UNIVERSITY OF LINCOLN

RE-AIM Evaluation of One You Lincolnshire Integrated Lifestyle Service: Interim Report

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School of Health and Social Care
College of Social Sciences
University of Lincoln

Contributors

The research team consisted of:

Emma Sayers, Research Assistant, University of Lincoln
Professor Jacquelyn Allen-Collinson, Qualitative Lead, University of Lincoln
Dr Dave Dawson, Co-Investigator, University of Lincoln
Dr Nima Moghaddam, Co-Investigator , University of Lincoln
Dr Hannah Henderson, Co-Investigator, University of Lincoln
Dr Ros Kane, Chief Investigator, University of Lincoln

For further details please contact:
Miss Emma Sayers
School of Health and Social Care
University of Lincoln
Brayford Pool
Lincoln, LN6 7TS
01522 886884
esayers@lincoln.ac.uk

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Abbreviations Key

CBT	Cognitive Behavioural Therapy
COM-B	Capability, Opportunity, Motivation, Behaviour Model
CRN	Clinical Research Network
GP	General Practice
HRA	Health Research Authority
KPI	Key Performance Indicator
ILS	Integrated Lifestyle Services
LCHS	Lincolnshire Community Health Services
LTHC	Long Term Health Conditions
NIHR	National Institute for Health Research
NHS	National Health Service
OYL	One You Lincolnshire
RE-AIM	Reach, Effectiveness, Adaption, Implementation, Maintenance
TA	Thematic Analysis

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Executive Summary

In 2019, Lincolnshire County Council commissioned Thrive Tribe to launch One You Lincolnshire, a county-wide integrated lifestyle service. The service aims to provide support for physical activity, smoking cessation, reduction in alcohol consumption, and diet and weight management for individuals, mainly with long term health conditions. The service aims to promote sustainable lifestyle change and behaviours by enabling access to stop smoking services, extended brief interventions for alcohol, diet and nutrition, and physical activity interventions. This evaluation was commissioned and funded by Thrive Tribe.

The study is being conducted in two phases: Phase One: Process (predominantly qualitative) evaluation (Year 1) and Phase Two: Outcome (predominantly quantitiatve) evaluation (Year 2). This report is presenting the findings from Phase One.

To date, we have collected qualitative data (from January to June 2021). Service users completed a pre-interview survey (N=28) and were then asked to participate in an in-depth interview. Service delivery staff, health professionals, and stakeholders were also invited to participate in interviews and focus groups, exploring, the effectiveness and implementation of the One You Lincolnshire service. Thirty individual interviews and seven focus groups were conducted, representing the views of a total of 53 individuals comprising key stakeholders (n = 3), as well as intervention staff management (n = 11), practitioner (n = 13) roles, external partners (n= 5) and intervention clients (n = 24). The use of the Reach, Effectiveness, Adaption, Implementation, Maintenance (RE-AIM) framework enabled any strengths and weaknesses occurring across the initiative to be identified and recommendations made for service improvement.

The evaluation found that despite major changes to service delivery implementation due to COVID-19, the service had high referral rates and success stories of sustained lifestyle changes for many clients. The service's strength lay in the rapport between clients and staff, effective and consistent delivery of behaviour change models and close intra-organisational working relationships. Nevertheless, a key challenge the service faced was establishing inter-organisational partnerships, ensuring consistent buy-in and sound conceptual underpinning of the nature of the service, relative to and as understood by wider community services. Overall, this evaluation found that One You Lincolnshire to be a very successful service in supporting behaviour change and preventing unhealthy risk factors across the county.

An integrated wellness service that offers a holistic approach was valued by service users and allowed them to address complex issues. Organisationally, pressures to disinvest before the long-term benefits to population health and well-being are realised may impact the formation of cross-county partnerships needed for a sustainable service delivery model. The findings raise important

questions about contract management and relationships between commissioners and providers involved in implementing these new ways of working.

Introduction

Policy background

Globally, unhealthy risk factors are the lead cause of mortality, responsible for 13% of all deaths in adults worldwide (Mathers et al., 2009). The most common behaviours are smoking, physical inactivity, poor diet, and excess alcohol consumption, which increase the risk of non-communicable diseases such as obesity, coronary heart disease, and stroke. In the UK, approximately 70% of adults have two or more risk factors (Evans and Buck, 2018) with around 40% of the UK's disability-adjusted life years attributable to the use of tobacco or alcohol, as well as hypertension and or being physically inactive (Newton et al., 2015).

Additionally, research has shown that when behaviours combine this leads to a compound risk of morbidity and mortality for many individuals. For example, an adult in mid-life who smokes, drinks to excess, is inactive, and eats unhealthily, is four times more likely to die in the following ten years than is someone with no known risk factors (Evans and Buck, 2018).

Despite the impact on morbidity and quality of life, as many risk factors are asymptomatic, public health interventions have struggled to engage individuals to seek out services required for behaviour change (Evans and Buck, 2018). Most approaches tackling multiple risk factors focus on single behaviour change interventions. Indeed, recent Public Health England guidance on stop smoking services states that:

> *Whilst there is some evidence for addressing risky behaviours such as poor diet and physical inactivity concurrently, multiple behaviour change interventions involving smoking are not effective in successfully supporting smokers to stop (Public Health England, 2017).*

There is, however, a growing body of literature to suggest the benefit of a multi-armed approach to improve health outcomes. For instance, Johnson et al. (2014) showed that using a multiple-behaviour change approach made individuals 1.4 to 1.5 times more likely to make progress in relation to a second behaviour. The NHS Long Term Plan (2019) emphasised Integrated Care Systems that focus on removing traditional divisions between the NHS and council services at a national and local level to provide various risk factor support services (NHS, 2020).

As such, there have been several interventions targeted at reducing deleterious lifestyle behaviours in the UK, with a shift to a more integrated method of support, reinforced by the evidence that shows a synergistic relationship between multiple risk factors and an individual's overall risk of ill health. Consequently, many local authorities have begun to implement innovative

integrated care systems. One such approach is the use of Integrated Lifestyle Services (ILSs). ILS are often not-for-profit private organisations commissioned by local authorities, which connect local health behaviour providers with primary care services through a single access point. This service model is becoming increasingly common as local authorities move towards a preventive, community service approach. Between 2017 and 2019, 14 ILSs were formed across England, increasing to 33 by 2020 (RCPysch, 2019).

ILSs aim to promote positive, healthy behaviour change, enabling individuals to engage in smoking cessation alongside reduced alcohol consumption simultaneously, for example. The services take a proactive person-centred approach. As such, individuals who may have previously received support only for smoking cessation are also encouraged to use a holistic approach to their health, and to consider their eating habits, alcohol consumption and exercise levels, through health coaching, habit trackers, nutrition guides and group exercises. Despite the movement away from a siloed approach, there is still limited evidence regarding the effectiveness of tackling multiple risk behaviours simultaneously and the factors influencing service user engagement. There is thus a need for research to focus on these issues and explore integrated lifestyle services at a local level in the UK.

In Lincolnshire, Lincolnshire County Council commissioned Thrive Tribe, a non-NHS provider, to design and implement an integrated lifestyle service called One You Lincolnshire (OYL). ILSs focus on four lifestyles behaviours that have been shown to have the most significant impact on health and wellbeing: smoking tobacco, physical inactivity, obesity, and excess alcohol consumption (Sanders et al. 2021). The service model measures over 10,000 healthy lifestyle outcomes that summarise into the following Key Performance Indicator (KPIs).

- Reduction in smoking
- Reduction in obesity levels
- Increased participation in physical activity
- Increased number of people drinking within the national guidelines for men and women
- Increase in number of people eating five portions of fruit and vegetables on a 'usual' day
- Improvement in self-reported wellbeing by clients

Report overview

This interim report analyses the first 12 months of the evaluation of One You Lincolnshire. The report presents findings that will be updated when the final evaluation report is produced in July 2022. This report's findings will be used systematically to inform Thrive Tribe, Lincolnshire County Council, and Lincolnshire Community Health Services (LCHS) about the successes and challenges of delivering an integrated healthy lifestyle service within Lincolnshire.

The current report is reserved for stakeholders involved in the development, delivery, and management of One You Lincolnshire and a wider audience interested in delivering integrated lifestyle services in community settings. The report therefore assumes a certain level of knowledge and understanding of lifestyle services and behavioural change models.

The report is structured as follows:

Section 1: Provides a brief background and context to the One You Lincolnshire service.
Section 2: Describes the One You Lincolnshire service.
Section 3: Describes the evaluation framework.
Section 4: Details the data collection approach.
Section 5: Details the data analysis and data considerations.
Section 6: Presents the interim results.
Section 7: Presents discussion, recommendations, and next steps.

One You Lincolnshire Integrated Lifestyle Service

In June 2019, Lincolnshire County Council commissioned Thrive Tribe to deliver a range of Integrated Lifestyle support services over five years (Lincolnshire County Council, 2018). ILS focuses on providing high quality and accessible information and direct support available to adults in Lincolnshire to help them adapt and maintain healthier lifestyles focusing on the four lifestyle behaviours that have the most significant impact on health and wellbeing: smoking of tobacco, physical inactivity, obesity (food, nutrition, and a healthy weight), and excess alcohol consumption (Lincolnshire County Council, 2019b).

As such, Thrive Tribe implemented One You Lincolnshire as an ILS to promote sustainable lifestyle change and behaviours by enabling access to stop smoking services, extended brief interventions for alcohol, diet and nutrition interventions, and physical activity interventions through tier 1 and tier 2 support (Appendix A). A fundamental model of change used is the Capability, Opportunity, Motivation, Behaviour Model (COM-B) to identify what needs to change to be effective for a behaviour change intervention. COM-B identifies factors that need to be present for any behaviour to occur capability, opportunity and motivation, which interact over time so that behaviour can be seen as part of a dynamic system of change (West and Michie, 2020). One You Lincolnshire provides a service to eligible individuals for up to 12 months to support them in achieving their health outcomes via health information, signposting, goal setting, action planning, and support tailored to the client's needs.

Aim of One You Lincolnshire

One You Lincolnshire aims to support individuals to modify the four leading risk factors outlined above.

County-wide aims are to:

- Significantly increase physical activity, reduce obesity, excessive alcohol consumption and smoking rates, resulting in substantial behaviour change
- Improve health and reduce health inequalities.
- Contribute to the whole-system approach to reducing the overall cost burden to public services
- A reduction in health and social care activities
- Improve opportunities for engagement within communities, reducing social isolation.
- Offer positive health outcomes to partner and family members of clients through a whole systems approach.

One You Lincolnshire objectives are:

- To implement an integrated behaviour change service, which forms an integral part of NHS care pathways and allows for adults to access advice and support in order to self-care.
- To primarily support adults to make positive lifestyle choices which set out to embed healthy lifestyles within local communities whilst also reducing inequalities.
- To target access to the service in line with local need and areas of health inequalities.
- To provide robust data to demonstrate health outcomes for set client groups.
- To monitor and evaluate the delivery of the service to the stated outcomes.

The primary overarching service targets are summarised as:

- Reduction in smoking.
- Reduction in obesity.
- Increased participation in physical activity.
- Increased number of people drinking within the national guidelines for men and women.
- People supported from areas in Lincolnshire that have the greatest need.
- Increase in people eating five portions of fruit and vegetables on a 'usual' day.
- Improvement in self-reported wellbeing.

Service Delivery Model

Tier 1 – Digital Support

One You Lincolnshire includes tier 1 digital support through an online platform called 365 Response. The service acts as a single point of access, enabling client's access to the service anytime, via phone (Monday-Friday 8AM-8PM) and direct messaging on Facebook. Clients on the tier 1 pathway have a bespoke health plan created, setting out recommended goals for improving their health. As well as the health plan, the client portal gives the client access to:

- Instantly bookable appointments for programmes they are eligible to attend.
- Access to a range of self-help tools and apps
- Tracking and recording tools to enable the client to track progress against their goals.
- Information on a range of health and lifestyle information, including recipes, blogs, guidance.
- A searchable directory of local services, clubs, and facilities to help achieve goals and sustain healthy behaviours.

Tier 2 – Health Coaches

The tier 2 pathway gives clients access to a named Health Coach for the duration of their time with the service. Health coaches act as clients' point of contact and are responsible for following up with clients, tracking progress and discharge. If the initial assessment suggests the client will need extra help to build motivation or more support to achieve their goals, one or more sessions are offered with a Health Coach by phone, video, or face to face before and along-side attendance of a Tier 2 programme. The initial session with a Health Coach usually lasts 30 minutes and focuses on the following:

- The building of rapport with a client, presenting a welcoming and positive atmosphere.
- More in-depth assessment in priority areas
- Analysis of behaviour and barriers with the client based on the COM-B model
- Secondary goal setting to break down progress towards the primary goal.
- Applying Cognitive Behavioural Therapy (CBT) and Motivational Interviewing principles/techniques

Further Health Coach sessions include up to three 15-minute phone calls or face to face sessions and shorter, strategic phone calls, emails, or texts. Progress, goals and outcomes from both Health

Coach and Tier 2 programmes are logged by either the staff member or client on the digital platform to enable them to view their progress.

Access for health professionals and other referrers

The digital platform also has a section dedicated to health professionals and other relevant stakeholders. The platform provides a range of short films, animations, and tools on the main healthy lifestyle topics, each just a few minutes in length. The platform aims to enable frontline staff to understand their patients' lifestyle issues better and equip them to make high-quality, very brief interventions and referrals.

Service Referral Pathway

Clients are self-referred or referred via a health professional into One You Lincolnshire, with each client receiving an initial assessment that takes around 10 minutes to complete on the service's digital platform or by telephone by a locally based Triage and Support Officer or in person.

Eligibility

All clients using the service are adults over the age of 18 years old who have been identified as having an at-risk status and one or more unhealthy behaviour following the NHS Health Check (NHS, 2017). One You Lincolnshire eligibility criteria are the following:

I. People with long-term health conditions, whose condition is likely to be made worse by unhealthy behaviours, including diabetes, cardiovascular disease risk, liver disease, musculoskeletal conditions, osteoporosis, coronary heart disease and respiratory diseases.
II. At-risk adults who have undertaken an National Health Service (NHS) Health Check for Cardiovascular Disease Prevention, enabling primary care staff to refer directly into the ILS.
III. People engaged with the NHS's health optimisation policy regarding the future requirement for support for smoking cessation and weight management before surgery.
IV. Carers being supported in Lincolnshire who may be obese, a smoker, drink to excess, or be inactive.
V. People who smoke and are seeking help to stop smoking, particularly pregnant women, and their partners.

Service Areas

One You Lincolnshire operates in 17 sites across the county, with a range of interventions available across the region via online support and health coaches. Figure 1 shows the various activities in each site delivery service.

Figure 1. One You Lincolnshire Programmes available at each site grouped by risk factor. *Delivery mode changed due to COVID-19.

	Stop Smoking				Move More				Lose Weight/ Health Eating					Drink Less	
	Health Coach Appointment*	Specialist 1:1 Stop Smoking Programme	Stop Smoking in Primary Care*	28 Weeks Telephone and Digital Service	Specialist 1:1 Sessions with PA instructor*	Supervise Sessions in Leisure Facilities *	Group Programmes with PA instructor*	Get Healthy Get Active	Lose Weight with One You Lincolnshire	Man, V FAT Football*	Weight Watchers or Slimming World*	Our Path Phone and Digital Programme	Health Coach Sessions	One Year No Beer	Alco-Change
Lincoln	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Grantham	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
Boston	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
Spalding	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
Skegness	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Gainsborough	✓	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	✓	✓
Stamford	✓	✓	✓		✓		✓	✓	✓		✓	✓	✓	✓	✓
Sleaford	✓	✓	✓		✓		✓	✓	✓		✓	✓	✓	✓	✓
Louth	✓	✓	✓		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Bourne	✓	✓	✓				✓	✓	✓		✓	✓	✓	✓	✓
M Deeping	✓	✓	✓				✓	✓	✓		✓	✓	✓	✓	✓
Mablethorpe	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Horncastle	✓	✓		✓		✓		✓			✓	✓	✓	✓	✓
Holbeach	✓	✓		✓				✓			✓	✓	✓	✓	✓
Ruskington	✓			✓							✓	✓	✓	✓	✓
Long Sutton	✓			✓							✓	✓	✓	✓	✓
Coningsby	✓			✓							✓	✓	✓	✓	✓

Target Population Health Profile

Lincolnshire has a population of 755,833, with over 50% of illnesses in the county underpinned by lifestyle risk factors (ONS, 2018, Lincolnshire County Council, 2019a). Lincolnshire has a smoking

prevalence rate similar to the national and East Midlands average prevalence; 15.3% for Lincolnshire, 14.8% East Midlands and 13.9% England (Public Health England, 2020a). The Public Health Outcomes Framework (PHOF) reports the percentage of adults in Lincolnshire, aged 18 years and over, classified as overweight or obese (BMI of over 25 and 30) at 66.5%, significantly worse than the national average 62.3% (Public Health England, 2020b). There have been efforts to enable adults to be more active with 64.8% of adults in Lincolnshire reaching minimum activity levels[1]. Yet 24.9% of adults are inactive. Both indicators are worse than the England average (Public Health England, 2020c). In Lincolnshire, around 22.1% of adults drink over 14 units of alcohol a week (Public Health England, 2019). 6,746 of these are dependent on alcohol, with 12% requiring specialist treatment (Lincolnshire County Council, 2019c). It is estimated that the potential population size for One You Lincolnshire is almost 60,000 eligible adults (Table 1).

Table 1. One You Lincolnshire Potential Population Size.

Target cohort	Potential population size
Long term health conditions (LTHC)	48,973
Health checks	5,671
Health optimisation	1,067
Carers	1,820
Pregnant women who smoke	1,292
Workforce	1,012
Totals	**59,835**

RE-AIM Framework Evaluation

This evaluation uses the RE-AIM model, which was developed in 1999 in response to a need fora framework to evaluate public health interventions (Holtrop et al., 2018). The RE-AIM framework was first produced to help evaluators balance internal and external validity when developing and testing and implementing interventions. The goal of the framework is to be able to help maintain programme sustainability in community settings. The RE-AIM dimensions' constitutive definitions try to be as straightforward and intuitively appealing for community and clinical organisations (Glasgow and Estabrooks, 2018). RE-AIM includes five dimensions which are outlined in Table 2.

[1] NHS Physical Activity Guidelines: 150 minutes moderate intensity per week for adults

Table 2. The RE-AIM dimensions used in this evaluation and the scope of each dimension.

RE-AIM Dimensions	Scope
Reach	WHO is intended to benefit and who actually participates or is exposed to the intervention?
Effectiveness	WHAT are the most important benefits you are trying to achieve and what is the likelihood of negative outcomes?
Adoption	WHERE is the programme or policy applied and WHO applied it?
Implementation	HOW consistently is the programme or policy delivered, HOW will it be adapted, HOW much will it cost, and WHY will the results come about?
Maintenance	WHEN will the initiative become operational; how long will it be sustained (Setting level); and how long are the results sustained (Individual level)?

Reach refers to the absolute number, proportion, and representativeness of individuals who participate in a given intervention. *Effectiveness* is the impact of an intervention on important outcomes and includes negative effects, quality of life, and economic outcomes. *Adoption* is the absolute number, proportion, and representativeness of settings and intervention agents who initiate a programme. *Implementation* refers to the intervention agents' fidelity to and adaptations of intervention and associated implementation strategies, including consistency of delivery as intended and the time and costs. Lastly, *Maintenance* is the extent to which a programme becomes routine. Within the RE-AIM framework, maintenance also applies at the individual level and has been defined as the long-term effects of a programme's outcomes (Kwan et al., 2019).

One benefit of the RE-AIM framework is it provides a valuable starting point for determining the public health impact of interventions: reach, captures a given population who participate in a programme and describes their characteristics; effectiveness, refers to the positive and negative outcomes of the programme; adoption, can define the per cent of possible settings and staff that have agreed to participate in the programme; implementation indicates how a programme was delivered as intended and its cost; and maintenance, at the individual level, reflects maintenance of the primary outcomes (Sweet et al., 2014). Applying RE-AIM challenges researchers to ask questions about complex issues before, during, and after the implementation of a programme in real world settings. Among the many RE-AIM strengths is its robust structure and pragmatism that facilitates broad use across settings, populations, and interventions (Harden et al., 2018).

Aims and Objectives

The study aims to identify the impact of addressing multiple unhealthy behaviours for an individual in Lincolnshire through OYL Integrated Lifestyle Service and establish how OYL had been implemented, valuing the overall level and quality of outcomes as well as highlighting any potential risks and challenges that may impact the intervention in the future.

The objectives of the study are to:

1. Identify critical components of good practice of the client pathway, taking into account views from clients, programme staff, healthy lifestyle service subcontractors, and referral teams that together capture vital barriers and facilitators of OYL service implementation and delivery.
2. Identify access and acceptability of the service provision within client subpopulations against local population demographics and planned implementation of OYL.
3. Assess baseline effectiveness of OYL, exploring variables that moderate outcomes such as client, provider, and programme factors comparing to service targets and external benchmarks.
4. Evaluate the cost-effectiveness of OYL to the previous silo delivered services in Lincolnshire.
5. Develop clear recommendations for real-world settings that are suitable and amendable for service improvement of OYL;
6. Contribute to the growing body of evidence on the impact of integrated lifestyle service delivery and future quality assurance of service outcomes (to be reported on in the Phase Two report).

Research Activities

The main research activities of the evaluation are highlighted below and include:

1. Review literature on community-based integrated lifestyle services and documentation from OYL included initial proposal, service specifications, programme protocols made available to the research team.
2. Conduct interviews with clients referred, engaged with, completed, or dropped out of OYL between 2019 and 2021, to explore clients' perspectives, facilitators, and barriers to engaging with OYL and their experiences of COM-B support and outcomes.

3. Conduct semi-structured focus groups with delivery staff who have engaged with clients to refer, assess, support, or deliver programmes, such as: programme staff, support officers, lifestyle leads, programme subcontractors, and referral practices to explore how OYL has been adopted and implemented.
4. Conduct semi-structured interviews with key stakeholders covering history of integrated care in the area, the rationale for OYL, expectations from the programme, aim of the programme, models of integration, involvement with other sectors, governance arrangements, and learning points for the first year.
5. Conduct secondary data analysis on anonymised OYL data (2019-2022) to independently assess the quality of care for clients, measure behaviour changes, and determine service cost-effectiveness.

Outputs and Outcomes

Short-Term

- Conduct a formative, interim evaluation to report progress and how to assess OYL
    - Interviews with clients
    - Focus groups with OYL staff
    - Focus group with external providers of OYL services
    - Focus group with health professionals who refer into service.
    - Interviews with key stakeholder at OYL and Lincolnshire County Council
    - Analysis of qualitative data

Medium-term

- Conduct a summative evaluation to identify outcomes and impact of OYL
    - Identify the effectiveness and impact of OYL on client health outcomes.
    - Identify the effectiveness and impact of OYL on Lincolnshire lifestyle risk factors.
        - Smoking cessation
        - Weight management
        - Fruit and Vegetable intake
        - Alcohol reduction
        - Maintenance/improvement to wellbeing
        - Referrals to OYL
- Identify extent and impact on:
    - Cost-effectiveness of service
    - General Practice (GP) appointments

- Identify strengths, challenges, successes, and lessons learnt.
- Identify unanticipated outcomes.
- Make real-world recommendation for future delivery of OYL Integrated Healthy Lifestyle Service
- Provide dissemination plan to agree with OYL and the National Institute for Health Research (NIHR)

Long-Term

- Contribute to the body of evidence on integrated lifestyle services.
- Contribute to the body of evidence on targeted intervention for multiple lifestyle risk factors.
- Final dissemination plan
    - Dissemination activities
        - A publishable report in peer review journal
        - Conference report

Methods

Research Design

The study collected both quantitative and qualitative data from January to June 2021. In order to capture the views of a diverse range of clients, the research team implemented a pre-interview survey to assess the type of support and demographic of potential interviewees. An online survey was designed and delivered using Qualtrics software and asked potential client participants about demographics, how they were referred to the service and the pathways they used. The steering group piloted the survey, and changes were adopted where appropriate. The survey can be found in Appendix B. All interviews and focus groups (telephone and TEAMS) were conducted using a semi-structured interview guide with a range of OYL and other Health Professionals who referred and supported clients. Topic guides were developed with the steering group to ensure questions followed the RE-AIM framework. The whole group reviewed interview questions for appropriateness of question order and flow. Thus, key stakeholders, staff and clients themselves were allowed to contribute to the interview and focus group guides on its design phase.

Sampling and recruitment of participants

Between July 2019 and July 2020, OYL had 6,268 clients in its database. The service has eight Service Leads, with 33 Programme Staff ranging from Triage and Support Workers, Health Practitioners, Advisors, and Referral Generation Officers, shown in Appendix C. The service also works with 175 subcontractors across Lincolnshire. Staff were directly contacted via the research team, whilst a call for client participation was advertised on OYL's website and social media, with participants being able to telephone or email the research team to express an interest. Staff also used a telephone script to advertise the study to clients already engaged in the service. This advertising material was developed collaboratively with OYL, client representatives and the research team. The sample of participants was closely monitored to ensure diversity such as gender, ethnicity and carers status across the participation groups. Participation was voluntary, and recruitment of participants used an opt-in method in line with GDPR (2018).

Ethics

This study is defined as research and obtained Health Regulation Approval on the 22nd of December 2020 (Health Research Authority 2020 Appendix D). Project IRAS ID 289313. A steering committee (Appendix E) was established and met at three-month intervals to ensure all practical details of the study were progressing well and working well.

Data collection

Data collection took place between February 2021 and June 2021 and involved qualitative interviews and focus groups with various participants. During Phase One. in total, 53 participants have taken part in the study (Table 3). Participants who agreed to take part were given a detailed information sheet and consent form prior to any data collection. Participants were given the option to book an interview time with the researcher, and the interview was conducted via telephone or Microsoft TEAMS, as preferred by the participant. Only participants who provided informed consent and met the pre-interview screener were included in the study. Consent forms (via Qualtrics) were completed before the interview/focus group and stored as PDFs on a secure cloud-based server. The interviews/focus groups were recorded, transcribed, and transcriptions were stored on a cloud-based server. Participants had the right to revoke, decline or withdraw consent at any time during this study.

Table 3. The number of interviews completed by June 2021. There was a total of 24 service user interviewed and 29 of staff.

Individuals interviewed	February- June 2021
Service Users	24
OYL Staff	21
Health Professionals	5
Stakeholders	3
Total	**53**

Topic guides were used to ensure an overall consistent approach to each interview. However, the topic guides were used flexibly, with open and non-leading phrasing to allow participants to give their account in their own words, and to describe their lived experiences (Appendix F). Staff focus groups comcentrated on service delivery, and implementation whilst client interviews focused on the perceptions of the service, and the impact perceived by clients. Interviews ranged from 30 to 120 minutes in length.

Analysis and reporting

Transcripts were inductively analysed by the research team using the principles of thematic analysis (TA) proposed by (Braun and Clarke, 2006) to facilitate exploration of participants' lived experiences as situated within a broader sociocultural context of their health. A coding log was set up by the research assistant to ensure all data and recruitment files conformed to requirements regarding anonymity. All interviews were recorded verbatim and transcribed, except for one interview that was conducted over email. Each transcript was reviewed and coded by the original interviewer. An iterative data analysis process involved all research team members through periodic team meetings where differences in interpretation were discussed. NVivo software (Version 10) was used to interrogate the data and facilitate analysis. The qualitative data were thematically analysed as follows with the codes summarised as follows:

- A coding frame was developed based upon early rounds of interviews and refined by the research team until an agreed structured/hierarchical coding frame was developed.
- Summaries of significant findings were generated to identify recurrent themes and compare and contrast findings.

  The team was careful to consider outlier data and divergent accounts and issues, as well as commonalities, to identify key themes for the study as a whole.

Results

Characteristics of Clients

Overall, there were 28 responses recorded, with 24 agreeing to a follow-up interview (Table 4). The majority of respondents were female (n= 21), and nearly all reported their ethnicity as White British (n = 26) and living with LTHC (n=23). A quarter of participants had friends and family support them whilst 14% had caring responsibilities. However, the majority of participants did not have caring responsibilities (n=16). Self-referral was the most common route into the service, followed by a referral made by a GP on their behalf. Social media, word of mouth and work referrals were also noted by some participants. The majority of participants completed their assessment over the phone with the OYL triage team.

Once assessed, most participants were offered online information (tier 1 support) and access to a health coach (tier 2 support). 21% were only offered tier 1 support, and 25% only used a health coach for support and did not engage in any tier 1 support despite being offered. Overall, healthy eating was the most common type of support participants were engaged with and physical activity. Smoking cessation and alcohol reduction support was used by 21% of participants, respectively. Most participants engaged in more than one type of support, 57% of participants engaged in two programmes simultaneously, with most being healthy eating and physical activity. One participant did engage in three lifestyle programmes concurrently, whilst the remaining 39% of participants engaged in only one lifestyle programme.

Finally, most participants were currently working towards their goals and lifestyle changes during the study. A small percentage did not achieve or maintain their changes whilst in the study. Although 36% of respondents indicated that they had maintained their changes, when interviewed, some had no longer maintained their change suggesting some discrepancy between the screener questions and the follow-up interviews.

Table 4. Characteristics of clients of pre-interview survey

		N	%
Gender	Female	21	75
	Male	7	25
Ethnicity	White British	26	93
	Non-White British*	2	7
Living with a Long-Term Health Condition	Yes	23	82
	No	4	14
	Preferred not to answer	1	4
Carer Status	Had friends or family support them	7	25
	Had caring responsibilities	4	14
	Had friends or family support them AND had caring responsibilities	1	4
	Did not have caring responsibilities	16	57
Referral Route	Self-Referral	11	39
	Via GP	10	36
	Other Route	7	25
Assessment Process	In Person	3	11
	Via Website	5	18
	Via Phone	19	68
	Other Route	1	4
Level of Support	Tier 1 Support Only	6	21
	Tier 2 Support Only	7	25
	Both Tier 1 and Tier 2 Support	13	46
	Did not know	2	7
Type of Support Used**	Healthy Eating	20	71
	Increasing Exercise	13	46
	Reducing Alcohol Consumption	6	21
	Stop Smoking	6	21
Used Integrated Care Support	One Programme Only	11	39
	Two Programmes	16	57
	Three Programmes	1	4

Maintenance of Lifestyle Changes	Maintained changes	10	36
	Currently working on changes	16	57
	Did not maintain changes	1	4
	Did not achieve changes	1	4

*Due to the small sample size (n=28), some data were aggregated to ensure anonymity.

**Percentages equal >100 as participants could select multiple responses.

Reach

Referral routes into service

A wide range of clients were referred into the OYL through their GP, self-referral, friend recommendations or workplace wellbeing schemes. Most were told about the service from their GP and mentioned searching online to find more information about the service before making contact. Many who were referred via the GP were for healthy eating and weight loss. In contrast, self-referring clients were more likely to be for smoking cessation or alcohol reduction. Many self-referring clients either found the service via an online search engine or through social media such as Facebook. For self-referring patients, there seemed to be a delay between the initial contact with the service and eventual sign up. The need for multiple interactions was reported by health coaches who indicated that online advertising required 3 to 4 interactions before clients signed up.

> *It is almost the third or fourth time that they have heard about us…I know it takes me quite a few times to hear the same message to go – I might look at that.* ***Service Delivery Lead***

Some clients were referred via a friend, all referring from Slimming World or Second Nature, a digital online weight loss programme. Additionally, clients reached through their place of employment saw the email contact as positive but were apprehensive of disclosing their health in a workplace environment when OYL staff had physical stands in offices.

> *I saw a stand outside the cafe, promoting the work. I was pretty interested, but I would not like to have stopped at the stand and have a conversation with them. A few days later, I got the email, and they had a section on One You Lincolnshire.* ***Client with no LTHC***

Understanding of service before engagement

The service delivery model of OYL, working with multiple partners in the county, enabled a broad reach, with services able to cross-refer to one another, which increased the likelihood of clients

taking up more than one programme. Many clients mentioned that their GP had described the service as a wellbeing programme that offered weight loss support, although the specific support was not explained, but was communicated as general support.

> *[The GP] said, have you heard about One Lincolnshire? I said 'No'. And he said, 'Right, I'm going to suggest if you don't mind that, I'll put you on to them and then see how it goes from there'…But before that, and I haven't heard anything about One Lincolnshire.* ***Tier 1 Client***

GPs seemed to use the service more for signposting than direct referrals. Practices seem to understand the service mainly for weight loss and smoking cessation, with the alcohol reduction service being more for the self-referral pathway than perceived as a GP responsibility.

> *We then gave them [the clients] a little card saying you are eligible for this, ring this number. It's a bit quicker than having to fill out the form.* ***GP***

However, health coaches argued that GPs could pursue clients to take part, due to the power dynamic between health professionals and patients. Interestingly, health coaches noted that GP-referred clients sometimes appeared to be less motivated than self-referred clients. They considered this might be because clients felt obliged to attend the service due to the doctor's 'prescription' rather than their own motivation.

> *[The GP] was sending them [the clients] home and getting them to go and look at it [the service]. And what we found is that their referrals were low, basically, people weren't going home and having a look and making a referral…Sometimes when you talk to them [the clients] - Well the doctor has told me I need to come here. So initially they might be there a little bit begrudgingly.* ***Service Delivery Lead***

Accessibility and inclusion

A key group that was more likely to self-refer comprised clients who had unsatisfactory experiences with GP services. Clients mentioned a focus on weight above all other health needs. Interestingly, interviews with the GPs supported this with an overweight patient being easier to recognise than a client who needed to reduce their acholic consumption.

> *Unfortunately, GPs aren't overly helpful if you are simply fat. My joint problems came first. They're like, 'No, no, your joint problems because you're fat, some people just get fat, so*

stop being fat'. So, when this got suggested to me, it was like… how do I do this sensibly, without hurting myself? ***Client with LTHC***

Similarly, health coaches noted that the wide range of clients referred from the GP had complex health needs such as underlying eating disorders, mental health illness, and financial difficulties for example. Also, few men seemed to engage in weight loss pathways; this was due to a lack of awareness by health professionals of 'MANVFAT' programmes in referral.

ManVFat Football and Lose Weight With, they are not known that well to GPs. We all know that they form part of our flexible weight management offer for a client, so we know we have got a really broad offer, but to make sure that GPS understand. ***Service Delivery Lead***

However, there were more men on the stop smoking pathways. Subcontractors considered this might have been due to more shift workers participating who were more likely to be smokers.

The service also focused on reaching deprived areas, which was inferred through questions asked at referral to *see [the client's] background and where their kind of level of deprivation could be*. Stakeholders emphasised the need to work closely with GP practices in these areas. Despite the focus, some staff felt that some GP practices in deprived areas were harder to engage with due to shifting priorities and apprehension about longevity of OYL.

I think they [GP Practices] just got to a level of exhaustion. And so, they are just concentrating on what their priorities are, which I totally understand, but it's tricky because if they would engage, possibly more effectively, then those programmes would probably have a bit more longevity. ***Referral Staff Member***

Effectiveness

Integrated support

Most clients interviewed used more than one pathway simultaneously, such as increased physical activity and healthy eating. Many clients viewed the integrated support as beneficial to their wellbeing as it reinforced a holistic approach, focusing on substantial long-term changes rather than 'quick fixes'.

Healthy eating and increased exercise forced me to think of what small things I can do as a lifestyle change. As opposed to, just quick fix, eat salads every day, which is not sustainable for me long term. ***BAME Client***

Clients noted that participating in more than one lifestyle change solidified a mindset change that motivated them to prioritise their health. Similarly, coaches emphasised the need for a mindset change for the service to be effective for clients.

> *We can start getting them crossing over into different activities; the whole thing with the 12-week programme, that can get a mindset change; it is a long enough period to start seeing the benefits, seeing the difference, and seeing a change.* ***External Partner***

Interestingly, clients mentioned the reduced stigma associated with seeking support via OYL in comparison to siloed services for pathways of alcohol consumption and smoking cessation. Many clients viewed smoking and drinking as addictions and, therefore, both emotionally and physically challenging to overcome. However, due to the service being framed as a lifestyle service, clients could seek support without the stigma of addiction support but more under the guise of a wellbeing and lifestyle service. Framing the service as a lifestyle programme was reflected by health coaches and smoking advisors who noted the traditional stigma and stereotypes associated with support for drinking or smoking.

> *It's under lifestyle rather than an addiction. It's about promoting that healthy lifestyle. And it's an umbrella of weight, smoking alcohol exercise. So, it puts it in a different park to addiction.* ***Client with LTHC***

Peer vs one-to-one support

Pathways used a mixture of group support and one-to-one support models. Stop smoking programmes used weekly telephone one-to-one support with clients. Subcontractors noted the high success rate of the pathway regarding quit rate in comparison to their competitors where the industry standard was assumed to be a 50% success rate. Subcontractors also felt telephone support provided accountability and motivation for clients. The effectiveness of the smoking cessation pathway was reflected in client interviews who noted the positive attitude of smoking advisors who offered non-judgmental support and regular encouragement to maintain cessation.

> *Our quit rate is an average of 62%, which is pretty much as good at it can get. It's said if your quit rate goes into the sort of high 70s 80s, you start getting investigated.* ***External Partner***

In contrast, some clients found the alcohol one-to-one to support not as effective. Clients noted understanding units of alcohol as beneficial. However, clients were more likely to struggle to

sustain their weekly target due to a loss of motivation or underlying stresses. One client noted that support could be improved by having more structured weeks to encourage commitment to the weekly goal.

> *We're having the same conversation each week, which is fine, because you're telling me the right things. I am not in that mindset phase, I'm not ready to not do it.* ***Client who did not sustain change***

With regard to group support, many clients noted that the model was highly effective. Clients enjoyed building relationships with other service users and the gradual increase in their exercise or healthy eating choices week by week. Almost all clients noted the friendliness, encouragement and accountability provided by health coaches and the usefulness of tools such as food diaries, exercise booklets, quizzes, measuring cups and online exercise classes.

> *It was really, really interesting. There were little quizzes that got everybody involved. I don't think anybody dropped out. Everybody came every week.* ***Tier 2 Client***

Impact of underlying long-term health conditions

Many clients had significant health needs whilst participating in the service, ranging from mobility issues, post-surgery recovery, general anxiety disorders and complex mental health needs.

> *I'm autistic, I don't connect to my body very well. And I also have had various eating disorders. My brain and my body…'how can you not know if you're hungry?* ***Client with LTHC***

There was a range of factors that impacted a client's perception of the effectiveness of the service. For some, the service catered well to their specific health needs, such as providing modified exercise workouts, dietary modifications, and health coaches' emphasis on the importance of sleep and self-care for mental health.

> *I feel better in myself, because of medication I couldn't move very well. I'm now back to a size 14 and my moods improved because I'm thinner, I'm happier, and I'm feeling better in myself… It's made me come to terms with what I've got now because I can't change my body anymore.* ***Client with caring needs***

For some clients, however, the impact of long-term eating disorders affected their ability to lose weight and reach targets. This specifically impacted clients who struggled with their mental health and how they interacted with their own body.

> *I struggle with my mental health, it's something that's gotten progressively worse for me. A lot of it is the mental challenge of losing weight. When I get depressed or anxious, my go-to is food. In Slimming World, being able to eat unlimited amounts of rice and pasta, potatoes just didn't really work with my mental state…It was acknowledged, but there aren't services to support it.* ***BAME Client***

The interaction between eating disorders and weight loss was reflected in health coaches' concern for clients who required more specialist support for emotional eating and addressing the relationship between weight loss and eating disorders, something they were not skilled to do.

> *Things like thyroid problems, emotional eating disorders, specialised diabetes sometimes, these clients have done everything they can do in the past, and they found that they just have not lost any weight. As a service we are not commissioned to give the advice.* ***Weight Management Team Member***

Adoption

Fidelity to service delivery model

OYL had a robust quality assurance process for both internal and external service delivery. Adherence to policies was monitored both centrally by Thrive Tribe and through peer-to-peer quality assurance protocols. However, it was noted that COVID-19 had impacted on the service, with the original commissioned model being revised, for example via incorporating online programmes and expanding the eligibility criteria for the service. The change from the initial model was viewed as challenging so soon after the launch of the service and programme? leads having to communicate the changes to external partners to ensure conformity with the changes.

> *We got seven months into our contract, COVID hit, and then we have had to re-evaluate everything, so it has been quite tricky to make sure there is consistency in what we deliver because we have had to rewrite it three times in two years, which has been challenging!* ***Service Delivery Stakeholder***

Specifically, the alcohol pathway was highlighted as encountering some difficulties soon after launch due to low adoption of the pathway by health professionals referring into the service. Yet, many subcontractors did quickly engage in the service delivery model after launch. Subcontractors had specific metrics and targets set by OYL to ensure the service was being delivered as commissioned. These metrics were stated in partnership contracts and were therefore monitored regularly by OYL's quality assurance leads.

> *I think from an alcohol perspective; we struggled at the beginning of the contract because of the healthcare professional referrals; and what we were noticing was that we were not getting enough, but also, we were not getting the proper referrals for the alcohol pathway.* ***Service Delivery Lead***

However, the model was able to change and adapt as client barriers were recognised and recertified. Partners noted that the model did allow for flexibility and personalisation of the service by health coaches and service delivery staff, with partners required to adhere to general protocols and guidelines rather than specific rules when interacting with clients.

> *We have a loosely agreed structure…I monitor my team's calls to check adherence to certain fundamental principles. However, I am not overly prescriptive when it comes to saying that you must discuss this in every given situation as it does depend on the person and the client.* ***External Partner***

Communication with external partners

Overall, OYL established good working relationships with external partners. Partners emphasised that clear and timely communication with OYL aided the smooth operation of the service and the focus on clients enabled partners to work towards a common goal. Additionally, OYL offered an added benefit of acting as mediators between partners and GPs in some cases.

> *I think One You Lincolnshire's service lead's ethos is clear, consistent and concise messaging; and indeed, those three c's have formed the majority of our external communications with partners and clients; and that again has been an excellent ethos to build those communication networks and those partnerships.* ***Service Delivery Lead***

OYL staff who focused on maintaining partnerships noted different communication styles used for various subcontractors. It was highlighted that some difficult relationships with partners in turn, were less likely to adopt the service delivery model and refer to the pathways, suggesting a correlation between communication and adherence to protocols. For example, some GP clinics that did not engage readily in the OYL service were viewed as gatekeepers for clients in those areas.

> *Practice managers are hard to engage with; maybe a handful are very engaged, want to be involved, are happy, and want to see the value in the service, so they are very good at responding to our communication. Some would like to be more involved, but probably because of their capacity, they do not have the time to engage as much. Some do not seem to see it as part of their role to engage with us, and they are very much about being gatekeepers and stopping us from interacting with their practice, which can be frustrating.* ***Referral Team Member***

Some partners noted an improvement in both communication and service delivery compared to previous in-siloed services, with a clear understanding of the service being a contributing factor. However, other partners with previous lifestyle service contracts did mention a certain level of scepticism of the OYL service delivery model and the longevity of the service in the county.

> *When we resurrected the exercise on the prescription model, we were met with a little bit of negativity and distrust from certain providers. Because the funding was there, then it was cut, then it was brought back in and reduced; there was a lot of misunderstanding and much scepticism regarding the funding, and it would just be a flash in the pan, then disappear again. Nevertheless, we have tried to knit together partners across the county.* ***Service Delivery Lead***

Implementation

Usability of Response 365

Many OYL staff discussed technical issues they faced when using Response 365 software to complete administrative tasks and referrals for clients. The critical issues noted were slow responsiveness, erroneous data entry and a lack of user-friendly features. The impact of using a time-consuming system resulted in a loss of productivity for staff, logistical problems when the system double-booked clients and for some health professionals not using the system at all.

> *Some technical hitches that we find are pretty onerous navigating. We have had some staff that have worked well with it and managed to go on well, and other staff that have not; and it has been quite a challenge. We did not get to grips with that before lockdown.* ***External Partner***

Although, some subcontractors proactively ringfenced time for staff to carry out 365 tasks to counteract the system's delays, health professionals argued that using another system alongside other healthcare systems was still challenging to sync information and not conducive to their daily workload.

> *That is asking a lot of a healthcare professional who's already wrestling with many types of referrals, not just One You Lincolnshire.* ***Referral Lead***

However, 365 was viewed as applicable to exploring client journeys and to examine how integrated pathways were useful for service strategies. Indeed, triage staff spoke about providing ongoing support for any staff that needed it to help resolve the issue, which had led to fewer issues as the service progressed over time.

> *From when I started, 365 has improved a lot; we are essentially the guinea pigs for it; when the updates come, we have to find its faults, report back, and take it from there.* ***Referral Team Member***

Rapport between staff and clients

Another critical aspect of the service implementation was the rapport building, formed between clients and staff to promote take-up and maintenance of lifestyle programmes. Many clients highlighted the genuine care and respect health coaches showed to them and the positive impact on their health journey. A good relationship with the health coach also impacted how accessible

clients viewed the service and seemed to remove any stigmas or client anxiety; rapport was seen an essential component of ensuring commitment to the programmes.

> *The service is accessible. It is not restrictive. It has not got any of that vibe that you get from being too fat, too injured or too disabled.* ***Client with LTHC***

The clients noted that staff were non-judgmental and felt that staff truly wanted to help them improve their wellbeing authentically. This was solidified though staff ensuring that programmes were personalised to each client and that any goals were set together to ensure the client felt autonomy over their choices, motivations and outcomes.

> *When I suggested things, [the health coach] asked if I thought it was good or not, and she would give me ideas on cooking things or different recipes or different ideas. She was really she really good.* ***Client on integrated pathway***

Indeed, staff interviews correlated with clients' views of ensuring they were friendly and approachable throughout a client's journey. Rapport building was vital to service delivery across all pathways and helped clients feel motivated and optimistic that behaviour change was possible, the idea that someone was rooting for them.

> *When you feel like you can really rely on someone… [the health coach] had a charisma about him that he was really determined for me; not because he was assigned to me…He seemed he was really invested in me and he really emphasised the point that if I needed anything, just ask.* ***Client with sustained change***

Staff capacity and training

Stakeholder interviews revealed that staff training was an essential element of OYL, with all internal and external service delivery staff trained in the delivery model and 365 before the launch of the service. Following the initial training, staff were then offered immersive workshops with real-world scenarios to improve client-staff interactions and ensure staff were current with behaviour change techniques and skills.

> *The opportunity for ongoing training is something we have been conscious about doing throughout…we now have skills development workshops. The workshops focus on how to use those behaviour change techniques; so really chatting through scenarios and almost role-playing, learning to use the phraseology, the correct terminology, how to make it flow*

in a conversation; so, it becomes a genuine interaction, a real conversation. ***Quality Assurance Stakeholder***

The training was generally viewed as positive by staff and continually improved the quality of the service. However, some subcontracted staff did feel there was still a need for more training in 365, specifically as the initial training was not seen as sufficient for staff to feel confident in using the software.

After the first initial week's induction, we just hit the ground running. From my point of view, I was nervous about it. I have done the job for years, but with the new software, I do not think we had enough training on it. ***Pharmacist***

Additionally, some staff noted further training required for triage staff to ensure inappropriate referrals were not sent through to coaches and to help streamline the service. In terms of staff capacity, most staff noted a high workload but felt strongly supported in their roles and did not feel overwhelmed. Staff noted the benefit of working from home on increased capacity due to reduced travel to sites and visitations to clinics. There was also a correlation between a positive work culture and meeting targets noted by programme leads.

If you have not got that culture of the leadership team driving a values-based approach, it impacts on patient care, client care. I think for us, that is being a real key: making sure that you have got not only the head of the service that is ultimately signed up to and driving the KPI's for example, but also the team leads who in turn get their stuff involved, it is the full-service engagement. ***External Partner***

Maintenance

Monitoring of progress

To ensure client goals were met, staff took weekly checks to monitor clients progress and if milestones had been reached, such as 5% weight loss or sustaining not smoking. Although it was presented as optional for clients to monitor their progress, many did by using food diaries, recommended apps, sent updates to friends and family, and on group programmes, used WhatsApp chats to share milestones.

Writing it down did increase my amount of exercise because I was aware of what I should have been taking. I'd send a photograph attached to an email every week and then we'd get quite comprehensive feedback on it. ***Client with LTHC and on integrated pathway***

For weight loss pathways, SMART goals were used to help clients make manageable and achievable changes week-by-week. There was some variation in client interviews if health coaches had shared data on their weight loss journey and was down to the coach's discretion. Some clients received progress tracking via email whilst others did not receive any specific milestones, rather verbal/written encouragement on good progress, removing the focus from the goal itself.

> *We submitted weight measurements and whether we'd manage five fruit and veggie portions that week as SMART goals but then we would get feedback as well immediately.* ***Tier 2 Client***

Yet, some GPs mentioned not receiving any updates on clients once referred, making it uncertain for GPs whether the service was beneficial or helping clients achieve health outcomes. There was also a significant change in the model of monitoring progress during the lockdown as staff had to rely more on clients' honesty in self-reporting weight loss or smoking cessation without the ability to validate the results.

> *I do not get much feedback. I presume they are happy; I have not had any complaints. I have not heard anybody say it works well or it works poorly.* ***GP***

You had just got to take their word for it at the moment because when it was faced to face, you had the smoking monitors that they had to blow into so you cannot get away with it as such. Now it is just 'I have not smoked for how many days or how many weeks. You have to take their word for it. ***Referral Team Member***

Factors influencing maintenance

There was a mixture of clients that either maintained change after completing a programme or struggled to maintain changes. Factors that facilitated sustained health outcomes were noted as encouragement from friends, family and health coaches and reaching out to OYL when they were struggling earlier on.

> *[The health coach] was asking me to carry on doing the exercises…without the personal encouragement, I wouldn't get there.* ***Tier 2 Client***

Another critical facilitator was if a client had taken part in more than one pathway as clients were more motivated to continue implementing health choices if they were participating in a range of programmes and therefore observed the service as supporting a long term and holistic change rather than only their diet or drinking or quitting smoking. Interestingly, for clients that had taken up the service during the lockdown, a fear of COVID also acted as an incentive to maintain changes and reduce their risk of hospitalisation or morbidity.

> *Because of the structure of One You with the two programmes, that helped carry me along, I can maintain that momentum.* ***Tier 2 Client***

In contrast, poor mental health or complex underlying health conditions reduced the likelihood of maintaining changes. Clients interviewed stated that high anxiety levels made it difficult to sleep and then cascaded into unhealthy coping strategies such as increased drinking or crash dieting. In turn, some clients found themselves in a cycle of losing motivation or confidence and then having access to unhealthy food in their home, causing them to engage in disordered eating habits.

> *I started drinking wine to get to sleep because I couldn't sleep. And then when I drank wine, I just got to the point where I wasn't giving up smoking. I got to a point where I didn't actually care because I was so worried about everything.* ***Client with LTHC***

Outcomes of service delivery

Overall, clients had a positive experience of the service with beneficial outcomes. Some of the key outcomes noted in interviews were physical health improvements such as breathing better, reduced insomnia, weight loss, increased energy and decreased joint pain.

> *I was feeling better and happier myself. In those 12 weeks, I lost two stone and was obese instead of morbidly obese.* ***Client with LTHC***

In addition, many participants noted a psychological benefit of taking part in the programme, including increased self-belief and motivation in pursuing a healthy lifestyle, feeling equipped with nutritional information and feeling a sense of ownership over their health with *'it is becoming their decision'.* Another fundamental impact of the service was the extension of lifestyle changes to partners and family members, with some clients suggesting a domino effect as they made healthy choices in their households.

> *They were saying that for a female, you should have between 6 to 8 portions of starchy carbohydrate a day and then a male should have 8 to 10. That made me think because my husband's diabetic, and I know that we have to watch the carbohydrate intake for him, so it had impact on his life as well.* ***Client on integrated pathway***

Furthermore, staff noted the sense of joy they felt supporting clients meet their goals reflecting the strong rapport between staff and clients through a client's journey. Indeed, one client stated poignantly that the relationship with their coach helped them accept their long-term health condition and feel - *it's knowing their broken body isn't going to stop them from enjoying life.*

> *There is an emotional connection with the client. When my clients have had much progress, and you can hear how happy they are, I do not hide from that, I will say to them – Oh god, I am getting quite emotional, I am so happy for you! You are sharing that joy with them, and they love that because that is motivating as well.* ***Health Coach***

Limitations

The main research challenge for this study involved the recruitment of clients due to participants' choice to opt-in to the study. Clients were able to self-select for the interviews and therefore the research was limited to participants who decided to respond to the advertisements to take part in the evaluation. Clients' perspectives are unlikely to be entirely representative of all those involved in OYL.

Key Learning

Discussion and recommendations

Key benefits and challenges of One You Lincolnshire

OYL proactively ensured a diverse range of referral routes which may have reduced barriers for some groups. For example, more men attended weight loss groups virtually than in person, suggesting that an online delivery model offered greater accessibility for clients. Online service delivery was particularly beneficial during COVID-19 restrictions, where clients could still access the service through the lockdown. Indeed, a study by Li et al. (2020) supported the use of online technologies as an effective mechanism for referring and triage patients through a service. Online and telephone routes also had the added benefit of limiting in-person visits, which benefitted both clients and staff during the pandemic.

Another benefit was the ability of clients to engage in more than one pathway. An integrated service model revealed a decrease in barriers for stigmatised health needs such as smoking cessation or alcohol reduction. Framing smoking cessation and alcohol reduction as part of healthy lifestyle changes enabled clients who may not have sought support services engage in OYL. Although many clients framed smoking or excess alcohol consumption as an addiction, they often talked about a change of 'mindset' during the programme. Indeed, research focusing on communication in substance-dependent populations showed that framing, specifically gain-framed messages, positively impacted health outcomes, highlighting the critical role message framing has in lifestyle services (Goh et al., 2021).

Personalising the service for clients with complex health needs and carers needs was also a significant benefit. Rapport-building suggested staff had a good understanding of clients' needs. Similarly, an integrated lifestyle service in Dorset concluded rapport was a crucial element in behaviour change strategies to facilitate a person-centred approach (Powell and Thomas, 2021). As such, adjustments to diet, workouts, quit dates and days of the week to drink enabled each OYL clients to have a unique experience of the service. Clients noted empathy, active listening and creating a non-judgmental atmosphere as crucial factors that contributed significantly to a client's ability to attend sessions and sustain change.

More so, positive working relationships were discussed by staff. Previous studies have shown that organisational relationships are an active ingredient in many successful integrated lifestyle services (Cheetham et al., 2018). Likewise, many staff stated good communication between teams and a manageable workload. Management was noted as easy to talk to and non-hierarchal, enabling staff to be open with suggestions. Leadership in turn, talked highly of the positive attitude of their colleagues and the importance of recruitment to ensure that people had the same values as OYL. Staff noted that this played a significant factor in the successful implementation of the service. Interestingly, clients stated seamless transaction between pathways and health coaches, suggesting a strong correlation between organisational dynamics and client's experiences.

In contrast, a key challenge found was health professionals' decision-making. Practitioners tended to focus on weight management rather than smoking cessation and alcohol reduction pathways. An impact of practitioners focussing on weight loss resulted in gatekeeping and reinforced stigmas around smoking and drinking support. Evidence has shown that an emphasis on weight loss when defining health and well-being known as the weight-normative approach has been shown to foster stigma in health care and society and linked to adverse health and well-being (Tylka et al., 2014). Indeed, clients with poor relationships with health professionals noted how weight loss took priority above other health needs making it difficult to be aware or even access certain support groups.

Secondly, the quality and timing of initial engagement played a significant role in a client's journey through the service. Although same-day access has been shown to be a critical feature of integrated primary care (Dollar et al., 2018), delays between referral and follow-up were the main reasons for dropouts and attrition of clients. Some clients noted waiting up to 6 weeks to be contacted, which had a significant impact on their level of motivation. For clients that self-referred, there was an emphasis on plucking up the courage to access the service. Indeed, it often took multiple interactions before initial contact was made, suggesting a balance between the quantity and quality of interactions.

Furthermore, a legacy of decommissioning services led to an apprehension of some health professionals to adopt OYL due to a fatigue of constant service changes with new policies to learn and implement. There seemed to be a perception of some partners of how the partnership would not benefit their patient population. Specifically, in areas with high levels of deprivation, health professionals were particularly protective of their patients, fearing constant changes over time. A tension in partnerships was particularly challenging for referral leads when trying to roll out the service. Complex inter-organisational relationships were reflected in Misener and Misener (2016) findings that found instead of seeing how a service could complement each other, the focus was on differences and one group's permanency in relation to other groups.

Software issues was another key challenge across both OYL staff and external partners, causing delays and impacting productivity. Although there had been significant improvements during the evaluation, it was still highlighted as a persistent problem both with technical issues and additional training. In addition, some clients mentioned difficulty access the service via the website or online route. Many clients used the phrase 'IT savvy' to express their apprehension in using a digital service delivery model—for example, Zoom group sessions, apps such as Second Nature or OYL online services. However, many also noted that once they had used the service a few times, they became more confident in the tools and the service.

Recommendation 1 - improve direct referral routes

There is a need to improve direct referral routes from health professionals and workplace settings. Some clients were apprehensive of disclosing their health in a workplace environment when OYL staff had physical stands in offices. The study highlighted signposting by health practitioners rather than making direct referrals to OYL. Less direct referrals may have reduced the number of clients to smoking cessation, reduced alcohol consumptions and MANVFAT pathways. The role of practitioners is a vital component of the service necessary for networking, facilitating, team building, integrating care elements, and showing leadership. Yet, working partnerships are challenging due to different systems, timescales, processes and governance structures, and different terminology and conceptual understandings of the service. Therefore, working across boundaries to achieve services delivery is likely to require significant relationship building and the development of shared understandings in a non-politically neutral context.

Recommendation 2 - more comprehensive behavioural change training

There is a need for more comprehensive behavioural change training across both internal and external staff. Findings showed the need for additional training to support neurodiverse clients or clients with eating disorders. Some clients experienced practitioners who focused on weight loss as defining health and wellbeing and were impacted by eating disorders or thyroid problems. A diverse client group brings into question if 5% of the bodyweight goals should apply to individuals with underlying health problems that impact their ability to lose weight. The service may want to consider a weight-inclusive approach that emphasises viewing health and wellbeing as multifaceted while directing efforts toward improving health access and reducing weight stigma. Data suggests a weight-inclusive approach, which includes models such as Health at Every Size for improving physical (e.g., blood pressure), behavioural (e.g., binge eating), and psychological (e.g., depression) that upholds non-maleficence and beneficence for all clients (Tylka et al., 2014).

Recommendation 3 - continued rapport building

There is also a need for continued rapport building with clients to sustain change throughout a client's journey. A significant success of the service was the positive relationships coaches and advisors built with clients to attend sessions and reduce few dropouts. In contrast, some delays at the initial referral stage, in turn, had a positive correlation with attrition. Rapport building may start at initial engagement to address a client's willingness and ability to change and then throughout the service to address self-confidence and other emotional triggers that affect change, supported a client's ability to embrace and sustain positive change. As there were still relatively few participants from different ethnic groups, English language skills or neurodiversity, further research may be needed to understand the effect of rapport building on various client groups.

Conclusion

This report presents the finding of the first 18 months of the integrated lifestyle service OYL using the RE-AIM framework. The study recruited and interviewed service users, service delivery staff, health professionals, and key stakeholders to understand the service's implementation, fidelity, and maintenance. The service has a complex integrated model with various external partners and pathways that worked synergistically to create the overall programme. Despite major changes to service delivery implementation due to COVID-19, the service has had high referral rates and success stories of sustained lifestyle changes for many clients. The service's strength lies in the rapport between clients and staff, effective and consistent delivery of behaviour change models and close intra-organisational working relationships.

In contrast, a key challenge the service faced was establishing inter-organisational partnerships, ensuring consistent buy-in and sound conceptual underpinning nature of the service, relative to and as understood by wider community services. Consequently, this impacted referral into specific pathways and the adoption of the service in certain areas. While recognising that there have been challenges in delivering an innovative service, this process Phase One evaluation highlights several positive parts of the service. Participants all held the support they had received service in high regard and valued the practical, impactful and individually tailored sessions they received. These findings outline the positive impact despite navigating the dynamic nature of an organisation in 'real world' settings. This interim evaluation ultimately gave clients who had used the service the opportunity to talk about their intervention experience. The value of this approach is that, in addition to helping to determine whether a service should continue, it can also use clients views to shape and inform the design of any further services. Overall, this evaluation found that OYL to be a very successful service in supporting behaviour change and preventing unhealthy risk factors across the county.

Next Steps

The project to date has started to reveal the complexity of implementing a fully integrated lifestyle service around the four key areas of public health: smoking, physical activity, alcohol consumption and weight management. As such, several further research questions worthy of in-depth examination are emerging. The final evaluation will continue to use the RE-AIM frame to examine OYL routine data and the cost-effectiveness of the service. Phase 2 data will be investigated with the findings of this interim report to give a complete understanding of the service using a mixed-method approach.

Phase 2 analysis will expand on and investigate:

- Client demographics, social factors and the correlation to referral, attrition, and dropout rates
- A breakdown of referral areas with similar areas based on local area characteristics, using publicly available data
- The cost-effectiveness of the service comparing previous in-silo interventions to the OYL integrated service

The following steps include identifying and applying a dissemination plan to ensure the findings are communicated in journals and conferences to add to the growing literature of integrated lifestyle services.

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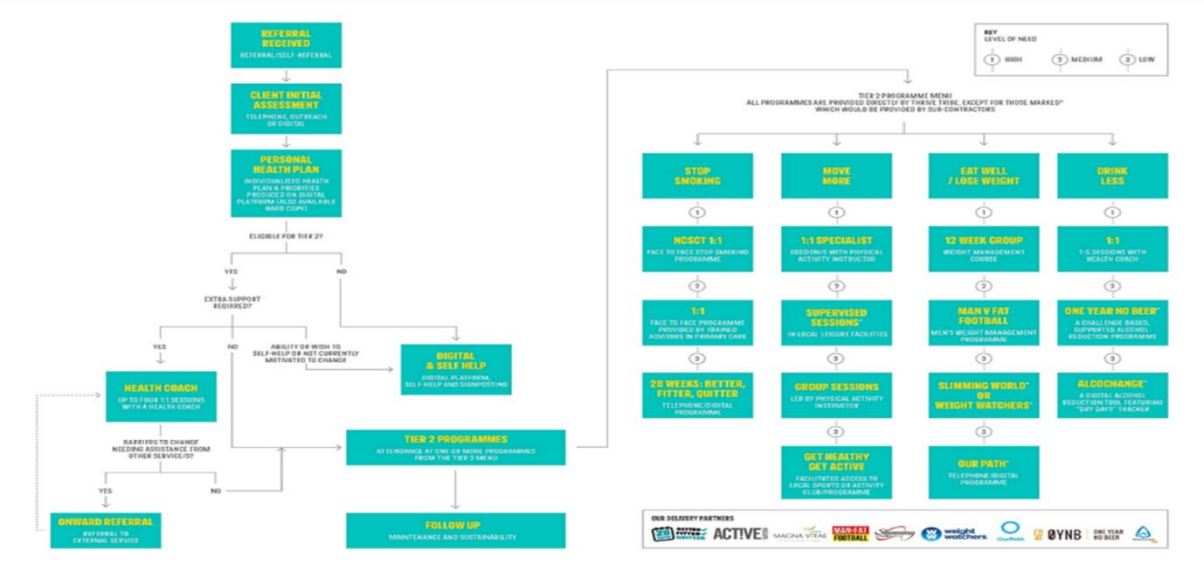
Appendices

Appendix A: One You Lincolnshire Delivery Model



Appendix B: Client Pre-Interview Survey

Start of Block: Introduction

Q1 **One You Lincolnshire Evaluative Study** Project ID: 289313
Researchers: Dr Ros Kane, Dr Hannah Henderson, Dr Dave Dawson, Miss Emma Sayers

Thank you for your interest in taking part in the One You Lincolnshire Evaluative Study.
HOW TO COMPLETE THIS SURVEY The survey should take about 10 minutes to complete; you may, however, take as long as you like. Some questions include the option to expand your answer and give comments. The arrows at the bottom of the page will help you navigate the survey. Press → to view the next set of questions. Before you submit your contribution, you can use ← it to go back and edit responses. Your answers will be treated in strict confidence by the research team. Your participation will be anonymous. This means we will not pass on any names to One You Lincolnshire or anything that could identify you. If you change your mind, please close your browser, and your responses will not be recorded. Once you have submitted your responses and received a "Thank you for your time and contribution" message, your answers can no longer be edited or withdrawn. If you have any questions or would like further information, please contact Emma Sayers at esayers@lincoln.ac.uk or 0152 288 6884 Please **press → to start**

Page Break

Q1 **How did you find out about One You Lincolnshire?**

- ☐ I was referred by my GP Practice (1)
- ☐ I self-referred on the One You Lincolnshire website (2)
- ☐ Other (3) _____
- ☐ I don't know (4)

Q2 **How did you complete your initial One You Lincolnshire health assessment?**

- ☐ I completed the assessment online (1)
- ☐ I completed the assessment over the phone (2)
- ☐ I completed the assessment in person (3)
- ☐ I did not complete an assessment (4)
- ☐ Other (5) _____
- ☐ I don't know (6)

Q3 **What One You Lincolnshire support were you initially offered?**

- ☐ I was offered online support via the One You Lincolnshire website only (1)
- ☐ I was offered support via a health coach only (2)
- ☐ I was offered both online support and with a health coach (3)
- ☐ I was not offered support (4)
- ☐ I don't know (5)

Q4 **What healthy lifestyle support did you take up?**

***Please select all that apply**

- ☐ Stop Smoking (1)
- ☐ Increasing Exercise (2)
- ☐ Healthy Eating (3)
- ☐ Reducing Alcohol Consumption (4)
- ☐ I did not take up support (5)
- ☐ I don't know (6)

Q5 **Please describe your progress with your health goals.**

***This may be goals you set with a health coach like running 10 minutes a day**

- ○ I achieved my health goals and maintained them (1)
- ○ I achieved my health goals but did not manage to maintain them (2)
- ○ I am currently working towards my health goals (3)
- ○ I did not achieve my health goals (4)
- ○ I did not set a health goal (5)
- ○ I don't know (6)

Page Break

Q16
We would now like to ask a little bit about yourself...

Q6, **are you managing a long-term health condition?**

***For example, hypertension, COPD, chronic pain, a mental health disorder etc.**

- ○ Yes (1)
- ○ No (2)
- ○ I prefer not to answer (3)

Q7, **do you have family or friend help you or do you have caring responsibilities?**

- ☐ I have friends/family help me (1)
- ☐ I have caring responsibilities (2)
- ☐ None of the above (3)
- ☐ I prefer not to answer (4)

Q8 **Please describe your ethnic group.**

- ○ English, Welsh, Scottish, Northern Irish or British (1)
- ○ Irish (2)
- ○ Gypsy or Irish Traveller (3)
- ○ Any other White background (4)
- ○ White and Black Caribbean (5)
- ○ White and Black African (6)
- ○ White and Asian (7)
- ○ Any other Mixed or Multiple ethnic background (8)
- ○ Indian (9)
- ○ Pakistani (10)
- ○ Bangladeshi (11)
- ○ Chinese (12)
- ○ Any other Asian background (13)
- ○ African (14)
- ○ Caribbean (15)
- ○ Any other Black, African or Caribbean background (16)
- ○ Arab (17)
- ○ Any other ethnic group (18)
- ○ I prefer not to answer (19)

Page Break

Q17
We would like to contact you if you are selected for the study

Q9 **Full Name**

_____

Q12 **Email Address**

_____

Q13 **Phone Number**

_____

Page Break

Q19
Thank you for completing this survey!

WHAT HAPPENS NEXT?

We want to capture a diverse group of individuals; therefore, **we are only selecting 30 people to take part in the interview stage of the study.**

Suppose you are selected to participate in an interview. In that case, you will be contacted by the research team shortly to book an interview slot.

If you do not hear from the research team within a week, you have not been selected on this occasion to take part in the research study.

Once you have press submit, your survey response can no longer be edited or withdrawn.

Please press → to submit

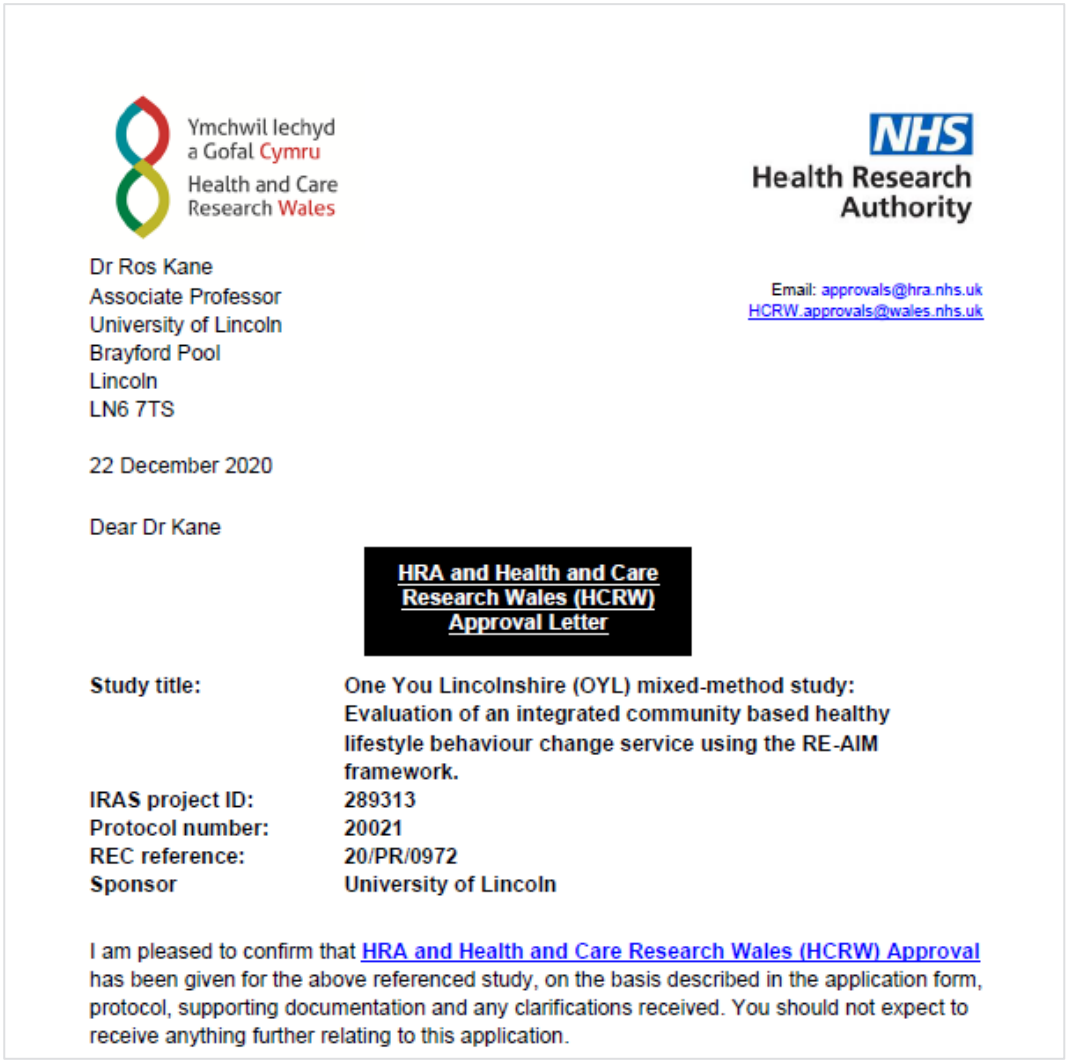
End of Block: Introduction

Appendix C: Sampling and recruitment framework

Participant Group	Sample Size
GP Staff (GPs, social prescribers, nurses)	4
Slimming World/Weight Watchers and Get Healthy Get Active Subcontractors	3
One Year No Beer, 28 Weeks	3
Adult Weight Management Lead, Alcohol Lead, Physical Activity Lead, Smoking Cessation Lead	4
Senior Triage Officer, Referral Generation Lead, Health Coach Team Lead	3
Adult Weight Practitioner, Man V Fat Coach	3
Triage Worker, Referral Generation Officer	3
Physical Activity Coach, Health Coaches	4
Stop Smoking Advisor, Pharmacy Facilitator	3
Total	**30**

Participant Group	Sample Size
Carer	2
BAME	2
Long Term Health Condition	2
LCC employees	2
Clients not motivated	2
Clients not eligible for service	2
Clients eligible but do not take up service	2
Tier 1 clients	2
Tier 2 clients	2
Low need support	2
Medium need support	2
High need support	2
Drop out clients	2
Clients that did not maintain sustained change	2
Clients that did maintain sustained change	2
Total	30

Appendix D: Health Research Authority (HRA) Approval



Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Dr Ros Kane
Associate Professor
University of Lincoln
Brayford Pool
Lincoln
LN6 7TS

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

22 December 2020

Dear Dr Kane

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

Study title:	**One You Lincolnshire (OYL) mixed-method study: Evaluation of an integrated community based healthy lifestyle behaviour change service using the RE-AIM framework.**
IRAS project ID:	**289313**
Protocol number:	**20021**
REC reference:	**20/PR/0972**
Sponsor	**University of Lincoln**

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.

Appendix E: Steering Group

Organisation	Stakeholder
Thrive Tribe / One You Lincolnshire	Head of Service
Thrive Tribe / One You Lincolnshire	Head of Quality
Lincolnshire County Council	Public Health Programme Manager
NIHR	East Midlands Public Health Research Specialty Manager
Lincolnshire Community Health Services NHS Trust	Cardiac Rehabilitation Associate Nurse Specialist
Carers First	Central Services Manager
One You Lincolnshire	Service User

Appendix F: Client Topic Guide

Client Topic Guide

1. **Contextual information**

Section Aim: warm up the participant and gain any relevant contextual information about health status and support history.

- Activities on a day-to-day basis
- Health conditions and disabilities
  - A brief history of the condition
  - How health status affects their day-to-day life
- Main barrier to support and impact on life.
  - Feelings about the impact of health
  - The extent of family and friends for support and social wellbeing

2. **Understanding views on the OYL referral process**

Section Aim: to gauge clients' awareness of being referred/self-referring to OYL.

- How OYL support was communicated to clients
  - Prompt GP appointment before referral
  - Empowered to seek change for self-referral.
- Attitude and understanding of the purpose of the referral.
  - Feelings before signing up.
  - Expectations of signing up.
- Recall of topics discussed with support officers.
  - Health condition
  - Motivation for change
  - support available.
- Views on triage support workers delivering initial health assessment.
  - The tone of the assessment
  - Feelings about the tone
  - Able to raise all the concerns they had.
    - If not, what topics would they have liked to discuss and why.

3. **Clients view of engaging in OYL support.**

Section aims: to explore clients' initial feelings about OYL support.

- Initial expectations
- Level of empowerment at that start of support
- Concerns
- Understanding of health coach role to move client through pathway.
- Number of meetings with a health coach (tier 2 clients)
  - How often the meetings and how long

    - Content of meetings
    - What they liked/disliked about the meeting
    - The tone of the meeting
    - Feelings about the tone
    - Able to raise all the concerns they had at the meeting.
        - If not, what topics would they have liked to discuss and why.
- Anything they would want to change about the meeting.
    - purpose of the meeting
    - Delivery
    - Modality

4. Views on access to OYL Programmes

Section Aims: views on taking up support, including barriers to setting goals and outcomes of pursuing goals.

- Description of goals generated with a health coach/ online.
- Views on these goals
    - Clear
    - Realistic
    - Empowered to make change rather than told.
- Understand what they had to do to achieve goals made.
- Whether they came up with the goals themselves – empowerment.
- If not – who decided.
- Process of deciding which support to take up.
    - Discussion with a health coach
    - Discussion with family and friends
    - Discussion with programme facilitators/advisors/officers

5. Taking part in the support offered

Section Aim: To explore the experiences of those who decided to take up support offered.

- What Support was taken up?
    - Move More
    - Stop Smoking
    - Eat Well, Lose Weight - Second Nature, Man V Fat, Slimming World
    - Drink Less – One Year No Beer
- Experience of taking part in support.
    - Activities involved.
    - Type of Support (one-to-one)
    - Frequency of Support
    - Location and access to support (COVID online support)
- View on Support
    - What they like/dislike with support
    - Met expectations.
    - Impact of Support

    - Anything they would change about support.
- Outcomes because of achieving goals.
    - Confidence
    - Motivation
    - Sustained lifestyle changes

If not perused, goals.

- Barriers to perusing goals.
- Lack of support of health coach
- Changes in the health condition
- Nature of goals (too ambitious)
- Lack of follow up from health coach.
- Lack of interest if referred by GP.
- How can the process of setting goals be improved?

For those who decided not to take up support offered by OYL

- Reasons why
    - Illness or poor health
    - Age
    - Caring responsibilities
    - Unsuitable support offered.
    - Lack of confidence
- Any factors that would encourage take-up.
    - Accessibility to support
    - Time of day support is offered.
    - Format of Support offered

UNIVERSITY OF
LINCOLN

University of Lincoln
Brayford Pool
Lincoln
LN6 7TS

Telephone: +44 (0)1522 886644
Fax: +44 (0)1522 886974
Email: enquiries@lincoln.ac.uk
www.lincoln.ac.uk