Weight-loss maintenance in weight management services:
The views of public health commissioners, service providers and service users

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Foreword

This is a report of a series of consultations conducted February – June 2014 with individuals concerned with commissioning, providing or using adult weight management services in England. The purpose of the consultation was to establish how weight loss maintenance is currently addressed by Tier 2 services (those providing community-based, lifestyle-focused, practitioner-guided interventions), and how services might be developed to support it more effectively. The consultation was conducted by researchers from the University of Exeter Medical School.
Executive summary

A majority of the commissioners and providers consulted thought that current services do not adequately address weight loss maintenance. Many Local Authority commissioners have inherited a portfolio of programmes whose primary measure of effectiveness is short-term weight loss. They are currently focusing on the mechanics of the commissioning process and on achieving equitable provision for the populations they serve. As yet, there is little incentive for providers to develop programmes that specifically address the sustainability of behavioural and lifestyle changes required for long-term weight loss.

The short duration of most programmes (almost invariably 12 weeks) was seen as the primary obstacle to supporting weight loss maintenance. No rationale, other than historical precedent, was offered for this duration, and most respondents felt longer-term interventions were needed to establish and stabilise new behaviour patterns. Local political and financial commitment to weight management services varied geographically, influencing both the range of current services and the potential for their development. The limited breadth and choice of current provision in some areas was a barrier to addressing the complexity of factors influencing individual behaviour, and of matching the needs of all sectors of the target population. Some commissioners were exploring the potential of payment by long-term results, to encourage providers to focus on weight loss maintenance; however, many noted the difficulty in obtaining long-term outcomes data for programmes, which impedes reliable judgements on their effectiveness in promoting weight loss maintenance. Finally, addressing weight loss maintenance in programmes was limited by the paucity of scientific evidence regarding particular maintenance interventions, and of explicit practice guidelines from NICE and other authorities on addressing maintenance in weight management services.

Assuming adequate resources were available, there was broad agreement on several features of an ideal weight loss maintenance service. It would include a range of programmes that address the needs and preferences of different segments of the overweight population, and the different stages individuals are at in the “weight management journey”. Programmes would be flexible and deliverable in a variety of formats, including group and individual, face-to-face and telephone or internet-based, and employ new communication and self-monitoring technologies where appropriate. More attention would be given to learning the skills of maintenance, and to addressing the psychological factors that influence it. Views on the length of programmes varied: some felt that lifelong support should be available for those who need it, whereas others thought this would undermine the development of a self-management approach they thought was essential for successful maintenance. However, most agreed that more than three months was needed if both weight loss and maintenance were to be adequately addressed.
Proposals for service development

The following recommendations are based on views expressed commonly among at least two of the three groups consulted (service commissioners, providers and users). They are not necessarily evidence-based or the views of the authors.

General principles

- Recognise weight loss maintenance as a vital phase of successful weight management that may be addressed as part of weight loss programmes, or in stand-alone maintenance support services.

- Provide a range of programmes with different formats and intensity levels, including flexible formats (such as drop-in sessions), to address the needs and circumstances of different groups and individuals.

- Integrate personal assessment into programmes, to identify the factors influencing behaviours required for weight loss maintenance, and to guide the form of interventions for each individual.

- Focus on helping individuals develop weight loss maintenance behaviours that are enjoyable and personally fulfilling for them, and therefore more likely to be sustained.

- While some forms of ongoing support group may be required by some individuals engaged in weight loss maintenance, these should focus on developing self-efficacy, self-management skills, and reducing dependency on the group as a source of motivation. Their effectiveness should be assessed by these criteria as well as by weight maintenance.

Programme content

- Participants should be educated in the principles of weight loss maintenance, including the psychology of maintenance and its implications for the individual.

- Participants should learn the skills of weight loss maintenance, including identifying external and internal barriers to maintenance and risk-of-lapse situations, developing strategies to deal with them, and addressing behavioural influences such as stress, comfort eating and negative self-concept.
EXECUTIVE SUMMARY

- All services should promote and facilitate engagement in physical activity as well as dietary regulation for weight loss maintenance.

Evaluation

- The collection and analysis of long term outcomes data could be facilitated and made objective by tasking a third party to complete it. This could be the “hubs”, clinicians or Health Checks programmes that refer individuals to services or a collaborating academic group.

- As far as possible, evaluation data should be collected for all individuals who enrol on programmes, not only those who complete them.

- Programmes should be evaluated not only in terms of weight loss and attendance levels, but also broader indicators that are of concern to both policy-makers in Local Authorities, and the target groups. These might include social-care uptake and social engagement, mental wellbeing and functional capability.

Resources

- Practitioners delivering programmes should be able to address the psychological factors involved in weight loss maintenance. This requires knowledge and skills in assessment and behavioural maintenance principles and training.

- Commissioners should consider using Payment by Results to encourage providers to focus on long term outcomes.

- Commissioners and providers should promote, co-opt and support local community engagement in the provision and leadership of maintenance support programmes. This could improve the longer-term sustainability of support groups for those who need them, and help tailor programmes to local circumstances and demographics.
Current provision

Referral, entry and coverage
Entry to the majority of weight management services required referral by a GP or other health professional, sometimes via the Health Checks programme. A small number of services were currently, or planned to be, open to self-referral. Typically, referrals were made to a "lifestyle hub", whose staff screened the individual for eligibility, advised on available programmes, and referred the client to the agreed programme. In some cases, hub staff were trained in Motivational Interviewing so they could assess and enhance the client’s readiness for change and commitment, help develop initial weight management goals and negotiate an action plan, including which services they would access. In other cases, the hubs had a mainly administrative function, collecting data and signposting to available services.

Most commissioners thought their services were meeting demand, with relatively short waiting lists, but some thought there was huge scope for expansion if there was more public awareness of the problem of obesity and the availability of such services. Current recruitment levels varied but cited figures suggested typically less than 2% of the adult population per year. Statutory requirements to address inequalities in health meant that many commissioners were targeting deprived areas or lower socioeconomic status groups. Despite this, many thought that the services commissioned did not meet the needs of under-represented groups such as men and ethnic minorities, or were inadequate in rural areas.

Providers of weight management services
These included:
- Local Authority leisure services
- Other Local Authority in-house services
- Voluntary groups and charity organisations (e.g. YMCA)
- Community Interest companies (profit-making but assets only used for social objectives)
- Commercial companies (Slimming World, Weight Watchers, private leisure companies)
- GP practices and other NHS-based groups led by clinicians, e.g. practice nurses, community pharmacists, dieticians, physiotherapists and health psychologists.

The in-house and clinical providers tended to provide tailored services for particular client groups e.g. ethnic minorities, men, people with a physical or mental disability, or with clinical conditions such as diabetes or depression.
Service and programme models

A wide range of service models was reported, although there was considerable variation in the breadth of provision. For example, some services included five or more different types of programme, using several providers; others had only one or two.

Typically the range of options included at least one commercial slimming organisation. Some provision used pre-existing programmes, e.g. Weight-Watchers groups; some adapted programmes developed by others (e.g. Shape-Up – http://www.weightconcern.org.uk/shapeup) and Counterweight – http://www.counterweight.org/) and some were created specifically to meet a service category in the commissioning brief, for instance by focusing on diet or physical exercise. Many were described as emphasising lifestyle change rather than focusing on specific restrictive diets. Although behaviour change principles were referred to in some programme descriptions, commissioners were not always confident that they were implemented well in practice. Table 1 on page 8 provides an illustration of the variety of programmes offered.
Table 1: Examples of the range of existing programmes

Four phone-based consultations over 12 weeks with a Health Trainer, trained in weight management, dietetics and motivational interviewing using Royal Society of Public Health courses. Use of motivational interviewing, progressive goal-setting, a manual, signposting to other services and organisations, including physical activity. Draws on Department of Health “Let’s Get Moving” course.

A suite of programmes taking place at a community centre, concerned with healthy lifestyle behaviour change, but adapted to focus specifically on weight management to fulfil the commissioning brief. Including (i) a 12 week tapered weight management programme with a group format but some 1:1 opportunities, focusing on education on nutrition, physical activity and behaviour change, run by trained non-clinicians; (ii) a family-based intervention developing cookery skills and confidence; (iii) cook and chat sessions involving education on food, labelling, healthy eating in supportive social environment; (iv) a series of 1:1 interviews focusing on goal setting and behaviour change; (v) a “friendly gym” adapted for use by the disabled and overweight; (vi) walking groups; (vii) community café for peer support; (viii) a group-based diabetes prevention programme.

An initial 1:1 session with a behaviour change specialist for goal setting in diet and physical activity, followed by periodic contact during supervised sessions in a gym (twice a week for 12 weeks), plus 12 vouchers to use with Weight Watchers.

A slimming on referral scheme: 12 vouchers for use with Weight Watchers or Slimming World. Clients join existing group meetings with a focus on development of eating and physical activity plan, individualised on the basis of personal goals. Led by trainer trained by the organisation. Group meetings consist of weigh-ins, allowing time for individual consultations, plus group sessions which may have educational talks or reviews of individual stories with peer support. Marketing of food products. After 12 sessions the client can continue if they pay, or for free if they maintain their target weight.

Counterweight programme, delivered by a commercial organisation: 1:1 face-to-face or telephone advice with a Health Trainer lifestyle adviser 1-2/week for 12 weeks. The focus is on weight management and lifestyle change. Also, piloting a group-based intervention using the Counterweight approach, delivered by a dietician in a GP practice.

Initial meeting with a weight management coordinator (a level 3 Exercise Professional with additional weight management training) for physical assessment, questionnaires, goal-setting, programme planning; followed by gym induction and 12 weekly group gym-based programme, plus vouchers for individual gym attendance twice weekly over same period. Weekly contact with the coordinator for provision of written materials, Motivational Interviewing and other behaviour change techniques.
Initial meeting with a dietician then a behaviour change specialist looking at motivation and goals, followed by 12 week programme of 90 minute group (12-15 people) sessions, facilitated by both specialists. Consists of weigh-in, education on food, cooking, diet and exercise, behaviour change techniques plus facilitated group sharing. Some opportunities for 1:1 work in weigh-in plus final 1:1 session after programme. Also given vouchers for physical exercise: gym once a week or swimming 3-4 times a week, or exercise classes. Can be used at any Local Authority leisure centre.

12 weeks support by a Health Educator, with education on food, a healthy eating pack, food diary, plus six 1:1 sessions with a physical exercise instructor in that time. Unlimited use of leisure centres including gym and exercise classes, walking group.

Six weekly 90 minute group (~14 people) sessions run by a health psychologist with a heavily psychological emphasis; developed under IAPT (Improving Access to Psychological Therapies) initiative for people with depression or anxiety who are also obese. Focus on self-regulation skills, mindfulness in eating, use of tactics to manage cravings. Emphasis that obesity is not the person’s fault but strongly influenced by obesogenic environment and other external factors. Talk about craving, bingeing, nocturnal eating. Stigma and shame a big issue for clients: pre-group 1:1 session helps build trust; also additional opportunities for 1:1 IAPT sessions if needed.

Six face-to-face contacts over 12 weeks with an Health Care Assistant in a GP surgery, or a pharmacist, trained in Motivational Interviewing, with an accompanying self-accessed web-based programme; emails are sent if the client has not used the website for some time. Programme created by a GP based on stages of change model of behaviour change.

Most programmes were in group format, although some were said to include opportunities for 1:1 consultation, or to begin with 1:1 sessions for assessment, goal setting and planning. Programmes specifically based on a 1:1 format were uncommon and were usually of more limited duration, or used telephone rather than face-to-face consultations. Programme duration was almost invariably 12 weeks or less.

All initial weight management programmes were free to participants. In some cases, clients were given vouchers they could exchange for participation in a set number of programme sessions; in several physical exercise programmes, they could attend unlimited sessions in a set time-frame.
Outcomes and evaluation

A range of measures were used (see Table 2), most commonly weight loss and attendance levels, which were Key Performance Indicators. Commissioners typically specified a 5% weight loss target but several respondents criticised this on several grounds: many clients who reached the target were still clinically obese, yet ineligible for further support; clients themselves were often unsatisfied with this target and could be demotivated by it; and for some clients on a rapidly increasing weight trajectory, stabilising bodyweight or reducing the rate of increase could be regarded as success. Data were collected at the end of the programme (usually three months), sometimes at six months, rarely at 12 months (and in one case at 24 and 48 months). Data collection was increasingly difficult at successive time points because of lost contact and non-response, and data were very rarely sought from those dropping out of programmes. Hence, measuring effectiveness reliably was problematic, particularly for long term outcomes. The value of comparisons between different programmes – particularly between commercially-provided and clinician-led services – was also questioned, because their participant profiles were typically quite different.

Assessments were sometimes completed by the referring hub, but usually by the service provider. Data collection by providers was regarded as problematic in several respects: the process could be seen as unobjective as there is a clear conflict of interest; there was little incentive for providers to collect long term data and some were more diligent than others; some providers resented the burden and cost of chasing clients with whom they no longer had contact. Some commissioners were experimenting with other approaches, such as using referring hubs or independent bodies (such as university based researchers or GPs) to collect follow-up data. It was also suggested that, where strongly evidence-based programmes were used, only a minimal set of outcome measures (e.g. auditing against benchmark standards for weight loss) might be required, so that resources could be focused on service delivery.

Table 2: Assessment measures used in programmes

<table>
<thead>
<tr>
<th>Physiological</th>
<th>Personal</th>
<th>Programme / Process</th>
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<tbody>
<tr>
<td>Weight loss</td>
<td>Achievement of goals</td>
<td>Attendance rate</td>
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<tr>
<td>Rate of weight loss</td>
<td>Self-image</td>
<td>Length of telephone consultations</td>
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<tr>
<td>Percentage body fat</td>
<td>Physical activity (e.g. IPAQ)</td>
<td>Numbers reaching specified weight loss (usually 5%)</td>
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<tr>
<td>Waist circumference</td>
<td>Confidence</td>
<td>Qualitative feedback</td>
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<tr>
<td>BMI</td>
<td>Social engagement</td>
<td>Client satisfaction with programme</td>
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<tr>
<td>Blood sugar</td>
<td>Mental health</td>
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<tr>
<td>Blood pressure</td>
<td>(e.g. Warwick Edinburgh</td>
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<td>HbA1c</td>
<td>Mental Wellbeing Scale)</td>
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<td></td>
<td>Quality of life</td>
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<td>Qualitative feedback</td>
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<td>Satisfaction with outcomes</td>
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Weight-loss maintenance in current provision

Several ways of addressing weight loss maintenance within services were currently in use:

1. Clients could repeat the programme (usually with one of the commercial weight-loss organisations and identical to the original programme). In some cases, eligibility depended on attendance or initial weight loss criteria; in others, they could attend a different type of programme.

2. Signposting to other services and opportunities at the end of programmes. These typically focused on local leisure centres and physical activity-focused groups. In some cases, clients could obtain discounted membership or sessions in these services. Clients could also join a commercial weight management group at their own cost, though both Weight Watchers and Slimming World allow maintainers to attend sessions for free as long as they maintain their target weight.

3. Provision of a maintenance-focused programme, which clients could attend on completion of the weight loss programme. These took the form of group sessions, usually on a less frequent basis than in the initial weight loss phase. They were sometimes facilitated by a health practitioner, otherwise run on a voluntary basis by their members with institutional support. They might provide education sessions but their primary focus is on social support for maintenance.

4. Addressing behaviour maintenance within existing programmes. In some cases this involved a minimalist approach employed at the end of a programme, e.g. prompting maintenance-related goal-setting or recruiting a weight management buddy. However, some programmes gave substantial emphasis to behaviour change and self-management principles throughout, encouraging the adoption of sustainable strategies and learning self-management skills from the outset.

Facilitators and barriers to addressing weight-loss maintenance

High level drivers in were thought essential to raise the profile of obesity services in general, and maintenance in particular. In Local Authorities, who fund Tier 2 programmes, political commitment and resource allocation varied between areas consulted, with annual per person spends between £80 and £200 cited. In some cases, the policy imperative to reduce health inequalities led to a focus on providing equal access rather than on long-term outcomes. Commissioners suggested that national guidelines for weight management services were insufficiently explicit in their recommendations for addressing weight loss maintenance, and some providers said there was limited or no attention to weight loss maintenance in their commissioning briefs.

Some smaller non-commercial providers, many of which emphasise self-management and maintenance, were thought to be disadvantaged by their poor marketing compared with commercial providers, which meant that both commissioners and service users might overlook them. Providers with limited financial resources, who might offer innovative ways of addressing maintenance, could also be disadvantaged by retrospective payment by results.

Strategies used or suggested by commissioners to encourage providers to address weight loss maintenance included: making three year contracts to encourage a longer-term perspective; providing financial incentives such as making a percentage of payments contingent on longer-term maintenance outcomes; ensuring commissioning briefs explicitly refer to maintenance, and ask how it will be addressed; stopping the practice of re-referral to the same programme but providing follow-on programmes targeting maintenance; and encouraging and supporting local community and voluntary groups to establish social support-focused maintenance groups.
There was broad agreement among commissioners, providers and users that many people need considerably longer than 12 weeks to develop the sustainable behaviour changes needed for weight loss maintenance. Hence, some form of longer-term support was thought essential by most respondents. Some commercial providers and users saw overweight/obesity as a Long Term Condition for which lifetime support should be available; others were concerned that such models encourage dependency and could be counter-productive to the development of essential self-management skills.

There was also some criticism of the marketing of processed foods in commercial programmes, as being incompatible with developing a healthy long term eating pattern. Also, some suspicion was voiced of the profit motive in long term commercial programmes, although it was noted that attendance of both Weight Watchers and Slimming World groups is free for those who maintain their target weight. In any case, there was consensus that some form of longer term support would be necessary for many people, focusing on embedding stable behaviours for weight management.

It was thought essential that practitioners delivering programmes should have knowledge of behaviour change principles and the ability to facilitate the development of self-management skills. Providers and service users also stressed the importance of practitioner confidence and personal commitment, to build trust and challenge client mind-sets. Many respondents suggested that the ability to help people address underlying psychological issues was also needed to address weight loss maintenance effectively for some people. The desirability of, but difficulty in, engaging health psychologist expertise in this area was recognised, although in some cases they have been involved in the development of programme content and training of practitioners. Trainer quality was seen as key to the success of weight management programmes, and this might entail providing tailored training for all staff involved in delivering programmes, including those in leisure centres.

There was common recognition of the broader societal, economic and environmental factors that were at least as important as weight management programmes in determining weight outcomes at a population level.
An ideal service

Respondents were asked to describe their ideal service and programmes to effectively address weight loss maintenance. A number of broad principles and specific features were commonly suggested:

**Principles**

1. A variety of pathways and programmes with varying content and format should be available after initial weight loss, to suit different segments of the target population and the changing levels of support people need as they progress.

2. Programmes should be capable of personalisation so that the particular needs, circumstances and preferences of individuals can be addressed.

3. Weight management programmes should explicitly address weight loss maintenance in their content and processes, and recognise that the issues, challenges and strategies required may differ from those needed for weight loss.

4. Many people will require more than 12 weeks support in order to stabilise the behaviour changes that are required for successful weight loss maintenance. However, programmes should aim to reduce dependency and the development of autonomy and self-management skills.

**Content**

1. All weight management programmes should aim to develop personal knowledge and skills in behaviour change and maintenance.

2. They should include personal profiling to identify individual circumstances and influences on behaviour, so that strategies may be developed to address these. This might include the use of food and activity diaries, identification of (and problem-solving to address) high risk and behavioural lapse situations and the factors influencing them.

3. Psychological issues that affect individual weight loss maintenance capacity should be addressed where appropriate. These may include stress, mood-related eating, self-esteem and the deeper needs that food may be serving for the individual.

4. Maintenance-focused work should aim to help individuals find patterns of eating and physical activity that are satisfying and enjoyable for them, and that are not perceived to clash with other priorities and commitments.

5. Programmes focusing on maintenance should encourage and facilitate nationally recommended levels of physical activity.

6. Signposting to ongoing community based services and opportunities that would support maintenance should be comprehensive.

**Delivery**

1. Support levels should be graded so that they are intensive initially and gradually tapered as appropriate for the individual.

2. Personalisation of services may require ongoing availability of 1:1 consultations, and drop-in sessions, to assist individuals in solving problems related to maintenance as they arise.
3. Groups containing both weight losers and maintainers could be mutually beneficial, providing role models for the losers and motivational reminders for the maintainers. However, the ideal is that maintainers do not become dependent on the group for their motivation.

4. Where on-going groups are provided, self-efficacy and self-management may be promoted by making them peer-led, using a network of volunteers who can call on expert help when needed.

5. Practitioners delivering programmes should have knowledge of behaviour change and maintenance principles, and skills in promoting self-management. Skills in person-centred counselling (e.g. Motivational Interviewing) and Cognitive-Behavioural techniques may be beneficial in promoting weight loss maintenance.

6. Practitioners should be able to recognise when clients would benefit from professional psychological help with mental health problems, and a referral pathway should be available to them.

7. Ideally, some form of health psychology expertise would be available to assist in planning programme content and provide advice when needed.

8. Appropriate training, monitoring and in-service support should be used to ensure quality standards across all providers.

9. A range of delivery formats should be available, including group and 1:1 sessions, telephone, text, computer programmes, internet-based material, smartphone apps and social media.

10. Ways of integrating data collection with existing systems, such as the Health Checks programme and electronic patient records, should be investigated to enhance the comprehensiveness, reliability and long term capture of relevant data.

11. Users want programmes to be convenient, accessible, affordable (some want them free, others are willing to pay) and to take family responsibilities into account (e.g. by providing crèches).
Appendix 1 – Research needs

Respondents were also asked what questions they thought the Research Community could address to help them support Weight Loss Maintenance more effectively. Among the issues raised were:

The meaning and significance of weight loss and weight loss maintenance
- More data on typical weight trajectories in population, so we know how much weight would have increased without interventions.
- Differences between clinical and personal significance in weight loss and their implications for weight loss maintenance.
- How can collective norms be challenged, so that obese people living in an obese community can still appreciate that they need to reduce their weight?
- How are weight loss and other mediators related to health and quality of life outcomes, and to socio-economic indicators of interest to policy-makers?
- The value of temporary weight loss, so that the long term success of programmes can be fairly assessed.

Service and Programme models
- What options are available to support weight loss maintenance, what are their costs and benefits, and are there examples of current good practice?
- What are the contextual factors that influence programme effectiveness and that commissioners should consider in the choice and design of programmes for local implementation?
- Are different types of service or programme more appropriate for different segments of the population? Examples are men, different ethnic and cultural groups, people with learning difficulties, people living in rural areas.
- Is there a demonstrable case for more psychological/mental health input in programmes to support weight loss maintenance?
- Can telephone-based weight management interventions be effective and economic?
- Given the prevalence of obesity, will the overall benefits of programmes be maximised by focusing on a more narrowly defined population?
- What would be the impact of economic measures such as outcomes-based payments to service providers, or charging clients for services?
- Can and should weight management services merge with other lifestyle/Behaviour Change programmes (e.g. smoking cessation, drug and alcohol) to allow sharing resources, gain economies of scale and create synergy?
- Help make NICE and other guidelines more specific in their guidance on weight loss maintenance.

Needs and motivators

- What are the incentives that lead people to weight management services, and the factors that influence their choice of one type of programme over another?
- How to meet the needs of people who aren’t attracted by current provision (or well-known programmes), but might value something else (especially men).
- How to motivate people to increase their levels of physical activity.

Evaluation

- Setting benchmarks: what can a good weight management service achieve, and which measures should be used over what timescale to assess services?
- How can academics be encouraged to collaborate with commissioners and providers to ensure robust evaluation of existing programmes, not just new ones of their own creation?
This consultation involved:

- Commissioners: 12 individuals responsible for or advising on commissioning of adult Tier 2 weight management services in 10 English Local Authorities and in Public Health England.

- Providers: 13 individuals working as providers of Tier 2 services. These included Local Authorities, and NHS, commercial or Third Sector organisations. In addition, data was drawn from a workshop involving 60 healthcare practitioners working in lifestyle intervention services for diabetes prevention.

- Service Users: 22 people with experience of intentional weight loss and maintenance.

Local and regional contacts, snowball sampling and promotion through relevant networks (e.g. the NHS Health Checks Forum) were used to identify commissioners and service providers; service users were invited to participate through local advertising of the consultation. The majority of participants were from West or Southwest England, but several were from Northern England, London, or national organisations. Data were gathered by individual interviews, workshops, or written responses.

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