How can Tier 3 Weight Management services in the UK better support people living with obesity and trauma-related binge eating? A qualitative study of healthcare professionals' perspectives.

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Frequently Used Acronyms

AN	Anorexia Nervosa
BE	Binge Eating
BED	Binge Eating Disorder
BN	Bulimia Nervosa
CBT	Cognitive Behaviour Therapy
CBT-E	Cognitive Behaviour Therapy – Enhanced
CCGs	Clinical Commissioning groups
ED	Eating Disorder
EDS	Eating Disorder Service
HCP	Healthcare Professional
ICBs	Integrated Care Boards
JSNA	Joint Strategic Needs Assessment
MH	Mental Health
MDT	Multidisciplinary Team
NHS	National Health Service
O-BE	Obesity related binge eating
ONS	Office of National Statistics
PHE	Public Health England
PLwO	People Living with Obesity
QOF	Quality Outcome Framework
TIC	Trauma Informed Care
WLI	Weight Loss Intervention
WM	Weight Management
WMS	Weight Management Service

ABSTRACT

Background: Obesity rates have risen significantly over the past three decades. Emerging research highlights strong links between obesity, binge eating disorder (BED), and trauma. Individuals experiencing these intersecting issues are often supported across separate services, Tier 3 Weight Management (WM) and Eating Disorder (ED) services. However, the literature suggests that these services are struggling to meet the complex needs of this client group, and current national guidelines remain insufficient and fragmented.

Aim: This study aimed to explore how Tier 3 WM services can better support people living with obesity-related binge eating (O-BE) and trauma, and what challenges healthcare professionals (HCPs) face in delivering this support.

Method: Fifteen semi-structured interviews were conducted with HCPs working across WM, ED, and general practice settings. Data were analysed using reflexive thematic analysis (RTA).

Findings: Five themes were identified: (1) ED and obesity: Where does BED fit?; (2) Whack-a-mole' service delivery is failing to meet the needs of the whole person; (3) The Obesity economy: commissioning, decommissioning and recommissioning services; (4) Feeling complicit in a system that sets people up to fail; (5) Expanding provision beyond short-term targets towards long-term change.

Conclusion: A significant gap exists in the recognition and treatment of O-BE, compounded by fragmented service structures and poor cross-sector collaboration. National evaluation frameworks fail to capture these service inefficiencies, leading to a cycle of short-term commissioning and missed opportunities for integrated care. The emotional toll on HCPs, who often feel powerless, frustrated, and morally conflicted within these systems, is a key finding of this study. Addressing these structural and emotional challenges is essential for improving care and outcomes for individuals living with O-BE.

Contents

CHAPTER ONE

INTRODUCTION

CHAPTER OVERVIEW

This chapter aims to introduce the reader to the research topic, provide a comprehensive background into the subject area and give the reader a good understanding of obesity related binge eating and the service provision within weight management and eating disorders services in the UK. It will also provide a comprehensive review of the literature, identify gaps in research and provide a rationale for this study.

BACKGROUND

The subject of obesity has garnered significant attention in recent decades. At the time of this study, a titular search for the term "obesity" in academic databases such as EBSCOhost yielded over 275,000 results, with the number more than doubling when expanded to include abstracts. This substantial body of literature likely reflects three key drivers: the rising global prevalence of obesity; the well-documented adverse health consequences associated with it; and advances in biomedical research that have deepened our understanding of obesity at both molecular and systemic levels (Makki & Wolowczuk, 2013; Lee & Lee, 2014; Hildebrandt et al., 2023). Obesity is now recognized not only as a major public health issue but also as a complex, multifactorial disease involving genetic, metabolic, behavioural, and environmental factors (Hruby & Hu, 2015).

In contrast, research into binge eating (BE) and binge eating disorder (BED) has received comparatively less attention, despite longstanding evidence that BE behaviours are prevalent in society. BED was only formally recognized as a distinct psychiatric diagnosis in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) in 2013

(American Psychiatric Association, 2013), highlighting its relatively recent clinical authentication. Public and professional understandings of eating disorders (EDs) continue to evolve. Conditions like BED have historically been underdiagnosed or mischaracterized, often conflated with occasional overeating—due in part to ambiguities in distinguishing normative overeating from pathological BE, particularly when underlying psychological or emotional causes, such as trauma, are overlooked (Kessler et al., 2013; Udo & Grilo, 2018).

Trauma, like obesity, has become an increasingly prominent focus in both healthcare and mental health (MH) research. Over the past few decades, there has been a notable rise in trauma-based studies and a growing integration of trauma-informed approaches into healthcare policy and practice, particularly in the UK (Sweeney et al., 2018). This shift reflects broader recognition of the long-lasting effects of trauma and its strong associations with various health outcomes, including obesity and eating behaviours (Felitti et al., 1998; Wiss & Brewerton, 2020). Numerous studies have documented the link between adverse childhood experiences (ACEs) and later-life obesity, with trauma exposure contributing to emotional dysregulation and maladaptive coping behaviours such as BE (Danese & Tan, 2014; Hemmingsson et al., 2014). Therefore, examining obesity, BE, and trauma, both as distinct phenomena and at their points of intersection, provides an important foundation for this study.

OBESITY

Defining Obesity

The terminology used to describe obesity varies across contexts, ranging from colloquial expressions like "fat," "plump," or "curvy," to clinical terms such as "overweight," "unhealthy BMI," "excess weight," or "obese" (Puhl, 2020). These varied terms can complicate both research and communication. For example, "unhealthy BMI" may also refer to underweight individuals, "overweight" may not accurately reflect higher obesity categories, and "excess weight" can include individuals with a healthy BMI (body mass index) but high body fat percentage. Thus, consistent definitions are essential.

Medically, obesity is defined as excessive fat accumulation that poses health risks (World Health Organization, 2024). Common metrics for measuring fat accumulation include weight, waist circumference, waist-to-hip ratio, and bioimpedance, but BMI remains the most widely used measure, in line with NHS and NICE guidelines. BMI is calculated by dividing a person's weight in kilograms by their height in meters squared and is categorized as follows: underweight (<18kg/m^2), normal weight (18–24.9kg/m^2), overweight (25–29.9kg/m^2), and obese (≥30kg/m^2). The obese category is further divided to improve specificity (Weir & Jan, 2019):

Obesity class I	30-34.9kg/m^2
Obesity class II	35-39.9kg/m^2
Obesity class III (often referred to a morbid obesity)	≥40kg/m^2

This study will use the terms "obesity" or "obese" (except where participant quotes use alternative terms), referring to individuals with a BMI ≥30kg/m^2. Although BMI categorisation is not the focus of this study, understanding its implications offers useful context for service development and treatment delivery in the UK. Since WM services are commissioned based on local need, an accurate understanding of obesity prevalence is essential. Service provision across the UK will be explored later in this chapter.

A historical understanding of obesity – A consequence rather than a cause.

Historical references to obesity date back to Hippocrates (460–370 BCE), who noted the link between excess weight and premature death (Bray, 1990; Haslam, 2016). Though rare in ancient times and lacking the term "obesity," it was recognised as a health risk, and

Hippocrates advocated food reduction and exercise, a framework that still influences modern healthcare (Schachter, 1982).

Over time, various restrictive diets and interventions emerged, including high-protein diets, liquid diets, very low-calorie approaches, and physical exercise. However, studies such as Miller (1999) have questioned their long-term effectiveness, citing high dropout rates and persistent obesity trends. More recently, medical interventions like bariatric surgery, which alters the digestive system to reduce intake (Elder & Wolfe, 2007), and pharmacological treatments like Orlistat and Semaglutide, which influence fat metabolism or suppress appetite, have gained popularity (Gudzune & Kushner, 2024).

The traditional view of obesity as a simple imbalance of calories consumed versus calories expended is now widely critiqued as overly reductive (Westbury et al., 2023). Contemporary literature presents a more complex picture involving hypothalamic appetite regulation, metabolic traits, sugar consumption, gut microbiome, and environmental influences (Westbury et al., 2023; Gómez-Ambrosi et al., 2024). This broader understanding has contributed to research on the social determinants of health, which consider how factors such as socioeconomic status, social mobility, and access to healthcare influence physical health (Braveman, Egerter & Williams, 2011; Marmot et al., 2012).

A pivotal study by Felitti et al. (1998), the Adverse Childhood Experiences (ACE) Study, (a large US-based population study) was among the first to identify strong associations between early trauma and adult health outcomes. ACEs can be characterised by these 10 profiles: physical, sexual & psychological abuse; physical & psychological neglect; witnessing domestic abuse; close relative substance misuse; close relative with MH difficulties; close relative incarceration and parental separation or divorce on account of relationship breakdown (Quizhpi et al 2019). Some research studies have widened the scope and included bereavement and witnessing a major incident (Downey et al 2017). The ACEs study found that the prevalence of morbid obesity (BMI >40) increased with the number of ACEs reported. Subsequent research has affirmed these associations, identifying psychological, biological, and environmental mechanisms linking early adversity to obesity (Chu & Chu, 2021; Quizhpi et al., 2019). Traumatic experiences may impair neurocognitive functions, like inhibitory control and emotional regulation, that influence eating behaviours (Stice & Burger, 2019; Hawkins et al., 2020).

Prevalence and Importance

According to the World Health Organization (WHO, 2024), global obesity rates have tripled since 1975. As of 2016, 13% of the world's population, approximately 650 million adults, were considered obese. Childhood and adolescent obesity also increased, from 4% in 1975 to 18% in 2016.

In the UK, adult obesity rose from 21% in 2000 to 29% in women and 27% in men by 2019. High BMI is now the third leading factor driving mortality and disability (Global Burden of Disease, n.d.). The NHS currently spends over £11.4 billion annually on obesity-related healthcare (Obesity Healthcare Goals, 2024), highlighting the need for effective strategies.

Obesity significantly affects life expectancy. One study found that individuals with a BMI >45 could lose 5 to 13 years of life, equating to an average of 6.6 years, a 17% reduction in life expectancy (Fontaine et al., 2003). Another study showed that years of life lost increased with age but tapered in the oldest age groups (Stevens et al., 1999). When factoring in lifestyle behaviours, the impact is even greater: non-smoking women and men in their 40s with obesity could lose 7.1 and 5.8 years, respectively, while smokers faced even higher reductions, 7.2 and 6.7 years, respectively.

Psychological theories of obesity

Psychological theories highlight how emotional regulation and cognitive processes influence obesity. The affect regulation model suggests that individuals overeat, especially highly palatable foods, to manage negative emotions like stress or sadness (van Strien, 2018). This coping pattern often begins in early life when healthy emotional regulation skills are underdeveloped. Macht (2008) showed that negative emotions increase the likelihood of consuming calorie-dense foods, particularly among those with low interoceptive awareness. Over time, this can lead to habitual emotional eating and weight gain.

The reward sensitivity model focuses on the brain’s dopamine system. People with obesity may be more sensitive to food-related cues, resulting in heightened reward responses and overconsumption (Stice et al., 2008). Neuroimaging shows hyperactivation in reward centres like the striatum (a part of the basal ganglia, central to reward processing), and repeated exposure to rewarding foods may reduce dopamine receptor sensitivity, leading to greater consumption for the same effect (Kenny, 2011; Volkow et al., 2013).

Psychodynamic theory introduces the role of unconscious emotional conflict and early relational experiences. Unresolved attachment needs can manifest through disordered eating and weight gain (Blissett & Haycraft, 2008). Individuals with insecure attachment styles, particularly anxious or avoidant, are more likely to engage in emotional or compulsive eating as a form of self-soothing (Wilkinson et al., 2010). These behaviours reflect attempts to manage distress and assert control in unstable relational contexts. Studies have linked early attachment insecurity to binge and compulsive eating (Troisi et al., 2006), pointing to the value of exploring family dynamics and developmental experiences when designing obesity interventions.

TRAUMA

Defining Trauma

In healthcare research, trauma is typically categorized as either physical or psychological. Physical trauma refers to serious bodily injuries, such as blunt force trauma (e.g., concussions, deep cuts, broken bones) or penetrating trauma (e.g., open wounds caused by piercing objects) (NIGMS, 2020). Psychological trauma, as defined by the National Institute of General Medical Sciences (NIGMS), involves emotional or psychological injury resulting from extremely stressful or life-threatening situations. However, this definition is limited by its medicalized framing, describing trauma as an "injury."

The UK Office for Health Improvement & Disparities (OHID) provides a broader and more comprehensive definition: "Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as harmful or life threatening. While unique to the individual, generally the experience of trauma can cause lasting adverse effects, limiting the ability to function and achieve mental, physical, social, emotional or spiritual well-being" (OHID, 2022). This study adopts the OHID definition of trauma. Moreover, the trauma discussed here extends beyond clinically diagnosed conditions like Post-Traumatic Stress Disorder (PTSD), encompassing broader experiences of psychological harm, such as early childhood trauma or ACEs.

A historical understanding of Trauma

Understanding the history of trauma provides a strong foundation for appreciating the breadth of research in this area. Although the terms PTSD and complex trauma are relatively recent, the study of trauma-related stress dates back much further. Early descriptors like "shell shock," "combat fatigue," and "railway spine" referred to what we now recognize as trauma responses (Van der Kolk et al., 2007; Jones & Wessely, 2006).

The Industrial Revolution and the early 20th century marked significant advances in science and psychology, prompting early investigations into trauma's impact on both physical and mental health (Lasiuk & Hegadoren, 2006). Figures like Briquet connected "hysteria" to childhood trauma, while Edouard Stierlin examined trauma's effects following disasters (Van der Kolk, 2007). However, these findings were not yet fully conceptualized as trauma-related stress. Early psychiatry often misunderstood the mind-body relationship in trauma, attributing symptoms to moral weakness or malingering. Terms like "railway spine" reflected an early recognition of physical and psychological trauma following accidents but lacked comprehensive theoretical grounding.

The aftermath of World Wars I and II marked a turning point, exposing entire populations to extreme trauma. These experiences prompted deeper inquiry into the origins and consequences of trauma, ultimately laying the groundwork for contemporary understandings of PTSD and complex trauma (Van der Kolk, 2007; Jones & Wessely, 2006).

Van der Kolk (2003) highlights how traditional psychiatric diagnoses often overlook how trauma disrupts early development, leading to misdiagnosis of MH conditions that fail to address the trauma itself. Early experiences shape a child’s worldview and influence future behaviours and relationships (Bowlby, 1969). Trickey and Black (2000) note that trauma from a single event can lead to both immediate behavioural changes and delayed psychological effects. In adulthood, trauma is associated with a heightened risk of persistent MH difficulties (McLaughlin et al., 2017).

Experiences of early trauma and ACEs have been linked to long-term health consequences. Research has shown that individuals exposed to ACEs are at greater risk of learning and behavioural difficulties, obesity, and other chronic health issues that extend into adulthood (Burke et al., 2011). Psychological consequences may include increased drug use, suicidal ideation, and suicide attempts (Afifi et al., 2008). These compounded risks contribute to higher mortality rates, underscoring the critical need for early intervention and support (Bellis et al., 2014).

Prevalence and Importance of Trauma

The prevalence of trauma and ACEs in the UK general population is alarmingly high, with 47% of individuals reporting at least one ACE during childhood and 9% reporting four or more (Bond et al., n.d.). In the original ACE study, Felitti et al. (1998) found that approximately two-thirds of participants had experienced at least one ACE, with over one in five (20%) reporting three or more. These early adversities correlated with a range of health conditions, including obesity, depression, substance use, and cardiovascular disease. This foundational research launched a large body of work examining the lasting effects of early trauma and positioned ACEs as a major public health concern (Hughes et al., 2017; Anda et al., 2006).

While population-level data on trauma among people living with obesity (PLwO) remains limited, numerous studies suggest significantly higher rates of childhood trauma among PLwO compared to individuals in lower weight categories (Mundi et al., 2021; Wiss & Brewerton, 2020). For example, Özer and Yilmaz (2024) found that 53.8% of individuals with obesity reported childhood trauma, compared to 32.8% of those without. Notably, 50% of participants with obesity reported physical neglect, compared to just 22.4% in the non-obese group. These findings reinforce earlier evidence that trauma, especially neglect and emotional dysregulation, may be disproportionately prevalent in PLwO and should be considered in assessment and treatment planning.

Clinically, the significance of this link lies in how trauma contributes to patterns of emotional dysregulation and maladaptive coping. Trauma, particularly during early development, disrupts the hypothalamic-pituitary-adrenal axis (a communication network that is a part of the body’s stress response system) and increases chronic stress, which can manifest in behaviours such as emotional eating (Danese & Tan, 2014; Tomiyama, 2019). Longitudinal research shows that the severity and accumulation of ACEs not only predict obesity but also its degree, further demonstrating the cumulative health impacts of trauma (Williamson et al., 2002; Hemmingsson et al., 2014). These insights emphasise the need for trauma-informed approaches within obesity care models.

Psychological theories of Trauma

Psychological theories offer frameworks for understanding how trauma shapes MH and behaviour. These models inform therapeutic practice by explaining both cognitive and relational consequences of traumatic experience.

Cognitive theory proposes that trauma disrupts foundational beliefs about safety, control, and self-worth, resulting in maladaptive patterns such as overgeneralization, catastrophic thinking, and persistent negative self-appraisal (Ehlers & Clark, 2000). These cognitive distortions maintain trauma symptoms, including intrusive thoughts, hypervigilance, and avoidance. Trauma-focused CBT has shown strong efficacy in addressing these patterns by restructuring thought processes and improving cognitive resilience (Beck et al., 2015; Cusack et al., 2016).

Attachment theory, developed by Bowlby (1969), focuses on how early caregiving relationships shape emotional regulation, self-concept, and interpersonal functioning. Inconsistent, neglectful, or abusive caregiving environments can lead to insecure attachment styles and increase vulnerability to maladaptive behaviours, including BE. Research has found that individuals with histories of attachment-related trauma are more likely to engage in disordered eating as a coping mechanism during periods of distress (Agüera et al., 2020). This is particularly relevant in the context of obesity and EDs, where insecure attachment has been linked to poor emotional regulation and reliance on food for comfort (Burton & Abbott, 2019).

Taken together, these psychological frameworks highlight the importance of addressing both cognitive distortions and relational vulnerabilities. Integrating cognitive and attachment-based approaches provides a more comprehensive understanding of trauma's long-term effects and supports the development of holistic, trauma-informed interventions.

BINGE EATING (BE) & BINGE EATING DISORDER (BED)

Defining BED

Given its association with both obesity and trauma, understanding the characteristics of BED further contextualises the complexity of obesity. BED is often confused with bulimia nervosa (BN) due to their shared binge eating features, so a clear definition is essential. According to the DSM-5, BED is defined by recurrent episodes of binge eating, where an individual consumes an unusually large quantity of food within a discrete period (e.g., two hours), accompanied by a sense of loss of control. These episodes are marked by distress and occur without regular purging behaviours. Although not part of the diagnostic criteria, secretive bingeing is strongly associated with BED (Lydecker & Grilo, 2019; Lydecker et al., 2019; Perelman et al., 2023).

A historical understanding of BED – becoming an ED in its own right

BED was initially classified as a subgroup of BN, given the shared psychopathological features (Hay et al., 1996). Both conditions include recurrent bingeing, body dissatisfaction, and high rates of comorbid mood disorders (Latner & Clyne, 2008). However, research in the 1990s and early 2000s highlighted important differences: individuals with BED were typically more overweight, had a later age of onset, and higher rates of substance misuse (McCann et al., 1991; Spitzer et al., 1992; Hays et al., 1996). These distinctions contributed to its formal recognition in the DSM-5. Some studies questioned the clarity of this distinction, noting overlaps in bingeing behaviour regardless of purging (Wonderlich et al., 2009; Myers & Wimans, 2014). Still, the core psychopathology of BED appears more closely linked to the BE itself rather than body size, especially since weight loss interventions can exacerbate BE symptoms. This supports the idea of obesity as a consequence rather than a cause (Latner & Clyne, 2008). Spitzer and colleagues also found BED to have a higher lifetime prevalence (that is, the proportion of a population who have met diagnostic criteria for the condition at any point in their lives) than AN and BN combined, adding further support for its inclusion as a distinct ED (Spitzer et al., 1992).

Prevalence & Importance of BED

Accurately estimating BED prevalence has been difficult due to underdiagnosis, limited awareness, and the stigma that EDs primarily affect underweight individuals (Smith & Goldschmidt, 2024). In the UK, BED is estimated to affect approximately 725,000 individuals (National Institute for Health & Care Excellence (NICE), 2019), though the true figure may be higher. If around 28% of UK adults live with obesity, and studies suggest that 25–50% of those individuals exhibit BED symptoms (De Zwaan et al., 1994; Hay et al., 1996; Herpertz et al., 1998), the scale of the issue is likely underestimated.

BED is a multifactorial condition involving genetic, psychological, environmental, and sociocultural influences. Some studies have shown that individuals with a family history of EDs or obesity have a heightened risk of developing BED (Trace et al., 2013). While research on BED genetics remains mixed, irregularities in brain chemistry, particularly dopamine and serotonin have been implicated in compulsive eating and appetite control (Yilmaz et al., 2015; Kessler et al., 2013).

BED is strongly associated with both obesity and trauma. Studies report that obese individuals with BED experience higher levels of ACEs than their obese counterparts without BED (Amianto et al., 2018; Grilo & Masheb, 2002). A systematic review of 70 studies found elevated rates of abuse, neglect, and bullying among individuals with both obesity and BED compared to controls (Palmisano et al., 2016). These early experiences often contribute to emotional dysregulation, low self-esteem, and body dissatisfaction. Many individuals use food as a coping mechanism to manage difficult emotions such as anxiety, depression, and loneliness (Heatherton & Baumeister, 1991).

Psychological theories of BE

Several psychological theories help explain the development and maintenance of BE/BED by examining emotional, cognitive, and interpersonal mechanisms.

Emotional Regulation Theory posits that BE functions as a maladaptive strategy for coping with negative emotions. Although it may temporarily relieve distress, it often reinforces a cycle that contributes to weight gain and psychological harm (Heatherton & Baumeister, 1991).

Cognitive Behavioural Theory (CBT) suggests that negative core beliefs and cognitive distortions, often shaped in early life, lead to disordered thinking around food, self-worth, and body image (Fairburn et al., 2003; Burton & Abbott, 2019). This can prompt restrictive dieting, bingeing, and guilt, forming a cycle that CBT interventions aim to disrupt.

Interpersonal Theory (IPT) emphasises the impact of relational difficulties, such as grief, social isolation, and poor communication, in triggering BE (Agras et al., 1995; Miniati et al., 2018). These stressors may reduce emotional resilience and increase reliance on food for comfort. IPT focuses on improving interpersonal functioning to reduce emotional distress and the reliance on disordered eating.

Together, these theories offer a multi-layered understanding of BE/BED, informing interventions that address not just eating behaviours but also the underlying psychological, emotional, and social dimensions.

Connecting Obesity, Trauma & BED

To understand the interconnectedness between obesity, BE, and trauma, cognitive and attachment theories offer helpful insight. Early trauma can shape negative core beliefs about the self, such as feeling inadequate or unworthy, which may lead to emotional distress and maladaptive coping strategies like BE (Beck, 1976; Ehlers & Clark, 2000). While eating may temporarily soothe distress, it reinforces these beliefs and contributes to cycles of disordered eating and weight gain (Fairburn et al., 2003). Similarly, when caregiving in early life is emotionally inconsistent or neglectful, individuals may struggle with emotional regulation and turn to food for comfort (Bowlby, 1969; Mikulincer & Shaver, 2007). Over time, this coping strategy can become deeply embedded, particularly when food has been used in place of emotional connection (van Strien, 2018).

This dynamic becomes more concerning when unresolved trauma and poor emotional regulation lead to repetitive BE episodes. Without adequate coping resources, emotional eating may escalate into entrenched behaviours marked by a loss of control—eventually meeting the threshold for BED. What begins as a seemingly benign response to distress can evolve into a clinically significant pattern, underpinned by early attachment disruptions and trauma-related beliefs (Wardle et al., 2002; Agüera et al., 2020). This progression underscores the need for trauma-informed, psychologically integrative approaches in treating obesity and BE.

Subsequent research continues to affirm these theoretical links, highlighting the risks of overlooking trauma and psychological distress in the treatment of obesity and eating disorders (Danese & Tan, 2014; Gómez-Ambrosi et al., 2024; Bryant et al., 2015). When unaddressed, these factors often result in poor outcomes, frequent relapse, and deepened feelings of failure, outcomes that reinforce the very behaviours services aim to change (Wooley & Garner, 1991). Therefore, to support people living with obesity and BE effectively, it is essential to examine how UK healthcare structures are set up to respond, and where systemic limitations may be undermining long-term recovery.

UK HEALTHCARE SERVICES

The complex interplay between obesity, BE, and psychological trauma has gained increasing recognition in public health discourse, with growing evidence highlighting the negative impact on both physical and mental health. In response, UK healthcare strategies have evolved to address these interconnected issues, placing greater emphasis on trauma-informed and evidence-based approaches. National initiatives now increasingly recognise the psychological distress and trauma that often underpin some physical and mental health conditions, advocating for the integration of trauma-informed care (TIC) across services.

The NHS Long Term Plan (NHS England, 2019) explicitly endorses the implementation of trauma-informed approaches in MH services, particularly by expanding access to psychological therapies for individuals with complex trauma histories. The Improving Access to Psychological Therapies (IAPT) programme has played a central role in delivering scalable, accessible interventions for common MH conditions, including trauma-related difficulties. However, critiques of IAPT highlight its limited capacity to support those with complex trauma and comorbid conditions such as BE or EDs (Clark, 2018), reinforcing the need for more integrated and specialist services.

In parallel, tackling obesity remains a critical national priority. Public Health England's (PHE) report *From Evidence into Action* (2014) identified obesity as one of seven major public health challenges and called for population-level interventions grounded in scientific evidence. The urgency of this agenda was further amplified during the COVID-19 pandemic with the publication of *Tackling Obesity: Empowering Adults and Children to Live Healthier Lives* (UK Government, 2020), which emphasised preventative strategies, WM services, and broader public engagement. These initiatives call for coordinated national action, involving partnerships between the NHS, local authorities, and PHE (now replaced by the OHID).

While ED services commissioned by the NHS have historically prioritised restrictive-type disorders such as AN and BN, BED has remained under-recognised and inconsistently treated. Some progress has been made through the expansion of adult and adolescent community ED services within NHS England's Community MH Framework. However, BED-specific services remain underdeveloped in many regions. Although the NICE guidelines for EDs (NICE, 2017) recommend CBT-ED for BED, access often depends on local commissioning decisions and may not align with the needs of people living with obesity and BE.

Weight Management Services

WM services in the UK are structured within a nationally recognised tiered model comprising four levels (see Figure 1), designed to support individuals based on the severity and complexity of their needs. Positioned as a key component of the national strategy to address obesity, these services offer a framework for delivering interventions across primary, secondary, and specialist care settings. The tiered model aims to ensure that individuals receive appropriate support at the right level of care, with pathways that facilitate progression, if necessary, based on clinical need and response to treatment.

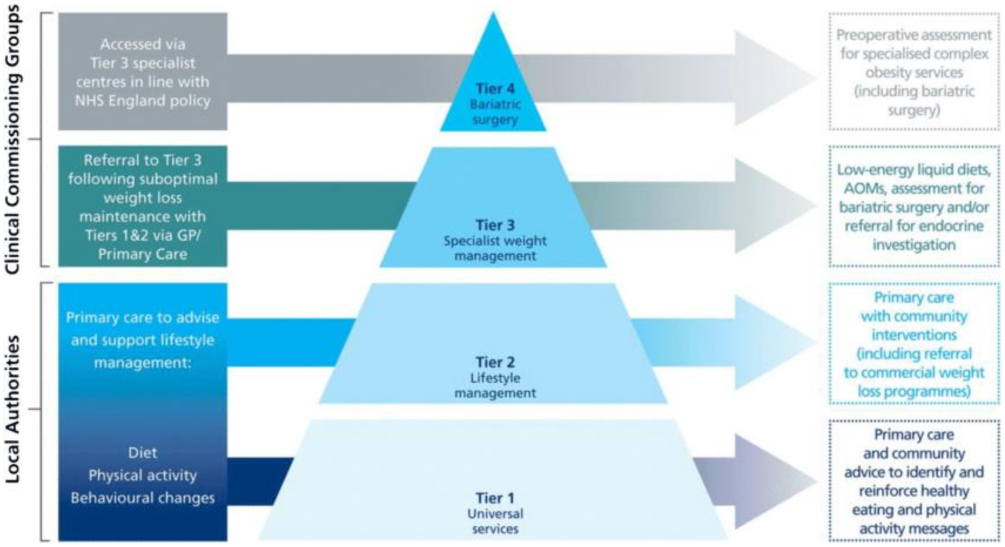

Figure 1: Tiered Weight Management Services in the UK (Hazelhurst et al., 2020)

Tier 3 Weight Management Services

Tier 3 WM services deliver specialist, multidisciplinary support for individuals with complex obesity, typically those with a BMI of ≥40, or ≥35 with significant comorbidities such as type 2 diabetes, hypertension, or sleep apnoea (NICE, 2014). Clients are referred primarily via GPs or secondary care, although prior participation in Tier 2 services is not mandatory (Coulton et al., 2015). Tier 3 services are particularly likely to engage clients with psychological complexity, including those with undiagnosed or comorbid eating difficulties.

Tier 3 services are typically delivered by a multidisciplinary team (MDT), which may include dietitians, psychologists, therapists, specialist nurses, endocrinologists, and physical activity experts. The team works collaboratively to develop tailored care plans, usually delivered across 6–12 months, with comprehensive assessments used to determine suitability and screen for comorbidities. Support may involve behavioural therapy, dietary advice, supervised physical activity, and psychological interventions such as cognitive behavioural therapy (CBT) or motivational interviewing (MI) (Wadden et al., 2012). These interventions are particularly relevant for individuals being considered for Tier 4 services, with Tier 3 acting as a preparation phase that includes pre- and post-operative psychological and nutritional support (NICE, 2014).

However, individuals displaying symptoms of BE are frequently excluded from Tier 3 services. This exclusion reflects concerns that weight loss interventions may exacerbate binge eating (Latner & Clyne, 2008; Myers & Wimans, 2014). Instead, support for BED is often redirected to ED services, even though WM teams may be better placed to detect these symptoms given their contact with individuals experiencing both weight-related and psychological difficulties.

Tier 3 services are locally commissioned by Integrated Care Boards (ICBs), which assess regional population needs and align provision with national guidance. Health needs assessments rely on data from the Joint Strategic Needs Assessment (JSNA), a statutory tool developed by local authorities in collaboration with health services, as well as sources like the Office for National Statistics (ONS), OHID, and local health records. These data are used to determine priorities and support commissioning in accordance with NICE guidance (CG189 and QS127), which outlines evidence-based criteria for effective WM interventions (NICE, 2014).

Eating Disorder services

Eating disorder care in the UK is delivered through specialised MDTs, commissioned by ICBs based on local population needs. While ICBs oversee community-based services, NHS England is responsible for commissioning specialised inpatient services, particularly for adults with severe and complex ED presentations (NHS England et al., 2019). Most services operate in the community but provide access to day patient or inpatient treatment for clients at significant physical or psychiatric risk that cannot be managed in community settings. Their MDTs typically include psychiatrists, psychologists, dietitians, nurses, and occupational therapists, working collaboratively to provide comprehensive care.

Access to ED services generally begins with a referral via the primary care providers (GPs), who identify clients presenting with symptoms indicative of an ED. Upon referral, clients undergo a comprehensive assessment to determine the appropriate level of care. Some services have implemented self-referral pathways to improve accessibility, allowing clients or their carers to seek specialist assessment without GP referral (Micali et al., 2013). Importantly, clients do not require a formal diagnosis of BED to access ED services; clinically significant symptoms identified during assessment are sufficient to initiate support, which may include receiving an official diagnosis. For this reason, this study will use the term obesity-related binge eating (O-BE), alongside BED, to distinguish its focus from obesity alone and to encompass individuals who may meet the clinical criteria for BED but have not received a formal diagnosis.

ED services support a spectrum of conditions, including BED, AN, BN, and other specified feeding or eating disorders (OSFED). OSFED includes diagnoses such as avoidant/restrictive food intake disorder (ARFID) and night eating syndrome (NES), which do not meet full criteria for AN, BN, or BED but still cause significant distress and impairment (American Psychiatric Association, DSM-5, 2013).

Treatment approaches are multidisciplinary and integrate psychological, nutritional, and medical support. Psychological interventions include CBT, family-based therapy (FBT), and enhanced CBT (CBT-E), which is tailored to EDs and focuses on addressing maladaptive behaviours and cognitions. Interventions may take the form of individual sessions, group work, or guided self-help. For BED specifically, NICE guidelines recommend a stepped approach beginning with guided self-help, followed by group therapy, and one-to-one therapy if necessary (NG69, NICE 2017).

In addition to psychological support, ED services offer nutritional rehabilitation, helping clients establish balanced eating patterns, and medical monitoring to manage physical complications arising from EDs. While pharmacotherapy is not considered a primary treatment modality, selective serotonin reuptake inhibitors (SSRIs) may be prescribed when comorbid conditions such as anxiety or depression are present (Hay & Claudino, 2012).

This structure reflects an effort to deliver holistic, needs-led care. However, the accessibility and consistency of ED services vary considerably across regions, contributing to a fragmented experience for many clients. These issues will be further explored in the next section, which addresses the critiques of both WM and ED services in the UK.

Critiques of WM & ED services in the UK

Despite their intended benefits, both WM and ED services, have been widely critiqued for limited accessibility, inconsistent provision, and failure to meet the needs of individuals with complex presentations. Systematic reviews have described WM services as “highly variable,” “underdeveloped,” and “poorly integrated,” with significant regional disparities in team composition, intervention components, and referral pathways (Brown et al., 2017; Hazlehurst et al., 2020). This has led to what is often termed a “postcode lottery,” where access to care is determined more by geographic location than by clinical need. ED services face similar criticisms. A report by Beat (Lives at Risk, 2019) highlighted stark inequalities in adult community ED services, including long waiting times, inconsistent provision, and delays in assessment and treatment. These service gaps often lead to clinical deterioration and increased risk, particularly for individuals presenting with BE or comorbid MH difficulties.

A further challenge lies in the mismatch between national guidance and local commissioning decisions. While NICE guidelines recommend evidence-based interventions for both WM and ED services, implementation depends heavily on local resources, priorities, and interpretations. For instance, although BED is recognised as a distinct diagnosis, services for BED remain inconsistent and underdeveloped in many areas, often falling between WM and ED provision. This lack of coordinated care leaves individuals with O-BE in a treatment limbo, with neither service fully equipped or mandated to meet their needs.

In addition, treatment goals across WM and ED services are often misaligned. WM interventions tend to prioritise weight reduction, whereas ED services, emphasise psychological recovery and caution against weight-focused approaches, as they may reinforce disordered eating. National guidelines reflect this contradiction: WM pathways may advocate for bariatric surgery as a first-line treatment for individuals with a BMI ≥ 50 kg/m^2 (Johnston et al., 2023), while ED guidelines prioritise psychological support for BED. Without clear pathways that integrate both perspectives, individuals with O-BE are at risk of receiving fragmented or even counterproductive care.

This issue is compounded by insufficient attention to trauma across both service types. Although TIC has been promoted in policy, national implementation remains inconsistent, with no standardised requirements across services. Trauma continues to be under-recognised in primary and secondary care settings, often due to limited training and insufficient infrastructure to support routine screening (Emsley et al., 2022). These shortcomings contribute to missed opportunities for early intervention and may undermine the effectiveness of both psychological and weight-focused treatments, particularly in cases of complex trauma.

Addressing these issues requires a coordinated national response. Standardised guidelines, dedicated funding, workforce training, and the development of integrated care pathways that consider the full psychological and physical profile of individuals with O-BE will be essential to ensuring equitable, trauma-informed, and effective service provision.

LITERATURE REVIEW

Background

O-BE, often shaped by underlying trauma, presents a complex clinical picture that typically requires support from both ED and WM services. As highlighted earlier in this chapter, the co-occurrence of these difficulties is not only common but also challenging to address within current service structures. Despite growing awareness of the need for integrated, trauma-informed approaches, there remains a lack of a unified NHS-wide strategy for recognising and addressing trauma across services (Emsley et al., 2022; Huo et al., 2023). Consequently, it is unclear how effectively existing care pathways meet the needs of people living with O-BE.

This review seeks to examine how services support this client group, with a particular focus on the experiences of HCPs. Exploring the perspectives of HCPs offers valuable insight into how complex client needs are navigated within the realities of ED and WM service provision. HCPs are well positioned to reflect on both the clinical and systemic factors that shape care delivery, including resource constraints and commissioning structures. The review prioritises studies that consider BE symptoms rather than formal BED diagnoses, in recognition of the fact that clients can access services without a confirmed diagnosis. The central question guiding this review is: *What are the experiences of HCPs supporting clients with O-BE and experiences of trauma?*

Methods

Information Sources

The literature search was conducted between July and December 2023, using the EBSCOHost and Google scholar platform, studies focusing on the experiences of HCPs and clients within weight management services were retrieved from the following electronic databases: American Psychological Association (APA) PsycARTICLES; Cumulative Index to Nursing & Allied Health Literature Ultimate (CINAHL); E-journals; MEDLINE and Google Scholar.

Terms

Table 1: Search Terms

Terms Used	Results
"Tier 3 weight management" AND staff AND experiences or perspectives or attitudes or views	292,000 (Full text search) 0 (Abstract search)
"binge eating" AND obesity AND staff AND experiences or perspectives or attitudes or views	147,901 (Full text search) 0 (Abstract search)
obesity AND experiences AND weight management	120 (Abstract only search)

Inclusion & Exclusion criteria

The titles and abstracts of the studies were read and reviewed against the following initial inclusion:

1. Studies from primarily peer reviewed journals were included, providing a good quality standard for the literature review
2. Studies using qualitative or mixed methods were included, due to the exploratory nature of the review question. However, only the qualitative responses from mixed methods studies would be considered.
3. Studies that looked at the experiences of HCPs and clients within WM, ED or primary care services.

Initially, the third inclusion criterion was studies that explored the experiences of HCPs only, working within tier 3 WM services & ED services supporting the client group of interest, however this returned no results. The final inclusion criterion stated above was used after it was amended to widen the scope and include more studies.

Research studies were excluded for the following reasons:

1. If they did not report on the experiences of HCPs and clients directly from their own data collection
2. If only quantitative data was collected.

There were no geographic, age or publication date restrictions placed on the search to ensure all relevant papers were retrieved. Results were filtered only to include studies in the English language.

Search Strategy

A systematic search and screening process was undertaken to guide the selection of relevant literature. As detailed in the PRISMA flow diagram, it depicts the progression from initial identification to the final inclusion of studies.

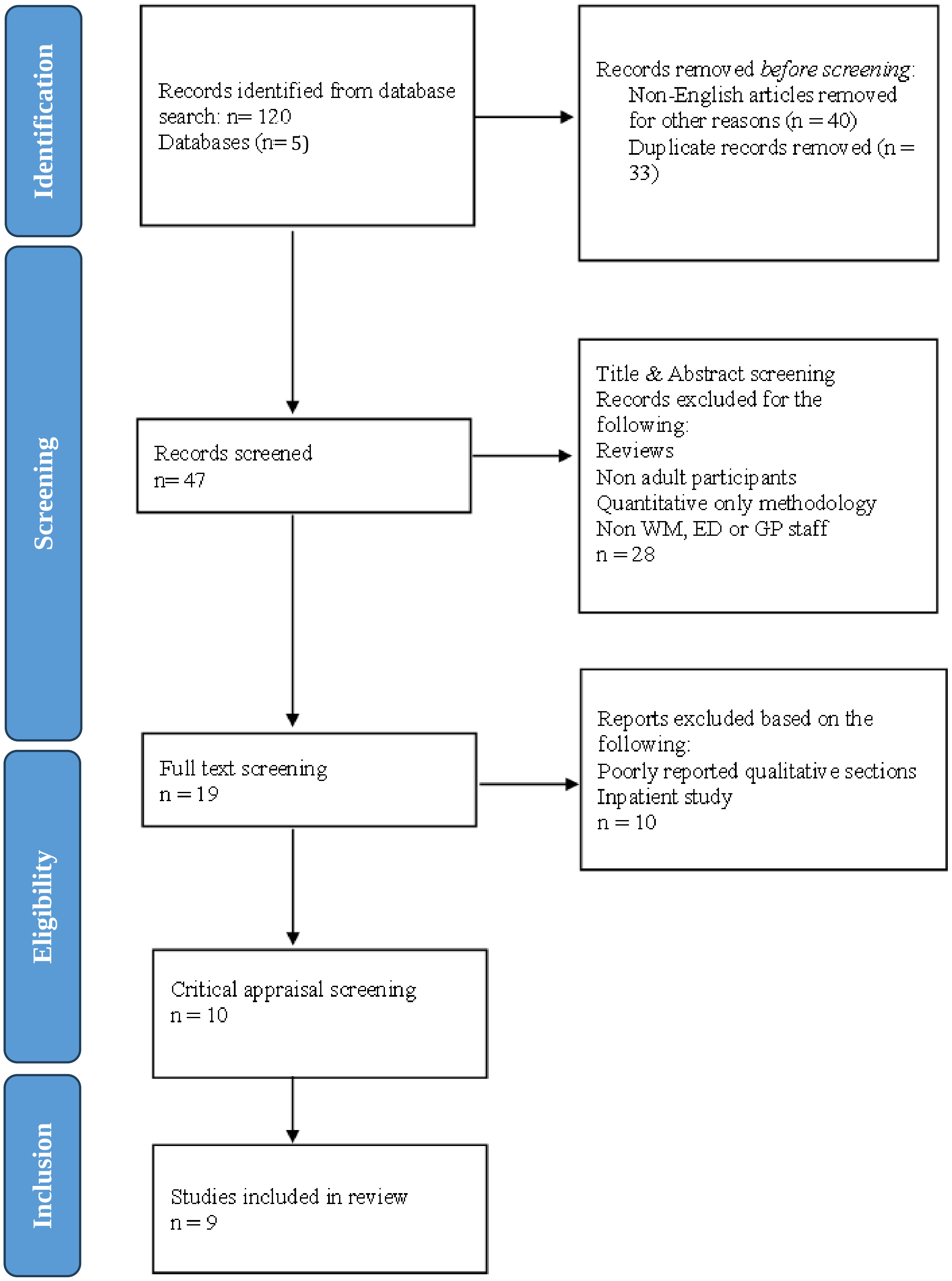

Figure 2: PRISMA Diagram of Search

Quality Assessment of Studies

The Critical Appraisal Skills Programme (CASP) checklist for qualitative studies (Brice, 2024) was used to assess the quality of included papers. The CASP tool helps determine whether study findings are valid, relevant, and applicable to local contexts. Rather than using a formal scoring framework, quality was determined based on an initial screening of the first two CASP questions: (1) 'Was there a clear statement of the aims of the research?' and (2) 'Is a qualitative methodology appropriate?'. These helped assess whether the study's goals were clearly articulated and whether qualitative methods were suitably applied to explore participant experiences.

Quality of the studies will be assessed based on the following questions:

1. Was the research design appropriate to address the aims of the research?
2. Was the recruitment strategy appropriate to the aims of the research?
3. Was the data collected in a way that addressed the research issue?
4. Has the relationship between researcher and participants been adequately considered?
5. Have ethical issues been taken into consideration?
6. Was the data analysis sufficiently rigorous?
7. Is there a clear statement of findings?
8. Is the research valuable locally?

The number of criteria met by each paper is indicated in the study characteristics table.

Data Analysis

This review utilised a thematic synthesis framework to systematically identify and analyse patterns within the data. Thematic synthesis integrates results from multiple qualitative studies to generate overarching themes and deeper insights into a particular topic (Thomas & Harden, 2008). Combining elements of thematic analysis with systematic review methods, it allows for the generation of new concepts or ‘higher-level interpretations’ from primary research findings (Braun & Clarke, 2021, p. 250).

This approach was chosen for its capacity to offer a comprehensive understanding of HCPs’ experiences working with clients presenting with O-BE and trauma. Thematic synthesis can highlight shared concerns and service challenges across contexts, generating insights that may not be apparent in single studies (Dixon-Woods et al., 2005; Lucas et al., 2007). Its structured but flexible design also makes it well-suited for informing person-centred, evidence-based interventions in healthcare settings (Thomas & Harden, 2008). However, the method is not without critique. One critique is that it can oversimplify complex qualitative findings by reducing rich, context-specific narratives into thematic categories (Barnett-Page & Thomas, 2009). There are also concerns about researcher bias during coding and interpretation, particularly in the absence of standardised procedures for theme development. Despite these limitations, thematic synthesis was considered the most appropriate method for this review given its utility in making meaningful sense of diverse qualitative evidence within applied health research.

Thematic synthesis involves three stages:

1. *Line-by-line coding* – Each study was read twice before findings were imported into MAXQDA, a qualitative data analysis tool. Each line was coded for meaning and relevance to the review question.
2. *Development of descriptive themes* – Codes were grouped into conceptually related categories to construct descriptive themes.
3. Generation of analytical themes – These descriptive themes were further interpreted in relation to the review question and used to explore shared concepts across studies.

Results

Table 2: Characteristics of Included Studies

Author	Location	Key features of sample	No. of Participants	Methodology	Data collection	Data Analysis used	Themes	Criteria met using CASP checklist (post screening)
Watkins et al 2023	UK	PLwO and staff experience of specialist weight management services	81 Participants n=57 were the experiences of PLwO and n=24 semi-structured interviews	Qualitative	Online Forum data Semi-structured interviews	Thematic Analysis	Six Themes 1. Making the first move 2. Uncertainty & Confusion 3. Resource issues 4. Respect & Understanding 5. Mode of delivery 6. Desire for ongoing support	6/8
Marwood et al 2023	UK	Services users with self-reported mental health issues, staff of WMS and commissioners	53 n= 27 service users n=9 commissioners n=17 weight management service providers	Mixed methods	Surveys and one to one interviews	Thematic Analysis (qualitative component)	Four Themes 1. Mental health and weight have a bidirectional relationship. 2. Service user understanding of, and need for, mental health support. 3. Service user experience of weight management services 4. Obesity as an identity.	7/8
Holt & Hughes 2021	UK	HCPs and PLWmO	28 n=14 HCPs n=14 patients (service users)	Qualitative	Semi-structured interviews and surveys	Themes developed from Delphi method	Five themes: 1. Knowledge & Education of HCPs 2. Public perception/stigma 3. Healthcare resources 4. Previous experience of healthcare Service design/ provision	7/8

Nederveld et al 2021	USA	Primary care staff (physicians, practice clinicians, dietitians etc)	75	Qualitative	Semi-structured interviews	Grounded theory hermeneutic approach	Three themes: 1. Clinicians & staff involved in primary care obesity management believe that addressing obesity is an essential part of primary care services 2. Providing obesity care can be challenging because many practices opt out of treatment 3. Despite the challenges many clinicians and others find treating obesity feasible, satisfying and worthwhile Four challenges 1. I don't know how to comprehensively tackle this problem 2. This is a complex, multifaceted problem 3. I simply don't get paid enough to provide weight management compared to other services and it is a huge hassle to try I am fighting an obesogenic American culture	6/8
Venkatesh et al 2021	USA	PLwO & symptoms of BE	20	Qualitative	Semi-structured interviews	Thematic Analysis	Three themes: 1. Ability to access the intervention 2. Ability to complete intervention recommendations Preferences for Intervention Features	5/8
Mazza et al 2019	Australia	GPs and general practice staff	38 n=20 GPs	Qualitative	Semi-structured interviews	Thematic Analysis	Five themes: 1. Environmental context and resources	7/8

			n=18 Practice staff				2. Knowledge 3. Emotion 4. Beliefs about consequences Motivation and goals.	
Kime et al 2018	UK	Practitioners, HCPs, clients and volunteers from healthy weight services	91 n=33 Practitioners n=9 HCPs n=41 Clients n=8 Volunteers n=7 Children	Qualitative	Focus groups & Semi-structured interviews	Thematic Analysis – framework approach	Four ‘global’ themes: 1. Staff competencies 2. Access 3. Empowerment Weight loss	7/8
Royall et al 2017	Canada	HCPs and patients	n=56 HCPs n= 34 Patients	Qualitative	Focus groups	Content Analysis	Eleven themes: 1. Raising awareness among patients developing intention 2. Screening for obesity/health risk 3. Clinical care assessment & diagnosis 4. Skill building/education/counselling 5. Ongoing support 6. Social & peer support 7. Coordination/collaboration/partnerships 8. Creating awareness among health professionals 9. Adding new expertise to the team 10. Marketing Lobbying/advocacy	7/8
Homer et al 2016	UK	Service users of Tier 4 WMS accepted for bariatric surgery	18	Qualitative	Photovoice tasks & Semi-structured interviews	Framework Analysis	Three headings: 1. Negative experiences of obesity 2. Experience of weight management services Expectations of normality	7/8

Study Characteristics

Nine studies were included in the final synthesis. Table 2 outlines their key characteristics. The focus of the studies varied, some evaluated specific local weight management programmes (Kime et al., 2018), others explored perceptions of tiered weight loss services (Marwood et al., 2023; Homer et al., 2016), while others centred on primary care staff experiences (Mazza et al., 2019; Nederveld et al., 2021). Despite these differences, all studies sought to understand the perceptions and experiences of their participants.

There were inconsistencies in reporting demographic data. Six studies reported on gender (Watkins et al., 2023; Mazza et al., 2019; Marwood et al., 2023; Royall et al., 2017; Homer et al., 2016; Venkatesh et al., 2021), while only three reported on ethnicity (Watkins et al., 2023; Venkatesh et al., 2021; Marwood et al., 2023). Consequently, comparative demographic analysis across all studies was not feasible. In those reporting this data, participants were predominantly White/Caucasian and female. Only three studies acknowledged the under-representation of the male perspective (Marwood et al., 2023; Watkins et al., 2023; Venkatesh et al., 2021).

Three studies included both HCPs and clients: three focused on HCPs alone, and three on clients only. Among studies detailing participant roles, most participants were female. This gender imbalance was noted as a limitation in several studies, suggesting a need for further research exploring male perspectives. Of the six studies including HCPs, only four specified participant roles or disciplines (Nederveld et al., 2021; Royall et al., 2017; Watkins et al., 2023; Mazza et al., 2019). The remaining studies referred to participants broadly as HCPs, limiting insight into how professional roles and service contexts may shape HCPs' experiences.

Four studies were conducted outside the UK (Nederveld et al., 2021; Venkatesh et al., 2021; Mazza et al., 2019; Royall et al., 2017). Health system differences, particularly in primary care funding models, influenced service challenges across contexts. In Australia, the US, and

Canada, barriers were more evident in primary care, whereas in the UK, challenges emerged at the secondary care level due to variable availability and commissioning of specialist services in their local area.

Sample sizes varied, ranging from 18 (Homer et al., 2016) to 81 participants (Watkins et al., 2023). Larger samples often utilised focus groups or surveys in addition to or instead of interviews. While qualitative studies typically involve smaller samples (Guest et al., 2006; Braun & Clarke, 2013), because larger samples may limit the depth of interpretive analysis. However, smaller samples tend to allow richer, more nuanced understanding, aligning with the hermeneutic principles that underpin qualitative inquiry.

Methodological considerations

All but one study used qualitative-only methodologies; Marwood et al. (2023) employed a mixed-methods approach. Reflexivity, a cornerstone of qualitative rigour, was largely absent. Only Royall et al. (2017) mentioned researcher-participant relationships, but this was addressed briefly and lacked critical reflection. Ethical considerations were also under-reported. Although all studies noted ethical approval, none offered reflection on the potential emotional impact on participants, especially in studies concerning BE and mental health.

Analytical Approaches

Thematic analysis was the most commonly reported method, used in three studies (Kime et al., 2018; Venkatesh et al., 2021; Watkins et al., 2023). Other approaches included grounded theory (Nederveld et al., 2021), content analysis (Royall et al., 2017), Delphi methodology (Holt & Hughes, 2021), the Theoretical Domains Framework (Mazza et al., 2019), and framework analysis (Homer et al., 2016). Two studies did not specify the analytical method used, despite describing their design as qualitative. Most studies provided some detail on their analytical processes, though depth varied. Marwood et al. (2023) and Holt & Hughes (2021) offered the least transparency regarding their analytic approach.

Synthesis of findings

Four analytical themes were developed from the data synthesis: (1) The complexities of obesity are acknowledged, but help seeking remains a challenge; (2) ‘The gatekeepers of services’ become unwitting barriers to accessing services; (3) HCPs grapple between feelings of frustration and sympathy when working with the client group; (4) Client experiences significantly impact engagement and intervention outcome.

Please note the term ‘patient’ was often used in the studies so that term will be used within the synthesis of findings, outside of this section, the term ‘client’ will be used.

The complexities of obesity are acknowledged, but help seeking remains a challenge

Obesity is widely recognised as a multifaceted condition, often interwoven with MH challenges. However, the lack of adequate psychological support remains a critical barrier to effective intervention. Several studies emphasised the importance of addressing emotional and MH difficulties before tackling weight-related behaviours, as unresolved psychological distress often perpetuates harmful cycles (Marwood et al., 2023; Venkatesh et al., 2021; Watkins et al., 2023; Holt & Hughes, 2021). HCPs expressed concerns about the complexity of obesity, noting that many of its contributing factors fall beyond the remit or capacity of primary care (Watkins et al., 2023; Mazza et al., 2019; Nederveld et al., 2021).

Help seeking was often hindered by stigma. Six studies discussed stigma, but Holt & Hughes (2021), Marwood et al. (2023), and Homer et al. (2016) explored this most deeply, highlighting the internalised shame and cultural stigma experienced by patients. Despite generally sympathetic attitudes toward PLwO, both patient and HCP participants recognised the detrimental impact of stigma on help seeking. Patients described themselves as ‘*a* *failure'*, '*weak and pathetic'*, and '*at fault'*. These views were sometimes reinforced by stigmatising attitudes among HCPs, contributing to reduced help seeking, particularly from GPs, who are the main referrers to WM services.

While stigma acted as a barrier, the presence or deterioration of physical health comorbidities often served as a catalyst for help seeking. All nine studies explored motivators for accessing support, with conditions such as gallbladder dysfunction (Watkins et al., 2023) and sleep apnoea (Homer et al., 2016) making it easier for patients to initiate weight-related discussions indirectly.

'The gatekeepers of services' become unwitting barriers to accessing services

This theme emerged from the relational experiences between patients and HCPs. Participants in both groups frequently cited a lack of awareness of WM and other appropriate services, which hindered referral from primary care. Limited awareness extended from commissioners-participants (Watkins et al., 2023) to frontline staff in primary care (Mazza et al., 2019; Royall et al., 2017; Holt & Hughes, 2021).

Training disparities between primary care providers (i.e. GPs, practice nurses) and specialist WM staff were greater than anticipated, and this gap was viewed as problematic (Nederveld et al., 2021; Mazza et al., 2019; Holt & Hughes, 2021). As a result, PLwO.,' were often misdirected to inappropriate services, or not referred at all (Royall et al., 2017; Mazza et al., 2019). Several studies noted that insufficient training and experience left some HCPs feeling unprepared to initiate conversations about obesity. Concerns about embarrassing patients or damaging rapport contributed to hesitancy in raising weight-related issues (Mazza et al., 2019; Nederveld et al., 2021). Others cited time pressures and a lack of personal relatability: some HCPs acknowledged difficulty in empathising, admitting, for example, that they did not know 'what it's like to be overweight or to lose weight' (Mazza et al., 2019). Discussions around weight were also seen as time consuming and difficult to integrate into routine appointments (Holt & Hughes, 2021).

HCPs grapple between feelings of frustration and sympathy when working with the client group

This theme also stemmed from relational experiences, particularly from HCPs reflecting on their role in supporting patients. HCPs expressed frustration over the lack of progress in patients' weight loss, compounded by what they viewed as an 'obesogenic culture' that normalised obesity and undermined efforts to 'break the cycle' (Nederveld et al., 2021; Mazza et al., 2019). Some questioned the effectiveness of WM services altogether, perceiving them as inadequate or ineffective (Holt & Hughes, 2021).

Despite this, many HCPs expressed empathy for patients and recognised the challenges of addressing weight in clinical conversations. HCPs, especially in the Mazza et al. (2019) and Nederveld et al. (2021) studies, described concern about harming the therapeutic relationship, leading to patient disengagement. These tensions between frustration and sympathy reveal the emotional burden placed on practitioners working in constrained systems.

Client experiences significantly impact engagement and intervention outcome

This final theme focuses on the lived experience of patients navigating WM services, from referral to treatment. Patients highlighted systemic issues such as unclear referral pathways, geographical disparities in service delivery, limited resources, and socioeconomic barriers (e.g. cost of healthy eating), all of which negatively impacted intervention outcomes (Watkins et al., 2023; Kime et al., 2018; Holt & Hughes, 2021; Venkatesh et al., 2021; Homer et al., 2016; Nederveld et al., 2021).

Patients detailed structural and social barriers to intervention completion and accessing services. Highlighting frustrations with treatment wait times and interpersonal experiences, as well as challenges with the cost of interventions, healthy food, and transport, even in a digital intervention context Venkatesh et al. (2021).

Patients also described a wide range of interpersonal experiences with HCPs, which significantly influenced their engagement. Negative encounters with GPs, such as perceived blame or lack of empathy, led to hesitancy in seeking referrals (Watkins et al., 2023; Homer et al., 2016). Some patients reported disappointment with HCPs within WM services, who they had expected to show more understanding of the challenges associated with obesity (Marwood et al., 2023).

Despite these challenges, seven of the nine studies reported at least some positive experiences of engaging with WM services (Marwood et al., 2023; Kime et al., 2018; Watkins et al., 2023; Nederveld et al., 2021; Homer et al., 2016; Holt & Hughes, 2021; Venkatesh et al., 2021). However, few studies discussed whether these positive experiences translated into sustained improvements in health or service engagement over time.

Discussion

The aim of this review was to explore the experiences of HCPs supporting clients with O-BE and trauma. Given the specificity of this topic, limited literature directly addressing this focus was anticipated. Initial searches yielded no relevant studies, therefore it was necessary to broaden the inclusion criteria. This involved incorporating client perspectives alongside HCPs' views and removing the requirement for explicit mention of BE symptoms or trauma. These adjustments enabled the inclusion of more relevant studies, although they somewhat diluted the specificity of the original review question.

The included studies demonstrated considerable variation in research aims, methodologies, and analytical approaches. As a result, some themes were strongly represented in only a few studies rather than consistently across the literature. For example, the intersection of psychological difficulties and obesity was explored in depth in some papers (e.g. Marwood et al., 2023; Watkins et al., 2023), while largely absent in others. This variability limits the generalisability of findings. Additionally, many studies grouped overweight and obese participants together, despite internationally agreed definitions distinguishing the two. This conflation risks oversimplifying the unique experiences of PLwO and may lead to poorly targeted interventions (Puhl & Heuer, 2009). Another inconsistency was the reporting of HCP job roles, making it difficult to determine which professionals or service settings most frequently encountered this client group.

Despite these limitations, the synthesis revealed a range of intersecting challenges and insights. Most notably, a significant gap remains between recognising the complexity of obesity and translating that understanding into effective, empathetic care. Although HCPs often acknowledged the multifaceted nature of obesity, many lacked the training or resources to support clients adequately. This reflects wider research indicating that fewer than half of doctors feel competent in supporting PLwO or referring them appropriately (Foster et al., 2003; Bourhill et al., 2021). A similar lack of training was observed within WM services, cited by some studies as contributing to inadequate support alongside clients' hesitancy to seek help. These findings align with existing research into factors contributing to high intervention dropout rates, poor long-term weight maintenance, and increasing obesity prevalence (Malterud & Ulriksen, 2011; Puhl et al., 2021).

Improved HCP training and more tailored interventions are critical to addressing these challenges. However, little is known about the factors shaping HCP knowledge and attitudes or the structural constraints that affect intervention delivery. Despite longstanding recognition of obesity's complexity, limited systemic progress has been made. Studies have been raising these concerns for several years (Metcalfe et al., 2023), suggesting broader structural deficiencies in service design, commissioning, and delivery. The gatekeeping role played by HCPs, particularly in referral processes, further complicates support. This has implications not only for access but also for the trust and transparency in HCP-client relationships. For example, in the context of referrals for bariatric surgery, HCPs' gatekeeping roles may inadvertently encourage clients to withhold information about BE or trauma to access certain treatment pathways, ultimately negatively impacting healthcare and undermining rapport & trust (Johnston et al., 2023).

Lastly, there is a notable gap in research exploring the experiences of HCPs working within ED services, particularly regarding BE treatment outcomes and dropout rates. The original research question – What are the experiences of HCPs supporting clients with O-BE and experiences of trauma? – is only partially answered by the current literature. Future studies focusing on ED service contexts and the systemic frameworks within which HCPs operate could generate deeper insights into how to better support this client group. These findings provide a rationale for the present study, which seeks to explore this gap in greater depth and contribute to the development of more effective, trauma-informed care pathways.

Limitations

This review was subject to several limitations. Due to the limited number of studies directly addressing the research question, it was necessary to broaden the inclusion criteria to incorporate studies from clients' perspectives and to remove the requirement for explicit reference to BE symptoms or trauma. While this increased the number of relevant papers, it also diluted the original focus on HCPs' perspectives. As the aim of the review was to explore HCPs' experiences, even if it resulted in fewer studies, maintaining the original focus may have allowed for a more in-depth and coherent synthesis of their specific insights. The inclusion of client focused studies introduced different aims and participant experiences, which may have skewed the thematic emphasis away from service provider perspectives.

Further limitations were evident in the characteristics of the included studies. Most reported predominantly female participants, with a notable lack of male perspectives across both HCP and client groups. This imbalance may contribute to a gender biased understanding of obesity-related experiences and support needs. Similarly, there was limited representation of individuals from racially marginalised backgrounds, despite growing evidence that cultural and structural inequalities influence access to care and health outcomes (Atkin & Chattoo, 2007). The omission of these perspectives restricts the transferability of findings and highlights the need for more inclusive research in this area.

The studies also varied in terms of methodological rigour, with few demonstrating reflexive engagement with the ethical complexities of their work. Discussions of researcher positionality, potential bias, and the emotional or psychological impact on participants were largely absent, particularly in studies addressing sensitive topics such as stigma, trauma, and mental health. This lack of reflection potentially limits the ethical depth and interpretive richness of the findings.

Finally, the studies were conducted across differing healthcare systems, including the UK, US, and Australia, each with distinct referral processes, service structures, and funding models. This geographical variation complicates the synthesis of findings and their application to the UK context. In the US and Australia, the primary challenges were linked to funding models within primary care, whereas in the UK, systemic disparities in commissioning and availability of secondary care services emerged as key issues (Capehorn et al., 2016; Finer et al., 2024). These differences affect the generalisability of findings and underscore the importance of examining HCPs' experiences within the specific system in which they operate.

Future Research

Future research should aim to address the gaps identified in this review by focusing specifically on HCPs' experiences within the systemic and organisational contexts that shape care for individuals with O-BE. As highlighted earlier, HCPs are well-placed to offer insights into the limitations and opportunities for improvement within current service structures and referral pathways. However, this review was limited by the inclusion of studies that focused on clients' perspectives due to the scarcity of research directly exploring HCPs' views. While this broader scope allowed for a more substantial synthesis, it diluted the specificity of the findings and limited the ability to draw conclusions about HCP perspectives alone. Future research would benefit from a more focused approach, even if this results in a smaller evidence base.

In addition, future studies should aim to incorporate more diverse demographic perspectives, particularly male participants and those from racially minoritised groups, whose voices were underrepresented in the reviewed literature. There is also a need for greater ethical reflexivity in future research, particularly in studies involving stigmatised populations, through more explicit engagement with issues such as researcher positionality, power dynamics, and participant vulnerability (Berger, 2015; Malterud, 2001). These considerations will enhance the transparency, rigour, and impact of future work in this area.

RATIONALE FOR THIS CURRENT STUDY

The growing prevalence of obesity within society has been shown to impact people's life expectancy, quality of life, and physical health significantly. Literature reveals a strong association between obesity & BE, there also tends to be symptoms of underlying MH difficulties, often rooted in ACEs and trauma. Addressing these root causes through targeted services and interventions is crucial for improved outcomes. However, despite existing service provisions across ED and WM services, the current system appears ineffective in addressing the complexity of O-BE and ensuring the long-term maintenance of intervention outcomes. Although services and studies have attempted to improve O-BE by focusing on interventions and enhancing HCP training and awareness, understanding additional gaps and challenges in service delivery and provision is important to gain a deeper understanding of what else impacts outcomes. Factors such as stigma have been identified as underlying causes affecting the efficacy of interventions and HCP training. However, further exploration into how the current systemic frameworks guiding services and interventions impact treatment outcomes and HCP training would provide a greater insight into any unaddressed issues that might be due to the current system in which these services are delivered. HCP are well-positioned to provide insights into the gaps and challenges they face within services and suggest effective ways to better support this client group, whilst considering the constraints of resourcing and commissioning systems. Lastly, to the best of the researcher's knowledge this is the only study in the UK that explores the experiences of HCPs working within Tier 3 WM & ED services, supporting people with O-BE.

Primary Aim:

To understand how Tier 3 WM services can better support people living with obesity related BE and experiences of trauma, and what challenges they encounter supporting this group?

Research Questions:

Reflecting on some of the aforementioned barriers to service delivery, the following research questions will be the focus of this study:

1. How effective or beneficial are the current services? Are they meeting the needs of this client group?
2. What are the gaps and challenges in service delivery/provision for this client group?

CHAPTER TWO

METHODS

CHAPTER OVERVIEW

This chapter aims to provide an outline of the methodological process for this study. It will first present the ontological stance of the researcher, the epistemological position of this study and a reflexive positionality statement, with the hope to provide a greater understanding to the reader about the origins of the chosen topic. It will then demonstrate how the method and design was selected from the philosophical position. It will detail the analysis, procedures, participant related information and ethical considerations.

EPISTEMOLOGICAL POSITIONING

Ontological position

Taking some time to identify the ontological and epistemological position of the researcher provides a foundational basis for a robust study, alignment between the belief system underpinning the research approach and research question is a pre-requisite to rigorous research (Teherani et al., 2015).

Ontology is the study of 'what is' (Crotty, 1998), Hiller (2016) elaborates further, that it is the study of being and the nature of existence, simply put ontology poses the question 'what is out there?' and in research is asks 'what are we studying?'. Understanding the ontological position in research is important because ontology is interested in claims about existence, which impacts epistemological positioning and overall affects what is researched and how it is researched (Bryman, 2016). Ontological positioning can be categorised in two ways, the first uses a spectrum between realism and relativism where theoretical perspective can be placed anywhere between the opposing ends (House, 1991). Realism is based in the philosophical belief that there is a single objective reality that exists independently of thoughts and beliefs. On the other end of the spectrum, relativism is based on the belief that reality is a subjective experience that is socially constructed and therefore there are multiple realities which are subject to change (Levers, 2013; Denzin & Lincoln, 2005; Al-Ababneh, 2020). The second way categorises ontology into four schools of thought: positivism; interpretivism; critical realism & pragmatism. Positivism and interpretivism sit on opposite ends of the spectrum, positivism reflects realist beliefs and interpretivism reflects relativists beliefs. Critical realism and pragmatism sit somewhere in the middle of the spectrum incorporating both realist and relativist ideals.

Critical realism has its basis in realist philosophy which can be divided into two types: direct realism and critical realism. Direct realism remains close to its empirical roots of objectivity and scientific enquiry. Whereas critical realism posits the interpretation of the objective reality is down to social conditioning and how the world is experienced (Al-Ababneh, 2020).To further expand on this, critical realists believe there is a distinction between the observable world (things we can see and measure) and the real world (things we cannot see), and that the observable world is shaped by the real world. This can be further understood through these three concepts the empirical (the things we can see), the actual (the processes and experiences we can’t see) and the real (the underlying structures and mechanisms that underpin the empirical). Critical realists believe that it is in the recognition of all three concepts that a greater understanding of world is achieved. Therefore, from an ontological perspective critical realists believe that the underlying structures and mechanisms are the real world and are independent from thoughts and experiences.

Epistemological position

Epistemology is concerned with how we know what we know, what justifies us in believing what we believe and what standards of evidence we should use in seeking truths about the world and human experience (Audi, 2010). For clarity, a helpful example could be to think about the ontological position on the earth being round. Epistemology would look at the knowledge of the earth's spherical shape, how is it known, justification of belief and what evidence should be used to know if the earth is round. There are three main types of epistemologies: objectivism (meaningful reality is separate to social actors); constructionism (meaning is derived from human experience and engagement) and subjectivism (meaning comes from anything except the object) (Al-Ababneh, 2020). From an epistemological perspective critical realists, tend to sit between objectivism and constructionism, because they believe that difference between all three of its concepts (empirical, actual and real) are valuable and must be acknowledged in order to understand the social world (Sayer, 2004; Madill et al., 2000).

This study lends itself well to the critical realist paradigm, firstly the *empirical* observable parts of O-BE and trauma are the BMI, BED diagnostic criteria, BE symptoms and mental health problems. Secondly, we aim to explore the unseen processes such as healthcare provision, service delivery, cultural & societal norms the *actual* elements that influence the empirical. Lastly, the data in this study may reveal or explore the underlying structures and mechanisms that perpetuate the observable parts.

Researcher's Self-disclosure

Axiology highlights the role of values in research, acknowledging that studies are inherently value-laden due to the researcher's biases and cultural perspectives (Al-Ababneh, 2020; Saunders et al., 2009). In line with the critical realist paradigm underpinning this study, it is essential to declare and consider potential researcher bias to uphold the study's integrity. My choice of research topic, focusing on O-BE and the complex client group at its center, is rooted in my personal experiences.

I am a Black African female in my thirties, pursuing a Doctorate in Clinical Psychology while working as a trainee clinical psychologist. I have struggled with my weight since childhood, crossing into obesity during my teenage years, although I only began associating myself with the term in my twenties. Today, as a visibly obese woman, the label feels exposing and finite ever present in medical records, interactions with the world, and even in solitude. My personal journey includes trying various weight loss strategies—calorie restriction, low-carb diets, ketogenic and vegan lifestyles, gym routines, jogging, and personal training. While some led to significant weight loss, none resulted in sustained long-term success. Reading literature on the guilt, shame, and self-blame experienced by obese individuals resonated deeply with my own struggles. Years ago, my GP referred me to a Tier 2 WM service, where I attended sessions on healthy eating and exercise. However, I left feeling disappointed, as the intervention merely reiterated public health messages I already knew, offering no new insights or tailored support.

Beyond my personal experiences, I bring professional insights from over seven years of NHS service, working across various healthcare settings. This dual perspective raises questions about which identity might dominate during the course of this study and how it could influence the findings. Initially, my motivation for this research stemmed from a desire to better understand the systems supporting individuals like me. However, delving into literature on obesity and trauma, and their wide-ranging impacts was deeply personal, prompting open discussions with my supervisor, peers, and family about the emotional toll of the work. Through this study, I have come to recognize the systemic challenges faced by HCPs in supporting this population, challenges I had not previously considered, as my personal narrative had focused on perceived inadequacies within myself or the interventions.

As a visibly obese woman conducting interviews, I also reflect on how my appearance might influence participants' responses. I am acutely aware that participants may form assumptions about my motivations or personal connection to the research topic based on my physical appearance. This could lead to responses being shaped by a desire to appear empathetic or overly cautious to avoid causing offense, potentially altering the authenticity of their accounts. Alternatively, participants might feel more comfortable sharing candid views, perceiving me as someone who might relate to or understand their perspectives on obesity-related challenges.

This dynamic could introduce both strengths and limitations to the research. On one hand, my lived experience might foster a sense of shared understanding and rapport, encouraging participants to delve deeper into their thoughts and experiences. On the other hand, it might create an implicit bias in how participants frame their responses, particularly when discussing sensitive topics such as stigma or systemic shortcomings in services. Additionally, I reflect on how my own reactions during interviews might be influenced by my experiences. I may unconsciously align with certain narratives or feel more attuned to discussions that resonate with my personal story, which could inadvertently shape the direction of the interview. Recognizing this, I have made a conscious effort to approach each interview with an open mind, allowing participants to lead the conversation and ensuring their voices remain central. These reflections highlight the importance of balancing transparency and neutrality. To mitigate potential biases, I have incorporated regular reflexive practices to identify and address sensitivities, biases, and assumptions. I also maintained a journal to document my thoughts and feelings after each interview. This helped me critically evaluate how my positionality might be influencing the research process and allows me to remain accountable to the study’s aim and to authentically represent participants’ experiences. Moreover, I have sought feedback from my supervisor to ensure that my interpretations are grounded in the data rather than my own experiences.

This reflexive statement aims to provide transparency and openness about my motivations for undertaking this study, my approach, and how my personal and professional experiences shape my research lens. By intertwining these perspectives, I hope to contribute meaningful insights into the systemic barriers and opportunities for supporting individuals living with O-BE.

Methodology Rationale

Qualitative methodology's primary concern is the exploration of individuals and how they perceive and interpret the social world (Roberts, 2014). Therefore holding in mind the aims of this study and the critical realist approach, the qualitative methodology would be most appropriate for this study, for the following reasons. Critical realism is interested in uncovering the underlying mechanisms and unseen processes that impact the observable events, in this case, how underlying mechanisms impact those being supported by healthcare services for obesity related binge eating. Both approaches highlight the importance of context when understanding experiences or social problems and qualitative can involve detailed contextual analysis (Sandelowski, 2004; Roberts, 2014).

A quantitative methodology would have been unsuitable for this research because its typically traditional realist perspective on reality does not accommodate the exploration of participants' individual and shared experiences and the meanings behind them, nor does it allow for the consideration of differing viewpoints.

Unlike traditional realist approaches, critical realists believe that causality can be gleaned from non-empirical approaches, and like qualitative methods causality is complex, multi-layered and contextually derived (Braun & Clarke, 2021). Critical realists acknowledge researcher bias and influence on studies and qualitative methods allow for a researcher reflexivity through the research process (Al-Ababneh, 2020), which is particularly pertinent for this study. Like quantitative methodology, qualitative methods have multiple methods for data collection: interviews; focus groups; ethnography; participant observation; journal analysis (Sofaer, 2002). All of which are designed to gather rich and contextualised data in the hope to understand complex social experiences.

DESIGN

The literature review in the preceding chapter revealed there is little to no research on this particular subject area therefore the research aim of this study is novel, therefore an exploratory research design would be best suited to this study. In rudimentary terms, exploration is the process in which we study, examine, analyse and investigate something (Stebbins 2001), however in some way all research designs possess those characteristics. Exploratory research design is primarily concerned with bringing to light and new knowledge where there is a gap in the literature or a lack of research on a particular group or topic area (Swedburg 2020 p.17). The explorative designs suit the open-ended nature of the research questions for this study. The questions are designed to explore rather than test for specific predications or hypotheses.

Despite its suitability to this study there are some challenges that come with an exploratory research design, firstly there is little to no research for the researcher to draw from or build on, which can require a degree of flexibility in the structure of the research and a need to maintain focus on the research question to avoid tangential aims that veer far away from the subject area. There is also the issue of data overload, due to the open-ended nature of the design it can result in a large amount of data (Sofaer, 2002; Tenny et al., 2022), however this can be mitigated by focused questions during data collection to ensure as much as possible relevant information is gathered. Lastly, the outcomes of the data could be unpredictable and or inconclusive (Tenny et al., 2022), to mitigate this researcher adaptability is important, as it may require a pivot in research focus as new insights emerge during the data collection process.

Sampling

As the primary concern of exploratory research is to bring to light new knowledge and understanding, sampling is not focused on being statistically representative but to gain greater insights into a particular issue or population. This study has engaged two sampling methods, purposive sampling and snowball sampling. Purposive sampling is where the researcher selects participants based on specific characteristics that are relevant to the research question, this is often employed in exploratory research of fringe populations (Naderifar et al., 2017). For this study in particular this type of sampling allows for the researcher to select participants that have sufficient experience and knowledge within the healthcare settings that will most likely encounter the client group of interest. Additionally, as highlighted within the literature review, awareness of the challenges people with O-BE faced is uncommon amongst HCPs outside of WM & ED services. Therefore, targeting participants specifically within these services is necessary to achieve the objectives of the study. There are some concerns with the method, as it can be subject to researcher bias & influence, there is limited generalizability, difficulty with replicability and the potential for missing variability (Etikan et al., 2016). Some of these issues can be mitigated through establishing a clear and detailed inclusion & exclusion criteria and selecting participants that represent a wide range of organisations, geographical regions, disciplines and demographics. Additionally, engaging in reflexive practices throughout the recruitment, data collection and analysis process and declaring any potential biases. However, the theoretical framework for this study, does not view limited generalizability and replicability as flaws in the research process. It acknowledges researcher bias as part of the process in gaining rich in-depth insights into the underlying mechanisms of the social world.

Snowball sampling is where current study participants recruit potential future participants from among their colleagues or acquaintances that work in the desired settings. This sampling can be employed when recruiting in niche populations or when recruitment of participants begins to wean during the recruitment process. Some of the concerns with this method is that it can lead to sampling bias and a homogeneous sample (Parker et al 2019). In the case of this study, it could mean the majority of participants are from one particular organisation, service or team, or the sample could be concentrated in one geographical region. Purposive sampling and the researcher access to participants' job and demographic information, will be able to mitigate sampling bias, because if participants appear to be concentrated in one area or characteristic the researcher will be able to pivot recruitment to ensure a more heterogenous sample. Although snowballing will not be the primary sampling method it is important to note that it may be required to gain sufficient data for the study.

Data collection

Given the research questions, theoretical framework of this study, interviews were preferable than other forms of data collection such as focus groups and open-ended surveys. Interviews allow time for deeper exploration of the individual's perspectives & experiences, whilst facilitating a confidential space for them to speak openly and candidly. For these same reasons the use of semi-structured and unstructured interviews is preferable because of the level flexibility and adaptability is allows during the interview, such as being able to modify questions or ask follow-up questions based on what might be coming up in the data (Sofaer, 2002; Tenney et al., 2022). The use of semi-structured interviews is a common form of data collection within qualitative research (Harvey-Jordan & Long 2001) and in thematic analysis (Braun & Clarke 2013). Using a series of open-ended questions provides opportunities for themes and sub-themes to develop without imposing a rigid structure on the responses. Semi-structured interviews are particularly advantageous for research in 'uncharted territory' where the extent of knowledge discovery is not completely known. This approach allows researchers to identify useful leads and pursue them, thereby facilitating a deeper and more nuanced understanding of the research topic. However, unlike unstructured interviews, it allows for the researcher to ensure the interview remains focused in the topic, rather than veering off into irrelevant areas.

PROCEDURE

Recruitment process

The University of Essex, and the Health Research Authority (HRA) granted ethical approval for several NHS and non-NHS sites across England (see appendices I & III). During the HRA ethical application process, the researcher was required to make contact with NHS & non-NHS sites to express an interest in recruiting employees to the study. Several sites were contacted via an email (see appendix VIII) sent to their designated research & development (R&D) teams, they were also sent a copy of the thesis proposal. Five NHS sites and four non-NHS sites were contacted, sites were chosen based on whether they provided Tier 3 WM services or ED services. Additionally, sites were limited to England only due to the jurisdictional differences across the four devolved nations. All five NHS sites agreed for the study to be advertised to staff for recruitment pending HRA approval, only two non-NHS sites responded, one agreed for recruitment amongst their staff (pending HRA approval) and the other site declined on the basis they did not offer therapy and do not employ HCPs (although this had not been clear on their website). The remaining two non-NHS sites failed to respond despite several attempts to contact them via email.

Once approval was granted the R&D teams of the sites were informed of the approval, and they were sent the approval letter. Three of the research teams requested an information pack including a copy of the final application form; the HRA approval letter (appendix I); participant information sheet (PIS) (appendix V) and the consent form (appendix VII). Two of the sites took responsibility of advertising the research study to relevant service/teams within their trust. The other sites required the researcher to advertise their study to the relevant service/teams themselves. The recruitment sheet (see appendix IV), the PIS and the approval letter was emailed to relevant teams either directly, as provided by the R&D teams or service contact or sent via the R&D teams. There was also the opportunity to present the research study at the MDT meetings of two Tier 3 WM services and one ED service, attending via Microsoft Teams, a ten-minute presentation of the study was given on the background, rationale, aim and design of the study. The presentations garnered interest from potential participants who eventually consented to be interviewed. Once recruitment slowed, the research study was sent to work colleagues, to send on to suitable candidates, additionally, a snowballing sampling method was utilised and potential participants were recruited through participants who had already taken part in the study. Upon the completion of ten interviews, it was noticed several participants spoke of the impact GPs have on how the client group of interest accesses services. As referrals tend to come through the GP there has been a sense from current participants that GPs will often encounter this client group, but not fully understand how best to support them and sometimes make inappropriate referrals (this was highlighted in the literature review). Several of the participants highlighted the important role GPs could play in improving service delivery for this client group. After some consideration, the input of primary care staff was thought to be an important one which could add to the richness of the data, so it would be beneficial to recruit and interview GPs as part of this research study. An application of amendment was made to the HRA to extend the inclusion criteria to GPs, and the application was granted (appendix II). GPs operate separately from NHS trusts, usually as standalone businesses therefore there was no requirement to seek approval to advertise from them prior to the application of amendment. The study was then advertised to colleagues, acquaintances and via doctor and nurse Facebook groups.

Interview process

Once participants had expressed an interest in the study, they were emailed the PIS and the consent form to read through, if they had any questions they were to respond to me via email prior to signing the consent form. Only one participant requested further clarification regarding confidentiality and anonymization, which was clarified verbally during an online meeting. To ensure flexibility for the work-life balance of participants the option of weekday, weekends, morning, afternoon and evening interview slots were offered. Participants were also given the choice, dependant on the day, of whether to interview face-to-face or online; all participants opted to conduct their interview online. All interviewes were conducted on Microsoft (MS) Teams, according to the NHS England Transformative Directorate, MS Teams offers a secure end to end encrypted virtual means of communication suitable for NHS services. The encryption data belongs to the NHS organisation rather than to Microsoft, therefore if there is a breach in Microsoft data, the organisation' data is not compromised, additionally the use of MS Teams has been standardised across most NHS services.

Prior to the start and recording of all interviews an introduction to the research study was provided, demographic information was taken, participants confirmed their understanding of the PIS and their consent to take part and be recorded. The interviews were recorded via two means; MS Teams offers a recording and live transcription feature, which was used for all interviews. Additionally, the interviews were audio recorded on an encrypted Dictaphone, issued by the University of Essex, this offered a backup recording for the researcher, and all participants were made aware of both means of recording.

Upon completion of the interview, the participants were thanked for their time and contribution and a debrief was carried out to find out how they found the interview process, if the interview had raised any issues for them and if there was anything they thought could be improved or asked about that was not. Some expressed their interest in the results of the study and asked about the researcher's special interest in the subject area, which was briefly discussed. Two participants recommended other organisations that would be useful to speak to concerning this topic and a few participants asked if GPs would be interviewed as part of this study. None of the participants expressed any difficulties with subject area spoken about in the interview but were encouraged to speak to their supervisor or employee assistance support service, if anything arose later on. All participants were asked if they knew of potential participants who would be eligible to take part or if they would kindly send the recruitment information on to their teams and colleagues. Lastly, there were reminded they could contact the researcher via email if they had any further questions and they could be sent the final report after successful completion of the viva, if they so wish.

Materials

In order to guide the topic of the research interviews, researchers often utilise interview schedules. Interview schedules are several questions that have been prepared beforehand to serve as a guide for researchers when collecting data, allowing the researcher to ensure the participants remain on topic to increase the likelihood of collecting data relevant to the study (Braun & Clarke, 2013). The interview schedule also leaves room for other topics to arise during the interview that may have not been considered by the researcher (Choak, 2013). The interview schedule is made of two parts, the first asks questions about the participant's own experience working within services and with the client group. Then the second part asks for their perspectives on service provision and delivery as a whole, when it comes to the client group of interest. The list of questions was developed by the researcher and derived from the literature review and the research questions of this study, for example the schedule included questions such as: What are the gaps and challenges you face when supporting this client group? How effective are the current services in meeting the needs of this client group? The complete interview schedule can be found in the appendices (appendix X). A participant monitoring sheet (see appendix IX) was also developed by the researcher to collect demographic and professional information & the service context of each participant.

PARTICIPANTS

A total of 21 HCPs expressed an interest in taking part in the research study, two males and nineteen females, prior to signing the participant consent form. Upon following up HCPs to participate in the study after an expression of interest, only 15 responded to emails inviting them to read the PIS and sign the consent form. The 15 that responded were included, additionally 15 was the intended sample size. This sample size aligns with guidelines for thematic analysis, which indicate that data saturation is generally achieved with 8 to 16 participants (Guest et al., 2006; Braun & Clarke, 2013; Creswell 2014). Notably there were only female participants, despite efforts to recruit male participants through email prompts and direct recruitment messages to male HCPs. Two thirds of the sample described themselves as Caucasian (White), the rest of the sample described Afro/Caribbean, Asian, Mixed or Other Ethnicity. The majority of the sample were under the age of 44, with one participant being between 45-54 and another opting not to disclose their age. The sample represented a variety of disciplines that work within the targeted service context, although those who reported a psychology related discipline represented more than half of the sample. Two thirds of the sample either currently worked or had worked in a WM service, with the rest of the sample representing ED services or GP services. The geographical location of the sample was the most varied characteristic, with locations from across England, three participants covered services nationwide, although the majority of the locations were concentrated in the south and east of England. All participants met the minimum length of time within a service context requirement, with the shortest length of service being 6 months to the longest being 19 years (M= 6.83 years).

Inclusion & Exclusion criteria

To ensure the relevant participants were recruited the following inclusion and exclusion criteria were employed.

Inclusion criteria

The inclusion criteria were selected based on the background information, the literature review and the study objectives.

- Participants were included if they were a HCP currently working within a tier 3 WM, ED or GP service.
- Participants were included if they were a HCP who had previously worked within a tier 3 WM, ED or GP service within the last 24 months from the start of recruitment.
- Participants who met the first two criteria were then included if they had worked within the relevant services for at least 6 months. The reason for this was to ensure they had sufficient experience within these services to provide comprehensive and reflective responses to the interview questions.
- Once participants satisfied the preceding criteria they were included if they had a clinical role within the relevant services. This would include, but is not limited to healthcare assistants; nurses; doctors; occupational therapists; nutritionists; dieticians; psychologists; psychiatrists; physiotherapists, physical health specialists etc.

Exclusion criteria

Participants were excluded if their designated roles within these services were non-clinical, this would exclude but is not limited to admin; clerical; domestic or corporate staff. Participants were excluded if they had worked for less than 6 months within the relevant services.

ANALYSIS

Reflexive Thematic Analysis (RTA) is a qualitative research method designed to identify and interpret patterns or themes within qualitative data. Developed by Virginia Braun and Victoria Clarke, RTA’s key characteristics include its emphasis on reflexivity, researcher subjectivity, and flexibility in the analytic process. Reflexivity in RTA refers to the researcher’s ongoing critical reflection on their influence on the research process, including how their values, assumptions, and theoretical commitments shape the themes that emerge.

Unlike more structured forms of thematic analysis, RTA does not aim for a “detached” or “objective” analysis but rather embraces the idea that the researcher’s interpretations are central to the creation of themes. This approach also allows for a more flexible and organic process of coding and theme development, where themes are not simply “found” but are actively constructed by the researcher in dialogue with the data (Braun & Clarke, 2013; Terry et al 2017). RTA is particularly well-suited for exploring complex phenomena, as it facilitates the construction of rich, nuanced thematic narratives that reflect the researcher’s interpretations and theoretical perspectives (Braun & Clarke, 2021).

RTA aligns well with the critical realist approach, which as previously mentioned believes that our objective reality is mediated by our understanding of it within the context of our social and cultural influences (Braun & Clarke, 2013). Additionally, RTA encourages researchers to explore how social realities are interpreted and constructed through the lens of participants’ experiences and the researcher’s reflexive engagement, thereby revealing the interplay between individual experiences and broader social structures.

Despite its widespread use and flexibility, RTA has drawn several critiques. One concern is its lack of standardisation, which can lead to inconsistencies in how the method is applied and reported, particularly by researchers unfamiliar with the method, who may conflate RTA with coding reliability or positivist approaches (Braun & Clarke, 2021; Nowell et al., 2017). Additionally, RTA's emphasis on researcher subjectivity and interpretation has raised concerns around rigour and transparency, especially in contexts where external validation is expected (Terry et al., 2017). Critics also argue that the flexibility of RTA can be a double-edged sword, as it may be misapplied without sufficient reflexivity or theoretical coherence (Clarke & Braun, 2018). Lastly, because RTA does not rely on participant validation, therefore it may be viewed as less suitable in disciplines or settings that prioritise replicability or generalisability (Nowell et al., 2017).

Nonetheless, these critiques often reflect misunderstandings or misapplications of RTA rather than inherent flaws in the method itself. When applied reflexively and coherently, RTA provides a robust framework for producing rich, analyses grounded in participants' lived experiences and researcher interpretation.

Analysis Process

All interviews were audio recorded and transcribed during which all identifying information was removed or pseudonymised, in line with the PIS (appendix V) and consent form (appendix VII). Then the six-phase analytical process for RTA was followed (p. 6 Braun & Clarke 2022).

1) **Dataset familiarisation** - Braun and Clarke (2021) suggest that thorough reading of the data is essential for identifying meanings and patterns. They emphasize the necessity of being fully immersed in the data set to gain deeper insights and to make reflexive notes about the researcher's interaction with and impact on the data. To follow this guidance, a reflective diary was maintained throughout the data collection and analysis phases.
2) **Data coding** – Coding refers to the initial step of labelling data points identified in the early stages of analysis. These codes can represent various levels of analysis, ranging from descriptive to interpretative. Preliminary codes were identified using MAXQDA 24.3.0, a software programme designed for qualitative and mixed method analysis (see appendix XI). These codes were chosen and assigned to segments of the transcripts based on their relevant interest or meaningfulness to the research question. The coding process was kept broad to ensure no potentially important data was excluded.
3) **Initial theme generation** – After coding, the codes can grouped to form themes, which are concepts that provide a deeper level of understanding. A theme "captures something important about the data in relation to the research question" (p.82 Braun

and Clarke, 2006) .The initial steps of this process was carried out in two ways, firstly the MAXQDA 24.3.0 allows the user to generate databases of code patterns and frequencies in order to see what codes occur most frequently or which codes often occur together (see appendix XII). The researcher focused most on generating code patterns rather than code frequencies, the rationale for this is that frequency of codes is more indicative of quantitative research methods. Code patterns were then arranged into four groups:

a. HCPs' experiences of working within services
b. HCPs' experiences of working with the client group
c. HCPs' perspectives on how to improve services to meet the needs of the client group
d. The impact of the work on HCPs

The researcher then went through all the tables and the codes again to identify any codes that may not have occurred in a pattern but may have been of interest or relevance to the research question. Then patterns were then categorised into seven groups i.e. 'codes/patterns that directly answer the research question' and 'codes/patterns that raised new issues not considered but might be of interest' (see appendix XIII) and from this initial themes were developed.

4) **Theme development and review** – A more in-depth review of the initial themes can be conducted to ensure they are analytical rather than descriptive in nature and to ensure they represent the dataset and the key findings. This involved an iterative process that involved rearranging codes and sub-themes and cross-checking with the original data to ensure accurate reflection of the themes. The themes and sub-themes were also reviewed with the researcher's thesis supervisor to ensure they appropriately categorized the codes and that themes were relevant and meaningful.
5) **Theme refining, defining and naming –** Themes and their subthemes were refined and clearly defined to ensure they described the key findings and then they were

appropriately named to capture the core meaning of the data and to capture the attention of the reader whilst aptly informing them what to expect within the theme. This process continued on, into phase 6 the report writing stage, in writing up the findings and discussion chapters, better and more meaningful ways were found to define & name the themes.

6) **Writing up the report** – The themes were subsequently reported on in this study. They were arranged in a way to provide a clear narrative of the findings, supported by relevant excerpts from the data. The final themes and their write-up aimed to present a coherent argument in response to the research questions.

TRUSTWORTHINESS

Trustworthiness was ensured through deliberate attention to transferability, dependability, and credibility, each of which was embedded in the design, research process, and reporting of the study.

Transferability was supported through the inclusion of rich contextual detail regarding the research setting, participant characteristics, data collection procedures, and analytic approach. Descriptions of the sample demographics, recruitment processes, and setting were included to allow readers to assess the relevance of the findings to other populations or service contexts. The depth and transparency of methodological reporting means that this study could be meaningfully adapted in alternative settings, such as tier 4 bariatric services, to explore how individuals with more complex presentations and higher clinical needs experience weight-related care. Similarly, the approach could be extended to other domains, such as community mental health services, where trauma-informed care is increasingly relevant and there is a growing emphasis on integrating service user narratives into care planning and policy development (Sweeney et al., 2018).

Dependability was addressed by maintaining detailed records throughout the research process. Although RTA does not aim for replication in the positivist sense, a clear and coherent documentation of analytic decisions, coding processes, and theme development was maintained to ensure transparency and internal consistency. The stages of analysis, from familiarisation through coding, theme construction, and refinement, were reflexively documented, with researcher reflexivity acknowledged as a strength rather than a bias. This documentation contributes to a robust and transparent analytic trail, supporting the coherence and stability of the findings within the interpretive framework adopted.

Credibility was of great importance in the analytic process. In line with RTA’s epistemological stance, the emphasis was on producing themes that authentically reflected participants’ lived experiences, while also recognising the interpretive role of the researcher. Great care was taken to ensure that themes were grounded in the data and portrayed participants’ meanings accurately. This was achieved using longer, context-rich participant extracts, which allowed readers to see the nuance and complexity of individual experiences as they were expressed. By prioritising participants' voices and engaging reflexively with the data, the analysis sought to remain aligned with the ethical and epistemological commitments of qualitative research grounded in subjectivity and co-construction of meaning.

The study’s commitment to reflexive and transparent practice across all phases of the research process supports its trustworthiness.

Member checking can be commonly used in qualitative research to enhance credibility; however, it presents several challenges, particularly within methodologies such as RTA. One major critique is that member checking presumes participants are best positioned to validate the "accuracy" of findings, which assumes a fixed or objective meaning in qualitative data. However, in RTA, meaning is understood as being actively constructed through the researcher's interpretive engagement with the data, rather than directly extracted from it (Braun & Clarke, 2019; 2021). Once participants have shared their narratives, they effectively hand over the data, and the task of meaning-making becomes a reflective, analytical process based in the researcher's epistemological, and contextual positioning.

As such, the ownership of the analysis and resulting themes lies with the researcher, not the participants. The researcher draws on their reflexive insights, disciplinary knowledge, and familiarity with the broader literature to construct themes that extend beyond participants' immediate understandings (Terry et al., 2017). Returning themes to participants for validation may inadvertently suggest that there is one correct or authentic interpretation, which contradicts the core principles of RTA. Additionally, participants may interpret their contributions differently when presented with decontextualised thematic summaries, or they may feel pressured to agree with the researcher’s framing, introducing social desirability bias rather than genuine validation (Birt et al., 2016).

A final point to consider is, in sensitive research areas such as trauma or mental health, member checking may also place an emotional burden on participants, particularly if they are asked to revisit distressing experiences. In this study, this would prove not to be a significant concern, as trauma was rarely spoken about by participants and even when it was spoken about, it was not very personalised to themselves. Despite this the epistemological rationale for omitting member checking is well validated. As mentioned previously, credibility in RTA is established through reflexivity, transparency of the analytic process, and close attention to how participant meaning is represented within broader interpretive frameworks (Nowell et al., 2017).

ETHICAL CONSIDERATIONS

Consent

Potential participants were sent the PIS, which provides them with details & purpose of the study; what their involvement would entail; how the recordings and transcripts will be kept and used; confidentiality data protection information; what happens if they wish to no longer participate in the study; and the contact details of the investigator. This level of detail was to ensure participants were able to make an informed decision. Potential participants were given 7 days from when they received the PIS to decide whether they wished to take part in the study or not. If potential participants were unable to communicate adequately in spoken or written English, translation or interpreting services would be offered to facilitate communication, however this was not required during this study. A signed consent form (appendix VII) was obtained from all participants prior to the commencement of their participation. A provision was made for a participant who previously gave informed consent then lost their capacity to consent during the study, the participant would be withdrawn from the study. Data already collected with informed consent would be retained and used in the study, however no further data would be collected or any other research procedures carried out on or in relation to that participant. The participant would be informed in a letter or email that the consented transcript of their interview will be used in the study, but no further data will be collected from them. This step was not required during the course of this study.

Confidentiality

Confidentiality has been carefully considered for the purposes of this study and the protection of its participants. Interviews will be audio recorded via Microsoft (MS) Teams if conducted via video conferencing but will be audio recorded via a Dictaphone if conducted face to face. The recordings will be transcribed by the primary researcher and/or an independent professional transcriber and all identifying information and personal details will be removed and pseudonymised. All recordings and transcriptions will be stored and password protected within the primary researcher’s own personal network drive on a NHS Trust secure laptop. The transcripts will be coded within MAXQDA software and extracts from the transcripts will be used within the research paper, which will be written in MS Word. All audio tape recordings and any personal data will be destroyed within a year of the study completion and thesis viva outcome.

Risks

A risk assessment was conducted which was a requirement of the ethical process, overall there was low risk of harm towards participants. Within the interviews there will be discussions about O-BE and traumatic experiences, this could be triggering for some participants, particularly for those with lived experience. Participants will be fully brief on the study contents and the topics that may arise prior to the interview. Participants will be reminded to utilise their NHS Trust's Employee Assistance Programme contact details, and non-NHS participants will be provided with the contact details of their organisation's equivalent. Participants will also be encouraged to check in with their supervisor or manager if they are feeling upset or distressed following the interview. The researcher will also be exposed to discussions on the same topics, which may be upsetting and distressing. Therefore, debrief sessions with personal tutor and/or thesis supervisor in regular meetings are available and or when the need arises.

Burdens

It will be important to be mindful of the time it will take to complete interviews with participants, whether they complete it during working hours or in their own personal time. This is particularly important in busy services where interview time may impact service delivery or if done in their own personal time, may impact on work –life balance. Participation will aim to minimise impact for participants by limiting interviews to no more than 90 mins, it will also offer online as well as in person interviews to suit participants and reduce travel time. The researcher will be as flexible as possible to accommodate different time slots for participation and offer the opportunity to divide the interview across sessions if time is limited. Participants will not be made to feel participation is obligatory and if they decide to not continue the interview, their decision will be respected and honoured without prejudice.

Dissemination

Given the unique nature of the research and the potential significance of its findings for a traditionally underserved client group, it is crucial that the findings are widely shared once the study is completed and marked. The study will be shared with the study participants and the participating services and NHS trusts. It can also be shared with the local commissioning boards, local tier 3 WM services & ED services with the hope that there is some rethinking about service provision for this client group at a policy and a service level. Additionally, the study may be published as a journal article, tailored to meet the submission criteria of academic journals like: International Journal of Obesity; British Journal of Obesity; Journal of Eating Disorders; International Journal of Eating Disorders; International Journal of Behavioural Nutrition & Physical Activity; British Journal of Health Psychology and British Journal of Clinical Psychology.

CHAPTER THREE

FINDINGS

CHAPTER OVERVIEW

This chapter discusses the findings of the present study in relation to the research questions and aims. It will begin with a reflexive statement by the researcher during analysis then will report participants' demographic disciplines and service area. Then an analysis of the data will be presented, discussing the themes and subthemes generated from the reflexive thematic analysis. Verbatim extracts from participants are presented to illustrate the analysis and describe the experiences of participants as they have perceived them. All participants have been given pseudonyms and any identifiable information has been removed from their extracts to preserve their anonymity.

Reflexivity in Data Analysis

Throughout this study, maintaining a reflective journal proved instrumental in navigating the complexities of my intersecting identities as a researcher, HCP, and person living with obesity. This layered positioning often evoked mixed emotions, balancing professional empathy with participants and a personal resonance with the issues discussed. The interactive nature of the interviews brought these internal tensions into sharp focus, as I moved between my clinical perspective and lived experience.

During interviews, I was acutely aware of my own physical visibility as an obese woman, which I believed might influence participants' responses. Despite framing my video angel to limit potential bias, participants' comments often prompted a range of emotional reactions. While I remained professionally grounded, moments of denigrating remarks about the client group triggered heightened alertness, making me question whether such views were observed in their colleagues or personally held by the participants themselves. Despite this, engaging with the participants' narratives allowed me to empathize with the difficult position HCPs in this service area find themselves in, balancing their desire to provide holistic care within the restrictive frameworks in which they operate. This insight has also deepened my appreciation for the complexities of service provision and the emotional toll it can take on both clients and professionals. Furthermore, this reflection has been personally transformative, helping me to reframe my past experiences with WM services viewing them as reflective of systemic gaps in understanding and support. This shift has not only informed my analysis but has also inspired me to advocate for meaningful changes in service delivery that address both client and HCP needs. This process has underscored the importance of reflexivity in research, as it allows for a deeper connection between personal experiences and broader systemic insights.

Interestingly, participants exhibited distinct communication styles that could be broadly categorized in these three ways:

- passionate advocacy – participants who spoke with strong emotion and conviction, often driven by a desire to challenge stigma,
- clinical detachment – participants who tended to maintain more of an emotional distance while discussing their experience and,
- resigned pragmatism – participants who were resigned to the systemic/service challenges, often conveying a sense of weariness or learned helplessness.

These variations not only enriched the data but also highlighted the complex emotional and professional landscape within which HCPs operate. I also found that no one participant exhibited a single communication style, many exhibited 2 or 3 of the styles albeit to varying degrees, this highlights the importance of capturing qualitative data. I also felt a particular excitement when participants raised challenges or perspectives I had not previously considered, this would have been harder to capture in a feedback survey, but most importantly it affirms the value of HCPs unique insights in addressing systemic issues in service delivery and kept me hopeful for the potential impact this study could have.

However, not all interactions were as open. Some participants were reluctant to share candid feedback, citing concerns about potential repercussions—a sentiment that took me by surprise. As an HCP accustomed to providing constructive feedback, I had assumed that feedback (although not always easy to hear) is encouraged, universally welcomed and safeguarded by most organisations. This realisation highlighted my own assumptions and prompted me to reconsider the broader cultural and organisational dynamics that might stifle open dialogue, particularly in competitive environments where service contracts might be at stake.

In analysing the data, I remained deeply conscious of the need to authentically represent participants' voices, recognizing their perspectives as a vital contribution to understanding the systemic issues in WM services. This process reinforced my commitment to amplifying the voices of my fellow HCPs while critically engaging with their experiences to construct a nuanced, balanced narrative.

Participant Demographics and Professional Context

Fifteen participants participated in the study, the demographic information of participants can be found in Table 3 demographic information such as age and professional information has been grouped to preserve participants anonymity.

Table 3: Research sample demographics

Demographics		n=15
Gender	Female	15
	Male	0
Ethnicity	Afro/Caribbean	2
	Arab	0
	Asian	1

	Caucasian	10
	Mixed or Multiple Ethnic Origin	1
	Other Ethnic Origin	1
Age	18-24	2
	25-34	3
	35-44	8
	45-54	1
	55-64	0
	65+	0
	Prefer not to say	1

Table 4 offers the professional context of the sample, such as their discipline, location and the type of service they work in. Length of experience working within the target service context, ranged from 6 months to 19 years (M= 6.83 years).

Table 4: Discipline, Service and Location Context of sample

Service Context & Professional Discipline		n=15
Professional Discipline	Dietetics	3
	Physical Health specialism	1
	GPs	2
	Psychology	8
	Weight Management Specialism	1
Service Context	Eating Disorder Service	3
	General Practice	2

	Tier 3 Weight Management Service	9
	Weight Management Service	1
Location of service	Cambridgeshire	2
	Essex	2
	Kent	3
	London	2
	Manchester	2
	Nationwide	3
	Peterborough	2
	Sussex	1

DATA ANALYSIS

The interviews lasted between 33 mins and 1 hour 4 minutes (m= 43 minutes). The total data collected was 10 hours 55 minutes. From the 15 interviews, five themes and 14 sub-themes were generated.

1. **ED and obesity: where does BED fit?**
    1.1. Less sympathy towards people struggling with BE
    1.2. Support disparities between BE and other EDs.

2. **'Whack-a-mole' service delivery is failing to meet the needs of the whole person.**
    2.1. Clients are bounced between services –HCPs unsure where support should begin.
    2.2. 'That's not our remit – HCPs' uncertain about clinical responsibility.
    2.3. 'The left hand doesn't know what the right hand is doing'

3. **The obesity economy: commissioning, decommissioning and recommissioning services.**
    - 3.1. ‘More money is not the answer’ – The implications of referral incentives
    - 3.2. ‘There doesn’t seem to be much learning going on’ – Issues with sharing data
    - 3.3. Incongruence between service need and availability

4. **HCPs can feel complicit in a system that ‘sets people up to fail’.**
    - 4.1. Feeling frustrated and disillusioned with services
    - 4.2. Getting emotionally invested in the work
    - 4.3. Finding meaning in the work

5. **Expanding provision beyond short-term targets towards long-term change**
    - 5.1. A more personalised approach to health
    - 5.2. Integrated care as solution to the challenges in service delivery
    - 5.3. Rethinking KPIs – Improving follow-up and outcome monitoring

Theme One: ED and obesity: where does BED fit?

This theme presents the challenges participants reported concerning interventions for O-BE within current service provision. In the first subtheme participants reported a general lack of sympathy for O-BE within public opinion and amongst HCPs, the implications of these unsympathetic views are discussed in the second subtheme. Participants also reported notable disparities in service provision and treatment between BE and other EDs such as AN and BN.

1.1 Less sympathy towards people struggling with BE

What became apparent early on and throughout the data collection process is the perceived lack of sympathy and obesity associated stigma that comes with BE. One participant believed that lack of sympathy, is connected to the stigmatised physical consequences of BED when compared to other EDs, which for BED is often a larger body.

"I also think it's not spoken about as much as other eating disorders, really. I guess there's not the same kind of sympathy-- this is my personal opinion as well. But there's not the same kind of sympathy that other eating disorders might have. So if you saw someone with anorexia, people would be like, "Oh, they must be unwell. They're really unwell." But actually, people with binge eating disorder can also be very physically unwell. But I feel like it's viewed as laziness or eating too much. There's less of an understanding of the mental reasoning behind it and what's actually going on and how it can also be linked to trauma and all kinds of things." – Lara (Psychology, EDS). Another participant mentions how well documented it is in health literature that there is a general distrust of PLwO towards NHS services, *"However, subconsciously and throughout the literature research and things like that, the observations that have been made throughout society, we find that people who are obese are less inclined to engage with other aspects of healthcare because of perhaps their experience with healthcare practitioners and feeling that they are not as well understood or going to be cared for."* – Faith (GP, Primary Care).

A practical example was given by one participant, about how the negative perception of people with BED may look like in a service context, which may perpetuate thoughts that they are lazy and unable to change. *"And like I sort of said earlier that we know that people with binge eating were more likely to drop out of our group. So, I think a lot of these people are just recorded as dropouts. That's it. All classed as, you know, not ready to change. And it just, yes, it just does it a disservice and it's not addressed because they're just never looked into it."* Joan (Psychology, WMS).

The narratives in this subtheme are that clients experience an unsympathetic and stigmatizing healthcare service, this impacts their inclination to engage in services and how their engagement is perceived, which in turn impacts appropriate service provision. What was also apparent was the sympathy interviewees had for the struggles of this client group, as they appeared to empathise with their plight. Interestingly, no participants indicated that they themselves held such negative views about the client group. If they do not share the negative views of others they had encountered, it could be interesting to understand how they navigate this in their working environments.

1.2 ***Support disparities between BE and other EDs.***

This subtheme is derived from the potential implications of what an unsympathetic and stigmatizing healthcare system may look like for people with O-BE. Firstly, participants reported there being little to no guidance on a national level for interventions that have been tailored for BE when compared to other EDs. Diana reported CBT and self-guided interventions are often used for BED, but questioned their effectiveness, finding the intervention lacking when compared to the interventions used for other EDs.

> *"I think compassion work is quite a big part of eating disorder work in general. But yeah, I think because of the NICE guidelines being very much focused on CBT and guided self-help for binge eaters, I think sometimes it lacks a little bit more than other treatments for eating disorders because there's often a lot of other suggestions for other treatments, like for anorexia for example."* – Diana (Psychology, EDS).

Diana compares the treatments options for BE with other EDs like anorexia, and she alludes that BE does not have as many options. She suggests more compassion focused work could be more beneficial for BE, rather than the one size fits all CBT option, which is an evidence-based therapy, however, may not always be sufficient in addressing the complexities of the client group.

There appears to be a general lack of knowledge about BE/BED as a diagnosis within the client group themselves, when compared to other EDs, *"When I was starting with people, they'd say, "Actually, I had no idea that this was even a diagnosis" because I don't think it's really as spoken about as other eating disorders are."* – Veronica (Psychology EDS).

Another participant believes this lack of knowledge stems from BE/BED not being included in clinical/professional training for many HCPs, therefore they struggle with even identifying BE, differentiating it from other EDs and sharing this knowledge with the client group.

> *"Training, I think for staff, and having an awareness of binge eating and being able to differentiate between overeating and binge eating and then knowing what to do and where to refer to is important. Because as I said in [organisation name], yes, I have had that training, so obviously that was external training that came in and got delivered probably about six months since I started at [organisation name]. Whereas even when I was working with clients living with obesity in the past, we did not have training to pick up on this or would not know where to refer to this. So now that I am moving back into general dietetics, I will have more of an awareness of this... Even in University as a dietician, you know we had maybe a couple of modules on weight management but not much on binge eating as far as I am aware."* – Selena (Dietetics, WMS)

Selena also mentions HCPs can struggle with knowing the appropriate referral pathways for this client group, this suggests there is a lack of clarity on where support for BED sits in terms of service context, this` is discussed further in theme two. What seems apparent is there is less understanding and knowledge about BED when compared with other EDs, and it may consequently impact referral pathways and overall service delivery.

Some participants remarked on BED carrying less risk than other EDs. *"Because in the south* of [name of location], *there isn't really a pathway for people with binge eating disorders to be treated. There's this new branch of IAPT that will take some disordered eating. And I think often the risks are lesser with binge eating disorder than they might be with patients that purge or are of very low weight."* – Diana (Psychology, EDS). It might be deduced from Diana's comments that BE is more in line with disordered eating than with AN or BN, therefore as '*there isn't really a pathway'* for BE, so it might be best placed in IAPT.

Improving Access to Psychological Therapies (IAPT) now NHS Talking Therapies, is a primary care service where the public can access/ self-refer for support with milder mental health difficulties. Diana’s suggestion aligns with the narrative that BE carries less risk overall, and participant Joan confirms this and explains the implication for the client group, *“But speaking to clinical leads, people with binge eating, I get it, they're doing the risk stratification, they're often passed as low risk compared to anorexia and bulimia. So, they might well be waiting a very long time for that service.”* – Joan (Psychology, WMS).

Considering the disparities in knowledge base, intervention options, and perceived risks between BE and other EDs, it is important to evaluate the suitability of ED services in supporting individuals with O-BE. It is essential to determine whether these services can adequately address BE while taking into account the obesity component. Selena does not think ED services are set up to manage the obesity component, *“But then that eating disorder service is not necessarily set up to deal with the weight management side.”* – Selena (Dietetics, WMS). Demi recalls seeing support for BED, but obesity was not really factored in, *“Yeah, so in training we were attached to a mental health hospital which helped patients with eating disorders, various types. Obviously, anorexia nervosa, but also binge eating disorders. I wouldn't say obesity was really managed in that service, to be honest with you”* – Demi (GP, Primary Care).

The participants highlight significant challenges in the treatment and support of O-BE within current healthcare services. The lack of sympathy and stigma, may lead to disparities in service provision and training gaps, which essentially undermine effective care for individuals with O-BE/BED.

Theme Two: ‘Whack-a-mole’ service delivery is failing to meet the needs of the whole person.

The second theme highlights how professionals compared service delivery to the "whack-a-mole" arcade game. In this analogy, services are seen as attempting to tackle various issues one at a time without addressing the underlying complexities, like hitting moles with a mallet as they repeatedly pop up. This approach is depicted as fragmented and insufficient, as new problems continually arise, quickly overwhelming the limited tools available. Participants describe the current service model as operating in silos, failing to meet the comprehensive needs of the individuals they serve.

2.1. Clients are bounced between services –HCPs unsure where support should begin

Just over half of the participants discussed seeing clients getting stuck between services more often than not. The initial service they have been referred to is unable to deal with the client's issue until another issue has been resolved by a different service.

> *"So sometimes it's tricky where there are comorbidities quite closely entwined. Sometimes you can't always tell which is the primary diagnosis... I think that's some of where we're shifting a little bit in terms of trauma-informed care and thinking in eating disorder services and I think in psychology in general. Because otherwise people just get bounced between services, you know, oh, you've got some trauma and you've got an eating disorder. We've tried the eating disorder work, but it has not worked. So go to trauma. They try trauma, the eating disorder flares up. So, it can feel a little bit like whack-a-mole, in which we are treating one, but then the other is coming up. So actually, do we need to think a bit more holistically about how we work with these clients."* – Diana (Psychology, ED).

Here Diana explains HCPs grapple with identifying where to start with the support of the client group. Another participant shares similar views, also `drawing on the lack of information available to service providers, which ties in with the subtheme,

> *"I suppose they must feel like they're kind of bound from one to another.*

> *Do you look at the trauma first? Do you look at the outcome of the trauma? Do you try and tackle the obesity part first and hope that that kind of goes on? So, I suppose it really is that each of the services not having enough information about all the other services to be able to create one personalized plan for a client."* – Caroline (WM Specialism, WMS).

Caroline highlights the lack of coordination between services, questioning whether to address trauma, its effects, or obesity first, and emphasizes the need for better inter-service communication to create personalized care plans.

In this subtheme the participants really encapsulated the challenges they often face when trying to understand how best to support this client group, even more so they captured the palpable frustration this client group must feel when help-seeking. Participants also spoke about the long waiting lists for the different services, which may also exacerbate the help seeking experience and feeling stuck between services. A more holistic approach was suggested by several of the participants, which could be a way of addressing how to best meet the needs of whole person.

2.2. 'That's not our remit' – HCPs' uncertain about clinical responsibility.

This subtheme captures the uncertainty of where clinical responsibility for this client group lies, as participants reported not always bring clear who would take responsibility for clients that sit outside their remit.

> *"From accessing a service point of view, I would say, dare I say something like that it kind of feels like it's somebody else's role. That client's much higher needs than what our service can offer. So, they need to go to a different service, but that different service probably has the same outlook actually this client needs to deal with this part first and then they come back to us."* – Caroline (WM Specialism, WMS).

Caroline expressed the sentiment that some services perceive clients with complex needs as falling outside their remit. She noted that when one service feels a client requires more support than they can provide, they refer the client to another service. This often leads to a cycle where each service defers responsibility, assuming another will address the client's needs, which echoes the concerns from the previous subtheme about clients being bounced between services.

Another participant suggested that the limited criteria of services mean clients are often left on long waiting lists, stuck between services,

> *"For example, let's say a client who needs some sort of mental health support. Either there is a waiting list or that there are some clients going #back and forth because the other, let's say other service has some criteria and it's also like they're borderline. They're not meeting any criteria to be in, but you can't help them in any case, this kind of frustration not created by us, but created by this, you know, frame we have to fit in*."
>
> – Janna (Psychology, WMS).

Janna adds that clients frequently fall through the cracks due to stringent service criteria. Patients might be borderline in meeting the criteria for different services, so are unable to receive support, leading to frustration and unmet needs. This rigid framework can leave patients stuck on waiting lists between services that neither fully accept responsibility for their care nor provide comprehensive support. While the need for service criteria is understood and necessary, addressing the needs of clients who fall between service gaps is important. These clients are most often referred back to their GPs and managed in primary care however, it should also be considered how well-equipped GP practices are in managing the complexities of this group.

Selena questions if O-BE should only sit under ED services, *"So that would mean they would have to go to an eating disorder service, but then that eating disorder service is not* *necessarily set up to deal with the weight management side. I imagine that these clients are a little bit stuck between services, so yes, it is probably hard to kind of diagnose what level of thinking they have and where they are best placed."* – Selena (Dietetics, WMS). She highlights that ED services aren't as well equipped to manage the obesity component and therefore HCPs are uncertain about appropriate care pathways.

One participant explained how they grappled with the lack of clarity in the scope of the service they currently work, which can cause uncertainty as to what the appropriate level of support to provide for clients, particularly when in their clinical judgement they might need more than what the service is able to provide.

> *"I struggle with understanding the scope of my practice because I can just do like a light touch sort of psychological support, you know, thinking about behaviour change type stuff. But then because I'm seeing what people need is more than that, I'm then struggling to know what support is appropriate to provide. Because it's like…oh, I could do this, but it's going to be more effective if I do this. But I also don't have, we are not, the provision isn't there to do this. So, maybe part of it is about me needing to work out what the, what the scope of like what my role actually is in terms of what I can provide because I guess it's like when I'm in a one-to-one with somebody, I've just got an open-ended space where I can do what I want as I see fit to serve the needs of that patient, I suppose. So, it's up to me to determine what I do at that time. And so, yeah, I don't know. So, I guess what I'm trying to say is that a service issue, or is that about me balancing like, you know, the needs of the patient and not really knowing how best to do that at the moment?"* – Abigail (Psychology, WMS)

The complexity of clinical responsibility is further illustrated by Abigail, who struggles with the lack of clarity about the scope of her practice. She feels limited to providing "light touch" psychological support, despite recognizing that many clients require more intensive intervention than her service can offer. This incongruence between her professional training as a psychologist (where she is trained to support with more complex needs) and the service's scope leaves her uncertain about how best to meet her clients' needs. Participants highlighted the unclear delineation of clinical responsibility for client group. This ambiguity often results in clients being passed between services without receiving adequate or timely care. These accounts underscore the lack of integration among services treating this client group, therefore HCPs find themselves in roles and services with poorly defined boundaries, which can lead a piecemeal approach to care.

2.3. ‘The left hand doesn’t know what the right hand is doing’

In this subtheme, participants capture their experiential concerns about the set-up of service delivery. They discuss the lack of connectedness there is between services, which often results in one area of a client’s health needs being met, at the cost of another area usually being unmet.

> *“But unfortunately, what I tend to find happens is, and it's not by any particular role, it's just the way that our healthcare system is set up, is that people tend to segment off different areas of the body. So, mental health is seen as very much, unfortunately still very separate from the physical health side of things. And so those two areas don't quite marry up and people, you know, the left hand doesn't really know what the right hand is doing, and as a result, your mental health might be looked after perfectly, and then as a result, your physical health isn't quite as monitored and looked after.”* – Faith (GP, Primary Care).

Faith does not attribute this issue to any particular role or service but suggests this way of working is endemic within our healthcare system. It is also important to hold in mind Faith’s role within primary care services, which may mean she has an important insight into working with a variety of services across the spectrum of healthcare needs.

Faith's comments are supported by the next participant Zara, who reflects on her experiences, not just in WM services but across the NHS. Zara does acknowledge the strides taken with more MDT- based services but questions the effectiveness of services when provision still remains quite fragmented with no clear pathway for clients.

> *"The fact that we have an MDT that comprises of physical and mental health professionals, I think is amazing. I think we're getting there, but they're still all separate. I think I see it all the time... If you have addiction issues, you go to your addiction center... If you've got mental health issues, you go here, weight issues, you go there. They're all completely separate services... It leaves patients bouncing back and forth. There's no correct order. There's no pathway. I saw it when I worked previously in mental health with addiction. It was like backwards and forwards… It's the same with weight management. It's like, "Well, you're too psychologically complex for us." They go and try and get some type of support and they're told, "Well, actually your primary problem is your weight." Then you need to readdress that. Just people are getting bounced back and forth throughout services and it's unfair. It really makes people lose trust in healthcare. It's quite inefficient."* – Zara (Psychology, WMS).

Zara paints a vivid picture of what some clients may experience when being referred to services. Their difficulties with OB, MH & BE are segmented and dealt with by separate specialist services, despite how interlinked they can be. Consequently, no single service can completely support clients to resolve their issue because they are working separately, seemingly not communicating with each other and failing to address the needs of the whole person.

Within the team that she works, Veronica described never witnessing any joint working with other services, *"To my awareness, I've never been involved in anything or seen any sort of joint working with their weight management team. However, they sometimes do have psychologists in the team. But if we are talking eating disorder service and the weight management, I've never really seen any link-up."* – Veronica (Psychology, EDS). It is important to mention that Veronica was only one of a few participants who had never witnessed joint working. The majority had encountered some attempt at joint working between services, however it did not appear to be particularly effective or sufficient,

> "*There probably needs to be more joined-up thinking and working between different services. Yeah, like for example, I've recently been trying to liaise with an eating disorder service to get more information on binge eating disorder assessment and referral pathways and things like that so that we can update our protocol. And it's taken months because every time I contact them, someone's like, oh, yeah, yeah, we'll get back to you. Or I get an automated email and then they'll give me a piece of information and it's not sufficient."*
>
> – Abigail (Psychology, WMS).

Abigail shared her challenges liaising with an ED service to update protocols for BED assessment and referral pathways. Her experience of delays and insufficient information reflects the broader issue of inadequate communication and collaboration between services. The disjointedness of services could be compounded by tier 3 services models being quite different across the country. Joan highlights the heterogenous nature of WM services across the country, '*if you did an audit over the of country of what the different services look like, they all look so different. They're not standardized at all…. Some are very much dietician-led, some are very much psychologist-led. Even the community ones, some are very similar to tier two services, which I don't think is necessarily a bad thing, like, whereas some are, yes, they're just so varied."* – Joan (Psychology, WMS).

To summarize, in this theme participants depict an ineffective and disjointed system, which operates very much like a 'whack-a-mole' game, once one service has tried to whack one issue such as obesity, more issues pop up in their place, like BE symptoms. The limitation of remit or service provision halts any further intervention, until another service steps in using their own mallet to whack the new issue but in doing so might exacerbate the previous issue which they are not equipped to deal with or may raise a new issue such as experiences of trauma. Meanwhile clients are left on waiting lists, stuck between services that have no clear pathway and who do not communicate with each other on which issue to address first, or how to address all issues collectively.

Theme Three: The obesity economy: Commissioning, decommissioning and recommissioning services.

This theme really discusses the participants' views and concerns on how services are funded and commissioned for WM services. None of the participants are involved in commissioning of services but felt that frontline staff not being involved could be a reason why they felt where funding is being directed is misguided. The first subtheme highlights the possible detrimental impact of financially incentivised referrals.

3.1. More money is not the answer' – The implications of referral incentives

This subtheme has emerged from one participant, although this specific issue was not necessarily raised by other participants, it connects with the theme and subthemes around the impact on how these services are funded. Mary's insights shed light on an important issue, firstly Mary wonders about the variation of HCPs available within private WM services when compared with NHS run services. Due to the competitive nature of contract bidding, she wonders if private services can sometimes prioritize cost over expertise, potentially compromising the quality of care. *"Well, I would say within the NHS, from my experience,* *you work as part a multidisciplinary team, I used to work with paediatricians or psychologists. And you always have that kind of expertise and support. I think private services its more tricky because obviously [they are] winning contracts. The prices are important so they can afford to save on expertise."* – Mary (Dietetics, WMS). Mary's observation that private WM services might cut costs (by not hiring certain HCPs) to win contracts raises concerns about the adequacy of expertise within these services. Secondly, Mary talks about her experience of seeing clients being referred repeatedly to T3 WM services, with little screening from the referrer as to their suitability for the service. She suggests the referral process appears to be influenced by financial incentives for GPs, leading to repeated referrals without adequate screening for suitability.

> "*...the Tier 3 program is 18 months. However, the support gets less and less as we go along. So, it starts off weekly and it goes monthly. Then some people will stop engaging and then they think they're no longer getting any support. So, they go back to GP and ask for another referral. So sometimes we've already got a referral, we know the patient's receiving care, but they go back to the GP for another referral…it's very easy, it seems to get a referral. I think the GPs just use the same referral form and they just sort of change the dates... And also I think there has been extra funding for GPs. They've been incentivized to make referral. So, I think some patients just think, "Oh, if this doesn't work, I'll try the other". This doesn't work. Or maybe… that's just the nature [of] how it is with weight management. You try one thing, it works, and then things change, and you try a different one*."
>
> – Mary (Dietetics, WMS)

It can be inferred from Mary's comments that there does not appear to be any kind of screening process prior to referral to T3 WM services at the primary care level. This causes an inefficiency in the referral process with clients leaving T3 WM services and returning repeatedly when the weight loss has not been achieved. Mary suggests that this type of cyclical referral process is driven by GPs who are financially incentivised to refer clients, however there does not appear to be much exploration on why clients have to be repeatedly referred. Mary does not explicitly comment on the implications of cyclical referrals on WM services, however she does highlight that this is the nature of weight loss in general, a type of trial and error process. Though other participants do not explicitly discuss repeated referrals, but they do wonder about how the commissioning boards evaluate the effectiveness of a WM service and what lessons have been learnt from services that have not or do not work, which is addressed in our next subtheme.

3.2. 'There doesn't seem to be much learning going on' – Issues with sharing data

In this subtheme participants question the evaluation and lessons learnt process when WM services are being commissioned and decommissioned. There was a real sense in this subtheme that participants weren't concerned with more funding for WM services, but with how current funding is being used and generally felt there has been an ineffective use of 'taxpayers' money. They have surmised this differently; Zara does not feel the commissioning boards are taking the opportunity to truly listen to and implement the suggestions of HCPs who work with the client group.

"But even so, even though they listen, even though they hear us, they don't make any changes. And I think what's frustrating to me is that I see tier 3 services being set up and then decommissioned because they don't work. Then they're set up in the same way and then decommissioned again, then set up in the same way. It feels like there's not much learning going on about why Tier 3 services don't work. It's very clear to me why they don't work. So why are they making them again and again and again in the same way. They need to be scrapped and the money needs to go elsewhere." – Zara (Psychology, WMS)

This next participant, Mary suggests the increasing obesity rates would indicate that WM services are ineffective, and commissioners need to seriously evaluate the WM service delivery. Interestingly Mary suggests that there is not enough of a budget to evaluate services or 'think slightly differently' as she has termed it. "*And I personally think-- I probably shouldn't be saying this (laughs). There should be more thought around, "Well, we put all this money in weight management, but why are [obesity] rates going up?" And if what we're doing now is not working, why aren't we-- I know everyone thinks now it's all about weight loss injections. [But], at the end of the day we're spending taxpayers' money. I think it would be really good if-- The commissioners, it would be helpful if they could just maybe think slightly differently or maybe they are, but there's not the budget."* – Mary (Dietetics, WMS). Notably, Mary began this section with questioning whether she should say anything at all, this reluctance was noticed in a few other participants, however she was most explicit in stating it. What is coming through the comments of these participants is there is not much clarity on how WM services are actually evaluated and what makes them effective or successful.

The next participant offers a rationale for the lack of clarity by suggesting that there is little evidence on what a successful T3 WM services should actually look like. "*But a big problem with that I think is that there's very little evidence out there on what, well, I mean some are totally digital as well. That's the sort of newer ones that are coming out, purely digital tier 3s [WM services], which we've never seen before. But yes, there's really limited evidence and a lot of tier three providers are reluctant to share outcomes... So it is really difficult to then put a policy, like put anything together because we don't know what the best next option is when we think we do… I think people saying they know exactly what the best way is, is untrue. We are still finding our feet. Everyone is.*" – Joan (Psychology, WMS)

This subtheme emphasizes participant concerns about the repeated implementation of ineffective T3 WM services without incorporating lessons learned. They highlighted poor evaluation practices, lack of evidence, and reluctance from some services to share outcomes, calling for greater accountability, innovation, and effective use of taxpayer funding in service planning.

3.3. Incongruence between service need and availability

In this subtheme participants talk about the disparities between the need for service provision and what is available for clients. Selena highlights the regional disparities in the availability of T3 WM services, describing them as ‘completely unfair’.

> “*Yes, until you work in the NHS you do not realize quite how random it is in terms of what different areas get how it is all linked up, and how the commissioning works. So yes, it is a postcode lottery, which is completely unfair some areas do not have a Tier 3 service at all, some areas do not have any eating disorder service... Yes, I would say they are not distributed evenly really, clients are living everywhere with these needs, but potentially where they live, they are not able to access the right service.”*
>
> – Selena (Dietetics, WMS).

Selena also remarks on her insider experiential perspective which has provided her with a vantage point to see these disparities that clients would not necessarily be aware of, highlighting the importance of the healthcare professionals’ contribution in healthcare study. Similarly, this next participant Veronica highlights regional differences as being problematic for clients. Veronica experience is slightly different, she currently works in ED services, and she described working in one area, which was divided into a north and south team. However, the north ED team provides services for BED but the south team did not.

> “*I think the north team is commissioned to treat binge eating disorder, whereas the south team isn't commissioned to treat binge eating disorder, which I found quite an interesting shift just because actually the prevalence of binge eating disorder was really high in my last team... In the south we*

> *just can't. I think that's something I've sort of maybe struggled with a bit coming from a service where I've seen the work [for BED] be really effective. We've got a lot of people in the books with that diagnosis and then to just not be commissioned [long pause]. It makes me think there's probably so many people that need help but there isn't the right places to go*."
>
> – Veronica (Psychology, ED).

Here is another example of the incongruence between service availability and local need, additionally, Veronica offers an important reflection, that because there is no service provision in one area, there may not be sense of how prevalent O-BE is.

The next participant further consolidates the disparity between the demand for services and what services are available, offering insufficient resources as a reason.

> "*In principle with a lot of organizations, if the money is not there, you cannot increase your capacity to take on more individuals as well as your staff, your training, and your resources to be able to make it happen..., I do not think it matters what service you work for, there is always going to be that strain that you cannot keep up with the demand… there are so many overweight, obese people out there that do need the support. There are just not enough services… to keep up with the demand*."
>
> – Olivia (Physical Health Specialism, WMS).

What is clear throughout this subtheme is that HCPs do not have a real sense of the rationale of how and what services are allocated across different regions. Overall, this theme highlights participants' concerns about the commissioning and funding processes for WM services. Issues include inefficiencies caused by financially incentivised referrals, repeated implementation of ineffective Tier 3 services without adequate evaluation, and regional disparities in service availability. Participants emphasize the need for better use of resources, greater accountability, and input from frontline HCPs to align service provision with client needs effectively.

Theme Four: Feeling complicit in a system that sets people up to fail .

This theme captures the impact of the work on participants, they discuss what feelings come up for them when supporting this client group and feeling some complicity in clients not being able to achieve their goals and/or lose weight. We talk about the relational element of their work and how they become invested in the support they give clients, and in some cases when they are not able to support clients. Lastly, participants discuss the meaningful nature of their work, which can be a motivator to counter the overall sense of helplessness they sometimes feel in a system that sets people up to fail.

4.1 Feeling frustrated and disillusioned with services

Nine out of the fifteen participants expressed feelings of frustration with services. Which aspects of their work frustrated them varied from frustration to how services were commissioned to the ineffective way of measuring client success to the effect of societal stigma PLwO often face. In this interview Trisha, spoke about working in one of the first T3 WM services set up in the UK, back in 2009 and the frustration felt with the lack of clinician involvement at the decision-making level of service set up. "*And I guess what is relevant, that again, it was at a time, so this was back in 2009, it was at a time when commissioning was, they had all the power... And this was my big frustration is that there were non-clinicians making decisions about clinical services and therefore setting the targets. And so, it was a very weight [focused] target, weight loss, target driven service. And as a psychologist, the weight was often the least important aspect in the room. So, I found that phenomenally frustrating and I think in hindsight, harmful.*" – Trisha (Psychology, WMS). Trisha, vividly recounts her frustration with non-clinicians making critical decisions about clinical services. This experience underscores a common concern among HCPs: the disconnection between administrative decision-making and clinical realities.

Trisha also later describes the limitations of her role and the expectations of them as clinicians, which lead her to make the decision to leave WM services. "*And also, you know, [we] did uncover some eating disorders, and so we made sure they got to the right place, but unfortunately the right place with a ridiculously long waiting list. So then that felt awful, kind of, you know, I wasn't allowed to treat them. So, they just had to sit and wait in limbo but, the big but is, that I felt the system was not designed to help people succeed in a meaningful way. Especially when it was recommissioned, it was all about 5% weight loss and so the individual difficulties issues such as medical problems, trauma, it was always like, well the message that we were being given as clinicians, said that didn't matter, and which is why I had to leave, because I didn't want to be implicit in that kind of system."* – Trisha (Psychology, WMS). Trisha's decision to leave was due to the system's focus on weight loss targets rather than holistic patient care highlights a critical flaw in how success is measured in these services. Like Trisha other participants described the "system" structure as most problematic for them, Mary has chosen to remain working the services but describes a growing disillusionment with the system, "*I suppose over time we become a bit sort of disillusioned or I suppose maybe more realistic*." – Mary (Dietetics, WMS). Zara broadened this frustration to the political landscape and societal discourse and perspectives on 'overweight' and 'disabled' people. "*There are definitely times I've come away from work being like, "What am I doing? This not helping, the service needs to be better." I think it leads to a lot of frustration about wider services, frustrations with commissioners and how the commissioning works, frustration with the government and how the government works. Like much wider frustrations with society and how the pressure that they have put on our patients to exist in a way that is not their reality. The way that society makes no accommodations for people who are disabled, people who are overweight. It brings up a lot of frustrations that are much wider than just in a work setting. So, yeah, I think it's shared amongst our team and it rubs off on each other and makes people feel like... Yeah, it makes it tense at work, I think when people are coming and feeling disheartened."* – Zara (Psychology, WMS). Zara appears to deconstruct the purpose of her work, because she recognises that her frustrations with the service, she works for are underpinned by elements beyond the ‘work setting’. She also observes a type of transference of frustrations within the ‘team’, leaving HCPs disheartened.

Janna accepted the limitations of the WM services and rationalised it as better than there being no services at all. She then talks about the impact of the clients’ traumas and adverse childhood experiences on them.

> “*…you feel like you're helping people, you are doing something for them in a way, supporting them, so it's really fulfilling…. So it's better than nothing of course, but it's limited and sometimes you just want to, you know, do more for them because obviously you're caring, that's why… Apart from that, like hearing from them in regards to their trauma, of course it's sometimes really hard, difficult because we have some clients coming from really difficult backgrounds in terms of, you know, from their childhood to the things they experience and everything, all the trauma, and it can be really difficult for you to process. And sometimes we get some clients dealing with some mental health issues and feeling suicidal. This is another layer of it and it's of course it's impactful, but we have some resources in place like the clinical supervision debrief, things like that.*” (Janna – Psychology, WMS).

Janna reflected on the importance of clinical supervision in helping HCPs to ‘process’ the difficult things they are hearing from clients.

This subtheme highlights that the frustrations experienced by HCPs are multi-layered and are influenced by both immediate work environments & larger societal dynamics. Participants describe an emotional toll of their frustrations that is palpable, creating a work atmosphere that can be tense and disheartening.

4.2 Getting emotionally invested in the work

In this subtheme participants reflected on how invested they had become in the experiences of clients. The next participant explains her invested emotions have led her to take a protective stance over the client group. She rationalises this based on her assumptions that most of the client group would have had a negative experience engaging with HCPs, therefore she aims to position herself to be the antithesis to that experience.

"*So, I think I get very emotionally invested in patients who do experience binge eating. I get overly protective. I feel extreme pressure to do the right thing because I-- and again, I always make the assumption like, 'This patient has probably experienced some kind of stigma relating to their weight or their behaviours'. I put this kind of immense pressure on myself like, I want to be the first professional that isn't like that to them...' It's painful to me to think about the experiences they've had, from hearing like my family members talk about really traumatic experiences of accessing services as well.*" – Lara (Psychology, EDS). Lara also offers her lived experience of having a relative(s) with similar difficulties to the client group of interest, who have described their experiences as traumatic, thus instigating the protective stance she takes. The next two participants differ on the emotional impact the work has on them. '*You have to have those boundaries to be able to protect yourself, but then when you go home at night and think of the things that they [clients] have told you, it makes you contemplate what is even going on with everything if that makes sense? And I just think it makes me even more passionate in the sense that I know all the amazing things that I have helped patients with.'* – Olivia (Physical Health Specialism, WMS).

"*I think personally, I have a very uncomfortable feeling that I am selling somebody a dream. Like I'm giving somebody, "There's so much hope" and I see them and I just think there's so much that can be improved... And then when we don't, I feel like they're obviously let down and I feel guilty and sad that we've not been able to help them.*" – Zara (Psychology, WMS).

Here you see participants emotionally affected by their work and how it has impacted them differently, one participant feels protective, another put in boundaries but feels motivated and the last participant grapples with feelings of guilt and sadness.

The subtheme explores how deeply participants connect with the experiences of clients, often driving their commitment to providing compassionate care but also exposing them to emotional strain. Lara describes feeling protective of her clients, motivated by her assumptions about the stigma they have faced and personal experiences with a family member. Olivia balances her emotional investment with boundaries, finding motivation in the positive outcomes she helps achieve, while Zara struggles with guilt and sadness when client progress falls short of expectations. This emotional engagement highlights the dual-edged nature of their investment fostering client-centred care while emphasizing the need for support systems like clinical supervision to help HCPs manage the emotional demands of their work.

4.3 Finding meaning in the work

In this subtheme several participants describe how they find meaning in their work and being encouraged and motivated by their experiences. These meaningful experiences are not necessarily measured or captured by outcomes measures, weight loss targets and key performance indicators (KPIs). The first participant, Aisha talks about how the work in WM services has raised her own awareness of BE and given her a new perspective,

"*It has made me more aware of the needs. It has generated an interest… to explore and understand how could this be integrated. And at personal level, as a dietician… having enough awareness about this has created a lot of understanding of seeing and talking about these issues and not looking at it as just a straightforward approach for weight management. It has, helped me to know like, you know, this is something I have to broaden my mindset to understand their needs"*– Aisha (Dietetics, WMS). Aisha's acknowledgment of the need to move beyond a narrow, weight-centric approach toward a more integrated and holistic understanding of clients’ needs reflects a key shift in perspective. By recognizing that addressing obesity requires more than simple strategies for weight loss, Aisha demonstrates a growing awareness of not oversimplifying client care.

Zara prioritizes improvements in a client’s mood or their ability to engage in activities they previously couldn’t, rather than focusing solely on weight loss. “*Personally, I'm not excited by someone losing weight. But I'm excited when I see that their mood has improved, that they've gone out of the house when they don't usually feel able to, that they can now lift up their children. When you see the real changes that is meaningful to people's lives, it kind of keeps you going. But overall, when you look at our outcome measures, we look at our results and you see that we're not meeting any of our KPIs, it can feel quite disheartening kind of just on a service level. But on a personal level, like you're not doing good work.”* – Zara (Psychology, WMS). As Zara remarks, those meaningful achievements aren’t captured by outcome measures and weight loss targets, which is how their service is measured for its effectiveness, therefore despite Zara’s examples of meaningful change, she can still feel disheartened.

In her role within primary care services, Faith finds meaning in the support of the community organisations that are available to support clients. This has empowered in her work and reduced the pressures she sometimes feel holding clients alone.

> *“So, now knowing that there's a larger community at work, other organizations that might be able to help patients with information and with education, that's very empowering because at first when patients come in, you sort of feel that a lot of the pressure is on you as a single practitioner to help them with this situation and the issue that they might bring up… And then patients can also support themselves, refer themselves to these things as well. It's just you are understanding and knowing that they are available. I think it's been*

> *very encouraging as a practitioner because you no longer feel that the responsibility and pressure is just on you to help that one patient and their family*." – Faith (GP, Primary Care)

This last participant describes how she feels encouraged by the positive feedback the service receives, so despite the demands of her job, she thoroughly enjoys it.

> "*But yes, I always tell them I love my job, I would not change my job, it is very, very demanding. As I said earlier, I do not just do Tier 3, I have Tier 2 as I have mentioned, so it is maniacal at times, but it is when they finish their program… [you] get feedback from the program…it is all worthwhile because you have got them back on track. They are now able to spend more time with their children, they are now able to go on holidays because they can fit in that plane and see whatever that might be. And it is like you have improved their quality of life, nothing can beat that in all fairness."*
>
> – Olivia (Physical Health Specialism, WMS).

Finally, Olivia's reflection on the positive feedback from clients serves as a powerful reminder of the intrinsic rewards of this work. Despite the demanding nature of her job, the tangible improvements in her clients' lives provide a deep sense of fulfilment and validate the challenges faced.

The narratives within Theme Four paint a complex picture of the emotional and professional lives of HCPs who support PLwO. While they often feel complicit in a system that fails to fully support their clients, they also derive significant meaning from their work. This dichotomy of frustration and fulfilment highlights the need for systemic changes that align outcome measures with the holistic and individualized care that HCPs strive to provide.

Furthermore, it underscores the importance of emotional support and professional development opportunities for HCPs to sustain their motivation and well-being.

Theme Five: Expanding provision beyond short-term targets towards long-term change

This final theme was developed from the ideas and beliefs of the participants in how service provision and delivery could be improved to better support the client group. The ideas centred around: the service approach shifting the focal point; the importance of how well the various services that encountered the client group, worked together and rethinking how success or effectiveness is measured.

5.1 A more personalised approach to health

Several participants expressed a desire for a more integrated, holistic approach to supporting PLwO and O-BE that considers the complex interplay of physical health, mental health, and social factors. Joan highlights the importance of having various supports, including WM, BE support, and trauma support, under one roof. This integration would provide clients with comprehensive care tailored to their specific needs.

> *'I mean, my dream for what [an] ideal tier 3 service would look like is having, you know, the weight management side, the binge eating support side, and I think trauma support as well, all under one roof. So we've got therapists who are, you know, specialized in that area, but also work that their work is within weight management… but failing that just, I mean, we talk about integration, but it is just really difficult, if all services were running at the level they should be, were able to have enough funding and see enough people to meet demand. It would just be a totally different experience. But it's not going to happen.'* – Joan (Psychology, WMS).

Joan acknowledges that making her suggestion a reality is improbable, by beginning her suggestion with '*… my dream for what ideal tier three would look like…*' and ending it with '*…it's not going to happen*'. There is a recognition that the limitations on resources that will inevitably bE the deciding factor or barrier to any significant change in service provision and delivery. Could the limitations on resources and funding be a reason HCPs may not give feedback on what they envision an idealistic service could look like? Joan's addendum at the end of her thoughts suggest she may be hesitant to share her vision with commissioners and decisionmakers on service provision, which could mean they may never hear grander ideas that may seem improbable but could be potentially quite effective for the client group.

Abigail, notes that current lifestyle and nutrition advice often feels outdated and generic, advocating for more personalized diet plans and psychological support tailored to individual needs, emphasizing the importance of moving beyond basic, one-size-fits-all guidelines.

> *'Well, I'm just reflecting on a conversation that I had in a meeting recently with a doctor. And he was like talking about… the kind of lifestyle advice and nutrition advice that they [clients] are provided with, which [he thought] is outdated. It's just, you know, they're showing them… the government guidance of what a healthy plate looks like and do 150 minutes of exercise a week and [I] think it's just like very basic, a lot of it's like out of date, in his view it was out of date advice. And I think actually, in terms of nutrition to have people actually be provided personalized diet plans. I think a lot of the patients actually want that and they join the program expecting that, and they don't get that at the moment… something like that would be really, really useful. So just for it to be more tailored, I think just, yeah, more psychological # support, more tailored nutrition.'* – Abigail (Psychology, WMS).

The sentiment, that current guidance is outdated, is echoed by another participant whose experience of supporting a more ethnically and religiously diverse population highlights significant gaps in service provision where these groups are concerned.

'…a lot of our patients are black African or black Caribbean and the types of food that they're eating is food that-- the dieticians, who are both white – so their way of eating is quite different… I think for a lot of the patients this is a way that they've always eaten. Their foods are important to them… they're part of their kind of community and social lives… I think the other part of it is that our examples are maybe not so culturally relevant... If we use like an eat well plate for example, the foods on there are not always the foods that people relate to … A large portion of our patients are very religious. So, we have a lot of Muslim patients, we have a lot of Christian patients, and we have a lot of Jewish patients. So, what's difficult there is that some of the psychology content doesn't feel so relevant to them... we do a lot of mindfulness, for some patients, they do not want to engage with it because it doesn't fit with their cultural beliefs … We're also very strict in our attendance policy and obviously there are lots of different holidays that come up. There was one time where there was all the different holidays that was going on. There was Passover, there was Eid, and there was Easter at the same time…We made a big deal about Christmas and how people eat a lot at Christmas and how that brings up anxieties for people. Maybe we didn't do the same for the other kind of religious celebrations, where again, food might be involved and so it's relevant. So, I think there's a lot that we need to be considering and I think it's a long way for our service to come to be culturally relevant and for people to feel represented and heard.'

– Zara (Psychology, WMS)

Zara comments underscore the significant cultural barriers that exist in WM services, highlighting the need for more culturally sensitive and representative approaches to effectively engage diverse client groups. Additionally, she highlights there is a need at policy level to review how it may indirectly discriminate against those who observe different religious holidays to the larger population. This disconnect and oversight can lead to patients feeling that the advice is not applicable to their lives, potentially reducing their engagement and adherence to treatment interventions and recommendations.

5.2 Integrated care as a solution to the challenges in service delivery

Participants advocated for a multi-agency approach, highlighting the need for better collaboration and communication between different services. Faith and Veronica both discussed the importance of clear communication and joint sessions to ensure that clients receive consistent and coherent advice across different services. '*I also think that perhaps education about what realistically Tier 3 services can actually offer patients might be helpful to practitioners. Because I think then you can also be very honest with your patients about what is potentially available in that service and then perhaps that will open up the opportunity for us to do more than the sort of community setting to help them.'* – Faith (GP, Primary Care)

Veronica pointed out the conflicting messages patients often receive from different services. She suggested better linking of WM services and ED services, possibly through joint sessions or shared consultations, to provide a more cohesive care experience. '

> *So, I do think actually maybe … a better link up with those weight management teams would be-- I always think why has it not happened to be honest. And also sharing, obviously with patient consent, those [psychological] formulations and passing that information on where appropriate just so the weight management team then has a much better understanding because as I say, I don't know too much about what goes on in the weight management systems. But if someone in the weight management system is telling the patient to restrict their intake, actually*

> *that goes against so much the work they would've been done. And then it's conflicting all the messages and it's thinking, "Okay, what professional should I be trusting at this point?" So, I think maybe linking that up a bit more and whether it's like a joint session at the end or is the referrals going on or just something like that would be really beneficial.'*
>
> – Veronica (Psychology, ED)

Faith then suggests leveraging community resources, such as social prescribing and NHS Health Checks, to provide additional support and guidance. This approach would ensure clients have access to a broader range of services and support mechanisms, enhancing their overall care experience.

> '*So if we could try to open up our opportunities for people to access support elsewhere, like for example, our community pharmacies, and our secondary care services. We have a great resource in social prescribing now and I found that when I'm really struggling with directing people to the right services, our social prescribing team might have heard of new services opening up, that they can offer to patients and support them..*' – Faith (GP, Primary Care).

Faith's recommendations of services people with O-BE should use, validates her point of being uncertain of the 'right services', highlighting the lack of information available to primary care staff. However, incremental steps towards better communication, collaboration, and utilization of community resources can significantly improve the care experience for clients.

5.3 Rethinking KPIs – Improving follow-up and outcome monitoring

Participants discussed the limitations of current key performance indicators (KPIs) and the need for better or different metrics to assess client progress. Aisha, a dietitian, noted that GPs should be able to create ‘forward plans’ for clients, ensuring seamless transitions between services and ongoing support.

> ‘*What I can think of is like, you know, again, the awareness at the GP levels to be able to get the right referral to the service, and creating and sketching a forward plan... Because if a client goes to even the eating disorder service and they have completed the program and recovered. I think GP is able to reroute this client to the right service at that time. I think that would be address the need because them jumping from one to the other service won't be very helpful. Because, with the weight management service, we don't have the follow up to know where the client is in terms of the other service.*’ – Aisha (Dietetics, WMS).

Aisha comments reflect a gap in the system where post-intervention follow-up often lacks structure. She highlights the necessity of continuity in care, particularly in facilitating seamless transitions between services and ensuring clients receive ongoing support tailored to their evolving needs.

Zara highlighted the inadequacy of weight loss as the sole measure of success. She argued that other health indicators, such as improved blood sugar levels, blood pressure, mental well-being, and physical activity, should also be considered when evaluating the effectiveness of WM services. ‘*Actually, are there better indicators that their health is improving? We're always looking at weight loss, but actually, what happens if their blood sugar level is more well controlled or actually their blood pressure has decreased or they feel better mentally, they have more energy, they can move more. All of those measures have improved, but because they haven't lost any weight, it feels like we're not meeting what we should be in terms of commissioners expectations, patient's expectations.*’ – Zara (Psychology, WMS).

Zara’s critique of weight loss as the sole measure of success reveals a deeper issue with how success is defined in WM services. Her suggestion to incorporate non-scale indicators highlights the need for a more comprehensive approach to health. This also raises questions about how commissioners and policymakers prioritize and evaluate service outcomes, often at the expense of addressing the full spectrum of client needs.

Demi brings attention to the practical challenges faced in ensuring follow-up care, particularly in the context of limited resources and competing responsibilities.

> ‘*So, obviously with things like binge eating, it's not about weight management, it's about accessing mental health services and being engaged in them. And I guess for those patients, we as GPs need to make sure that those patients are doing that. But I won't lie to you, we have so many things to be doing that it's very hard for us to be chasing patients. But we have people in the clinic, I guess that can help us with that now. With weight management in particular as it stands now, not really the exercise based one, but the dietary based services, they are checking on them. And we get letters to say, this person has no longer been engaging with the services now being removed. So that would tell us that, okay, it wasn't successful if they maybe did one or two sessions and dropped off. So, that, that can be helpful to know, but then what do we do with that information? ... It's not necessarily possible to be chasing every one of these patients.... So, in terms of how we can improve it, it would be best if we had someone in the community engaging with patients who can also just make sure that they are continuing with their goals.*’ – Demi (GP, Primary Care).

The reliance on GPs to bridge gaps in service provision highlights the systemic strain on primary care, where the responsibility for follow-up often exceeds capacity. Demi’s suggestion of having a dedicated community-based support role is interesting, emphasizing the importance of personalized engagement to sustain client motivation and adherence to their goals.

In this theme participants emphasize integrating physical health, MH and social factors into service delivery, with a call for more culturally sensitive and individualized interventions to improve engagement and outcomes. Collaboration between WMS and ED services is highlighted as crucial, with participants suggesting joint sessions, better communication, and leveraging community resources like social prescribing to enhance care coordination. Participants also critique the reliance on weight loss as a sole metric of success, advocating for broader indicators. While resource limitations pose challenges, participants propose incremental steps like community-based support roles and better collaboration between services to address systemic gaps, ultimately aiming to better meet clients’ comprehensive needs.

CHAPTER FOUR

DISCUSSION

Chapter Overview

This chapter will discuss the findings outlined in the previous chapter, in relation to the current literature and the research aim & questions posed at the start of the study. It will then discuss the strengths and limitations as well as the policy and clinical implications and directions for future research. Finally, the chapter will conclude with a reflexive account from the researcher to detail their learning during the research journey.

SUMMARY OF FINDINGS

To the best of the researcher’s knowledge this study is the first in the UK to explore the experiences of HCPs who support clients living with O-BE and experiences of trauma. Existing literature is predominantly from the perspective of clients receiving services, often detailing their struggles with help seeking, barriers to accessing services and interactions with seemingly unsympathetic HCPs. The relatively small amount of literature that does focus on the perspective of HCPs tends to highlight their challenges with poor client engagement, high drop off rates, relapse, frequent weight gain and lack of resources (mainly training. This study is unique in that it turns the lens of focus on the frameworks of service provision in place and the impact as reported by those tasked with service delivery.

The aim of this study was to understand how Tier 3 WM services support the client group of interest and what challenges they encounter supporting them. Two research questions were proposed: (1) How effective or beneficial are the current services in meeting the needs of this client group? (2) What are the gaps and challenges in service delivery for this client group?

Theme One: ED and obesity: where does BED fit?

This theme explores the challenges participants reported concerning interventions for O-BE within current service provisions. Current service provision solely for O-BE/BED sits within ED services, but these findings highlight why this current structure may be problematic for O-BE. This theme comprises of two subthemes: *Less sympathy towards people struggling with BE* and *Support disparities between BE and other EDs*. The first subtheme reminds us that stigmatizing and unsympathetic societal views of obesity are prevalent and widespread, and that they exist within healthcare. This aligns with well-established literature on obesity stigma in general (Brewis et al., 2011; Malterud & Ulriksen, 2011; Puhl & Heuer, 2009: Ryan et al., 2023; Emmer et al., 2020; Bertakis & Azari, 2005; Brown, Flint & Batterham, 2022; Homer et al., 2016). At this juncture it is important to note that the stigmatizing or unsympathetic views of O-BE are most likely due to the obesity factor rather than the BED factor, as it is the most visibly different aspect of BED, as most people with BED tend to binge in secret (Lydecker & Grilo 2019; Lydecker et al., 2019). Stigma towards larger bodies is well documented in literature (Brewis et al., 2011; Furber & McGowan, 2011; Tomiyama et al., 2018; Rao et al., 2024), however a vignette study looking at BED stigma vs weight stigma found BED to be a highly stigmatized ED and that weight stigma may be driven by assumptions about a person's eating behaviour rather than their body size per se (Hollett & Carter, 2021), regardless, experiencing stigma is a consequence of O-BE. Although, the impact of stigma and lack of sympathy in service delivery for this client group is the focus of this subtheme, however providing an understanding of what elements of O-BE are stigmatized is a helpful to hold in mind when comparisons are made between BED and other EDs. Therefore, the next section will focus specifically on the medical classification on BED specifically when compared to other EDs.

Participants raised concerns that the lack of sympathy and stigma underpin the views that BED carries less urgency, therefore HCPs tend to be more dismissive or slower to respond to clients' needs when compared with AN & BN. One rationale for this perception, may lie in the medical classification of deaths related to EDs. According to Johnston et al., 2023, upon death, AN is much more likely recorded as a primary cause of death, whereas BED is far more likely to be recorded as a secondary factor, with i.e. cardiac arrest or metabolic disease being recorded as the primary cause. Consequently, statistical information on EDs often cites AN as the ED with the highest mortality rate (Statistics for Journalists - Beat, n.d.) even though the full impact of BED may not be completely realized because it is most likely underrepresented in mortality statistics, thus reinforcing the notion that it is less severe. Therefore, unsympathetic and stigmatizing views may not be the only reason BED is deemed less serious than other EDs and is much more likely to be intertwined with medical classifications and perspectives on BED.

Another indicator of weight stigma within WM and ED services is the lack of consistent follow-up for individuals with O-BE after disengagement or dropout. Rather than viewing disengagement as a clinical signal requiring deeper exploration, it is often interpreted by HCPs as non-compliance or unwillingness to change, reflecting an individualised framing that overlooks the relational, systemic, or service-level contributors to disengagement. This perception is echoed in research documenting high dropout rates and low adherence among individuals with O-BE, alongside HCPs' expressions of frustration, resignation, and blame toward this client group (Mazza et al., 2019; Nederveld et al., 2021; Ponzo et al., 2021; Neri et al., 2024). Such attitudes risk reinforcing cycles of disconnection, where clients' withdrawal from services is pathologised rather than meaningfully understood.

Participants in this study similarly highlighted the enduring challenges of engaging individuals with O-BE, noting that clients frequently felt misunderstood, dismissed, or emotionally unsupported. These experiences were often compounded by the absence of structured follow-up or continuity of care, which further reinforced clients’ perceptions that their needs were not valued. This dynamic aligns with the concept of 'service weight bias', in which implicit or explicit weight-related assumptions shape the quality of care clients receive (Tomiyama et al., 2018). Empirical studies have shown that individuals with higher body weight may face longer referral times, reduced clinical engagement, or avoidance of physical examination all of which contribute to fragmented care and poorer health outcomes (Bertakis & Azari, 2005; Phelan et al., 2015). The effectiveness of WM and ED services in addressing O-BE is therefore constrained not only by clinical limitations but also by structural and attitudinal barriers. While some HCPs actively strive to mitigate stigma, broader systemic issues, such as inconsistent follow-up protocols, lack of trauma-informed training, and service fragmentation, these issues continue to undermine efforts to provide equitable, person-centred care for this complex client group.

The second subtheme looks at the clinical implications for the client group, when services appear unsympathetic and stigmatizing, consequently there are notable disparities in service provision between O-BE and other EDs. Our findings reveal several disparities: lack of tailored national guidelines for BED; limited treatment options; significant gaps in training and knowledge base of HCPs and lower perception of risk. Participants expressed frustration as under current national guidelines there are no protocols on how to support this client group within T3 WM services, beyond assessment and referral on to ED services. As discussed in chapter one, research literature suggests weight loss interventions can exacerbate symptoms of BE, therefore clients should be treated for BED first (Fairburn et al 2003; Masheb et al 2011). However, our findings suggest HCPs do not believe this should be the only approach and whether individuals with O-BE should participate in weight loss interventions is complex and debated among researchers and clinicians. There are studies that support the idea of weight loss intervention alongside psychological support for BE (Wilson et al., 2010;

Brownley et al., 2016). Opening-up the possibility of simultaneously support for both obesity & BE components would require further consideration around which service is most suitable for this client group, but it would also provide this service area with the tailored national guidelines needed to improve service provision and health outcomes.

Participants reveal that even though there may be an ED service available in a particular region, they will not necessarily offer BE support or a BED pathway. Local commissioning of services is most likely the reason for this disparity, as services are commissioned based on the healthcare needs of the local population according to the available evidence. However, it was established in the introduction of this study that BE/BED is more prevalent than AN & BN combined, so provision for BE/BED should surpass that of AN & BN. Yet, as established previously in this theme BED is often perceived to carry less risk than other EDs. According participants' perceptions, decision-makers with limited resources carry out risk stratifications and conclude that BED does not require the same priority or service provision as AN or BN. Some research reports that BED can have quite severe health consequences especially with delayed treatment exacerbating their symptoms (Kessler et al 2013), however it does not carry the immediate life-threatening risks associated with AN (Hudson et al 2007. It is important to note that there is an information gap between the number of people diagnosed with BED and the prevalence of BED symptomology (Smith & Goldschmidt, 2024; De Zwaan et al., 1994), therefore the scale of the problem is also not fully understood. Without clarity on the scale of the problem BED presents, no conclusion can be fully drawn as to the relative risk.

The final notable disparity is the lack of training on BED for HCPs. Our findings highlight there is a significant gap in the knowledge base of HCPs concerning BED, either not knowing how to identify symptoms and differentiate it from other EDs or not knowing what support or interventions are available and the referral pathways, all of which create a barrier to effective service delivery. A study of medical students found that education on obesity was a low priority and most teaching around obesity focused on the biology, epidemiology and comorbidities with little to no education on the sociocultural and psycho-behavioural aspects of obesity (Butsch et al., 2020) There is also a gap in research on the client group which could also explain its minimal inclusion in HCP training & education. A report on EDs looked at the allocation of funding for MH in the UK and found that even though EDs account for 9% of those with MH difficulties, EDs only received 1% of the research funding available (All-Party Parliamentary Group on Eating Disorders et al., 2021). The report goes on to state O-BE/BED is particularly impacted by this as an 'underserved group', and the lack of research focus and funding is evident in limited research literature and subsequent lack of training for HCPs. Ultimately, recognising the complexities and serious health implications of BED is crucial for improving service delivery and patient outcomes. Addressing these issues requires comprehensive training for HCPs, development of tailored national guidelines, and an expansion of treatment options beyond standard CBT to include more compassionate and personalized approaches.

Theme Two: The 'whack-a-mole' service delivery is failing to meet the needs of the whole person.

The 'whack-a-mole' service delivery described in this theme reflects significant gaps in how services address the needs of this client group. The three subthemes form a type of trifecta that restrict services from meeting the needs of clients. The first subtheme *Clients are bounced between services –HCPs unsure where support should begin* speaks to the lack of guidance there is in how to support the complexities of the client group. The second subtheme *'That's not our remit – HCPs' uncertain about clinical responsibility.*, is self-explanatory, HCPs grapple with who and what services should be taking responsibility for the client group and where to refer them to. The third and final subtheme *'The left hand doesn't* *know what the right hand is doing'* reveals the lack of communication and connectedness between services and how problematic this can be for the client group.

In the first subtheme, the findings depict a service delivery model which involves dividing the client group into diagnostic categories, pulling obesity and BE apart and attempting to treat them separately. However, this has caused a type of continuous whack-a-mole game, in which HCPs use an intervention to manage obesity but find it may exacerbate the BE. Another service will treat the BE but will not address the obesity potentially causing further issues such as MH comorbidities, which is addressed by another service. The findings reveal HCPs feel they have no real sense of direction as to where best to start with supporting this client group, while clients are left in the void between services on referral waiting lists. The limited research literature on BE and BED advises resolving the ED first (Fairburn et al 2003; Masheb et al 2011) and this could consequently improve obesity. However, there are studies that argue for integrated care pathways for conditions like BED, for example Grilo et al. (2016) found that combining CBT-E, WL intervention and pharmacotherapy had a better outcome than individual interventions.

Participants working in WM services questioned whether ED services are equipped to support O-BE, highlighting the need to address both conditions simultaneously. However, this focus on obesity conflicts with research suggesting that obesity is not central to BED's psychopathology (Latner & Clyne, 2008; Myers & Wimans, 2014). Research suggests that trauma often underlies both obesity and BED (Wooley & Garner, 2001; Danese & Tan, 2014), yet trauma-informed care was notably absent from many participants' interviews. This gap may reflect the absence of a unified NHS wide strategy, unclear definitions and limited implementation of trauma-informed approaches across NHS services (Emsley et al., 2022). Without addressing trauma as the root cause, current service frameworks risk focusing on symptoms rather than holistic, effective care (Huo et al., 2023).

The second subtheme, highlighted the ambiguity around clinical responsibility, where participants expressed uncertainty about which service should take the lead in treating this client group. This ambiguity is reflected in literature, one study reports there has been a long history in UK ‘obesity policies’, where no single stakeholder is willing to take clinical responsibility for obesity (Capehorn et al 2016). This may be in part due to the government’s longstanding non-interventionalist approach to obesity, therefore policies and strategies tend to centre around individual responsibility rather than a structural responsibility (Metcalfe et al 2023). This might explain why guidelines around WM services can feel unclear, Johnston et al (2023) argues that the flexibility of guidelines on tiered WM services is intended to allow for variance across the UK, however it has left service models open to interpretation causing further variance. What participants might be experiencing is local service criteria restrictions that are determined region by region and service by service. What is apparent, is the need for national guidelines that offer clear boundaries for WM services, with the hope of facilitating a more homogenous service model across the UK. In the findings, participants working in WM services expressed frustration about being equipped with the skills and training to support clients with MH, ED and other clinical presentations, but being unable to provide interventions for these issues due to service limitations. Participants particularly noted that these limitations are frequently tied to how services are commissioned, as funding and resources are often designated for specific conditions or populations, leaving little flexibility to address overlapping or intertwined conditions, this is supported by literature that looks at how WM services are commissioned across the UK (Finer et al., 2024; Metcalfe et al., 2023). This service limitation may detrimentally impact intervention waiting times, further exacerbating the health challenges for this client group (Tomiyama et al., 2018; Phelan et al., 2015). Allowing HCPs within WM services to offer additional support for O-BE and MH could enable clients to access comprehensive support that meets their needs, whilst potentially reducing overall service waiting times.

The concept of *clinical harm* refers to the deterioration in physical or mental health caused by prolonged waiting times for access to services (*NHS Performance and Waiting Times*, 2019; Holt & Hughes, 2021) and demand for services have increased significantly especially in the aftermath of the COVID-19 pandemic. Currently the waiting time for ED & MH services is anything from 5 months up to 2 years (*Waiting Times on the Mind – Adult Community Eating Disorder Services – the Conservative Mental Health Group*, n.d.; (*Two-fifths of Patients Waiting for Mental Health Treatment Forced to Resort to Emergency or Crisis Services*, 2020) While some healthcare systems track and develop strategies to mitigate clinical harm and reduce waiting times, this approach appears underexplored in relation to WM services (*Interventions That Can Support the Health and Well-being of People With Obesity on Healthcare Waiting Lists*, 2024). An alternative option to long waiting lists could be to offer support whilst waiting, Public Health Wales is currently exploring the feasibility of providing brief interventions that can be done with clients whilst they're waiting for more comprehensive treatment, such as text-based support (*Interventions That Can Support the Health and Well-being of People With Obesity on Healthcare Waiting Lists*, 2024). The gap in addressing intertwined conditions reflects broader systemic issues in commissioning and resource allocation. Expanding the remit of WM services to include trauma-informed and BED-specific care could help bridge this gap, providing a more holistic and effective response to clients' needs while reducing the harm caused by prolonged inaccessibility to appropriate care.

The third factor contributing to the failure of services in meeting the needs of the 'whole person', is developed from the final subtheme. Participants experienced current WM & ED services as fragmented, disjointed and consequently ineffective. Several reasons were spoken about, barriers to joint working, such as poor communication between WM & ED services or having vastly different service models across T3 WM services. However, what appears to underpin this disjointedness is the way in which the NHS in general approaches patient treatment and care, a participant working in primary care services described a system that tends to ‘segment off parts of the body’ (Faith, GP), dealing with conditions separately. This critique is not unique to the NHS, but has been ascribed to health and social care across the UK in general, in an annual State of Care report by the Care Quality Commission (CQC), the independent regulator of health & social services, they found that in areas where services failed to work together lead to a greater barrier to access services, than in areas where services worked more connectedly (*Heath and Social Care Services Crippled by Disjointed Approach*, 2018). Looking specifically within WM services, Hazelhurst et al (2020)’s review of the challenges in integrated clinical pathways for obesity management in the UK, questions the efficacy of T2, T3 &T4 WM services, if there is not more joined up working with each other and with other agencies that offer support that WM services.

Participants questioned the value of inter-service communication when there is no clear consensus on clinical responsibility or prioritization of client needs. This uncertainty underscores a systemic failure to address the complex, multifaceted requirements of this client group. Resolving these systemic issues will be important to improving service delivery, as further research into the psychological and physical needs of the client group is essential to inform service provision and ensure care is both targeted and effective.

Participants questioned the value of inter-service communication when there is no clear consensus on clinical responsibility or prioritisation of client needs. This uncertainty underscores a systemic failure to meet the complex and multifaceted requirements of people living with O-BE. The consequences of this fragmentation extend beyond service inefficiencies, potentially contributing to clinical harm, exacerbation of mental and physical health conditions, and the reinforcement of weight stigma within the healthcare system (Tomiyama et al., 2018; Holt & Hughes, 2021).

To resolve these systemic shortcomings, a coordinated, multi-level response is required. This includes the development of nationally standardised guidelines for obesity and eating disorder care that explicitly address comorbidity, clarify service boundaries, and mandate integrated care pathways. It also calls for commissioning reform to enable flexible, trauma-informed approaches within Tier 3 WM services and beyond, allowing practitioners to respond holistically to the psychological and behavioural needs of this population (Hazelhurst et al., 2020; Metcalfe et al., 2023). Moreover, ongoing research into the lived experiences and outcomes of those with O-BE is essential to inform evidence-based practice and avoid perpetuating one-size-fits-all models of care. Without such efforts, there is a risk that services will continue to operate in silos, leaving this vulnerable population underserved and inadequately supported.

Theme Three: The obesity economy: Commissioning, decommissioning and recommissioning services.

This theme highlights the detrimental impact, of how WM services are commissioned and funded, on the client group. The subthemes highlight three particular issues raised by the participants: firstly *'More money is not the answer'- The implications of referral incentives* – this suggests financial incentives for referrals may compromise service quality and create cyclical referral patterns that do not address the root causes of obesity. Secondly '*There doesn't seem to be much learning going on' – Issues with sharing data,* this highlights how contract bidding for WM services might lead to organisations being less likely to share outcome data, particularly if the data is unfavourable, therefore the system lacks a robust evaluation framework. Lastly, *The incongruence between service need and availability,* this refers to the geographical disparities in service availability and funding, is not as equitably distributed as it should be.

The first subtheme interestingly was developed based on the concerns raised by only one participant and therefore it could be concluded that this is on individual's opinion and unlikely to be a popular view amongst HCPs within this area. However, an alternative perspective could be, that it is more likely that HCPs who work in these services are unaware of the financial incentives system in place for GP services. Within NHS England the Quality & Outcomes Framework (QOF) is an optional pay for performance scheme, which offers financial incentives for general practices for achieving certain targets and outcomes in patient care and treatment (British Medical Association, 2024; Coulman et al., 2023). Although it is voluntary, 97.3% of GPs in the UK have opted in and it apparently accounts for at least 10% of their income (NHS England. 2024, August 29). There are specified indicators that GPs must meet to receive payment, for obesity, GP practices will receive a payment for recording adults 18+ with a BMI of 30kg/m2 or more, however there are no indicators/requirements for making referrals or treatment for obesity. For BED and in fact EDs overall there are no indicators or requirements for GPs to maintain records or make referrals for treatment (NHS England. 2024, January 30). Therefore, the suggestion that financial incentives are causing cyclical referrals may not be the case and in fact the opposite might be true, the lack of financial incentives for obesity and BE could be causing poor record keeping and consequently repeated referrals. In fact a cohort study in England looking at support of obesity within primary care, found that a number of GPs regularly did not record patient weights, making it difficult to grasp the scope of the issue (Coulman et al., 2023). The efficacy of the QOF has been called into question with Scotland scrapping the scheme completely (McLaughlin et al 2017), and studies finding its beneficial effects inconclusive (Hackett et al., 2014; Green et al., 2020). It is unlikely we'll have financially incentivised and/or mandated referral and treatment for O-BE, as it does not align with the government's non-interventionalist approach to obesity (Metcalfe et al., 2023), however it is worth considering that without it, the likelihood of things changing significantly for this client group may be minimal.

In the second subtheme our findings show a real sense of exasperation from HCPs, who highlighted the lack of effective evaluation of WM services, describing a broken link between feedback and meaningful change. Reasons given include the lack of information sharing between services, local government and with researchers on intervention outcomes, additionally the absence of any clear or mandated evaluation framework for these services nationally and locally. This critique supports the growing body of literature highlighting the lack of efficacy of WM services due to little to no evaluation processes (Hazelhurst et al., 2020; Fair et al., 2020; Theis & White 2021). Some studies suggest that T3 WM services appear to be effective, however follow-up after an intervention is usually quite short, so it is hard to know if a successful outcome has been maintained (Avenell et., 2018; Alkharaji et al., 2019; Hinde et al., 2020). Thesis & White's (2021) review of 'obesity policy' in the UK found only 24% of the policies included any service monitoring or evaluation plan, and these were not always mandatory. Another review looking specifically at best practices approaches for managing EDs in people with a higher weight, highlight the challenge of drawing on best practices when there is such limited evaluation and research in the services that support this client group (Ralph et al., 2022).

One participant raises concerns about the impact of contract bidding on learning and information sharing. Contract bidding in WM services involves a competitive process where various providers submit proposals to deliver specific services commissioned by NHS bodies or local authorities (Chambers, 2007). The process is designed to ensure that services are delivered efficiently, effectively, and at a reasonable cost (Metcalfe et al., 2023). However, based on the findings in this study there is a concern that contract bidding may create pressures that impact transparency of service efficacy. Participants in the findings suggested private organisations may be less likely to share treatment/intervention outcomes or progress particularly if the results are less favourable, as it could impact the organisations' ability to win contracts. This aligns with reports that the NHS tendering process can create structural inequality, workforce challenges and poor evaluation (Community *services: taking centre stage*. n.d.). A review of international studies looking at the effects of contracting out healthcare services, found that the service quality outcomes were scarcely examined making it difficult for there to be a comprehensive assessment on overall effectiveness of service delivery (Petersen, Hjelmar & Vrangbæk 2018). Interestingly during the recruitment for this study, it was a challenge communicating with non-NHS services with the aim of recruiting participants. Except for one organisation, the rest of the services were largely unresponsive to emails on the research proposal, unlike NHS services, where responses were prompt and showed a willingness to engage with the study. This gave further credence to the argument that there is a reluctance to engage with research and share information.

The final subtheme captures the impact of regional disparities across WM & ED services. This is probably one of the most frequently raised critiques of these services across the literature – with HCPs and clients highlighting the gap between client need and service availability (Coulman et al., 2023; Johnston et al., 2023; Finer et al., 2024; Capehorn, 2022, Theis & White, 2021; Holt & Hughes, 2024. Consequently, HCPs may not be able to refer clients on to suitable services, if those services are not available locally, therefore clinical pathways are less likely to be developed for this client group. According to the participants, financial constraints seem to be a main factor in the regional disparities. This has been evidenced by various studies reporting how some regions benefit from sustained investment and development of healthcare services, while others have experienced chronic underinvestment (Relton et al., 2014; Avenell et al., 2018). However, the lack of information sharing and evaluation monitoring could also be a factor here. Limited information means ICBs cannot appropriately allocate funds, and limited research means it is hard to completely grasp if services are addressing the needs of this client group. Without requirements to document this client group, financial incentives for referrals to WM or ED services, or consistent follow-up after interventions, ICBs potentially lack the data needed to assess local need, making effective planning and budgeting for services challenging.

In summary, participants highlight systemic inefficiencies, misaligned incentives, and a lack of adaptive learning that may exacerbate the "cost of obesity." Resolving these issues could be more cost-effective in the long term, requiring frontline HCP involvement in commissioning decisions, the implementation of rigorous evaluation frameworks, and a culture of adaptive learning that aligns services with evolving population needs. However, without structural reform, the current system risks perpetuating fragmented care, widening regional inequalities, and leaving individuals with O-BE unsupported in services not designed to meet their complex needs. Embedding accountability, transparency, and inclusive service planning will be essential to ensure that future commissioning frameworks are not only efficient, but also equitable and person-centred.

Theme Four: HCPs can feel complicit in a system that sets people up to fail.

This theme delves into the complex emotional landscape experienced by HCPs working within their respective services. It highlights the profound impact of their work on their emotional well-being, their sense of professional efficacy, and their perception of the healthcare system's effectiveness. The narratives reveal a dichotomy: feelings of frustration and disillusionment juxtaposed with moments of deep meaning and personal fulfilment. The second subtheme *Getting emotionally invested in the work*, provides a helpful rationale for why HCPs in the first subtheme are *Feeling frustrated and disillusioned with services* and the third subtheme *Finding Meaning in the Work*. Beginning with the second subtheme, some clients may experience HCPs as distant unconcerned and uncaring, this was also highlighted in the literature review of this study, however these findings reveal that HCPs do not only become emotionally invested in their work, but also feel a personal sense of responsibility for the perceived failings of services. This emotional investment appears to be somewhat of a double-edged sword, as it can drive HCPs to provide compassionate, supportive, person-centred care as they advocate for their clients. However, there is an emotional tax or burden that the participants described where they feel almost culpable and complicit in services failing to meet the needs of the client group. It is not often the research literature, looks at the sense of personal responsibility and complicity HCPs can feel when there are gaps and challenges in the services they work in. Most research either centres on a specific intervention for combating workplace stress or explores work-based stress as a result of an epidemic/pandemic or another crisis point. Due the uniqueness of this study, there is no literature to draw direct correlations with, however, these findings bare similarities to studies that found that HCPs regular interactions with patients and their families can be a source of stress, conjuring feelings of anger, embarrassment, fear and desperation particularly when the client needs are unmet (Koinis et al 2015; Boumans & Landewood 1996). These findings also correlate with a Swiss study looking at HCPs experiences of delivering palliative care for children, where HCPs found the failure of treatment/service distressing and burdensome (Bergsträsser, Cignacco & Luck 2017). The emotional toll underscores the importance of support systems for HCPs, such as clinical supervision and debriefing sessions, which may be crucial for processing the challenges they face. However important, that approach seems reactive, a more preventative approach could be to look at the challenges of service delivery and minimising them to ease some of the burden on HCPs. It is fair to say that that won't necessarily ease the 'emotional investment' of HCPs in their client's challenges in accessing services, however it may reduce the feelings of frustration and disillusionment.

In the first subtheme, the findings reveal that not much has changed in service provision. This subtheme captures a shared sense of disillusionment among participants regarding the lack of meaningful progress in service provision. Participants reflected on the fact that not much has changed in the structure or priorities of WM services over the past 15 years. Those with experience of the early WM services spoke of familiar frustrations, issues such as the disconnect between administrative decision-making and clinical realities, and the continued emphasis on weight loss targets over holistic, person-centred care. Interestingly, more recently qualified HCPs described almost identical challenges, suggesting that the problems are not only longstanding but systemic and embedded in the way services are commissioned and delivered.

You can almost trace an experiential journey through the narratives: many HCPs entered this field with a sense of hope, passion, and motivation to support a stigmatised and underserved client group. Over time, however, this hope often gave way to exasperated burnout or a more subdued acceptance of service limitations. These emotional responses were not just individual, but reflective of broader frustrations with a system perceived as resistant to learning or evolution. This aligns with the second subtheme in theme three, '*There doesn't seem to be much learning going on*', where participants questioned why service models have remained stagnant despite evident gaps in outcomes and persistent challenges.

These lived realities resonate with wider policy-level critiques. Theis and White (2021), for example, reviewed obesity policy over a thirty-year period and found remarkably little change in the approach to obesity, despite increasing prevalence and growing complexity, particularly in cases involving binge eating and mental health comorbidities. This lack of meaningful progression, both in practice and policy contributes to a climate where HCPs feel unsupported, unheard, and professionally constrained. Whether met with burnout or reluctant acceptance, the emotional toll described by participants underlines the urgent need for systemic learning, structured feedback loops, and emotional support mechanisms such as clinical supervision and cross-disciplinary collaboration. Without these, services risk continuing to fail not only the clients they aim to support, but also the practitioners tasked with delivering care within them.

Despite the aforementioned challenges, this has not stopped HCPs from finding the work they do important and meaningful, as seen in the third subtheme. Participants expressed a sense of meaning or purpose that often appears to arise from the positive changes they witness in their clients that are not captured by traditional outcome measures such as weight loss. Their positive experiences also arise from a sense of personal & professional achievement, for example by broadening their understanding and approach to weight management, in a way they may not have done before. There is limited research looking into the experiences of HCPs within WM & ED services; therefore, this study spotlights a perspective not often sought. However, their perspective does resonate with other studies that have looked at the experiences of HCPs across other services (Sinclair et al., 2017 & Hall et al., 2024). In the Sinclair et al., 2017 study HCPs delivering compassionate care, described a strong sense of purpose derived from meaningful connections with their patients and helping alleviate their suffering. Lastly, the participants described the importance of support and community amongst HCPs being a very valued and meaningful aspect of their work. It is particularly helpful in alleviating some of the pressures of supporting the client group, felt by lone practitioners such as GPs. Therefore, increased connectivity between GP, WM & ED services will be crucial to meeting the needs of the client group but also the needs of the HCPs supporting them. In summary the emotional challenges faced by HCPs are explored in this theme, revealing feelings of frustration and disillusionment. Feeling complicit in systemic failings that hinder holistic care, which can lead to stress and a sense of personal responsibility. Despite these challenges, many find the work they do meaningful, driven by positive client outcomes and personal/professional growth. The findings emphasize the need for proactive support systems, improved service delivery, and greater connectivity between services.

Theme Five: Expanding provision beyond short-term targets towards long-term change

The fifth theme offers the much-needed perspectives of HCPs on ways services can be improved. HCP recommendations make up the three subthemes: in the first subtheme *A more personalised approach to health* they request a shift in the service approach, to be more personalised to individuals whilst holding in mind cultural factors that may influence successful long-term change. In the second subtheme *Integrated care as a solution to the challenges in service delivery,* HCPs highlight the necessity of cohesive service connectivity and joint working. Lastly in the third subtheme *Rethinking KPIs – Improving follow-up and outcome monitoring,* HCPs implore decision makers to re-evaluate success/outcome metrics/measures of interventions and services.

The first subtheme is developed from the participants' advocacy for the need of a more personalised approach to support for this client group, due to their complexity, as no one service is equipped to fully meet their needs. Participants suggest this can come in the form of a pathway through services particular for this client group or in the form of an 'all under one roof' service that is able to adequately address O-BE and experiences of trauma. The call for a more personalised approach to care is certainly not a new one, our findings add to the research literature on the benefits of a more personalised approach to healthcare in general (Goyal-Mehra et al., 2022; Kalarchian & Marcus, 2015). However, HCPs also recognise the practical challenges of delivering more personalised care, particularly when navigating the tension between national healthcare strategies designed for the general population and the need for local services to meet the individualised needs of their clients. Despite these challenges, some services have successfully implemented local-level adaptations that reflect the specific needs of their client populations, demonstrating that personalised care can be embedded even within broader policy frameworks (Ayedi et al., 2021).

There is a small but growing body of literature on the significant cultural barriers that exist in WM services and across healthcare in general, highlighting the need for more culturally sensitive and representative approaches to effectively engage diverse client groups (Andrews et al 2017; Maynard et al., 2023). In findings of this study, there were three key issues identified concerning the cultural gap in services: firstly, the lack of cultural representation among HCPs which impact how guidance is perceived, because clients experience a disconnect with guidance that does not take their traditional foods and eating habits into consideration, creating the feeling that the advice is not applicable to them, potentially impacting engagement with services. Cultural representation amongst HCPs in WM services will be a challenge particularly when individuals that identify with an ethnic group other than White/Caucasian make up only 18.3% of the UK population according to the 2021 Census by the ONS (Population of England and Wales, 2022). However, HCPs developing a greater cultural competence and providing advice that respects and incorporates the traditional foods and eating habits of their clients and the communities they serve, could bridge the gap in services. The second key issue is the cultural disconnect between some religious groups and some of the psychological content in WM and ED services, that may not align with their beliefs such as, mindfulness. Although mindfulness has been adapted to be secular in content, its Buddhist roots (Carmody et al 2008), may be problematic for some faith groups. Therefore, holding these cultural tensions in mind could increase engagement, improve treatment outcomes and foster greater client-clinician relationships. The final issue raised was how strict attendance policies and the lack of recognition of various cultural and religious holidays outside of Christmas holidays could further alienate clients. Inclusive practices, such as acknowledging and making accommodations for different cultural and religious observances, would be beneficial. Literature suggests that culturally adapted interventions are more effective in engaging clients and improving health outcomes, adherence to recommendations and all overall satisfaction with treatment (Benish et al 2011; Chin et al 2007; Betancourt et al 2002).

Our second subtheme encapsulates the participants' call for more integrated care concerning this client group. Some envisioned fully integrated services where O-BE and MH support 'all sit under one roof', enabling simultaneous or collaboratively planned interventions for comorbidities. Others emphasized the need for improved communication and liaison between WM, ED & GP services to ensure updated & clear referral pathways. A third perspective advocated for collaborative referrals, assessments, and joint sessions involving both WM &

ED HCPs, fostering shared decision-making and comprehensive care. The third concept of integrated care probably sits in the middle of all three and might be the idea most plausible to implement, that could still have an impact in improving services for the client group. However, the concept and practical application of integrated care is not without its challenges. Nonetheless, this model builds on existing infrastructure, aligns with NHS priorities on joined-up care, and may therefore represent a feasible and impactful step toward more holistic service provision.

The participants' varied views appear to echo the conceptual variation of integrated care in literature, some research literature supports the effectiveness of more integrated care in managing chronic health conditions (Katon et al 2010; Thornicroft et al 2019). For instance, the Katon et al. (2010) demonstrated that collaborative care models, which integrated mental health services with primary care, significantly improved outcomes for patients with depression and diabetes. The need for more integrated care models is often seen in the recommendations of research articles that highlight issues with past and present health care systems (Gongora-Salazar et al., 2022; van der Feltz-Cornelius et al., 2024). However, the concept, structure and efficacy of integrated care systems seems more elusive. A review analysing the empirical research and theoretical work on integrated care found the efforts to unify a multiplicity of services, objectives and policies has been very challenging (Hughes, Shaw & Greenhalgh 2020). Additionally, they found the intention or agenda behind more integrated care, differed across different groups of people, for some it was to improve the client experience of services and for others it was to reduce funding costs and hospital admissions. Another challenge to a move towards more integrated care is the geographical location of services, WM & ED services are not mandated to be available in every region, so service availability will differ based on local resources and commissioning decisions. So, there could be an ED service in one area, but not a WM service, even if there is a WM service in the area, it may not be a tier 3 WM service, or there might be an ED service, but they do not offer a BE pathway/support. The establishment of integrated care systems in the UK aims to improve the integration and coordination of services, including WM & ED care. However, the practical implementation and effectiveness of these systems in ensuring consistent service provision across all areas remains to be seen.

Lastly, in the last subtheme, the findings highlight the need to review how clients are followed up after engagement with WM services, and how an intervention or service or has been deemed to be ‘successful’. Participants argue that KPIs that focus solely on weight loss targets and completion of the intervention are limiting and problematic for potentially two reasons. Firstly, it fails to capture non-weight improvements that could positively impact mental and physical health. We might also miss the beneficial impact on service pressures and costs when data such as reduced GP visits or hospital admissions are not taken into account. Secondly, solely capturing weight loss targets and intervention completion rates could potentially askew the perception of WM services being more effective and successful than they actually are. So even though a client may have completed a WM programme and lost 5% of their body weight at the end, however, if not followed up whether the weight loss has been maintained and if their MH has improved will not be known. Research by Kushner and Ryan (2014) emphasizes that focusing solely on weight loss overlooks other critical health benefits. They argue that improved metabolic health, increased physical activity, and enhanced mental health are significant outcomes that should be factored into success metrics. Similarly, MacLean et al. (2015) suggest that a multifaceted evaluation approach that includes these broader health indicators can provide a more accurate and meaningful assessment of WM services’ effectiveness.

HCPs not only call into question, what needs to be followed up, but also how it is followed up. There was an emphasis on creating forward plans and ensuring seamless transitions between services, either between WM or ED or the GP. Research supports coordinated care plans and continuous patient follow-up can significantly improve long-term health outcomes, particularly for chronic and MH conditions (Herbert et al 2014; Jackson et al 2013). The participants who worked in WM services felt that GPs, should be the key point of follow-up, as they hold overall responsibility for the coordination of all services delivered to each client. However, participants within primary care services expressed the significant challenges they face in following up and ensuring continuous client engagement with WM or ED services, time constraints, insufficient resources and ‘GP patient lists’ having risen by 42% in the last 10 years (Davies, ONS, 2022), making the reality of following up with patients very difficult. Participants’ suggestion of more HCPs within primary care that can help with following up clients is an interesting one, but not a new one. There has been a shift towards specialist liaison HCPs within primary care services/GP practices in the last few years, such as a mental health liaison, or diabetes nurse, dieticians, social prescribers (Gibson et al., 2023, Tomaschek et al., 2022). The suggestion from a participant that they could offer support with following up more clients after intervention or non-engagement, could be a helpful one, to counter the time constraints faced by GP services concerning follow up.

In conclusion, HCPs advocate for the need for broader physical & mental health metrics and robust follow up after service engagement to better assess the effectiveness of WM services for this client group. Implementing these suggestions will requires addressing systemic challenges and resource constraints, but the potential benefits for client outcomes and healthcare efficiency could be worth the initial investment.

THE OVERALL STORY

Taken together, the five themes in this study offer a rich account of the systemic, structural, and emotional challenges involved in supporting people with O-BE within UK healthcare services. Although each theme focuses on different aspects of care delivery, they collectively highlight an overarching concern: current service models are poorly aligned with the complex needs of this client group, and this misalignment places a significant burden on the HCPs who work within them. Across the data, a picture emerges of a system shaped by fragmentation, stigma, and inefficiency. One central point to these findings is the disconnect between the complexity of client needs and the often inflexible nature of service provision. Participants described how care is divided into distinct pathways, with obesity and BE addressed separately, despite their frequent comorbidity. This division is not just diagnostic, but is deeply embedded in how services are commissioned, resourced, and evaluated. Referral processes are siloed, outcome measures mainly focus on weight loss, and service boundaries are shaped by rigid eligibility criteria that do not always consider psychological comorbidities or cultural context. As a result, individuals are passed between services with little continuity or coordination, in what participants described as a frustrating cycle of "whack-a-mole" care.

What stood out most powerfully, however, was not just the inadequacy of the system, but the emotional toll it takes on HCPs delivering care. A clear thread running through the data was the sense of internal conflict and moral distress experienced by HCPs, many of whom entered services committed to meaningful care, only to find themselves constrained by systemic barriers. Participants described feeling emotionally invested in their work, yet increasingly disillusioned by services. Some reported feeling complicit in a model of care that fails to address the root causes of client distress. This emotional burden, heavy and often unspoken, reveals not just a service gap but a moral conflict that many HCPs carry silently.

These emotional responses are central to understanding the real impact of systemic dysfunction. When interpreted reflexively, the data reveals more than gaps in policy or service delivery issues; it highlights the emotional cost on the workforce itself. This is where the study's central story unfolds, in the space between what HCPs strive to offer and what the system permits them to deliver. While many participants still found purpose in their work, these experiences were often shadowed by a sense of futility. Theme Four, captures this strain most clearly, showing how the emotional and ethical burden of HCP work is tied to structural limitations. Therefore, improving care for people with O-BE must go hand in hand with addressing the needs of the HCPs who support them. These considerations are further explored in the clinical implications and recommendations section.

STRENGTHS & LIMITATIONS

Strengths

This study has several strengths that are important to note of this study, firstly, it is the only known study that has sought the perspectives of HCPs within WM, ED & GP services, supporting clients with O-BE, with the aim of understanding if current service provision is meeting the needs of this client group. Therefore, it offers valuable insights into the gaps and challenges of current service provision, that take into account the complex needs of this client group, whilst identifying systemic shortcomings.

The recruitment and inclusion of participants from several NHS sites across various geographical locations means the findings have greater generalizability. Yet the idea of generalizability in qualitative research can be controversial, because qualitative research does not concern itself with large scale replicability and is more concerned with deepening the understanding of specific situations and phenomena (Tuval-Mashiach, 2021). However, there is an argument for it, if the purpose of the study and its research questions/aims to build a new theory and fill a gap in literature (Tuval-Mashiach, 2021). Generalizability can be better framed as transferability, which is the extent to which findings might apply to other similar settings (Stalmeijer et al., 2024). The multi-region sample allows for enhanced transferability and have a broader relevance, because it is apparent that the challenges and gaps in service delivery are not unique to one area or even to one NHS or non-NHS site. The issues are systemic, and the underpinning framework and guidance of the service area are where the issues lie. The inclusion of participants across three service areas provided insight into the similarities and differences in their experiences. The differing opinions on how to meet the needs of the client group and the follow-up process, for example, were important contentions to note, that may not have been picked up if only one service type was included in the study.

The sample size can be viewed as another strength of this study, achieving the number of participants it set out to recruit, the sample size aligned well with the chosen methodology and analysis of this study. Fifteen participants was sufficient enough to provide the relevant information for a broad range of experiences across the services. The extensive amount of data gathered from each interviewee also aids greater understanding of the difficulties this niche client group may encounter in accessing services and the HCPs that support them and allowed for a contextual focus on the unique challenges faced within this service area. Furthermore, the smaller sample size provided the opportunity to reflect on the researcher-participant interaction, which is an important aspect of chosen analysis. The semi structured interview process allowed for participants to not only discuss the research focus of the study, providing detailed and rich data for analysis, but to raise issues in service delivery the researcher had not considered prior to this study. Issues such as HCPs feeling complicit in the failures of service delivery, may not have come up in a structured questionnaire.

By authentically opening up about my experiences, biases, perspectives and privileges, I have ensured a full picture of the position from which this study was carried out. Therefore my reflexivity throughout is another strength of this study, offering readers, a transparency throughout the research process. Maintaining a reflective log throughout the study helped capture real time thought processes and allow for reflection at the end of each process. The in-depth reflection on participant interaction in the findings chapter also contributes to the overall rigor and credibility of the study, as it aids the reader’s understanding of how participants may have been impacted by their perception of my own experience as part of the client group.

Limitations

Despite its strengths, this study is not without its limitations. There were no male participants, despite best efforts to recruit male HCPs across all three service areas by specifying male only participants towards the end of the recruitment stage. Their perspective would have been valuable, because unfortunately the history of this subject area tends to be far more female-oriented with mainly female participants whether clients or HCPs (Pagoto et al., 2012). Research in WM has found that male participants are typically harder to recruit than female participants even though they are affected by obesity to a similar degree as women (Pagoto et al., 2012), the likely reasons for this are: (a) the specificity of this service criteria for recruitment would reduce the likelihood of male participants, as there tends to be more female staff in WM and ED services than male staff and (b) as discussed in the introduction chapter of this study, the majority of people who present with O-BE are female, therefore the study may not have appealed to potential male HCPs in the same way it might appeal with females. A male participant might have been able to identify where services are not meeting gender specific needs, so this will need to be considered in further research in this area. Despite this limitation, many of the gaps and challenges in service delivery weren't gender specific and more systemic and policy driven, therefore can still be beneficial for male and female clients.

Another potential limitation is that some may perceive the representation of participants from an ethnic minority as low with two thirds of the participants identifying themselves as Caucasian (n=10). However, this ratio aligns with what ethnic groups make up NHS staff nationally, with 74.% identifying as Caucasian and 25.7% from ethnic minority groups (*NHS Workforce*, 2023). It is important to note that that percentage concerns NHS staff only and does not factor in services commissioned by the NHS. Notwithstanding, it can be said the sample does slightly better in representation of ethnic minority than the NHS staff national percentages. The overrepresentation of psychological roles within the sample, is a further limitation of the work, with just over half of the sample reporting a psychological role (n=8).

Additionally, despite the researcher’s best efforts, no nurses or WM/ED doctors were recruited within this study, their inclusion would have been beneficial to see if more medically inclined HCPs such as nurses and doctors, experience the same challenges in the service delivery than allied HCPs. Furthermore, this study might have overlooked discipline-specific challenges that nurses and doctors may encounter although, the experiences of doctors within GP services were gained. Further research with these HCPs would provide additional insight.

A final limitation of this study lies in the exclusive use of online interviews, which naturally restricts the observation of non-verbal cues such as body language or subtle shifts in emotion, elements that can enrich understanding in qualitative interviewing. Additionally, the potential for technological difficulties (e.g., poor connectivity, sound or video issues) and varying levels of digital literacy may have impacted the smooth flow of interviews or even limited participant engagement. In some cases, these factors can lead to shorter or less detailed responses, particularly if participants felt less comfortable or struggled to establish rapport in a virtual setting. Some of these factors were addressed by giving participants the choice to conduct the interview in person or online. When online interviews were the preferred option, ensuring all participants had their video and audio turned on, so facial expressions and voice inflections could be observed. Additionally, time was factored into each interview to allow for any connectivity issues to be resolved. Lastly, reflective journaling was also undertaken by the researcher which helped deepen the data and support a more nuanced understanding of participants’ experiences.

IMPLICATIONS & RECOMMENDATIONS

Clinical implications & recommendations

An overhaul of outcome measures/metrics

The findings make it apparent that outside of weight loss percentage and treatment completion rate there needs to be a better metric of outcomes, because the current metrics paint an incomplete picture and askew actual service efficacy. Therefore, it is recommended that several other metrics be recorded pre, post and during intervention, including but not limited to: (1) cognitive and emotional risk factors, measures that identify issues with low self-worth, low mood and perfectionism, (2) self-stigma, capturing this pre and post and in follow up with be particularly helpful, as self-stigma is highly associated with increased binge episodes, (3) number of visits to the GP, (4) changes in cholesterol levels and blood pressure checks. This recommendation would need to work alongside a comprehensive client follow-up process.

Better follow up of progress is required

The findings reveal that the long-term impact of interventions on the client group is not completely understood and therefore it is not known if the support from WM services has had any long term effect on clients or reduced the financial burden of obesity on healthcare resources. One of the reasons for this is the lack of follow-up with clients whether they drop out of an intervention or go on to complete the intervention as highlighted in the findings and in the literature (Booth, Prevost & Gulliford 2015; Alkharaiji et al 2019). Therefore, as suggested by participants, a regular and consistent follow-up process across a longer period of time would provide greater insights into the efficacy of services and interventions. A longitudinal study on a sample of men engaged in a football fitness program, who were followed up 3.5 years post intervention, saw long term improvements in dietary and physical habits and sustained weight loss (Gray et al 2018), providing evidence for the success of this intervention.

Development of a robust recording & evaluation process

The findings highlight that the scope of the O-BE problem is not fully understood and the effectiveness of services not properly measured. Therefore, it is recommended that there should be consideration for incentivizing primary care services to keep up to date records of clients suffering with O-BE and whether they have engaged in WL interventions. This would align with how other chronic conditions such as diabetes are also recorded and managed in primary care. It is also recommended that WM services better assess their service provision through a comprehensive evaluation framework. The evaluation framework should be homogenous, clear, robust and a requirement across all tier 3 WM services, whether NHS based or otherwise. Although this study focused on tier 3 services, but tier 2 & tier 4 services could benefit from such as framework, as they are closely linked to tier 3 WM services. Services should be mandated to share their outcome data to aid learning and reduce replicating service models that are not working. Such a framework would also aid commissioners in their decision making and funding allocation.

Considering the impact of the work and valuing the voice of HCPs

Findings highlight the importance of recognizing and responding to the emotional toll of the work on HCPs. To address this, services should provide regular, protected reflective spaces, not just to discuss clinical cases, but to explore the impact of the work itself. This could normalize emotional responses, reduce isolation, and foster a more resilient workforce. Additionally, creating structured opportunities for HCPs to voice their concerns and contribute to service development is essential. Too often, strategic decisions are made without input from those delivering care on the ground. Involving frontline HCPs in shaping service pathways can help ensure that policies are informed by lived experiences, improving both HCP wellbeing and effectiveness of care. Supporting the emotional wellbeing of HCPs is not separate from good clinical practice, it is integral to it.

More thinking about the impact of trauma

Despite it being one of the contributing factors to O-BE, there was a notable lack of discussion about trauma during the interviews and in the literature in general. This might be due to the lack of clear policies and guidelines on what TIC looks like, however TIC is crafted in a way that guides HCPs on how to hold trauma in mind, rather than address it. Therefore, WM services to think about how their service delivery could incorporate interventions that discuss and address trauma, as trauma can be implicated in non-BED obesity too.

More culturally relevant treatment interventions

These findings highlight that current service provision and policies underpinning those services may not hold in mind culturally and ethnically relevant challenges in service provision, which may impact client experiences and potentially the outcome of an intervention. Cultural competence in healthcare is essential for ensuring that interventions are effective and respectful of patients' cultural backgrounds. Therefore, it is recommended that there is a review at policy level to adapt guidelines ensuring that they do not indirectly discriminate against a particular group.

A move towards integrated care

A clear definition and a framework for integrated care specific to this service is needed. Even amidst regional disparities, varying service models, and other challenges of integrating services, such a framework would guide service modelling and foster more cohesive delivery. This requires services to establish well-defined pathways between WM, ED, and GP services, ensuring HCPs are aware of and can easily access these pathways. Additionally, services should evaluate whether the complexity of this client group requires support from a single, unified team, or whether coordinated care across multiple services would be more effective. For example, findings from this study suggest that clients are often passed between services without clarity on who holds clinical responsibility. Exploring a unified care model, where ED and WM services work collaboratively, potentially within the same team, could address this issue by reducing fragmentation and improving continuity of care.

Policy Implications & Recommendations

Review of current policy and national guidelines

The findings highlight that current national guidelines on obesity and BED inadequately address the interconnectedness of these conditions, leaving HCPs uncertain about how best to support this client group. Considering the prevalence of BED, its low treatment rates, and high dropout rates, developing guidelines that provide a framework for collaboration between WM, ED & GP services would be highly beneficial. Moreover, mandating treatment and support for BED, similar to the requirements for AN & BN could help bridge these gaps and improve outcomes for this underserved population.

Review of QOF indicators of BE & OB

The absence of indicators within the QOF that financially incentivize GPs to record and refer clients for support with EDs and obesity, may contribute to underreporting of these conditions. Introducing such indicators could enable ICBs to better understand the scope of the issue within their local populations and allocate funding appropriately. It is important to acknowledge that even with this information, due to national funding constraints, ICBs may still struggle to meet local need, however the information can be useful for data gathering, would could potentially inform research and improve the understanding of this client group.

Lastly, incentivised reporting and referrals could encourage GPs to engage patients in discussions about O-BE, fostering dialogue about their symptoms, needs, and available support options.

Mandatory training for HCPs

Our study aligns with existing literature highlighting the lack of training and awareness among HCPs regarding obesity and BED separately and as comorbidities. While post-qualification training could enhance HCPs' ability to support this client group, incorporating obesity and BED education into core pre-qualification clinical modules would ensure that knowledge and awareness are embedded early in the careers of HCPs. Given the growing prevalence of obesity in the UK and globally, it is essential for HCPs to fully grasp both the medical and non-medical factors contributing to these conditions and the develop a good understanding on the most effective support/interventions for this client group.

FUTURE RESEARCH

Future research should address several critical gaps in understanding and improving the support provided by WM & ED services. One priority is developing more comprehensive metrics for assessing client progress. Current measures, such as weight loss alone, fail to capture the full scope of improvements in mental, emotional, and physical health. Research exploring holistic and individualized success indicators could offer a more accurate reflection of intervention efficacy & outcomes and provide insights into the nuanced benefits experienced by clients. Additionally, it would help us understand what factors help sustain weight loss with the aim to scale up and replicate such results. Research could also help us examine the clinical and psychological harm caused by prolonged service delays, many clients face significant health risks while waiting for support from services, and research into the consequences of these delays could underscore the need for streamlined referral pathways and the need for interim strategies to mitigate their impact. Similarly, the feasibility of implementing in-depth follow-up protocols post-intervention warrants investigation, as such measures could help maintain client progress, reduce relapse rates, and promote sustained well-being.

Another critical focus for research is understanding systemic and organizational factors that influence service delivery. The role of QOF metrics and financial incentive referrals in shaping referral patterns, client outcomes, and service workload would benefit from closer examination. Insights into these dynamics could inform policy adjustments that improve service efficiency and effectiveness for both clients and service providers. Furthermore, exploring the emotional and professional impact of working in WM and ED services on HCPs is vital. Research could shed light on how systemic challenges and organizational structures affect HCP well-being, guiding the development of targeted strategies such as improved organizational support systems, training, and workload management to alleviate the emotional burden of delivering care in these complex service areas. By addressing these research gaps, future studies can contribute to more effective, equitable, and sustainable models of care.

Final Reflections

Completing this thesis often brought significant internal challenges, as I detailed in the Methods chapter. I frequently questioned the wisdom of pursuing this research, particularly as someone who identifies with the client group. However, reflecting on the journey, I now see that my subjectivity and sensitivity were not limitations but essential drivers that could help ignite even the smallest change within a complex healthcare system.

At times, the enormity of this study felt overwhelming. Only now, in completing it, do I realize how much of this weight came from a sense of responsibility to do justice to the work, given my personal connection. This connection, while challenging, also provided me with invaluable insights into the systemic issues within WM & ED services—insights I will carry with me throughout my career. It reinforced two important truths: first, that the challenges faced by frontline staff often exceed their capacity, making their contributions all the more significant and worthy of recognition; and second, that understanding these systemic barriers has allowed me to reframe my own experiences within WM services, helping me release some of the internalized guilt and shame I carried, though not entirely.

Writing the discussion chapter proved particularly illuminating. Wearing my "client hat," I was forced to confront past frustrations with WM and GP services. This process deepened my understanding of the systemic challenges these services face—challenges often invisible to clients. It also helped me connect with the participants as fellow HCPs. Theme four, which explored the emotional toll on HCPs, resonated deeply with me. It highlighted how little space is afforded to HCPs to reflect on the emotional impact of their work, particularly when systems are underperforming. This realization has inspired me to prioritize these conversations in the future, especially when facilitating supervision or reflective spaces. I believe creating opportunities to explore how work affects HCPs could not only support their well-being but also reveal valuable insights that might otherwise go unnoticed.

Throughout the research, I often found my thoughts straying down tangential paths (the impact on children/adolescence; comparing services across a 20 year span; the impact of AL medication), threads that were relevant but fell outside the scope of this study. This highlighted the multifaceted nature of the topic. With more time, I could have delved deeper, nonetheless, these tangents underscored the richness of the subject and the necessity for continued exploration and advocacy. The insights gained through this process have not only deepened my understanding of systemic challenges but also strengthened my resolve to contribute meaningfully to the field.

CONCLUSION

This study represents the first UK-based exploration of HCPs’ experiences supporting clients with O-BE and histories of trauma. The findings reveal a clear misalignment between the complex support needs of this underserved client group and the limitations of current service provision. By recruiting HCPs from Tier 3 Weight Management, Eating Disorder, and GP services, the study addressed a significant gap in the literature. Through reflexive thematic analysis, the data illuminated systemic challenges that mirror existing concerns in the literature, while also offering fresh perspectives grounded in frontline experience. Crucially, the study also provided space for HCPs to voice their frustrations, share their insights, and offer suggestions for improvement at clinical, policy, and research levels. A notable finding was the emotional burden many HCPs carry in this work, often feeling complicit in a system that sets clients up to fail, which warrants further exploration and consideration. These contributions deepen our understanding of the structural and relational dynamics shaping care delivery and offer valuable guidance for enhancing support for this client group and the services designed to help them.

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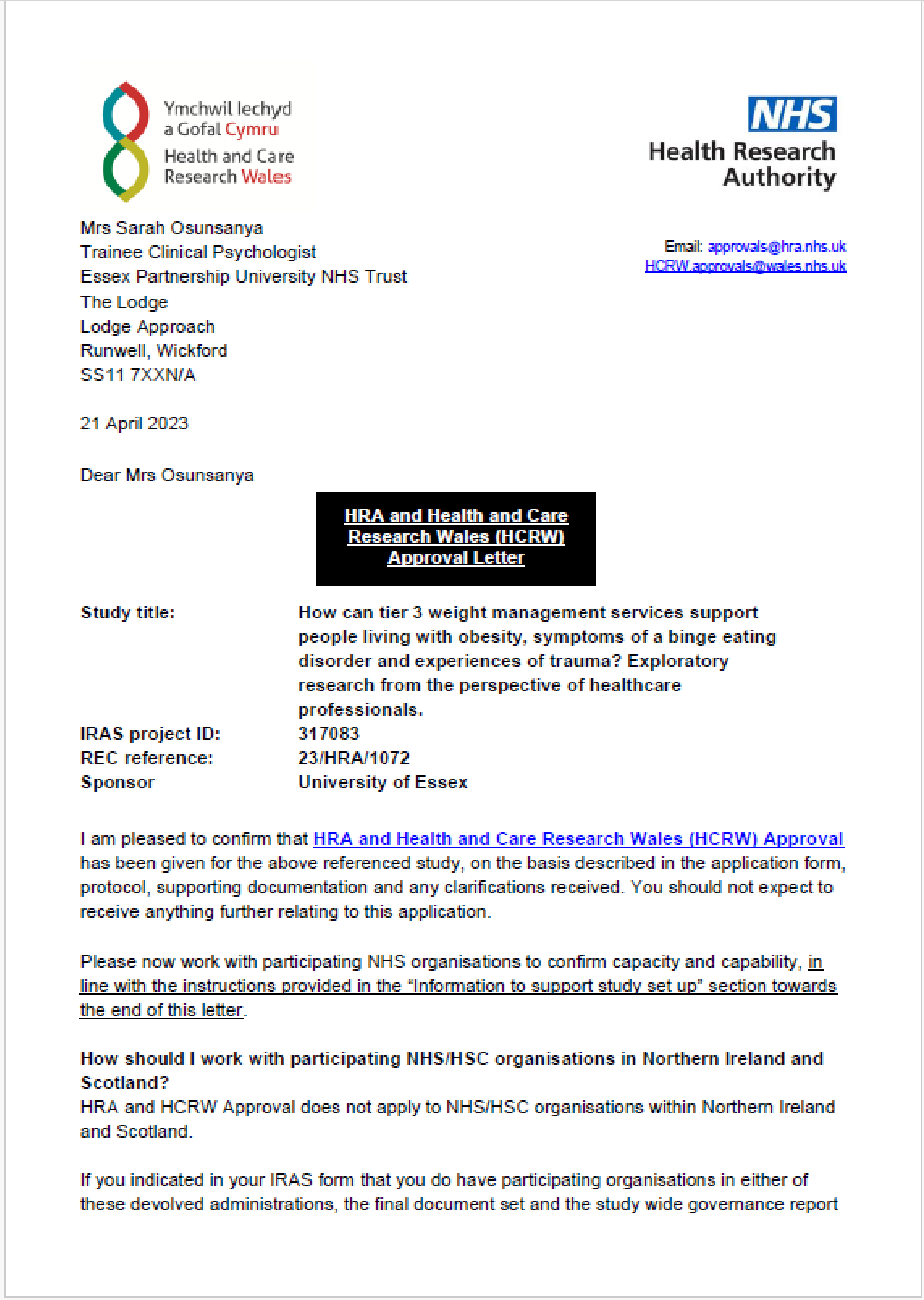
APPENDICES

Appendix I – Health Research Authority Approval letter



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Mrs Sarah Osunsanya
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21 April 2023

Dear Mrs Osunsanya

HRA and Health and Care Research Wales (HCRW) Approval Letter

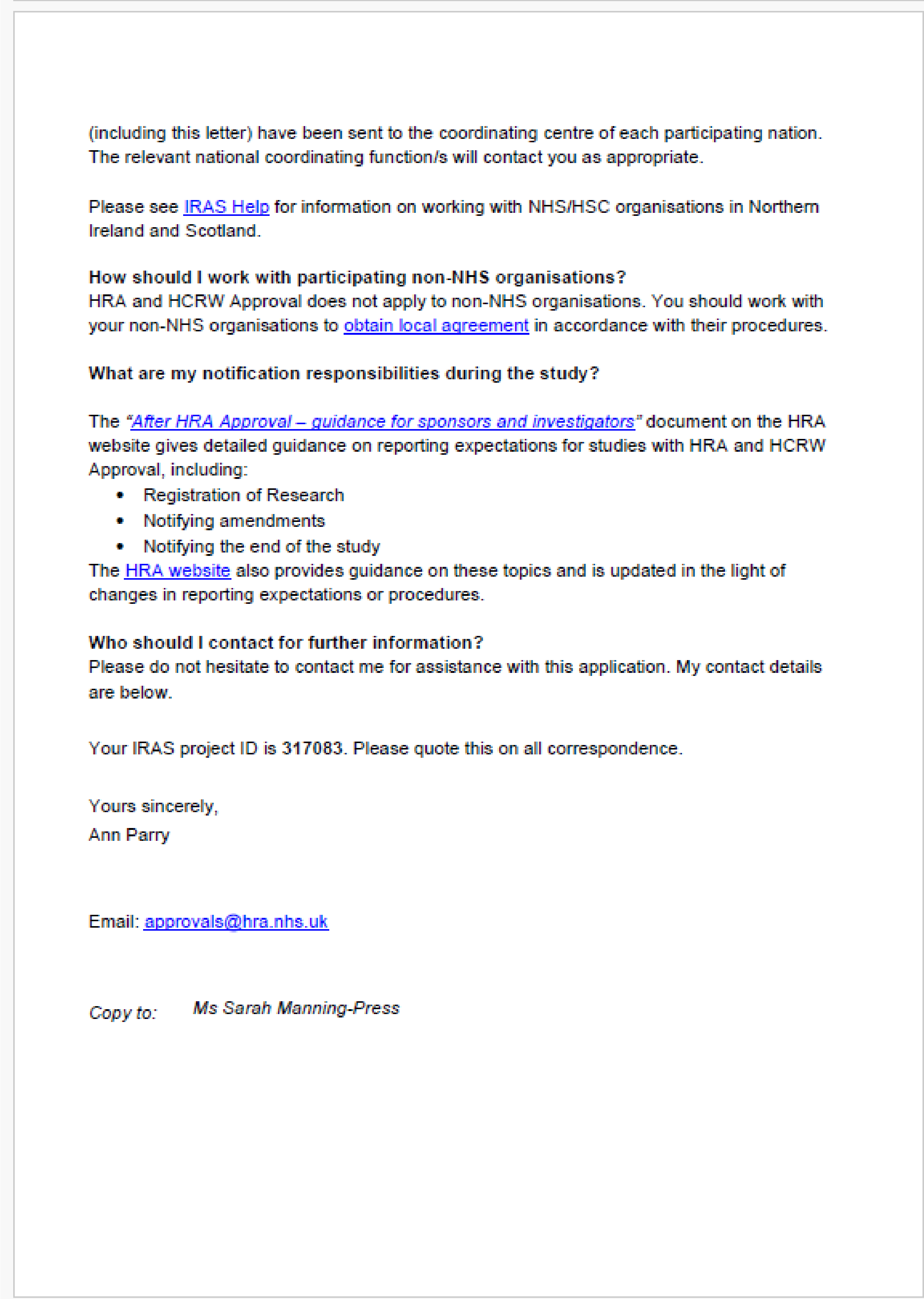
Study title:	**How can tier 3 weight management services support people living with obesity, symptoms of a binge eating disorder and experiences of trauma? Exploratory research from the perspective of healthcare professionals.**
IRAS project ID:	**317083**
REC reference:	**23/HRA/1072**
Sponsor	**University of Essex**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report



(including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The *"After HRA Approval – guidance for sponsors and investigators"* document on the HRA website gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

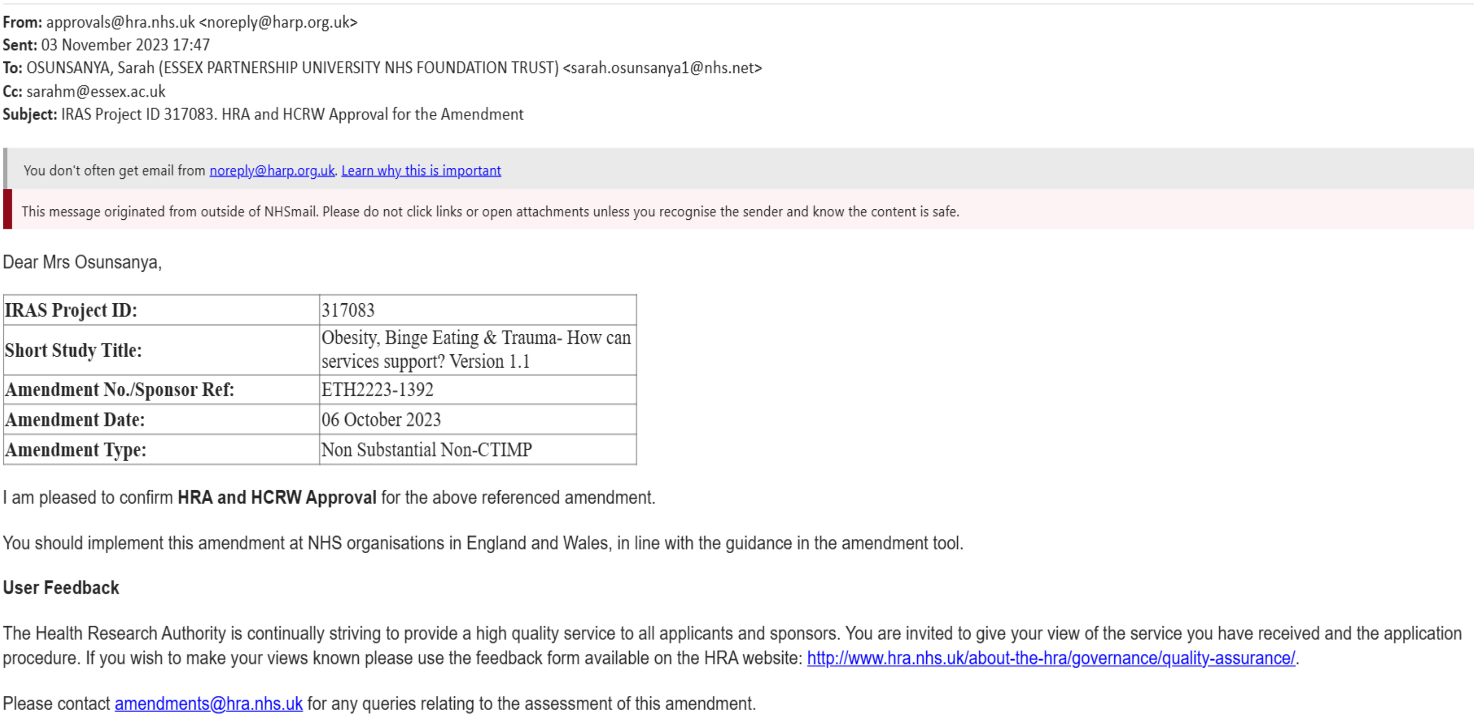
Your IRAS project ID is 317083. Please quote this on all correspondence.

Yours sincerely,
Ann Parry

Email: approvals@hra.nhs.uk

Copy to: *Ms Sarah Manning-Press*

Appendix II - Health Research Authority Amendment Approval email



From: approvals@hra.nhs.uk <noreply@harp.org.uk>
Sent: 03 November 2023 17:47
To: OSUNSANYA, Sarah (ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST) <sarah.osunsanya1@nhs.net>
Cc: sarahm@essex.ac.uk
Subject: IRAS Project ID 317083. HRA and HCRW Approval for the Amendment

You don't often get email from noreply@harp.org.uk. Learn why this is important

This message originated from outside of NHSmail. Please do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear Mrs Osunsanya,

IRAS Project ID:	317083
Short Study Title:	Obesity, Binge Eating & Trauma- How can services support? Version 1.1
Amendment No./Sponsor Ref:	ETH2223-1392
Amendment Date:	06 October 2023
Amendment Type:	Non Substantial Non-CTIMP

I am pleased to confirm **HRA and HCRW Approval** for the above referenced amendment.

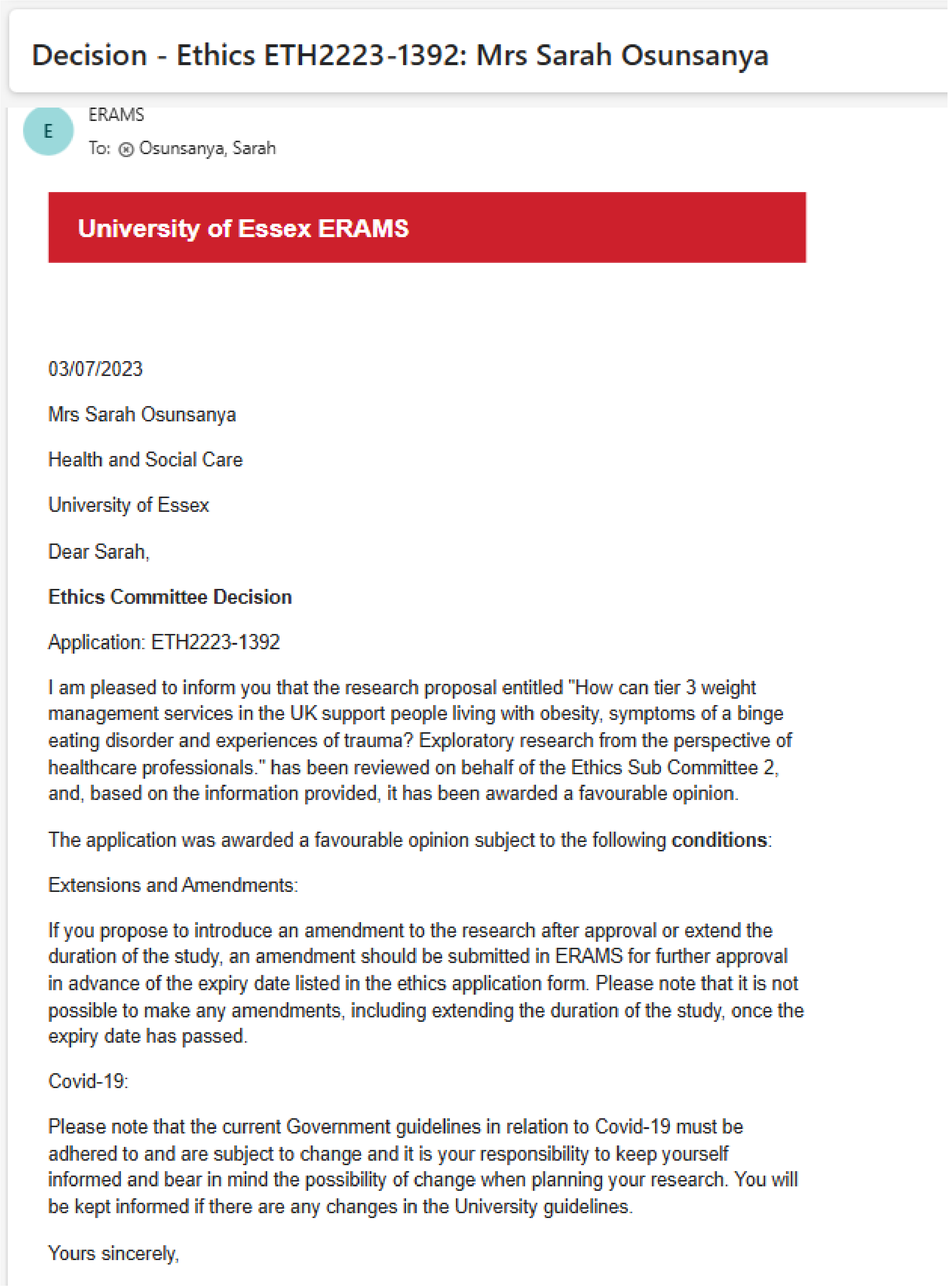
You should implement this amendment at NHS organisations in England and Wales, in line with the guidance in the amendment tool.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.

Please contact amendments@hra.nhs.uk for any queries relating to the assessment of this amendment.

Appendix III – University of Essex Ethics Approval letter



Decision - Ethics ETH2223-1392: Mrs Sarah Osunsanya

ERAMS
To: Osunsanya, Sarah

University of Essex ERAMS

03/07/2023

Mrs Sarah Osunsanya

Health and Social Care

University of Essex

Dear Sarah,

Ethics Committee Decision

Application: ETH2223-1392

I am pleased to inform you that the research proposal entitled "How can tier 3 weight management services in the UK support people living with obesity, symptoms of a binge eating disorder and experiences of trauma? Exploratory research from the perspective of healthcare professionals." has been reviewed on behalf of the Ethics Sub Committee 2, and, based on the information provided, it has been awarded a favourable opinion.

The application was awarded a favourable opinion subject to the following **conditions**:

Extensions and Amendments:

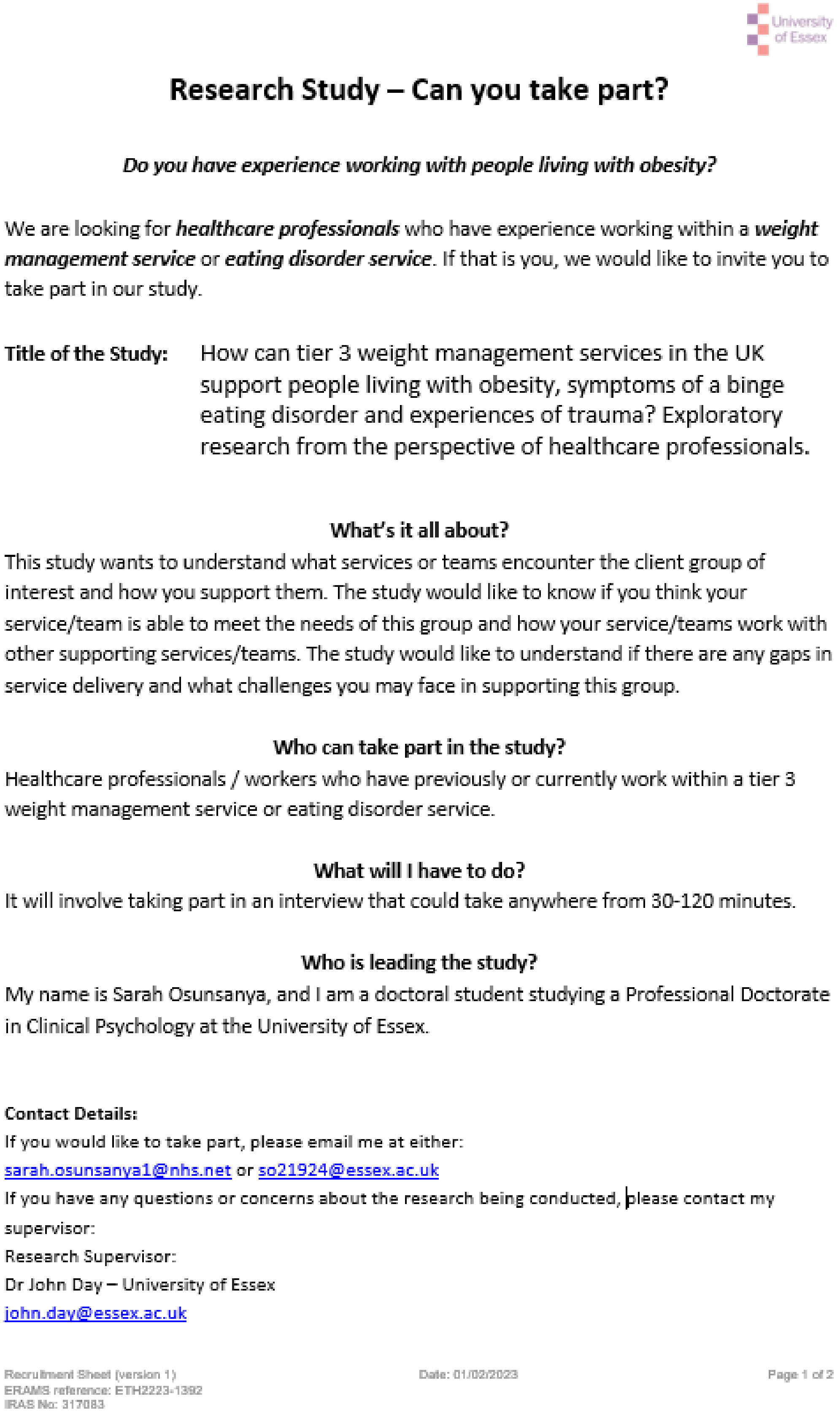
If you propose to introduce an amendment to the research after approval or extend the duration of the study, an amendment should be submitted in ERAMS for further approval in advance of the expiry date listed in the ethics application form. Please note that it is not possible to make any amendments, including extending the duration of the study, once the expiry date has passed.

Covid-19:

Please note that the current Government guidelines in relation to Covid-19 must be adhered to and are subject to change and it is your responsibility to keep yourself informed and bear in mind the possibility of change when planning your research. You will be kept informed if there are any changes in the University guidelines.

Yours sincerely,

Appendix IV – Participant Recruitment Sheet



University of Essex

Research Study – Can you take part?

Do you have experience working with people living with obesity?

We are looking for ***healthcare professionals*** who have experience working within a ***weight management service*** or ***eating disorder service***. If that is you, we would like to invite you to take part in our study.

Title of the Study: How can tier 3 weight management services in the UK support people living with obesity, symptoms of a binge eating disorder and experiences of trauma? Exploratory research from the perspective of healthcare professionals.

What's it all about?

This study wants to understand what services or teams encounter the client group of interest and how you support them. The study would like to know if you think your service/team is able to meet the needs of this group and how your service/teams work with other supporting services/teams. The study would like to understand if there are any gaps in service delivery and what challenges you may face in supporting this group.

Who can take part in the study?

Healthcare professionals / workers who have previously or currently work within a tier 3 weight management service or eating disorder service.

What will I have to do?

It will involve taking part in an interview that could take anywhere from 30-120 minutes.

Who is leading the study?

My name is Sarah Osunsanya, and I am a doctoral student studying a Professional Doctorate in Clinical Psychology at the University of Essex.

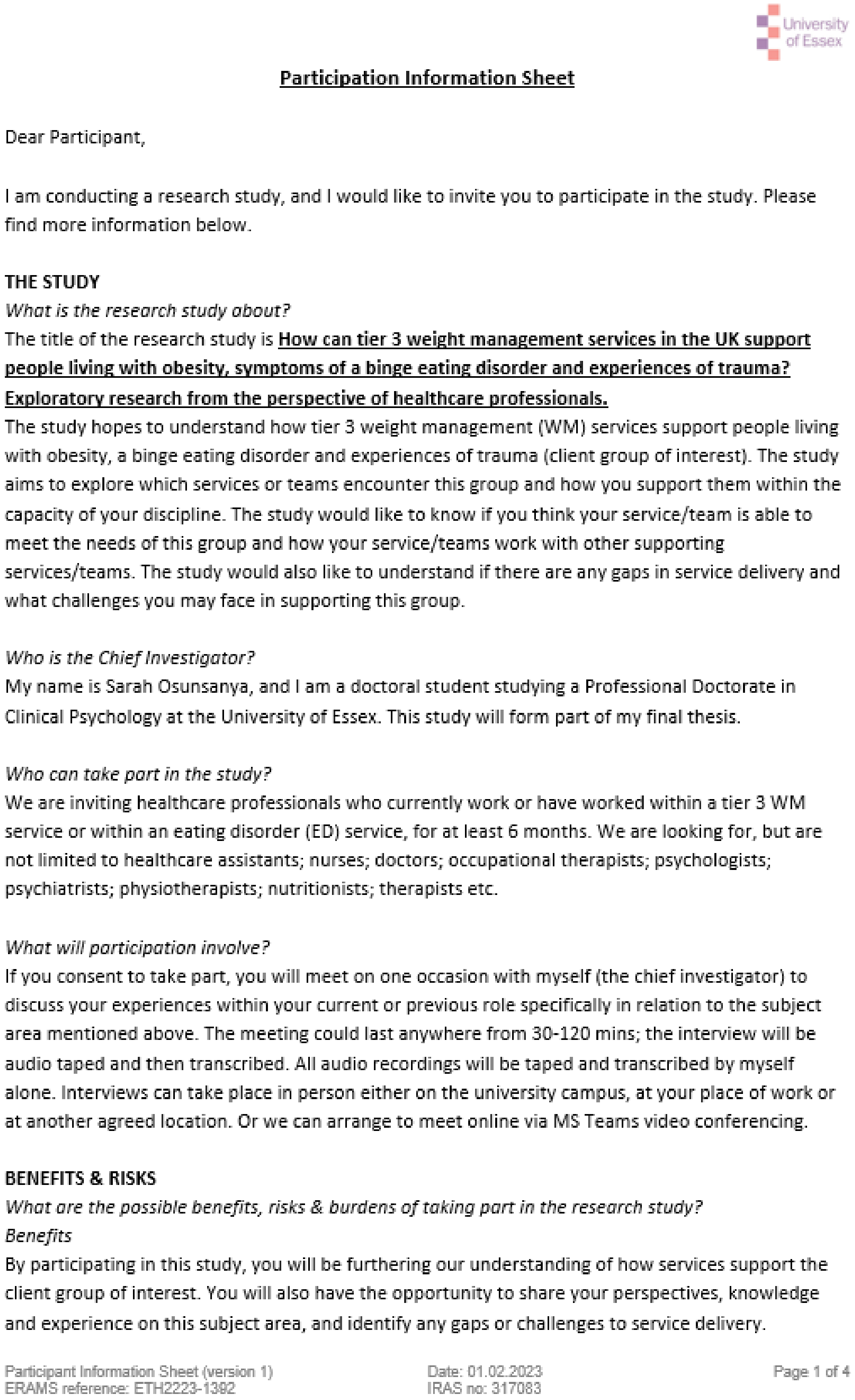
Contact Details:
If you would like to take part, please email me at either:
sarah.osunsanya1@nhs.net or so21924@essex.ac.uk
If you have any questions or concerns about the research being conducted, please contact my supervisor:
Research Supervisor:
Dr John Day – University of Essex
john.day@essex.ac.uk

Recruitment Sheet (version 1)
ERAMS reference: ETH2223-1392
IRAS No: 317083

Date: 01/02/2023

Page 1 of 2

Appendix V – Participant Information Sheet



Participation Information Sheet

Dear Participant,

I am conducting a research study, and I would like to invite you to participate in the study. Please find more information below.

THE STUDY

What is the research study about?

The title of the research study is **How can tier 3 weight management services in the UK support people living with obesity, symptoms of a binge eating disorder and experiences of trauma? Exploratory research from the perspective of healthcare professionals.**

The study hopes to understand how tier 3 weight management (WM) services support people living with obesity, a binge eating disorder and experiences of trauma (client group of interest). The study aims to explore which services or teams encounter this group and how you support them within the capacity of your discipline. The study would like to know if you think your service/team is able to meet the needs of this group and how your service/teams work with other supporting services/teams. The study would also like to understand if there are any gaps in service delivery and what challenges you may face in supporting this group.

Who is the Chief Investigator?

My name is Sarah Osunsanya, and I am a doctoral student studying a Professional Doctorate in Clinical Psychology at the University of Essex. This study will form part of my final thesis.

Who can take part in the study?

We are inviting healthcare professionals who currently work or have worked within a tier 3 WM service or within an eating disorder (ED) service, for at least 6 months. We are looking for, but are not limited to healthcare assistants; nurses; doctors; occupational therapists; psychologists; psychiatrists; physiotherapists; nutritionists; therapists etc.

What will participation involve?

If you consent to take part, you will meet on one occasion with myself (the chief investigator) to discuss your experiences within your current or previous role specifically in relation to the subject area mentioned above. The meeting could last anywhere from 30-120 mins; the interview will be audio taped and then transcribed. All audio recordings will be taped and transcribed by myself alone. Interviews can take place in person either on the university campus, at your place of work or at another agreed location. Or we can arrange to meet online via MS Teams video conferencing.

BENEFITS & RISKS

What are the possible benefits, risks & burdens of taking part in the research study?

Benefits

By participating in this study, you will be furthering our understanding of how services support the client group of interest. You will also have the opportunity to share your perspectives, knowledge and experience on this subject area, and identify any gaps or challenges to service delivery.

Participant Information Sheet (version 1) Date: 01.02.2023 Page 1 of 4
ERAMS reference: ETH2223-1392 IRAS no: 317083

Ultimately, your contribution could potentially influence policy for change or review in the support of this client group.

Risks

Research interviews will include discussions about an eating disorder and traumatic experiences of clients/patients you work or have worked with. This could be upsetting or potentially triggering particularly those with similar lived experiences. To mitigate this, I will provide you with your NHS Trust's Employee Assistance Programme contact details, and for non-NHS staff you will be provided with the contact details of your organisation's equivalent. Additionally, I would encourage you to check in with your supervisor if you are feeling upset or distressed following the interview. Lastly, I just want to remind you that specific details about clients/patients will not be required, I want to capture your experience as a healthcare professional in working with the client group and how this informs the wider context and service delivery.

Burdens

Research interviews would take up some of your time, whether it is within working hours or in your personal time. I am conscious of how that time may affect service delivery or your work-life balance (if done in their own personal time). To mitigate the effects, interviews throughout the study will be limited to no more than 120 mins. I will aim to be as flexible as possible and am able to offer varied interview time slots (including evenings and weekends). You will also have the opportunity to divide the interview across more than one session if time is limited. Lastly, I would encourage you to check with your supervisor if you wish to participate in the research interview during working hours, to ensure service delivery is not affected.

MY INFORMATION

In this research study we will use information from your interview and demographic form. We will only use information that we need for the research study. We will let very few people know your name or contact details, and only if they really need it for this study.

Everyone involved in this study will keep your data safe and secure. We will also follow all privacy rules.

We will make sure no-one can work out who you are from the reports we write.

The information pack tells you more about this.

What information will be collected?

The demographics form will collect information such as your name, role, gender, age range, service/team, how long you worked in your relevant role etc. This information is collected as part of a monitoring and screening process. The interview will collect information about your experience and views of the subject area.

Will my information be kept confidential?

The audio tape recordings and transcripts will be accessible only to the chief investigator, they will be saved to an NHS server via the personal log in details of the chief investigator on an NHS issued laptop, where all data is encrypted. Please also be aware that all audio tape recordings will be backed up to the University of Essex server via the personal log in details of the chief investigator, where all data is encrypted. The recordings will be transcribed and pseudonymised which means all identifying information will be removed (e.g. names, job title, service/team, location etc). Information that will be included, will be your discipline e.g. nursing or occupational therapy and how long you have worked within the service. To ensure this information cannot identity you, length of service, for example, will be written as a range e.g. 'under a year' or '1-2 years' in service. Direct quotations from pseudonymised transcripts will be used to write up the study and the final report will be a doctoral thesis.

What happens to my information after the study?
Once interviews are uploaded to the servers, they and transcribed, all recordings will be deleted from any audio devices. Once the study is completed and the thesis is marked by examiners, all audio tape recordings and any personal data collected will be destroyed.

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.
- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

How will we use information about you?
We will need to use information from your interview and your demographic document for this research project.
This information will include

- Relevant job role,
- Gender,
- Age range,
- Service/team,
- How long you worked in your relevant role
- Direct quotations from your interview

People will use this information to do the research or to check your records to make sure that the research is being done properly.
People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead. We will keep all information about you safe and secure. Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

Where can you find out more about how your information is used?
You can find out more about how we use your information

- at www.hra.nhs.uk/information-about-patients/
- by asking one of the research team
- by sending an email to so21924@essex.ac.uk or sarah.osunsanya1@nhs.net

GDPR & COMPLAINTS

Will the use of my data meet GDPR rules?

Yes. GDPR stands for the General Data Protection Regulation. In the UK, we have to follow the GDPR rules and the Data Protection Act. The chief investigator will have access to and manage your data and ensure GDPR rules are maintained throughout. The legal basis for processing personally identifying data is that it is in the public interest. Consent to participation in research is not the same as consent as the legal basis for processing under data protection legislation. An example is that a person is asked to consent to participate in research but is told that, if they agree to participate, data about them will be processed for a task in the public interest. The data controller is the University of Essex (dpo@essex.ac.uk).

Who can I contact of I have a complaint?

If you have any concerns about any aspect of the study or you have a complaint, in the first instance please contact me as the chief investigator of the study, using the contact details below. If are still concerned or you think your complaint has not been addressed to your satisfaction or you feel that you cannot approach me, please contact the departmental Director of Research, Camille Cronin (e-mail camille.cronin@essex.ac.uk). If you are still not satisfied, please contact the University's Research Governance and Planning Manager, Sarah Manning-Press (e-mail sarahm@essex.ac.uk). Please include the ERAMS reference which can be found at the foot of this page.

Contact Details:

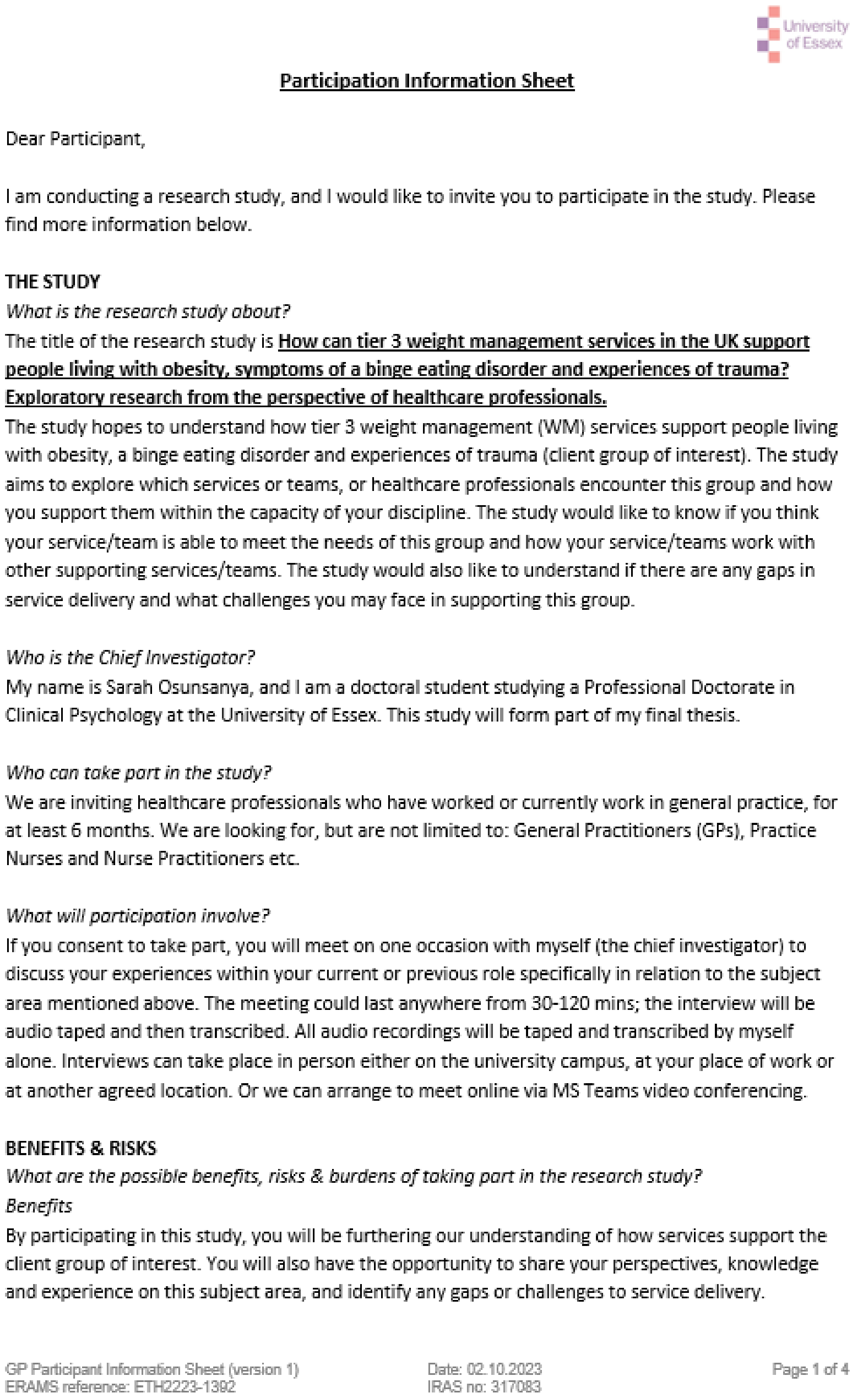
If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me:

Sarah Osunsanya
so21924@essex.ac.uk or sarah.osunsanya1@nhs.net

If you have any questions or concerns about the research being conducted, please contact my Research supervisor:

Dr John Day john.day@essex.ac.uk
School of Health and Social Care,
University of Essex
Wivenhoe Park
Essex
CO4 3SQ

Appendix VI – Primary Care Services Participant Information Sheet



Participation Information Sheet

Dear Participant,

I am conducting a research study, and I would like to invite you to participate in the study. Please find more information below.

THE STUDY

What is the research study about?

The title of the research study is **How can tier 3 weight management services in the UK support people living with obesity, symptoms of a binge eating disorder and experiences of trauma? Exploratory research from the perspective of healthcare professionals.**

The study hopes to understand how tier 3 weight management (WM) services support people living with obesity, a binge eating disorder and experiences of trauma (client group of interest). The study aims to explore which services or teams, or healthcare professionals encounter this group and how you support them within the capacity of your discipline. The study would like to know if you think your service/team is able to meet the needs of this group and how your service/teams work with other supporting services/teams. The study would also like to understand if there are any gaps in service delivery and what challenges you may face in supporting this group.

Who is the Chief Investigator?

My name is Sarah Osunsanya, and I am a doctoral student studying a Professional Doctorate in Clinical Psychology at the University of Essex. This study will form part of my final thesis.

Who can take part in the study?

We are inviting healthcare professionals who have worked or currently work in general practice, for at least 6 months. We are looking for, but are not limited to: General Practitioners (GPs), Practice Nurses and Nurse Practitioners etc.

What will participation involve?

If you consent to take part, you will meet on one occasion with myself (the chief investigator) to discuss your experiences within your current or previous role specifically in relation to the subject area mentioned above. The meeting could last anywhere from 30-120 mins; the interview will be audio taped and then transcribed. All audio recordings will be taped and transcribed by myself alone. Interviews can take place in person either on the university campus, at your place of work or at another agreed location. Or we can arrange to meet online via MS Teams video conferencing.

BENEFITS & RISKS

What are the possible benefits, risks & burdens of taking part in the research study?

Benefits

By participating in this study, you will be furthering our understanding of how services support the client group of interest. You will also have the opportunity to share your perspectives, knowledge and experience on this subject area, and identify any gaps or challenges to service delivery.

Ultimately, your contribution could potentially influence policy for change or review in the support of this client group.

Risks

Research interviews will include discussions about an eating disorder and traumatic experiences of clients/patients you support or have supported. This could be upsetting or potentially triggering particularly those with similar lived experiences. To mitigate this, I will provide you with the Practice's Employee Assistance Programme contact details, and for non-NHS staff you will be provided with the contact details of your organisation's equivalent. Additionally, I would encourage you to check in with your supervisor if you are feeling upset or distressed following the interview. Lastly, I just want to remind you that specific details about clients/patients will not be required, I want to capture your experience as a healthcare professional in working with the client group and how this informs the wider context and service delivery.

Burdens

Research interviews would take up some of your time, whether it is within working hours or in your personal time. I am conscious of how that time may affect service delivery or your work-life balance (if done in their own personal time). To mitigate the effects, interviews throughout the study will be limited to no more than 120 mins. I will aim to be as flexible as possible and am able to offer varied interview time slots (including evenings and weekends). You will also have the opportunity to divide the interview across more than one session if time is limited. Lastly, I would encourage you to check with your supervisor if you wish to participate in the research interview during working hours, to ensure service delivery is not affected.

MY INFORMATION

In this research study we will use information from your interview and demographic form. We will only use information that we need for the research study. We will let very few people know your name or contact details, and only if they really need it for this study.

Everyone involved in this study will keep your data safe and secure. We will also follow all privacy rules.

We will make sure no-one can work out who you are from the reports we write.

The information pack tells you more about this.

What information will be collected?

The demographics form will collect information such as your name, role, gender, age range, service/team, how long you worked in your relevant role etc. This information is collected as part of a monitoring and screening process. The interview will collect information about your experience and views of the subject area.

Will my information be kept confidential?

The audio tape recordings and transcripts will be accessible only to the chief investigator, they will be saved to an NHS server via the personal log in details of the chief investigator on an NHS issued laptop, where all data is encrypted. Please also be aware that all audio tape recordings will be backed up to the University of Essex server via the personal log in details of the chief investigator, where all data is encrypted. The recordings will be transcribed and pseudonymised which means all identifying information will be removed (e.g. names, job title, service/team, location etc). Information that will be included, will be your discipline e.g. nursing or occupational therapy and how long you have worked within the service. To ensure this information cannot identity you, length of service, for example, will be written as a range e.g. 'under a year' or '1-2 years' in service. Direct quotations from pseudonymised transcripts will be used to write up the study and the final report will be a doctoral thesis.

What happens to my information after the study?
Once interviews are uploaded to the servers, they and transcribed, all recordings will be deleted from any audio devices. Once the study is completed and the thesis is marked by examiners, all audio tape recordings and any personal data collected will be destroyed.

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.
- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

How will we use information about you?
We will need to use information from your interview and your demographic document for this research project.
This information will include

- Relevant job role,
- Gender,
- Age range,
- Service/team,
- How long you worked in your relevant role
- Direct quotations from your interview

People will use this information to do the research or to check your records to make sure that the research is being done properly.
People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead. We will keep all information about you safe and secure. Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

Where can you find out more about how your information is used?
You can find out more about how we use your information

- at www.hra.nhs.uk/information-about-patients/
- by asking one of the research team
- by sending an email to so21924@essex.ac.uk or sarah.osunsanya1@nhs.net

GDPR & COMPLAINTS

Will the use of my data meet GDPR rules?

Yes. GDPR stands for the General Data Protection Regulation. In the UK, we have to follow the GDPR rules and the Data Protection Act. The chief investigator will have access to and manage your data and ensure GDPR rules are maintained throughout. The legal basis for processing personally identifying data is that it is in the public interest. Consent to participation in research is not the same as consent as the legal basis for processing under data protection legislation. An example is that a person is asked to consent to participate in research but is told that, if they agree to participate, data about them will be processed for a task in the public interest. The data controller is the University of Essex (dpo@essex.ac.uk).

Who can I contact of I have a complaint?

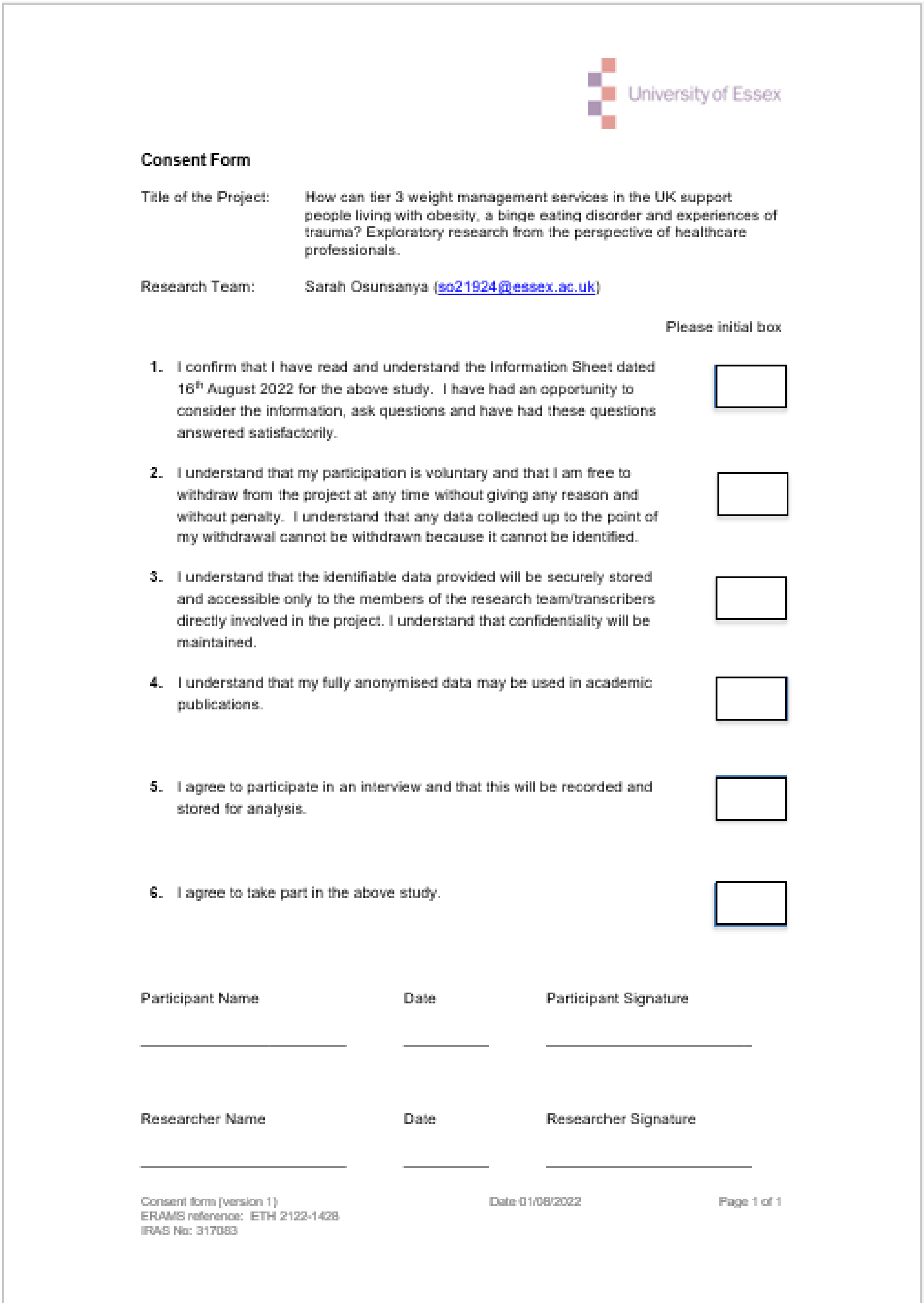
If you have any concerns about any aspect of the study or you have a complaint, in the first instance please contact me as the chief investigator of the study, using the contact details below. If are still concerned or you think your complaint has not been addressed to your satisfaction or you feel that you cannot approach me, please contact the departmental Director of Research, Camille Cronin (e-mail camille.cronin@essex.ac.uk). If you are still not satisfied, please contact the University's Research Governance and Planning Manager, Sarah Manning-Press (e-mail sarahm@essex.ac.uk). Please include the ERAMS reference which can be found at the foot of this page.

Contact Details:

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me:
Sarah Osunsanya
so21924@essex.ac.uk or sarah.osunsanya1@nhs.net

If you have any questions or concerns about the research being conducted, please contact my Research supervisor:
Dr John Day john.day@essex.ac.uk
School of Health and Social Care,
University of Essex
Wivenhoe Park
Essex
CO4 3SQ

Appendix VII – Consent Form



University of Essex

Consent Form

Title of the Project: How can tier 3 weight management services in the UK support people living with obesity, a binge eating disorder and experiences of trauma? Exploratory research from the perspective of healthcare professionals.

Research Team: Sarah Osunsanya (so21924@essex.ac.uk)

Please initial box

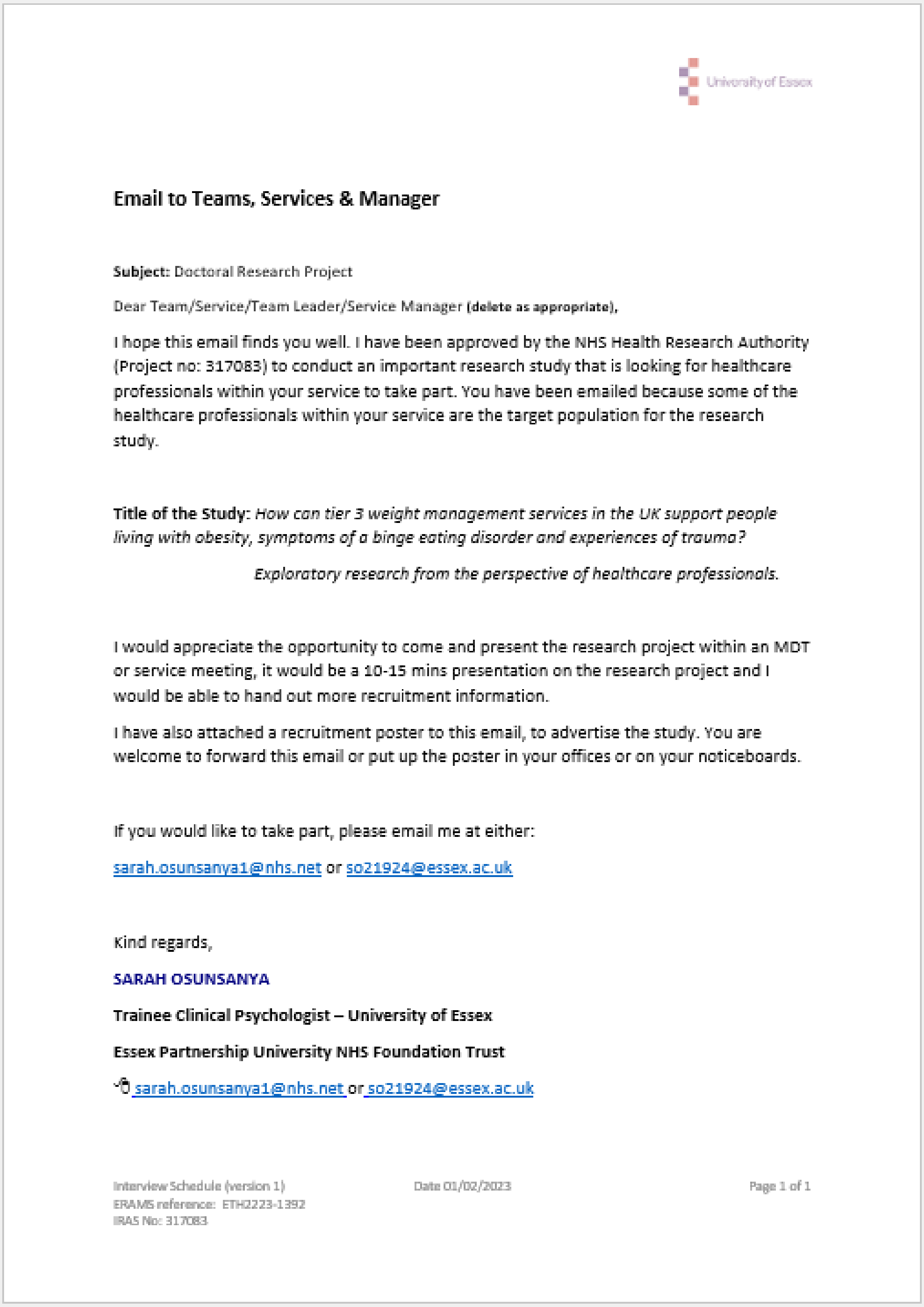
1. I confirm that I have read and understand the Information Sheet dated 16th August 2022 for the above study. I have had an opportunity to consider the information, ask questions and have had these questions answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw from the project at any time without giving any reason and without penalty. I understand that any data collected up to the point of my withdrawal cannot be withdrawn because it cannot be identified. ☐
3. I understand that the identifiable data provided will be securely stored and accessible only to the members of the research team/transcribers directly involved in the project. I understand that confidentiality will be maintained. ☐
4. I understand that my fully anonymised data may be used in academic publications. ☐
5. I agree to participate in an interview and that this will be recorded and stored for analysis. ☐
6. I agree to take part in the above study. ☐

Participant Name ____________________ Date ________ Participant Signature ____________________

Researcher Name ____________________ Date ________ Researcher Signature ____________________

Consent form (version 1) Date 01/08/2022 Page 1 of 1
ERAMS reference: ETH 2122-1428
IRAS No: 317083

Appendix VIII – Email to Teams and Services



University of Essex

Email to Teams, Services & Manager

Subject: Doctoral Research Project

Dear Team/Service/Team Leader/Service Manager **(delete as appropriate),**

I hope this email finds you well. I have been approved by the NHS Health Research Authority (Project no: 317083) to conduct an important research study that is looking for healthcare professionals within your service to take part. You have been emailed because some of the healthcare professionals within your service are the target population for the research study.

Title of the Study: *How can tier 3 weight management services in the UK support people living with obesity, symptoms of a binge eating disorder and experiences of trauma?*

Exploratory research from the perspective of healthcare professionals.

I would appreciate the opportunity to come and present the research project within an MDT or service meeting, it would be a 10-15 mins presentation on the research project and I would be able to hand out more recruitment information.

I have also attached a recruitment poster to this email, to advertise the study. You are welcome to forward this email or put up the poster in your offices or on your noticeboards.

If you would like to take part, please email me at either:

sarah.osunsanya1@nhs.net or so21924@essex.ac.uk

Kind regards,

SARAH OSUNSANYA

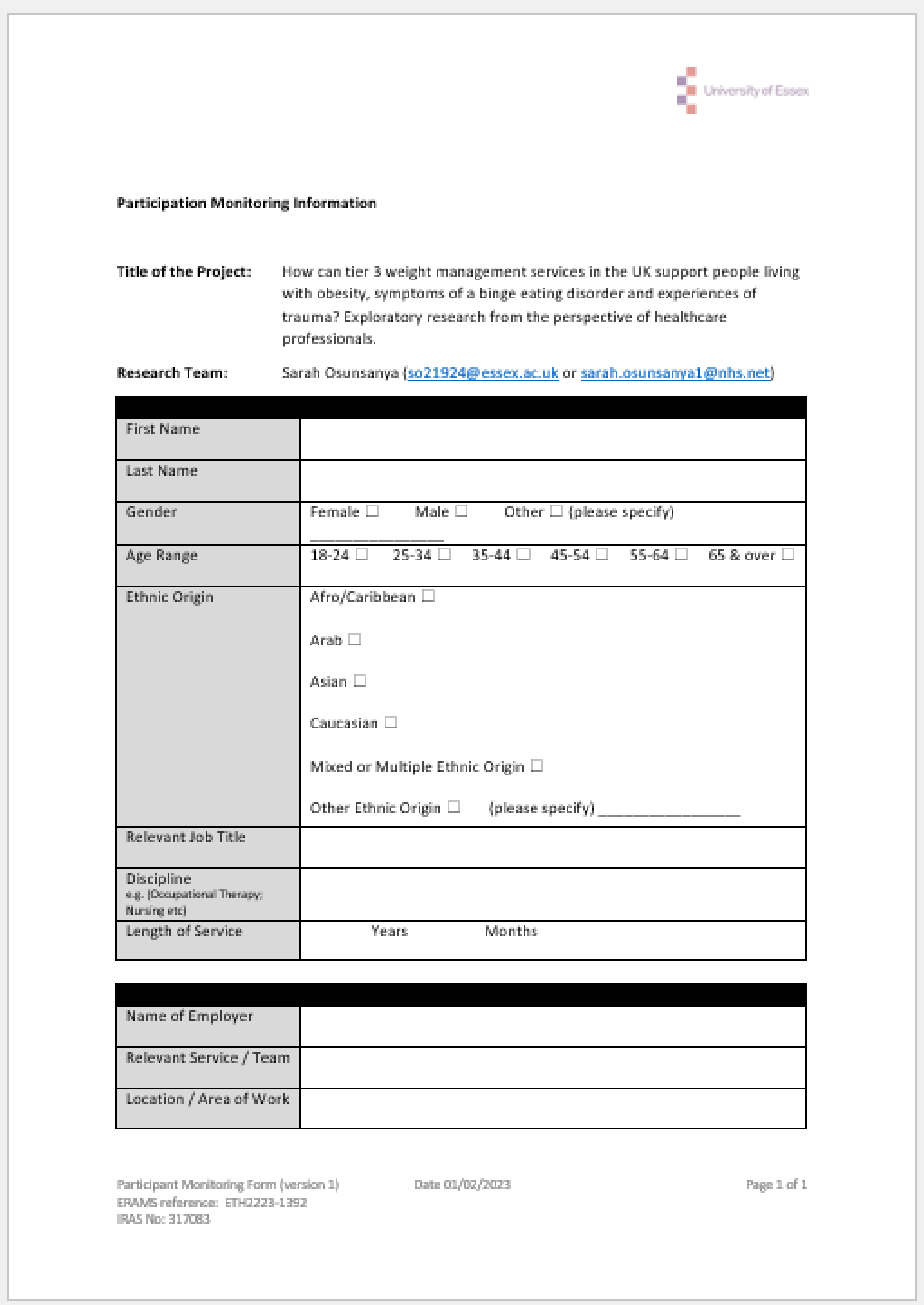
Trainee Clinical Psychologist – University of Essex

Essex Partnership University NHS Foundation Trust

🖱 sarah.osunsanya1@nhs.net or so21924@essex.ac.uk

Interview Schedule (version 1) Date 01/02/2023 Page 1 of 1
ERAMS reference: ETH2223-1392
IRAS No: 317083

Appendix IX – Participant Monitoring Form



University of Essex

Participation Monitoring Information

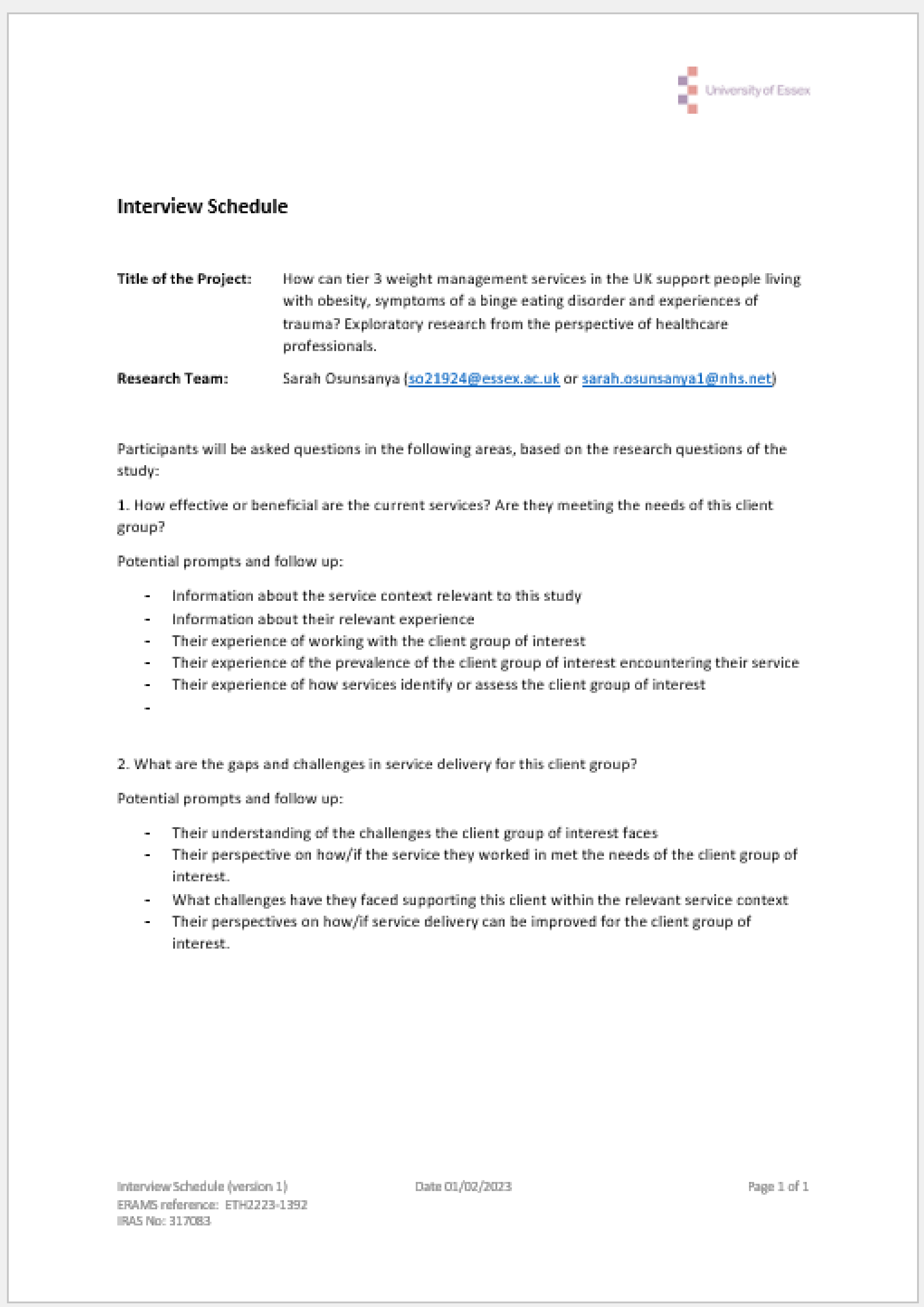
Title of the Project:	How can tier 3 weight management services in the UK support people living with obesity, symptoms of a binge eating disorder and experiences of trauma? Exploratory research from the perspective of healthcare professionals.
Research Team:	Sarah Osunsanya (so21924@essex.ac.uk or sarah.osunsanya1@nhs.net)

First Name	
Last Name	
Gender	Female ☐ Male ☐ Other ☐ (please specify) ________________
Age Range	18-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-64 ☐ 65 & over ☐
Ethnic Origin	Afro/Caribbean ☐ Arab ☐ Asian ☐ Caucasian ☐ Mixed or Multiple Ethnic Origin ☐ Other Ethnic Origin ☐ (please specify) _________________
Relevant Job Title	
Discipline e.g. (Occupational Therapy; Nursing etc)	
Length of Service	Years Months

Name of Employer	
Relevant Service / Team	
Location / Area of Work	

Participant Monitoring Form (version 1) Date 01/02/2023 Page 1 of 1
ERAMS reference: ETH2223-1392
IRAS No: 317083

Appendix X – Interview Schedule



University of Essex

Interview Schedule

Title of the Project: How can tier 3 weight management services in the UK support people living with obesity, symptoms of a binge eating disorder and experiences of trauma? Exploratory research from the perspective of healthcare professionals.

Research Team: Sarah Osunsanya (so21924@essex.ac.uk or sarah.osunsanya1@nhs.net)

Participants will be asked questions in the following areas, based on the research questions of the study:

1. How effective or beneficial are the current services? Are they meeting the needs of this client group?

Potential prompts and follow up:

- Information about the service context relevant to this study
- Information about their relevant experience
- Their experience of working with the client group of interest
- Their experience of the prevalence of the client group of interest encountering their service
- Their experience of how services identify or assess the client group of interest

2. What are the gaps and challenges in service delivery for this client group?

Potential prompts and follow up:

- Their understanding of the challenges the client group of interest faces
- Their perspective on how/if the service they worked in met the needs of the client group of interest.
- What challenges have they faced supporting this client within the relevant service context
- Their perspectives on how/if service delivery can be improved for the client group of interest.

Interview Schedule (version 1)
ERAMS reference: ETH2223-1392
IRAS No: 317083

Date 01/02/2023

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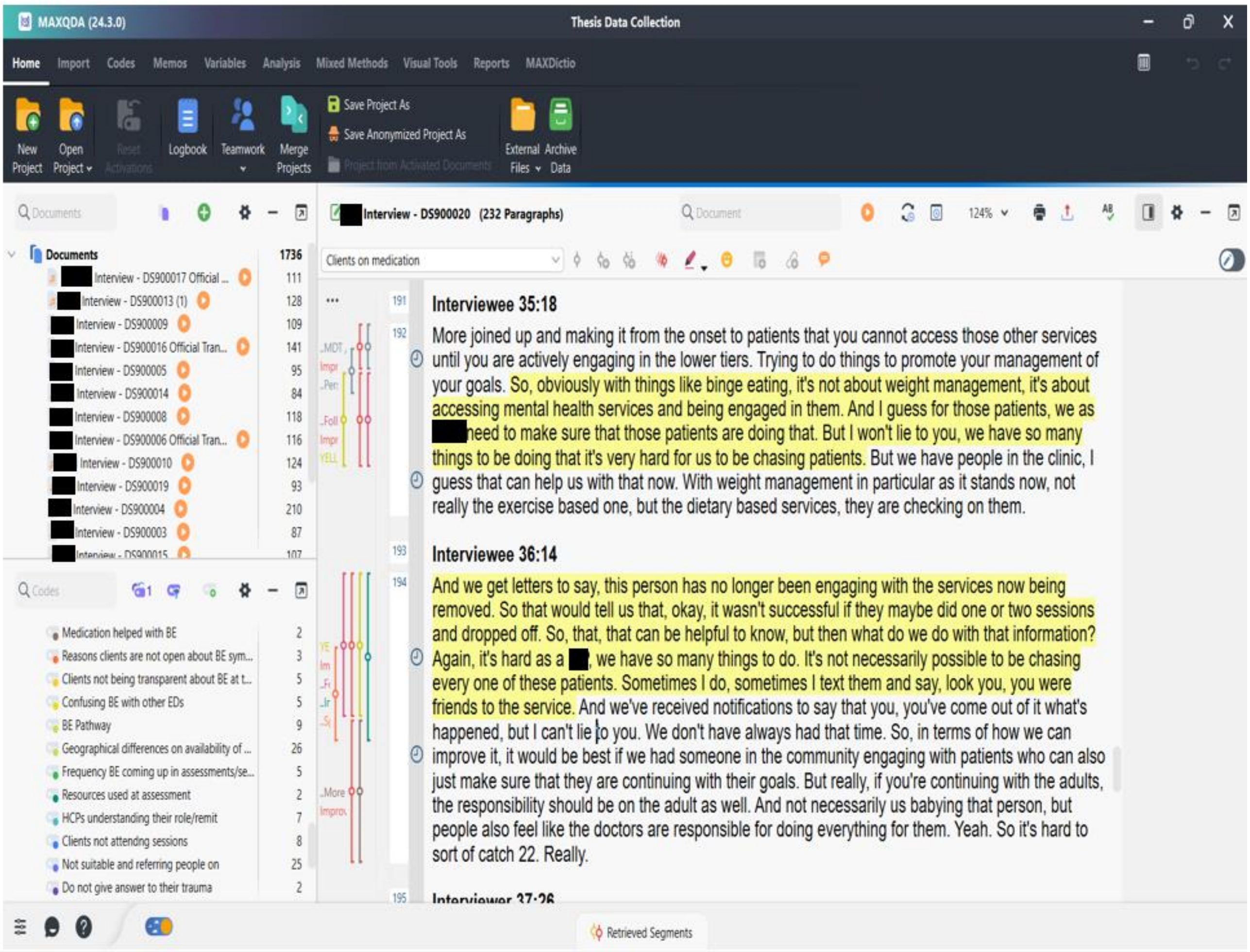
Appendix XI – Coding Process on MAXQDA



Documents	1736
[redacted] Interview - DS900017 Official ...	111
[redacted] Interview - DS900013 (1)	128
[redacted] Interview - DS900009	109
[redacted] Interview - DS900016 Official Tran...	141
[redacted] Interview - DS900005	95
[redacted] Interview - DS900014	84
[redacted] Interview - DS900008	118
[redacted] Interview - DS900006 Official Tran...	116
[redacted] Interview - DS900010	124
[redacted] Interview - DS900019	93
[redacted] Interview - DS900004	210
[redacted] Interview - DS900003	87
[redacted] Interview - DS900015	107

Codes	
Medication helped with BE	2
Reasons clients are not open about BE sym...	3
Clients not being transparent about BE at t...	5
Confusing BE with other EDs	5
BE Pathway	9
Geographical differences on availability of ...	26
Frequency BE coming up in assessments/se...	5
Resources used at assessment	2
HCPs understanding their role/remit	7
Clients not attendng sessions	8
Not suitable and referring people on	25
Do not give answer to their trauma	2

[redacted] Interview - DS900020 (232 Paragraphs)

Clients on medication

191 **Interviewee 35:18**

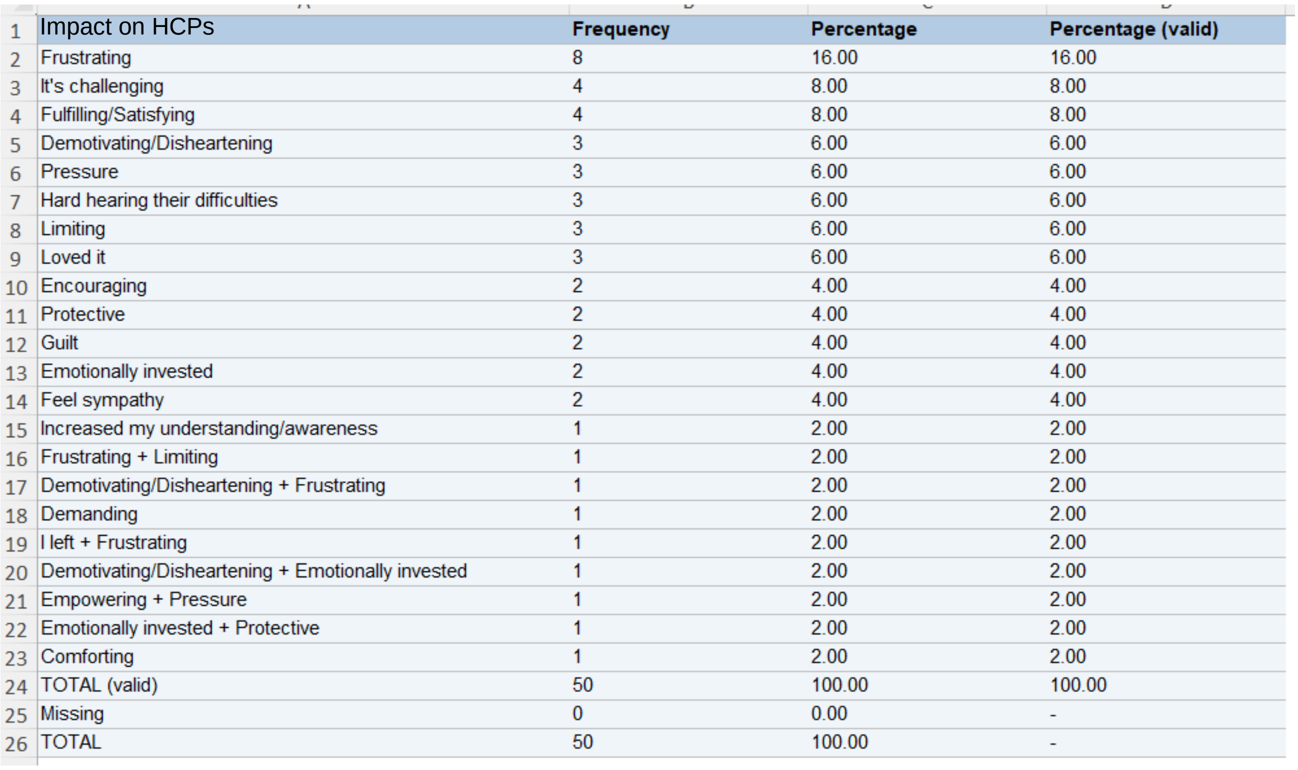
192 More joined up and making it from the onset to patients that you cannot access those other services until you are actively engaging in the lower tiers. Trying to do things to promote your management of your goals. So, obviously with things like binge eating, it's not about weight management, it's about accessing mental health services and being engaged in them. And I guess for those patients, we as [redacted] need to make sure that those patients are doing that. But I won't lie to you, we have so many things to be doing that it's very hard for us to be chasing patients. But we have people in the clinic, I guess that can help us with that now. With weight management in particular as it stands now, not really the exercise based one, but the dietary based services, they are checking on them.

193 **Interviewee 36:14**

194 And we get letters to say, this person has no longer been engaging with the services now being removed. So that would tell us that, okay, it wasn't successful if they maybe did one or two sessions and dropped off. So, that, that can be helpful to know, but then what do we do with that information? Again, it's hard as a [redacted], we have so many things to do. It's not necessarily possible to be chasing every one of these patients. Sometimes I do, sometimes I text them and say, look you, you were friends to the service. And we've received notifications to say that you, you've come out of it what's happened, but I can't lie to you. We don't have always had that time. So, in terms of how we can improve it, it would be best if we had someone in the community engaging with patients who can also just make sure that they are continuing with their goals. But really, if you're continuing with the adults, the responsibility should be on the adult as well. And not necessarily us babying that person, but people also feel like the doctors are responsible for doing everything for them. Yeah. So it's hard to sort of catch 22. Really.

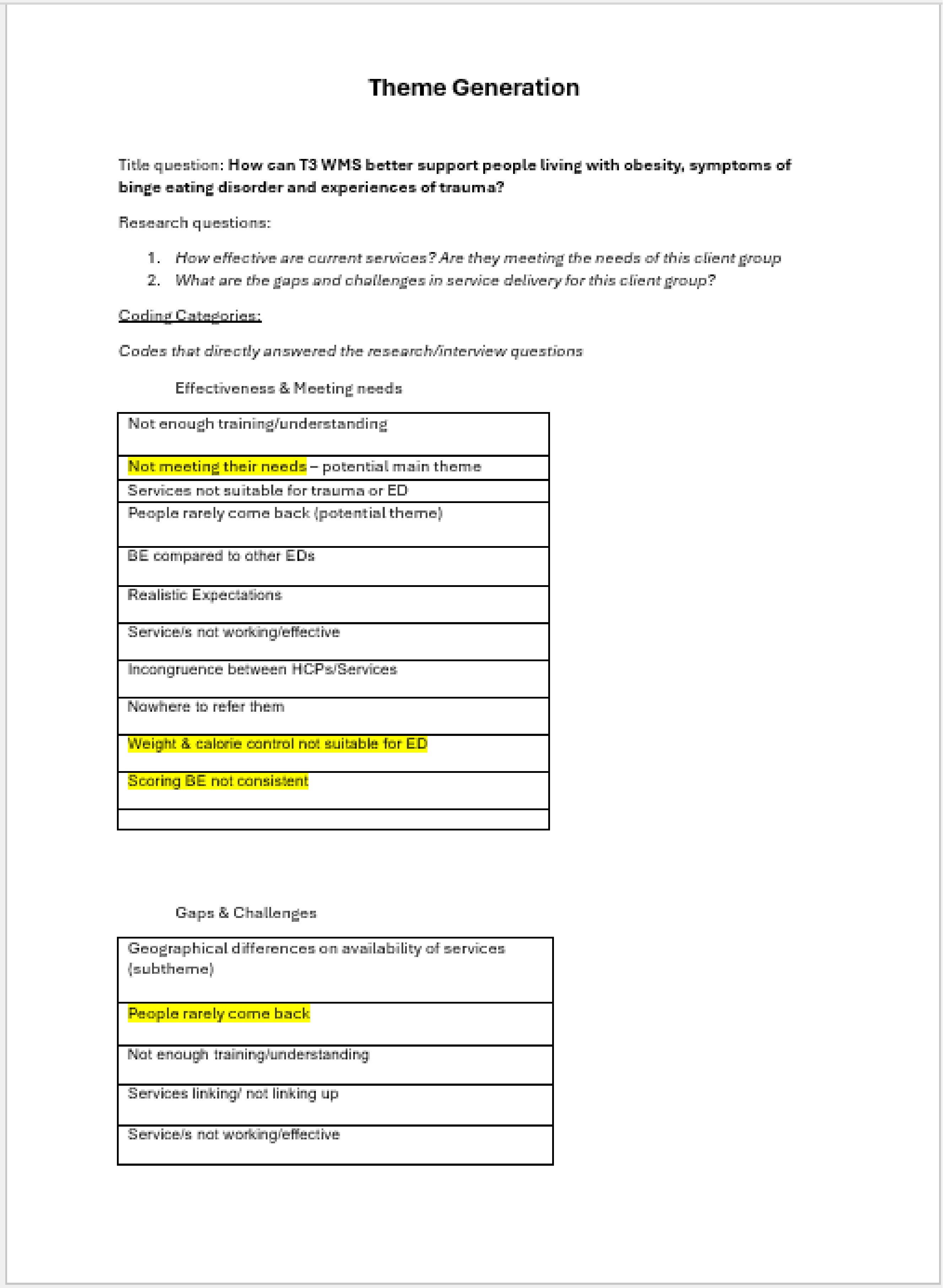
195 **Interviewer 37:26**

Appendix XII – Thematic Analysis Process: Coding Patterns



Impact on HCPs	Frequency	Percentage	Percentage (valid)
Frustrating	8	16.00	16.00
It's challenging	4	8.00	8.00
Fulfilling/Satisfying	4	8.00	8.00
Demotivating/Disheartening	3	6.00	6.00
Pressure	3	6.00	6.00
Hard hearing their difficulties	3	6.00	6.00
Limiting	3	6.00	6.00
Loved it	3	6.00	6.00
Encouraging	2	4.00	4.00
Protective	2	4.00	4.00
Guilt	2	4.00	4.00
Emotionally invested	2	4.00	4.00
Feel sympathy	2	4.00	4.00
Increased my understanding/awareness	1	2.00	2.00
Frustrating + Limiting	1	2.00	2.00
Demotivating/Disheartening + Frustrating	1	2.00	2.00
Demanding	1	2.00	2.00
I left + Frustrating	1	2.00	2.00
Demotivating/Disheartening + Emotionally invested	1	2.00	2.00
Empowering + Pressure	1	2.00	2.00
Emotionally invested + Protective	1	2.00	2.00
Comforting	1	2.00	2.00
TOTAL (valid)	50	100.00	100.00
Missing	0	0.00	-
TOTAL	50	100.00	-

Appendix XIII - Thematic Analysis Process: Theme Generation



Theme Generation

Title question: **How can T3 WMS better support people living with obesity, symptoms of binge eating disorder and experiences of trauma?**

Research questions:

1. *How effective are current services? Are they meeting the needs of this client group*
2. *What are the gaps and challenges in service delivery for this client group?*

Coding Categories:

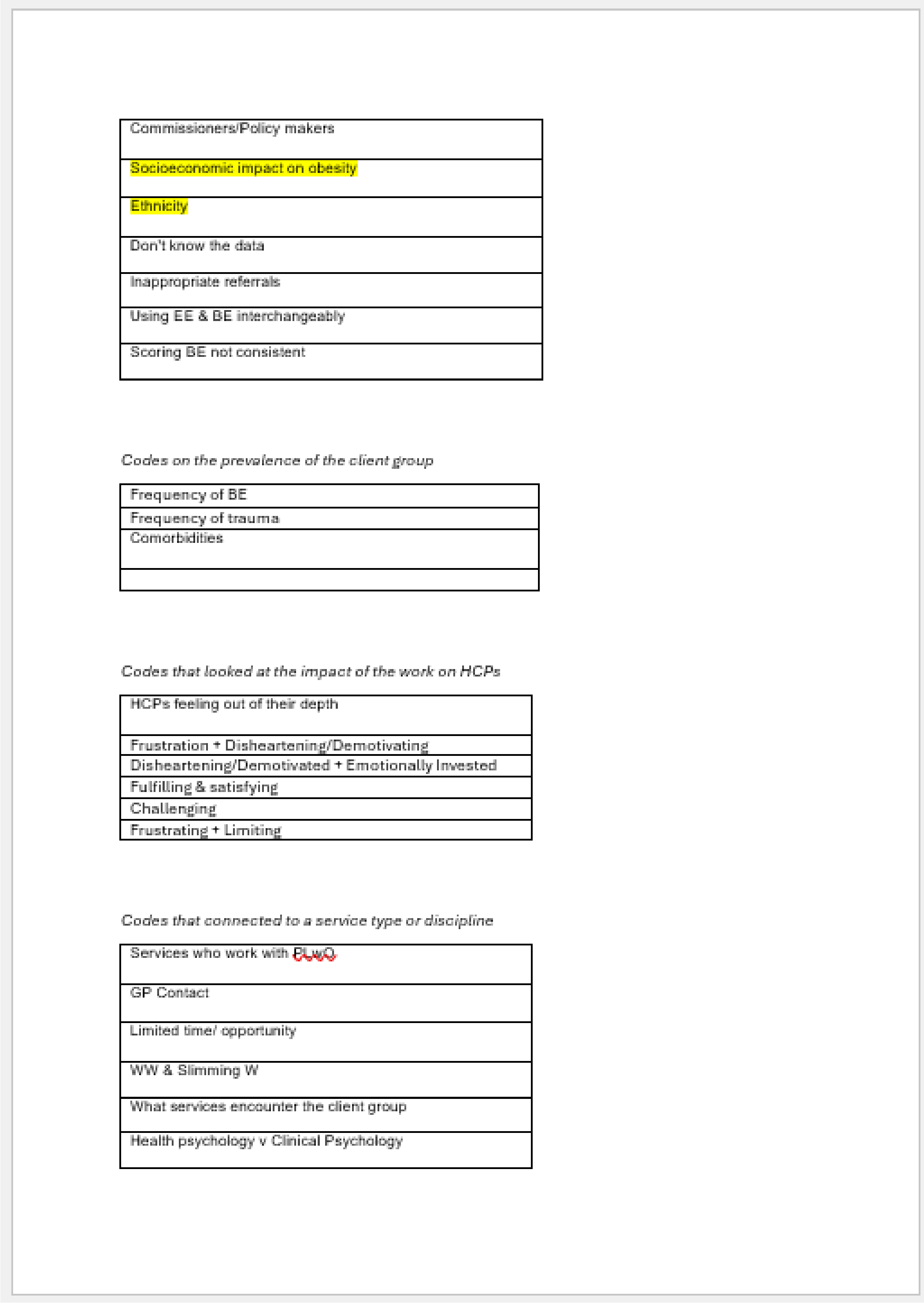
Codes that directly answered the research/interview questions

Effectiveness & Meeting needs

Not enough training/understanding
Not meeting their needs – potential main theme
Services not suitable for trauma or ED
People rarely come back (potential theme)
BE compared to other EDs
Realistic Expectations
Service/s not working/effective
Incongruence between HCPs/Services
Nowhere to refer them
Weight & calorie control not suitable for ED
Scoring BE not consistent

Gaps & Challenges

Geographical differences on availability of services (subtheme)
People rarely come back
Not enough training/understanding
Services linking/ not linking up
Service/s not working/effective



Commissioners/Policy makers
Socioeconomic impact on obesity
Ethnicity
Don't know the data
Inappropriate referrals
Using EE & BE interchangeably
Scoring BE not consistent

Codes on the prevalence of the client group

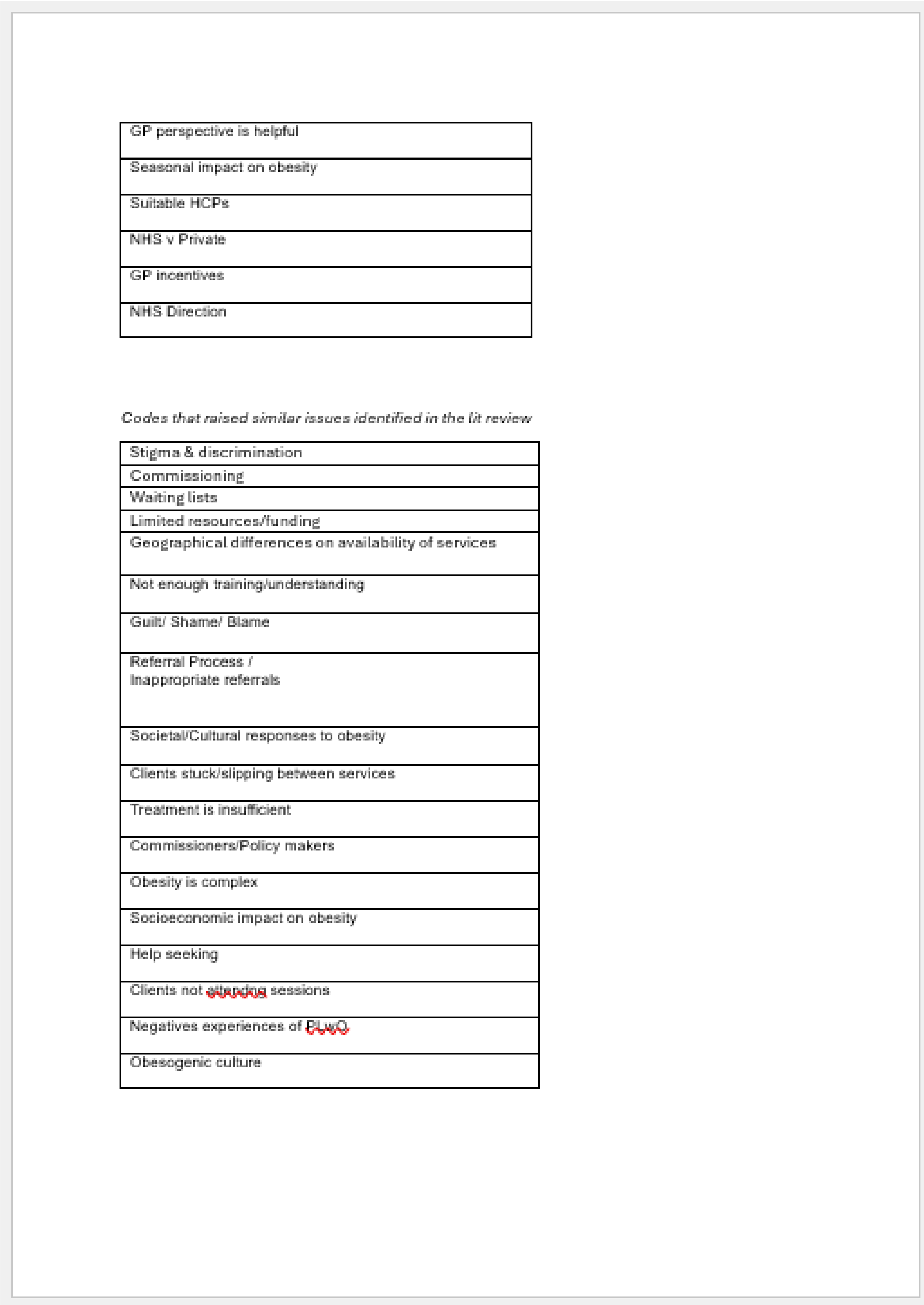
Frequency of BE
Frequency of trauma
Comorbidities

Codes that looked at the impact of the work on HCPs

HCPs feeling out of their depth
Frustration + Disheartening/Demotivating
Disheartening/Demotivated + Emotionally Invested
Fulfilling & satisfying
Challenging
Frustrating + Limiting

Codes that connected to a service type or discipline

Services who work with PLwO
GP Contact
Limited time/ opportunity
WW & Slimming W
What services encounter the client group
Health psychology v Clinical Psychology



GP perspective is helpful
Seasonal impact on obesity
Suitable HCPs
NHS v Private
GP incentives
NHS Direction

Codes that raised similar issues identified in the lit review

Stigma & discrimination
Commissioning
Waiting lists
Limited resources/funding
Geographical differences on availability of services
Not enough training/understanding
Guilt/ Shame/ Blame
Referral Process / Inappropriate referrals
Societal/Cultural responses to obesity
Clients stuck/slipping between services
Treatment is insufficient
Commissioners/Policy makers
Obesity is complex
Socioeconomic impact on obesity
Help seeking
Clients not attending sessions
Negatives experiences of PLwO
Obesogenic culture