

**Somerset Community Pounds**

**Evaluation Report**

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# Executive summary

The Somerset Community Pounds project was an innovative pilot project aimed at helping community groups lose weight and raise money for their local community cause. As part of the Somerset County Healthy Weight Healthy Lives Obesity Strategy and reducing inequalities in CHD and diabetes work programme, the weight loss intervention was run over a six month period from September 2011 to February 2012.

The evaluation adopted a qualitative approach that complemented a quantitative component conducted by NHS Somerset. Data was collected from participants (n = 22) and stakeholders (n = 5) engaged on the scheme. Analysis was guided by research questions stipulated by NHS Somerset. Following a deductive analytic approach data was initially coded into broad text units which held relevance to the research questions. This identified a number of themes and sub themes relating to participant and stakeholder experiences, attitudes and perceptions.

Overall, analysis revealed that, from the perspectives of the participants involved in this evaluation, the intervention had led to a number of changes including weight loss, improved mobility and increased quality of social interaction. The monetary incentive provided a core attraction for participants and helped the activities stand out from other community activities. Low cost activities and the potential to raise community funds provided strong impetus for participation in the project. Embedding the project in community settings fostered a sense of collective responsibility both to the community sites involved and between the participants. This provided a source of motivation for engagement in activities. Wider effects of participation were felt in participants’ families including greater knowledge and awareness of healthy lifestyles and increased engagement by partners and siblings.

Stakeholders reported increase skills and confidence in managing and delivering community interventions. Initial challenges included funding procedures and arrangements for managing the project, particularly communication. Overall, stakeholders identified that encouraging and supporting the participants to continue activities beyond the lifespan of the project provided a potential means of developing a lasting legacy which provided continued benefits for participants.

# Introduction

## Background

The Somerset Community Pounds project was an innovative pilot project aimed at helping community groups lose weight and raise money for their local community cause. It supported national efforts by the NHS to implement a range of innovative community interventions in an attempt to address the rising levels of obesity. The project adopted a community development approach and was primarily focused on communities with the highest health and social needs in Somerset as part of the County Healthy Weight Healthy Lives Obesity strategy (2010-2013) and and reducing inequalities in CHD and diabetes work programme. Community settings have become the principal arena in which the contemporary health promotion discourse is played out and may provide the best chance at developing culturally sensitive interventions that build individual and organisational capacity to affect behaviour change and the environment in which it takes place (Butterfoss & Kegler, 2002).

Members of the community (adults over the age of 18 years), who were classed as overweight or obese using Body Mass Index criteria, pledged to lose weight over a six-month period as part of an overall community effort through a targeted programme of physical activity opportunities and lifestyle advice. The project used NHS Health Trainers, community centre staff, district council active lifestyle and community development staff, and exercise professionals to deliver a broad programme of support, advice and health promoting activities such as exercise classes, cooking classes etc., targeted at three specific community settings in Frome, Yeovil, and in Taunton. Commencing in October/November 2011, it ran over a period of six months and supported overweight/obese adults to pledge to lose weight as part of an overall community effort. Total community weight loss (i.e. number of pounds) was rewarded at the end of the six month period, with equal levels of funding (£1 for every 1lb lost), with the money invested in health promoting projects within their communities.

The evaluation adopted a qualitative approach that complemented a quantitative component conducted by NHS Somerset. The aim of the qualitative component was to investigate participants’ motivations for taking part and their perspectives on the nature of the project in terms of successful weight loss after 6 months. Focusing on community groups and families, the evaluation provided a unique opportunity to understand more about motivations for successful weight loss, implications of the project for those that took part, their families and the communities in which they live, and to further develop knowledge of interventions that could make a difference to community health.

## The problem

There has been a steady increase in the number of people who are overweight and obese, both nationally and in Somerset which, similar to other counties in England, is reflecting the national trend (Department of Health, 2009a, 2009b). In response, the Government has published the national strategy *Healthy Weight, Healthy Lives* with the ambition to ‘be the first major nation to reverse the rising tide of obesity and overweight in the population by ensuring that everyone is able to achieve and maintain a healthy weight’ (Department of Health, 2008: p. xi). Recent data identifies that 25% of Somerset adults are obese (South West Public Health Observatory, 2010) and with direct costs of overweight and obesity estimated at £138.8 million for NHS Somerset (Darlington PCT, 2010), healthy weight has been identified as a priority in the County and District Sustainable Communities Strategy for Somerset.

## The response: community health and physical activity interventions

Community interventions continue to pose challenges to health professionals and the academic community (Biddle & Mutrie, 2009). They have the potential to positively impact public health but owing to the need for appropriate and relevant targeting of specific groups they are notoriously difficult to manage (Kahn et al., 2002). Historically, the most effective interventions have targeted specific population groups and the strengthening of community support. Timing is also a principle factor and interventions of at least 3 to 6 months in duration are desirable (Kahn et al., 2002). Mass media and social marketing campaigns have been deployed to promote physical activity and support community-based interventions (Cavill & Bauman, 2004; Kilgour, Baker, & Crone, 2011). Such approaches have recently been used in the national Change4Life campaign which includes a specific marketing strategy to help support the achievement of national obesity ambitions, as well as promoting broader lifestyle changes (Department of Health, 2011).

Financial incentives have also been investigated as a means of supporting lifestyle modification (Finkelstein, Linnan, Tate, & Birken, 2007; Volpp, et al., 2008; Volpp & Das, 2009). Financial incentives are often incorporated with diet and exercise advice and administered using cash incentives, refunds and lottery-style payments (Cawley, Price, & Hall, 2009; Paul-Ebhohimhen & Avenell, 2008). These approaches have been shown to be effective for weight loss in the short term (Jeffery, 2004; Volpp et al., 2008) but it is difficult to isolate effects of financial incentives from other factors (Paul-Ebhohimhen & Avenell, 2008). Evidence is much less convincing for effects over the long term (i.e. 12 months or more), which suggests that financial incentives may not be sufficient alone for sustained weight loss (Paul-Ebhohimhen & Avenell, 2008). As such, it is suggested that approaches that promote weight loss maintenance following cessation of financial incentives should provide a key focus for research and evaluation (John et al., 2011). Usefully, research elsewhere suggests that greater weight loss during the intervention phase results in greater net weight loss after unsupervised follow-up i.e. after the intervention has completed (Barte et al., 2010). Hence, it is critical that individuals are able to use the intervention phase to maximise weight loss in order to improve long term outcomes. With this in mind it is recommended that studies deploy qualitative approaches in order to assess the approach through which financial incentive can best serve as tools for motivation (Paul-Ebhohimhen & Avenell, 2008).

# Evaluation aims, objectives and plan

The evaluation team was commissioned by NHS Somerset to undertake a qualitative evaluation of the Somerset Community Pounds project.

## Aims

From the outset, the over-arching aim of the evaluation was to address research questions that investigated participant and stakeholder experiences. These are presented in Sections 2.1.1 and 2.1.2. For findings from the stakeholder evaluation please refer to: Baker, C., Crone, D. & Kilgour, L.K. (2011). *Somerset Community Pounds Evaluation Report - Stakeholders*. University of Gloucestershire, U.K.

### Research questions – participants

1. What has been effective in supporting any change(s)?
2. If people have not been successful, why not?
3. What role has the community aspect of the project played?
4. What role has the community monetary incentive played?
5. Has there been a knock on effect of changes within families, even though this is an adult focused project? If so what have these changes been?
6. If people chose not to engage with the project, why was this?
7. What does the community feel would support them in the future?

### Research questions – stakeholders

1. What were the processes involved in the setting up, management and delivery of the project at commencement through to completion?
2. What were stakeholders’ experiences of participating in the project?
3. What was the perceived of impact of the project on the community?
4. What was the perceived of impact of the project on families within the community?
5. In general, what were the experiences and recollections of interesting case studies/stories of involvement in the project?
6. Opinions regarding sustainability of the project beyond the duration of the funding period.

## 2.2 Objectives

Five objectives were established to address the evaluation aim and research questions:

1. Conduct a group interview with intervention participants at the three pilot sites (in situ) exploring motivations, expectations, and opinions of the project for them as individuals, for their family and for the community.
2. Conduct group interviews with participants at the three pilot sites who completed the project from the pre-intervention focus group.
3. Conduct individual telephone interviews, using a semi-structured interview schedule, with participants who were not successful, identified from their previous participation in the pre-intervention focus group.
4. Conduct a family group interview at the three pilot sites.
5. Conduct a group interview with stakeholders i.e. project staff to explore the opinions and perceptions of those involved in the management and delivery of the project.

## Research plan

In support of the aim, research questions and objectives a two-stage research plan was formulated which included the following components. This highlights the relative timing of the interviews:

### **2.3.1 Early intervention phase** (within four weeks of commencement)

1. Group interview with intervention participants at the three pilot sites (in situ) exploring motivations, expectations, and opinions of the project for them as individuals, for their family and for the community.

### **2.3.2 Post intervention phase** (at the conclusion of the intervention)

1. Group interview with participants at the three pilot sites who completed the project from the pre-intervention focus group;
2. Individual telephone interviews with participants who were not successful from pre-intervention focus group;
3. Family group interview at the three pilot sites;
4. Group interview with the intervention staff.

# Evaluation design and methods

The evaluation deployed a qualitative study design to investigate participant perspectives of the Somerset Community Pounds project.

## Ethics approval and data protection

Prior to commencement ethical approval was sought from the University of Gloucestershire Research Ethics Committee to ensure compliance with the necessary regulations. Data protection was assured through the use of anonymised participant data, with electronic records held on password protected University computers and raw data stored in locked filing cabinets within a secure office.

## Participant selection, recruitment and informed consent

The aim was to recruit approximately ten participants from each of the evaluation sites from a purposive sample from the three sites at Yeovil, Frome and Taunton (*n* = 30). Recruitment was undertaken at the point of participant’s involvement in the project. The start dates for the project varied and different approaches were used according to the context at each site. Hence, participant recruitment was conducted according to the circumstances at each centre, for example, at one centre a member of the evaluation team recruited participants directly by attending the main project launch event. Information letters outlining the aims of the evaluation were discussed with participants and letters of consent were obtained where participants agreed to take part. To ensure that non-completers were retained in the sample, participants were also asked to confirm whether they would be happy to be involved in the evaluation of the project whether they completed the project or not. A mix of indirect and direct recruitment took place at the other sites via site visits by a member of the evaluation team and coordination of the recruitment process by the centre staff. All participants received and signed evaluation consent forms. Stakeholders who had been directly involved in the management and delivery of the project (*n* = 5) were invited to attend a group interview to discuss their experiences. All participants consented to be interviewed.

## Research methods

To accurately capture participant and stakeholder experiences across the duration of the project the evaluation team explored the following themes:

* Participants’ experiences of the pathway
* Motivations for sustaining physical activity
* Exposure to new physical activity types
* Advantages/positive aspects of taking part
* Disadvantages/less positive aspects of taking part
* Effects of participation on family, friends and peers
* Perceptions of physical activity and health

The themes were developed specifically to address the research questions outlined in Sections 2.1.1. and 2.1.2. A range of group and individual (face-to-face and telephone) interviews were conducted to address the aims of the research using a range of unstructured interviews and semi-structured interview approaches. The intention was to capture participant perceptions at two points in time i.e. at commencement and after completion. At the outset, the evaluation team, in consultation with NHS Somerset, established the following interview formats and estimated sample size:

1. Group interviews with participants who completed the project from the pre-intervention focus group (estimated *n* = 4 to 7 group interviews).
2. Individual telephone interviews with participants who were not successful from pre-intervention focus group (estimated *n* = 2 to 4 telephone interviews).
3. Family group interview (*n* = 3 families; *n* = 1 family to be identified and recruited from pre-intervention focus group).
4. Stakeholder interview (*n* = 5) with project staff directly involved with the management and delivery of the intervention.

The individual and group interviews were undertaken using a semi-structured interview guide and recorded on a digital voice recorder. To comply with data protection requirements the recordings were transcribed verbatim and transferred to a password-protected computer of the researcher undertaking the interview. The original sound file was deleted from the recorder and the subsequent transcripts (Word file) were stored on University-based password protected computers.

Close collaboration with staff at the three sites was essential due to a number of challenges including delays to project commencement and communication issues. To ensure that the evaluation was conducted successfully, data collection approaches were altered to fit the situation and context. For clarity, Table 1 details the nature of interviews conducted during the evaluation. In total, 22 participants were interviewed during phases 1 and 2 (males *n* = 6, females *n* = 16) in addition to 5 stakeholders.

Table 1. Phase 1 and 2 interviews, focus groups and total number of participants

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Interview type** | | | | | | | | | |
| **Group** | | | **Individual** | | | **Family** | | | **Stakeholder** |
| **Site** | **1** | **2** | **3\*** | **1** | **2** | **3\*** | **1** | **2** | **3\*** | **All** |
| Phase 1 | 6 | 6 | 4 | 1 | - | 2 | - | - | 1 | - |
| Phase 2 | - | 8 | - | 4 | 8† | - | - | 1 | - | 5 |

\*Interviews were conducted 6 weeks prior to completion of the project. †Including 3 interviews with couples.

# Data analysis methods and procedures

Interviews were transcribed verbatim and transcripts were downloaded into the qualitative software package NVivo 9 (QSR International Pty Ltd) which was used to store and manage the data in preparation for analysis. The data analysis approach was informed by the brief set out by the commissioning agency. Following a deductive analytic approach data was initially coded into broad text units which held relevance to the research questions. These were reviewed independently by each member of the research team to verify the meaning and researcher understanding of each unit. This approach allowed the researchers to unpack the data according to the specified research questions and to minimise bias via the use of researcher triangulation (Bryman, 2008). Where data allowed, further sub themes were developed to provide a deeper insight into the data and provide a richer account of participant and stakeholder experiences.

# Results

This section presents findings from qualitative analysis. For clarity, it is divided into seven sections according to the Research Questions outlined in Section 2. The data is presented according to themes that emerged during data analysis. Sub themes are used to expand the main themes in order to provide a richer account. Participant responses are quoted verbatim and are presented without identification to maintain anonymity. Where larger sections of text are presented ‘I’ indicates the interviewer and ‘P’ represents the participant.

## What has been effective in supporting any change(s)?

For reference, Table 2 highlights principle changes identified over the course of the project. These provide the contextual backdrop for the factors identified by participants as important for engagement in the project.

Table 2: Principle changes over the course of the project

|  |  |
| --- | --- |
| *Personal (physical and psychological)* | *Social / environmental* |
| * Weight loss * Increased fitness * Improved skills and knowledge of health issues i.e. healthy eating, importance of physical activity * Sense of satisfaction and achievement * New/renewed exercise schema | * Increase in the number of participant’s social ties * Increased frequency of social interaction * Awareness of community resources |

Participants reported a number of factors that were important to their engagement in the project. These related to the principle theme that the project provided a *unique approach* to targeted weight loss. This uniqueness was characterised by several properties. The first sub theme *enjoyment* related to the feelings that participants derived from engaging in the range of exercise classes provided through the project, and in the consultation sessions with project staff, i.e. the health trainers, centre staff. The contrast with more traditional exercise settings for example, gyms, provided them with a unique and different experience to weight loss programmes they had experienced previously; ‘*if you went to a gym, just there on a running machine, brain death sets in. But if you go to a class with other people you can have fun whilst doing it, you don't feel like you're exercising, it's just fun*.’ Here, the onus was on participation itself rather than concerns with the environment in which it took place, which in other settings could have provided a source of distraction i.e. a fitness suite. The feeling of enjoyment put participants at ease and helped foster a sense of camaraderie between participants in the classes; ‘… *the fact that there’s others here doing the same isn’t going to make us competitive about it. But we might talk about it, especially on the day somebody comes in to weigh us, we’ll talk about it we’re aware of it going on aren’t we, other people doing it. And if we know there’s a weigh- in coming up we try a bit harder don’t we…’*

The second sub theme *familiarity* related to the feeling that the project helped establish an environment that was non-threatening and facilitative:

I: ‘*So what’s so different about the project here?*

P: *It’s that it’s not too formal, you’re not too pressured…*

I: *How does that help you?*

P: *Well, I’m more relaxed about it I think. I did the six week weight management course at the #### where I work and they were advertising classes that were available so I picked up on the fact that Zumba was part of the scheme. So, I signed on to do that, it was something extra to do, it was nice to do something different in the evenings and meet new people. I live on my own so it’s a case of trying to get out in the evenings and meet new people, the social thing. I think particularly this time of year* [winter] *it would be easy to sit in and watch the telly when it’s cold and dark. It’s something else to do.’*

Integrating the project within regular group activities at the community centres was an important aspect of familiarity; ‘…*it encourages people to do something about their weight, it's a group situation, you've got information, it's a nice place to come to…’* For regular visitors this helped to establish a cohesive environment in which participants felt comfortable in sharing their experiences. Conversely however, there were situations when familiarity, as an effective way of sustaining engagement, actually tested the motivation of participants who were not regular visitors to the centres; ‘…*I mean they were very welcoming, they didn’t sort of exclude us but I discovered it was sort of a long standing coffee morning and their activities. And because I joined the weight programme I sort of tagged along on to it*…’ This did not necessarily provide a barrier to participation but it was evident that it affected participant perceptions; ‘…*whereas for me I wanted to do the Tai Chi, and the coffee morning was part of that, for the others who had been going for years, it was their coffee morning and they tolerated the Tai Chi, if that makes sense?’* Hence, familiarity in this sense was something that new or infrequent centre users had to get used to. Whilst no single participant reported that this was necessarily a problem it was apparent that, in some circumstances, it was important that regular users of the centres needed to make participants who did not regularly use the centres feel welcome and at ease.

The third sub theme *support* was crucial for supporting engagement. Support provided a set of resources which increased participants’ resilience and helped them stay motivated throughout the project; ‘…*it can [help] people because people will take out the information and show other people and encourage them to come along, motivating others. There's nothing like seeing somebody who's lost a lot of weight!*’ The aspects of staff and peer support helped to distinguish between the types of support available.

Firstly, *staff support* provided an important resource; ‘…*the instructor is great. She helps us. She doesn’t make me do what I can’t do, she lets me get on with it and make us feel like we’re all part of the class. I’ve been to classes before and it wasn’t like that, you felt like you were an outsider, like you weren’t involved…that’s helping me stay here, I probably wouldn’t have come back before*.’ Staff support was particularly important because participants were able to form trusting relationships through which expert advice and support was received; ‘*Our main contact, has been with ####, and to have picked up with her coming here on a regular basis has been very useful. It has encouraged us to lose weight, and the schemes approach to weight loss…I mean neither of us are good at losing weight, you know…I think the friendly chats [were] really good. I’ve been on other schemes and it wasn’t bad but it’s very, very impersonal and this is what we’re going to talk about today whether you’re interested or not. It was alright. But here it’s much more about how you are getting on, much more personal*…’ This provided an important means of integrating participants into the activities and making them feel welcome.

*Peer support* helped establish an environment that was relaxed; ‘…*it was all quite relaxed, nobody sort of saying, “what have you lost”, people did say what they’d done in a casual way but it was all quite supportive*…’ and friendly; ‘…*it allows people to be really sociable with each other and that. Like with the swimming, I got to know everybody and got to know some new people too*…’ Together, staff and peer support provided crucial elements of participant experiences that were unique to each individual that encouraged sustained engagement even when attendance was infrequent; ‘…*we haven’t been coming [regularly] for the past six months…we’ll carry on until we reach six months and see how we do over six months. The thing that’s been very helpful to us is sort of reaffirming what we vaguely knew in the back of our minds so it’s given us information on a friendly basis as to how to tweak things*…’

The fourth sub theme *accessibility* related to the ability of participants to engage successfully with the project and sustain weight loss activities. *Cost* was a crucial factor for many participants. Reduced-cost or free sessions were of particular importance. These encouraged participants to try activities that they had previously been put-off from doing; ‘*I got two free tickets to the Zumba class. And I’ve really enjoyed going to the Zumba. I’ve been interested in the Zumba before but it was only when I got the free ticket that I thought I can’t waste this, it would be bad. So I went along…*’ It was also important for encouraging participants to return to activities or modes of exercise that they felt were financially too burdensome to do regularly; ‘…*if classes are on it's often quite expensive. The classes that I quite like to go to are on in the day when I’m working or expensive and in the evening… they put things on and sometimes it's like a fiver a class and if you want to do that regularly it's past most people's budgets. They've got it up here now, I don't know for how many weeks, but it's a pound!*’ Hence, *accessibility* and the pricing strategy helped to mediate or reduce the effects of financial concerns and encouraged participation in project activities.

## If people have not been successful, why not?

Participants identified a number of factors that had influenced perceived levels of success with the project. The theme *challenges* helped to explain the types and effects of these factors. These were identified directly i.e. by participants, and anecdotally i.e. participant observations about others.

The first theme *illness and injury* related to personal health factors that potentially prevented or impeded progress; ‘*I’ve had cancer, and treatment, and that’s still coming out of me so that’s why I’m still putting on the pounds.*’ Similar factors were also recognised as challenges to other participants in the project; ‘…*there was, ####, she had a bit of a problem, she came back, she had a problem with her foot or something so she couldn’t come, but she loved it. She wanted to go back*…’ These problems did not necessarily prevent engagement. For some, overcoming personal health factors that potentially prevented or impeded progress presented a positive challenge; ‘… *in hospital, I had stents fitted, came out being overweight…for some years now. And I know it’s a lot overweight. Couldn’t tell you what it is in kilos but there we are. So I’ve lost a stone and I need to get another two and a half stone off of me so that I’m down to fourteen. If I can get to fourteen I’m happy, if I can go more than that, thirteen, I’m even more happy but fourteen is the aim*.’

The sub theme *lifestyle factors* related to established behaviour i.e. dietary habits that participants recognised as potentially detrimental to their progress:

P1: ‘*You’ve tried to cut out the alcohol and the snacks haven’t you?*

P2: *Yeah, alcohol more than snacks…*

P1: *It’s frustrating when you are trying and nothing happens*

P2: *Trouble is, after you’ve spent sixty years practising snacking it’s difficult to give it up! Even just a few biscuits every once in a while, they said that can be half a kilo a year, even that.*

P1: *In my case, one week I had four hypos which meant I had to address that… I wonder whether it would have been more productive if there was a questionnaire that indicated peoples’ health issues, you know, relevant to what’s happened at the end…’*

For some participants engagement in the project helped to highlight these factors and provided an opportunity to address them; ‘*I saw it advertised and I knew that I was overweight and wanted to slim down. Habits were bad and I wanted to retrain and that’s what this programme’s all about. I had done the food course beforehand over December and January. So this is a good follow up, to put things into practice*…’ Hence, consistent with the principle theme *challenges*, lifestyle factors did not necessarily lead to unsuccessful outcomes but did influence the nature of progress made. This was recognised by participants, some of whom indicated that more support in addressing these would have been useful; ‘*I tell you what would be interesting, and that’s a cheap, easy healthy cooking session. We all watch the programmes on telly but we don’t keep half a dozen spices in our houses! A lot of us don’t have the time or the skills to cook things from, you know, the basics. What we need is cheap healthy living!*’

## What role has the community aspect of the project played?

The principle theme *kinship* describes participant perceptions concerning the community aspect of the project. This related to the ways in which participants were able to increase understanding of their community, develop and strengthen bonds with other community members, and feel that each shared common concerns; ‘…*if you're the only one doing it you feel you're going off to the naughty class but with everybody doing it you're just part of the crowd.*’ Participants identified a number of factors that characterised the principle theme which are explained via two main properties.

The first sub theme *sharing* helped foster the sense that participants were part of a group that could support and encourage engagement:

P1: *Well, it’s very friendly, there’s a big rapport*

P2: *And with the single ladies, to go on the exercise classes, they teamed up…*

P1: *Of course I was the only guy, and they took the mick out of me but I give as good as I got! They’re very friendly atmosphere, you did feel like you was part of a team. You felt like you were being led and every week it was down, down, down*

This gave a focus for activities and stimulated interest beyond the exercise classes and other activities; ‘*I think it's really good, making it a community thing has been great. [We] have been comparing pedometers, talking about it. I think having everybody involved instead of having to sneak off to a weight loss class once a week has been good*.’

The second sub theme *connectivity* referred to participants’ sense that being part of the local community was a bilateral relationship in which they could make their own contributions; ‘*I did want to do something for the community, sort of thing, and anything you do goes back to the community. It really boosts people’s motives, gets them going and that… if you do more it does more for the community, the centre, it’s a really good way of doing it*.’ The strength of participants’ connectivity varied. For existing centre users connectivity was strong; ‘*We’re all service users of the community centre so if we can give something back then that’s a good incentive…and it’s not costing us anything to do it’*. For others i.e. those who were not regular centre users i.e. participant who travelled from further afield to the centres, *connectivity* was apparent although not as strong; ’…*this isn’t my community so I’m not that bothered about the money but if they get something for it then, all the better. I must say, this is one of the better community halls, so it needs to be kept up, it’s come so far since when I was younger, they need money to keep going*.’

It was also clear that engagement in the project helped to renew or foster a new sense of connectivity; ‘*I think the thought that from somewhere else a bit of cash was coming in to this office that we’d known about for a little while, we liked that idea. Now we know it’s here I’m going to bring up some jam they can sell to help keep it going, you know? We hadn’t done much with them before…I guess we hadn’t felt the need*.’ Hence, *connectivity* provided a means for participants to act on their concerns for the community around them and to build and maintain relationships. Interestingly, it was evident that as participants became increasingly involved in the project their lack of connectivity posed a challenge to their engagement; ‘*People with my particular circumstances tend to be younger than me and, you know, [those] retired like me are in different circumstances, so I don’t really know anybody like that…perhaps something like a register or something of people who are like minded and want to do similar activities…if I knew somebody who could pick me up and I could pay some petrol , you know, the companionship of going swimming together regularly, that’s something I’d like to do*…’ Hence, it was apparent that *connectivity* was something that was both a community and individual concern.

## What role has the community monetary incentive played?

The theme *attractiveness* highlighted that participants were cognizant of the significance of the monetary incentive. The sub theme *giving back* related to desire to make a meaningful contribution to the community; ‘*I did want to do something for the community, sort of thing, and anything you do goes back to the community. It really boosts people’s motives, gets them going and that because if you do more it does more for the community, the centre, it’s a really good way of doing it*’. In contrast, some participants felt that the monetary incentive was important but as part of a wider set of concerns, including personal motivations to lose weight; ‘*to be honest I don’t know if I’ve participated in it that heavily. I took part so that I could be weighed ‘cos I knew the centre was going to make some money out of it but I can’t say that I’ve particularly concerned myself with the peripheral bits and pieces of it…*’

The second sub theme *discovery* related to the attention drawn to the project activities by the monetary incentive; ‘*I attend a local church and I picked up the booklet that comes from here and it had about the project with the University. I thought it would be worthwhile, something that would be a good incentive and you know, it was worthwhile joining in with the project to see if things could be improved. And also, the community pounds, to see if we could raise money for the centre*.’ As a consequence, participants felt a sense of satisfaction that they could simultaneously raise money for their centre, be a part of a project that was being evaluated, access free or reduced-price classes and take part in group activities with the aim of losing weight:

P1: ‘*you can see what the money’s being spent on. There’s classes running already, obviously, but they’re going to spend more on the project*

P2: *It’s important that you can raise money without necessarily having to spend a lot yourself. And you get a benefit in return because you’re losing weight and doing different activities as well. It’s quite positive on both sides*

P1: *Yeah, I think obviously that everyone wants to help out their own community and if you can do it in a way that doesn’t impact your own life too much, but you can also get some benefit as well, it’s a win-win*…’

## Has there been a knock on effect of changes within families?

There was a single sub theme of the theme *familial impacts*. This was conceived as *enthusing*, a continuum along different configurations of familial relationships influenced participation. At one end of the continuum, participants were encouraged and supported by family members to participate in the project. This was particularly important if participants were infrequent or non-users of the centres; ‘*I think friends and family [are more important] than the people here. There are other activities, but as I said, I haven't got down to them for a number of reasons. My grandson used to come to the centre so I know a bit about it. But he's been at school now so I haven't been for ages but my daughter gave me a flyer and said why don't you come down, so the group environment has been quite positive*.’

At the other end of the continuum family members were motivated by participants to modify their behaviour in favour of positive lifestyle habits; *’…my son has been more interested in doing things, he’s only eleven. But he’s interested in doing more, we go swimming together now. And my mum, the other day said how much better I was walking and looking…she commented how I was able to keep up. So I do feel different, fitness and that. It’s not just the losing weight it, it’s being active and doing something different.*’ *Enthusing* could have significant effects within family units. One effect was the strengthening of relationships between family members:

P: ‘…*we haven’t done any of the food ones but my husband and I have joined ballroom dancing which he and I haven’t done. Well, I have but not together*

I: *So that’s a new activity for you in that you’re doing it together?*

P: *Yeah, it’s brilliant; we’ve managed to do some routines already*…

I: *So has that had an effect on your relationship do you think?*

P: *Yes! He’s always far too busy and we’ve really done anything different except for one particular hobby. So this is the first time we’ve done something jointly together*.’

The theme *familial impacts* highlighted that engagement in the project impacted family units but also that relationships within family units were important to participation itself. An important outcome of this synergy was that it helped to attract and retain new participants to the project; ‘*It was my mum and dad that invited me along to it, they said come along, it’s good. I like it, it’s really enjoyable…I usually come up to the boxercise and it’s cheap, it’s only a pound! Which is great, even with a gym membership it can be four or five pounds for a class, it can really add up.’*

## If people chose not to engage with the project, why was this?

None of the interviews with participants revealed individuals who had chosen not to engage with the project. However, several factors were highlighted that presented as a key theme *barriers to engagement* in the project. These presented very real challenges for participants because they often had to prioritise these over regular engagement and changed over time according to familial, work and social commitments. Some of these were predictable i.e. work patterns whilst others arose randomly and were harder to predict. The first sub theme *personal commitments* related to factors that participants had to reconcile with their ability to engage in the project, particularly *family* and *work*. These could have direct effects on engagement; ‘*Because my children do a lot of after school activities I’ve not been able to [attend] as it’s been on nights when they’re doing things so I haven’t been able to do as much of that side of things as I’d like to*…’ Clashes with work commitments were recognised as particular barriers which restricted or prevented engagement; ‘*I think if it's a community project it should be targeting all of the community. I do feel that everybody who works full time wouldn't be able to access it, they wouldn't be able to come to the weigh-ins. Most of the classes are in the day. If you're working 9 to 5 you can't get to the weigh-ins…my husband wouldn't have the time to come. There's a massive section of the community that wouldn't be able to access it*.’

Participants were acutely aware of the fact that scheduling project activities to accommodate as many people as possible was a significant challenge. What was interesting was that just because individuals understood this dilemma it did not necessarily mean that it could be supported in the long term, a consequence of which was decreased motivation; ‘*The timing could have been better. That was one thing we found difficult trying to fit it in but we did appreciate you can’t have a class for every single person to make it convenient you know? We did find it hard going toward the end because somehow you lose interest...*’

*Personal commitments* also had indirect effects in that they could take up a significant amount of time and energy; ‘…*in the hours that I’m working, the one I could get to was on a Friday between seven and eight and by then your energy levels have dropped….once the kids are in bed I’m exhausted. I've tried twice to get to it but physically couldn't do it. The others are 4 till 5 do I’m working, or in the morning so it's a bit of a shame I can’t get to it*.’

The second sub theme *proximity* related to participants’ place of residence relative to the site at which the project was running. It was evident that running the activities at local centres was a significant benefit of the project; ‘*For me it’s great that I can just walk up, being close by. For me, it’s a real challenge being able to fit everything in so having something so local is really good. I think if it was too far I just wouldn’t be able to do it*.’ However, given the popularity of the project and individual’s propensity to commute from areas further afield, *proximity* also presented a barrier to engagement. *Travel* related to difficulties participants experienced with reaching the centres. This was particularly relevant for those with mobility issues; *because I can’t walk very far it means from my house I have to get a bus into town and then one back out. And although it’s only probably five minutes on each one it’s the waiting in between. All in all, if I leave here for the ten o’clock bus I’m not back here until one. Occasionally I did team up with another girl and she drove which saved me a lot of time but she’s not very well at all, so there were lots of times she couldn’t go*’.

## What does the community feel would support them in the future?

A number of factors were highlighted by participants that could provide important information for similar projects in the future or for professionals and community practitioners working with local population groups. These are summarised using the following themes:

*Greater awareness of the project*

It was evident that participants had received information about the Project through a variety of channels. Whilst it was not possible to determine the effectiveness of communication i.e. through face-to-face contact, advertising or other, it was apparent that communication was inconsistent. Although this undoubtedly reflected the unique circumstances of each centre, in practice it meant that communication could appear ad-hoc or unplanned. As such, participants reported that there was a need for better advertising to support the project; ‘*I think it could have been promoted a bit better. There’s lots of leaflets when you come in to the centre but I don’t know if people have seen them. I think some people started but then dropped away, so they need to keep promoting it and get them on board…our contact with the scheme came through a family member so obviously that was a bit different… I’m sure others came through a different way…I didn’t necessarily see any flyers or anything like that*.’

*Monitoring and support*

Some participants reported that they struggled to maintain their motivation to engage in the project. Whilst the six month time frame presented a realistic window in which to lose weight it was evident that, for some participants, this required a sustained and very high level of motivation; ‘*It got off to a good start. The health trainer, I think we had six sessions during the six months. That was kind of one to one sessions, discussing how things were going, the different stresses in my life. So that was supportive in a talking kind of way. And she tried to advise me on different strategies to help me with the weight loss but at the end of the day it was down to me to try and keep to them. And I didn’t seem to have enough motivation because of things that were going on in my own family so I just felt as if I was gradually losing, the sort of persistence that you need*…’ It was also apparent that the project ran differently at each centre in terms of the type and level of support and monitoring available. This was most notable in respect of the dietary and lifestyle support provided. That this was highlighted both by participants who perceived that there was sufficient support and by those who did not underlined the importance of providing specific and consistent dietary and lifestyle support i.e. through providing eating plans or diet sheets.

*Appropriateness of activities*

The project activities did not uniformly appeal to all participants. It was recognised that there was a wide variety of activities available but participants did not necessarily feel that these suited their needs or preferences; *I would have like to have had more activities. There were other things organised, there was Salsacise which I had a couple of attempts at but a combination of family circumstances and the effects it had on me. It was too vigorous and I’m not in particularly good health so I couldn’t do that*.’

*Better quality equipment*

Project equipment to support participant weight loss efforts, particularly pedometers, provided a unique and appealing aspect of the project. Problematically, many respondents reported that these were of poor quality; ‘*The only criticism I have is that we were all given pedometers and they packed up in two weeks and that seemed rather a waste of NHS resources if they were going to supply those and they just pack up straight away!’* This was a source of frustration and potentially detracted from the overall experience of participation.

## Summary of themes

Table 3 summarises the main themes, their sub themes that emerged during analysis of participant data.

Table 3:Summary of themes - participants

|  |  |  |  |
| --- | --- | --- | --- |
| ***Section*** | ***Question*** | ***Theme*** | ***Sub theme*** |
| 5.1 | What has been effective in supporting any change(s)? | Unique approach | Enjoyment  Familiarity  Support  Accessibility |
| 5.2 | If people have not been successful, why not? | Illness and injury  Lifestyle factors | -  - |
| 5.3 | What role has the community aspect of the project played? | Kinship | Sharing  Connectivity |
| 5.4 | What role has the community monetary incentive played? | Attractiveness | Giving back  Discovery |
| 5.5 | Has there been a knock on effect of changes within families? | Familial impacts | Enthusing |
| 5.6 | If people chose not to engage with the project, why was this? | Barriers to engagement | Personal commitments |
|  |  |  | Proximity |
| 5.7 | What does the community feel would support them in the future? | Greater awareness of the project  Monitoring and support  Appropriateness of activities  Better quality equipment |  |

# Discussion and Conclusion

This section contextualises the research findings and addresses the research questions identified in Section 2.

## Research questions – participants

1. What has been effective in supporting any change(s)?

The focus on rewarding weight loss with money for community health projects provided a unique and compelling enticement for participants. This was particularly important during the initial stages of the project. Emphasising low cost, enjoyable and socially-oriented activities in which participants felt comfortable and supported by staff and peers was fundamental for supporting adherence and thus any changes that took place. These included weight loss, improved mobility and increased quality of social interaction. It is recognised that financial incentives alone may not be sufficient alone for sustained weight loss (Paul-Ebhohimhen & Avenell, 2008). Whilst it is impossible to comment with certainty that stakeholders maintained any changes over the course of the project it is evident that financial incentives should be augmented with socially-oriented, accessible and well supported activities.

1. If people have not been successful, why not?

Principal factors influencing participant success included illness, injury and lifestyle factors. These did not necessarily lead to unsuccessful outcomes and often helped identify other issues for participants to address. Hence, it is not possible to state clearly that any participants were not successful; rather that some faced additional challenges. This demonstrates that certain participants in community interventions such as this require additional support in order to maximise that chances of success. Access to additional services beyond the remit of stakeholders involved in the project delivery may help in this respect i.e. GPs.

1. What role has the community aspect of the project played?

Embedding the project in community settings fostered a sense of collective responsibility both to the community sites and between the participants. For many, this motivated participants to engage with the activities and with one another on a more profound level resulting in a greater number of high quality social ties. Not all participants were necessarily as involved this as others. However, for participants who were inclined to involve themselves in community affairs, the community aspect provided a reciprocal relationship which benefitted the project and participants though support and engagement.

1. What role has the community monetary incentive played?

The monetary incentive provided a core attraction for participants. This helped the activities stand out in terms of the supporting literature and drew attention to the aim of the project. Participants recognised the value of supporting the community through their involvement and were keen to become involved without necessarily focusing on weight loss as the primary motivating factor. Lifestyle modification interventions commonly use financial incentives as a means of supporting weight loss (Finkelstein, Linnan, Tate, & Birken, 2007; Volpp, et al., 2008; Volpp & Das, 2009). The results in this report suggest that such approaches might also include a community focus whereby the wider benefits of weight loss i.e. community development and cohesion, might also be promoted alongside those relating specifically to individual weight loss.

1. Has there been a knock on effect of changes within families, even though this is an adult focused project? If so what have these changes been?

Participants recognised several consequences on families including a sharing of knowledge and skills, engagement in activities by partners and siblings, and a strengthening of familial ties. Key to this was the enthusiasm shared by participants which encouraged other family members to try the activities for themselves. Hence, it is crucial that participants are supported to feel sufficiently satisfied with activities that they become ambassadors for healthy lifestyles in the family unit. This focuses attention on the nature and quality of activities and supporting services run within interventions which, to date, are not well reported upon. In this respect, sharing and promoting good practice and project successes may help to develop a clearer picture of ‘what works.’

1. If people chose not to engage with the project, why was this?

The findings of the report do not allow for an exploration of this because it was not possible to locate individuals who chose not to engage with the project. Factors which represented practical challenges were identified by participants that could potentially have presented barriers to engagement. These included personal commitments and proximity relative to the site at which the project was running. Opportunistic data capture methods i.e. at the time of a conversation with an individual who chooses not to engage with projects might provide a useful means of establishing clearer evidence.

1. What does the community feel would support them in the future?

Greater awareness and improved communication regarding the project activities were identified as key areas for improvement. In addition, more consistent monitoring and support, and a wider menu of activities were indicated as principal factors that would support the project going forward. This focuses attention on the administrative and management processes that underpin weight loss interventions. It is known that mass media and social marketing campaigns have commonly been deployed to support community-based interventions (Cavill & Bauman, 2004; Kilgour, Baker, & Crone, 2011) and such approaches are recommended. Whilst it is impossible to define a single management system that is capable of being transferred across multiple settings it is possible that investigating and sharing approaches will reveal a number of pertinent and valuable ways of supporting community engagement.

# Recommendations

Based on the discussion and conclusions above, which are in turn based on the synthesis of considerable empirical evidence, we make the following recommendations:

**Recommendation 1:** Monetary incentives could be used as an effective means of engaging participants and stakeholders in community weight loss intervention programmes. Benefits to the community i.e. access to financial resources and individuals i.e. low cost or discounted activities should be promoted equally.

**Recommendation 2:** A wide range of physical activity and health-enhancing activities should be developed to meet the needs and preferences of a variety of community members with contrasting needs. This might help to sustain long term motivation, engagement, support and opportunities for participation.

**Recommendation 3:** Activities should promote a range of health and social goals as part of a broad marketing strategy in order to provide maximum appeal to participants. These could include weight loss, physical literacy, healthy eating, and community development i.e. focusing on at risk or disadvantaged groups.

**Recommendation 4:** Alternative means of recording participants’ weight i.e. date-marked print-outs from weight machines in high street chains might provide a useful means of overcoming individual sensitivities and help maximise opportunities for data collection.

**Recommendation 5:** Weight loss intervention programmes should seek to connect with broader community programmes and services over time in order to help embed activities within the community and support long term engagement and sustainability.

**Recommendation 6:** Systems that allow for opportunistic data collection should be included in project designs to help gather data on certain elements e.g. reasons for not engaging. Basic training in data collection for stakeholders could be offered in support of this.

**Recommendation 7:** In terms of support materials e.g. poster templates, registers, etc., heavy branding with partner logos should be avoided. Materials that allow stakeholders flexibility in design and content could help develop media that is sensitive to the community context and identifiable by local residents.

**Recommendation 8:** Whole family approaches provide a potentially useful means of engaging a wider range of participants. Future intervention programmes might include family-specific activities or measures that allow greater flexibility for family members to bring partners and siblings to activities.

**Recommendation 9:** Sufficient time should be given to ensure that all partners understand the aims and scope of intervention programmes in order to alleviate initial administrative and management problems. This should include consultation to ensure that as much as possible is understood about the local context. Checks could be put in place to ensure that problems are detected i.e. a staff ‘project pack outlining aims etc., and regular scheduled communication.

**Recommendation 10:** Paperwork and administrative requirements around formal agreements i.e. funding should be simplified to ensure direct applicability to the organisation and its requirements, to minimise delays and to encourage full stakeholder engagement and support and not be perceived as a barrier to involvement.

**Recommendation 11:** Interventions should avoid periods of time where physical activity is difficult to maintain, such as holiday periods. It is recommended that intervention periods take into account seasonal changes and the changing nature of available activity opportunities. If holiday periods are unavoidable, planning of special sessions and/or or drop-in opportunities might alleviate any negative impacts on weight loss activities and monitoring/motivation.

**Recommendation 12:** Identifying and embedding exit routes from intervention activities, ideally that are linked to existing provision i.e. local walking groups and clubs, and ways of providing continued support from stakeholders beyond the lifespan of intervention might provide a useful adjunct in support of sustained weight loss.

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# Appendix A: Participant Interview Schedule

|  |  |
| --- | --- |
| **Section 1, General Opinions:** | **Prompts/follow up** |
| Can you tell me what health means to you? | Why so |
| Can you describe things about health in your community | What it ‘looks like’ |
| Tell me generally what you think about the rewards scheme | Previous experiences |
| **Section 2, Expectations:** |  |
| Can you tell me about your general expectations of the project? |  |
| What do you hope to achieve or expect to happen? | Long/short term. Nature of outcomes |
| Who do you think should help you on your journey? | Why so, how so |
| Why is that important? |  |
| Task (top 5): What key changes do you expect to see as a result of your involvement? | Aspirations, achievable? |
| Where do you expect to be at the end of the project? | ‘ideals’, how did they come to that idea |
| **Section 3, Motivations:** |  |
| Can you tell me about your personal motivations | why are you here? |
| In what way do you see your friends and family supporting your journey? | Key players, why, how |
| How does that make you feel? | Overall importance |
| **Section 4, Core questions** |  |
| 1. What has been effective in supporting any change(s)? 2. If people have not been successful, why not? 3. What role has the community aspect of the project played? 4. What role has the community monetary incentive played? 5. Has there been a knock on effect of changes within families, even though this is an adult focused project? If so what have these changes been? 6. If people chose not to engage with the project, why was this? 7. What does the community feel would support them in the future? |  |