A Realistic Evaluation of an NHS Community Weight Management Programme

MSc Public Health Nutrition

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Abstract

Introduction:

The “Lose Weight, Feel Great” (LWFG) pathway was commissioned by NHS Ashton, Leigh & Wigan with the aim to reduce the rising tide of obesity within the Wigan Borough (Hogg et al. 2010). The Community Weight Management Programme (CWMP) is one of the services offered and involves dietary advice, physical activity sessions and methods for behavioural change. Approximately 35% of service users are successful at losing 5% or more of their initial body weight; however other service users are not as successful. The aim of this dissertation was to understand the context and mechanisms which may facilitate or impede success.

Method:

Following a framework of Realistic Evaluation (Pawson & Tilley, 1997), 25 semi-structured telephone interviews where undertaken with people who had previously accessed CWMP. The interviews where transcribed verbatim and then analysed using Thematic Analysis to identify common themes (Howitt & Cramer, 2007).

Findings:

Seven Themes emerged from the interviews. Four themes related to mechanisms of CWMP, two themes related to contexts surrounding CWMP and one theme related to outcomes from CWMP.

Mechanisms involved:

- Group sessions
- Slimming World consultant & Wigan Leisure Culture Trust activity officers
- Physical activity sessions
- The Slimming World Eating Plans

Contexts involved:

- The Healthy Foundations Segmentation Model
- Motivation & Readiness to Change

Outcome:

- Change in Lifestyle

Conclusion:

Changes could be made to CWMP, such as increasing the number of free sessions, offer other LWFG services if CWMP does not appear to be appropriate, and provide more extensive information during the induction sessions. However, it is also important to take into account people's motivation to change, the segment that they may fit into and that changes to lifestyle are not just limited to the service users, but also family members. Changes to the programme will improve success rate and ensure that resources are used effectively.

Declaration of Original Work:

I hereby declare that the work contained here within is original and is entirely my own unless otherwise stated. It has not previously been submitted to support another degree, qualification, or other course.

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List of Abbreviations:

Abbreviation	Full Title
APHO	Association of Public Health Observatories
BC	Balanced Compensator
CWMP	Community Weight Management Programme
DAD	Dietary Advice Direct
DH	Department of Health
DOM	Dietitian in Obesity Management
FSA	Food Standards Agency
HCR	Health Conscious Realist
HI	Hedonistic Immortal
HSE	Health Survey for England
HT	Health Trainer
KTP	Knowledge Transfer Partnership
LfT	Live for Today
LREC	Local Research Ethics Committee
LWFG	Lose Weight, Feel Great
NHS ALW	NHS Ashton Leigh & Wigan
NHSD	NHS Direct
NHS GG	NHS Greater Glasgow & Clyde
NICE	The National Institute for health and Clinical Excellence
NOO	National Obesity Observatory
NRES	National Research Ethics Service
PA	Physical Activity

PIS	Participant Information Sheet
RCT	Randomised Control Trial
RE	Realistic Evaluation
SIGN	The Scottish Intercollegiate Guidance Network
SW	Slimming World
SWMS	Specialist Weight Management Service
UCLan	University of Central Lancashire
UF	Unconfident Fatalist
WHO	World Health Organisation
WLCT	Wigan Leisure & Culture Trust

"Our ambition is to be the first major nation to reverse the rising tide of obesity and overweight in the population . . ."

– HM Government, 'Healthy Weight, Healthy Lives – A Cross Government Strategy for England' (2008)

Chapter One:

Introduction

Lose Weight, Feel Great

It has been estimated that the level of obesity within the Wigan Borough is 26.5% in the adult population, whilst the England average is 24.2% (APHO & DH, 2010). NHS Ashton, Leigh & Wigan (NHS ALW) quickly realised that the levels of overweight & obesity would not reduce on their own and therefore invested in a fully integrated weight management pathway for three years.

NHS ALW aimed to produce a pathway that would not only treat but also prevent obesity; that would provide long term help and support; and that would include physical activity and not just dietary advice to promote healthier lifestyle choices.

The pathway was launched in January 2009 and is available to all adults aged 18 years or over. Lose Weight Feel Great (LWFG) involves a multi disciplinary team working across the Wigan Borough, mainly within community settings. The day to day running of LWFG is now being overseen by the Obesity Commissioning Team within the Public Health Department at NHS ALW.

LWFG is a free pathway that consists of five options:

- Specialist Weight Management Services (SWMS) for those with a BMI ≥40 kg/m² or 35 kg/m² with co-morbidities. This service offers 6 months of intensive support followed by a further 18 months of support.
- A Community Weight Management Programme (CWMP) for those with a BMI 25 – 40 kg/m². This service runs for 12 weeks and involves dietary advice, behavioural change techniques and physical activity sessions.
- Dietary Advice Direct (DAD) is another option which is offered to those with a BMI 25 - 40 kg/m². DAD is a website that is run by dietitians and provides up to date advice about diet and physical activity.
- The Health Trainer (HT) service is another option available for those with a BMI 25 - 40 kg/m². The HT's provide a completely person centred approach and therefore the service user has the choice in what they want to discuss, which is often weight management techniques; although other subjects, such as smoking cessation, may also be included.
- The LWFG website is available for anyone with a BMI below 25 kg/m² and provides information on dietary change, physical activity and behavioural modification (accessed at www.lwfg.co.uk).

Referral can come from a medical practitioner or via self-referral using a specific phone line which is answered by NHS Direct (NHSD), who then forwards the person to the most appropriate service.

Community Weight Management Programme

CWMP consists of a team from Wigan Leisure and Culture Trust (WLCT), and also a team from Slimming World (SW) who have joined together to provide a bespoke programme that incorporates dietary advice, physical activity and behaviour change. This approach is in line with the Obesity Guideline 43 from the National Institute for Health and Clinical Excellence (NICE, 2006). The sessions last for 12 weeks and involve 45 minutes of dietary advice and behaviour change, and then 45 minutes of tailored physical activity sessions. The physical activity sessions are varied every week and consist or aerobics, circuits, or walking sessions. SW provide the option of two different eating plans (SW, 2010); the "Red (original) and Green" Plan; which concentrates on protein or carbohydrate, and the "Extra Easy" Plan; which is in line with recommendations from the "Eatwell Plate", (Food Standards Agency, 2008). This aims to offer flexibility to those attending CWMP. Those who attend CWMP are provided with IMAGE therapy[1] after they have been weighed so that people are able to discuss their progress from the previous week (SW, 2010).

[1] IMAGE therapy stands for Individual Motivation and Group Support.

In order to complete the programme, 9 out of 12 sessions of both the physical activity and dietary advice session have to be attended. There are over 30 venues throughout the borough and 70% of the sessions occur out of hours (i.e. after 5pm at night). This is to ensure that the programme is as convenient and accessible as possible.

The "Lose Weight, Feel Great" Evaluation

The whole LWFG pathway is currently being evaluated using the National Obesity Observatories "Standard Evaluation Framework for Weight Management Interventions" (NOO, 2009) and also using a theoretical framework of Realistic Evaluation, in order to gain a better understanding of "what works for whom, under which circumstances" (Pawson & Tilley, 1997).

This dissertation will only look at the qualitative experiences of service users who have attended CWMP. The results of the remainder of the evaluation will be published elsewhere. Using a framework of Realistic Evaluation, the research will look into whether the service is suitable for everyone by considering the context and mechanisms experienced by those who have attended CWMP.

The experiences of those who have attended CWMP are important as there is currently a lack of high quality evidence regarding effective weight management programmes (NOO, 2009). The interviews may be able to shed light onto why approximately 35% of CWMP service users have been

successful in losing ≥5% of their initial body weight (as defined by NICE guideline 43, 2006[2]) whilst the remaining service users have been unsuccessful at losing more than 5% of their initial body weight (Hogg et al. 2010).

The results of this dissertation will be used by NHS ALW to modify LWFG and also the way NHS ALW engage with the population of the Wigan Borough, as specific groups of people may benefit the most from attending CWMP.

[2] The national Institute for Health and Clinical excellence (NICE) recommend that at least 5% of initial body weight should be lost in order to significantly reduce the cardiovascular and metabolic risk associated with being overweight or obese.

Literature Review

What is obesity?

The relationship between food, nutrition and health is now widely recognised. The level of food borne diseases has reduced in developed countries and therefore food related ill health and premature death is now more likely to be due to poor diet (The Health and Social Care Information Centre, THSCIC, 2009). The World Health Organisation (WHO, 1998) has identified obesity as a global epidemic. Overweight and obesity develop over many years and occur due to an intake of energy greater than the body's expenditure of energy. The prevalence reflects a change in society, as modern lifestyles have led to a decreased opportunity and motivation for physical activity, whilst the food industry provides an overabundance of energy dense food (Lang & Froelicher, 2006).

There are differences between being overweight and obese, although recently the two words have been used interchangeably, causing confusion (Lang & Froelicher, 2006). Being *overweight* means a person weighs more than the standard weight for their height and sex, and can be classed as pre-obese (Lang & Froelicher, 2006). Whereas *obesity* is defined as a health condition in which excess body fat has accumulated which may adversely affect health (WHO, 1998, see table 1).

Table 1: Health problems associated with obesity (WHO, 1998)

Greatly increased risk (relative risk >3)	Moderately increased risk (relative risk 2-3)	Slightly increased risk (relative risk 1-2)
Type II diabetes	Coronary heart disease	Cancer (colon, breast & endometrial)
Insulin resistance	Asthma	Reproductive hormone abilities
Gallbladder disease	Osteoarthritis	Polycystic ovaries syndrome
Dyslipidaemia	Hyperuricaemia	Impaired fertility
Breathlessness	Gout	Low back pain
Sleep apnoea		Anaesthetic risk
		Foetal defects associated with maternal obesity

N.B. Relative risk estimates are approximate. The relative risk is the risk measured against that of a non-obese person of the same age and sex. [E.g. an obese person is at least three times more likely to develop type II diabetes than a non-obese person].

One way of categorising whether someone is overweight or obese is to use Body Mass Index (BMI) as a measure. BMI is a quick, simple and non intrusive method that involves using a person's height in meters (m) and weight in Kilograms (kg, NHS, 2010).

Table 2: BMI definitions (THSCIC, 2009)

Definition	BMI range (kg/m²)
Underweight	Under 18.5
Normal	18.5 - 24.9
Overweight	25 - 29.9
Obese	30 - 39.9
Morbidly obese	40 +

BMI is not the most accurate tool as is it cannot distinguish between fat and muscle mass, and health risks across BMI ranges may differ depending upon

ethnic origin (NHS, 2010), however, other methods can be more difficult to use (Gibney et al. 2007)

In the UK, The Health survey for England (HSE, NHS Information Centre, 2008) uses BMI as one measure of overweight and obesity. During the most recent study by the HSE, 24% of adults where found to be in the obese category and a total of 65% of men and 56% of women where either overweight or obese. The Foresight Report (2007) calculated that by 2050, 60% of men and 50% of women would be obese if no action were to be taken.

There are also costs to society and the economy. Foresight estimated that weight problems cost the economy approximately £16 billion per year, but this may rise to £50 billion per year by 2050 if no action is taken (DH, 2009).

The House of Commons Select Committee (2004) estimated that 34,100 deaths were attributable to obesity, which equates to approximately 6.8% of all deaths in England. The DH estimates that having a BMI of 25 kg/m² will decrease life expectancy of English men by two years (DH, 2004b). However, having a BMI of above 30 kg/m² has been associated with a reduction in life expectancy of 7 years for men and 6 years for women when comparing to those of normal weight (Peeters et al. 2003). Along with a reduction in life expectancy, quality of life will also be affected, as obesity leads to many different disorders and diseases (as shown in table 1).

*'Securing Good Health for the Whole Population' (*Wanless, 2004), classed obesity to be similar to smoking in terms of the level of disease associated

with it. NICE guideline 43 (2006) suggests that individuals with a BMI above 25 kg/m² should aim to lose between 5% and 10% of their initial body weight in order to improve cardiovascular and metabolic risk factors. It is therefore imperative that effective weight management programmes are produced to tackle to the potential rise in obesity, and the economic and health outcomes that are associated with it.

Obesity Policy

As a response to the Foresight report (2007), the Government set out its plan in "Healthy Weight, Healthy Lives: A Cross-Government Strategy for England" (2008) The aim was to produce a sustained programme to help people maintain a healthy weight and reverse the rising trend of overweight and obesity. To do this five strategies were promoted:

1. **Children**: Ensure children are able to grow properly whilst maintaining a healthy weight. This will prevent childhood weight problems leading onto adult weight problems.
2. **Promoting Healthier Food Choices**: This strategy aimed to reduce the consumption of foods that are high in fat, sugar and salt whilst increasing people's fruit and vegetable intake.
3. **Physical Activity**: The aim was to improve the amount of physical activity people are undertaking as part of their daily routine.

4. **Incentives for Better Health**: Improve understanding of health and improve the value that people place on the long term impact of their decisions
5. **Personalised Advice and Support**: Provide preventative support and treatment options to facilitate weight loss and maintenance.

NHS and Commercial Weight Management Programmes

As mentioned in the introduction, there are relatively few evaluations of NHS weight management programmes (for search strategy see appendix A). Many NHS Hospital Trusts and NHS Primary Care Trusts are commissioning programmes; however, there is currently a lack of high quality evidence regarding effective weight management programmes (NOO, 2009). The following interventions all describe how many people were able to successfully lose ≥5% of their initial body weight but there are other aspects that could also be considered to improve the success rate.

NHS Greater Glasgow & Clyde (NHSGG) has been running a weight management service since 2005 (DOM, 2008). A multi disciplinary team involving dietitians, clinical psychologists, and physiotherapists are employed to support patients whilst they develop skills to manage their weight (NHSGG, no date). Patients must be referred from their GP and have a BMI of >30 kg/m² to be eligible to join the programme.

An evaluation is currently being undertaken and is due to be released late 2010, however, interim reports suggest that approximately 1 in 4 service users have successfully lost ≥5Kg[3] by taking part in an 18 week lifestyle intervention programme (NHSGG, no date). This appears to be one of the more successful NHS weight management programmes in Britain. However, data from NHS GG currently does not contain any information regarding the difference between those who have been successful and those who have not been successful.

Recent work by the DH may be able to shed some light on this area. As part of "Ambitions for Health" (DH, 2008), the DH has carried out insight work into attitudes and behaviours using the English public, and have been able to develop a segmentation model based on behaviour, lifestyle and attitudes (DH, 2010). Segmentation is important as it can be a useful tool in understanding where resources should be focused, and by looking at psychological factors as well as demographics, so that a rounder picture can be developed. The recent research has provided 5 segments (DH, 2010):

1) **Health Conscious Realists (HCR):**
    - HCR's feel good about themselves, are self motivated, realistic, disciplined and goal driven.
2) **Balanced Compensators (BC):**

[3] Scottish Intercollegiate Guidance Network (SIGN) are the Scottish equivalent to the National Institute for Health and Clinical Excellence (NICE) in England. SIGN guideline 115 recommends that 5Kg of initial body weight should be lost in order to improve cardiovascular and metabolic risk. This is inline with NICE recommendations.

- This segment of people have an aspirational outlook with goal setting and planning to control health. They reject prescriptive interventions.

3) **Hedonistic Immortals (HI):**
    - HI's do not see health as a concern. Pleasure is a priority and therefore they focus on the here and now and so consequences are dismissed.
4) **Live For Today's (LfT):**
    - LfT's show little evidence of planning or goal setting. Lifestyles are often chaotic and unstructured. They make few efforts to be healthy and are generally uninterested in health issues. Key influences regarding health are friends and family.
5) **Unconfident Fatalists (UF):**
    - Typically pessimistic and fatalistic in outlook. They try to escape from problems of everyday life by choosing unhealthy behaviour choices.

The segmentation model is useful as it may be able to identify those who are at risk of adopting unhealthy behaviours at an earlier stage, and help to assist in the development and targeting of services (DH, 2010).

"Your Choice" was a weight management programme commissioned by South Manchester PCT for those with a BMI >25 kg/m². It consisted of a group education day, involving topics such as healthy eating and exercise, and then one to one appointments for monitoring and support (Gaynor, Hanna & Green, 2009).

The evaluation of “Your Choice” looked at whether people understood what was taught, as well as their weight loss. 14% of completers lost 5% of their initial weight (this would equal just over 8% of everyone taking part in the evaluation). However, results from the questionnaire showed that 81% had a better understanding of healthy food, 78% felt they better understood food labelling, and 70% reported to have increased physical activity (Gaynor, Hanna & Green, 2009). Therefore if people felt that they had a better knowledge and understanding, were people able to put this knowledge into practice? If so, why were more people unable to successfully lose weight?

One option could be that social desirability bias has occurred; meaning that the people taking part in the evaluation may have over reported good behaviour in order to be viewed in a favourable manor (Bryman, 2004).

Another possible reason could be due to habits which are routine behaviours that occur sub-consciously. They are specific behavioural responses to cues in the environment (Verplanken & Faes, 1999). Research has suggested that intentions may not be able to break habits, only mask them. Therefore this may be one reason why the people from “Your Choice” had a greater understanding of healthy eating, but did not produce successful weight losses.

Nottingham City PCT carried out an intervention that involved a dietitian led group support sessions. Patients with a BMI of over 30 kg/m² could be referred by a medical professional or could refer themselves after reading posters that advertised the project. Of those who met the desired criteria,

216 participants commenced the 14 week group support, with further sessions delivered at 4, 6, 9 and 12 months. 13% of all participants achieved a 5% weight loss (Read et al. 2004). Although not stated, there may be a difference between those who referred themselves onto the programme and those who where referred by a medical practitioner.

Prochaska & DiClemente (1984) proposed the "Stages of Change" Model[4] to explain why some people show certain psychosocial characteristics when asked about change. It is therefore important to understand if people are prepared for change when undertaking such a programme (see figure 1). Those in the later stages are more likely to succeed in adopting behaviour change. However, the model has not consistently demonstrated this when looking at overall weight loss and the weight management behaviours related to it[5] (Krumme et al. 2004)

[4] Sometimes known as the Transtheoretical model

[5] 55% of the women in the study where in the action stage for overall weight loss, however, when broken down into weight management behaviours fewer women were in the action stage.

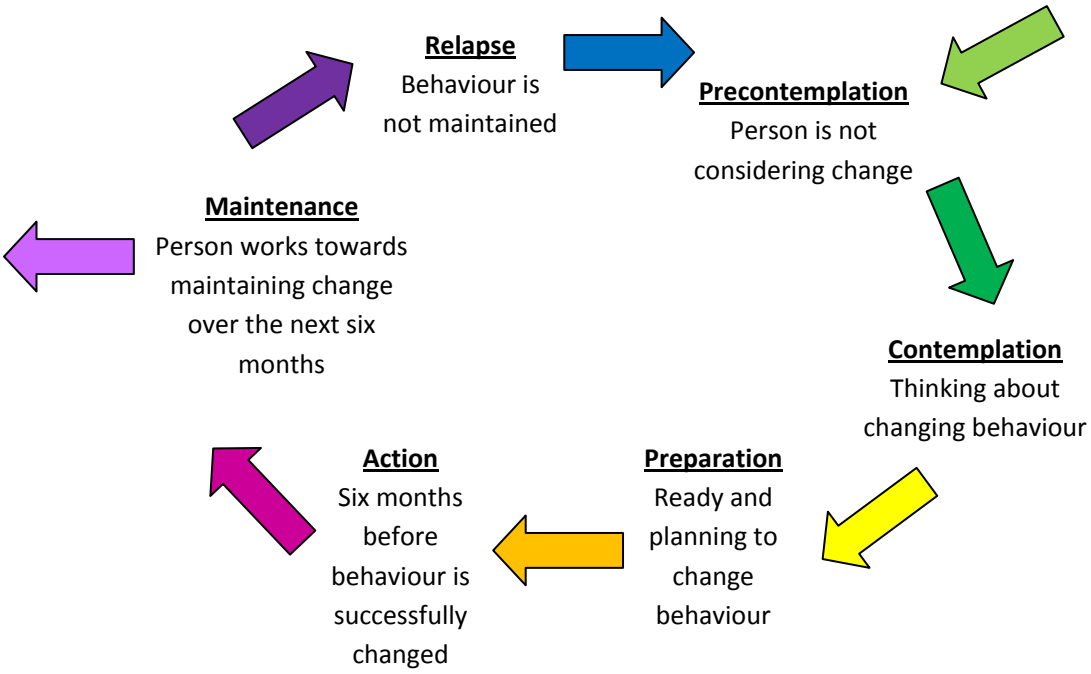


Figure 1: Stages of Change. Individuals may enter at the pre contemplation stage and go through the cycle to successfully maintain the behaviour change. However, some attempts will not be successful and the individual may relapse and start the cycle again.

Therefore, using the model above, if individuals are advised to enter a weight management programme while they are in the pre contemplation stage, it is less likely that they will be successful in losing weight, or indeed stay on the course (Binks & O'Neil, 2002).

SW has previously collaborated with southern Derbyshire health district to allow those with a BMI of over 30 kg/m² to attend SW classes free of charge. Overall 107 patients where recruited, but only 91 patients attended at least one session. Sixty-two patients completed the 12 week course of which 57% reached 5% weight loss (overall this would be 33%; Lavin et al. 2006).

Again there appears to be a number of people who are not attending the initial session therefore, once again, are people at the correct stage to undertake a weight management programme?

An intervention ran by Walsgrave Hospitals NHS Trust involved physical activity session and dietary advice (Reed et al. 1999). Aquafit sessions were promoted for those with a BMI of over 35 kg/m² at a cost of £1 per session. A dietitian would also be present to facilitate the sessions and provide support, weigh-ins and to arrange a monthly programme. A proportion of those who attended the session were invited to take part in the evaluation. Of those who regularly attended and accepted the invitation to take part in the evaluation (five participants), the average weight loss was 5.9%. However, for those who did not attend as regularly (25 participants), the weight loss was lower, 3.2%. Five participants is a small number to base quantitative research on, and possible self selecting bias could have occurred (Rothman, Greenland & Lash, 2008). Nevertheless, Weight Watchers have also found that those who regularly attend sessions also lose more weight.

Weight Watchers teamed up with three health regions to offer a referral programme for those with a BMI of over 28 kg/m². Overall 31% of the patients lost >5% but those that who attended more regularly lost more weight than those who attended less regularly (Poulter & Hunt, no date). Once again, showing that individuals who regularly attend are capable of reaching greater weight loss. What difference could be at play between those who attend more and those who attend less?

Motivation could be a key factor in weight loss. Motivation can be split into Intrinsic motivation which involves behaviours that are carried out by an individual purely for the satisfaction of performing the task (e.g. exercising because the person finds it fun), and extrinsic motivation which can be thought of as a means to an end (e.g. exercising because they will feel guilty if they don't lose weight (Vallerand & Bissonette, 1992)).

Extrinsic motivation can be split into four categories. They can involve rewards or constraints made by an individual or other people around the individual (interjected and external regulation), or can occur when a behaviour is chosen by an individual because they feel it is important (identified regulation) or finally choosing and integrating behaviour in line with an individual's own goals and aspirations (integrated regulation (Vallerand & Bissonette, 1992)).

Intrinsic motivation is thought to be a more positive motivation and produces greater interest and superior learning. Whilst extrinsic motivation is thought to be less positive because influence and performance are less self-determined. Interjected and external regulation are the weakest motivations because people do not necessarily feel that the behaviour is what they want to do. Whereas identified and integrated regulation are more self directed and therefore a stronger motivation (Vallerand & Bissonette, 1992).

Accelerated Concepts are a business development company that have produced incentivised plans for weight loss. The company has previously

joined up with Eastern and Coastal Kent PCT to commission “Weight Wins”; a one year trial with 400 places available. The programme consists of monetary incentives for weight loss, with an extra bonus for those who complete the programme. Participants are given a welcome pack with weight loss tips and are requested to weigh in once per month. Two thirds of the participants dropped out before the 12 months programme had finished (Rossiter, 2010), therefore this shows that monetary incentives may only work for so long, possibly due to external motivation (Vallerand & Bissonette, 1992). It is important to understand more about what will work for people as NICE (2010) have suggested that rewards may be an effective way to encourage people to engage in positive behaviour change and have opened a public consultation on the matter.

Other PCT’s (such as Blackpool and Durham) have employed weight loss strategies using The Counterweight programme. The programme has been operating since 2000 and has been shown to be an effective model for obesity management within general practice (Counterweight, 2008). The model involves dietitians, who specialise in obesity management; working across PCT’s to provide training and support for healthcare staff in order to put the Counterweight programme into practice. Nurses are then able to offer education through discussing weight management, and topics include, The Eatwell Plate (FSA, 2008), meal planning, physical activity, and behaviour management. This could be on a one to one basis or in a group setting.

In a recent study produced by Counterweight (2008), 1906 patients with a BMI of over 30 kg/m² (or over 28 kg/m² with co-morbidities) followed a plan between 3 and 24 months. Of the 775 patients who attended appointments for at least 3 months, 26% had lost 5% (which is 11% overall). Of the 548 that carried on for at least 6 months, 38% reached 5% (totalling 10% overall). Length of time may be an important factor in changing behaviour. Using the "Stages of Change" model once again, it has been suggested that 6 months is the minimum time required in order to maintain behaviour (Prochaska & DiClemente, 1984), which may also relate back to habits and motivation.

Allan, Hoddinott and Avenell (2010) have recently suggested that there are major differences between commercial and health service weight loss groups. The main findings involved:

- Difference in access - health services involved referral from medical practitioners whilst commercial clubs involved self referral
- Difference in engagement – commercial clubs used consultants who had previously gone through the weight loss process and could share their experience whilst health service leaders could become ambivalent due to lack of time and resources.
- Difference in running of the sessions – health care sessions are often small and for a fixed amount of time, whereas commercial clubs are a branded package that people are able to dip in and out of.

- Health services were better for people suffering from chronic conditions and also hard to reach groups, such as men.

CWMP uses commercial partners and self referral which is different to normal health care programmes. However only 12 free sessions per year are offered and CWMP may not be suitable for those with chronic conditions. Therefore could there be changes made to CWMP to improve rates of successful weight loss to over 35%?

Evaluation

Evaluation is important because it investigates the effectiveness and value for money that a programme provides, and therefore should be included in the design of a programme (Tones & Green, 2004). However, evaluation can also produce new knowledge which can then be used to change how a programme runs, and potentially lead to policy changes at a local level (such as at the Greater Manchester Public Health Network) or at a national level (such as with the DH) as it has been recommended that evaluations should be built into the policy making process (SPMT, 1999).

Randomised Control Trials (RCT's) have been used as a "gold standard" for research, however RCT's may not be suitable for Public Health interventions which are often complex. An RCT may miss important factors that facilitate change, or produce barriers to change (NOO, 2009). Instead, approaches to evaluation that are based on qualitative research have emerged and are

based around an in depth understanding of the context in which an intervention occurs and the views of the stakeholders that are part of the study (Bryman, 2004). One such approach to evaluation is Realistic Evaluation (RE, Pawson & Tilley, 1997).

Realistic Evaluation

RE uses principles of critical realism, in a sense that it recognises that the only way to understand, and therefore change the social world, is to identify the structures that generate events. The structures may not be immediately apparent (or observable) and therefore practical and theoretical frameworks are used. This means that hypothetical mechanisms can be used to understand why an outcome may or may not have occurred. (Bhaskar, 1989, cited in Bryman, 2004)

Pawson & Tilley (1997) suggest that most evaluations miss out on a range of causal agents and therefore the research can be deemed as inconsistent. This is because individuals vary and therefore may react differently in different circumstances. RE therefore tries to understand *"what works for whom, under what circumstance?"*

In order to do this, RE uses a combination of mechanisms and contexts in order to account for the outcomes that occur.

Mechanism (M) + Context (C) = Outcome (O)

Therefore by studying the mechanisms that are triggered in a particular context, a causal relationship can then be observed. RE therefore considers the complexity of a programme, and not just how successful it appears to be. (Pommier, Guevel, & Jourdan, 2010)

In the case of this dissertation, the outcome is weight loss (either successful or unsuccessful), the mechanism is CWMP (of which there may be variations in the programme) and the context will involve environmental factors.

The final CMO themes will lead to an understanding of which individuals may benefit the most from CWMP and which social and cultural resources are necessary to sustain the change (Pommier, Guevel, & Jourdan, 2010).

Aim:

To produce a greater understanding of why some service users attending a Community Weight Management Programme are successful at losing weight (≥5%), whilst other service users are less successful at losing weight (<5%).

Hypothesis:[6]

Those who are successful at losing >5% of their initial body weight will have made more lifestyle changes due to CWMP

Objectives:

1) Understand service user's perceptions of how the Community Weight Management Programme (CWMP) has worked for them
2) Identify the mechanisms that have been important in engaging and supporting service users in CWMP
3) Identify the context in which people are undertaking CWMP
4) Use the themes to produce a series of recommendations for developing CWMP
5) Use the themes to produce a series of recommendations for engaging with the people who would most benefit from CWMP

[6] The Aim is the Realistic Evaluation Programme Theory which will be used to focus the data analysis

Chapter 2:

Methodology

As mentioned in the literature review, an overall framework of Realistic Evaluation (Pawson & Tilley, 1997) will be used in order to understand what context and mechanisms are the basis for the difference in outcomes (e.g. successful or unsuccessful weight loss).

Study design

This is a qualitative study which uses a semi structured interview technique (appendix B). This technique allows for a series of questions to be asked, although the timing of the questions are able to be varied, depending on how the interview progresses. The questions are quite general (compared to structured interview questions) and this allows for the participant to talk about what they believe is relevant. The researcher is also able to ask further questions if a reply appears to be significant (Bryman, 2004).

The interviews were carried out over the telephone (using speakerphone) and recorded before being transcribed. Carr & Worth (2001) have found that telephone interviews are comparable in quality with face-to-face interviews. Telephone interviews where undertaken due to two factors. The first being the amount of time available to the researcher; telephone interviews require less time as the researcher is not having to travel to meet each participant

(Bryman, 2004). The second factor was the safety of the researcher and the participant. As the researcher would be meeting participants alone, an alternative was required to meeting in the person's home. The Social Research Association's (SRA) code of practice recommend meeting in a public place, such as the participant's workplace, (SRA, no date), however, this may be off putting for potential participant's (Mann & Stewart, 2000) and so telephone interviews were deemed to be the most viable option.

The time the calls were undertaken differed to ensure everyone had a chance to take part. The first attempt to call was always undertaken during working hours whilst further attempts to call where undertaken in non-working hours (after 6pm).

Sampling

Purposive sampling was chosen as it allows for participants to be chosen who would be relevant to the research question (Bryman, 2004).

Richard Bandler and John Grinder co-founded the field of Neuro-Linguistic Programming (1975) after investigating transcriptions from several successful therapists. The aim of reviewing the transcripts was to understand why these therapists had been so successful while other therapists had not been as successful. Even though the therapists had different personalities they had used similar patterns and techniques with their clients.

For this dissertation a similar type of sample technique will be used as it is important to understand what patterns of contexts and mechanisms can lead some people being successful in losing weight while others have not been as successful.

Inclusion criteria consisted of:

- Each person having a BMI between 25 & 40 kg/m²
- Each person must be over the age of 18
- No more than three people have seen the same consultant/activity officers in order to get a good spread of the sessions
- To interview a similar number of service users who have had successful and unsuccessful weight loss (e.g. ten participants from each group).

Exclusion criteria consisted of:

- Service users who have received only HT, DAD or SWMS.
- Service users who have received CWMP as well as HT, DAD, or SWMS

The information to find the participants came come from ADASTRA[7]. This is the database used by NHS ALW to capture information from LWFG, such as demographics, success rate, booking times etc.

[7] ADASTRA (Advanced Heath and Care, 2010) is used by many NHS trusts as a database, appointment book in and call log system

Table 3: Purposive sampling, overall 40 people received an invitation letter

Weight loss <5% *(Total 20 participants*)		Weight loss > 5% (Total *20 Participants)*	
≥9 sessions (Completer) *15 participants*	<9 sessions (non-completer) *5 participants*	≥9 session (Completer) *15 participants*	<9 sessions (non-Completer) *5 participants*

It was decided that more completers (those service users who had attended nine or more sessions) would be required as they have made it to the end of the programme and therefore their weight loss is unambiguous. However, those who have not completed the course may still be able to contribute information as there may have been something about the mechanism of CWMP that did not suit them, or there could have been something important about the context they found themselves in. However, the last weight that was entered would have to be used as the final weight loss, which may not have been the same as if they had completed[8]

[8] For example, someone may have only completed eight sessions with a weight loss of 4.8% and therefore classed as unsuccessful and a non completer. However, if they had returned for week nine their weight loss could have been 5.1% which would have classed them as successful and a completer. Also someone may have completed eight weeks and lost over 5% but they did not return to CWMP as they began to put on weight, therefore their weight loss may have reduced below 5% and this would mean that they would not be classed as successful.

Sample Size

Ensuring that the correct numbers of people are recruited can be difficult using qualitative research methods. If the number is too small, the research question may not be adequately answered, however, if the sample size is too large, the data may become saturated or too large for analysis to be undertaken accurately (Bryman, 2004).

The aim of this study was to undertake at 20 telephone interviews. Jago et al (2010) have used 30 semi-structured telephone interviews to look at parents' perceptions of family physical activity, whilst Oteng-Ntim et al (2010) held telephone interviews with 22 healthcare professionals regarding their views of a community based maternal obesity intervention. Therefore 20 interviews will provide similar numbers to other studies regarding diet and physical activity.

For 20 interviews to be undertaken more service users would have to be invited to take part due the potential of non-responders, therefore initially 40 letters were sent out. If 20 people had not been recruited, further letters would be sent out using the same inclusion and exclusion criteria.

Each person was called up to three times before they were classed as non-responders. Therefore as more than 20 people responded, the interviews were still be carried out, as the information will be important and it would be difficult to decide who to exclude.

Population

Table 4: Break down of those who were invited to take part

	Invited
Gender	10 males
	30 females
Age range (years)	20 – 74
Start BMI range (Kg/m²)	24.9 - 39.2
Successful weight loss (>5%)	15 completers
	5 non-completers
Unsuccessful weight loss (<5%)	15 completers
	5 non-completers

Procedure

An invitation pack was produced and sent to all potential participants. The pack contained an Invitation Letter, a Participant Information Sheet and a Consent Form (see appendix C, D, & E).

The invitation letter discussed the need for the LWFG evaluation, including benefit to the service users, and concluded by stating the researcher will call to discuss whether the service user wants to take part (Appendix D).

A Participant Information Sheet (PIS) provided more depth about what would be involved in the interview and the service user's right not to take part (Appendix E).

A Consent form included a number of statements for the person to look over and tick if they agree with it (Appendix C). As the interview will be carried out over the phone, verbal consent will also be asked for as it is not expected that all consent forms will be returned.

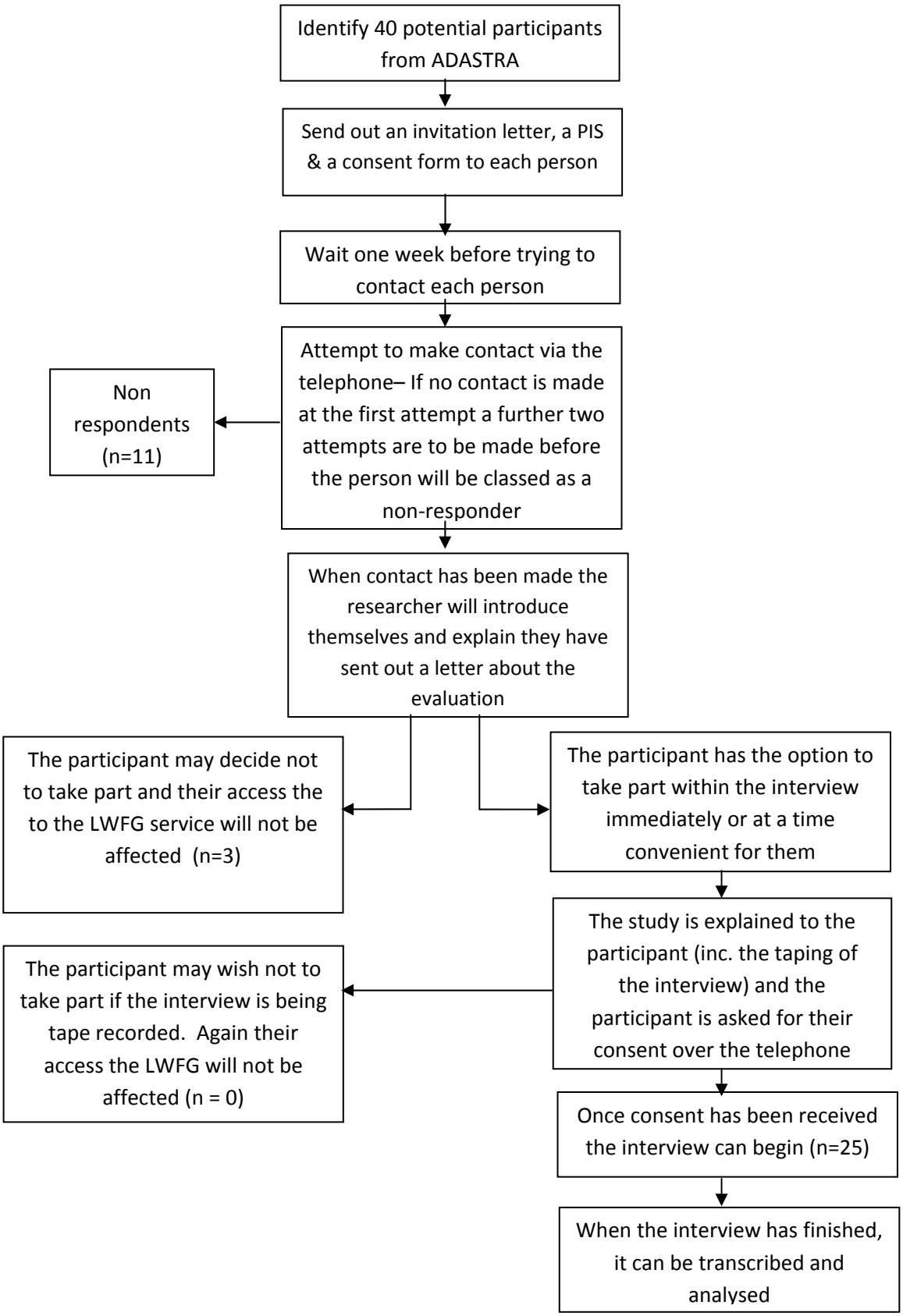
An interview schedule involved questions about access to the LWFG pathway (via NHSD) and then about CWMP itself (appendix B). The interview schedule has not been tested for reliability or validity as the North West Ethics Committee decided a pilot study was not required and therefore the questions where not tested. As stated on the letter received from the National Research and Ethics Service, the full evaluation of LWFG was not deemed as research and therefore did not require approval (see appendix F).

A digital tape recorder (Olympus WS-311M) was required so that the interviews could be replayed and transcribed. The participants were advised over the phone that the interview would be tape recorded.

A telephone that has a speakerphone option was required in order to tape the telephone interviews.

The full procedure is outlined in figure 2

Figure 2: Data collection procedure



Data analysis

All interviews were re-played and transcribed verbatim. Each participant was given a unique code to ensure the data would be anonymous. Any names where removed during the transcription stage and they were changed to a relevant code; for example *[SW consultant], [PA activity officer], [wife], [participant 1].* This was to ensure confidentiality of the written data.

The aim of the analysis is to concentrate the data by developing themes of common ideas or concepts; therefore by using the framework of Realistic Evaluation the key contexts and mechanisms would be identified. Thematic analysis was used to identify these key themes. Thematic analysis involves coding of interviews to identify a limited number of themes which represent the data overall. In order to do this the transcripts are looked over numerous times so that the researcher can become familiar with the transcripts. Also numerical indications can be used, such as the number of participants who have referred to a particular theme (Howitt & Cramer, 2007).

The interviews were being analysed as they were transcribed and then again several times after the transcription had been completed, such as when important sections were cut from the transcripts. These made up many themes which where analysed against the objectives of the study.

The transcripts were coded using the participants recording number (e.g. 51) and the code will also contain (<5%) or (≥5%) so that the successful participants could be recognised easily from the unsuccessful participants. Therefore an example would be:

"…quote…" (<5%, completer, 51)

The quotes were finally reviewed and analysed before a summary of the findings was presented. The recommendations can then be captured from the findings.

Ethical Considerations

LWFG has been commissioned by NHS ALW, therefore a National Research Ethics Service (NRES) application was filled out. The North West Ethics Committee decided that the whole evaluation did not fulfil the research criteria and therefore did not require ethical approval from them. The National Research Ethics Service confirmed this (Appendix F).

The whole evaluation is being undertaken using a Knowledge Transfer Partnership (KTP) grant. Dr Rachel Hall is the Research and Development manager at the PCT and is one of the KTP members. Dr Hall is therefore regularly updated on the progress of the evaluation and is in contact with the Greater Manchester Primary Care Research Governance Partnership (ReGroup) who support research with the 10 PCT's in the Greater Manchester Area (ReGroup, no date).

In order to carry out the evaluation, a Knowledge Transfer partnership was begin between the University of Central Lancashire (UCLan) and NHS ALW in order to improve knowledge transfer between the NHS and academia. Dr Ailsa Brotherton from UCLan (the academic partner of the KTP), filled out an ethics form which was accepted by The Faculty of Health and Social Care Research Ethics Committee.

Dr Basma Ellahi consulted Dr Stephen Fallows (a former chair of the University of Chester Ethics Committee) and it was decided that ethical approval from the University of Chester was not required for this dissertation, as UCLan acceptance met the University of Chester's procedures.

The SRA's Ethical Guidelines (2003) state that there are certain obligations that the researcher should carry out to ensure the confidentiality and safety of participants:

1. Avoid Undue Intrusion:
    - Try to use available data before starting a new study.
2. Obtain Informed Consent:
    - The participant should be informed that they do not have to take part within the study and that they are entitled to withdraw from the study at any time without repercussions.
3. Protect the Interest of the Subjects:

- The researcher should protect the subject against the potentially harmful effects of participating with the study, which would include providing information about the consequences prior to the start of the study.

4. Enabling participation:

    - The researcher must pay particular attention to the needs of the population and be as flexible as possible.

5. Maintain confidentiality:

    - Data should be stored safely with restricted access

6. Prevent disclosure:

    - The researcher should take appropriate measures to prevent the data from being released in a way that would allow for a subjects identity to be disclosed or inferred.

When using the ethical guidelines from above, currently there is little data available regarding weight management interventions (see lit review), therefore there is a need for this type of dissertation. All participants were asked if they would like to take part within the evaluation and told they could drop out at any time. All participants were sent a participant information sheet which included information about possible risk. When trying to contact potential participants, the researcher called participants' during different times of the day to try and ensure the greatest flexibility possible. All data is

stored on an encrypted data stick and participants' names have been removed to prevent disclosure of identity.

Chapter 3:

Findings

Twenty five telephone interviews where undertaken, which lasted between 2 minutes, 26 seconds and 18 minutes.

Table 5: Breakdown of participants

Unsuccessful (<5%)			Successful (≥5%)		
Code	**Gender**	**Completer**	**Code**	**Gender**	**completer**
54	F	No	51	F	Yes
55	F	Yes	52	F	Yes
56	F	Yes	53	M	Yes
58	F	No	57	F	Yes
59	F	Yes	60	F	Yes
65	M	Yes	61	F	Yes
67	F	Yes	62	F	Yes
68	M	Yes	64	F	Yes
69	F	Yes	66	F	Yes
72	F	Yes	70	M	Yes
73	F	Yes	71	F	Yes
75	F	Yes	74	F	Yes
76	F	Yes			

From the analysis of the interviews, a number of key themes where identified. The main findings can be split into contexts, mechanisms and outcomes.

Mechanisms:

- Group sessions (Theme 1)
- SW Consultant and WLCT Physical Activity Officers (Theme 2)
- Slimming World Eating Plans (Theme 3)
- WLCT Physical activity sessions (Theme 4)

Contexts:

- Motivation (Theme 5)
- Segmentation (Theme 6)

Outcome:

- Change to lifestyle (Theme 7)

Theme 1 - Group support

Theme 1 involves only aspects of the group and the support from the group members whereas the support provided by the SW consultants and PA officers is involved in Theme 2.

SW group sessions:

When asked questions about the Slimming World sessions, several different ideas arose. Some people found that they received a lot of support from the people around them:

> *"I thought it would frighten me, I thought it was umm very inviting because everyone was so chatty and you know, exchanged things" (≥5%, completer, 66)*
>
> *"Got plenty of support that way…And additional information as well, you know, recipes' and things like that" (≥5%, completer, 71)*
>
> *"You start bouncing off each other and you know, I'll try that this week, what do you think, and I did this with this…so your learning more and more off other people" (≥5%, completer, 70)*
>
> *"And we're all trying, we all know that we're overweight, and we're all trying to do something about it, and your there to support each other … and somebody will say can I eat this? And is it alright to eat that? And I did, I find that very supportive." (<5%, completer, 75)*

Whilst other people, particularly males, found the group sessions to be uncomfortable. This could be due to the personalities in the class, or for

males, the fact that majority of CWMP members are female (92%, Hogg et al. 2010).

> *"I didn't go to the [SW] classes very often … I just felt a bit overpowered by the fact that there were loads and loads of women there." (<5%, completer, 55)*

> *"Well I didn't think there were a lot of men going, so, you know what I mean, you felt like a spare part sort of thing" (<5%, completer, 68)*

Some people felt that the sessions where more like catching up with friends and could allow them to have their own time. This may be useful as people feel at ease[9];

> *"It was like an outing for me every week, it was like, err, it was my time.... it was for me" (≥5%, completer,66)*

> *"It was just like a friendly get together each week I suppose" (≥ 5%, completer, 61)*

However, it can also have the potential for people not to take the sessions seriously. So even though people may turn up, they may not engage and learn from the sessions.

> *You can have a laugh, although, you know, she [SW consultant] wants you to be serious about it, you know what I mean? (<5%, non completer, 54)*

Some people felt that the group sessions where not useful:

> *"I'll be honest; I just thought what a waste of time"(<5%, completer, 69)*

[9] This may relate to the Live for Today segment – see contexts (Theme 6)

And other people where simply unable to stay for the SW group sessions due to other commitments:

> *"I mean cause of the children I didn't actually stay to the actual counting session" (<5%, completer, 72)*

Physical Activity Group sessions:

With regards to the Physical Activity (PA) sessions there appeared to be a difference between the sessions with SW and the sessions with PA.

> *"The group sessions in exercise were great, but I didn't like the group sessions in the Slimmer's World…I got more out of the exercise" (<5%, completer, 65)*

When it came to PA, some people where initially wary of the classes as they did not want to be singled out:

> *"It was because of the age group…because the people in the classes were in the same position as me, they were all overweight, and out of condition…I wouldn't have picked to go to an exercise class in, under the circumstances and everything" (≥5%, completer, 71)*

> *"There was a full range of people there taking part in the exercise classes, a full range meaning different ages and different sexes. Umm, and you were just made to feel comfortable and it was great" (≥5%, completer, 53)*

However, once people had started the sessions they felt that they were able to work as hard as they could without feeling pressurised by the other service users or the PA officers and that they could help each other.

> *"It was the team camaraderie as well, during the exercise classes, everybody was willing one another to do well… You didn't feel*

pressured, like I said you could go at your own pace" (≥5%, completer, 52)

"I had a bad shoulder… but every time I was in that much pain, so he [PA officer] said to me just to do it at your pace and when you can do it" (≥5%, completer, 74)

"you were also told by whoever was doing it to do it at your own pace… when you were just starting off they weren't making you do anything that was to strenuous for you" (≥5%, completer, 61)

"the exercise group sessions they help because obviously you've got other people doing it with you". (≥5%, completer, 53)

Theme 2 - SW Consultants and WLCT PA officers

Group support was mentioned in theme 1; however, the SW consultant and the PA officers appear to be a crucial mechanism of CWMP.

SW consultants

All SW consultants have to have been a member of SW when they apply to become a consultant (SW, 2010). The support provided by the SW consultants appears to be an important factor in weight loss:

> *"You know, you get lots of encouragement from [SW consultant], she still send me text messages every week" (≥5%, completer, 70)*

> ***P***[10] *"You can ask her any questions, she's got an e mail address, you can e mail her, or you can ring her."*
> ***I*** *"Right so she's quite approachable then?"*
> ***P*** ***"****Ohh, yeah, she's very approachable, yeah." (≥5%, completer, 62)*

> *"They were very good, yeah. Very informative, and... if you want something they didn't, they couldn't help you with there and then, or sort out there and then, then they'd get back, straight back to you". (<5%, completer, 76)*

However, one interviewee suggested that the support wasn't available from the SW consultant:

> ***P*** *"Well the diet session I didn't really think much of, but the exercise I thought was really good."*
> ***I*** *"Right, so with regards to the actual diet sessions, was it just that the support wasn't there for you?"*
> ***P*** ***"****Yeah, she just, she wasn't interested [SW consultant]." (<5%, completer, 56)*

[10] P = Participant, I = Interviewer

And some people also felt that their needs exceeded the knowledge of the SW consultants and some research has stated that commercial groups are not as capable of dealing with chronic conditions (Allan, Hoddinott & Avanell, 2010).

> *"I think for me I could have done with a proper, a dietitian…I have all the health issues" (<5%, completer, 73,*

Some people also found that SW where able to provide a lot of information using several different methods, so that people are able to access information in a format that might suit them better, rather than just speaking to the SW consultant.

> *"the booklet and the recipe's worked because it was interesting doing the recipes, my wife and I, but getting the information from Slimmer's World rep, wasn't that great". (<5%, completer, 65)*
>
> *"I thought, that was excellent, I felt as though I was totally re-educated you know [using the SW books]" (<5%, completer, 62)*

When someone attends their first sessions of CWMP, they are provided with an introductory talk and given information about the sessions, and the eating plans. However, it appears that the initial introduction may not be adequate for everyone;

> *"In the second visit I even took my wife along so [SW consultant] could explain… as [wife] was doing the catering" (<5%, completer, 55)*

> *"I just think perhaps for me, they'd made it a bit complicated" (<5%, completer, 75).*

Overall some people suggested that the combination of the support from the SW consultants and PA officers helped and encouraged them to change their lifestyle:

> *"I think it was because it was a combined exercise class, and the talk from the SW, was really, really good, and the help and advice from the instructor as well" (≥5%, completer, 60)*

PA officers

Every PA officer who is taken on by WLCT has to demonstrate that they are able to develop exercise sessions for people with varied and complex health needs and provide client centred support. This is very important for CWMP as some people will present with co-morbidities (such as high blood pressure) and there is also a range of ages (WLCT, 2009).

> *"…my knees started, troubling me after a few sessions and then I struggled with my knees actually. But ummm.... we had a fantastic bloke who took us for the exercise; he was very good, you know very considerate, very thoughtful you know. If in any way it was a problem to us, to sit down. And he, he's brilliant" (≥5%, completer, 66)*

> *[PA officers] explained to me that there was a couple of exercises that they advised me not to do, cause of my blood pressure.(≥5%, completer, 62)*

Some people found that the PA officers would ask the service users if they thought they could try to increase the intensity of the activity and explained why this would be a positive factor.

> *"[PA officer] said you could do as much or as little as you wanted, but [PA officer] would obviously try and get you to up your game every week, and do more and more, but if you didn't want to [PA officer] didn't push you, but obviously [PA officer would] have a chat with you*

and say look you're not really working hard enough, and if you don't work a little bit more it won't do you much good. But, yeah, that actual exercise classes were great" (≥5%, completer, 53).

The PA officers also explained that there were other activities and classes going on around the borough so where able to provide extra information, especially to those who where coming to the end of their 12 weeks.

"I mean the exercise people did suggest alternative exercise stuff, and saying about going to the leisure centres and what they could offer, and the fact that you could get reduced rates having been through this program. So they were very good" (<5%, completer, 72)

Overall, people had positive things to say about the SW consultants and the PA officers

"Absolutely fantastic, they're right for the job if you know what I mean? [PA officers]" (<5%, non completer, 54)

"we had a fantastic bloke who took us for the exercise" (≥5%, completer, 66)

"the Slimming World itself, the leader was absolutely fantastic and I still go" (≥5%, completer, 60)

Theme 3 - The Slimming World Eating Plans

SW offers flexibility as it suggests two different eating plans. The "Red (Original) and Green Day" plan and the "Extra Easy" plan (which involves Syns[11], SW, 2010). However, the "Extra Easy" appeared to suit people better.

> *"I did, mostly the red days, the green days, I'm not, carbohydrates don't really suit me, I tend to blow up with carbohydrates with rice and potatoes and that, you know. So, I'm more for a red day, but the extra easy is good you know, you can combine the 2 there…" (< 5%, completer, 59)*
>
> *"I think I did try red and green. Looking at the booklet, I did have a go, I found to do the extra easy, umm.... well it suited me". (<5%, non completer, 54)*
>
> *"Believe it or not, a couple of years ago I had tried SW, and the red day, green day, I just couldn't get my head around it…I spoke to [SW consultant], when I did me induction with her, and she said there's extra easy, well that suited me down to the ground" (≥5%, completer, 70)*
>
> *"I'm not overly keen on the red days" (≥5%, completer, 71)*
>
> *"the green day, red day, I just couldn't get my head round them ones" (≥5%, completer,74)*

The perception was often that people were not dieting, but just eating in a healthier way and without restrictions.

> *"Oh well it was excellent actually, it really worked for me, it isn't like a diet, it's like an eating plan. Because I eat absolutely loads…you could eat what I call normal meals" (≥5%, completer, 61)*

[11] Syns are Slimming Worlds alternative to fat and calorie counting. A person is allotted a specific number of Syns per day. Any food that is not classed as a "free food" (low energy dense food) has a Syn value. This can include "healthy extras" (such as dairy products) and food such as chocolate and alcohol.

"SW, it doesn't feel like you're on a diet… you don't feel that you are deprived of anything" (≥5%, completer, 60)

"I liked the fact that nothing was cut out" (<5%, completer, 62)

SW states that you can stay a healthy weight without depriving yourself or feeling hungry (as mentioned above), and that strict rules and regulations do not apply (SW, 2010). However, it appears that those who said they adhered to the plan completely appeared to lose greater amounts of weight than those who used the plan as a guideline, and therefore this may suggest that rules do apply.

"It worked out well for me, it's the, errr, I'm actually cooking from it tonight, it's the Extra Easy [recipe book]. I do stick by it… I do stick by the rules" (≥5%, completer, 66)

"I mean it's a healthy diet… As long as you count the syns…it's worked really well, the diet" (≥5%, completer, 62)

"If you keep to the plan it works" (≥5%, completer, 51)

"I didn't follow it 100%" (<5%, completer, 67)

"I did follow the eating plan, not 100%, but who does?" (<5%, completer,75)

Some people where able to follow the SW eating plan very easily:

"I found it quite easy to follow and fitted in with the rest of the family" (<5%, completer, 76)

However, here people have shown that even if the SW diet they chose was initially complicated they were able to overcome this barrier and lose weight.

"…I thought it was a complicated diet [red and green days]...so it's not straight forward" (≥5%, completer, 71)

"At first I thought it was a bit hard [Extra Easy plan], but I got used to it…and I did do well then" (≥5%, completer, 74)

"I think once I got in to it, ummm, it was just understanding the plan, with SW its red days, green days. Ummm, they do the..... extra easy…I spent a sort of week following it to the letter, and then I made it work for me. So it was great, I lost... about 36 and half pounds. I have still kept a lot of the good habits...." (≥5%, completer, 52)

However If the person was unable to follow the rules of one eating plan, they had the option to change to the other eating plan.

"I think for me, one of the plans was the extra easy, couldn't seem to get to grips with that, whereas the red and green seemed to work better for me". (<5%, completer, 76)

SW suggests that the majority of their free foods are easily available to buy and are cheap (such as eggs, carrots and beans; SW, 2010). Only one interviewee mentioned that the food that was recommended was too expensive,

"the cost of all this food, it's expensive food you know" (<5%, completer, 73)

However, another interviewee mentioned that they were able to use up all the food they had bought before starting CWMP.

"…I've got my cupboards full, I have to use what I've got…then I sort of learnt how to use what I'd got" (<5%, completer, 69)

Theme 4 – WLCT Physical Activity sessions

Increasing Physical Activity (PA) has been proven to lower blood pressure, cholesterol, insulin resistance, reduce the risk of osteoporosis and osteoarthritis and can improve the symptoms of some mental health conditions (NHS choices, 2010).

As mentioned in Theme 1, the groups support was very important when the PA sessions where underway. However, the actual sessions opened up options to people who would normally have put off exercising.

> *"Once I got used to doing the exercise, I suppose that was a good thing in a way, it made me, it made me exercise which was difficult at the beginning, but I got used to it, and I got to enjoy it" (≥5%, completer, 61)*
>
> *"[the exercise classes] got me off my backside on a Saturday morning and made me go and do it … you know you can sit until the cows come home and say your going to exercise, and you never go" (≥5%, completer, 70)*
>
> *"the first thing I did it really stimulated me to carry on what they taught me, I was doing it everyday at home… and I started to feel better within the first few weeks, it was amazing" (<5%, completer, 62)*

People enjoyed the session so much that they wanted to carry on with the sessions once the 12 weeks had finished, and some instructors allowed this if there was room.

> *"It [PA classes] could have been a little bit longer" (≥5%, completer, 70)*
>
> *"when you've been on the LWFG, to make room for other people that's on the scheme, your not actually allowed to go in, ... its... its iffy, you can go in depending on the instructor. If there's no places for*

"you to actually stand, cause obviously their allowed so many in" (≥5%, completer, 53)

One interviewee pointed out that she had been unable to partake in the PA sessions due to a previous medical condition, and felt that she would have lost more weight if she had been able to do both sessions.

"I found I wasn't losing weight because I, because I couldn't do the exercise, and I do think that you've got to do the both." (<5%, completer, 75)

And the PA sessions actually helped one interviewee as she had previously attended SW sessions but preferred CWMP because the PA sessions where included.

"I mean it made me go, [PA officer] was very good. But when I went before it was.... well, it weren't interesting. But because the exercise was in with it, I think that's what made it" (≥5%, completer, 51)

Context

Theme 5 - Motivation & Readiness to change

Health appears to be a common reason for starting CWMP. From the interviews, six people appeared to have been referred via a medical practitioner. Three people lost <5% and three people lost >5% therefore there may be differences due to the type of referral.

External regulation (extrinsic motivation) appears to be one of the reasons why the following people took part in CWMP. However feeling obliged to behave in a particular way does not necessarily lead to success as the change in behaviour is not self-governing (Vallerand & Bissonette, 1992)

> *"the doctor advised me to lose some weight, umm just for the sake of.... having better movement" (≥5%, completer, 52)*
>
> *"I'd had trouble with kidney stones…they [medical professionals] said it's because of my weight" (≥5%, completer, 70)*
>
> *"I went for a check up with being over 60 at the hospital….. and the only thing they found wrong with me was that I was overweight" (<5%, completer, 69)*

Research has shown that when people are referred by a medical practitioner they are not necessarily motivated to participate (Binks & O'Neil, 2002). When looking at the "stages of change" model the following person could have been in the pre-contemplation stage but attended CWMP because they felt it was compulsory to do so and therefore would be less likely to succeed.

P* – *"I went dragging my feet" (haha)
I* – *"So you felt like you were doing it for someone else, maybe rather than doing it cause you felt like you wanted to?"
***P* – *"Oh I certainly, no it's not something I would choose, no" (<5%, completer, 69*)**

Again another type of external regulation appeared, from the people surrounding them, rather than medical professionals.

"the group sessions were alright, I mean, and you know your motivation wouldn't be as high, would it?" (<5%, completer,68)

P *"you had to go to them [both LWFG classes] so it made me do it, and so it got me off my backside on a Saturday morning and made me go and do it…you know you can sit until the cows come home and say your going to exercise, and you never go. I don't, or I might do it twice and then stop"*
I *"so it kind of gave you the motivation to do it?"*
P *"Oh definitely, definitely" (≥5%, completer, 70)*

From their comments, there appeared to be several people who were in the preparation stage at the time of starting CWMP, however, the change may not be maintained as the people appear to be using interjected regulation (extrinsic motivation) and carried out the behaviour because they felt they should be doing it.

"I thought it was about time, health wise anyway" (<5%, non completer, 54)

"I need to lose weight and I want to lose weight …if I could lose a bit of the weight I won't be putting such a pressure on my heart" (<5%, completer, 75)

"I thought I better do something about it [weight], while I still can" (<5%, completer, 55)

Identified regulation appears to have been used successfully by some people, in that they valued the behaviour that they where undertaking. So by positively changing their behaviour they were able to use it as goal for the future (and therefore would be more likely to maintain the behaviour).

> *"when you won the ergh Slimmer of the Week, and different awards, I thought it errr gave you the feeling of more of a challenge for the week after…" (≥5%, completer, 66)*

Other people seemed to be motivated internally and the CWMP programme provided them with something that they wanted and enjoyed:

> *"I was really pleased, because I really wanted to lose weight" (≥5%, completer, 60)*
>
> *"I enjoyed the company" (≥5%, completer, 57)*
>
> *"It wasn't a chore going to it [PA sessions]" (≥5%, completer, 56)*
>
> *"because the exercise was in with it, I think that's what made it" (≥5%, completer, 51)*

As the whole LWFG pathway is a free service this appeared to be an important reason for people to start the programme, possibly moving them from contemplation, to preparation and then action.

> *"I thought it [LWFG] was excellent because it gave me an incentive and it also saved me money…2 of my friends were already going… meant that we could do it together" (≥5%, completer, 61)*
>
> *"I was eligible for the free SW class" (≥5%, completer, 52)*
>
> *"You know how you get the 12 weeks free?" (<5%, non completer, 54)*
>
> *"I may well have gone and done that, cause I kept thinking about, oohh, I could lose a stone you know, but just having that incentive and that little push, sort of got me going" (≥5%, completer, 61)*

"It was great, it was ideal, I mean to be honest the thing that put me off in the past was the cost of it, so it really helped that it was funded" (<5%, completer, 72).

As mentioned earlier in the literature review (Vallerand & Bissonette, 1992),. extrinsic motivation is the most difficult to upkeep. The programme may not have been successful for some people as their motivation was extrinsic and so they may have relapsed back into using their old habits.

"it was easy to follow the diet, it's just hard for me to stay on the diet (haha)…When you've got 2 young kids and you want to eat what they're eating" (< 5%, completer, 72)

"The diet itself was great. It was fine the diet. Ummm, I'm just, I'm just awkward, I'll do really well one week and then I'll not do it the next" (<5%, completer, 56)

No one appeared to use integrated regulation, although this is unsurprising as this is the most difficult type of motivation to upkeep and requires a lot of self-determination (Vallerand & Bissonette, 1992)

Overall people felt that they would have liked to have stayed on CWMP for longer, which may suggest that they may feel that they will only be able to lose weight whilst they are on the programme and may struggle to maintain the changes once they have finished the programme. Using the stages of change model 12weeks (3 months) may not be an appropriate length of time (as shown by the Counterweight Research, 2008).

"I could have carried on for longer" (71)

"I think that it could be for longer" [LWFG] (<5%, completer, 68)

Theme 6 - Healthy Foundations Segmentation Model (DH, 2010)

Using information from the qualitative work carried out for the DH, the service users have been split into different segments. However, not all interviews gave an indication of which segment the person may belong to, therefore the questionnaire may be needed to confirm segments (DH, 2010b).

Health Conscious Realists

HCR's are usually self motivated and comfortable with control. They are realistic, disciplined and goal driven. They often feel good about themselves and capable of choosing behaviour

> *"I've reached my target goal now, and I'm quite happy now, I'm hoping that I can maintain it" (≥5%, completer, 66)*

HCR's often like to rise to the challenge, even if it was not seen as an easy goal.

> *"when you won the ergh Slimmer of the Week, and different awards, I thought it ergh gave you the feeling of more of a challenge for the week after" (≥5%, completer, 66)*

Healthy living is often seen as positive and enjoyable and it can improve self esteem.

> "… I soon got in to it. And I really enjoyed errr, I started going to aqua aerobics on a Tuesday … and the exercise as well on a Thursday

…So it's keeping me fit as well in my old age" (haha) (≥5%, completer, 62)

HCR's will also allow themselves treats as they are generally living a healthy lifestyle

I "Was there anything that you thought didn't work very well about the diet?"
P "No, we can eat the bread, and he can have his bacon and egg on a Sunday morning, and things like that, it all worked really well… You know, and things like potatoes, and pasta which we both like" (≥5%, completer, 62)

CWMP may therefore be a useful service to help HCR's get back on track as the DH estimate that 32% of HCR's have high BMI[12].

Balanced Compensators

BC's have an aspirational outlook with goal setting and planning to control health. They reject prescriptive interventions and want information purely so they can make their own mind up.

Therefore as BC's like to make their own choices, referral by a medical professional may therefore not be welcomed.

"I told them then [medical professionals] that it's not the sort of thing that I like but I'll go because I ought to go" (haha). (<5%, completer, 62)

[12] High BMI is not defined in the literature; therefore it could be a BMI above 25 kg/m² or 30 kg/m².

BC's often feel that information is all they require for them to maintain their health.

> ***P – "****But the actual [SW] sessions, there just, not, you know it's my character as well, you know I just don't like things like that to be honest".*
> ***I – "****So you'd rather just get the information and do it yourself?"*
> ***P – "****I would, yeah, yeah". (<5%, completer, 62)*

BC's often agreed that exercise classes would be a sensible option and would produce positive long term outcomes.

> *"I preferred the exercise… I was doing it everyday at home" (62)*

CWMP does not seem to be the most suitable option for BC's. 29% of BC's have a high BMI but a service that is not as structured and prescriptive as CWMP may suit them better. Dietary Advice Direct is another option on the LWFG pathway which may be more suitable, as information is provided but the individual chooses what they feel they need to change.

Live for today

LfT's Show little evidence of planning or goal setting and their lifestyles are often chaotic and unstructured. LfT's generally make few efforts to be healthy and are usually uninterested in health issues. Key influences regarding health is generally received from friends and family. The interviews showed that 11 people had started CWMP after speaking to friends or family and of those, eight were able to lose >5%.

LfT's are interested in interventions that promote structure and trust the NHS brand. They support interventions that are linked together as they realise there are overlapping behaviours.

LfT's do not have a consistent philosophy with regards to health.

> *The diet itself was great. It was fine the diet. Ummm, I'm just, I'm just awkward, I'll do really well one week and then I'll not do it the next (<5%, completer, 56*)

LfT's rely heavily on social support

> *"you get all new friends and all that" (≥5%, completer, 74)*
>
> *"Two of my friends were already going … So it meant that we could do it together" (≥5%, completer, 61)*

LfT's often respond to immediate "health threats", therefore they may respond well to referral via medical professionals

> *"I'd had trouble with kidney stones…they said its because of my weight" (≥5%, completer, 70)*
>
> *"the doctor advised me to lose some weight, umm just for the sake of.... having better movement" (≥5%, completer, 52)*

Leading a healthy lifestyle can also be seen as an aspiration that may not be achievable due to other circumstances – so they may be motivated for a short time.

> *"it was just personal circumstances at the time I didn't carry on with it" [SW classes] (≥5%, completer,52).*
>
> *"you know just being honest with you, ummm well we had an event in the family that caused a few a meals (haha)… I've put a few pounds*

back on, of which I want to get my head round it again now" (<5%, non completer, 54)

LfT's like a structured programme because it provides support in an otherwise "chaotic" lifestyle.

"it got me off my backside on a Saturday morning and made me go and do it" (≥5%, completer,70)

"*exercise and the diet program as well, yeah I thought it was a good idea" (<5%, completer, 68)*

LfT's Use social influences to define what acceptable behaviour is.

"the exercise group sessions they help because obviously you've got other people doing it with you". (≥5%, completer,53)

"it was the team camaraderie as well, during the exercise classes" (≥5%, completer, 52)

LfT's can also be sceptical about whether initiatives can actually produce positive behaviour, such as weight loss maintenance.

"I just have to keep it off now" (≥5%, completer,61)

29% of LfT's have a high BMI therefore CWMP may be a suitable option as it involves support, to change different health behaviours and offers group support which is valued by LfT's.

It is important however, to be aware that not all LfT's will be successful as their motivation can change, and this may be a point to look upon for the future.

Hedonistic Immortals

This segment did not appear in the interviews. However, HI's often have more problems with risky behaviour, such as drinking, smoking and drug taking.

HI's want convenient, easy access facilities, with instant results. They need reward focused behaviours to consider changing behaviours therefore it could be expected that CWMP would not be something that would attract HI's.

Unconfident Fatalists

UF's are typically pessimistic and fatalistic in outlook. They try to escape from problems of everyday life by choosing unhealthy behaviour choices. All UF's exhibit low self esteem, and dissatisfaction with life which can lead them to become isolated. Low self esteem, lack of motivation and a depressive outlook, all combine to lead some to have compulsory unhealthy behaviours.

UF's often feel that they lack a sense of control over their own health

"I need a hypnotist" (<5%, completer, 72)

UF's often feel that health is a positive thing but it may be unachievable.

I mean, because of the children I didn't actually stay to the counting sessions…maybe that would have helped me on my way" (<5%, completer, 72)

Often UF's are already unwell and believe it could be difficult to achieve a healthy lifestyle.

> *"I think for me I could have done with a proper, a dietitian….I have all the health issues" (<5%, completer, 73)*

> *"…I've been thinking that if I could lose a bit of the weight I won't be putting as much pressure on my heart…but, if, you know, one thing is cancelling out the others…" (<5%, completer, 75)*

Interviewee 59 had attended SW several times but as with other UF's their state of mind is often linked to their health choices.

> *"I didn't lose enough weight, because, like I said I'd been suffering from depression… and then even when I went back in October, I still wasn't really well" (<5%, completer, 59*)

LfT's often believe that healthy lifestyles are generally unachievable

> *"the cost of all this food, it's expensive food you know" (<5%, completer, 73)*

the DH estimate that 33% of UF's have a high BMI, which is the highest of all of the segments. However, CWMP does not appear to be the most appropriate option. The Health Trainer service is another option on the LWFG pathway and this service may be more appropriate as they are able to provide a client centred approach and are successful at improving self esteem and confidence which appears to be crucial (NHS ALW, 2010)

Outcome

Theme 7 –Lifestyle change

Previous research on weight maintenance shows that those who are able to maintain weight loss are successful at changing their diet and substantially increase their physical activity levels (Klem et al. 1997)

The SW eating plans appear to have been effective for some people as it has made them think about portion sizes and what they are actually eating.

> *"Monitoring the portions and monitoring what I was eating was effective" (≥5%, completer, 71)*
>
> *"it's kind of about checking your portions and things like that" (≥5%, completer, 66)*
>
> *"it's just keeping a check on what you are actually eating, but you don't feel that you are deprived of anything" (≥5%, completer, 60)*
>
> *"I have dieted with her [wife] on different, ummm, programs, and the SW one seems to be definitely, definitely one that works cause I've lost 3 stone up to now… I think it was the way that it taught me how to eat, and what to eat" (≥5%, completer, 53)*
>
> *"It was actually changing your way of eating which I think you would stick too long term" (<5%, completer, 76)*

This could lead to learning new ways of cooking and trying new recipes.

> *"the booklet and the recipes worked because it was interesting doing the recipes, my wife and I" (<5%, completer, 65)*
>
> *"the booklet and the recipe's worked because it was interesting doing the recipes" (<5%, completer, 65)*
>
> *"I can do my big shop, and I can plan every day, out the SW magazine, we get those every month, and we look inside and we keep trying different things" (≥55, completer, 70)*

The SW eating plan appears to fit in well with family life, which is positive as it is not only the service users who benefit from CWMP but they are also able to put what they have learnt into practice and improve the eating habits of other members of their family.

> *"The food that's in the book [Extra Easy book] suits me and it also suits my family cause my family help me out with it as well cause they eat the Keema curry and things like that" (≥5%, completer, 70)*

> *"you could eat what I call normal meals, ummm that you can have a family meal, and there's no reason for you to feel any different from the family, because your all eating a perfectly normal meal" (≥5%, completer, 61)*

> ***P**- "It's not like, ohh there's your tea, now I need to sort mine out differently"*
> ***I – "**Yeah, so you can kind of incorporate it in your daily life?"*
> ***P – "**Yeah, it's very easily, you know, even if you were eating out, you could actually work it in to the plan" (<5%, completer, 76).*

In fact some people have found that they have completely taken on board the SW eating plan and appear to be thriving from it.

> *"you might know how serious it is for me, my daughter over Christmas bought me the 2 SW recipe books, and she also enrolled me for the 12 month magazine" (≥5%, completer, 66)*

> *"I go in the website because there's a website you can go on and that helps you, and give's you different recipe's and that, you know which I've been printing off, and putting, I've got a file and some loose, ergh plastic sheets, you know" (≥5%, completer, 62)*

The PA sessions have become popular overall and extra sessions have been provided by WLCT at the discounted rate of £1.50 per session.

> *"I didn't only go to the [PA session] on Tuesday… I then joined the Monday [PA session]" (<5%, non completer, 54)*

"so we continue with it [PA session], I continue on and pay now" (<5%, completer, 65)

"we go there on a Wednesday just to keep up our exercise classes" (≥5%, completer, 53)

"I ended up doing an extra [PA] session on Wednesday evenings" (≥5%, completer, 52)

Other people choose to do extra PA which didn't involve the PA sessions provided by WLCT's PA officers.

"I do quite a bit of walking now actually" (<5%, completer, 67)

"So all the time I was at this Slimming thing, I was actually going to the gym and doing a couple of hours twice a week, and doing Slimming as well. So I had quite..... a lot of exercise. So obviously since then… I've lost 3 stone" (<5%, completer, 55)

Some people seem to have focused on the cost of PA, whereas there are many option in the borough for free exercise (such as Health Walks; WLCT, 2010)

"I know it's only about 1.50, but if you want to do a couple a week [PA sessions] it adds up when you're not working" (<5%, completer, 73)

Chapter 4:

Discussion

Review of Findings

Many Weight management interventions have focused solely on the number of people who have successfully lost >5% of their initial body weight; as recommended by NICE (2006). However, there appears to be little research to suggest whether greater numbers of people could attain this goal, as this would be beneficial in terms of health, and also resources.

As mentioned previously, Richard Bandler and John Grinder co-founded the field of Neuro-Linguistic Programming (1975) after investigating transcriptions from the Gestalt Therapist Fritz Perls, Psychotherapist Virginia Satir and later the Psychiatrist Milton Erikson. The aim of reviewing the transcripts was to understand why these people had been so successful while other therapists had not been as successful. Even though the therapists had different personalities they had used similar patterns and techniques with their clients.

From this viewpoint and using a framework of Realistic Evaluation (1997) the aim of this dissertation was to understand why some people had been more successful at losing weight over a 12 week period than others. By reviewing the 25 transcripts, seven key themes emerged to produce a CMO that may help to understand the different techniques employed by the service users and also any differences within the programme (see table 5)

Table 6: CMO of CWMP

	MECHANISM				**CONTEXT**		**OUTCOME**
	Theme 1: Overall Group Session	Theme 2: SW consultants & PA officers	Theme 3: PA sessions	Theme 4: SW eating plan	Theme 5: Motivation	Theme 6: segmentation	Theme 7: Change to lifestyle
Successful weight loss (≥5%)	Enjoyed SW sessions Enjoyed PA sessions	Happy with the support from SW consultant and PA officer	People started exercising again Tried new activities Wanted more sessions	Understood plan Followed the rules	Intrinsic motivation Identified regulation Contemplation or preparation stage	HCR's Some LfT's Possible UF's who have graduated to LfT's?	Aware of portion sizes and monitoring behaviour Increased PA Family included
Unsuccessful weight loss (<5%)	Did not enjoy SW sessions Did not mention PA sessions	Overall happy with support although some felt that more support could have been provided by SW consultant		Struggled to understand plan Used plan as a guideline	Interjected regulation Pre-contemplation stage	Some LfT's BC's UF's	Changed eating habits Learnt new recipes / cooking methods Increased PA

Theme 1 – Group support

Those who had lost ≥5% generally found the group support useful in both the SW and PA sessions. They also felt at ease in both sessions and found support from each other.

Those who had lost <5% generally focussed on the SW group session and found it to be less useful and concentrated on this part of CWMP. There was little mention about the group PA sessions.

Overall group support for the SW classes appears to be constructive for some people but detrimental for others, whilst the support in the PA sessions appears to have been positive and constructive.

Social support is considered to be an important aid for weight loss and maintenance. However, when looking at support from a partner, it is not always positive and can interfere with the long term outcomes (Elfhag & Rossner, 2005). Therefore it may not be useful to encourage partners to join the programme together

Locus of control also appears to be important. If a person has an internal locus of control they feel they have better control over their own behaviour and events around them, whereas those with an external locus of control feel they are less in control of their behaviour. Using the Weight Locus of Control Scale (Saltzer, 1982) participants who showed more internal control also appeared to show more confidence in their weight loss behaviours. Whereas those with an external locus appeared to perceive more barriers to losing

weight and where dissatisfied with the social support they received (Holt, Clark & Kreuter, 2001). This may provide an explanation as to why some services users felt that they did not enjoy the group support sessions, and further research may be required to be undertaken with regards to Locus of control.

Theme 2 – SW consultants and PA officers

Overall the majority of service users where satisfied with the support the received from the SW consultants and PA officers. They provided timely information and encouragement, but would also query the service user if they felt the person could be trying harder.

Professional support has been found to maintain treatment outcomes, possibly due to enhanced vigilance, motivation or encouragement and support (Perri, Sears, & Clark, 1993). Therefore the SW consultants and PA officers may enhance weight loss purely by being present.

The SW consultants and PA officers are similar to community food workers as they try to raise people's awareness of the link between, diet, physical activity and health. SW consultants are similar to food workers in that they adapt and provide new recipes to those attending sessions. Similarly they also provide new foods for people to try, and can offer advice on buying food on a budget (Way To Work, 2010 & SW, 2010). SW consultants encourage people to cook with fresh ingredients so that it can cost less than processed

foods, and so the SW eating plans may be suitable for those on low-incomes (SW, 2010)

Exercise on referral schemes have previously used personal trainers to produce an exercise plan tailored to the needs and requirements of the person (NHS Choices, 2010). For CWMP, the PA officers are required to provide individualised support whilst working in a group situation. At the end of the sessions with the personal trainer a review of the person's progress is undertaken and further advice is provided (NHS Choice, 2010). However, although the PA officers talk about the options available (such as other exercise classes throughout the borough) they may not be able to talk to each person on a one to one basis and discuss their progress.

Research has suggested that by providing information, this can be enough for some people to increase physical activity (Isaacs et al. 2007), and some service users have gone on to join other classes therefore a tailored plan may not be necessary for everyone.

Theme 3 – The SW Eating Plan

Those who had lost ≥5% understood the plan (even if initially they had struggled to understand it) and they were able to put the information into practice and tended to stick to the rules.

Generally those who had lost <5% found that they struggled to understand the eating plan and instead of using the SW consultant, some looked for

sources of information elsewhere. They were also more likely to use the eating plan as a guideline rather than stick to the rules. Therefore there does appear to be a difference between the two groups, in that different methods of eating and gaining advice are put into place.

SW have a team of dietitians and nutritionists to ensure that an up to date approach is taken (SW, 2010). The “Extra Easy” plan is the newest food plan and appeared to be the most commonly used eating plan by those who where interviewed. “Extra Easy” it is similar to the guidelines suggested by the Eatwell Plate (FSA, 2008) in that it encourages a balanced diet. The Eatwell plate is comprised of approximately 80% fruit, vegetables, starchy carbohydrates and protein, which are all free foods on the “Extra easy” plan. SW also encourages members to eat calcium rich foods and foods that contain dietary fibre. SW recommend that the more energy dense foods should be limited and therefore contain a specific Syn value (SW, 2009).

Weight watchers are another commercial company who have worked with the NHS and published results (e.g. Poulter & Hunt, no date). Weight Watchers have an original points system and a new version called ProPoints which was launched November 2010. The difference between the two plans is that the original points system was based purely on calories and saturated fat in food, however, ProPoints, advocates food that will make people feel more satiated (filling foods) and therefore can be a better weight loss choice (Weight Watchers, 2010). For example one slice of wholemeal toast, a poached egg and two rashers of bacon has 8 Pro points, and a muffin with jam and butter has 9 ProPoints, whereas previously they both would have

had 5 ½ points. This new system should help people see the difference between healthier versions of food rather than just base it on points (Daily Mail, 2010). For example one of the people taking part in the trial, Gillian Rea stated:

> *"For instance, a banana and a curly wurly would have the same points - so instead of eating healthily I would eat what I preferred; the curly wurly*" (Daily Mail, pg 53, 4.11.10)

However, Slimming World already appears to be doing this; for example members are encouraged to fill a third of their plate with free food (such as vegetables) so that the calorie value is low, but the meal becomes filling. There is then a specific number of Syns available per day for more calorific and less satiating food, such as chocolate and ice cream, and therefore there isn't a trade off between healthier foods (SW, 2010), such as the example above, which compares banana's and chocolate.

Diets and eating plans can be difficult to understand and require a lot of cognitive processing (Shaw & Tiggemann, 2004) therefore this may make it difficult for people to stick to. However, a lot of food on the "Extra Easy" plan is free and therefore, in theory, makes it simpler to understand, although some service users did struggle with the concept and it may have exceeded their resources.

Theme 4 - PA sessions

Overall the PA sessions helped people get back into exercise. Some people tried new activities and a lot of people seemed to want more sessions with the PA officers. There seemed to be little difference between those who had successfully lost weight and those who had not, however, as PA is important for general health and wellbeing (NHS, 2010) this is a positive response and seemingly popular mechanism.

Previously exercise on prescription has been used as an intervention. One study has found that a 10 week programme of exercise classes or walking sessions may not be more effective than providing information on available of sessions (Isaacs et al. 2007). It was also suggested that advice about exercise may be enough to initiate people into action. However, from the interviews, service users mentioned that under the circumstances (e.g. weight, health, confidence etc) it is unlikely that they would have taken up such an offer. Conversely, at the end of the 12 weeks, it appears that information would be enough to encourage people to join other classes and continue exercising.

Telephone support has also been suggested to improve uptake of physical activity within Primary Care patients (Green et al. 2002). The PA officers and SW consultants already appear to contact service users to check on their progress and offer additional support, as suggested by some interviewees.

Theme 5 – Motivation & Stages of Change

Overall people seemed pleased that the service was free and it provided an incentive that many people had been waiting for.

Very few people used internal motivation and so various types of external motivation where used. One problem with external motivation is that it is more difficult to stay motivated and so it is easier to revert back to old habits (Verplanken & Faes, 1999).

Those who used health as a reason to start may be more likely to regain weight. It is thought that those who lose weight for reasons other than health may be more confident in their ability to lose weight; which was then linked to an increased self-esteem as the person felt more competent to cope with the challenges faced in their life (Ogden, 2000),

Referral from a medical practitioner is not always positive as some people will not be ready to change or will feel that they are only trying to change their behaviour for someone else (Binks & O'Neil, 2002), and this was supported by the comments from some service users.

Theme 6 – Health foundations Segmentation (DH, 2010)

HCR's and some LfT's appear to be the most likely segments to thrive using CWMP. (LfT's would require a mechanism to ensure they where able to keep motivated even when stressed). However, UF's and BC's did not appear to find the service as useful.

It is possible for UF's to "graduate" to become a LfT as they already share some characteristics. Therefore it may be useful to monitor UF's as CWMP may become something that they could find useful. Health Trainers may be a more appropriate option for UF's as they can provide a person centred service which can improve confidence and self esteem (NHS ALW, 2010). This could then lead them to move towards starting 12 weeks of CWMP.

25% of population are thought to be LFT's and 21% are thought to be HCR's. This equals 46%, which is a large proportion of the population (DH, 2010). Synthetic estimates[13] are currently being produced so that each area (such as NHS ALW) has a better picture of the percentages within each segment. However, as an overall picture, The Northwest of England has the same percentages as the England average; therefore CWMP may be a useful programme as 60% of the LfT's and HCR's have a high BMI (DH, 2010b).

The research from the DH suggests LfT's welcome the idea of a health check as they do have some concerns over their health and HCR's welcome and take advantage of a health check as they like to be in control of their health (DH, 2010b). NHS ALW employs a "Find and Treat" programme which aims to find people with high blood pressure, high cholesterol and early signs of diabetes. The programme has been successful and advice is also offered surrounding healthy eating and increasing exercise (NHS ALW, 2010). This may be an opportunity to make more people aware of LWFG and CWMP, particularly for LFT's and HCR's.

[13] Synthetic estimates are used when real data is unavailable or statistics are too small to provide reliable estimates. (Wirral NHS, 2010)

Overall the segmentation model has been proposed to help reduce the Health Inequalities at a local and national level. This is because some interventions can widen the gap if they are not able to engage with the correct population. Therefore the segmentation process can help target people to ensure the effect will be limited. The research has been carried out with different audiences using qualitative and quantitative data (DH, 2010b).

Other segmentation processes have previously been used (cited in Harrison et al. 2010),

Table 7: Examples of segmentation systems

Classification System	Number of segments	Segmented according to:
Index of Multiple Deprivation (IMD, 2007) quintile	5 or 10	Multiple deprivation: income; employment; health and disability; education, skills and training; barriers to housing and services; crime and living environment.
People and Places (P2)	13	Age; household composition; housing; employment; income; transport; leisure; spending patterns; general health; area stability.
Health ACORN	23	Indicators of existing health; lifestyle indicators; property value; location.
Office for National Statistics (ONS)	20	Demographics; household composition; housing; socioeconomics.
Mosaic	11	Demographics; socioeconomics and consumption; financial measures; property characteristics; property value; location.

Along with IMD (2007), The Healthy Foundations Lifestyle segmentation has the fewest segments (5) but also looks at age, attitudes, behaviours as well as demographics; therefore may be able to provide a more holistic understanding of population in England (DH, 2010)

Theme 7 – Lifestyle change

Generally those who lost >5% mentioned the most lifestyle changes in relation to diet; however, there seemed to be an equal split regarding PA. An interesting finding to note was that several service users mentioned that they had made changes not only to their own diet, but also to their family's diet. This relates back to the governments policy (Healthy Weight, Healthy Lives, 2008) in trying to help children maintain a healthy weight. Therefore, even though the children are not attending the SW sessions, they may still be able to benefit from the changes that their parents are making.

This may also be useful for males as CWMP attracts a majority of females to its classes (92%, Hogg et al. 2010), and the principles may be put into practice when back at home. Some service users mentioned that their husbands had been eating similar meals and some male service users mentioned that they had previously been on a diet because their partner had. This is useful as levels of overweight and obesity are higher in males than females (HSE, 2008) and therefore this may be a method of reducing obesity without having to provide a direct intervention.

Some service users had mentioned that they had noticed that they needed to monitor what they where eating and reduce their portion sizes. Research has suggested that this type of self monitoring behaviour can reduce over time (McGuire et al. 1999). One reason could be that it is too difficult for some people to watch what they are eating over a prolonged period of time (Byrne, Cooper & Fairburn, 2003) and therefore slip back into old habits. Therefore it may be useful to offer support after the 12 weeks have finished either by providing help via the telephone or by the SW consultants/PA officers talking about the other services available from LWFG.

Use of a Realistic Evaluation Framework

The National Obesity Observatory (2009) has provided a Standard Evaluation Framework to follow in order to regulate the type of information collected in weight management evaluations. Section 38 states that potential facilitators and barriers to lifestyle change should be assessed. However it does not state a particular theory or concept that should be followed in order to do this. Realistic Evaluation (Pawson & Tilley, 1997) was chosen as it allows for investigation of "*what works for whom, under what circumstance*"

Realistic Evaluation appears to be useful as it provides information not only about outcomes, but also allows for the views and opinions of service users to be explored which is often missed by Randomised Control Trails (RCT's); the gold standard used to look at the effectiveness of an intervention (NOO, 2009).

RCT's can be expensive and may be impractical for many Public Health interventions. RCT's are useful if looking purely at specified outcomes (NOO, 2009), however, many community based programmes, such as CWMP, have several elements and partnerships that would be difficult for an RCT to measure. Therefore when comparing RCT's to Realistic Evaluation, RCT's would be able to provide information about "*what works*" but would be less able to provide information about "*for whom, under what circumstance*" (Pawson, 2006). Findings from evaluations using Realistic Evaluation may therefore be just as useful to evidence-based policy makers as RCT's have been, because RE evaluations will allow for a wider view of social programmes, which RCT's may miss (Pawson, 2006).

Recommendations

Albert Humphries created the SWOT analysis to evaluate the strengths, weaknesses, opportunities and threats faced by a project or business. Using the information from the CMO themes, a strategic plan can be produced to provide recommendations for the development of CWMP.

Table 8: SWOT analysis of CMO themes

Strength	Weakness
• Combined PA and dietary advice • Professional support improves treatment outcomes • Free service is useful for those on a low income • Self referral can improve motivation • Treating LfT's and HCR's who are a large proportion of the population, who also have high BMI's	• Diet Plan not suitable for all • Diet plan may require more/different format of explanation • Dietetic expertise required for chronic conditions • Monitoring stops after 12 weeks • Some people are not keen on group session of SW (possible external locus of control)
Opportunity	**Threat**
• Increase number of sessions to improve chance of permanent behaviour change • Provide information packs to those finishing the sessions so that people are aware of other services in the borough • Include LWFG information with "find and treat" • Use telephone support	• Motivation – ensure referral occurs for people who are ready to change • Segmentation – the service does not provide what all segments require • Encouraging everyone with a BMI above 25 kg/m² to join • Encouraging partners to join the same group

• Capture UC's who become LfT's after help from Health Trainers • Segmentation model could be used for referral by Dr's and also by NHS Direct • Refer into another service if CWMP is not suitable	• People with health problems may struggle to maintain weight

Using information from the SWOT analysis recommendations can be made considering the contexts and mechanisms of CWMP.

Mechanism - CWMP

1) Group diet sessions do not appear to work for everyone therefore a different service, such as Dietary Advice Direct may be more suitable along with information about Physical activity programmes throughout the Borough.

2) People have different learning styles, therefore during the initial induction session, provide information in different ways when discussing the eating plans.

3) Provide training on specialised conditions for SW consultants so that they are able to meet needs of more people

4) Provide leaving packs for those finishing their 12 weeks, with information about the other options available on the LWFG pathway, and also throughout the borough, such as free health walks.

5) If CWMP does not appear to be suitable for someone then they could be referred onto another section of the pathway.

6) Increase the length of time of the programme. Counterweight (2008) has shown that weight loss can increase by 6 months; therefore 3 months may currently not be an adequate amount of time.

Context

1) It is important to assess people's motivation to change before referring onto CWMP. This could be done at the Doctor's surgery or could be done when the person rings NHS Direct.

2) Those who are intrinsically motivated appear to be more successful, therefore social marketing could be used to attract people to a service that they would want to participate in, rather than feel like they have to participate in.

3) It is important to assess which segment people fit into. However, this may require a borough wide approach in order to understand which services suit different segments? The DH has produced a short questionnaire (DH, currently unpublished) which could be used to identify people using different services, such as CWMP.

4) Try to engage with HCR's and LfT's, through word of mouth or health checks (such as "Find and Treat").

Limitations of the Evaluation:

Qualitative data cannot often be generalised to the whole population – however, RE allows for people to understand *"what works for whom, under what circumstance"*, therefore findings are not necessarily generalisable to the whole population, just to those attending CWMP in the Wigan Borough.

It can be difficult to ensure the context and mechanisms are correct; for example, motivation could be a context or a mechanism depending on whether it is related to CWMP or the individual. Previous research has used it as a context and a mechanism (Tilley, 2000, Pitman et al. 2010)

Even though telephone interviews have been shown to be comparable to face-to-face interviews (Carr & Worth, 2001), non-verbal cues such as body language are missing during telephone interviews. Research suggests that communication comprises of 55% body language, 38% tone and only 7% words (Mehrabia, 1980). This makes it difficult to ensure the correct information is put across and interpreted in the correct way when using telephone interviews. Therefore along with misinterpretation and the researchers views on what themes have emerged, bias may occur.

Theme 6 looked at the Health Foundation's Life Stage Segmentation model (DH, 2010). A questionnaire has been produced by the DH (currently unpublished) therefore it may be useful to ask people to fill it in and see if the responses match with the findings. This is because the interviews can only provide a rough estimate (although the questionnaire was produced from the interviews and focus groups carried out on behalf of the DH)

As this is part of a wider evaluation of LWFG, the researcher only asked questions regarding CWMP, therefore important contexts may have been missed. However, questions diverting away from the evaluation of LWFG may have been classed as research and would therefore require NRES approval.

Researcher Reflections:

The researcher is a Knowledge Transfer Partnership (KTP) Associate working with NHS ALW. The researcher has attended sessions of CWMP, has met and liaised with members of staff from SW and WLCT and has met and spoken to service users of CWMP before carrying out the research. The researcher is also undertaking the rest of the LWFG evaluation, therefore, is aware of the qualitative and quantitative results from the other services. The researcher may therefore unintentionally infer meaning due to the close involvement with the whole evaluation, and the people within it. However, the close involvement may also lead to a deeper understanding of the data.

Also as a member of NHS ALW, the researcher often receives information that has not yet been published, for example, Rossiter (2010). Often this data is published elsewhere, in this case on the Telegraph website (Smith, 2010). There are problems when using reports of studies as the information may be biased or may be inaccurately reported. Therefore in this dissertation, even though a search of the literature may highlight information other than journals (such a E-newspapers), unpublished data has been used.

The CWMP interviews have been carried out after the HT and DAD interviews, therefore the researcher has been able to practice prior to carrying out the CWMP interviews, and so may have been able to capture more information than may have been possible if the CWMP interviews had been carried out first.

The researcher is also trained in counselling skills up to level three (Person Centred Counselling (Rogers, 1979) and therefore is aware that it is important to listen and to paraphrase, which the researcher tried to do whilst undertaking the interviews. However, when providing this type of feedback it can be difficult not to provide leading questions, for example:

> *P: "I went dragging my feet"*
>
> *I: "So you felt like you where doing it for someone else maybe, rather than doing it because you felt like you wanted to?*
>
> *P: "Oh certainly, it's not something I would choose, no." (<5%, completer, 69*)

Chapter 5:

Conclusion

It is likely that NHS weight management programmes are currently not engaging with the correct people for the service they are providing.

In order not to misuse resources by trying to engage with the whole population of the Wigan borough, it is important to identify who will benefit from CWMP by:

- Trying to engage with HCR's and LfT's
- Assessing readiness to change
- Assessing motivation

With regards to CWMP, possible changes could be made:

- Group sessions are not appropriate for everyone, therefore it may be useful to refer the person onto another service if they think it would benefit them
- People have different learning styles therefore it may be useful to re-examine the initial induction session to ensure people are able receive a greater understanding of the eating plans.
- Increase the time period from 12 weeks to improve weight loss.

Overall this dissertation will add to the limited evidence base for weight management interventions in the UK. Even though different approaches to Evaluation could have been used, the framework of Realistic Evaluation has offered a perspective on what parts of CWMP work and under what circumstance; therefore allowing NHS ALW to make changes to the programme, engage more effectively with the population of the Wigan Borough, improve success rate and therefore use resources more effectively.

Chapter 6:

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Appendix A

Search strategy used:

"Weight management" AND (evaluation OR analysis) AND NOT (child* OR animal)

Database	number
Springerlink	415 (English only)
Google*	11,300,000 (first 500 scanned)
Google scholar	2720
Interscience (Wiley)	75
Science direct	85,000 (first 250 scanned)
Pub med	402
Elsevier	96 (weight management only)
Emerald	0
Nutrition Journal	0
British Journal of Nutrition	71
Journal of Nutrition	10
American journal of clinical nutrition	24
European journal of clinical nutrition	0
American dietetic journal	137
Cambridge journals	203

** Google would not normally be used as a tool for a literature review, however, many NHS weight management programmes have not been published in journals or presented at conferences and therefore important information would be missed.*

Appendix B:

Beginning of the recording:

"The following interview will look at parts of the service that you may have found useful and an also parts that you may have found less useful. We'll start with how you felt about accessing the service and then move onto CWMP. If at any point you wish for anything to be clarified or decide you no longer wish to participate then please feel free to say. The interview will be tape recorded and the information will be stored in accordance with NHS ALW information security policy. Could you confirm that you would like to take part in the evaluation?"

NHSD

Accessing service:

- How did you hear about LWFG?
- Can you tell me about your experience of phoning the LWFG help line?
- What did you initially think about the service you had been directed to?

CWMP interviews:

The service received:

- How did you feel about the diet section of the programme?
    - What worked well/didn't work well
- How did you feel about the exercise section of the programme?
    - What worked well/didn't work well
- What was your overall experience of the group session?
- How did you feel about the information and support provided?
- Do you have any other comments/improvements?

Appendix C:

Service Evaluation Consent Form

Study Name: Evaluation of the 'Lose Weight, Feel Great' pathway.

Participant's Name: ……

Investigator's Name: *Samantha Hogg, Research Associate, NHS Ashton, Leigh and Wigan.*

		Please initial box
1.	I agree to take part in this service evaluation.	☐
2.	I have had time to read the Participant Information Sheet and I understand it.	☐
3.	The evaluation has been fully explained to me, and my questions have been answered	☐
4.	I understand what I am expected to do.	☐
5.	I am happy for any comments I provide to be used in any articles that may be published and understand that they will be anonymised.	☐
6.	I understand that I am free to stop taking part in this service evaluation at any time, without giving a reason.	☐
7.	If I choose not to take part or to stop, I know that my care or legal rights will not be affected in any way.	☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

Appendix D:

Public Health Department

NHS Ashton, Leigh and Wigan

66a Standishgate
Wigan

Lancashire

WN1 1AH

((((Insert Date)))

Dear .....

Re: Invitation to take part in a service evaluation of 'Lose Weight, Feel Great!'

You are being invited to take part in the evaluation of 'Lose Weight, Feel Great' because you have taken part in the programme. It is important for NHS Ashton, Leigh & Wigan to evaluate this newly launched service in order to look at its effectiveness, assess whether it has been of benefit to you and whether the programme provides value for money.

Please read the enclosed information leaflet about the evaluation and feel free to ask any questions that you may have before making a decision about taking part.

I will contact you via the telephone in approximately one week's time to ask if you have any questions about the evaluation and to ask if you are interested in taking part. If you have any queries in the meantime, please do not hesitate to contact me on Tel: or via email

Thank you for considering taking part in the study,

Yours sincerely

Samantha Hogg

Associate

NHS Ashton, Leigh & Wigan

Tel:

Mob:

Appendix E:

Participant Information Sheet

Evaluation of the 'Lose Weight, Feel Great' programme.

You are being invited to take part in an evaluation of 'Lose Weight, Feel Great'. Before you decide whether you would like to participate, it is important for you to understand why the evaluation is being carried out and what is involved. Please take time to read the following information carefully and discuss it with friends and relatives if you wish. You are entirely free to decide whether or not you want to take part in this evaluation, and if you chose not to take part your access to the 'Lose Weight, Feel Great' service provided to you will not be affected. If there is anything that is not clear, please do not hesitate to contact me.

Introduction

'Lose Weight, Feel Great' is a new community weight management programme for the Wigan Borough. It has been designed to help people to lose weight and to maintain the weight loss in order to improve their health, well-being and quality of life. There are a number of services delivered as part of the programme including those provided by NHS Direct, the Specialist Weight Management Service, Wigan Leisure and Culture Trust, Slimming World, Dietary Advice Direct and NHS Health Trainers.

What the Evaluation hopes to answer

The main aim of the evaluation is to determine if these services are meeting the needs of the local population and to evaluate how successful they are in achieving weight loss. The evaluation will also make an assessment of the value for money provided by the services. The results will inform the NHS of any changes that may need to be made.

Why have you been invited to take part?

You have been invited to take part in the evaluation because you have accessed one of the services provided as part of the 'Lose Weight, Feel Great' programme.

What are the risks of taking part?

It is not anticipated that there will be any risks of taking part.

What the evaluation involves

The evaluation involves a face to face interview to seek your opinions and views about the 'Lose Weight, Feel Great' service you have received.

You will have a minimum of one week to decide if you wish to take part in the evaluation. If you agree to take part the evaluation will be explained to you.

The interviews will take place over the telephone. Consent will be required, either by signing a consent form or by verbally accepting to take part.

Do I have to take part?

Taking part in the evaluation is completely optional and will not affect any service that you currently receive from 'Lose Weight, Feel Great'. You can decide at any time not to continue with the evaluation**.** If you do decide to withdraw from the evaluation after the interview has taken place, the information you provided as part of your interview will be destroyed and will not be included in the evaluation results**.** However, once the analysis has been completed and the results published, it will not be possible to remove the information you provided at this stage.

Important Information

This evaluation is being funded by NHS Ashton, Leigh & Wigan and a Knowledge Transfer Partnership Grant.

Should you have any questions at any point now or later on, please do not hesitate to contact me:

Samantha Hogg, Associate, Tel:

Alternatively, you may like to discuss the evaluation with an independent person or should you have any complaints please contact the Research and Development Manager at the Primary Care Trust, Dr. Rachel Hall or Dr. Linda Dack who can be contacted on Tel: or the Greater Manchester Research Governance Partnership on

Appendix F:

NHS

National Research Ethics Service

North West 9 Research Ethics Committee – Greater Manchester West

Room 181
Gateway House
Piccadilly South
Manchester
M60 7LP

Tel: 0161 237 2392
Fax: 0161 237 2383

28 September 2009

Linda Dack
Acting Research & Development Manager
NHS Ashton, Leigh & Wigan
66a Standishgate
Wigan
WN1 1AH

Dear Linda

Full title of project: **Evaluation of an integrated community weight management pathway: 'Lose Weight, Feel Great'**

Thank you for seeking the Committee's advice about the above project.

You provided the following documents for consideration:

- Summary of Proposal

These documents have been considered by the Chair of the Committee

I enclose a copy of our leaflet, "Defining Research", which explains how we differentiate research from other activities. The Chair has advised that the project is not considered to be research according to this guidance. Therefore it does not require ethical review by a NHS Research Ethics Committee. In the opinion of the Chair this project is service evaluation.

This letter should not be interpreted as giving a form of ethical approval or any endorsement of the project, but it may be provided to a journal or other body as evidence that ethical approval is not required under NHS research governance arrangements.

However, if you, your sponsor/funder or any NHS organisation feels that the project should be managed as research and/or that ethical review by a NHS REC is essential, please write setting out your reasons and we will be pleased to consider further.

Appendix G: Example of an interview.

Interview – Participant 66

Interviewer – I
Participant – P

I – If I just go through a few things quickly with you first, basically the interviews just to look at your experience of the Community Weight Management service, that was the Slimming World and exercise classes.

P – Right

I – If at any point you want anything to be clarified or you don't want to take part anymore then just let me know, that's absolutely fine.

P – Okay love. Okay.

I – And finally the interviews being tape recorded, but all the information will be stored in accordance with the NHS's security policy, so umm any problems just let me know.

P – Okay love

I – So can I just confirm that you want to take part?

P – Yes love, yeah.

I – Excellent, so first of all, how did you hear about LWFG?

P – Ergh, my sister-in-law

I – Right okay, and can you tell me about your experience when you phoned up the helpline?

P – Ergh, it was quite good actually yeah, yeah. Yes it was helpful, yeah.

I – Were they able to put you on a session that was close to home or one that was appropriate for you?

P – Yes, it was where I wanted to go to.

I – Yeah, great, Umm, I mean what did you initially think about the service that you'd been offered?

P – I thought it was very good, I was, I was quite pleased with everything.

I – Brilliant, umm I mean if we look at the diet section first of the Slimming World part, was there anything that worked particularly well for you?

P - ...Ummm.... the book I thought, let's just have a look, and I'll tell you what it is

I – Right okay

P – It worked out well for me, it's the ergh, I'm actually cooking from it tonight, it's the extra easy.

I – Right, is it the recipe book?

P – Yes

I – Okay, I mean was there anything about the sort of Slimming World sessions that you know didn't work very for you?

P – No, no, because I have been to Slimming World once before, and it's always worked for me.

I – Right

P – But having said that, I do stick by it

I – Yeah

P – You know I do ergh; I do stick by the rules

I – So, it's kind of about checking your portions and things like that.

P – Yeah

I – Yeah, brilliant. I mean looking at the exercise then, was there anything about those sessions that worked well for you?

P – Ergh, the exercise was very good, the only problem is I've developed problem with my knees, my knees started, troubling me after a few sessions and then I struggled with my knees actually. But ummm.... we had a fantastic bloke who took us for the exercise; he was very good, you know very considerate, very thoughtful you know. If in any way it was a problem to us, to sit down. And he, he's brilliant.

I – Yeah, so umm, was he able to sort of tailor it to your needs then?

P – Pardon, what was that love?

I – Was he able to sort of give you exercises that suited you best?

P – Yes

I – Yeah

P – Yeah, definitely.

I – Right, I mean was there anything that you about the sessions that didn't work, obviously you've said that you had problems with your knees, but was there anything else?

P – No, no, I ergh I tried to take part in everything even though my knee's was a problem to me, ummm I went because I enjoyed the class so much.

I – Brilliant, that's great. I mean what was your overall experience of the sort of group sessions, so the Slimming World sessions and also the exercise sessions, how did you find being in a group?

P – I thought it would frighten me, I thought it was umm very inviting because everyone was so chatty and you know, exchanged things. And it was like an outing for me every week, it was like ergh, it was my time.... it was for me.

I – Yeah, ahh that's really nice. Umm I mean how did you feel about the information and support that was provided then, did you find it useful?

P – Yes

I – Yeah, excellent

P – Yes, and when you won the ergh Slimmer of the Week, and different awards, I thought it ergh gave you the feeling of more of a challenge for the week after.

I – Yeah, so did you win Slimmer of the Week then?

P – A few times.

I – Oh, well done, that's brilliant.

P – Yeah, yeah.

I – Ah excellent, umm I mean I'm sort of coming to the end of my questions really, so do you have any other sort of comments or improvements that could be made?

P – None at all, I don't think there's any improvements at all, everything's spot on, I think the girl who took us for the ergh, for the Slimming World was, was a nice person.

I – Yeah

P – She was there if you wanted any questions or anything, and I think [PA Officer] who took us for the exercises was superb

I – Ahh brilliant.

P – Yeah, I've no, no downside to any of it.

I – Excellent, ahh that's really good news, umm I mean..

P – As a matter of fact, I've had a few friends that have joined since.

I – Ahh okay, so you kind of spread the word?

P – Yes

I – Brilliant, that's what we need (haha), yeah that's kind of all my questions really, so if you've got anything else or you know you've got any questions yourself, umm my phone numbers on the letter I sent out, so you know feel free to get back in touch.

P – Well, you might know how serious it is for me, my daughter over Christmas bought me the 2 Slimming World recipe books, and she also enrolled me for the 12 month magazine.

I – Ahhh great, so you've really taken it on?

P – Oh yeah, yes I mean I've lost 2 stone with it.

I – Ahh Brilliant, well done.

P – Yeah

I – And well done on being Slimmer of the Week, I bet you were the envy of the whole class

P – Well I got that 2 or 3 times actually

I – Yeah

P – Yeah, so ergh, I've reached my target goal now, and I'm quite happy now, I'm hoping that I can maintain it.

I – Yeah, cause once you reach your goal you can carry on going for free

P – Yeah

I – Yeah, ahh well done for that.

P – Thank you for that

I – Yeah, well thank you very much, and any problems just get back in touch, but well done.

P – Thank you very much

I – Okay then, thank you very much

P – Okay love, bye

I – Cheers, bye.