopter sites that they try to align gaps in staff workload with staff taking up the WSA (e.g. trying to align the end of one project with the start of the WSA)
- checking if all early adopter sites have access to an expert in systems mapping (Phase 3), administrative support (for day-to-day WSA support), a project coordinator preferably with public health expertise (for day-to-day WSA management), support for data collection or synthesis (Phase 2, e.g. PHA Health Intelligence team, local data analyst and Arc GIS expertise) and others depending on future phase/step requirements. This could be part of the site readiness assessment
- trying to secure at least one dedicated staff member in PHA to work on becoming an expert in the PHE guidance and its resources to offer detailed day-to-day support to local sites, make required adaptations and share learning. This person would act as a point-of-contact with local leadership groups to ensure consistency was maintained across local sites
    - but preferably, a small team of postholders as deemed appropriate by PHA (possibly an officer (£38-47k salary) or senior officer (£48-58k salary) role) as well as a dedicated team leader in PHA to avoid further procurement. Another option may be to have a dedicated resource sit within Community Planning in each local site, but they would need to connect to PHA to maintain consistency.

R4b. Regional partners

Through the Community Planning Partnerships, continue existing good practice of enabling and encouraging regional partners (e.g. PHA, ROPIG members, Sport NI as well as others) to sit in early adopter site teams, to reassure local leaders that the commitment to the WSA is held at the highest levels and to encourage them to commit to the WSA at the local level.

ROPIG should also continue existing good practice of having a representative from the local councils within their group to help members understand the local structures, such as Community Planning, where the WSA sits.

R4c. Promote an interdisciplinary approach

Linked to following systems working behaviours: Creating an environment for change; Having an appropriate mindset; Developing a shared aspiration and vision

PHA could develop their good practice further by considering whether it could be helpful to highlight the value of individual stakeholder expertise and contributions, and how they inform the WSA further, as well as the need for interdisciplinary approaches to encourage stakeholder rapport and subsequently improve joint-working. Consider:

- emphasising the importance of all skills during local workshops, and that one skillset is not going to solve the problem – akin to one individual-level intervention is not going to solve the obesity problem
- providing, or encouraging networking opportunities to take place for stakeholders and other system partners
- encouraging early adopter sites to set stakeholders small projects to collaborate on early on to build rapport and respect
- showcasing good practice by sharing case studies or local examples.

R5. Prepare tools, materials and processes

R5a. Agree acceptable levels of flexibility

Linked to following systems working behaviours: Implementing appropriate governance structures

While learning continues, the PHA could develop their good practice further by considering whether there is a level of flexibility in following the guidance that is feasible and appropriate for early adopter sites, and if/where there are hard boundaries where guidance/materials/tools must be followed exactly. A collaborative approach, in which both local early adopter sites and the PHA discuss the potential pros and cons of adhering to the guidance to a higher or lower degree, is preferable. Consider:

- different sites might need different degrees of flexibility due to capacity/financial resource, or the needs of their stakeholder groups who may, for example, find formal email templates alienating or inappropriate. Similarly, acknowledging that variations in size, geography and infrastructure of local sites may mean some steps may take more or less time, so flexibility in timelines may be required
- using the bespoke progress tracker tool **(see Adapted progress tracker tool to WSA to Obesity in Northern Ireland)** to highlight where guidance needs to be adhered to strictly by early adopter sites
- allowing for some flexibility in local workshop content in phase 2 (but this may be applicable to workshops in later phases too) where feasible, to avoid a 'product over process' approach to implementation which can result in stakeholders feeling that they are not contributing anything meaningful to the implementation decision-making process
- discussing and agreeing roles and responsibilities around workshops with early adopter sites and include explicit examples of who will lead what/when
- agreeing with early adopter sites on any boundaries that may need to be imposed on local team decisions, and why, from a regional perspective.

R5b. Support for generating buy-in

PHA could develop their good practice further by considering whether local leadership groups have sufficient support, information, and materials, to outline the relevant details of the WSA to key audiences to generate their commitment e.g. senior leaders who need to support the implementation and local or regional-level stakeholders who need to contribute to the implementation. Consider:

- ensuring that potential early adopter sites and key stakeholders are aware that the WSA is coming, as early as possible to generate interest; regularly providing small amounts of information about roles they will play, and promoting the potential benefits to build buy-in
- including an explanation of the need for a longer-term approach to tackling obesity, compared to shorter-term, individual-level approaches
- identifying short-, medium- and long-term outcomes (including examples) that can be used to help persuade audiences of the more immediate benefits of supporting the WSA
- as part of a communication strategy or library of resources, compile key information that can be shared with different audiences either by regional teams or early adopter sites seeking buy-in from local leaders (e.g. evidence for the WSA, case studies).

R5c. Adaptations (PRIORITY)

While being transparent with early adopter sites about the fact that the PHE guidance was developed for the English context, PHA should continue their existing good practice of acknowledging that this means adaptations will be required and no one delivery context will be the same as another, as well as identifying new adaptations as required as the three current early adopter sites continue implementation. They could also develop their good practice further by considering:

- whether it could be helpful to ask early adopter sites to determine if any adaptations are required to fit their local context early on in implementation and on a phase-by-phase basis
    - but preferably, where standardised adaptations to the tools or processes that might be needed for all early adopter sites have already been identified, PHA could make sure new sites are aware of and have access to them to prevent wasted resource (see recommendation R5e) before implementation begins, including reviewing any recommended tools for availability/accessibility and finding alternatives (e.g. Arc GIS is now the standard replacement for the SHAPE tool for asset mapping in phase 2 for the EA sites).

Where feasible, PHA should continue their existing good practice of advocating for early adopter sites to create and use digitised versions of materials when seeking contributions from stakeholders as this enables documents to be kept live (fitting with the cyclical and iterative nature of the WSA and see recommendation L4c) and allows for:

- ongoing contributions as new stakeholders come on board throughout the implementation process
- contributions to be collected from organisations/individuals who may need more reminders than others or who are unavailable during certain times
- easier document sharing with and between early adopter sites.

R5d. Pilot tools/materials

Where adaptations of materials occur, PHA could develop their good practice further by considering whether they can make time and space to pilot materials/tools, or ask EA sites to pilot them, before rolling them out. Piloting could include asking one or two end-users to use the adapted materials and provide feedback on how easy and accessible they are, and whether anything could be done to improve them before use.

R5e. Repository

Linked to following systems working behaviours: Employing strategic learning

PHA could develop their good practice further by considering whether and how they, or another organisation, could create a repository to share all adapted and other materials being used across local and regional teams to increase the efficiency of implementation. This may require seeking a new, widely accessible platform to host the materials to enable individuals from the variety of involved organisations to successfully access them

R5f. Data access

Phase 2 of the PHE guidance requires access and understanding of data around obesity and other related conditions or environmental factors in the target area. However, there is also scope for such data to be used as early as phase 1 to help motivate senior partners internally or externally to support and commit to the WSA. PHA should continue their existing good practice of seeking out routes to access good quality data for early adopter sites such as accessing local area profiles via the PHA Health Intelligence team, but PHA could also develop their good practice further by considering whether it would also be helpful to:

- seek support from other partners who may also collect data e.g. Sport NI, or ask sites if there are any useful local data controllers that it could be helpful for leadership groups to establish relationships with to expand their data profile (e.g. GP practices)
- signpost early adopter sites to relevant partners as early as possible so that data can be used by leadership groups to help make the case when generating commitment from local senior representatives during phase 1
- highlight the need for good quality data to early adopter sites early on, so they can seek routes to data via their own local connections or senior partners to expand their data profiles should they wish to. For example, further small-area data could help inform the choice of target area/population at the local level.
- where feasible, ensure regional or local-level data collection that occurs will be high quality. For example, this may require adapting current practices or increasing standardisation in measurement tools. This will improve the quality of the WSA in the longer-term but may require understanding and influence from the Department of Health to facilitate change.

R5g. Regional strategies

As the responsibility for public health sits primarily at a regional level within Northern Ireland, many regional level strategies will be relevant to the implementation of a WSA at the local level. To that end, to streamline phase 2 of the PHE guidance and the WSA more generally, PHA and the Department of Health, and beyond as applicable, should continue their existing good practice of collating and summarising any strategies that may be relevant to changing the obesogenic environment in NI (e.g. education, infrastructure, environment), keep this summary live, and regularly review it for new additions to be shared with early adopter sites and local partners.

This could also help generate buy-in and commitment as part of phases 1, 3 and beyond by helping regional and local stakeholders to understand the relevance of their role or organisation to the WSA, as well as highlighting how the WSA can meet the needs and priorities of others in the system.

R6. Capturing and sharing learning

R6a. Shared learning network (PRIORITY)

Linked to following systems working behaviours: Employing strategic learning

PHA should continue their existing good practice of facilitating and maintaining a cross-leadership group shared learning network among the early adopter sites, but could also develop their good practice further by considering:

- making space for open discussions of barriers and challenges as well as enablers for implementation within the shared learning network
- letting early adopter sites take the lead within the network meetings or set a precedent for site updates and sharing of the barriers and enablers they have experienced. This could be via shared responsibility for the agenda between PHA and EA sites and a standing agenda item of brief 5–10-minute updates from each early adopter site
- encouraging shared problem solving of barriers among the early adopter sites and PHA within the shared learning network meetings while acknowledging that solutions may not be one-size-fits-all due to site differences. Therefore, further adaptations and discussion may be required but could begin within the network meeting
- inviting people with lived experience or members of the public from sites into this space to further support learning and problem solving of presented barriers
- providing more notice for shared learning network meetings, perhaps by arranging the meetings for an entire year-long period up-front, to ensure early adopter sites can prepare to share their learning
- creating 'testimonial' videos with active early adopter sites to share their learning and top tips, to facilitate later sites learning as well as boosting motivation for new sites to come on board and increasing site readiness. These could be stored in a shared repository (see recommendation R5e) as part of a library of tools/materials for the WSA in NI, and/or incorporated into communication plans (see recommendation R3a).

R6b. Capture learning and additional impact

Linked to following systems working behaviours: Employing strategic learning

PHA, the ROPIG T&F group, and other regional-level stakeholders, could develop their good practice further by considering whether it could be helpful to devise a method to capture learning around the implementation, both at the local and regional levels, to inform subsequent evaluations, resourcing needs, and capacity building endeavours. Due to the complexity of the WSA implementation process and what it requires, a variety of additional changes, both positive and unintended, may occur. For example, existing local and regional structures, procedures and ways of working may change overtime due to the WSA. These changes demonstrate how the WSA can add value beyond its intended use for obesity prevention and so it could be beneficial to share them when seeking support. Consider:

- using the progress tracker tool **(see Adapted progress tracker tool to WSA to Obesity in Northern Ireland)** to capture learning at each phase or step of the implementation process quickly and easily. This can be done by both PHA and early adopter sites, with data collated at regular intervals
- creating an 'impact tracker' form or something similar to capture any additional impact, outside of obesity and its related behaviours, that the implementation might be having
- reviewing resource needs regularly and monitoring resource use at local and regional levels, capturing physical, financial and human resources. This could be a standing agenda item at the shared learning network for example and inform improved resourcing for future sites.

Local recommendations

Local-level recommendations are targeted at WSA stakeholders from smaller area-specific organisations, groups and councils (or EA sites) in NI already involved in the WSA work. For example, the leadership groups, the WSA working or system network groups which could include representatives from Community Planning Partnerships, third-sector organisations, Health and Social Care Trusts, and other local partners. However, it is acknowledged that some of these individuals may have both regional and local-level remits and therefore regional-level recommendations (see pp 4-14) may also be relevant to them. A simplified infographic of local recommendations is also available.

L1. Prepare for implementation

L1a. Resource and capacity

Linked to following systems working behaviours: Creating an environment for change

Early adopter sites should continue their existing good practice of identifying any human, physical (e.g. venue for workshops), financial (e.g. creating workshop materials) or skill-based (e.g. training around public involvement) resource requirements at the local level as early as possible. Where feasible they could develop their good practice further by considering if they could:

- ensure existing local staff have capacity (this may require reaching out to senior managers), try to align the start of implementation with the close of other work which may free up some staff capacity and allow the WSA to become a priority. Alternatively, try and identify if and where other work may become obsolete with the introduction of the WSA and use this to make the case to secure key staff capacity for the WSA
- check if there is any associated resource allowance available via Community Planning as the WSA sits under this structure
- identify or seek in-house administrative support for day-to-day WSA support (e.g. is there an administrative assistant that can be shared by another team?), a project coordinator preferably with public health expertise for day-to-day WSA management (e.g. are there any local PHA officers that could have their work redirected to the WSA?), support for data collection or synthesis (Phase 2, e.g. is there a local data analyst and/or someone with Arc GIS expertise?), and others (e.g. communications or marketing expertise for reaching or maintaining engagement with stakeholders or the public and capacity for involving people with lived experience/the public), depending on phase/step requirements. Although it is acknowledged that no two sites will be the same in terms of their available in-house resources
- where existing in-house human resource is not available, consider seeking joint funding from regional partners such as but not limited to PHA or local partners such as Health and Care Trusts, to recruit to new roles. Consider:
    - making the case that appropriate resources will enable WSA goals to be met and help to maintain timelines, and that providing funding for additional human resource should positively influence all partners in the system
    - seeking funding partners (e.g. PHA, HSCT, Sport NI, third-sector organisations) that may have priorities that align with the WSA and therefore offering a new route for their objectives to be met (e.g. tackling health inequalities)

    - sharing when funding is provided by other partners as this will demonstrate that local funders are taking the WSA seriously and it could encourage other funders to contribute (e.g. in shared learning networks, council meetings, WSA stakeholder meetings or events)
- keep track of resource needs and use to share your learning with future local sites and regional partners, e.g. using a progress tracker tool **(see Adapted progress tracker tool to WSA to Obesity in Northern Ireland)**, to enable better resourcing in future (see recommendation R6b).

L1b. Leadership group membership

Linked to following systems working behaviours: Developing a shared aspiration and vision

When considering leaders for the local leadership group or for wider support, early adopter sites should continue their existing good practice of seeking out those who are well-connected in their local council, passionate, influential and who can facilitate further buy-in for the WSA. They could develop their good practice further by considering if they could:

- include a trusted/established member of the public or person with lived experience or someone who can represent people with lived experience within the leadership group
- enable leadership groups to establish rapport, for example by holding in-person rather than online meetings. This may require ensuring all members can commit to these, as in-person meetings may put pressure on representatives who struggle to travel. Groups could aim for a mix of hybrid and in-person meetings, following initial in-person meetings to begin building rapport
- establish ways of working among the leadership group early on such as defining roles and responsibilities
- ensure shared understanding of the WSA, the PHE guidance and the WSA goals among the leadership group. For example, early adopter sites could advocate for wider local attendance at WSA training, the leadership group could review the PHE guidance and materials together and ask different team members to explain different sections to the rest of the group, helping to surface any misunderstandings
- ensure accountability within the leadership group, e.g. by using the progress tracker **(see Adapted progress tracker tool to WSA to Obesity in Northern Ireland)** and assigning tasks to members and revisiting the tracker at regular meetings.

L2. Optimise communication

L2a. Communication

Linked to following systems working behaviours: Establishing effective communication mechanisms

Local leadership groups could develop their good practice further by considering whether creating a local communication strategy (informed by the regional-level communication strategy, see recommendation R3a) would help to ensure local team members, partners, stakeholders and people with lived experience/public members can maintain and build on their understanding of the complex approach over time. Consider:

- informing potential members of the local team that the WSA is coming and its benefits, and suggesting roles they may play, to help begin generating interest and facilitate buy-in,
- agreeing frequency of communications and modes of delivery between the leadership group and stakeholders/partners and between early adopter sites and people with lived experience/ public. This could be especially valuable for maintaining engagement and good working relationships if there are periods of time when their direct input is not needed (e.g. newsletters or digest emails for stakeholders or senior leaders in between in-person workshops/meetings)
    - but preferably, using the regional communication strategy where available (see recommendation R3a), to provide information on key elements, such as language around the WSA and obesity, (e.g. how to refer to those with lived experience of overweight/obesity, any agreed terminology to explain what a WSA is, or any agreed names for the local WSA)[8]
    - and preferably, mapping out different key audiences, stakeholders, partners and people with lived experience/public and consider any tailoring that communications to these groups might need, making the plan 'localised' (e.g. language adjustments, groups-specific 'hooks' to maintain their interest etc.)
- managing expectations around interim communications to avoid stakeholders disengaging overtime and to ensure they are ready to re-engage when needed
- committing to regular upstream communication with regional partners and other early adopter sites to facilitate learning and problem-solving (e.g. by contributing to shared learning network sessions.)

L2b. Tailor communications

Linked to following systems working behaviours: Establishing effective communication mechanisms

Local leadership and working groups should continue their existing good practice of using a variety of approaches to communicate with local partners, stakeholders and people with lived experience/the public depending on whether established relationships already exist (e.g. formal/informal, presentations, newsletter, emails, discussions). This might mean existing materials from the PHE guidance may not be appropriate in all instances, such as formal email templates. (Also, see recommendation L4b.)

L2c. Transparent governance structures

Linked to following systems working behaviours: Developing a shared aspiration and vision; Implementing appropriate governance structures

Local leadership groups should continue their existing good practice of sharing proposed governance structures with partners and stakeholders in workshops to ensure commitment and agreement, and to promote a broad understanding of roles/remits. This allows for transparency around accountability and for any gaps to be identified in key stakeholders.

[8] Following data collection, in consultation with people with lived experience, one site reported that as of October 2025 their WSA is now named: 'Healthier Systems 4 Healthier Weight'

L2d. Openness and honesty

Linked to following systems working behaviours: Developing a shared aspiration and vision; Employing strategic learning

Leadership groups, PHA staff, and stakeholders at all levels, are all partners in the WSA implementation process, and everyone is experiencing a learning curve around WSAs. Therefore, early adopter sites could develop their good practice further by considering whether there is a safe space where they can openly and honestly share their challenges and frustrations as well as successes. Consider:

- committing to raising all queries or concerns in shared learning networks or other meetings with other local and regional teams
- encouraging and making space for stakeholders (including people with lived experience/public contributors) to raise all queries or concerns in workshops or other stakeholder activities/events
- model this behaviour by also being open and honest with stakeholders (including people with lived experience/public contributors) in workshops or at other stakeholder activities/events.

L3. Generate commitment

L3a. Identify partner needs

Linked to following systems working behaviours: Creating an environment for change; Undertaking collective action; Using systems thinking

Early adopter sites could develop their good practice further by considering whether they have a good understanding of stakeholder needs and priorities to help generate their commitment for the WSA. Several potential approaches could be taken, some requiring specialist support from local government. Consider:

- spending time early on, to facilitate phase 1 and beyond, to understand how the WSA will meet the needs or priorities of potential system partners across different sectors. E.g. consider using the mapped regional strategies to identify where the WSA can address commitments/challenges/priorities (see recommendation R5g)
- being open to compromise, especially with businesses who may be concerned about the impact on their revenue and profit margins
- explaining how a healthy society can benefit business revenues by offering more choices to their customers and by identifying whether businesses have social responsibility commitments which the WSA could help them fulfil, therefore generating further support for the WSA from their customer base
    - but preferably, identifying whether local government partners can offer incentives for businesses to engage with the WSA e.g. offering 'health' credentials which allow for additional promotional benefits for their business via the WSA programme[9]; or offering reductions in local business rates if they engage with the WSA and are seen

[9] For example, see the Herts Responsible Food Award: https://www.hertfordshire.gov.uk/services/health-in-herts/herts-responsible-food-award/herts-responsible-food-award.aspx

to be taking actions that align with the programme. Public contributors could help with designing such incentives.

L3b. Communicate stakeholder 'fit' (PRIORITY)

Linked to following systems working behaviours: Creating an environment for change; Undertaking collective action; Using systems thinking

Early adopter sites could develop their good practice further by considering whether they understand why different stakeholders are relevant to the WSA and are being invited to contribute, particularly if they sit outside of the health sector (e.g. Education, Social Work, Community, food networks, Sport NI, debt advice, local growth partnerships and the private sector). They should communicate this understanding to stakeholders to ensure both their uptake and their ability to meaningfully and effectively contribute. Consider:

- identifying what the unique selling point of the WSA is for individual stakeholders (could be informed by work done for recommendation L3a)
- where feasible, have informal/preparatory recruitment discussions or conduct preparatory work with such stakeholders to raise their awareness prior to workshops to establish how their work/goals relate to the WSA before they formally engage
- in workshops or other stakeholder events, showing stakeholders where they sit in the obesity system (e.g. using visuals) and where their contributions may be particularly important amongst the phases and steps of PHE guidance, adapting PHE materials accordingly for those who may be less aware of what role their work may play in the obesity system
- ensuring regional oversight teams (e.g. ROPIG task and finish group) have a clear understanding of their role within local sites, including what role they play when in direct contact with stakeholders and early adopter sites in workshops. For example, are they advisors or stakeholders and therefore, what is expected of them in terms of their contributions to events?
- emphasising that as the WSA sits under Community Planning, the WSA is the responsibility of multiple sectors and organisations, not just health.

L3c. Strategic and early recruitment of stakeholders (PRIORITY)

Local leadership groups should continue their existing good practice of being responsible for compiling stakeholder lists as they have the best understanding of local context. They could also consider:

- ensuring that invitations to engage with the WSA appear credible. This could be by establishing rapport with stakeholders, meaning that initial overtures must occur prior to invites along with an explanation of how the work relates to an invitee's role
- ensuring methods of identifying and recruiting new stakeholders are GDPR compliant (e.g. Phase 2, Step 4 Network analysis, resource G from PHE guidance is no longer appropriate).

They should also continue their existing good practice by using a snowball recruitment approach where known stakeholders are recruited first and then expanding to unknown stakeholders, but could develop their good practice further by considering whether they could cast a wider net when recruiting stakeholders from the very start by:

- performing stakeholder mapping sooner than phase 2 to better inform recruitment (and the stakeholder recruitment plan, see next point), with the understanding that this could be challenging as leadership groups need to familiarise themselves with the PHE guidance before explaining it to new stakeholders
- planning out stakeholder recruitment, and engagement timelines to ensure a strategic approach (e.g. creating a Gantt chart or bespoke Engagement Planner could help keep track of what teams should be doing when, along with estimated time for planned engagement activities)
- using a personal approach, through existing connections, to reach new stakeholders where feasible and be clear about the ask to ensure the right people attend and can prepare
- engaging with umbrella bodies (one site is already doing this) to maintain breadth of representation (e.g. GP Federation, Education) and asking them to discuss key topics with their clients and feedback to the leadership group
- drawing on support from senior leaders to identify and engage with key local or regional stakeholders and work to generate understanding of the players in the wider system, outside of health
- establishing connections with hard-to-reach sectors e.g. private sector and industry, via organisations or connections such as the Chamber of Commerce, Business Boards, through functions provided by the council, or by Business Support Networks
    - See recommendations L3a and L3b and think about 'what's in it for them' and how you can persuade them of the benefits to them of engaging in this work
- establishing connections with sectors and organisations focused on children and young people as long-term users of the system
- being transparent with stakeholders about recruitment lists and attempts to engage with system stakeholders, to reassure them that the net is being spread wide, and to help them to accurately identify gaps
- establishing a commitment from key regional organisations early and outlining expectations such as whether they need to attend any/all workshops (e.g. Sport NI, Education sector, transport.)

L3d. Seek local data early

Linked to following systems working behaviours: Creating an environment for change

While identifying relevant local data on obesity in phase 2 will also enable baseline assessment of a site's starting point and eventual monitoring of progress and outcomes, leadership groups could also use such data to help demonstrate the need for the WSA and generate buy-in from senior accountable officers and stakeholders during phases 1 and 2. Therefore, local leadership groups could develop their good practice further by considering what data there is on levels of obesity earlier than phase 2. The more localised the data the better it will be for understanding some of the highest priority communities in the locality which may be helpful at the action planning phase.

L4. Enable valuable stakeholder contributions

L4a. Stakeholder contributions (PRIORITY)

Linked to following systems working behaviours: Employing strategic learning; Developing a shared aspiration and vision

Local leadership groups could develop their good practice further by considering whether they have created a sufficiently safe environment with ample opportunities for stakeholders to contribute in meaningful ways during activities/workshops and where they can see how their contributions are informing the direction of travel, by:

- where feasible, consistently inviting the same people and delivering events in person rather than online so stakeholders can build relationships with the group, learn from each other and subsequently build their confidence to contribute, (incentivising attendance via Continuing Professional Development credits for staff where feasible could help with consistent attendance rates)
- embedding trust and rapport-building into any stakeholder engagement
- demonstrating outputs of stakeholder activities e.g. showing results of mapping exercises,
- creating a safe environment for: Q&A sessions, discussions among stakeholders around activities and their experiences, discussions between stakeholders and presenters, and for stakeholder contributions
    - ensuring a good balance between time for the above discussions and number of presentations e.g. sending some information out beforehand could help ensure in-workshop time for discussions
- being transparent with stakeholders and ensuring that any information shared with them is consistent and accessible
- enabling contributions/discussions from a range of stakeholders by creating a variety of opportunities to meet different needs/preferences e.g. a mix of large and smaller group discussion opportunities, tools and technology that allow for online and/or anonymous contributions such as Miro or Mentimeter during or post-event
- ensuring there are interactive elements to workshops where stakeholders can see how their contributions are informing the next steps.

L4b. Workshops (PRIORITY)

Local leadership groups should continue their existing good practice of running workshops for phase 2 tasks and activities. However, they could develop their good practice further by considering if they could adapt phase 2 workshops as well as future workshops, as follows, where staff capacity allows:

- send out invites with at least one months' notice period to ensure availability of stakeholders
- provide clear information on the purpose of workshops to stakeholders, ensuring that agendas that are sent out in advance that map on to what happens in workshops
- run more than two phase 2 workshops, splitting different tasks across them to avoid confusion over complex and lengthy tasks that can't be completed in one sitting, e.g. one for action mapping, one for asset mapping, one for results of these tasks and opportunities for further items to be mapped if missing. Alternatively, but perhaps less feasible, consider extending the duration of workshops
- try to minimise time between workshops to retain momentum
- ask stakeholders to do preparatory work to progress work further within workshops or create subgroups to progress work further between workshops. The latter could also allow for those with specific expertise to contribute in a more effective manner relative to their

knowledge and expertise levels (this would require explicit outlining of needs to ensure the right expertise is identified)

- situate the workshop activities within the wider WSA work and context by:
    - including recaps of the 'big picture', aims, short-, medium- and long-term goals, the implementation process, and progress and status against phases/steps, and what has happened between workshops as well as recapping key concepts. Stakeholders may struggle to re-embed themselves in the work if there have been large gaps between workshops, plus they have multiple competing priorities meaning that the WSA will only be one of many pieces of work they are involved in. Summary videos could help
    - explaining how and where different tasks and their outcomes fit into the WSA process and inform its implementation
    - continuously relating content/process to the local context and picture – this can also help stakeholders better identify relevant additional stakeholders to engage with
- tailor workshops/content to various levels of knowledge, and to account for different styles of learning, to ensure breadth of understanding across different stakeholders, e.g. visual representation as well as discussions can help, as can accessible rather than technical language
- schedule sufficient time to demonstrate results of mapping exercises, to ensure stakeholders can fully appreciate functionality and purpose
- use workshops to start the 'slow drip' process of teaching stakeholders about the WSA and how different elements will 'fit together' and to progress the transition to systems thinking (see recommendation L6a).

L4c. Live documents/activities

While practically this could be challenging, local leadership groups should continue their existing good practice of keeping all documents and activities 'live' for as long as possible and consider their completion as an ongoing iterative process. New stakeholders will come on board at various points in the implementation process and it could be valuable to revisit various activities with them e.g. asset mapping. Using digital versions of documents could help maintain live documents over time and allow stakeholder contributions throughout the implementation process and beyond.

L5. Strategically recruit and involve people with lived experience and the public

L5a. Methods of engaging/involving people with lived experience and/or public

Linked to following systems working behaviours: Engaging communities in a WSA

Where available, local leadership groups should continue their existing good practice of looking for and drawing on existing local public consultation routes provided under the council or other partner organisations to purposefully involve people with lived experience of overweight or obesity, or the public, in the WSA.

However, early adopter sites should be wary of relying purely on existing routes that might result in consulting the same people repeatedly or excluding certain groups due to differing accessibility needs. It could be helpful to ask any of your partners that work in local Universities to see how they ensure diverse recruitment of public contributors to their research projects.

Third sector organisations that work with specific populations and hold their trust, can often be a good way to reach under heard groups and involve them, including any organisations that host community health champions or people working in similar roles.

Finally, national recruitment platforms also exist where you can advertise your requirements for public contributors e.g. https://www.peopleinresearch.org/

L5b. Purposefully involve and engage people with lived experience/public early

Linked to following systems working behaviours: Engaging communities in a WSA; Developing a shared aspiration and vision

Local leadership groups and WSA working groups could develop their good practice further by considering how to strengthen their alignment with the PHE guidance[10] and exploring how to purposefully involve people with lived experience or members public from the outset (who to involve will depend on needs/purpose of their involvement as identified by leadership groups and may include people of healthy weight too, if deemed helpful). The underlying principle should be that those who are involved do not have to be 'perfect' representatives, but that any public involvement will be preferable to none[11]. Consider:

- whether Community Planning VCSE representatives could help support access to and consultation with people with lived experience
- what role representatives will play, what time commitment and resource this may entail for them, and what will be required of them and making this clear to any potential representative you wish to involve e.g. via an induction process if necessary
- whether representatives may require any training to be able to meaningfully and effectively contribute (e.g. training to better understand what type of contributions the leadership team are looking for, how to make contributions using technology if needed, information about the WSA and what it is and what boundaries there are to manage expectations following contributions or suggestions from these representatives)
    - however also consider whether people with lived experience/public members need to have a full breadth of understanding of the WSA (and also communicating that this level of understanding is not required when recruiting them if this is the case), or if a partial understanding to fit the needs of the project and to facilitate their

[10] The PHE guidance suggests that 'a pragmatic approach [to community involvement] would be to include VCSE organisations from the beginning and to identify additional community members and organisations as work develops' (pp 34) and on pp 36 it suggests that community representatives are part of the system network and will include participants from workshop 1 (phase 3) and workshop 2 (phase 4), However, it still primarily advocates for community involvement throughout the entire implementation process (see the systems behaviour 'Engaging communities in a whole systems approach' described on pp 25). As such, there is scope for community representatives such as PLE or members of the public to be consulted, invited to get involved or contribute to the WSA work from as early as phase 1 without waiting for an in-depth co-design process to be put in place.

[11] PHIRST Connect acknowledges that professional stakeholders were also asked to contribute to phase 2 workshops in an additional capacity of having lived experience of being overweight or obese, if applicable, however sites can go further by inviting individuals for the sole purpose of sharing their lived experience.

ability to contribute is more appropriate. This could reduce the chances of people with lived experience/public members feeling overwhelmed by information, as well as reducing the capacity required from early adopter sites to involve public members.

- tasks or discussions that people with lived experience/public members could be involved in before phase 3, and preferably from the very start of implementation, to allow their knowledge and understanding of both the WSA and public health to begin to develop, could include:
    - exploration and understanding of the WSA, how it will fit with service development or council priorities and ways of working and what benefits could be accrued or should be sought by taking up a WSA
    - language or naming issues for the work
    - ways to tackle push-back from local industry or commercial organisations in the system
    - creating a lay summary of what a WSA is to help explain it to future people with lived experience/public stakeholders
    - providing insights into the local context
    - identifying other key people with lived experience/public groups who could help with physical and skill-based asset and hazard mapping
    - help design and send invites to other relevant people with lived experience/public organisations and individuals who teams may wish to engage
- identifying any existing connections with umbrella bodies or groups who have access to target groups. Group leads could take specific discussion points/questions to these groups and feedback the results to leadership groups, or leadership groups could attend existing group meetings to discuss concerns in person. This could help reduce any perceived power imbalances
- recruiting from general members of the public rather than only targeting people with lived experience of obesity, to reduce the chances of recruits feeling stigmatised, as well as recruiting or consulting children and younger people as applicable, as they will be the longer-term beneficiaries of changes achieved in the obesity system
- varying the approach to engaging with the people with lived experience/public to fit the needs of the work and those offering their time e.g. one-off engagement with specific groups or representatives as needed versus long-term engagement with individuals who may be able to champion the work overtime, within key target groups
    - with a mixture of the two based on short and long-term project needs probably the most preferable
- starting early to begin building effective working relationships with any groups you may wish to continue engaging with as the implementation continues. This can help build people with lived experience/public members' confidence to contribute as well as the early adopter sites' confidence about the value of the contributions they are receiving
- meeting the people with lived experience/public where they feel comfortable and at venues which they can easily access, (e.g. in community settings). Alternatively, or as well, provide online or hybrid options and/or offer to cover travel costs to ensure events are more accessible to members of the people with lived experience/public who may struggle to attend events in person for a variety of reasons
- adapting any content and mode of delivery to fit their knowledge levels, accessibility needs or preferences e.g. providing accessible materials such a videos or informally worded

explanations or questions before events can enable contributions, providing anonymous or post-event feedback opportunities
- appointing someone to support them at in-person events e.g. having a pre-meet with them to prepare them for the meeting, meeting them at the door on the day, introducing them to others, and then having a debrief with them after the event. This could help people with lived experience/public members feel comfortable, confident and able to contribute
- where appropriate, include people with lived experience/public representatives on event agendas. Not only can this help to demonstrate the value of the WSA for the public, but could also further encourage the public to attend as they can see people like themselves already included in the work
- ensuring a 'you said, we did' feedback process for people with lived experience/public to demonstrate how their contributions have been incorporated, and to build and maintain trust (e.g. see guidance on giving feedback to public contributors here: https://arc-eoe.nihr.ac.uk/sites/default/files/documents/Guidance-for-Researchers-PPI-Feedback_2018.pdf)

L6. Help facilitate a mindset shift

L6a. Shifting mindsets

Linked to following systems working behaviours: Using systems thinking

Local leadership groups should continue their existing good practice of reviewing and revisiting the wider causes of obesity (e.g. using appendix A, in resource E) at regular intervals both within leadership groups and with stakeholders. This helps to generate the shift in mindset from individual-level approaches to the system-based approach to obesity prevention. They could develop their good practice further by considering:

- whether it could be helpful to feature the wider causes regularly in workshops as part of scene-setting or recaps to ground the attendees before activities begin, e.g. showing the visual representation of the wider causes of obesity mapped to actions[12]
- whether it could be helpful to revisit the wider causes in regular meetings of the leadership group,
- whether it could be helpful to include the wider causes in any materials used to generate buy-in or when presenting the WSA work.

For further information or to ask a question about these recommendations, please contact the PHIRST Connect Research team at phirst@herts.ac.uk

[12] Following data collection, PHA did report that the wider causes of obesity were revisited and reviewed with sites at regular intervals.