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Stakeholder perceptions of the CHANGES weight management service

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Executive Summary

- The purpose of this study was to gain a stakeholder perspective of the impact and effectiveness of the CHANGES weight management service. In order to gather the necessary information, semi-structured interviews (16 in total) were carried out with service providers, commissioners and those who refer patients into the service. Patient perspectives of the service will be explored in an ensuing report.

- Four main themes emerged from analysis of the resulting data:
  - Aspects of CHANGES
  - Lifestyle sessions
  - Bariatric surgery
  - Outcomes of CHANGES

- A number of critical factors were identified as key to contributing to successful outcomes:
  - Communication between services
  - Patient motivation and awareness of CHANGES
  - Post surgery care (provided by private provider via specialist commissioning)

- There was consensus amongst those interviewed that CHANGES relied upon motivated and compliant patients in order to achieve optimal outcomes.

- Interviewees agreed that psychological support was a crucial element of CHANGES.

- There were indications that CHANGES experienced a higher patient dropout rate than expected particularly in the later stages of the service although 79% of patients do complete the first 3 months of the programme.

1. Introduction

Obesity is defined as abnormal or excessive fat accumulation that may impair health, and studies suggest that without intervention reversal of obesity is uncommon (Colquitt et al, 2009). Whilst adult obesity in Knowsley is slightly lower than the national average, levels have increased from 14.1% in 2001 to 20% in 2006. Furthermore, 18.2% of Knowsley's Year 6 pupils are obese which is higher than the national average (Knowsley Public Health Intelligence Team, 2008). The evidence that obese adolescents remain obese into adulthood (Gordon-Larsen et al, 2004), together with the predictions of rising obesity rates in England suggest that Knowsley's adult obesity rates are set to increase.

According to Picot et al (2009), for a standard Primary Care Trust (PCT) population of 250,000, there would be 5,250 cases of morbid obesity (Body Mass Index (BMI) ≥40). For NHS Knowsley, which is responsible for approximately 151,000 residents, based on the overall 2006 population value for England of 2.1% morbid obesity, this figure translates to 3,171 cases.

The National Institute for Health and Clinical Excellence (NICE, 2006) recommends that the components of a planned weight-management programme should be tailored to the individual's preferences, initial fitness, health status and lifestyle and should offer a care pathway which includes diet, physical activity, behavioural interventions, drug therapy and surgery.

Referrals to the NHS Knowsley CHANGES weight management service are made by health professionals such as the patient's GP, practice nurse or hospital consultant. CHANGES is considered a level three specialist weight management service. To enter the service patients must be over the age of 16 years and have a BMI greater than 30 kg/m^2 or 27 kg/m^2 with co-morbidities. Patients either receive one to one sessions with a dietician / dietetic assistant or they join group sessions. Patients can stay on the service for up to two years (depending on their complexity) and can also access cognitive behavioural therapy (CBT) sessions if deemed necessary. Linked in with CHANGES are several community run services including Measure Up, Activity for Life and Community Cooks which patient's can also access.

NHS Knowsley commissioned an independent study of CHANGES from Liverpool John Moores University, to evaluate the effectiveness of the project.

1.1. Aims

The main aim of the present study, which forms one part of the overall evaluation of CHANGES, was to explore the effectiveness and impact of CHANGES from a stakeholder perspective.

2. Method

A qualitative approach to data collection and analysis was taken, the aim of which was to describe the views of stakeholders* from two perspectives. The first aspect is concerned with the effectiveness of CHANGES in terms of outcomes for NHS Knowsley, and the second with the impact of delivery and the associated outcomes for patients.

2.1. Data collection

Data collection took place between September and November 2011. Sixteen interviews were completed in total and were conducted either face to face (11) or by telephone (4). One participant was emailed the questions and completed them electronically. Interviews were semi-structured and focused on the perceived strengths and limitations of CHANGES. Suggestions for improvement were also invited (for interview schedule see Table 1).

**** For the purpose of this report the term 'stakeholder' refers to CHANGES service providers, commissioners, referrers and those who providing supporting programmes. Interviewees included nurses, lifestyle advisors, community cooks, activity for life, health officers, commissioners, dieticians and CBT therapists.***

Table 1. Interview schedule

1. Can you tell me about your role as part of the CHANGES weight management service?
2. In what ways does CHANGES impact on the patient experience for those who have CBT/ 1:1/ Group?
3. In your opinion what are the main strengths of CHANGES?
a. For the service
b. For the patients
4. Can you tell me whether you think CHANGES represents good value for money?
5. Can you tell me what measures could be taken to improve the CHANGES?
6. Can you recommend any measures that could be taken to enhance the economic value of CHANGES?

2.2. Data analysis

Data were analysed using a framework analysis approach to identify emergent patterns and themes (Ritchie and Spencer 1994). This five stage process involved familiarisation with the data; the generation of a thematic framework; indexing of all transcripts; charting data and mapping data extracts to the framework; followed by a process of interpretation.

Two researchers undertook the initial framework generation during which a selection of transcripts were scrutinised independently and an index of the key issues, concepts and themes was devised. These drew on *a priori* issues linked to the aims and objectives of the study and on issues expressed by the participants. Findings were compared and a final framework agreed; indexing, charting and mapping processes were then completed and an audit trail was completed by a third researcher to ensure that all relevant data featured in the framework and that the final map represented the data that were derived from each of the individual transcripts.

2.3. Ethical approval

Ethical approval for this research was granted by Liverpool John Moores University Research Ethics Committee. The protocol was also presented to Northwest 12 Lancaster Ethics Committee (NHS REC) who deemed the work a service review and advised that NHS REC approval was not required in this case.

Confidentiality/anonymity

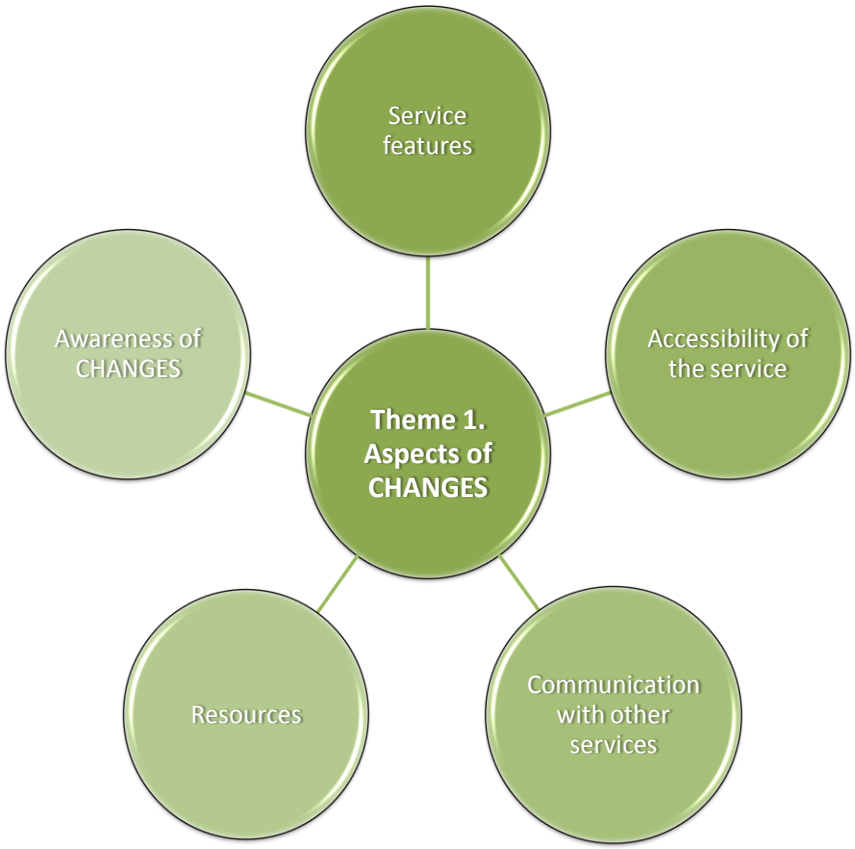
To preserve anonymity, a code was allocated to each participant and was used on all recordings and ensuing documentation. The list of master codes is known only to the research team. The master codes and corresponding names are kept in a locked filing cabinet and on a password protected university PC, accessible only by the research team. Interview recordings were available and listened to only by the researchers and when not in use stored in a password protected PC and destroyed after transcription. All interview transcripts are securely stored in locked filing cabinets and in University password protected computers. According to Liverpool John Moores University guidelines, research data will be stored for ten years and personal data will be destroyed on completion of the study.

3. Results

Analyses of the data elicited four main themes:

1. Aspects of CHANGES
2. Lifestyle sessions
3. Bariatric surgery
4. Outcomes of CHANGES

3.1 Theme 1: Aspects of CHANGES



Category: Service Features

It was evident that CHANGES was viewed as a well structured programme that incorporated the appropriate features of a weight management service including advice on healthy eating, psychological support and links with other services e.g. Activity for Life, Community Cooks and Measure Up.

The package is based on a 12 week programme, it's based on healthy eating. (PS1)

It is the place where patients need to get help and advice and need to unravel the issues and emotional baggage that causes poor lifestyle choices. (PS2)

I think it's really good that we specialise in the exercise because that's what we're really good at and then the same for them [CHANGES]. (PS4)

Several stakeholders described how much they valued the service and believed that Knowsley residents were fortunate in having access to CHANGES.

It's a very positive experience and I wouldn't have any hesitations in referring any of my clients into the service because it's an excellent service to have, we're very fortunate in Knowsley to have it. (PS3)

However, some stakeholders stated that not all feedback from patients had been positive. Some patients reported that CHANGES did not provide them with more in-depth information than they had already received from sessions in the community. However CHANGES does differ from lifestyle and community services. As a level 3 service, CHANGES can offer access to CBT, a 2 year support programme, recommendations for drug therapy (Orlistat), support with specific calorie restriction and referral to bariatric surgery, all of which are not available within other services.

If I'm honest I haven't had a very good feedback of CHANGES…most times the people have said they're not telling me anything you haven't told me. (PS7)

There was a suggestion that whilst a strength of CHANGES was being able to provide sessions within a patient's local area, most sessions took place in clinical buildings, which could be off-putting to patients. However previously CHANGES have offered services in non clinical buildings and the attendance was very poor. Furthermore patients are regularly asked which venues they would prefer and overwhelmingly choose NHS premises.

People are able to access in their locality is really good… Sometimes it can feel clinical for people in that it's in clinical buildings in the health centre…it can imply there's a bit of judgement around entering a health centre even though it's a non judgmental service for the service user going into a clinical building to see clinical staff can be a scary thought. (PS5)

There's a range of venues that are available. (PS13)

Stakeholders believed that one of the strengths of CHANGES was its commitment to constantly improving the service.

It's not one that rests on its laurels, it's constantly reviewing, evaluating, trying to improve, looking for feedback, evaluation from service users, audits, surveys. It's ongoing the whole time it's not like you ever sit comfortably, it's always about change and change for the better. (PS9)

Category: Accessibility of CHANGES

Referral into CHANGES is based on BMI criteria and the presence of co-morbidities. Generally patients can be referred into CHANGES if they have a BMI over 30 although this can be reduced to 27 if there are co-morbidities present.

The referral pathway is over 30 [BMI] it can be under 30 if you've got co-morbidities so some medical condition, we go up to 27 if you've got something wrong with you. (PS1)

If then we're getting people who are BMI 27 with co-morbidities we'll refer them into CHANGES. (PS5)

It was suggested that some referrers into CHANGES would like to see the BMI criteria lowered but it was also acknowledged that this would increase patient numbers which would have an impact on waiting times and potentially hinder patients who are clinically obese. In addition there are other commissioned lifestyle services available for patients with a lower BMI. CHANGES are responsible for training the staff in these services and offer ongoing supervision and support so all advice given is best practice and evidence based

It would be great if they dropped from [BMI] 30 to 26, that would be ideal for us because we could say to the general public we can get you in to see a dietician…you'd get people who could love that…we'd have no problem getting people in but you can understand if we've got 20, 30, 50 people who are all like 27 [BMI] who just have like a couple of pounds to lose and you've got all these obese people (PS1)

Previously, referrals into CHANGES were made by different health care providers including GPs, practice nurses or community services e.g. by lifestyle advisors. Stakeholders stressed that this system posed difficulties in referring patients into CHANGES but has now been improved by the newly-introduced 'one point of access' GP referral form. This form is completed by a GP or nurse and means patients can be referred into a number of different lifestyle services depending on which are the most suitable for them.

It's quite easy to refer into, as long as they've got a BMI of over 30 or they've got below that [with co-morbidities], the old system was a nightmare to get them into, it was all we need these bloods or we need that and other, the BMI is great for us as outside referrers because beforehand we'd have to say go back to your doctor and get all this information but the new one for us out in the community very user friendly. (PS1)

We've now got a joint referral form so if the doctors happy to also send them to Activity for Life they can tick it rather than say to the patient go back and get another referral they can just fax that straight over to us and I know a lot of people on the CHANGES they do it different ways so some people, might only be going once a week or in the group so they can access both at the same time. (PS4)

It is improving, it is kind of another referral, in saying that it should be on the same referral now but there have been problems in the past with referrals which I think has been a problem but that's being resolved as we speak. (PS6)

Generally, stakeholders were complimentary about the referral time frame (four weeks or less) stating that because it was a rolling recruitment, patients could be seen quickly and attend appointments whilst their motivation was still high. Stakeholders argued that with a long waiting time for appointments patients could lose motivation. However, some stakeholders discussed instances where patients had been referred into the service and had not received appointment letters. Whilst CHANGES would never lose referrals that they have received there are a number of reasons why this could occur, in the past referrals were often sent by fax which were not always reliable. However CHANGES are now promoting email referrals which are easier to track and are more dependable. Furthermore patients may not have responded to or disregarded the initial appointment letter, CHANGES now call up all patients who do not respond to the initial appointment letter to improve this.

The fact it's a rolling programme is a really big strength because if people have made that decision they want to change and they're in the right place to start losing weight and they really feel motivated they need to start straight away, if they're waiting by the time you get them into a service they may not be motivated anymore so I think that's a really big strength. (PS5)

But on occasions we have referred people into services while I've been out there in Asda, I might go [back] three months later and someone will go "Do you remember you referred me? I've heard nothing," and that infuriates me 'cause I think that's not good enough. (PS7)

Stakeholders explained that once patients had left CHANGES they could still access community run services (e.g. Measure Up) to gain additional support and that CHANGES could encourage this by referring patients into Measure Up post CHANGES. Some stakeholders said that whilst this was a possibility, they had never received any referrals from CHANGES, or that CHANGES had not informed them that they were referring patients to their services. However whilst this may be some stakeholder's perception, there is an exit strategy for patients who are part of the weight management pathway and often this wouldn't include patients being referred down into other services.

Kind of mixed experiences of that 'cause sometimes some of them have literarily come back down and turned up on the day and said CHANGES told them about us but we haven't screened [them to see] if they're ok to do exercise so we've had to adapt the exercises where normally we either do circuits or aerobics with them. (PS13)

CHANGES can refer down as part of their exit strategy so if people have completed their programme but still want to feel that they want to be part of a group and get more support they can refer into Measure Up (PS5)

There's nothing to say that when people have completed CHANGES, they can come back through us and have an exit route. (PS8)

I've never had any referrals off CHANGES. (PS1)

Stakeholders also suggested other exit strategies for patients leaving CHANGES such as accessing community cooks to assist in implementing the nutritional advice learnt during CHANGES. Community cooks is something which CHANGES already promote within their service.

Referring into Community cooks as an exit could be an option, I think most people would benefit particularly younger people who might not have experience [of] parents cooking at home because the parents might have gone out to work and it might have been ready meals. Lots of people in our community who we come across, it's like an instant society, just get it out the freezer and put it in the microwave. (PS8)

Category: Communication with other services

Stakeholders who refer into CHANGES felt that the team were easy to speak to and contact. Furthermore, if a patient had any issues, stakeholders felt confident that they could call or email the CHANGES team to discuss this with them.

Anything that they need to do they're happy and they're good at communicating so we have a good relationship with CHANGES. (PS4)

I mean we tend to have our main contacts at CHANGES so if we were doing Measure Up and we needed advice on something we can phone the department or email the department and I think we have got a good relationship with them. (PS5)

Occasionally there were comments regarding improvement of communication between services particularly with regard to the criteria for patient referrals. However CHANGES do try to ensure that the referral criteria is clear and simple and would be flexible regarding individuals who want/need support. Patients who did not qualify for CHANGES can be referred back to community and lifestyle services.

Its communication sometimes when you've referred a person, sometimes they'll [CHANGES] phone you up and be like "Why've you referred this person?" I had one instance where the daughter qualified for CHANGES and the mothers BMI was over 25 but below 35, I can't remember the exact number, but she had a back problem which meant she couldn't do the exercise. So I sent both of them over, said on both forms "need to be seen with each other", 'cause they wanted to support each other and then I get a phone call saying we can have the daughter but not the mother. I said well whys that and they said well that doesn't count as a co-morbidity so there's a bit of confusion about what counts as a co-morbidity sometimes.(PS13)

Category: Resources

Stakeholders were aware that resources could be improved but were realistic in their expectations particularly with regards to funding. There was an acknowledgement that with more staff the service would improve but it was also felt that with the resources they had available to them the service ran as well as it could.

It is hard obviously because of funding, you can't do a million and one different things and I think we have recognised that. Just looking at tweaking the pathway a little bit. (PS6)

Dare I say more staff? But yeah obviously it runs the way it does under the resources and I think if the resources were greater in terms of staff then there will be a difference and an improvement but obviously there are cost implications with that. So I think with the resources we've got we all like to think we do as best we can. (PS6)

There were some instances when stakeholders felt they did not have adequate resources to perform all their duties; in particular CHANGES service providers mentioned that their office space was small and often staff had to hot desk[1] which sometimes led to staff waiting to use computers. However as a rule Knowsley do not provide designated desks for clinicians as most of their time is spent in clinics and staff should be aware that if CHANGES offices are busy they can use the computers in their clinic rooms or use laptops.

We don't have enough computers, we don't have enough phones, it's like a hot bed of too much noise and activity for anybody to actually do anything constructive and have meetings or whatever… You just shrug you shoulder and think I'm waiting half an hour for somebody to log off so that I can get on a computer, that's not good. So that's my only gripe really with a view to better premises to do the job. (PS9)

There was also acknowledgement that some of the admin areas were not as organised as well as they could be and that the admin staff did not have much space which could impact on some of their duties. CHANGES are however introducing a new electronic booking system which will be paper free and they are also currently carrying out admin reviews which should help to resolve some of these issues.

We've got a rubbish database so that fails us a lot of the time, people say they don't receive letters, or [they] received [them] too late again. If admin had a bit more organisation and a bit more space they might function a bit better, more efficiently. Similarly the other staff, if they had a proper work base, the administrative side of things may run more smoothly. (PS9)

Some stakeholders felt that in order to see the required numbers of patients set by commissioners, patients usually had to be seen in a group sessions. However other stakeholders argued that many patients preferred the group options and enjoyed them and furthermore evidence supports the effectiveness of group sessions in relation to weight

[1] A desk and computer is not assigned to a particular member of staff

management. Additionally patients with complex needs (e.g. social phobia, work commitments) can be seen on a one-to-one basis.

To see the number [of patients] that commissioners want us to see, we have to put them into groups, otherwise we wouldn't see them. (PS6)

The evidence suggests that group based support is more effective. (PS14)

Category: Awareness of CHANGES

It was felt by stakeholders that CHANGES was not well known by Knowsley residents. Whilst most stakeholders felt it was important for CHANGES to have a community presence it was also recognised that advertising was expensive. Furthermore part of the role of lifestyle advisors is to promote different lifestyle services within the community. However CHANGES is working with the patient engagement team to ensure we are using patient champions to promote the service via word of mouth in the community and in addition CHANGES has a robust PR/marketing strategy in place. Some stakeholders felt that at referral on occasion GPs did not spend enough time with patient discussing what CHANGES would involve and often patients came into the service not knowing what to expect.

A lot of people know who Activity For Life are, if you said who are CHANGES a lot of people wouldn't have clue, for us we do the promoting, have you heard of this weight loss course, they go no I haven't heard of that lad, well here's the leaflet let me tell you about it. (PS1)

Sometimes we get clients who say that they don't really know about CHANGES but probably the same for us, a lot of the time it's word of mouth, it's quite a hard one isn't it cause you know we can't really spend the money on advertisements and things like that so the best thing is word of mouth isn't it? (PS4)

They might go into the GP and say I'm struggling I need to lose weight but they wouldn't know what CHANGES was. And unless the GP or practice nurse actually spent that time with them and said Ill refer you to a dietician, they wouldn't know that that was actually called CHANGES. (PS8)

Category: Psychological support

If deemed necessary, patients may receive psychological support as part of the CHANGES programme. Usually this is determined by dieticians who complete an assessment with patients at the end of the initial treatment phase; if patients are considered to have

underlying issues such as emotional eating or night binging then they are put forward for cognitive behavioural therapy (CBT).

The dieticians use a variety of things to assess that, whether they're making progress, whether there's very clear issues in disordered eating like night eating, secret eating, binge eating. (PS9)

Patients attend sessions for up to 12 weeks and these can be either group sessions or individual sessions. The numbers of referrals for CBT are considered by some to be too high leading to a reassessment of the referral criteria. Due to the high volume of patients coming through for CBT sessions, stakeholders felt that at times group sessions were a necessity rather than a preference even for those patients with more complex issues.

We have had an issue in the service where we've been getting too many referrals so we've had to look again at the referral criteria to start defining that more clearly so that we don't get so many people referred to us 'cause we're inundated with them really…sometimes [it's] a case of having to rather than wanting to put them in the groups. (PS9)

At one time the pathway was basically saying that anyone who's assessed, 70% would be going into a group, 30% going to one to ones. So straight away that blurred the well you know, if your showing even some complex signs from a pathway point of view, more people had to go into groups so that was as far as I was concerned a difficult area. (PS11)

But as far as I'm concerned it's still a very blurred area. I have cases of people going into groups with what I would consider more complex needs and to a degree the groups just scratching the surface of it. So frustrating in one sense. (PS11)

On the whole stakeholders were complimentary about the CBT service and believed the sessions were beneficial to patient wellbeing. In some instances stakeholders argued that CBT sessions were one of the most important parts of the CHANGES weight management programme for some complex patients.

People do say it has huge benefits really because it's getting them to think about things in a different way. I think that's where people get stuck about trying to lose weight, it's all or nothing from a dieting point of view and its how they perceive things and think about it and it does get people thinking about things differently. (PS6)

I think her PHQ 9[2] when she first came was 16, core was 16 and when she left she was 1 on PHQ 9 and 4 on the core so she's made fantastic in roads. She did say that was down to the CBT but I think it's the whole experience of everything that comes together overall. (PS9)

They felt it was a safe environment, people in the same boat as themselves and they just shared their experiences and their feelings. And when you're then asking well is there no one outside of this group, family, friends that you could have that safe, non judgemental type of friendship, you know discussions with and they say not (PS11)

A view expressed by some stakeholders was that whilst the CBT sessions were valuable to their patients, they should be more widespread and offered to a greater number of patients. This was because stakeholders believed that patients may need to address underlying issues before they could make changes to their lifestyle. CHANGES are now introducing an advanced practitioners role for a dietician who will be sharing and training up all staff on CBT so all dieticians will have some CBT skills. Furthermore all dieticians have some counselling training and motivational interview skills and training. Additionally there is a new pathway underway whereby all complex (60%) of patients, rather than just the 25%% seen by CBT, will have access to psych education groups run by a dietician. This is in addition to the advanced practitioner dietician who will be specialising in CBT approaches

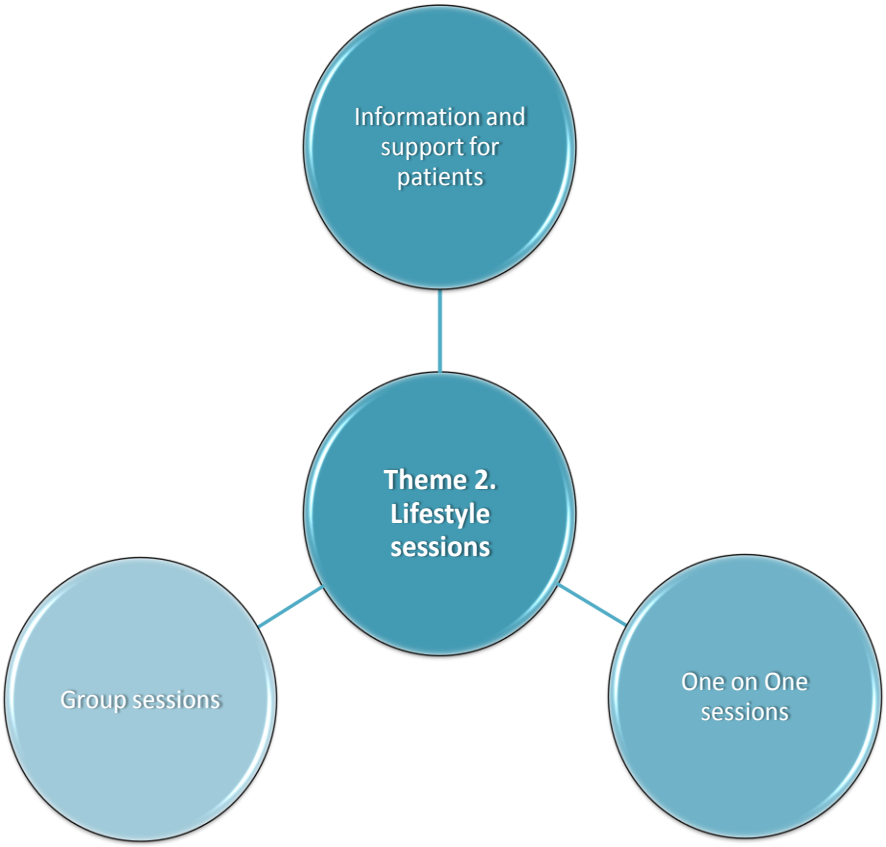
There is a whole underlying issues. I believe myself that people don't become obese because they just want to eat and do nothing, there's masses of other stuff that's gone on before it, what kind of triggers that…They should offer it [CBT] wider, to get people to understand why they do what they do. I don't know if the problem is that they don't open up to the dieticians 'cause they see them as authoritative. (PS7)

Cognitive behavioural therapists also have the option to signpost patients to other services if it is felt they need more support post CHANGES CBT, for example if a patient has high levels of depression they may be referred to a primary care mental health service to receive extra counselling.

[2] Patient Health Questionnaire - Measure of depression

I would always say play on the side of caution, just get them to us to assess and if that was the case I would be sign posting them. (PS11)

3.2 Theme 2: Lifestyle sessions



Category: Information and support for patients

Stakeholders were confident that the information and support provided to patients during CHANGES sessions was both useful and valuable.

So, education is really important but also the support that they give to people, group or one to one but after the programmes finished people can stay in service. Education and support are the main things. (PS8)

They get access to the most up to date evidence base in terms of weight management and they're an approachable team that delivers out in the community. (PS14)

Furthermore, stakeholders felt that the different services complemented each other; Activity for Life involves exercise, Community Cooks consists of cooking classes and CHANGES is involved with nutritional advice.

If CHANGES have got people who they might be getting the information about healthy diet but if their cooking skills, if they don't have very good cooking skills it's difficult to put into practice. (PS5)

So I think it's really good that we specialise in the exercise because that's what we're really good at and then the same for them. (PS6)

Stakeholders felt that the CHANGES programme was motivating for patients and offered support and advice in helping them to make appropriate lifestyle changes.

From the people that we've spoken to that have been through CHANGES they've found it a really positive experience, they seem to find it a very supportive programme. (PS5)

It is the place where patients need to, need to get help and advice and need to unravel the issues and emotional baggage that causes poor lifestyle choices. (PS2)

CHANGES also offer post programme support with patients able to come back to the group sessions to get weighed and receive additional support.

There's kind of a choice of programme length, people can be in the programme for up to two years but can leave as well. The support that's there so once people have been seen in the groups they can come back for regular weigh-ins and support. (PS6)

It was also mentioned that patients had faith in dieticians and that the word 'dietician' carried a lot of credibility with patients.

We may say to a person if you're overweight and you've been identified you know BMI over a certain level you will need to see a dietician, that word dietician seems to have a lot of kind of oh, dietician has the advantage, ...but you know without the dietician for the medical problems because we have a lot of people who are overweight but they might have IBS and stuff like that...and you're saying eat dark green vegetables and someone says I'm on warfarin, I can't eat that you go right but the dieticians being able to get them in for a one to one does seem to carry a lot of weight with people. (PS1)

Some stakeholders felt that patients did not find the dieticians approachable or friendly. However CHANGES informed the research team that regular service evaluations with service users had not reflected this view. The clinicians all undertake regular peer review as part of ongoing supervision. The counselling skills and other training dieticians have means that good rapport is a key skill in treating patients and there has been overwhelmingly positive feedback regarding this.

I think if you'd ask the people as well they'd say the assistants are the best ones to interact and they feel that the dieticians are not friendly, they just look at you. That's what people say "They just look at me with this stone face. (PS7)

Category: Group sessions

When referred into CHANGES around 70-80% of patients are allocated a place in a group session. Patients go to the group session every week for 10 weeks (although they can still go to be weighed after the 10 weeks). The groups generally consist of up to 12-15 patients although numbers have dropped as low as 7 when patients have not attended.

We tend to kind of stop at about twelve so anything up to twelve and most of the time we are trying to have twelve in the group but some weeks it can be as low as seven if people have not attended for whatever reason. (PS6)

Stakeholders generally reported that they felt the group sessions ran well and were beneficial to the patients. There was awareness that the group session did have a one size fits all model which might not be suitable for everybody but they felt that generally patients reported having a positive experience.

You can understand [with] the group session, the format you've got to try and cater to everybody but by and large [for] the patients it can be a positive experience. (PS1)

I think it's a really good scheme to be honest with you, some of the things I have heard off certain patients is it's too simple for some of them, the formats too simple but against that you've got a format where you've got to try and appeal to everybody and what you don't want to do is set something that's too highbrow and that persons sitting there thinking I haven't got a clue what's going on but some people had said I got treated like a kid there. (PS1)

Furthermore some stakeholders felt that being in a group environment had added benefits to patients as they had additional support from their fellow group members. However other stakeholders felt that some patients were "lost" in groups possibly because they were too shy or not assertive enough to speak out in a group environment. Stakeholders suggested that one way to ensure patients did not get lost in a group was for CHANGES to discuss progress with patients on a one to one basis every few weeks which is already a feature of the CHANGES service.

But they're [patients] getting that benefit from being in a group environment and the support of the group so there's benefits to both [groups and one-to-ones]. (PS6)

But sometimes I think what happens in groups is that you'll generally have people that are leaders, you'll generally have followers…I think sometimes people might get lost in a group, they're not assertive enough to say and then they think "I should have gone for the one to one"…But I think what could be good is…every three or four weeks speak to them people one to one. Take them out of the group situation; give them a phone call, what's going on, how are you finding it? (PS7)

Some stakeholders had the impression that the group sessions could be too structured and were run in a teacher-class format, with patients often being reluctant to speak up with questions or comments. However, no suggestions were made as to how the group session format could be improved and it was felt by these stakeholders that this was typical of the way most service's group sessions were run. Other stakeholders argued that the group sessions were relaxed and patients enjoyed them, learnt from them and gave positive feedback on the sessions. All CHANGES staff have received extensive training on group facilitation skills including meeting specific competencies which are signed off via peer review support on an ongoing basis.

There's no way round this because whoever gets the sessions you get the same thing it can be very much like a school kind of atmosphere, people sitting round the wall with this look on their face and the persons getting up and trying to do a bit of interaction and getting not a lot back. (PS1)

The groups are really good, everyone gets in together, it's really good banter…Most of the patients I've seen in clinic love the groups, they all enjoy them and think they're really good. (PS15)

The idea of 'male only' groups was mentioned by some of the stakeholders. The reasoning behind this was that males may not always feel comfortable being in a mostly female environment and that males were not always interested in in-depth nutritional information but rather what they could fit into their current lifestyle. This notion was met with mixed views from stakeholders however the overall consensus was that if male only groups were to be an option, they firstly needed to be trialled to see if the demand was there.

I think they've got different needs like women want to lose weight for different reasons to men, although most of them are just health and stuff. Also so different lifestyles like men work maybe more manual labour jobs and I do think having the separate groups or just the option to, if they don't mind, it's just having the option maybe. (PS15)

Most men who've been on our courses will say can we have male only but when you look at the numbers that we're getting, we wouldn't be able to justify having that at the moment unless we got a bigger influx. (PS13)

Category: One-to-one sessions

Patients have the option of having one to one sessions with a dietician instead of attending a group session. The decision to place a patient into one to one sessions was usually made by the dietician and based on the complexity (e.g. social phobia, work commitments) of the patient and whether it was felt they would not benefit from group sessions.

There could be safeguarding issues involved, they could be in a very domestic abusive relationship, could be that they're restricted because of a disability or something like that. (PS7)

It seems to be if you present a need for the privacy or maybe emotional [need], I think if the dietician thinks this person is not going to attend the group but they need support then it would be that [one to one sessions]. (PS1)

Stakeholders considered the one to one sessions to be more intensive than the group sessions, however, they also felt that those in the group sessions received more support so there were benefits to both. When asked whether they thought one to one or group sessions were the best option, stakeholders all stated that it depended on the patient and their needs.

I think it's nice to have both 'cause I think there's so many people with different complex needs you can't treat everyone the same so I think if you find someone is a little shy and they've got barriers they need that one to one so I think it's good to have that choice. (PS4)

3.3 Theme 3: Bariatric surgery

Category: CHANGES role

Referrals for bariatric surgery in Knowsley are made via CHANGES; bariatric surgery providers do not accept referrals directly from GPs or other health care providers.

We use CHANGES as a gatekeeper so we don't allow referrals to go directly from GPs to bariatric provider, we require all those referrals and requests to go to CHANGES and we have CHANGES looking at those, seeing if they meet those criteria and if they do they would onward refer that to the bariatric provider (PS2)

Sub category: Post surgery

Post surgery, patients are not able to access CHANGES but do receive support and information from their bariatric surgery provider for up to two years. However some

stakeholders believed the care received post surgery from the bariatric surgery provider was not adequate.

[Bariatric provider] have a contract to complete the bariatric procedure with the client and follow that client up for 2 years. So in theory if that contract is working perfectly then they are with [bariatric provider] for 2 years, there is an issue around that follow up but it's actually not within CHANGES contract to do that post 2 year contract. (PS14)

But if you're only going every three months to get your blood checked and weighed and to make sure you're taking the right nutritionals (PS10)

There was a general consensus by stakeholders that patients had a lack of support post surgery and did not know where to go for advice and support. Furthermore there is no commissioned post surgery psychological or dietary support required by CHANGES and stakeholders felt that patients suffered because of this. However it is not in CHANGES remit to offer patients support post surgery as this should be provided by the bariatric surgery provider. If a patient does complain to CHANGES about the lack of post surgery support CHANGES would always inform the bariatric provider commissioner and refer patients to PALS. Furthermore 2 years post surgery patients can go back in to the CHANGES service.

After surgery they've said there's no support, they come out and there's nothing there for them, you know there's nothing out there… we had one incident where this lady had the band and she was making herself ill because her feeling of social side was gone so we were running around trying to get this lady help and we couldn't get her any. (PS1)

I guess this is an issue isn't it really as the NICE guidelines do highlight that they should be supported after and so on and we don't have the capacity, we don't have the scope to do that post, so what I've said to patients that I've seen is clear that they speak to the service that has provided the surgery. (PS9)

She'd had a partial stomach removal sleeve. She was talking to us and I said to her what support do you get dietary wise, she said there is none. She said we get counselling before hand, then they have the operation and then apparently after the operation it's kind of like, Here's a piece of paper and that's it… But when I phoned up I spoke to CHANGES, because I wanted to refer but they said no we can't touch them. This to me is wrong 'cause they need dietary support. (PS10)

Once they have left our service I believe they have a follow up with a dietician but they don't in CBT, once they have left our service, they have been discharged from CBT and even before they've gone into surgery I think patients have been a little bit "God, is there no follow up". (PS11)

In some instances stakeholders had heard that patients had set up their own patient support groups however the support groups generally did not have any input from health care professionals.

In terms of bariatric surgery there are bariatric surgery groups and again the patients can be encouraged to look into that so they've got that as a support network but there's nothing that the service has specifically set up. (PS11)

I know there's support groups, there's one [Name of Support Group] that has opened up and they're supporting one and other. But there's no professional person there… They need professional input. (PS10)

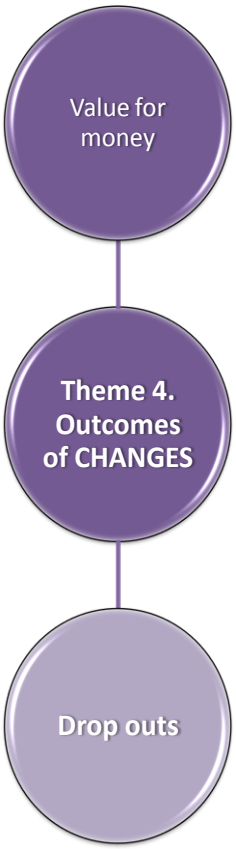
Category: Magic Bullet

There was a feeling by some stakeholders that occasionally patients were not prepared to give CHANGES a chance to work and considered surgery a magic bullet and an easy option for losing weight. However, there was also recognition that some patients were desperate and considered surgery a last resort.

So I tend to hear only from the patients who haven't done it, won't commit it, can't understand it, have no patience with it, have high expectations of it, it's a cosmetic world we're living in and I want an easy fix or are struggling so much they can't get help. (PS2)

I think some people especially when they might go private go in with the idea it's a magic wand and it's all gonna fix it and then it doesn't work. At the end it works for a bit but then they're like actually what do I eat with my food? What should I be eating? What should I be doing? (PS13)

3.4 Theme 4: Outcomes of CHANGES



Category: Value for money

When asked whether they thought CHANGES represented good value for money many stakeholders replied that they did not know how much CHANGES cost and what their outcomes were like so couldn't comment on how cost effective the services was.

I don't know the cost involved but yes I would imagine good value for money. (PS12)

Of those respondents who did give an answer, most considered CHANGES to be good value for money. Stakeholders discussed how good the service was and also the impact it was having on reducing obesity related co-morbidities. However, other stakeholders were aware that CHANGES were not meeting their outcomes in terms of weight loss.

In terms of NHS costs, yes I do because of the huge health risks and cost implications to somebody's overweight and all the co-morbidities that go with that so I think if we're, yes obviously services to cost to run but I think

the health implications and cost to the NHS and for want of a better word the burden that they would on the NHS is far greater than that. (PS6)

They're not meeting the outcomes that we would expect, for say six months, one year or two year outcomes. So from that aspect then no…the cost per client and cost per positive outcome in terms of weight loss isn't as good as it should be or could be and it is something they're gonna have to look at and potentially change their model especially if they're trying to win money or have continued finance in the future. (PS14)

Some stakeholders felt that Knowsley should spend more time with patients at the lower end BMI spectrum (those who are overweight or only just in the obese category) adding that these patients would be likely to put on more weight and add an extra burden to the NHS in the long run. However it should be recognised that CHANGES is a level 3 specialist weight management service and patients at the lower end of the BMI spectrum should be seen by community and lifestyle services.

"They're the people of the future that are gonna break the NHS because if you don't tackle it now as its approaching it's got to be preventative… I think it's that thing of they're not there yet they're just over, well I think you need to grab it before they are there. Because when it gets there, they're gonna be on a slippery road to nowhere" (PS7)

Category: Drop outs

CHANGES experience a relatively high number of drop outs during the length of the programme although 79% of engaged patients do complete the first three months of CHANGES. (Figures provided by NHS Knowsley) Some stakeholders were confident that these figures would improve as they believed CHANGES would adapt and re-evaluate its service constantly. Others suggested that CHANGES should make more effort in keeping contact with their patients, possibly through interactive platforms.

We're not doing as bad as the figures make out but sometimes the figures but obviously they're looking at figures from last year and as with any service were constantly kind of evaluating it and changing things so hopefully the figures that come out with show kind of improvement a year on. (PS6)

I feel in order to maintain the engagement they need to do a lot more with the client base around innovative ways to stay in contact and approach, texting, emails, internet based stuff or whatever and they need to do

more about setting you know actually quite realistic, smart goals really but in a way that's going to put some quite string expectation on the client in order to engage. (PS14)

There were various explanations offered for why the dropout levels were high. Some suggested that sometimes other commitments just got in the way.

For some people life gets in the way, other things happen. I say that really openly and honestly to people you know you might have the best intention in the world to go and do something then something major might happen in your life and things come to a stop. (PS8)

However, it was also suggested that patients often made excuses to not attend classes and that it was difficult to keep patient motivation high.

I do believe the overweight do find a lot of excuses and I don't mean that in a horrible way… everybody would always say oh I've got something coming up, oh I've got a wedding on Saturday…and then they'll always say oh I'll start the week after and it's you know CHANGES have got their work cut out with them cause it's really hard to keep people on track and keep them motivated. (PS4)

Furthermore, there was a suggestion that CHANGES should not take patients in to the service who they do not believe are motivated and engaged. However, it was also recognised that if these patients could not access the service at all their problems may just get worse.

Sometimes in my opinion the person isn't ready and isn't motivated to make changes so its whether we look at that, cause you're going to get a high dropout rate and high DNA [Did not attend] which reflects badly on us when actually we, I think, some of the stuff I was reading from another evaluation for another service was actually not accept people unless they're ready to get engaged. I think also we could argue that these people could be doing a whole lot worse gaining lots more weight if they weren't in our service. (PS9)

There was also a suggestion that dropout rates might be affected by which route patients come into CHANGES. If a patient has been referred via community services or has self referred rather being referred by the GP it was thought they were often more motivated possibly because they have been given more information by lifestyle advisors.

If they're self-referring to the measure up programme and they don't meet their criteria and actually meet ours and they refer them on, you see those ones are a lot more motivated. Some of the ones from GPs or health care professionals can be motivated but, especially if they've gone to the GP to ask for help, I think it's the ones that have been told by their GP that they have to lose weight or everyone's telling them that but the maybe don't want to do it themselves, they struggle a little bit more. (PS16)

Finally a few stakeholders suggested that the initial contact made by CHANGES could be improved. Once a patient is referred into CHANGES they are sent out an appointment letter and some stakeholder felt that a phone call to the patient to introduce the service would help encourage patients to attend the assessments. However CHANGES advised that 65% of appointment letters are returned by patients and those who do not reply are followed up with a phone call to achieve an 85% engagement opt in rate.

They just send a letter out with a date, if they have that initial phone call and speak to them. Because what I tend to do, anybody through as a referral to CHANGES I will bring them into clinic, I will speak to them 'cause doctors haven't got the time to do that, explain to them what the programme is about, is it what you want to do. Is that your choice to do that and I mean this is what CHANGES needs to do if they want to get the people to come in to the service. (PS10)

A lot of people I spoke to don't realise they're being referred to a dietician in the first place when you speak to them on the phone so I'm sure a lot of people receive an appointment to see a dietician they don't know what it's about, they won't go. (PS15)

4. Discussion

It was evident from interviews with stakeholders that they considered CHANGES to be a well defined programme incorporating the key elements of a weight management programme as described by NICE (2006). These key elements include diet, physical activity, behavioural intervention, drug therapy and surgery. At interview stakeholders seemed enthusiastic about their role and committed to their patients. In particular, CHANGES took pride in the CBT sessions and many felt that psychological and behavioural support was the crux of a successful weight management programme. However it was recognised that not all patients could access the CBT service and whilst some felt that CBT was essential other were more realistic in recognising that the number of CBT referrals were already at a maximum and to refer all patients would not only be impractical but would also drastically increase the waiting times for patients. CHANGES are introducing an advanced practitioner role to their service who will share knowledge on CBT and psychological and behavioural support with dieticians for use in their sessions with patients. Furthermore all dieticians have counselling and motivational interviewing skills and are equipped to provide psychological support to patients. Additional a new pathway is being introduced whereby the majority of patients will have access to psych education groups run by the dieticians. Stakeholders reported generally good communication between CHANGES and other linked services, feeling that they could contact them at any time to discuss any issues they had.

A key component of CHANGES involves group or one-to-one sessions in which dieticians and dietetic assistants work with patients and look at improving their diet and nutritional intake. Generally stakeholders viewed these sessions positively describing the information received as valuable to patients and also recognising that Knowsley were fortunate to have this service in place. In addition, links with community services e.g. Activity for Life and Community Cooks means that patients can receive advice on diet, physical activity and healthy cooking. On occasion stakeholders felt that the CHANGES service did not offer more specialist information than some of the community run services. The weight management service as whole should ensure the services they are providing to patients do not cross over to an extent where patients feel they are just receiving the same information repeatedly.

Many stakeholders were concerned about the lack of post surgery support for patients who undergo bariatric surgery. Patients should receive support from their bariatric surgery provider for two years post surgery yet some stakeholders felt that patients were abandoned after surgery and stakeholders did not know who they could refer them to, other than the approved bariatric provider Whilst it is not in CHANGES remit to take referrals from bariatric surgery patients the lack of support both emotional and practical means that patients are thought to be suffering and this should be considered by commissioners of the weight management service as a whole.

In terms of value for money, stakeholders believed that reducing patients' weight would have a financial impact on the NHS in the long term through the lessening of co-morbidities. However, it was understood that Knowsley experience a high rate of drop outs to their service and sometimes because of this group numbers are low. Suggestions were made for lowering the dropout rate such as engaging with patients more through interactive platforms, speeding up referral times and ensuring that patients understand what CHANGES involves before referral in order to make certain that only those who are motivated are referred.

5. Conclusion

The purpose of this evaluation was to explore the views of stakeholders with regard to the effectiveness and impact of CHANGES. CHANGES can be considered a valued service which is well integrated into the whole weight management service. Furthermore, it was evident that those whose work involves them in CHANGES are a strongly committed and enthusiastic team who celebrate the successes of their patients and where there is disappointment endeavour to be flexible in finding solutions to these problems. However, issues around the number of patient dropouts and levels of patient motivation mean that stakeholders feel that some patients are not adequately supported and not receiving the full benefit of the CHANGES service. The service has plans in place to address these issues

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