Dr Grainne McAnee PhD, MRes, BSc; Roisin Ferry BSc; Caroline Stack.

HEALTHY CONNECTIONS

Evaluation of Clarendon Medical Well-being Pilot for People Living With Obesity

> Once you started feeling better about yourself, that's when you started taking better care of yourself, thinking about what you are eating, thinking about exercising more. For me it just joined seamlessly, the mind and the body."
>
> Patient 3

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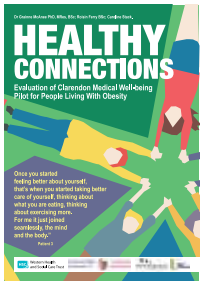

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Statement of Contribution

This evaluation was conducted on completion of Healthy Connections: a pilot well-being programme for people with a BMI > 40 implemented by social workers and patients at Clarendon Medical Surgery. The social workers began working in the practice as part of the Multi-Disciplinary Team pilot (MDT) which was created by a partnership between the Department of Health, the GP Federation and the Western Health and Social Care Trust (WHSCT). The idea of the pilot programme and the practical work of developing, implementing and recruiting to the programme was done by Roisin Ferry* and Caroline Stack. The programme was designed as a result of coproduction with the patients who would use it. Design of the prequestionnaire, face-to-face post programme interview questions, post programme group interview questions and questionnaires for facilitators was done by Grainne McAnee* and Roisin Ferry**. All participants and facilitators contributed to the data collected. Analysis of data was done by Grainne McAnee. Writeup of the report was done by Grainne McAnee, Roisin Ferry and Caroline Stack. The report was reviewed and agreed by the patients, the social workers and the researcher.

We would like to give a very special thank you to our patient group who dared to try something outside of their comfort zone and who were so whole-hearted and generous in their participation in this pilot.

"I thought you know what, I am going to be brave and just go" [Patient1]

*Corresponding author: Dr Grainne McAnee; email: g.mcanee@ulster.ac.uk; Tel: 07907677568.
**Corresponding author: Roisin Ferry; email: Roisin.Ferry@westerntrust.hscni.net; Tel: [07880001418].

Summary

“Normally whenever someone sees a fat person they think, “you need to exercise, you need to stop eating”, and it’s all about what they can see. But that’s not why I’m fat. I’m fat because of my mindset, I’m fat because of the trauma I’ve been through. I used to always ask myself why and now I finally understand. Without this programme I would never have understood that...it wasn’t just fat, it was so much more” [Patient2]

Social workers began working in GP surgeries within the WHSCT in 2019 including those in Clarendon Medical. Within this surgery the social workers identified barriers which they believed were preventing patients who were overweight attending the surgery and finding healthy ways in which to manage their weight. They invited patients with a BMI of over 40 to join them in a coproduction process aimed at designing a pilot programme which would help them manage their weight by understanding their relationship with food. The programme adopted the approach of embedding the social workers and the researcher into the process as well as promoting the ethos of facilitators as part of the group.

The main elements of the programme selected through this coproduction process were an introductory session, sessions on emotional eating and emotional regulation, sessions of Japanese taiko drumming, a personal development element and a celebration. Analysis was mainly qualitative with data collected through one-to-one interviews and a group interview. All facilitators were also asked for feedback. Pre-questionnaires were completed by patients and incorporated the Warwick Edinburgh Mental Well-being scale (WEMWBS) with the WEMWBS repeated after completion of the programme. Findings from the WEMWBS are presented however the Covid-19 pandemic interrupted completion of the programme by one year so it is recognised that such a major confounding influence plays a part in all quantitative findings.

Findings from the analysis showed that the patients found the programme overwhelmingly a positive experience. The process of coproduction allowed the patients to select what they needed and the results of the programme in terms of transformation and learning reflect that. The focus of the programme on the “inside”

rather than the “outside” proved to be the missing element in understanding the patient’s relationship with food. Outcomes included transformation of relationships with the self and with others, achievement and maintenance of sobriety, weight loss and the formation of positive and solid connections within and beyond the GP surgery. The patients see this as the starting point of making sustained changes.

It is recommended that this programme is further developed and run beyond a pilot. Development should be based on findings and on suggestions for improvement by both patients and facilitators. The process of coproduction was fundamental to the success of the programme and it is recommended this process is used to identify other groups who could tailor and avail of the programme. This report notes the importance of the MDT pilot placing social workers and other disciplines in GP surgeries because without this, the programme would not have happened. As it is part of an initiative in a GP surgery, patients benefit from the wide range of support available to them as they continue to pursue their health goals.

Keywords: Obesity; Well-being; Co-oproduction; Multidisciplinary Team; Social Workers; Intervention.

Background

Understanding Obesity

The term obese describes a person who is overweight. The most widely used method of measuring obesity is Body Mass Index (BMI). BMI is a measure of weight against height and is currently the most common way of deciding if a person is a healthy weight. With a BMI of over 25 a person is classed as overweight (nidirect, 2021). With a BMI of over 40 a person is classed as severely obese (nidirect, 2021). Obesity is linked to a range of physical conditions which include diabetes and hypertension as well as mental health conditions which include depression. The NICE guidelines on developing programmes aimed to address obesity in adults (NICE, 2016) report that life expectancy is reduced by an average of 2-4 years for those with a BMI of more than 30 and by 8-10 years for those with a BMI of more than 40. Within Northern Ireland obesity effects one in every four adults and around one in every five children between the ages of 2 and 15 years old (nidirect, 2021).

The behaviour which leads to obesity is eating in a manner that creates an energy imbalance, however the factors that lead to that behaviour are what needs to be understood and addressed to influence it and change it. A person's relationship with food is established in early childhood and is the result of a complicated interaction of effects which are based in biology, psychology and the environment. The British Psychological Society (BPS) in "Psychological perspectives on obesity" (2019) state that:

> **"Obesity is not a 'choice'. People become overweight or obese as a result of a complex combination of biological and psychological factors combined with environmental and social influences. Obesity is not simply put down to an individual's lack of willpower."** (Perriard-Abdoh et al., 2019, pp9).

Biological contributors to obesity include genetic influence. Over 100 twin studies show that 50-90 percent of differences in weight can be explained by genetic influence (Elks et al., 2012). Biological factors also include the impact of stress on the body with a well-established association between stress and obesity in adulthood (Wardle et al., 2011). This stress can include the stress of belonging to a stigmatised group as well factors as such as financial insecurity, family discord and physical or mental illness (Perriard-Abdoh et al., 2019).

Psychological factors are many and include:

- **eating behaviours which are established in childhood and show stability to adulthood** (Craigie et al., 2011);

- **food cues which mean that some people eat more in response to the sight, smell or taste of high sugar or high fat foods;**

- **dietary restraint which can lead to a subjective feeling of deprivation** (de Witt Huberts et al., 2013);

- **mental health problems which can create both a complex and bi-directional relationship with obesity (Perriard-Abdoh et al., 2019); and**

- **the impact of psychological adversity as chronic activation of the body's stress response system increases the risk of developing obesity** (Hughes et al., 2017)**.**

Social and environmental factors are recognised as important contributors to obesity. There are a range of these mechanisms which shape people's relationship with food. Food choice for example includes strategies by the food industry to encourage people to buy energy dense food and in larger quantities. These are strategies such as placing certain foods at eye level at checkouts, packaging food and drink in larger quantities that seem like good value and the aggressive promotion of food of poor nutritional quality as these represent the highest profit margins (Perriard-Abdoh et al., 2019). Other mechanisms are related to our lifestyle with jobs becoming more sedentary and involving more screen use, exacerbated with the effects of the Covid-19 pandemic.

An examination of social and economic status shows that there are stark economic inequalities in obesity. In the UK as well as other high income countries energy dense foods tend to be cheaper and so are more prevalent in areas of deprivation (Perriard-Abdoh et al., 2019). This manifests in ways such as more fast food outlets appearing in more deprived areas (Cummins et al., 2005) as well as more consumption of takeaway food in low-income families (Macdonald et al., 2007). Combined with these are factors related to the ability to engage in physical activity in poorer communities such as availability of green space and safe play spaces. Further to all of these is that people who experience more social and economic deprivation also experience higher levels of adversity which in turn leads to higher levels of stress (Wilkinson & Pickett, 2010).

This interaction between social and economic status and levels of stress perfectly illustrates how these biological, psychological and social factors all come together in a complex web. Some people will potentially experience a triple risk through genetic, psychological and environmental pressure which can lead to overeating and can make it difficult to make health choices that allow maintenance of a healthy weight.

Stigma and Obesity

Living with the effects of stigma is part of the experience of living with obesity. The belief by many people and by policy makers that obesity is due to a lack of willpower and poor self-discipline places it as a personal characteristic with very negative stereotypes (Perriard-Abdoh et al., 2019). This means that rather than trying to understand the complexity of the relationship between biology, psychology and the environment, the individual is blamed which leads to feelings of shame. Rather than motivating people or helping them to make sustainable changes weight stigma in society perpetuates a cycle of shame and weight gain at all levels of obesity. With an increasing BMI comes an increasing perception of discrimination against people because of their weight (Jackson et al., 2015). Perriard-Abdoh et al. (2019) sum this up:

> **"A view that positions the causes of weight gain as residing within individuals has resulted in a widespread cultural view that obesity is a negative personal characteristic. Public acceptance of this stereotype allows individual, group and organisational weight bias and discrimination to go unchallenged, in a way that other forms of discrimination do not. This has an impact not only on individual experiences but also on the way that policies and support services are designed."**

The impact of stigma has many negative effects for the individual. Many of these compound issues around eating such as an increase in disturbed eating patterns and feeling out of control with eating. It can also prevent people from attending the services that are there to help manage weight. In some cases, it can even prevent people from leaving their home. Anxiety around discrimination may combine with poor body image to increase behaviours such as exercise avoidance (Gatineau & Dent, 2011). In relation to health care, people living with obesity can worry that they will be viewed negatively by health care practitioners and will not be taken seriously which leaves them reluctant to address weight concerns (Bertakis & Azari, 2005).

The Programme

As part of the Western Trust MDT pilot, social workers became part of the multidisciplinary team working together at Clarendon Medical. The MDT pilot was formed in the Western Health and Social Care trust in response to the Department of Health's "Health and Well-being 2026 – Delivering Together" strategy (Dept of Health, 2021). The social workers who had been integrated into the GP practice observed the barriers experienced by people who were living with obesity and attending the practice. They saw the impact of stigma and shame manifested in a number of behaviours. Some patients were reluctant to come to the surgery at all. Some patients would not leave their car if they did come to the surgery. Some patients communicated their shame in jokes and put downs of themselves in visits to the surgery. The social workers wondered how many patients felt like this in their practice. They were aware of the health risks associated with obesity itself, compounded by issues around reluctance to access services due to shame and other weight related issues. They decided to take action.

There are many excellent programmes already in existence which address aspects of weight loss such as exercise and healthy food. The process of coproduction on which this pilot programme was built resulted in a programme which looked different to these more traditional programmes, one which addressed different issues. The main aim of the programme as decided by the patients was to focus on the specific issue of understanding the factors which make up our relationship with food. These include the emotional relationship each person has with food and with themselves. The programme aimed to enhance well-being. It aimed to provide ways in which patients could create connections with the self and with others. It aimed to remove the barriers that obesity can create between individuals and their health care providers. It aimed to provide ways of moving the body that created joy and connection. It aimed to use resources from within the local community to further develop and enhance these connections. In doing all of the above it aimed to address issues of shame associated with weight, replace them with understanding and in doing so allow the potential for real and sustained change. The programme aimed to build healthy connections.

The Programme as a Co-production

The main value behind the development of Healthy Connections was that it would be a co-production with the patients who would use it in line with the Department of Health's "Health and Well-being 2026 – Delivering Together" strategy (Dept of Health, 2021). In accordance with this each step of the process was guided by interaction with

the Westerns Trust's Personal and Public Involvement (PPI) team and the Senior PPI Implementation officer. This was done in line with the WHSCT Integrated Involvement Plan (WHSCT, 2021) which contains the following service user quote,

> **"Co-production means involving service users from the beginning, which really means getting together to have the ideas and come up with a project together, not afterwards once a project has been decided on".** (Service user quote, p11)

Once the need had been identified by the social workers and the idea began to form the social workers consulted the literature as outlined in the introduction section of this document and the "NICE guidelines on prevention and lifestyle weight management programmes for people living with obesity" (NICE, 2016). The lead social worker approached the MDT lead for social workers as well as the practice manager who both agreed they could progress the idea with the MDT team within the practice. This team is made up of all the professionals within the practice – the practice manager, the GPs, the Mental Health Practitioner (MHP), the physiotherapist, the pharmacist, advanced nurse practitioner, nursing staff, health care assistants and administrative staff. The social workers wanted to ensure that a wider perspective was explored and wanted to allow those who work within the practice to be aware of the issues faced by this group. It was decided to proceed with the idea of developing a programme.

In parallel with this process, the social workers began to talk to patients to ask them what they felt would be a helpful way to address the issue of their weight. This contact was initiated by sending a letter to every patient within the practice who had a BMI of over forty. The letter is contained in Appendix 1. All patients who replied then attended coproduction workshops in the form of phone calls and meetings and those who were interested became part of the panel which would decide what the programme would contain. As part of this process the social workers provided information on elements the programme needed to have to meet legal and ethical requirements as well as information on what kind of resources and facilitators were available in the community. The social workers also talked to the Health Improvement department within the Western Health and Social Care Trust as well as linking in with other local community groups such as the Bogside and Brandywell Forum with the double aim of identifying resources and groups that were already provided within the community and also to look for potential sources of funding.

During this process, the panel of patients identified what they thought would help them. As a result of this, a Dragons Den themed event was developed and held in which a range of facilitators were invited to meet with the panel and tell them about their service or programme. The panel then decided which elements the programme would contain in order to meet the need they had identified from the coproduction process.

The social workers took a novel approach as part of the concept of coproduction in deciding that "the professionals" involved with the programme would be embedded within it and experience it with the patients. This would include the social workers themselves and also the researcher. All facilitators would combine leading their element of the programme with active participation in the group. This would promote the development of relationships within and beyond the practice and would allow informed and involved insights into how the group and the programme worked.

Programme Elements

The final programme decided on for the pilot was made up of a number of components:

- **An introductory session in which the programme would be explained, participants would meet each other and the process of forming a group would begin. This involved the practice Mental Health Practitioner (MHP) who provided information and support on safety and who would be part of the support provided beyond the group. The MHP would be available to provide support on a one-to-one basis as would the practice social workers and came along to the group again to do check-ins.**

- **Six weeks of Taiko drumming. This was provided by Fiona Umetsu of Foyle Obon. This would allow the group as a unit to try something it was highly probable no one had already tried. Taiko drumming involves movement and expression and is a fun activity. It was one of the initial elements of the programme as it was felt it would provide a light-hearted and interesting way for the group to bond.**

- **The Taiko drumming was done in conjunction with two nights of work with Shauna Quigley – The Wellness Seeker - on understanding emotional regulation and our emotional relationship with food. Shauna also provided an online course to the participants on the same topics which extended this work beyond the two sessions.**

- **Personal Development. This section was delivered by Belong: Supporting Mental Well-being. This element of the programme consisted of emotional and spiritual development work facilitated through a mixture of different mediums including art and holistic therapies.**

- **A celebration. The programme would end with a celebration which would involve the whole team and all facilitators. The exact format of this celebration would be decided by the group as a whole as the**

The Facilitators

This section contains descriptions of each of the elements which were selected by the panel for inclusion in the programme. The sections are written by the facilitators who delivered each element. Each section contains information on who the facilitators are and what they wanted the patients to gain from their element in the programme. The final section provides feedback from each set of facilitators.

Foyle Obon

Who we are

Taiko is a form of drumming with its roots in Japan. Taiko translates as 'big drum' and they are big, beautiful, bold, energising, vibrant, visceral, empowering and magical. There is simply nothing else in the world that compares to the feeling of playing taiko.

Taiko drums have been part of Japanese traditions for centuries used in traditional ceremonies, theatre, and festivals. In the 1950s, a Japanese jazz drummer called Daihachi Oguchi first brought the different types of individual taiko drums together in an ensemble and created 'kumi daiko', which means team drumming. This is what is generally thought of as 'taiko' today. Team is at the heart of taiko. We play together, we respect each other, we have fun together, we create safe spaces together, we trust each other, we listen to each other and we share the Taiko love and joy.

In 1996 Fiona Kelly left Derry to find adventure in Tokyo, Japan. Along with adventure she found an all-female taiko drumming group – Sazanami Daiko – She joined and fell in love with taiko. She also fell in love with Katsu Umetsu from Yamagata Prefecture. Together they concocted a dream. They knew that taiko could be an amazing force for good here in Northern Ireland.

They started with one drum and big ideas in 2009. Fiona taught taiko and Katsu made the drums. They were the perfect team. 'Ibuki' was chosen as the name for their group because it means 'life breath' and has connotations of creating new life.

In the years since, Fiona has led projects such as Yujo Taiko bringing together Catholic and Protestant school children, Drum Like A Girl empowering teenage girls, Irodori Taiko collaborating with the LGBTQ+ community and so many more. She empowers participants by giving them tools in confidence building, teamwork, communication and community building.

As Fiona and Katsu's own family grew, they recognised the importance of creating spaces where diversity is celebrated. Where the two dominant traditions of Northern Ireland could come together along with the local Japanese community. The idea of a family festival was born, and the first Foyle Obon celebration took place in May 2015. The festival challenges racism and tokenism in the arts and beyond. It creates opportunities for the Japanese community to be included in the local cultural calendar and to share their traditions.

Our Aims

These were the aims of Foyle Obon in contributing to the Clarendon Medical programme in their own words.

One of the most important things to me as a facilitator is to hold a safe space for my participants. This space is one where people feel welcomed, feel comfortable to try new and challenging things, know that they can show their true selves, know that we operate from kindness and inclusion.

Taiko drumming is team based, performance art drumming with its roots in Japan. It involves a lot of movement and is quite high energy. It requires participants to be open to trying new things and trusting the space and the group they are working with. For this reason, it is an excellent team building vehicle. Sharing the vulnerability of trying new challenging activities gels groups together very quickly.

With this particular group, I was focused on tailoring my programme of taiko to allow them to trust their bodies, to try new movements and to believe that they had the right to own all of their space and place at the drum. For people with high BMI, there are elements of shame that hold people back from owning their space and loving their bodies in movement. I wanted to hold a space where this was celebrated and enjoyed.

I was also keen to share my love of taiko drumming, the history of the art form and how we use taiko drumming here in N Ireland.

The Wellness Seeker

Who we are

I am a therapist, professional trainer, keynote and TED speaker who has developed a unique methodology of healing called The Clearing Method. The Clearing Method is a guide to uncovering and healing the source of your suffering. The ' how to' of finding and healing the difficult wounds that lie within. A step-by-step system that gets to the root causes of suffering and dis-ease, switching them off at source.

The method is a psychotherapeutic, body centred tool, delivered through the person-centred relationship. My experience was that you can find a way to bypass the mind's need to sort and label, by using the emotional content within. I used the somatic sensations in my body to guide me to a place of healing. I witnessed and worked through a series of steps in order to free myself from the pain and turmoil of wounds within. Now I am teaching this method to Therapists and coaches to enable them to steer their clients out of their suffering.

Currently practicing as a Person-Centred Therapist in my home town of Derry City in Ireland, I have helped thousands of people journey home to their real self using ' The Clearing Method '. I run personal courses in emotional eating, self-development and eliminating anxiety. I run professional courses in anxiety coaching, life coaching and emotional eating training.

Our Aims

These were the aims of the Wellness Seeker in contributing to the Clarendon Medical programme in their own words. That patients would gain:

- **An understanding of the key principles of emotional eating,**
- **A detailed analysis of the particular principles that effect the patient's directly,**
- **An understanding of what is needed to heal emotional eating,**
- **An understanding of how overeating and emotions are linked,**
- **An understanding of how key events in their life have affected them emotionally and how those events are linked to eating,**
- **An understanding that there is nothing "wrong" with them. The shame that they felt due to lack of understanding has changed.**

Belong: Supporting Mental Well-being

Who we are

This is the story of 'Belong: Supporting Mental Well-being' who delivered the personal development element of the programme. It is written in the words of Dr Anne Tracey, Fiona Bell and Rosemary Bradley.

Anne Tracey PhD, Registered Counselling Psychologist with HcPC and Psychological Society of Ireland, practitioner therapist, writer and researcher.

Rosemary Bradley MSc Applied Psychology, Psychological Well-being Practitioner, Registered British Psychological Society.

Fiona Bell MSc, Registered Social Worker with NISCC. Also trained in Health Sciences, Community Drama, Transpersonal Art Therapy and currently training in Somatic Experiencing.

The genesis of this programme arose following discussions with Roisin Cartmill, Social Worker at Clarendon GP practice, about the unmet needs of a cohort of patients struggling with high BMI and other issues. Anne Tracey PhD and Fiona Bell MSc volunteered to design a bespoke 6-week pilot programme, that would sensitively engage and support this group, by way of emotional support and capacity building.

We began the programme in February 2020 using face to face group contact, but unfortunately had to suspend it after 4 sessions due to Covid restrictions. We later adapted the programme to make it suitable for an online format, delivering 6 sessions in February - March 2021. Rosemary Bradley MSc joined the team for the design and delivery of the 2021 online programme.

Understanding the multi-factor complexity behind high BMI and the attendant misinformation, negative cultural perception of a 'personal weakness/failing/laziness' and toxic shame and poor self-esteem that ensues, we sought to build the internal capacity of the participants, by firstly engaging with the 'human' rather than divorcing health from the personal.

Being informed by neuroscience and how dysregulation of the Autonomic Nervous System (ANS) creates a plethora of health issues including high BMI, we opted for a programme that would use creative means to explore the scientific concepts that informed our work.

Utilising creative means was a considered way to ensure participants had a direct experience of the concepts we were sharing, rather than opting for a traditional 'taught' approach. Alongside this, we ensured the programme created parity of esteem, by ensuring that all attendees were also participants, rather than a facilitator/researcher divide. Our aim was a shared human journey, where people would feel safe to begin to explore their inner world and the factors that impact their well-being.

The arts as a therapeutic tool was used with the intention to help participants gain a fresh way of viewing themselves and their inner resources; one that would support them emotionally and psychologically to enhance a sense of self-efficacy, resilience and empowerment. The programme was structured and developed to create the conditions for participants to experience regulation of their ANS. We hoped that participants would begin to experience ease within themselves and begin to connect with themselves as embodied, rather than disembodied selves. We hoped that participants would begin to reframe their self-view, building their self-esteem and feelings of being a worthwhile person with something valuable to contribute to the wider world. In designing the programme, we also hoped that participants would begin to experience a sense of inter-connection with each other, supporting each person to explore how a sense of belonging can foster emotional well-being through a reciprocal giving and receiving of supports.

In summary, our approaches were designed so that participants could experience a bridge to their own inner resources and capacity, building self-efficacy, self-esteem, and creating the conditions for a relaxation of the ANS thereby activating the innate healing impulse. We hoped to create an experience whereby participants could tap into the realization of their own healing impulse and resources, thus enabling the healing journey as a collaborative one, rather than the patient as passive bystander disproportionately reliant on external services and supports.

Our Aims

These were the aims of Belong: Supporting Mental Well-being in contributing to the Clarendon Medical programme in their own words.

If we were to increase members' 'capacity' to explore, understand and enrich the self, it was critical that the strategies we chose to aid that process would have to be well explained, meaningful and doable. In our view, talking about self-esteem was not the way to go. The underlying aim of our element of the Well-being programme was to employ meaningful and creative ways of working to support group members' in beginning the process of exploring and examining psychological and emotional aspects of themselves.

The hope was that the key gains for group members might include the following,

- **develop a sense of self and awareness of inner resources,**
- **reclaim a sense of personal power / self-empowerment,**
- **experience regulation of the ANS through a feeling of 'ease',**
- **identify personal needs and ways to meet those needs,**
- **start to reframe view of self with consequences for self-esteem and feelings of being a worthwhile person with something valuable to contribute to the wider world,**
- **experience a sense of 'belonging' through positive feedback, being respected, admired and treated with dignity within the group,**
- **experience parity of esteem and safe containment within the group, to enable personal and emotional sharing,**
- **the capacity to observe providing greater access to the ventral system and neocortex for thinking and social engagement, and in turn increase tolerance of distress and uncomfortable feelings,**
- **enable a greater sense of embodiment, rather than a disembodied sense of self,**
- **we hoped that engaging innovative approaches would gently stretch the parameters of the habitual lived experience of group members and open them to fresh insights and energy,**
- **enhance awareness and understanding of alternative approaches to health, informed by neuroscience, through the use of creative means the 'lived experience' of the group might lead to the outcome or consequence of seeking to live well, live better and flourish – in all enhanced self-management.**

Facilitator Feedback

The facilitators who delivered each element provided feedback on the programme. This was done in the form of feedback questionnaires. The questionnaire is contained in appendix 6 to this document and asked the following questions:

1. **What did you want the patients to gain from your element of the programme?**

2. **What do you think they did gain and how do you know?**

3. **What was the experience of facilitating on the programme like for you? What do you feel you gained from it?**

4. **Is there anything you would change if you were delivering your element of the programme again?**

5. **Any other comments?**

Foyle Obon Patient Feedback

Foyle Obon held in-person feedback sessions on completion of the six weeks of taiko drumming with the patients. Three questions were asked, and the responses are documented here.

What Surprised me Most About Taiko?

- That we had to use drumsticks.
- It was easy to pick up.
- Energetic.
- Japanese culture.
- It is way more than drumming.
- Putting words to piece was fun.
- Got [group member name] away from football.
- Social skills – teamwork.
- Connection to self and to others.
- I always leave happy.
- Enjoy the class but it impacted life outside.
- It was unexpected that it impacted life outside.
- It is interesting.
- Make your 'nevers' [belief that I could never do that] smaller.

How did taiko fit as part of this programme?

- It helped transform the group.
- It was transformative.
- Showed that the physical was accessible and do-able.
- Great exercise.
- Social.
- Confidence building.
- Not so serious.
- Release.
- Good for mental well-being.
- Good balance.

What is your taiko superpower?

- Positivity.
- Lovely energy.
- I love taiko!
- Showing up.
- Dedication.
- Determined.
- Not afraid to make mistakes.
- Musical talent.
- Overcome physical issues to take part.
- Got emotional release.

Foyle Obon Facilitator Feedback

This was Foyle Obon's response to:

"What was the experience of facilitating on the programme like for you? What do you feel you gained from it?"

I really loved the experience to work with such a diverse group of adults who were so open and willing to try and challenge themselves. The energy was so high, and it was

obvious that these people were starting to form a close team. They were so supportive and encouraging of each other, it was lovely to be a part of.

Every group I work with enriches my own learning about how best to facilitate a group. This group gave me insights in how I can structure my workshops to include those with limited mobility without making it a big issue and without it taking away from the experience for the participant.

Foyle Obon Suggestions for Improvement

Foyle Obon suggested some improvements they would make to future rollouts of the programme:

I would love to have longer with this group! To develop the programme into a mix of practical drumming sessions and sessions exploring in groups how to use this artform to express your body and voice, what it means to own your space, what it means to be vulnerable and share your talents, how we can share our taiko love with audiences.

Wellness Seeker Patient Feedback

The Wellness Seeker felt that the aims outlined above were met and she knew this through conversations in the sessions, messages she received after the sessions and conversations with the social workers.

Wellness Seeker Facilitator Feedback

This was the Wellness Seeker's response to:

"What was the experience of facilitating on the programme like for you? What do you feel you gained from it?"

The program was an amazing experience for me. The energy that was created within the group was a privilege to be part of. This energy was created by Roisin. Her relationship with the patients built the empathy and unconditional positive regard needed to facilitate this process. Although the entire program was not delivered, seeing the effects that the small amount of information had on the patient's was a privilege.

Wellness Seeker Suggestions for Improvement

The Wellness Seeker felt that the delivery of the entire emotional eating programme would have benefitted the patients even more.

Belong: Supporting Mental Well-being Patient Feedback

Belong reported that this was a very special and powerful group experience for all group members. They note the importance of the group remaining intact which was for four weeks initially face to face before the Covid-19 pandemic and then six weeks by zoom when it became clear face to face contact would not be possible. This is their response to:

"What do you think they (the patients) did gain and how do you know?"

- **From the word go there was a sense of camaraderie and connection. Critical to the process were regular weekly check-ins to assess how the group process around ritual, contract, intention and content was working.**
- **Group members reported that they felt accepted, respected, not judged and were supported to speak, share and take part in small group activities.**
- **The 'conditions' were experienced as safe, confidential and non-judgemental, evidenced by deep personal and emotional sharing.**
- **The group reported shifts in personal inner awareness that changed their outlook of situations and demonstrated profound compassion and respect for one another's journey in the programme.**
- **Group members reported a re-framing of their view of themselves, creating an additional positive impact on wider relationships.**
- **Group members experienced healing, learning, well-being and increased positive sense of self that allowed access to a sense of ease within themselves.**
- **Group members reported an increased insight into their personal needs, identifying how those needs could be met, including evidence of seeking external supports as needed.**

- **Participants reported they used the group exercises outside the formal group meetings, to further enhance their emotional well-being and facilitate restful sleep.**

- **Group members evidenced parity of esteem and ownership of the process, by seeking recordings of a group exercise and creating a private You-tube video to support their ongoing healing journey.**

- **All group members participated in the process, creating an equitable shared human journey, rather than a professional/participant divide thereby enabling a safe containment for a deep healing process to unfold.**

- **Group members described the fresh experience of feeling 'embodied' and developing a healthy, compassionate and more positive view of themselves.**

- **Group members found worries around the use of webcam and its impact on collective bond and capacity to share, were unfounded.**

- **At the end of the process, group members described the pilot programme as a step in the direction of healing and voiced their wish/interest in further work to deepen the process.**

Belong: Supporting Mental Well-Being Facilitator Feedback

This was Belong's response to:

"What was the experience of facilitating on the programme like for you? What do you feel you gained from it?

The roll out of any programme requires planning, management and leadership. However, core to the group process in 'Belong: Supporting Mental Well-being' was a sense of an equal playing field, a shared human journey, and parity of esteem for all group members. No one was asked to do anything that the entire group did not participate in. We were all in the process together. We all contributed, and we all learned from one another.

In designing the programme, we knew we were taking some 'calculated risks' in the innovative method of delivery and content. At the outset, we decided we would not approach the group in a traditional manner; directly exploring constructs such as self-esteem and the facilitator being the 'holder' of wisdom and knowledge. We wanted to shift the dynamic, and to inspire the group participants to realise that they

themselves are a tremendous source of insights, wisdom and guidance for their own healing journey. In doing this, we aimed to shift the loci of control to the participants themselves, and thus, enable empowerment.

Looking back now, we feel a great sense of joy and satisfaction in having taken an innovative approach. We gained confidence seeing how our model can work and we also learned how to further enhance the programme. Each one of us gained insights into our own healing journey's and we learned and were gifted so much from the generosity of all group members.

Facilitating through webcam, did require some adjustment and innovation, although the key ingredients like active and respectful listening, clearly communicated information and a well-designed plan, remained as important as ever.

It was a humbling and privileged experience to have participated in this wonderful journey of exploration with an exceptional and inspirational group of people. Together we made sense of our inner world and the factors that impact our lives, and received its gifts of healing, strength and inner resources gratefully. Demonstrating our own commitment to personal development offers support and encouragement to others reaching their own full potential.

Belong: Supporting Mental Well-Being Suggestions for Improvement

Belong suggested a number of improvements they would make to future rollouts of the programme.

- **It would be preferable to have the group together in a comfortable space where people feel comfortable. A residential setting comes to mind as a way of working.**

- **A roll out of a programme such as 'Belong: Supporting Mental Well-Being' perhaps deserves to be longer in duration. This was intended as a pilot and thus a 'taster' experience. It takes time for ideas/thoughts to distil, to be 'digested' so 6 online sessions of 1 ½ hours is relatively short.**

- **It might be helpful if group members had one-to-one support alongside the group process to aid assimilation of thoughts, ideas and the possibility of developing change in their lives.**

- **In terms of content delivery, in future we would adapt exercises to ensure they are multi-sensory, to match the different learning and perception styles of group participants.**

- Drawing on feedback from participants, we would also consider adding a weekly recorded exercise so that participants have the option to deepen the process at home, supporting the learning and insights from each week's group session.

- The addition of an add-on to existing participants who wish to progress deeper into the healing journey, would be fitting.

- Group members identified areas of interest as well as topics they would be interested in learning and experiencing more about. At the end of the process, group members said they would like to continue this work in some form, as well as supporting it being more widely available to others. Resources permitting, we would be keen to engage this group in a deeper exploration of what works, so that a future programme could be co-designed to ensure it matches the needs of people. The existing pilot group is small, but diverse in terms of gender and age, and a solid founding base from which to learn and respond in an evidenced way. We are committed to a process of continuous and iterative learning to further develop the programme.

The Covid-19 Pandemic

As the programme moved into the personal development element the Covid-19 pandemic began in a meaningful way. The programme was suspended for one year as a result. During this time contact and connection was maintained with the group and within the group using a number of strategies:

- **An email patient group was created in which the group could maintain contact with the social workers and could share helpful resources with each other.**
- **Access to a Zoom patient group which was part of the wider patient community during the Covid-19 pandemic, and which included set activities such as Zoom bingo at Christmas.**
- **When safety and weather allowed, several group meetings took place in outside forums. One was a BBQ at The Playtrail, which is a local outside play and educational resource which also provided the forum for an outside meditation.**
- **The social workers distributed gift bags to the group.**
- **The social workers provided the group with a well-being booklet which they designed for all patients at Clarendon medical based on the Public health Agency (PHA) 5 Stages of Well-being.**
- **Ongoing access to the social workers at the surgery for support.**

Conclusion of the Programme

Once it became clear that face to face interaction would not be possible for the group, and nine months had passed, it was decided that the final element of the programme would be facilitated in an online forum. As with every step of the process this was decided by asking the patients completing the course what they would like to do. The six weeks was reset to the beginning and the personal development element was delivered through a series of Zoom workshops.

Evaluation of the Programme

Overview

Evaluation of the programme was comprehensive and was in the form of interviews, questionnaires and feedback forms. At each stage of the evaluation process the patients received information sheets informing them of the process and their right to withdraw from it as well as support available to them. A strength of the programme was that the patients were part of the GP practice and as such had access to all the resources available to them within the practice encompassing physical and mental health needs. This support importantly continued after the conclusion of the programme. It is recognised that all findings were affected by the Covid-19 global pandemic which provided an unprecedented confounding influence.

Sample

There was recognition that as a pilot for a stigmatised group this would most likely be a small group. Initially 80 letters were sent to patients. Of these 23 patients responded. Fourteen patients made up the panel which decided on the programme elements. Five patients came along to the introductory evening and started the programme. One patient left the programme during it.

The patients who made up the core group were small but diverse. There were two male and two female patients. The age range of patients was 29-50 years old. One patient was married, two patients had children. Two patients were employed, one was unemployed, and one was on disability benefits. One group member was quieter and more introverted in nature. Patients are referred to as Patient 1, Patient 2, Patient 3 and Patient 4.

Method

The Warwick Edinburgh Mental Well-being Scale was used to measure well-being at the start and at the end of the programme. Due to the small sample size and because it was vitally important that the in-depth experience of each patient was explored and documented, the primary analysis approach was qualitative. This was facilitated through semi-structured one-to-one interviews which were completed by the researcher with each participant in the social workers office at the GP surgery. A group interview with all the participants, the social workers and the researcher was also conducted in the library area of the GP surgery. Interviews from the one to one and group sessions were transcribed. Coding and management of the material was done using a manual process. Qualitative analysis was done using Interpretative Phenomenological Analysis (IPA) (Smith et al., 1999).

IPA is a qualitative approach which is recommended for use with small sample sizes (Alase, 2017). The optimum sample size for IPA is between one and 35 (Brocki & Wearden, 2006) with a sample size of 3 to 6 being recommended (Smith, Flowers & Larkin, 2009). The primary goal of IPA is to investigate how individuals make sense of their experiences (Pietkiewicz & Smith, 2014). It seeks to explore in great detail the subjective view of individuals. For this it uses a two-stage process. In the first stage unique experiences are explored through a comprehensive and systematic analysis of each individual's narrative (Smith et al., 2009). The next stage is that the researcher extracts general themes from the collective narratives while respecting and staying true to individual narratives. The IPA framework requires a case-by-case approach. Themes are classified, organised and summarised in tabular format and master themes are identified, extracted and explored. Interviews are listened to and transcripts read numerous times in order to achieve and enhance familiarity, to maintain the sense of connection between interpretation and the individual narratives, to facilitate exploration at a general and specific level, and to enable a more comprehensive analysis. Through this process relationships are identified between themes which enable the formation of clusters which are hierarchies of master themes and their components (subordinate themes). Descriptive labels are then applied to each cluster with a complete narrative then developed to guide the reader through the interpretation theme by theme.

Reflexivity

IPA fits very well with the idea of coproduction and the embedding of the researcher in the process as it recognises the role of the researchers' own ideas and understanding in an interactive and dynamic process of making sense of participants' subjective accounts (Langdon et al., 2007). As a qualitative analyst must make sense of the themes that emerge it is important to acknowledge that their perspectives may be influenced by personal beliefs and opinions. Recognising this allows the researcher to be mindful that they should remain open to data being contradictory to their own preconceptions (Larkin et al., 2006). Reflective practice is therefore recommended (Smith et al., 2009). This process allowed me as the analyst to be aware of my own previous life history and experiences. For me this includes a lifetime of struggling with my own over-eating embedded in my urge to use food to self-medicate and comfort. There was also an awareness that as I had been embedded in this process and benefitted greatly from my participation I had to ensure that I was open to all findings in order to present a meaningful and complete analysis. A great benefit of this embedded approach as a researcher was that there was a build-up of trust with the patients which translated into an enhanced interview process which I feel may not have been the same without that foundation.

Interviews

One to one interviews lasted up to forty minutes and were recorded for transcription. The interviews were conducted in an informal and conversational manner. While the schedule of questions was followed, it guided rather than dictated and the researcher did also pursue related topics which the patients raised. Probes such as “can you tell me more about that?” or “why do you think that was difficult?” were used to ensure all relevant information was collected. A general final exit question was used to ensure everything had been fully explored. The group interview was recorded for transcription and included in the qualitative analysis and followed the same style and principles.

Questions asked at the interview sessions are contained in appendix 3 of this document and explored the following subjects:

- **What attracted patients to participate in the programme.**
- **The coproduction experience.**
- **What the programme was like.**
- **Strengths of the programme.**
- **Areas that could be improved.**
- **What had changed for patients because of the programme.**
- **How the Covid-19 pandemic had affected them.**

Topics explored at the group interview are contained in appendix 4 and were:

- **How results were to be presented – use of pseudonyms or identifiers.**
- **Previous programmes used to help manage weight.**
- **Experiences because of body size.**
- **Experiences attending the GP surgery.**
- **What the coproduction experience was like.**
- **How the group dynamic was created.**
- **A name for the programme.**
- **What was needed next.**

Questionnaires

Pre-questionnaires were completed by all participants. The questionnaire is contained in Appendix 2. These contained the Warwick Edinburgh Mental Well-being Scale (WEMWBS) as well as a set of questions. The pre-questionnaire was conducted as part of the introductory session. The WEMWBS was repeated on conclusion of the programme at the group interview.

Qualitative Evaluation Results: One to one and Group Interviews

The final sample included all four patients who had completed the programme, two men and two women. Table 1 shows the master and subordinate themes identified. The narrative that follows documents the patient's stories using these themes.

Table 1. Master and subordinate themes for the group

Master Themes	Subordinate Themes
Life experiences	Adversity Mental health issues Family dynamics Other weight loss programmes Experiences because my body is bigger
Motivation	Looking for something Coproduction Commitment to programme
Positive experiences	Social workers Removal of barriers Facilitators Programme design Group dynamic
Outcomes	A change in focus Transformation of relationships with self and others Sobriety Weight loss Being able to talk
Concerns	Dominant group member Boundaries Covid-19
The future	Continued development of this group Ideas to improve the programme

Figure 1. Word cloud produced from interviews with the patients.

Life Experiences

Asking what motivated the patients to do this programme prompted some of the patients to talk about previous life experiences. Two of the patients talked about adversities they had experienced as children. One of these was the loss of a parent at a very young age and the impact the loss had on them and their family.

> **"My father died when I was quite young, I was eight. I don't remember much of my childhood. Only recently have I realised how traumatic my childhood really was which is really difficult to come to terms with."** [Patient2]

Another patient told of how they had a medical condition as a child and young adult. This involved a number of surgeries and had a huge impact on how the patient viewed their own body. This patient was very slim as a child and young person with intermittent periods of weight gain but revealed that **"even when you could see every rib of my cage I still couldn't look at myself"** [Patient1]. This shows in a powerful way that how we see ourselves is impacted by so much more than what we look like on the outside and gives an important insight into how body image issues start with our journey through childhood and are influenced by many factors. Other life experiences discussed were addiction issues within the family and a history of eating disorders. One patient discussed how they were **"thin and bony"** [Patient4] until they went to work in England when they were 17 years old.

"I didn't have a parent telling me not to eat this, not to do that. I wouldn't go out walking much." [Patient4]

As well as bereavement as a child, one patient had also lost a sibling as an adult. For one patient who had used slimming clubs for "a lifetime" [Patient1] to manage their weight, it was the development of a disability which had impacted the effectiveness these traditional programmes had as it restricted mobility, ability to exercise and also came with a lot of medication.

"I was physically and mentally sick and had to go on a lot of medication. Whenever I started my medication, my weight ballooned over a couple of months." [Patient1]

Patients also discussed how they had been struggling with a range of mental health issues in the period immediately prior to the programme. For one patient this included low mood, for another issues around alcohol use.

Patients described perceived negative experiences around weight in relation to them or to their families. Two patients talked about other family members who also had weight issues. One patient described a "family obsession" with weight and openly negative comments being made to them by family members about their size.

"My father's family are nightmares about dieting it's just constant. What did you eat today and what weight are you now? This has been going on our whole lives and it's all about how you look." [Patient1]

All patients reported a wealth of knowledge in relation to "how" to lose weight.

"overweight people know, are educated in what's healthy and what's not…it's more the why." [Patient3]

Most patients described previous experience with a multitude of other programmes aimed at weight loss. These included both slimming clubs and gym and exercise programmes. All of the patients had good knowledge of factors such as what we eat and how we move being central to controlling weight. Most patients had been successful in losing a large amount of weight previously using these programmes with one patient describing **"phenomenal success"** and the winning of many awards, **"I was slimmer of the year"** [Patient3]. All have regained that weight and added more weight subsequently. Maintaining the weight loss was the issue.

Most patients described barriers to more traditional forms of weight loss programmes. For one patient the idea of weigh-ins would have been a barrier.

> **"I just didn't want to go through that because I knew that my weight was going to be really, really high. And I didn't want to look at that, because that sends me then into a spiral of comfort eating."** [Patient1]

For some patients, their restrictions around traditional forms of exercise would also have been a barrier, not because they don't want to exercise but because they **"walk really slow and I don't want to hold people back."**[Patient2]. All patients were open to try whatever was selected as the final makeup of the programme through the process of coproduction, **"I would have tried it because I was trying to keep an open mind."** [Patient2].

Patients reported a range of experiences they had had where they felt they were treated differently because of the size of their body. An interesting element of this was that they learned the message that there was something wrong with their body size and it was not always due to tangible things that people said or did. The message just got through to them. Messages around attraction and health were learned from sources such as family, the media and society. One patient talked of experiences in school when they were young and had put some weight on as being **"hell on earth"** [Patient1]. Shopping was mentioned by all patients as an unpleasant, sometimes horrific experience with one patient remarking, **"look at mannequins in shops"** [Patient3] as mannequins seldom if ever represent people with larger bodies. Another patient talked of having to just watch their friends try on clothes as they shopped in **"all the skinny shops"** [Patient2] and there were no clothes to fit them. Another patient spoke of how **"I realised it peeved me off going shopping"** [Patient4] because they could never find clothes to fit. The issue of finding clothes to fit their body was discussed by every patient. Another patient recalled how assumptions would be made about activities they would or would not take part in due to their size. Patients talked about how during periods when they have lost weight they were judged as being **"worth more"** [Patient2] and were **"put on a higher pedestal"** [Patient1].

One aspect of these experiences of particular relevance to this study is that most patients agreed that they do not like going to the GPs if they are in pain or discomfort as they feel like everything will be attributed to their weight,

> **"I have heard of a lot of people saying, that no matter what I went to the doctor about, it's always to do with your weight."** [Patient2]

Most of the patients were keen to stress they had no direct experience at this surgery of health concerns being dismissed as being due to their weight. They reported **"horror stories"** from friends. Again, there was this sense of just absorbing a general

message that due to their weight they were not entitled to the same care as other people who are not living with obesity.

Motivation

All the patients had an understanding that their relationship with food and weight was an issue. They had spent time reflecting on what their issues were and "were looking for something" to help.

"Overeating has got very little to do with actual hunger let's face it, or even just being greedy. A lot of times you're leaning on food for support but then whenever I overeat, I feel so guilty afterwards." [Patient1]

Some patients described how they **"knew something was missing"** in their understanding but they didn't know what that was but the program **"sounds like what I have been looking for"**[Patient2]. This patient described the relationship they had with food as an addiction.

"I feel like I am addicted to food and you can't go cold turkey off food. I would rather be addicted to literally anything else because I have to eat to survive." [Patient2]

This patient knew there was something more they needed to understand. Another patient described how when anyone brought up the topic of their weight they would cover their feelings by making jokes,

"To be honest I didn't know how to talk about it or ask for help or what do you do. When people mentioned it, I had a defence mechanism, I just laughed it off" [Patient4].

These jokes in no way reflected how they truly felt about their weight. The patients had tried many things and were ready for the missing part.

For all of the patients signing up to the program was a leap into the unknown as they had **"no idea what to expect"** [Patient1] and had **"never done anything like this before"** [Patient2] which speaks of their high motivation and the courage that it took to embark on something new and undefined.

"I thought you know what, I am going to be brave and just go" [Patient1]

The **"something new"** was something that would be designed by them and the process of coproduction strengthened that motivation with all patients describing the design process as positive, **"it just felt really good"** [Patient1]. The word **"excited"** was used many times by one patient during their interview and all patients spoke of the programme and the process used to develop it with enthusiasm.

> **"it felt good to be in a group that was growing as we were doing it. For me personally, I felt it was so important."** [Patient1]

One patient described how their feelings of power and control grew over time in the coproduction process. They revealed how at the beginning of the process they **"weren't speaking up yet"** [Patient2] but that changed over time to this patient embarking on a transformational healing journey.

A testament to the high motivation as a result of the coproduction process was the high level of commitment to the programme. It was extremely rare for any patient to miss a session with two sessions being the average amount missed by any one patient. This level of commitment survived a one-year break in the programme due to the Covid-19 pandemic with attendance levels being maintained before and after the break. Patients talked of how **"we are all still so connected after being apart for so long"** [Patient2]. The second phase of the programme was completed through a series of zoom meetings. Attendance remained at the same levels. The depth of commitment needed to perform this kind of work is reflected in an almost identical quote from three of the patients interviewed,

> **"It's hard work but it's really good work."** [Patient1, Patient2, Patient3]

Positive Experiences

Overwhelmingly the patients reported positive experiences as a result of their participation in the programme.

> **"I would just like to give a huge, huge, huge amount of thanks, to everybody that's been involved in this. Because this has actually been life changing for me. Crucially life changing. This program, and I don't want to sound dramatic or all over the top, probably saved my life."** [Patient1]

A selection of the words that were often used in relation to their experiences on the programme were "safe", "supported", "non-judgemental", " outstanding", "wonderful", "genuine", "real", "fantastic", "comfortable".

"it was something completely unexpected which was a million times better than I ever thought it could be." [Patient2]

One patient described that the programme attended to their **"physical, spiritual and emotional development"** [Patient3] while another described it as **"a voyage of discovery"** [Patient4].

The social workers played a central role in the programme from its conception and their role continues after its conclusion. All patients talked about how supported they felt by the social workers. They reported how they knew if they had any concerns they could **"lift the phone or send a message and someone would contact me"** [Patient1, Patient2]. The connections and relationships that were built because of this link with the social workers meant that the patients knew with great confidence that whatever issues they have currently or will have going forward, they can contact these social workers and they will be supported.

Patients reported how the social workers were instrumental in removing potential barriers as they arose - **"all barriers to taking part were removed"** [Patient1]. One of the main barriers mentioned by patients was the way in which people are invited to join programmes aimed at weight management. One patient described how a family member reacts to proposed interventions in terms of their weight, **"you don't need to point it out to me, I know, leave me alone."** [Patient2]. This speaks of the defensive barriers that people put up when they have been living with obesity and the care that needs to be taken in order to allow people to feel safe. This patient described the experiences their family member has had with attempts to manage their weight as "trauma with diets in the past." [Patient2] which tells us something of the reasons that these defences build up.

The initial letter from the social worker was mentioned by a number of patients as being something that removed this barrier for them, one said that **"if it had been worded even a little bit differently, I might have not come."** [Patient2] The letter was very open and honest about the issue of obesity and the purposes of the programme and that honesty reached past this barrier for these patients.

Other barriers were of a more practical nature such as being able to get to the locations of the different elements of the programme as they were not all in the GP surgery. As part of their role social workers were able to provide lifts when needed, **"that was all covered and it was just fantastic"** [Patient1]. Facilitators also played a crucial role in removal of barriers. As part of the facilitation for taiko drumming one patient who has mobility issues recounted how any issues were resolved with ease and they expressed their surprise at how easy it was for them to be accommodated and it was "no bother" for the facilitator to remove any and all mobility issues.

"…she (Fiona Umetsu) made everything so easy. I would've had bother standing throughout the drumming, but she showed me it was okay to do it sitting on the chair and I was able to sit up and stand down as I pleased according to my pain levels that week. That just blew my mind." [Patient1]

The facilitators of each element of the programme were mentioned by each patient for their skill and expertise, for the enjoyment they got from each element and for how each element contributed to their outcomes. The following section highlights each of the elements.

The introductory session was seen as important for a number of reasons including setting the ground rules about how the group would work safely together. Basic issues such as respecting agreed starting and ending times were mentioned as being of importance as well as issues around safety such as respect, confidentiality and boundaries. As part of this introductory work the practice MHP did a session with the group and as part of this asked them to rate how they felt on a scale from 1 to ten. One patient reported that,

"I had never in my life asked myself, "how do I feel right now?" and I actually thought, "I don't know". I was always worried about everybody else, all the time." [Patient2]

The taiko drumming was a revelation for most of the patients who had no idea what to expect and reported it to be **"mind-blowing"** [Patient1]. All patients reported that they enjoyed it, **"it was so fun…Fiona is amazing…it isn't just about drumming."** [Patient2] The patients were delighted to find that it combined fun with exercise. Two of the patients reported that they intend to continue with drumming as soon as lockdown eases and the drumming is allowed to continue.

"even if I had the worst week, you do the drumming and it's all out of your system, and you come out and you're buzzing… what a great idea for an exercise." [Patient1]

What the patients loved about the drumming was the way in which it approached exercise in a non-traditional way,

"that was a way getting everybody into doing a bit of physical activity, and they weren't running around a hall." [Patient3]

All patients reported a positive experience in working with the wellness seeker. This work provided discoveries and insights previously missing on how our relationship

with food is formed and maintained. The focus on the ways childhood influences this relationship, on how we build so many rituals around food, on how food serves us in our relationship not just with ourselves but with others to allow us to get our needs met was thought provoking and illuminating for the patients who already knew that **"there's a huge connection with emotional eating, there really is."** [Patient1] but may not have had the tools to explore and understand that relationship. One patient spoke of their surprise on discovering they were an emotional eater as they were certain they weren't. This patient valued this work because it goes into the **"why"** [patient4] people are overweight as opposed to the **"how"** to lose weight, which they already understand. Another patient described how when Shauna started to speak to the group they became really excited,

> **"I had never heard the term emotional eater until I came here and as soon as I heard it I went "that's me". I had never heard that before. They don't teach you about it in school, they don't tell you when you go to the doctor, then all of a sudden there it is, there is the answer."** [Patient2]

An important aspect of the work the wellness seeker did with the group was a follow-up online course. A number of the patients are completing or have completed the course which again speaks of the commitment of the patients in progressing their own development and knowledge.

All patients reported that they **"absolutely loved"** the work they did with the Belong group. One patient described this as the **"highlight of the programme."** [Patient3]. This is where the most profound personal discoveries were made. The process was described as **"gentle", "powerful" and "healing"**,

> **"it was an opportunity for me to talk to people, in a non-judgemental way … stuff that I haven't told anybody about my own fears and anxieties."** [Patient3]

The importance of having experienced and qualified facilitators to do this work was highlighted by a number of patients,

> **"parts of it can be dangerous … because there was a lot of emotion and a lot of tears and a lot of positive energy. But there was also a lot of negative energy that was being released through the emotions."** [Patient3]

This deep personal work has the potential to overwhelm people. The facilitators had just exactly the right combination of skills, experience and personal qualities to guide this process and keep everyone safe.

“There is an aura about them. They just bring calmness and stillness, and you really need that when you are doing stuff like that.” [Patient2]

The use of a range of holistic therapies to facilitate this process was something that the group responded well to, for example they **“loved the art therapy, outstanding**”. [Patient3]. They found that they looked forward to trying something new each week with the Belong group, **“I loved the excitement of “what are we going to be doing this week?””** [Patient1].

The design of the programme was discussed by the patients as being of primary importance. The unusual approach of embedding social workers and the researcher into the process was addressed in the interviews along with the conscious ethos that all facilitators would also be participants. This approach was welcomed by the patients as it **“put everyone on a level”** [Patient3].

“there’s a connection with everybody in the group and I’ve never felt that before and that includes all the facilitators because I feel like we are all part of the group together and there’s this camaraderie.” [Patient1]

“there was no, I’m up here teaching you…it wasn’t a case of people sat listening…everyone was sharing…it was fantastic.” [Patient3]

One patient talked about how when a **“professional”** member of the group made it clear they had gotten as much out of the group as patients had, it was **“beautiful to hear.”** [Patient3]. One patient had a lot of experience of many different types of programmes but felt this programme provided something new and different.

“…it’s the first program that I’ve ever taken part of that’s been like this and I’ve done hundreds of programs over the years probably. I take part in anything I can get my hands on, but this has been a life changing experience for me.” [Patient1]

The programme sequence was of prime importance. The introductory sessions framed the programme and covered the formation of the group contract. Patients discussed how the taiko drumming was an exercise that allowed them to come together in experiencing something no one had ever done before. It met the aims of both the social workers and Fiona Umetsu of Foyle Obon in promoting the group dynamic in the initial stages of the programme as it

"is an excellent team building vehicle. Sharing the vulnerability of trying new challenging activities gels groups together very quickly." [Fiona Umetsu, Foyle Obon]

Alongside this the deeper personal work started with The Wellness Seeker. Patients were introduced to tools which would allow them to start understanding the emotional component of their relationship with food. After the completion of taiko and the emotional eating/regulation work patients then embarked on the personal development element. Patients stressed how the placement of this work at the end of the programme was important. This is **"hard work"** and deeply personal.

All of the experiences in the programme which built up to the personal development work meant that the group had created a very strong, very safe group dynamic that they trusted by the time this element started. All of the patients referred specifically to the group dynamic and how important it was. That group dynamic was so strong that even after one year break in the programme due to Covid-19 it remained intact.

"it was as if two weeks had passed. It was that genuine, it was that wonderful, it was that comfortable." [Patient3]

Outcomes

This strong group dynamic was mentioned by all patients as being one of the defining features of the programme which created the conditions for very powerful individual outcomes. Most patients reported the programme as **"life-changing"**.

"The programme has changed my whole outlook on life. I see myself as a completely different person than last year." [Patient2]

All patients reported transformations in their understanding of themselves, their relationship with their body, food, weight, and even for some their family relationships. One patient summarised it as **"I have connected my mind to my body."** [Patient2]. Two patients reported weight loss. Some other outcomes were very individual to each patient.

Patients reported a change in their focus. Instead of discussion about weight and calories and what their bodies looked like on the outside, they were focused on their emotional well-being,

"we weren't sitting around talking about our weight all the time because that is exactly what would have put me off. I probably would not have come back if that is what we had of talked about on the first day." [Patient1]

> **"Until I was in this group I never realised that it was all physical (other weight loss programmes and tools), it's never inside, but the inside is actually the key to everything. Without that being right, you can't get anywhere."** [Patient2]

> **"what I found with this group is that it was helping me heal my head, helping ME heal in order to allow my body to heal and that's what I found vital. This group is the most important thing to me."** [Patient3]

Patients reported that their change in focus meant they were pursuing health goals because they wanted to take care of themselves and because they **"deserved this – to feel good**" [Patient 3]. They felt that the change in focus along with new understandings and tools provided through the programme, provided the missing element which would allow them to consolidate and use all the knowledge they already have about the mechanics of how to lose weight,

> **"My mindset is now, "I need to make me happy". And what makes me happy? If I eat 3 meals a day, I don't feel nauseous, and if I go a walk … It's what makes me feel happy ."** [Patient2].

> **"Because I am de-stressed about worrying about my weight, overall health wise that has to be good because I am not worked up about it all the time. That has to be good for your blood pressure and for your mental health."** [Patient1]

For one patient the outcomes of the group went beyond life-changing to **"life-saving"** [Patient1]. This patient came to understand that they had an issue with alcohol during the course of the programme which then became very evident to them during the Covid-19 pandemic. Because of the support network which resulted from the programme and in particular the relationship with the social workers, this patient was able to make the call they needed to get the support required and had achieved and was maintaining sobriety by the end of the programme. Furthermore, in the initial days of dealing with withdrawal symptoms, the patient used the mindfulness and breathing techniques taught by the Belong group and referred to these as **"skills for life"** [Patient1]. Because this programme is embedded within a GP surgery with social workers as part of the MDT pilot, that relationship will protect that recovery.

> **"It's a huge thing for my whole family for me to get sober... because it affects everybody … everybody was so worried about my health…if the program hadn't run I genuinely don't think I would've gone and got help…I wouldn't have known the first place to turn."** [Patient1]

Another patient reported a substantial weight loss during the period in which the programme initially ran. This patient felt during that time that,

"I was absolutely just flying. I had targets, I had goals and they were just winging themselves towards me." [Patient3]

This patient harnessed that energy into a three stone weight loss. This patient was also the most negatively affected by the impact of Covid-19. Their mental health and work life was greatly affected and the removal of the programme alongside all other forms of support meant that they were unable to sustain that weight loss with all the plans they had made being **"destroyed"** [Patient3].

"I had put in so much emotional and physical energy into getting myself into shape and that was part of the programme…it was all tied together…I did all the proper things…everything was just going in the right direction. And then Bang." [Patient3]

This patient walked a lot and no longer had access to that, although well liked walking spots were still open they were **"like Brighton Beach"** [Patient3]. No travel to Donegal was allowed. The patient was a member of a local council health centre which provided them with a central part of their physical and emotional self-care routine. This also closed. Their working life changed greatly. They described how **"everything that I used was pulled"** [Patient3]. The knowledge that there was nothing to be done about any of this combined with being at home all the time, being anxious and fearful, worrying about the impact on their family, and eating and drinking more, meant that all their hard work was undone. The patient was devastated when their weight **"began to creep back on"** [Patient3]. The distress the patient felt when discussing the impact of Covid and the fear that normal life was over, was palpable. However, with the ease in lockdown restrictions, the making of some important life altering decisions and the renewed contact with the group, the patient expressed the return of hope. Along with that, their weight loss process has started again. The patient feels that with the transformations they have made through the programme, they will achieve their health goals.

One patient who had lost their dad when they were young and had few memories of their childhood reported in the group interview that memories had started to come back of their childhood. They reported a transformation in their relationship with their mum and their siblings and that they **"are growing as a family for the first time ever."** [Patient2] That growth and change has been motivated by an understanding

of how they all had their own different experiences of trauma after their loss. They are now talking about their experiences with each other and working on their relationships,

> **"What I am realising now is that my weight literally doesn't matter. I need to deal with all of these core issues before I even start worrying about it. I know for a fact when I deal with that my weight is not going to be an issue."** [Patient2]

The patient realised that their coping mechanisms of pretending something just had not happened and ignoring it had been learnt in the family environment. This led to an inability to even know how they felt, never mind being able to articulate it. This patient had a series of very powerful insights about themselves such as understanding their need to control everything as a protection against abandonment,

> **"I like to be in control of everything all the time. I guess that's just been me micromanaging and feeling like if I sort everything out no one has to do anything, then they'll be happy. And they'll probably not leave me."** [Patient2]

They considered that their **"mind had been completely changed"** [Patient2] by the programme and the work they did within the group,

> **"And although it's hard that I'm in this now, I know…I'm on my way out of it. For the first time there is hope."** [Patient2]

A very important aspect of that group dynamic was that it allowed for all personality types which was mentioned by one patient,

> **"we had one extremely shy member…they still came every week and even though they didn't speak much, when they did they were listened to and I think that their input was phenomenal."** [Patient3]

This patient was introverted, and all patients respected this and allowed that patient to participate in the way that felt most comfortable for them. They valued greatly the input from that patient and showed respect for each other's differences. This patient attended most sessions but felt more comfortable before Covid-19 when all meetings were face to face. Although they imagined that a situation like lockdown would suit them well, they actually realised how much they wanted the world to open up and how much more comfortable they were with in person connection. They reported that the zoom interface was not good for them and they really struggled to connect in this way. This patient absolutely loved the taiko drumming and mentioned a few

times situations in which they **"were able to open up without realising"** [Patient4]. For them, **"to even ask for help was an alien thing"** [Patient4] which points to the importance of the makeup of the programme and the skill of all of the facilitators. This patient reported that they liked the support they found in the group. For them, the main outcome of the programme was the establishment of relationships in which they were able to find support and use their voice,

"It was able to make me talk a bit more. I don't really talk; it could take a long time." [Patient4]

Concerns

There were a number of concerns raised by patients during the course of the programme. Two patients referred to a dominant group member. The patients were very conflicted as they felt great compassion for their group member, but it made them feel less able to find the space to communicate what they were feeling, they felt the dominance was blocking what other people needed. A related concern was an issue that occurred outside of the boundaries of the programme between two group members. One patient who started the programme naturally transitioned out of the group and continued to be supported on a one-to-one basis by the social workers and other members of the surgery. The patients reported that because of the nature of the programme they felt able to speak up about these issues and they felt they had been dealt with appropriately and sensitively. Monitoring and management of the group was made much more effective by the embedding of the social workers into the group. All concerns raised by patients have been fed into recommendations for the programme. The safety talk will be expanded to ensure the issues of healthy boundaries are covered. One patient referred to the importance of the group contract which was agreed at the start of the programme and provided a structure in which to engage with and manage issues that can arise in group work.

Another issue of great concern was the enormous impact of Covid-19. No one had control of this, and it could not be changed. Patients described the sense of powerlessness that came with that,

"People felt they weren't in control, they were helpless. For me, I was powerless. I went to bits." [Patient3]

Patients expressed a number of fears which included the fear of passing Covid to anyone else,

"do you see the thought that I could have killed somebody by passing on Covid, that would have devastated me." [Patient3]

The impact on the programme was great. A number of steps were taken to help maintain connection within the group during this time and all patients took part in some or all of these events. The support and thoughtfulness of the social workers was again mentioned during this time,

> **"There was one day I came home, and Roisin and Caroline (the social workers) had come and left me a gift, it was a wee note pad and wee bits and pieces, and it was so nice"** [Patient1]

Patients describe the removal of the group and all other forms of support as well as the removal of strategies normally used to enhance well-being as being negative. The scale of this varied. For one patient in particular the impact of Covid was devastating. They described how over the course of the initial running of the programme, their physical, mental and emotional health was fantastic, and they lost three stone during that time.

> **"and then the restrictions that Covid brought…everything just came crashing down"** [Patient3]

The decision was made to complete the Belong element of the programme through zoom after a one-year break. This was agreed as always through the coproduction process and with the agreement of the patients. Most patients commented on the fact that the strong group dynamic survived intact even through the period of the pandemic.

> **"Do you know what I find so amazing about the whole thing? … a year later when we did the work over Zoom, it didn't really change how I felt. Like, wow."** [Patient3]

One patient, the more introverted member of the group, did struggle with connecting through the Zoom interface and commented that being in the same physical space as others was vital for them to allow the connection needed to do this most intimate of work. This patient also suggested longer timescales for the personal development sessions as it would allow them some social time and time to **"settle down to feel comfortable opening up"** [Patient4] before the **"work"** of the session began. This has also been built into recommendations for future development of the programme.

The Future

What happens next was an important topic to explore with the patients. There were two factors which emerged from discussions of the future. Firstly, and primarily the need for ongoing support for this group. The nature of the work meant that this

programme was viewed as a starting point for transformation of both mind and body. All patients felt that they needed to continue their personal development. The emotional element of this programme creates a duty to ensure that the patients are supported as they continue this journey. This has already begun with the social workers continuing to support the patients. One to one support may be one way to do this, and all patients were made aware at the final group interview of the counselling facility which is associated with the GP surgery with the social workers facilitating referrals.

As well as support in the form of one-to-one counselling an information session was scheduled to be held to provide the group with information on social prescribing and all of the programmes they have access to through that route. Patients expressed interest in membership for local sport and recreation centres, for exercise classes and for holistic therapies. All of these will facilitate the continued health journey that the group is on.

Accompanying the personal development was a wish to continue connection within the group. The group is seen as a centre piece for maintaining motivation to pursue health goals. One of the patients has taken part in walk leader training through the WHSCT and with the social workers will set up a walking group as soon as restrictions allow. This will be available to all patients and staff of the surgery and will combine physical activity with the social element of the group. This is one way to allow the group to continue to access the powerful dynamic they have created and that they have used to inspire change.

As well as this, the second element is to harness the success this programme has had and to further develop it. The programme is suitable for future work with this particular population but is also suitable to be customised for use with other groups within the patient population. It would be highly recommended that any customisation is done using the same coproduction principles that were applied to this programme and contributed to its success. Another possibility suggested through facilitator feedback and supported by the social workers is that the patients who took part in this pilot would be well placed to act as peer facilitators in further development and delivery of future courses. A number of patients have volunteered to become involved in the development of the Belong element of the programme which is seeking funding and would like to have the patients as part of their continued coproduction strategy in the role of co-designers and peer tutors.

Ideas to improve the programme going forward were given by all of the patients. These were unanimously to increase the duration and number of sessions for each element. One of the reasons for this was given by the more introverted patient who felt that when it came in particular to the personal development work, some social time to ease into the sessions would benefit them in relaxing and being ready to share as this is something they had never done before.

One patient would have liked more time to explore the work of the Wellness Seeker which was targeted at understanding the way our relationship with food starts and develops and how to use emotional regulation to change that. One patient suggested as an improvement when running the group again an element of one-to-one support should be built in as **"asking for it is really difficult for some people."** [Patient2]

Other suggestions were to add a group goal which would be related to the aim of the programme in terms of physical health, this might be regular walks culminating in a walk to a local beauty spot which would combine a social element such as having a tea or coffee and a chat.

> **"it's something achievable, it's a target… this is a culmination… this is about physical and emotional health so maybe at the start let's build in something**."[Patient3]

More practical considerations were also offered as improvements. For example, although the group worked very well in the space that was able to be used in the pilot for the personal development section which was mainly the waiting area in the surgery, a more comfortable relaxed setting was recommended by some patients and by the facilitators.

Quantitative Evaluation Results: Warwick Edinburgh Mental Well-being Scale

It is worth noting that in spite of the impact of the pandemic, most patients showed an increased score in terms of their well-being. With a small sample size and with the impact of Covid-19 as a major confounding factor no meaningful statistical conclusions can be drawn however the findings using the WEMWBS are detailed below.

Scores on Warwick-Edinburgh Mental Well-Being Scale

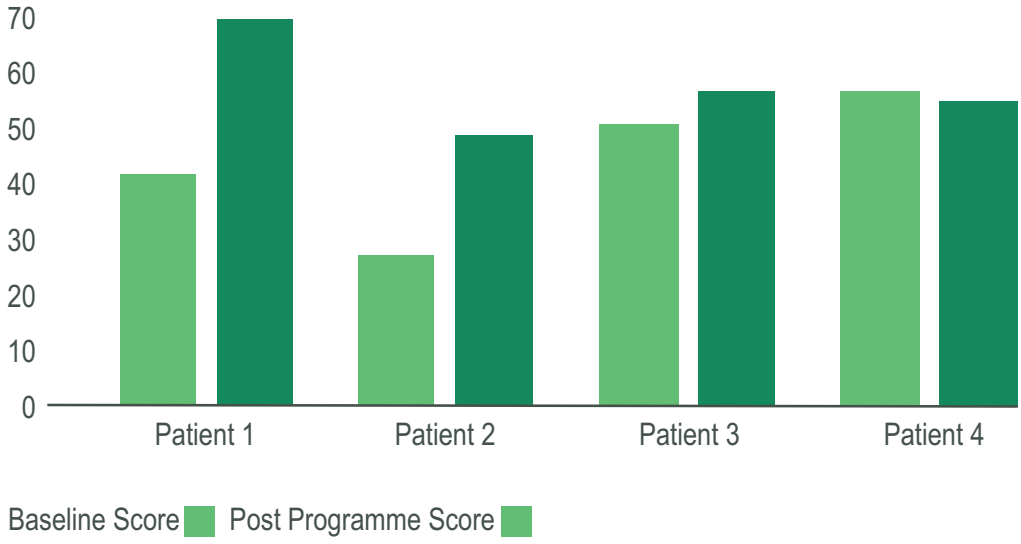

Figure 2. Scores on WEMWBS by Patient ID

There are 14 items on the scale which is contained in Appendix 1 and includes questions such as: I've been feeling optimistic about the future; I've been feeling useful; I've been feeling relaxed; and I've been feeling interested in other people. Scores were on a Likert scale from 1 to 5 with 1 being an answer of **'none of the time'**, 2 being an answer of **'rarely'**, 3 being an answer of **'some of the time'**, 4 being an answer of **'often'** and 5 being an answer of **'all of the time'**. The minimum score is 14 and the maximum score is 70. A higher score shows increased well-being. Figure 2 shows the WEMWBS scores at baseline and after completion of the programme.

The mean score before the programme began was 44 with a standard deviation of ±13.05. The mean score after the programme was 58 with a standard deviation of ± 8.85. Scores for patients 1, 2 and 3 all increased. Patient 1 went from 42 to 70 an increase of 28. Patient 2 went from 27 to 49, an increase of 22. Patient 3 went from 51 to 57, an increase of 6. Patient 4's score fell by two points from 57 to 55. The patients with the lowest scores at baseline increased the most. Patient 2 went from having all answers on a range from **'none of the time'** to **'some of the time'** to having all answers ranging from **'some of the time'** to **'all of the time'**. In a wider rollout of the programme, it would be beneficial to increase the database of results to facilitate meaningful statistical analysis.

Discussion

This programme was innovative and sometimes unorthodox in its approach. It was built on a foundation of a need observed within a clinical setting. Research was completed by the social workers into that need and how it should be approached. The principles of coproduction were applied, and the availability of the many disciplines now present in that clinical setting as a result of the MDT pilot were harnessed.

Coproduction was a core element in the design of this programme. The patients and social workers formed a panel and decided what the programme would contain. This led to high levels of engagement and motivation and this was evidenced in both feedback from the patients and in their strong attendance for all elements of the programme. The findings show that this programme filled a need that is not always recognised in weight management programmes. A need that as pointed out by the patients, cannot be attended to in these more traditional programmes as it requires the support and expertise of those qualified to do so. One patient described the programme as attending to **"physical, emotional and spiritual development"**. Another patient described how this programme focused on **"the inside"** when most weight loss programmes are **"all about the outside"** and further asserts **"I'm fat because of my mindset, I'm fat because of the trauma I've been through"**. This shift in focus represented what the patients felt was **"missing"** in previous attempts t o manage their weight loss.

The literature suggests that weight gain at this level is due to a complex set of factors from the biological, the psychological and the social (Perriard-Abdoh et al., 2019). Findings from this evaluation support that. Patients describe a range of experiences beginning in childhood for some that include loss of a parent, loss of a sibling, mental health issues including addiction and eating disorders, physical health issues, family physical and mental ill health, addiction issues and family struggles with weight. Giving patients the tools to explore and identify the emotional and spiritual aspects in their relationship with food has helped them find that missing part and begin a process allowing for sustained change. It is strongly suggested by these findings that this aspect be incorporated into future programmes for this population.

This programme has shown that by asking people what it is they need and developing a programme with them, engagement and commitment will be high. The ease with which suggestions for improvements were offered and the number of suggestions made reflected the ownership the patient group had of this programme. Their comfort in voicing improvements to be made, from the most introverted to the most extroverted members, testifies to the positive group dynamic which was created on this programme. This buy in and expectation that their voices mattered and would be listened to was created by building the programme on the principle of coproduction. This voice will be important in developing the programme further and in promoting the group to other patients within this population who may have felt it was **"just something they are sending to all the fat people"**.

The experiences of patients on the programme help give us an understanding of the barriers that exist for people with a high BMI in joining weight management programmes. These might be surprising and live very much outside that publicly accepted negative stereotype that can be built up of people living with obesity as being lazy or not wanting to change (Perriard-Abdoh et al., 2019). The reasons given by patients for not wanting to be weighed were that they already know their weight is high and seeing the number on a scale can actually lead to a period of disordered eating for them reflecting issues reported in the literature that can accompany attempts at dietary restraint (de Witt Huberts et al., 2013). Other patients expressed that they are afraid of holding others back if they join exercise groups. In this programme the use of taiko drumming allowed this group to enter into a very physical form of exercise that is infused with the taiko culture of respect and togetherness,

"We play together, we respect each other, we have fun together, we create safe spaces together, we trust each other, we listen to each other and we share the Taiko love and joy."
[Fiona Umetsu, Foyle Obon]

Other patients would like to see more of, for example, walking as an element in the group. This voice has been listened to and will be included in recommendations for development of the programme. This respect for the patient voice is also seen in the outcomes in the plans for a formation of a walking group when restrictions lift. This programme coordinated by the social workers and led by a patient from this programme who has completed a walking leader course over the duration of the programme. This programme will be available for any patient or professional from the surgery and highlights the way in which this programme has developed relationships between the GP surgery, the patients and the wider community.

Removal of these barriers has important implications for this population outside of the scope of weight management programmes. The barriers that people perceive about joining weight loss programmes reflect powerful barriers that may be stopping them accessing other kinds of care including primary care (Bertakis & Azari, 2005). It is concerning to note that in our sample of four patients, there is a trepidation about going to the GP with health issues as they feel everything will be attributed to their weight. People who are living with obesity are at higher risk of health issues and it is very important that they feel they can engage with general practice. Given that only a small proportion of those contacted joined the programme, the knowledge that this population may not be approaching the surgery with their health care issues should be considered with further initiatives provided to help change this negative and harmful message. This population can only benefit from feeling that they are safe in accessing support through their GP surgery. It allows them to access the GPs within the surgery but now all the other disciplines who are working together in GP surgeries to create a multidisciplinary setting in primary care.

There were a wide range of outcomes in this small but diverse patient group. Some of these were outcomes that were shared, such as the establishment of relationships and a firm support network or understanding of all the factors that make up the relationship patients have with food. Others were very personal, the establishment and maintenance of sobriety, the transformation in family relationships, the ability to ask for and engage in help. All of the patients reported that the most important outcomes were the shifts in their understanding, mindsets and relationships with themselves. There are some outcomes that cannot be recorded in any interview or logged in any database. These are the outcomes that have to be seen. These outcomes are in the way that a person carries themselves, in the difference in a person's face or in the way their eyes shine. These are all outcomes noted by this researcher in this patient group.

This programme would not have existed without the MDT pilot that placed social workers and other disciplines into GP surgeries. The main driving force for this programme were the social workers while the mental health practitioner also had a core role. The off-site availability of counselling services will also be pivotal in the ongoing personal development for the patients involved. In their feedback patients spoke of stronger and more confident ties to the GP surgery. The role of the social workers expanded beyond the surgery itself, connections have also been strengthened with departments in the WHSCT such as health improvements and the PPI office. In addition, relationships have been developed in the community through groups who were consulted in the design process, groups who auditioned to be part of the programme and the three groups who delivered the programme to such a high standard. This development of connections and relationships can only provide increased opportunities for patients who use the GP surgery to access the wide range of programmes which exist in the community. This will be of even more importance as the community emerges from the lockdowns made necessary as a result of the Covid-19 pandemic.

It is important to outline potential limitations of the study. The small sample limits the extent to which the data is representative of the group of people with a BMI of over 40. It does however follow the guidelines for the use of IPA which purposely selects small samples in order to enhance the depth of data and concentrates on quality over quantity. IPA adds the dimension of focusing on individual experiences which is not a feature of all methodologies and was considered of importance in this study. All data is self-report which lends itself to possible impact of bias to socially desirable narratives. This was mitigated by the reassurance of anonymity and confidentiality during the process of obtaining informed consent and through the use of identifiers. The use of semi-structured interviews is also a potential limitation as it can be supposed that themes are derived as a result of this. It is however necessary to remain focused on addressing the research questions. Semi-structured interviews are a common tool in the application of qualitative methodologies. Finally, it should be noted that only one researcher analysed this data which restricts interpretation and increases the

possibility that some themes may not have been detected. These potential limitations do not in any way invalidate the findings, but it is important to acknowledge them. In conclusion, the Healthy Connections project showcases the value of both the MDT pilot and the principles of PPI. The social workers in the surgery saw a need and applied the principles of evidence-based research, using NICE guidelines and the PPI framework to create alongside patients a programme which patients felt would meet their needs. It provided an alternative to more traditional weight management programmes. For this target group of people with a BMI greater than 40 it provided what they felt was a missing element, the why in their relationship with food and weight as opposed to the how to manage weight which they already had expertise in. The powerful outcomes are a testament to the process used, to the skill and expertise of all facilitators who engaged in the process and to the courage and determination of the patients.

Recommendations

1. **Follow up support and/or activities are recommended for this group. Patients reported that they are exploring areas of their own development that they have never before considered. This is work through which they will need supported. This support may be in the form of less formal meetings which all participants including facilitators, social workers and the researcher may attend. Within the GP practice structure there is availability of a certified counsellor who works from their own practice and can be seen by patients. All patients who have completed this programme have been offered this service. It is recommended that this offer is followed up and all possible interventions and support are offered.**

2. **It is recommended given the positive impacts this programme has had that it is run again. The range and nature of the impacts are powerful. The programme has offered something outside of the traditional programmes offered for weight management and has transformed the lives of the patients who took part. It is recommended that the programme is further developed incorporating changes suggested by the patients from this pilot. These include ideas such as:**

    - **Expansion of the group safety talk to include safety around boundaries. In a group doing work of this nature, it is inevitable that strong bonds may be formed between group members. In order to ensure everyone remains comfortable in the group it is wise to be careful with interactions outside of the group that could in any way threaten that. Some discussion around this would enhance the safety talk.**

- A comfortable space for the group to work in during the personal development session which allows for relaxing and facilitates the different kinds of work the programme entails.

- For the personal development sessions, a period for socialising and settling into the group before sessions begin to allow everyone to feel they are ready to do this work which includes sharing.

- A goal for the group to work towards which is related to the overall aims of the group. This goal should be decided by group consensus and may include for example, a walk to a well-known beauty spot which everyone agrees is within their capabilities.

- The inclusion of one-to-one support to work alongside the group element to provide additional support to patients to allow processing of the many issues that arise when this type of work is done.

3. It is recommended that further development of the programme should consider incorporating those patients who participated in the pilot group as peer facilitators. This would continue the principle of coproduction which was strongly emphasised in the pilot and which is a vital part of all services being developed under the Department of Health's "Health and Well-being 2026 – Delivering Together Strategy" (Dept of Health, 2021). It would also enhance the chances of allowing those who need this programme to feel it is a safe place for them to work on the changes they want to make.

4. It is recommended that training from The Wellness Seeker is rolled out to MDT staff which would facilitate this skill being available for use in future programmes where it is appropriate.

5. It is recommended that the professionals working within the MDT in the GP surgery would be integrated into the structure of any further programmes. This would facilitate patient understanding of the many disciplines now available within surgeries and promote the ethos of the MDT pilot. It was felt that input from the pharmacist, the physiotherapist and the advanced nurse practitioner for this group would have been invaluable. The efficacy of this approach was seen in this programme with the integration of the MHP.

References

Alase, A. (2017). The interpretative phenomenological analysis (IPA): A guide to a good qualitative research approach. *International Journal of Education and Literacy Studies, 5,* 9–19.

Bertakis, K. D., & Azari, R. (2005). The impact of obesity on primary care visits. *Obesity Research, 13,* 1615–1623.

Brocki, J. M., & Wearden, A. J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology and Health, 21,* 87–108.

Craigie, A. M., Lake, A. A., Kelly, S. A., Adamson, A. J., & Mathers, J. C. (2011). Tracking of obesity-related behaviours from childhood to adulthood: a systematic review. *Maturitas, 70,* 266–284.

Cummins, S. C. J., McKay, L., & MacIntyre, S. (2005). McDonald's restaurants and neighborhood deprivation in Scotland and England. *American Journal of Preventive Medicine, 29,* 308–310.

de Witt Huberts, J. C., Evers, C., & de Ridder, D. T. D. (2013). Double trouble: restrained eaters do not eat less and feel worse. *Psychology & Health, 28,* 686–700.

Elks, C. E., Den Hoed, M., Zhao, J. H., Sharp, S. J., Wareham, N. J., Loos, R. J. F., & Ong, K. K. (2012). Variability in the heritability of body mass index: a systematic review and meta-regression. *Frontiers in Endocrinology, 3,* 29.

Excellence, N. I. for H. and C. (2016). *Obesity in adults: prevention and lifestyle weight management programmes.* NICE London.

Gatineau, M., & Dent, M. (2011). *Obesity and mental health.* Oxford: National obesity observatory.

Hughes, K., Bellis, M. A., Hardcastle, K. A., Sethi, D., Butchart, A., Mikton, C., Jones, L., & Dunne, M. P. (2017). The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. *The Lancet Public Health, 2,* e356–e366.

Jackson, S. E., Beeken, R. J., & Wardle, J. (2015). Obesity, perceived weight discrimination, and psychological well-being in older adults in England. *Obesity, 23,* 1105–1111.

Langdon, S. A., Eagle, A., & Warner, J. (2007). Making sense of dementia in the social world: A qualitative study. *Social Science & Medicine, 64,* 989–1000.

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology, 3,* 102–120.

Macdonald, L., Cummins, S., & Macintyre, S. (2007). Neighbourhood fast food environment and area deprivation-substitution or concentration? *Appetite, 49,* 251–254.

nidirect (2021) Obesity (online). Available from Obesity|nidirect Last accessed 29/3/2021

NI Department of Health (online). Health and Well-being 2026 Delivering Together. Available from health-and-well-being-2026-delivering-together (health-ni.gov.uk) last accessed 30/3/2021.

Perriard-Abdoh, S., Chadwick, P., Chater, A. M., Chisolm, A., Doyle, J., Gillison, F. B., Greaves, C., Liardet, J., Llewellyn, C., & McKenna, I. (2019). *Psychological perspectives on obesity: addressing policy, practice and research priorities.*

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological Journal, 20,* 7–14.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research.* London: SAGE Publications.

Smith, J. A., Jarman, M., & Osborn, M. (1999). Doing interpretative phenomenological analysis. *Qualitative Health Psychology: Theories and Methods,* 218–240.

Wardle, J., Chida, Y., Gibson, E. L., Whitaker, K. L., & Steptoe, A. (2011). Stress and adiposity: a meta-analysis of longitudinal studies. *Obesity, 19,* 771–778.

WHSCT (2021) Integrated Involvement Plan (online). Available from WHSCT Integrated Involvement Plan|Western Health & Social Care Trust (hscni.net) last accessed 06/05/2021.

Wilkinson, R., & Pickett, K. (2010). The spirit level. Why Equality Is Better for Everyone.

Appendix 1: Initial letter

Dear [patient name]

My name is Roisin and I am the social worker in Clarendon Medical; I work alongside Caroline who is the social work assistant. Our roles are part of the change happening in G.P whereby other professionals are now available alongside the Doctors to support patients with all aspects of their health including: physical, emotional, mental and social.

The main area of our role is to promote the social well-being of Clarendon Medical's patients, in how they feel about themselves, how well they function and the overall quality of their lives. Myself and Caroline are here to work with individuals, families and communities to improve their social well-being. One of the ways we have being doing this is by developing groups from our patients who have similar needs and designing and/or facilitating programmes to support these needs.

So as with other programmes it starts with the patients, working together with us individually, discussing any issues that they are facing, exploring what is important, agreeing help and providing support. We both have met with patients who face difficulties with the above mentioned aspects of their life and this is relating to their weight, the medical term used to describe this condition is obesity. I myself am not familiar with use of this term and not sure how you feel about this term or the sense of stigma you may feel. Myself and Caroline's intention is not to offend anyone but rather to help.

As I said after meeting with patients who have difficulties in this area, we started thinking, can we help, how we can help. We hope to design and deliver a programme tailor made to patients whose BMI is 40+. We have begun to talk to relevant others who we believe can help us source what we need for this programme. We are definite that this programme will include an emotional well-being element that will assess if there are emotional triggers that you may need support to understand. We also intend if there is an emotional element around eating, relevant support will be offered. Furthermore we are partnering with community specialists in areas of health, nutrition, exercise and personal development who are motivated to design a programme with us just for you. This planned programme aims to be cohesive in that it provides for all the needs around weight and health.

How could you help us help you: if you have attended or received any support/ programmes to help you promote your Health can you share that with us? We really

want your input into the setting up of this programme and would value your knowledge and experience of anything that you think works and as such anything you have not found helpful; who better to advise than you because it's for you.

Initially this will be a pilot programme and therefore not immediately available to everyone, but if it shows to be a helpful, positive experience we hope to roll it out to all that need it. So with this in mind there is limited spaces to start with so can you advise if this is something you would like to be a part of. You can do this by contacting me or Caroline at the surgery; if we are not available you can leave a message that you are interested and we will get back to you.

Yours sincerely,
Roisin Cartmill, GP Social Worker
CLARENDON MEDICAL

Appendix 2: Pre-questionnaire, Consent Form

Consent to Take Part in Research

- I …….. Voluntarily agree to participate in this research study.
- I understand that even if I agree to participate now, I can withdraw at any time or refuse to answer a question without any consequences of any kind.
- I understand that I can withdraw permission to use data gained from my participation at any time.
- I have had the purpose and nature of the study explained to me and I have had the opportunity to ask questions about the study.
- I understand that I will not benefit directly from participating in this research.
- I understand that all information I provide for this study will be treated confidentiality.
- I understand that under freedom of information legislation I am entitled to access the information I have provided at any time while it is in storage as specified above.
- I understand that I am free to contact any of the people involved in the research to seek further clarification and information.

Signature of participant: _____

I believe the participant is giving informed consent to participate in this study.

Signature of researcher: _____

Date: _____

Consent Form

Name: _____

1. What was the thing or things that made you think 'yes I will do this programme'?

2. What are you hoping to get from this programme?

3. Do you feel you were consulted enough about what we included in the programme?

4. If not, what more could we have done to make sure this happened?

The Warwick-Edinburgh Mental Well-being Scale (WEMWBS)

Below are some statements about feelings and thoughts. Please tick the box that best describes your experience of each over the last 2 weeks.

Statements	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been feeling interested in other people	1	2	3	4	5
I've had energy to spare	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling good about myself	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been feeling confident	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5
I've been feeling loved	1	2	3	4	5
I've been interested in new things	1	2	3	4	5
I've been feeling cheerful	1	2	3	4	5

Appendix 3: One to one Interview Questions, Information Sheet, Consent Form

As you know, my name is Grainne McAnee and I am the researcher working on the well-being programme that you have been taking part in. I am conducting interviews with everyone today and thank you very much for giving your time to take part. I have an information sheet for you to read and a consent form for you to sign if you are OK to proceed.

The interview should take about 40 minutes and follow up interviews can be scheduled if needed. Everyone is being asked the same questions.

Are you happy and comfortable to begin?

1. **What attracted you to participate in this programme in particular?**

2. **Where you involved in the design of the programme and if so, what was that experience like? Can you tell me about it?**

3. **What was your experience of the programme? Can you tell me what it was like for you?**

4. **Did you have any concerns during the programme?**

5. **What were the main strengths of the programme, the best things about it?**

6. **What, if anything, would you like to see done differently?**

7. **Has the programme changed anything for you, and if so, what has it changed?**

8. **We had the Covid-19 pandemic which obviously completely disrupted the programme as we neared the end, how do you feel that was dealt with?**

Chief Investigator: Dr Grainne McAnee

Participant Information Form

Title of Study: Patient experiences of a pilot well-being intervention coproduced with social workers as part of the MultiDisciplinary Team pilot run through the Western Trust in Northern Ireland.

What is the aim of the Study?

Social workers and patients in a GP surgery in Derry coproduced a well-being programme which was offered to patients with a BMI >40. This study aims to explore the experiences of patients within that programme.

Who may Take Part?

Adult patients who have attended the well-being programme.

How the Study Will be Conducted

- **Recorded interview**

In order to understand your experience of the well-being programme and its impact on your health and well-being, I would like to record an interview with your agreement. The interview will be approximately 40 minutes.

I am aware that although you may agree to take part in the study, it may cause emotional upset. During the interview if you need to stop for any reason that will be respected. The recording will be stopped and will only resume with your permission, if and when you are ready. If you need follow up support, this will be available through Roisin, the GP social worker at the practice.

- **Confidentiality**

In this research, your identity will be protected at all times. Confidentiality will be maintained unless I hear something that concerns me. If there is disclosure during the interview and it becomes evident that someone is at risk I will inform the GP social worker who will follow the appropriate procedures within the surgery. All the information collected will be held securely and in confidence.

- **Right to withdraw**

At any time you may withdraw from the study. During the interview you can ask for the recording to be switched off and the contents erased. If this is your choice, no explanation will be necessary. Similarly, after the interview has taken place, if you then decide to withdraw and prefer not to have your material included, this will be respected.

- **Consent Form**

In advance of the interview, you will be asked to sign a Consent Form as an agreement that you accept and understand your involvement in the study.

- **Reporting the Findings From the Study**

When the interviews and the analysis are completed, all participants will be sent a draft report of the findings. You will be invited to read the report and offer feedback. It is important that the findings are well explained, that you 'recognise yourself' in the write up and highlight any important aspects of the Programme that are not included in the study so far.

When the study is completed and the final report is ready a copy will be given to each participant. An electronic copy can be emailed if that is preferred. If, at any time, you require any information regarding the study, I can be contacted at the email address or telephone number below.

- **The Benefits of the Study**

The knowledge gained through this research will help to increase understanding of the Programme and its potential impact on your health and well-being. In turn, this evaluation will help to enlighten all those concerned with the Programme, the medical practitioners and practitioner therapists.

Thank you for taking the time to consider this invitation.

Dr Grainne McAnee
Email: g.mcanee@ulster.ac.uk
Tel: 07907677568

Appendix 4: Group Interview Questions, Topics

- How do you want results to be presented – use of pseudonyms or no identifier at all.
- Previous programmes that you have used to help manage your weight.
- Experiences because of your weight.
- Experiences attending GP surgery.
- What the coproduction experience was like.
- How the group dynamic was created.
- What is a good name for the programme?
- What you need next.

Appendix 5: Group Interview Information Sheet, Consent Form

Chief Investigator: Dr Grainne McAnee

Participant Information Form

Title of Study: Patient experiences of a pilot well-being intervention coproduced with social workers as part of the MultiDisciplinary Team pilot run through the Western Trust in Northern Ireland.

What is the aim of the Study?
Social workers and patients in a GP surgery in Derry coproduced a well-being programme which was offered to patients with a BMI >40. This study aims to explore the experiences of patients within that programme.

Who may Take Part?
Adult patients who have attended the well-being programme.

How the study will be conducted

- **Recorded Interview**
  In order to understand your experience of the well-being programme and its impact on your health and well-being, myself and Roisin, the GP social worker would like to record a group interview with your agreement. The interview will be approximately one hour.

  We are aware that although you may agree to take part in the study, it may cause emotional upset. During the interview if you need to stop for any reason that will be respected. The recording will be stopped and will only resume with your permission, if and when you are ready. If you need follow up support, this will be available through Roisin.

- **Confidentiality**
  In this research, your identity will be protected at all times.

  Confidentiality will be maintained unless we hear something that concerns me. If there is disclosure during the interview and it becomes evident that someone is at Roisin will follow the appropriate procedures within the surgery. All the information collected will be held securely and in confidence.

- **Right to Withdraw**
  At any time you may withdraw from the study. During the interview you can ask for the recording to be switched off and the contents erased. If this is your choice, no explanation will be necessary. Similarly, after the interview has taken place, if you then decide to withdraw and prefer not to have your material included, this will be respected.

- **Consent Form**
  In advance of the interview, you will be asked to sign a Consent Form as an agreement that you accept and understand your involvement in the study.

- **Reporting the Findings From the Study**
  When the interviews and the analysis are completed, all participants will be sent a draft report of the findings. You will be invited to read the report and offer feedback. It is important that the findings are well explained, that you 'recognise yourself' in the write up and highlight any important aspects of the Programme that are not included in the study so far.

  When the study is complete and the final report is ready a copy will be given to each participant. An electronic copy can be emailed if that is preferred. If, at any time, you require any information regarding the study, I can be contacted at the email address or telephone number below.

- **The Benefits of the Study**
  The knowledge gained through this research will help to increase understanding of the Programme and its potential impact on your health and well-being. In turn, this evaluation will help to enlighten all those concerned with the Programme, the medical practitioners and practitioner therapists.

Thank you for taking the time to consider this invitation.

Dr Grainne McAnee
Email: g.mcanee@ulster.ac.uk
Tel: 07907677568

Participant Consent Form

Title of Study: Patient experiences of a pilot well-being intervention coproduced with social workers as part of the MultiDisciplinary Team pilot run through the Western Trust in Northern Ireland.

- I confirm that I have read and understand the information sheet for the above study, I understand the content and have had the opportunity to ask questions.
- I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason or explanation.
- I agree to the interview to be audio recorded.
- I am aware that confidentiality will be ensured at all times unless a cause for concern arises.
- I agree to take part in the above study

Signature of participant: _____

Signature of researcher: _____

Date:_____

Appendix 6: Facilitator Feedback Questionnaire

The social workers at Clarendon Medical ran a well-being program aimed at people with a BMI >40. You delivered an element of that programme which was made up of:

- **An introductory session**
- **Two sessions on emotional eating and emotional regulation with Shauna Quigley**
- **Six sessions of Taiko drumming with Fiona Umetsu of Foyle Obon**
- **Six plus sessions (due to covid-19) on personal development with Dr Anne Tracey, Fiona Bell and Rosemary Bradley**

We are very grateful for your contribution and would like some feedback. Your feedback is important to evaluate the programme and to allow us to develop it for future use.

There are 4 questions and a comments section, each with a text box to type your reply into.

Many thanks for completing this feedback form. We appreciate your time. If you have any questions please contact myself or Roisin by email or on the numbers below.

Roisin Ferry
roisin.ferry@westerntrust.hscni.net
078 8000 1418

Dr Grainne McAnee
g.mcanee@ulster.ac.uk
079 0767 7568

What did you want the patients to gain from your element of the Well-being programme?

What do you think they did gain and how do you know?

What was the experience of facilitating on the programme like for you? What do you feel you gained from it?

Is there anything you would change if you were delivering your element of the programme again?

Any other comments?

HEALTHY CONNECTIONS

Evaluation of Clarendon Medical Well-being Pilot for People Living With Obesity

Dr Grainne McAnee PhD, MRes, BSc; Roisin Ferry BSc; Caroline Stack.