Health Innovation East

Cambridgeshire County Council

Cambridgeshire Integrated Behaviour Change Service Evaluation

COMMISSIONED BY CAMBRIDGESHIRE COUNTY COUNCIL

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Part of the Health Innovation Network

Office for Life Sciences

NHS

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Executive Summary

Background

Cambridgeshire County Council (CCC) commissioned Health Innovation East to evaluate and review the current model of the 'Healthy You' Integrated Behaviour Change Service delivered across Cambridgeshire, with a specific focus on assessing the demand, capacity and integration of Adult Weight Management services and considering the role of a place-based approach to delivery. The evaluation findings and recommendations are intended to inform the re-procurement of the service across Cambridgeshire.

The evaluation aimed to:

1. Assess the effectiveness of the current delivery model on meeting performance and quality outcomes indicators.
2. Assess how efficiently the service model integrates a number of behaviour change services across different geographies and communities.
3. Identify any demand, capacity and unmet need issues in relation to the service, with focus upon weight management services.

Key findings

1. The Service engages well with people from deprived areas but men, people aged 18-30 years and those from Non-White ethnicity group are underrepresented within the Service, and Service KPIs are not consistently met

The three most engaged-with services across the five years, accounting for a total of 83% of service engagement, were the Tier 2 Adult Weight Management service, Place-Based Health Trainer service and the Stop Smoking Health Trainer service. The 'Healthy You' Service met KPIs for total number of referrals received in years 2,3 and 4, but not in year 1. In year 1, the Service did not meet 59% of its KPIs. In year 2, the Service did not meet 48% of its KPIs. In year 3, the Service did not meet 40% of its KPIs. In year 4, the Service did not meet 42% of its KPIs.

When patient demographics within referral and completion data (available for only six of the service interventions) were compared against the 2021 Census data for Cambridgeshire and Peterborough, it was reported that women were over-represented across the Service, except for Alcohol and Diabetes Health Trainer services in which men predominantly used the services. Services reported being slightly overrepresented from people reporting to be from a White ethnicity group when compared to the 2021 Census data. Other ethnicity groups were underrepresented, compared to 2021 Census data. Referrals into the Service are underrepresented by adults aged 18-30, except for the Mental Health Health Trainer service. Most services demonstrated

good engagement with service users coming from deprived areas at referral, with this figure for most services being around 30%.

2. ***Whilst the Service is not integrated efficiently, with limited evidence of collaborative working across teams, it is able to engage and reach patients across a vast geography***

Average waiting list times were unable to be sourced from Everyone Health's Data Support team as part of this evaluation. Qualitative investigation with key stakeholders involved in delivering the Service reported challenges including large waiting lists, high workloads, receiving a high number of inappropriate referrals and being unable to follow up patient referrals throughout the Service. Whilst there is evidence that referrals are made both internally and externally, it was regularly cited that teams within the Service do not work collaboratively together.

There were reports of successful community outreach and engagement work, particularly through Living Sport, generic Health Trainers and those delivering NHS Health Checks, where staff reported being able to foster community connections and engage with underrepresented groups. It was suggested that a hybrid approach to service delivery may be useful for any future service redesign, whilst maintaining the local community work.

3. ***Most services receive referrals exceeding capacity, whilst Adult Weight Management services are "overwhelmed"***

Most service interventions received more referrals than their capacity for at least two years of service delivery. The Falls prevention service, Stop Smoking service and Tier 2 Adult Weight Management services consistently exceeded capacity for referrals each year of service delivery. Both Adult Weight Management services were reported to be over-subscribed and an average 11% of all referrals to both services combined over the five years were considered inappropriate. Qualitative exploration confirmed that the services were overwhelmed by referrals, which is only increasing due to patient demand for weight loss injections. Staff continuously review waiting lists and offer patients on the list the MoreLife programme to enable them to complete a Tier 3 Adult Weight Management service, which is a necessary eligibility criteria for patients to receive bariatric surgery or weight loss injections.

Methods

Twenty-two stakeholders were invited to share their experiences of the current service delivery model. Stakeholders had experience of delivering or referring into the following service interventions of the 'Healthy You' Service: Tier 2 Adult Weight Management (Tier 2 Adult WM); Tier 3 Adult Weight Management (Tier 3 Adult WM); Stop Smoking (SS); Falls Prevention (FP); Living Sport; Clinical Contact Centre; Generic Health Trainer service (PB HT) and those delivering NHS Health Checks (HC); Alcohol Health

Trainer (Alcohol HT); Mental Health Health Trainer (MHHT); Diabetes Specialist Health Trainer (DSHT).

Analysis included primary data from interviews and focus groups, along with routinely-collected secondary qualitative data from Living Sport and Everyone Health reports, user satisfaction data and quantitative KPI data and reports provided by Cambridgeshire County Council and Everyone Health, from March 2020 to June 2024.

Summary

The evaluation identified that the Service has some particular strengths, including the breadth of service interventions offered, community outreach work which engaged people from underrepresented groups, and the ability for patients to self-refer into Tiers 1 and 2 of the Service. However, the Service faced particular challenges in terms of data sharing with Partners and subcontractors, which inhibited communication around referrals, high levels of inappropriate referrals, staff capacity disproportionate to the demands for some aspects of the Service, and limited evidence of communication and collaboration between staff within the Service resulting in a lack of service integration.

Recommendations

1. *Review of the KPIs:* the KPIs should be condensed to reflect an objective and biometric list of outcome measures.
2. *Implement a hybrid approach to delivery:* a place-based approach is considered feasible and a hybrid approach to service delivery would improve accessibility.
3. *Health Trainers to be based in GP practices and community spaces:* Health Trainers based in GP practices was reported to improve referral appropriateness.
4. *Implement a 'care coordinator approach':* to improve integration of the service, patients should have a point of contact in the Service.
5. *Changes to Tier 2 Adult WM referral paperwork:* the proforma should include a blood pressure reading to prevent patients being referred back to their GP.
6. *In-person monitoring for Tier 3 Adult WM patients:* patients receiving weight loss injections receive some in-person contact, for safety monitoring purposes.
7. *The 'Healthy You' brand should remain:* stakeholders reported that external agencies know the brand, which supports collaboration.
8. *Effective communication about the Service disseminated to staff:* eligibility criteria, referral processes and waiting list times for each service intervention should be updated and communicated to all staff on a regular basis.
9. *Staff training and connection:* staff should receive regular appropriate training and have the opportunity to communicate with others on a regular basis.
10. *Viewing live referrals:* staff should be able to view live referrals in the system and provide patients with updates on their referral.
11. *Targeted approach to tackle heath inequalities:* a new service may consider adopting a targeted approach to service delivery to reach patients who require more staff motivation to engage and have higher support needs.

Background

Cambridgeshire County Council (CCC) commissioned Health Innovation East to evaluate and review the current model of the 'Healthy You' Integrated Behaviour Change Service delivered across Cambridgeshire, with a specific focus on evaluating the demand, capacity and integration of adult weight management services. The evaluation findings and recommendations will inform the effective re-procurement of the Integrated Behaviour Change service across Cambridgeshire.

The 'Healthy You' Integrated Behaviour Change Service is a public health prevention service commissioned by CCC as a joint service working across Cambridgeshire and Peterborough. Peterborough City Council (PCC) delegated authority to CCC to commission the service on its behalf.

The programme aims to improve healthy life expectancy by addressing the main risk factors for chronic disease and early death: smoking, alcohol use, cardiovascular disease, diabetes, high blood pressure/cholesterol, physical inactivity, excess weight and poor diet.

There are three Tiers delivered through several contractual arrangements including Everyone Health, District and City councils and Living Sport across Cambridgeshire and Peterborough. The 'Healthy You' Service offers the following service interventions: Stop Smoking (SS), Falls Prevention (FP), Generic Health Trainers (previously Place-Based; PB HT), NHS Health Checks (HC), Alcohol Health Trainer (Alcohol HT), Mental Health Health Trainer (MHHT), Eastern European Health Trainer (EEHT), Specialist Carer Health Trainer (SCHT), Diabetes Specialist Health Trainer (DSHT), Tier 2 Adult Weight Management service (Tier 2 Adult WM), Tier 3 Adult Weight Management service (Tier 3 Adult WM).

The purpose of this evaluation was to inform the development of the service model for successful re-commissioning in October 2025, which is intended to adopt a place-based approach.

The evaluation aimed to:

1. Assess the effectiveness of the current delivery model on meeting performance and quality outcomes indicators.
2. Assess how efficiently the service model integrates a number of behaviour change services across different geographies and communities.
3. Identify any demand, capacity and unmet need issues in relation to service with focus upon weight management services.

Objectives of this evaluation

The evaluation addressed the following six objectives, which are broken down into more specific questions in the findings section:

1. Assess the effectiveness of the service interventions on meeting performance and quality indicators.
2. Assess whether the Service meets the demand and complexity of needs of local communities.
3. Assess whether Weight Management services are able to meet the demand for the services.
4. Assess the level of integration with wider partners at county and local area levels, e.g. primary care, District Councils and third-sector organisations.
5. Assess the strengths and limitations of the current service offer.
6. Make recommendations for future service model, including any changes to referral pathways, with consideration of similar services nationwide.

Methods

This was a mixed-methods evaluation to explore stakeholder experiences of the current service delivery, review the existing Service data and inform future service design.

Stakeholders for qualitative data collection were identified by Cambridgeshire Public Health colleagues. Health Innovation East scheduled semi-structured interviews and one focus group, which were conducted on Microsoft Teams with 22 consenting stakeholders. Some interviews involved up to three participants from the same service These took place over a three-week period between November and December 2024.

Health Innovation East recruited stakeholders from across the services to cover the breadth of the 'Healthy You' offer. The strategy was to recruit stakeholders from three key roles; service delivery, service management and referral into the services. In some cases, a colleague from PCC arranged and recruited to interviews which Health Innovation East staff co-facilitated.

We conducted one focus group with representatives from each District Council. We conducted nine interviews with service delivery staff and referring staff covering a range of 'Healthy You' service interventions:

- *Tier 2 Adult Weight Management service (Tier 2 Adult WM)*
- *Tier 3 Adult Weight Management service (Tier 3 Adult WM)*
- *Stop Smoking service (SS)*
- *Falls Prevention service (FP)*
- *Living Sport*
- *Clinical Contact Centre*
- *Health Trainer service (PB HT) and those delivering NHS Health Checks (HC)*
- *Alcohol Health Trainer Service (Alcohol HT)*
- *Mental Health Health Trainer service (MHHT)*
- *Diabetes Specialist Health Trainer service (DS HT)*

The interviews broadly covered the topics of the strengths and limitations of current service provision and considerations for future service design, place-based working and service user demand and need. The topic guides for these discussions can be found in Appendix 1. The Health Innovation East-led interviews and focus group were recorded for transcription purposes. Microsoft Teams transcripts and MP3 recordings were held securely in the data storage area on Health Innovation East's SharePoint. These were then anonymised prior to analysis. In the case of co-delivered interviews with PCC, the Health Innovation East evaluator took notes and saved these in the same secure SharePoint folder. Informed consent was sought from all participants prior to data collection activities alongside the provision of information sheets.

Secondary qualitative data obtained from Everyone Health and Cambridgeshire County Council was analysed. Specifically, this data comprised:

- *The Service's four annual reports, produced by Living Sport (Healthy You Tier 1 service Annual report (year 1, 2020-21); Healthy You Tier 1 service Annual report (year 2, 2021-22); Healthy You – Healthy Lifestyle Service Annual Report (year 3, 2022 - 23); Healthy You – Healthy Lifestyle Service Annual Report (year 4, 2023 - 24)*
- *Healthy You Integrated Lifestyle Service, a PowerPoint presentation on the service, produced by Living Sport*
- *The 'continuation of service' survey completed by Cambridge City District Council*
- *Healthy You's annual reports, produced by Living Sport (each report source)*
- *Service user feedback from the Service's four annual reports, produced by Living Sport (as above).*

A Strengths, Weaknesses, Opportunities, Threats (SWOT) analysis framework was used to categorise qualitative data, to support commissioners to identify which components of the current service work effectively and how the service may be adapted during commissioning to develop a more effective service. The same framework was used to categorise routinely collected qualitative user feedback within quarterly and annual reporting documents. These monitoring documents were provided by CCC on behalf of service providers who collect this data.

Health Innovation East analysed quantitative data provided by CCC. Data provided is routinely collected KPI monitoring in the format of spreadsheets and written reports. Reporting used within this report was completed by service providers on a quarterly and annual basis between March 2020 and June 2024. KPIs were identified for analysis to best consider the following evaluation objectives:

1. Assess the effectiveness of the service interventions on meeting performance and quality indicators.
2. Assess whether the Service meets the demand and complexity of needs of local communities.
3. Assess whether Weight Management services are able to meet the demand for the services.

Some of the KPIs were altered across the reporting cycle. Consequently, some programme indicators are inconsistent across years, for example in either target value or number. These have been reported in the findings. Any KPIs listed that were not accompanied by usable data have not been presented. KPI data was provided by Everyone Health for years 1 to 4. 'KPI not met' data for Tier 3 Adult WM services was derived from the year end of quarterly reports and did not include More Life data. Health Innovation East did not quality-assure the data provided.

Descriptive analysis was conducted in Microsoft Excel on annual data across the five-year period and is presented in the findings section. Where available, year 5 data was provided for the first two quarters only.

A brief desktop internet search of place-based approaches across the UK was conducted to explore service design and delivery of similar programmes.

Findings

We report the findings in line with the agreed evaluation questions and objectives.

Objective 1: *Assess the effectiveness of the service interventions on meeting performance and quality indicators*

Service user engagement

Service user engagement is defined by Everyone Health as service users who attended an initial consultation. Table 1 shows how many service users engaged in 'Healthy You' services for each year of service delivery.

Table 1: Number of service users who attended an initial consultation within each service

	Year 1	Year 2	Year 3	Year 4	Year 5
PB HT	1021	2474	2088	1886	763
Alcohol HT	15	70	83	70	28
Falls Prevention	169	339	428	360	214
MH HT	41	85	85	115	92
EE HT	3	33	16	19	9
SC HT	0	37	67	57	26
DSHT	2	66	121	101	43
SS	835	1152	1344	1369	712
Tier 2 Adult WM	638	1612	2788	1641	2026
Tier 3 Adult WM	56	426	431	276	165

The three most engaged-with services across the five years were; Tier 2 Adult Weight Management (Tier 2 Adult WM; n=8705, 32%), Place Based Health Trainer (PB HT; n=8232, 31%), Stop Smoking Health Trainer (SS; n=5412, 20%). These three services accounted for 83% of all service engagements across the five years and were consistently the most engaged-with service intervention each year of the programme.

KPI performance

As a collective, the 'Healthy You' Service was reported to have met KPIs for total number of referrals received in years 2,3 and 4 but did not in year 1. KPIs are considered 'met' when ≥100%. KPIs which achieve less than 100% are considered 'not met'.

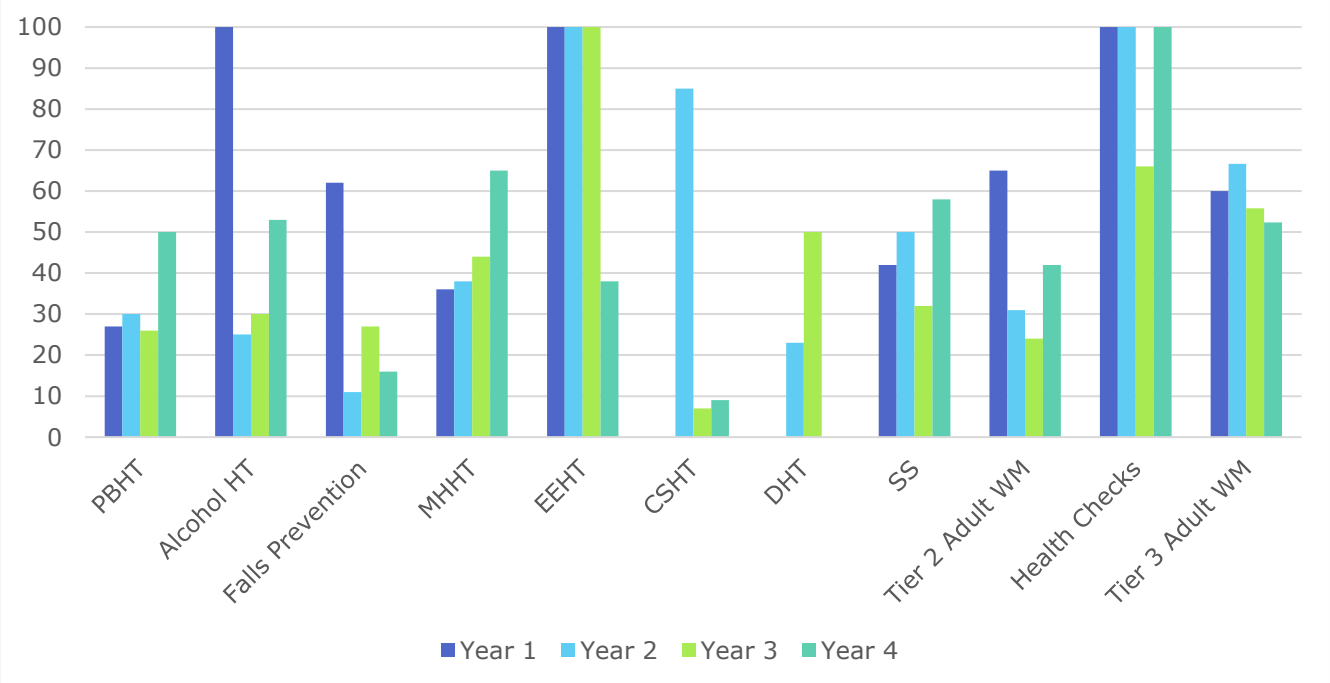
Number of KPIs for services ranged from three (HC years 1-4) to 43 (T3 AWM, year 3). A breakdown of the number of KPIs for each service, each year, are available within Appendix 2.

In year 1, the Service did not meet 59% of its KPIs. In year 2, the Service did not meet 48% of its KPIs. In year 3, the Service did not meet 40% of its KPIs. In year 4, the Service did not meet 42% of its KPIs.

The best performing service for KPIs over the four-year Service was Diabetes Health Trainer, which met 79% (n=34) of KPIs across a three year period and met 100% of its KPIs in year 4 (Figure 1). Note: The CS and DS HT services did not report KPIs in year 1. Conversely, HC did not meet 92% (n=11) of KPIs over the same time period, meeting the least number of KPIs of all services. Both the EE HT (n=11 KPIs) and HC (n=3 KPIs) did not meet 100% of KPIs on three of the four years. The Alcohol HT service did not meet 100% (n=7) of KPIs in year 1. The CS HT did not meet one KPI in years 3 (7%) and 4 (9%) respectively, which were the best performing scores, as a percentage, across the four-year data set.

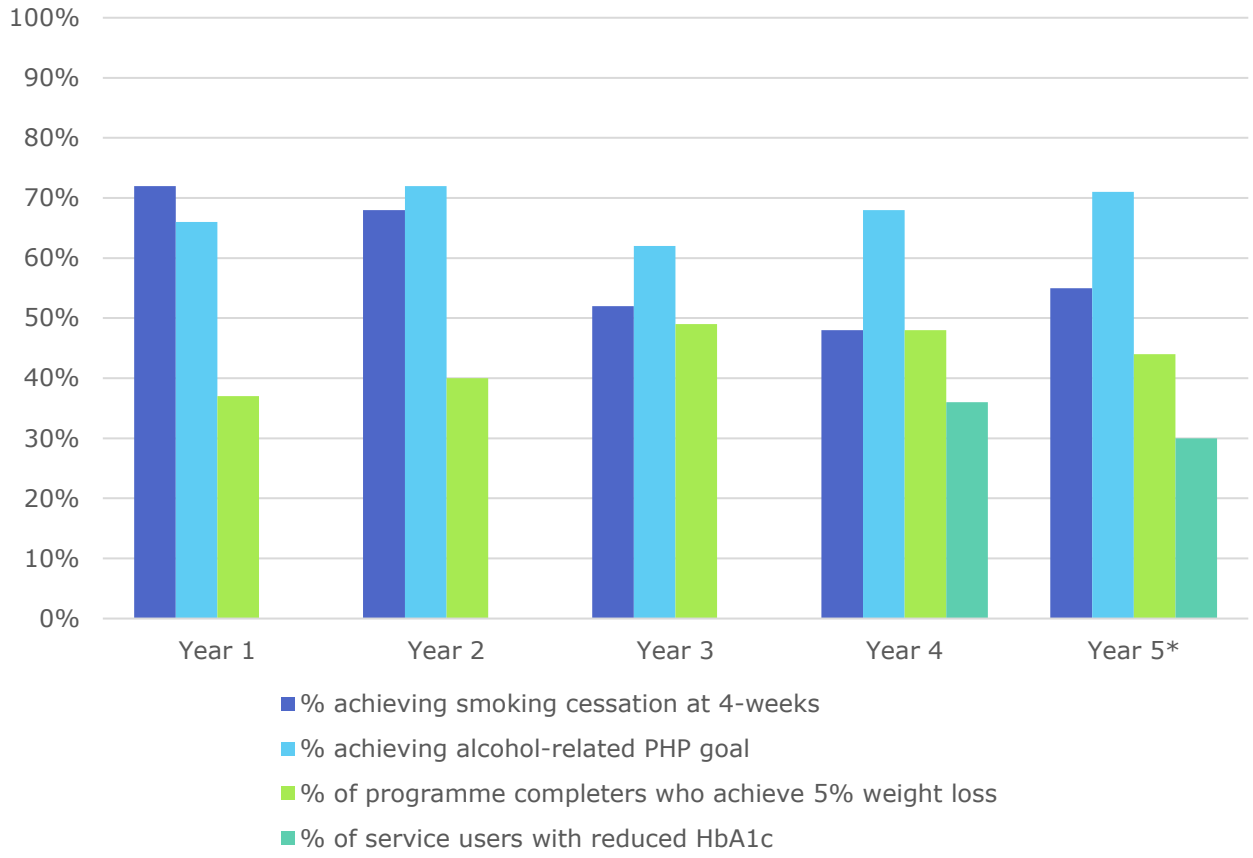
Six of the services (Alcohol HT, Falls Prevention, EE HT, CS HT, Tier 2 Adult WM and HC) performed worst, or joint worst, in their first year of delivery, and four services (PB HT, MH HT, HC and SS) in year 4. Year 3 saw the highest percentage of KPIs met, with five services (50%) having their best performing year for KPIs (PB HT, CS HT, SS, Tier 2 Adult WM, HC). In year 2, two services (Alcohol HT and Falls Prevention) had their most successful year of meeting KPIs.

Figure 1: Percentage of KPIs that were not met by services each year of delivery.



The aim of the 'Healthy You' Service is to improve healthy life expectancy by addressing the main risk factors for chronic disease and early death: smoking, alcohol use, cardiovascular disease, diabetes, high blood pressure/cholesterol, physical inactivity, excess weight and poor diet. Figure 2 shows how often any available outcome targets of these risk factors were met each year of Service delivery.

Figure 2: Chronic disease risk factor outcome indicators available across SSHT, DS HT, Alcohol HT and Tier 2 WM programmes. *Year 5 data is partial.



Objective 2: *Assess whether the Service meets the demand and complexity of needs of local communities*

Service User demographics compared to local region

Comparisons between referrals and completions

Data at both referral and completion was available for only seven out of the eleven services and therefore, only these have been illustrated in this section. These were compared against the relevant metric taken from Census 2021 to understand to what extent the data is representative for the population of the Cambridgeshire and Peterborough authority.

Gender

As can be seen from the graphs below (Figures 3 and 4), most service users across different services at both referral and completion were female. Given that, according to data from Census 2021, the distribution of males and females in Cambridgeshire and Peterborough is roughly equal (females: 51% vs males: 49%), females were overrepresented in most services. The exception to this trend were the Alcohol HT service, with over 77% (N = 423) of service users being male at referral and 80% at completion, and the DS HT service. Interestingly, in the DS HT service there were 84% (N= 504) females and 16% (N= 96) males at referral, with this trend reversing to 51% females and 49% males at completion, suggesting that the service performed better at retaining males.

Figure 3: Percentage of female service users at referral and completion across the five years, against relevant data from Census 2021 for the local authority.

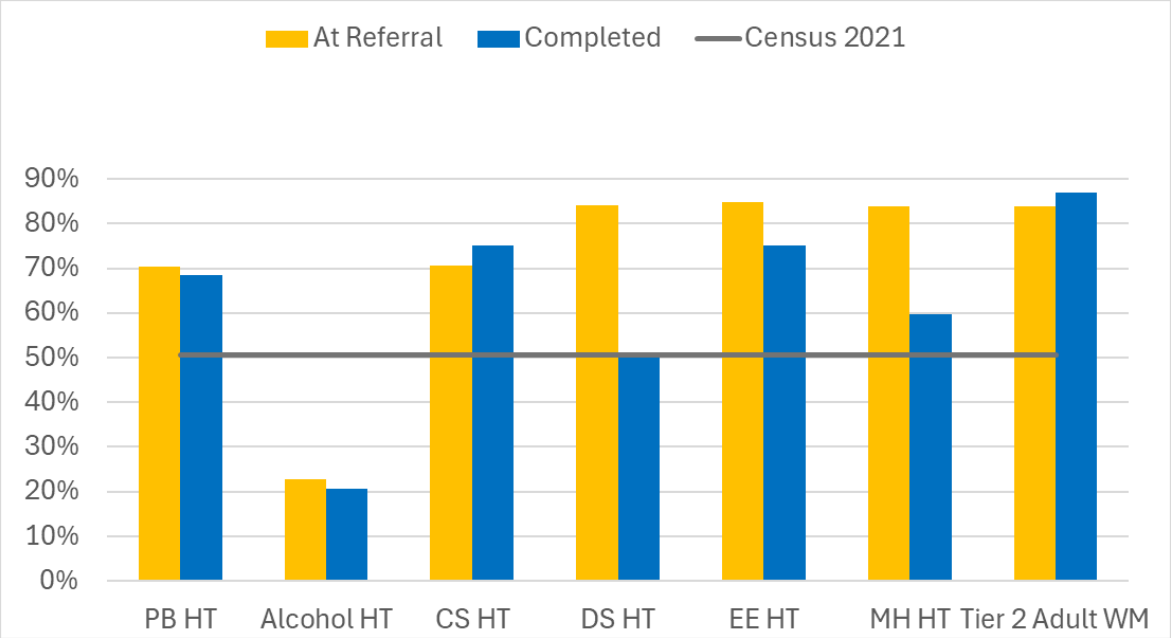
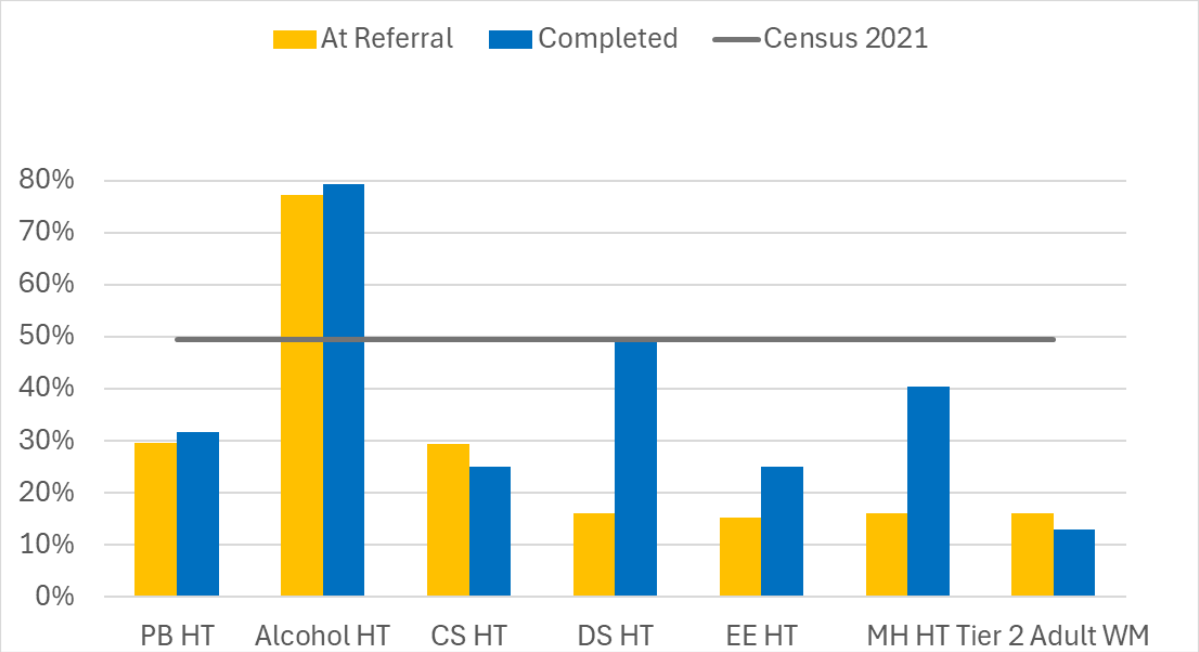


Figure 4: Percentage of male service users at referral and completion across the five years, against relevant data from Census 2021 for the local authority.

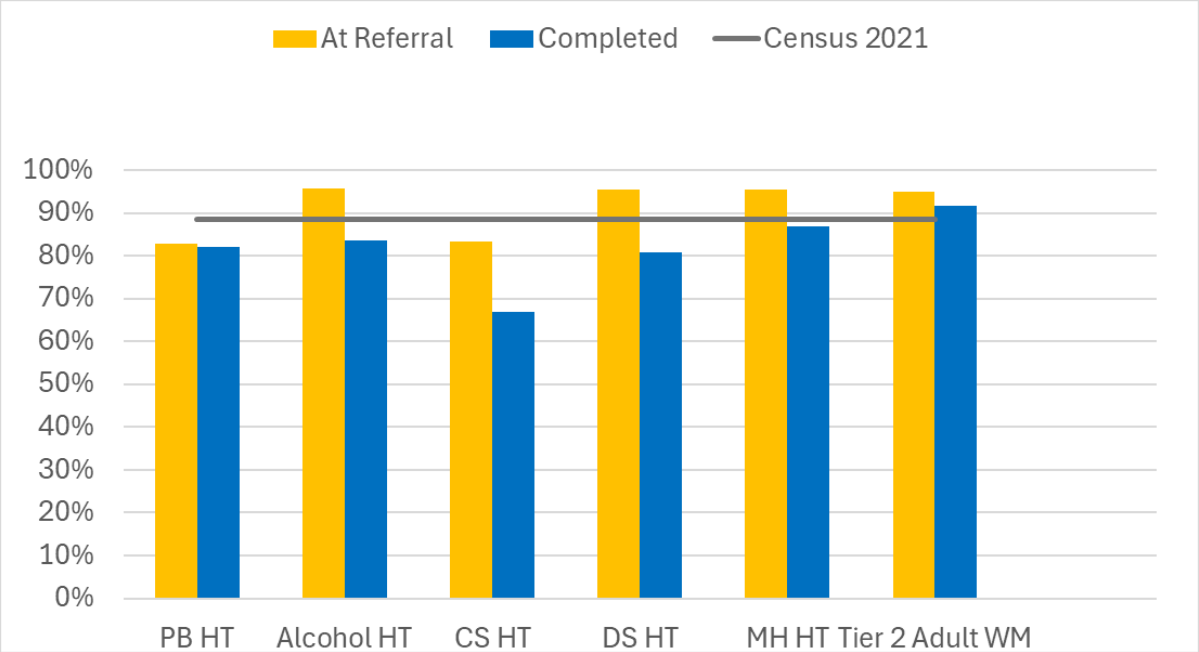


Ethnicity

Any White ethnicity background was most represented out of the five high-level ethnicity groups (any Asian, any Black, any Mixed, any Other and any White). The White ethnicity group was slightly overrepresented for four of the six service interventions, when compared to the population of any White ethnicity for the Cambridgeshire and Peterborough authority (88.6%, Census 2021). The percentage of service users from White ethnicity, however, dropped at completion for all six services (Figure 5).

Importantly, most services did not achieve a representative figure for the other four high-level ethnicity groups at referral (Figures 6,7&8). For example, only 1% (N = 6) of the service users of the Alcohol HT service were from any Mixed ethic background at referral, as compared to the population figure percentage for the authority being 2.9%. Interestingly, a lot of the services managed to retain a high proportion of their Non-White service users, so that for many, the percentage of completers from those ethnic backgrounds was higher than the percentage of referrals. For instance, the percentage from any Mixed ethnic background for the Alcohol HT service increased from 1% at referral to 3% at completion. For brevity, the graph illustrating these rates for any Other ethnic background has been included in Appendix 3.

Figure 5: Percentage of service users from any White ethnicity background at referral and completion across the five years, against relevant data from Census 2021 for the local authority.



*EE HT has not been plotted as service users were only White.

Figure 6: Percentage of service users from any Asian ethnicity background at referral and completion across the five years, against relevant data from Census 2021 for the local authority.

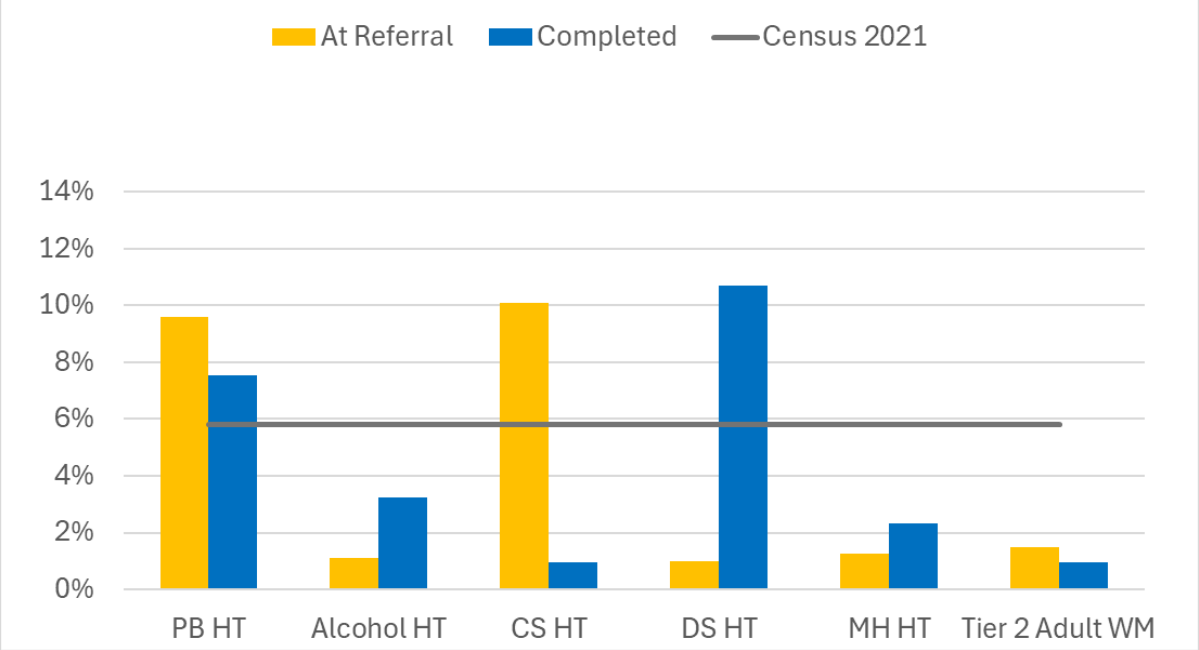


Figure 7: Percentage of service users from any Black ethnicity background at referral and completion across the five years, against relevant data from Census 2021 for the local authority.

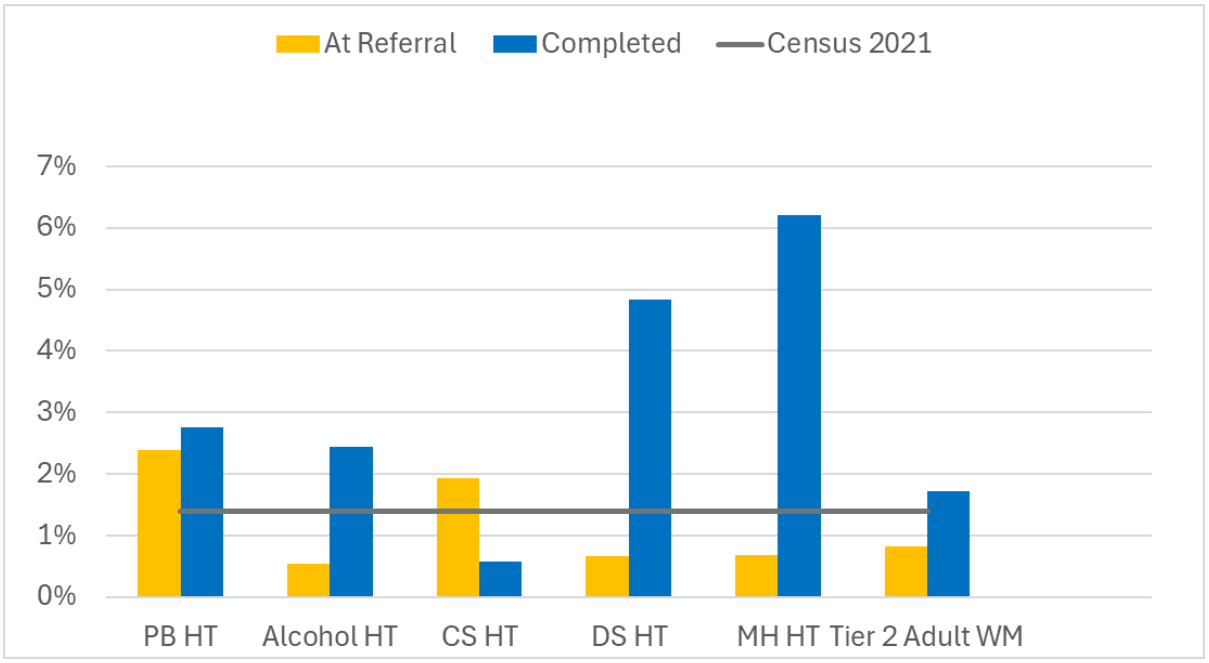
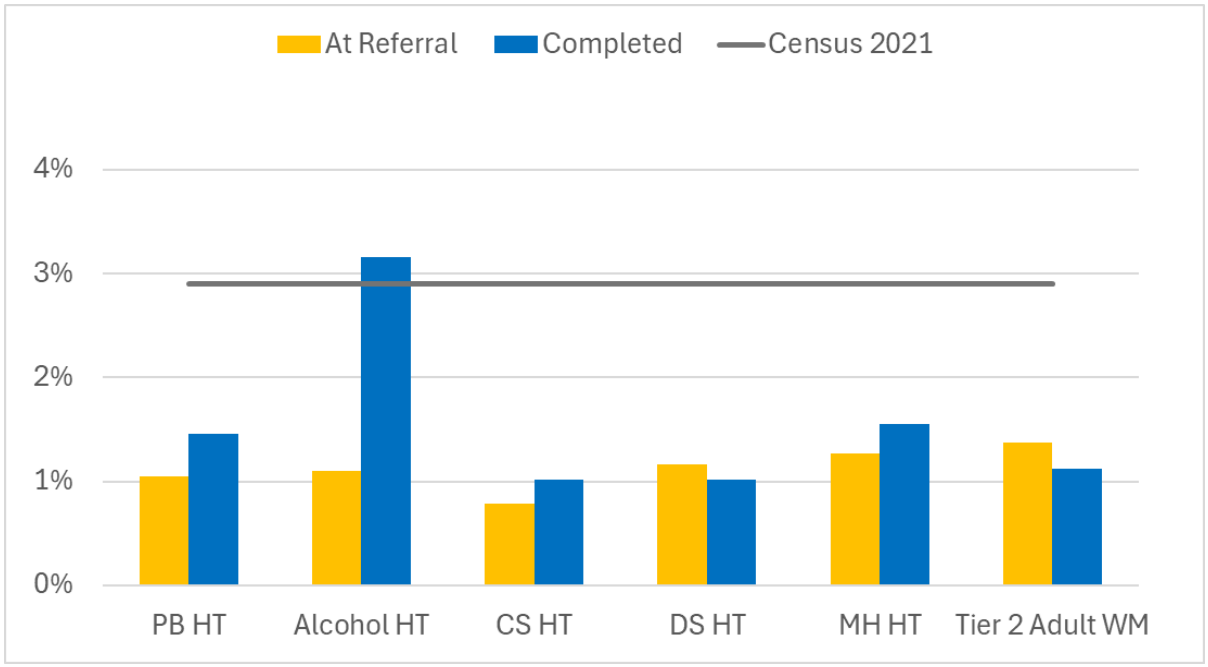


Figure 8: Percentage of service users from any Mixed ethnicity background at referral and completion across the five years, against relevant data from Census 2021 for the local authority.



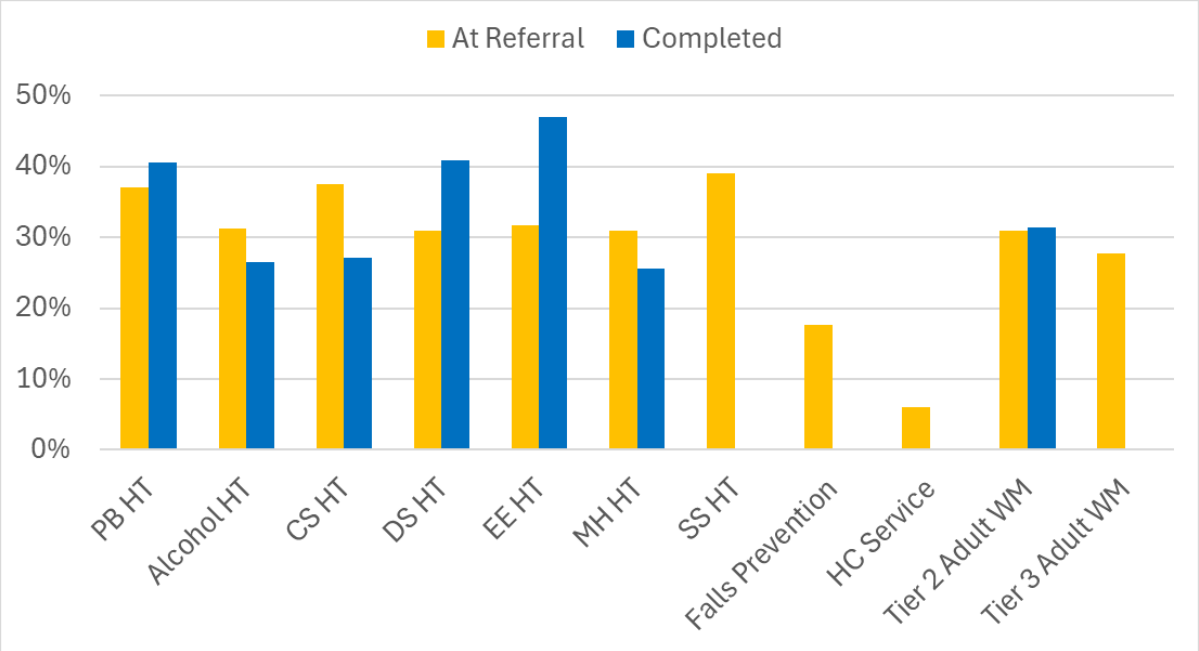
Deprivation

Data has been plotted for all eleven services at referral, as well as for the seven services for which this was also available at completion (Figure 9).

Most services demonstrated good engagement with service users coming from deprived areas at referral, ranging from 6% (HC service) to 39% (SS), with this figure for most services being around 30%. Additionally, three out of the seven services for which data was also available at completion, had higher proportions of service users from deprived areas at completion than referral (PB HT: 41%; DS HT: 41%, EE HT: 47%), demonstrating good engagement and retention of service users from deprived areas.

The percentage of referrals received from deprived areas was also a KPI for four of the services (PB HT, SS, DS HT and Adult WM Tier 2). The first three of these services all achieved this target in their final year of service. While the Adult WM Tier 2 service did not achieve this in their final year, they had done so for the previous three years of service.

Figure 9: Percentage of service users who came from deprived areas at referral and completion across the five years.



Demographic Data by Year

Age

This section presents the breakdown of service user age brackets at referral by service and year of service. These have been plotted for all 11 services for the age brackets for which such data was present (i.e., not all services had service users from all age groups). These were compared against the relevant metric taken from Census 2021 to understand the extent to which the data is representative for the population of the Cambridgeshire and Peterborough authority.

As can be seen below, age representation at referral was stable across the five years for the majority of services. Overall, services uniformly engaged a representative proportion of the population in the 31–40-year-old bracket, as can be seen below. Most services fell short of representing the 13.1% 18–30-year-olds in the local authority (Figure 10) and demonstrated an overrepresentation of the groups in the older age brackets (41-50, 51-60, 71-80). Finally, while the demand for some services was relatively stable across age groups (16% to 18% for MH HT across the three different age groups below), the SS was far more popular for service users in the 41-50 age bracket than the 18-30 age bracket. For brevity, only three of the graphs have been presented here. Additional graphs can be found in Appendix 3.

Figure 10: Percentage of service users at the 18-30 age bracket at referral across the five years, against relevant data from Census 2021 for the local authority.

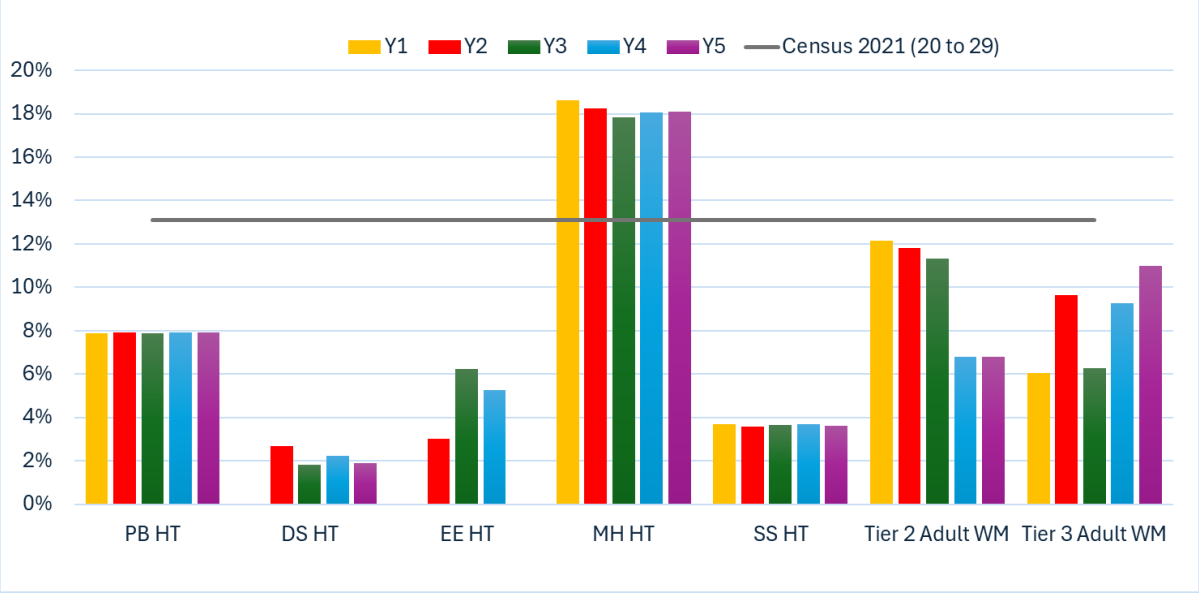


Figure 11: Percentage of service users at the 31-40 age bracket at referral across the five years, against relevant data from Census 2021 for the local authority.

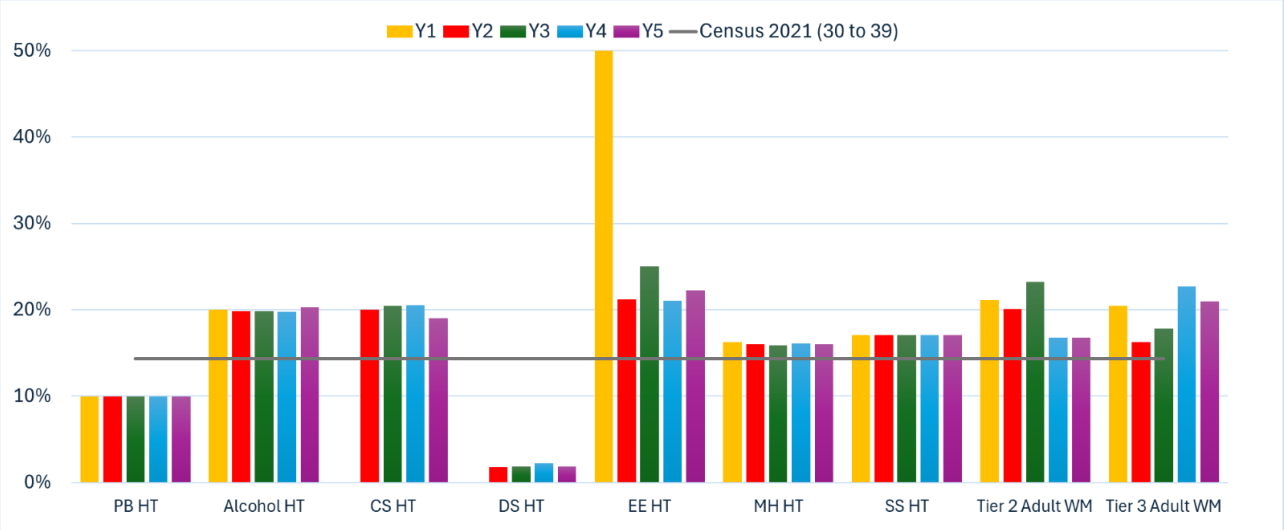
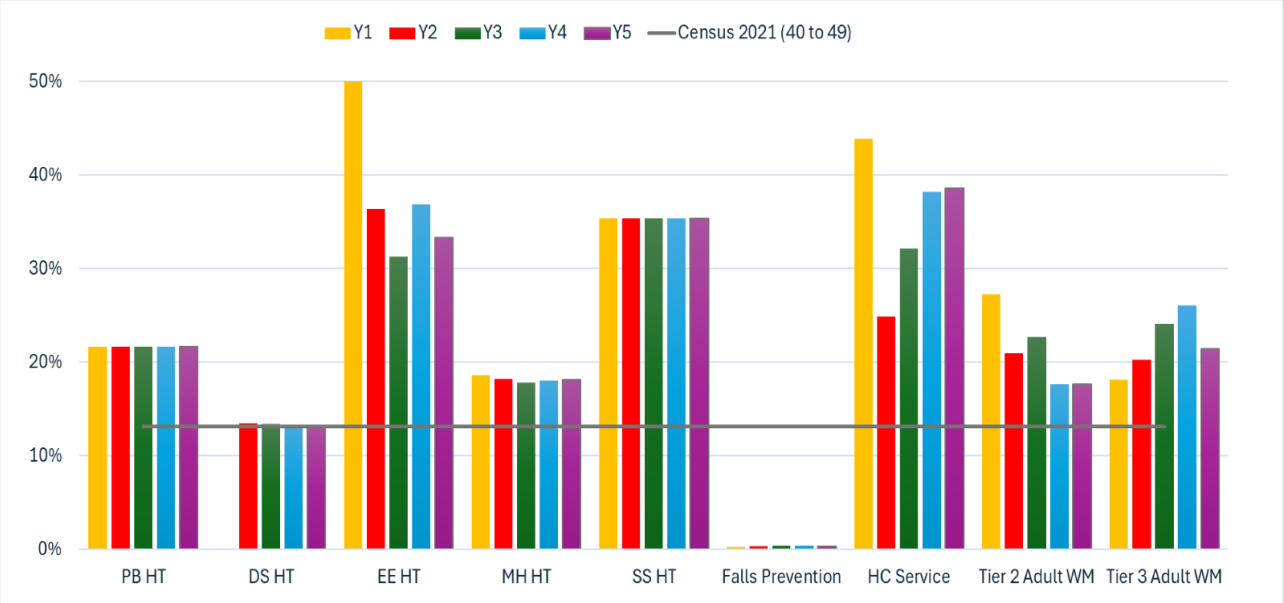


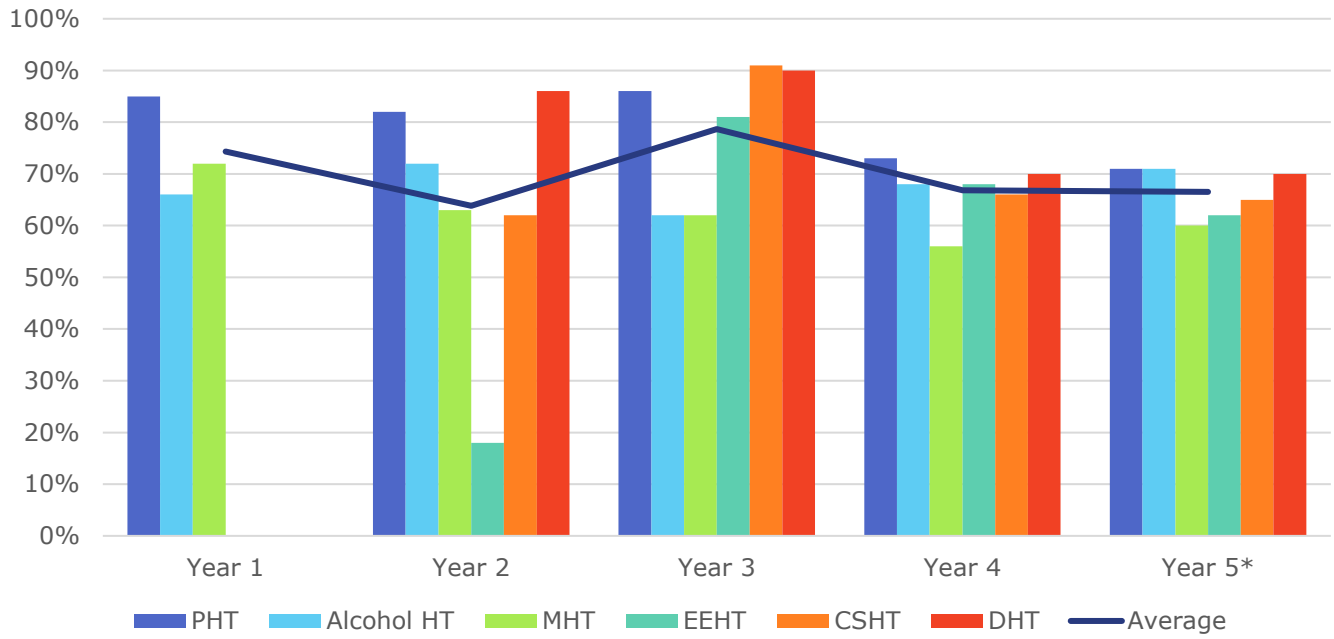
Figure 12: Percentage of service users at the 41-50 age bracket at referral across the five years, against relevant data from Census 2021 for the local authority.



Goals

Figure 13, below, shows how often patients' main Personal Health Plan (PHP) goal was met across services. This gives an idea of how patients' individual needs, via their own goals, were met. Service users engaging with the PBHT service and the DSHT service achieved 79% of their PHP, on average, across the five years.

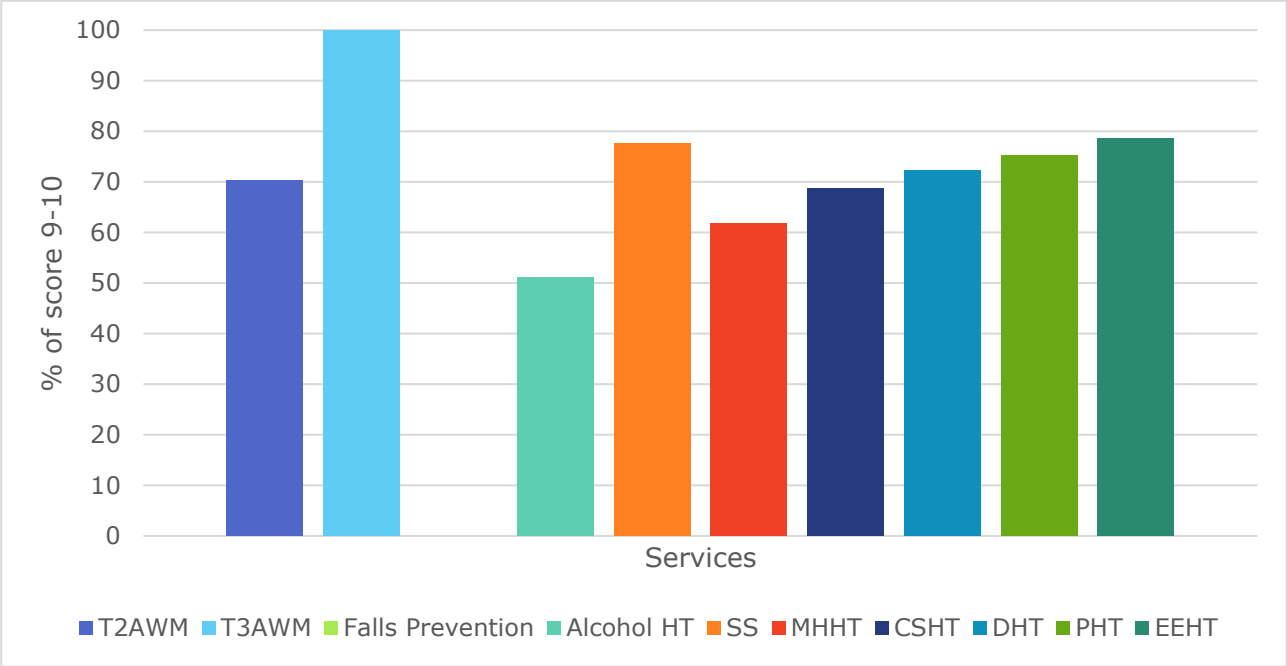
Figure 13: Percentage of service users who achieve their main Personal Health Plan goal



Stakeholder reporting of the service meeting the needs of local communities

A patient satisfaction survey was shared with service users to gather their feedback when they left the service. Response rates across services to the patient satisfaction survey vastly varied from three responses (Tier 3 Adult WM and Falls Prevention) to 624 (Tier 2 Adult WM). Figure 14 shows how many service users (%) are considered 'promoters' of the service they engaged with.

Figure 14: Percentage of scores of 9 - 10 on the *'Would you recommend the programme to family or friends?'* question from the satisfaction survey



0= not at all likely and 10 = extremely likely

Furthermore, based on the secondary data analysis of reports collated by Living Sport, feedback from service users has been very positive across districts, programmes and individual services so far. Overall, the most common physical health gains service users mentioned were an improved fitness level and a reduction in weight, with these improvements being consistent with the service/programme they had accessed (e.g., more strength and better posture after the Body Balance programme). Moreover, some also mentioned psychological benefits such as more confidence and better mood and having felt a sense of belonging. The general feedback service users gave on the contents of the programmes was that they found them interesting, kept them motivated and that some had learned new skills as a result of taking part (e.g., playing netball). Finally, very positive feedback was also received from service users who had been offered support by Tier 1 services while being on the waiting list for Tier 2 Adult Weight Management. Patients reported being impressed with the quick, pro-active and patient-tailored approach, so that they were signposted to an appropriate programme to suit their needs. Finally, service users were grateful to staff who they described as friendly, supportive and motivating, while they found the delivery mode to be accessible to different ages and levels of ability.

However, service user feedback had not been consistently collected, with some districts being more proactive than others. For example, in year 1 a single locality (Huntingdonshire) mentioned they had received some feedback from

service users. Importantly, some improvements to collecting patient feedback were reported in year 4, with some districts currently trialling the more accessible administration of questionnaires to their users via scanning a QR code.

Our qualitative investigation with stakeholders identified that whilst services focussed on engaging people from deprived areas, the Service does not effectively support patients most in need of support. It was reported that some patients in the Fenland area were more difficult to motivate, along with those areas having unreliable public transport links, making it problematic for some patients to travel to classes. It is suggested that the Service currently meets the needs of the 'mass' local population with lower support needs, rather than targeting patients most in need of support. It is reported that women are served by the Service more than men and this may be because men are less likely to accept or initiate a referral from a General Practitioner (GP). District Councils, Living Sport and Generic Health Trainers were reported to be well-placed to foster community connections and reported understanding the needs of the local population. The Stop Smoking service was reported to be suitable for highly motivated patients with low support needs who were able to engage with the service via telephone calls. The Tier 2 Adult Weight Management service tends to engage mid to older adults and rarely engages with younger adults. The virtual nature of the Tier 3 Adult Weight management service is reported to be flexible with patients' life commitments and MoreLife is a suitable option for those from a prison population.

It was reported that the Alcohol service does not currently meet the complex needs of patients for whom the service is designed. The Diabetes service was reported to have not yet engaged with those from the Eastern European community. The needs of patients with frailty are not currently met and these patients are referred to community services at Cambridgeshire and Peterborough Foundation Trust instead. The Stop Smoking service is less suitable for patients who have higher support needs or whom require more motivation to quit smoking. Some patients attending Tier 2 Adult Weight Management services are less comfortable meeting in-person. Patients deemed not suitable for Tier 3 Adult Weight Management services due to binge-eating or because the patient requires more individualised support are referred externally for support.

Objective 3: *Assess whether Weight Management services are able to meet the demand for the services*

Whilst this evaluation had a focus on assessing the demand and capacity of Weight Management services, as an integrated behaviour change service, it is necessary to present the demand and capacity of other service interventions for comparison and review.

Service demand in relation to commissioned capacity

Tier 2 Adult WM received the highest number of referrals over the five years, totalling 12,048 an average of 2409 (125%) over capacity each year. Both the EE HT service and MH HT service received an average of 58% referrals over capacity over the years the services were delivered. However, for the MH HT service this accounted for a total of 444 service users, meanwhile the EE HT service reported a total of just 15 referrals over capacity in years four and five. Table 2 outlines the demand for services which exceeds commissioned service level capacity. The vast majority of services receive more referrals than commissioned capacity over at least two years of service delivery. The PB HT service is the only service which received no referrals above their capacity across the five years of service delivery. In all cases where demand exceeded capacity referral KPI targets were reported by Everyone Health as met, and in all cases where demand did not exceed capacity referral KPI targets were not met.

Table 2: Number of referrals received by services above capacity each year

	Year 1	Year 2	Year 3	Year 4	Year 5*
PB HT n(%)	-	-	-	-	-
Alcohol HT n(%)	-	-	26 (17)	17 (11)	-
Falls Prevention n(%)	82 (32)	563 (108)	104 (10)	484 (46)	251 (43)
MH HT n(%)	-	31 (21)	38 (17)	240 (109)	135 (145)
EE HT n(%)	-	-	-	9 (90)	6 (200)
CS HT n(%)	-	-	33 (55)	13 (22)	15 (56)
DS HT n(%)	-	71 (178)	124 (310)	198 (275)	21 (66)
SS n(%)	260 (33)	585 (37)	308 (19)	437 (27)	487 (61)
Tier 2 Adult WM n(%)	111 (11)	3178 (159)	3779 (161)	3432 (147)	1548 (147)
Tier 3 Adult WM n(%)	-	425 (120)	323 (78)	534 (98)	-

Falls Prevention, SS and T2 Adult WM consistently exceeded capacity for referrals each year of service delivery. The DS HT exceeded capacity by 166% (n=103) on average each year of delivery, totalling 414 referrals over the five years, which was the highest in total demand over capacity.

Three services in year 3 (Alcohol HT, DS HT and Tier2 WM) had their highest year of referrals (%) over capacity in the five-year period, whilst three others came in year 5, despite this only accounting for two quarters worth of data (SS, EE HT and MH HT).

Inappropriate referrals into Weight Management

Both Tier 2 and Tier 3 Adult WM services received more referrals than the capacity of the service (Table 3).

Table 3: Number and percentage of inappropriate referrals to the service and the percentage of those that account for the number above capacity.

	Year 1	Year 2	Year 3	Year 4	Year 5
Tier 2 Adult WM n(%)	126 (12)	590 (12)	490 (8)	948 (16)	150 (6)
% of inappropriate referrals above capacity	114	19	13	28	10
Tier 3 Adult WM n(%)	15 (3)	14 (2)	34 (4)	180 (16)	182 (28)
% of inappropriate referrals above capacity	0	3	11	34	0

Over the five years, an average 11% of all referrals to both services combined were considered inappropriate. The Tier 2 programme had its highest over-subscription in year 4 (n=180, 16%), whilst Tier 3 was already oversubscribed by 28% (n=182) in the first two quarters of year 5. In year 1 of the Tier 2 programme 114% of referrals over capacity could be accounted for by inappropriate referrals. This suggests that once the inappropriate referrals were filtered out, the service would not have been overcapacity across the year. In year 4, Tier 3 weight management service received 180 inappropriate referrals, accounting for 34% of referrals over the capacity of the service.

Do commissioned levels of service meet demand?

Stakeholders reported the service is currently overwhelmed by demand for Adult Weight Management services, which is only increasing due to the very high demand for weight loss injections. Staff reported that PCC commissioned places do not meet the current demand for the service.

Exploration of options used to manage exess demand for weight management treatment

The Adult Weight Management services have adopted several strategies to manage excess demand. The teams respond to GP enquiries about eligibility criteria, attempting to ensure that only appropriate referrals are received. The Tier 2 Adult Weight Management service refers patients with balance issues to the Falls Prevention service to improve confidence and strength, who refer those same patients back to the Adult Weight Management service when they are stronger. Living Sport also intervened to

reduce waiting times by supporting some patients from the Tier 2 waiting list with Tier 1 services.

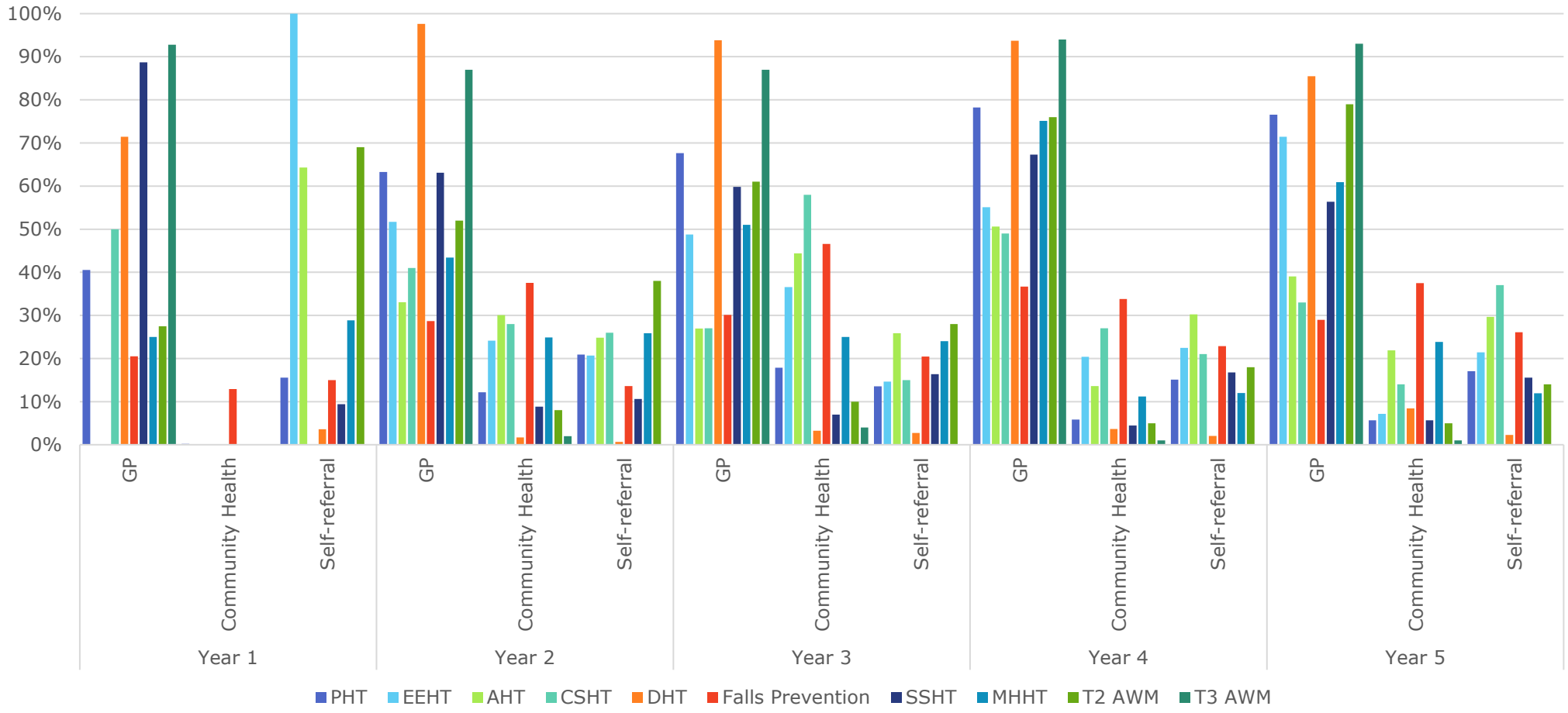
The Tier 3 Adult Weight Management service offers three services which are mostly virtual offers: Fresh Start is entirely virtual, MoreLife is mostly virtual and Cambridge University Hospital now mostly offers virtual appointments. The service states that patients must wait 12 months before they begin any Tier 3 intervention again due to the high patient demand and limited resource on offer. The MoreLife service is able to see patients with most medical conditions which has been effective at reducing the waiting list at Cambridge University Hospital. Eight to ten patients are referred to Cambridge University Hospital every month for intensive weight management, surgery or due to having a co-morbid cancer diagnosis. The waiting list was 1.5-2 years for the Tier 3 Adult Weight Management service but staff are now contacting patients to offer them MoreLife instead, to reduce waiting times. Patients are advised that they are required to complete 80% of any Tier 3 service to be eligible for bariatric surgery and so more patients are now accepting the MoreLife offer. Staff are now triaging patients on the waiting list for both weight loss medication and bariatric surgery. Tier 3 staff reported being able to manage the demand for Weight Management services in Cambridgeshire, because there are sufficient funded places.

Objective 4: *Assess the level of integration with wider partners at county and local area levels, e.g. primary care, district councils and third-sector organisations*

Where do service interventions receive referrals from?

Referrals into the 'Healthy You' service were predominantly made by the GP, community health services and patients themselves (Figure 15). These accounted for over 90% of referrals made in years 2,3,4 and 5, and 74% in year 1. Year 1 had a higher % of referrals from 'unknown' or 'other' sources into services. Most referrals into all services, excluding the Falls Prevention service, are made by GP practices. Most referrals into the Falls Prevention service are made by the Community Health Service, with GPs their second most frequent referrer, although these were seen to switch between years. In Tier 3 Adult WM services, referrals were received from the GP, hospital and community health services.

Figure 15: Most frequent referrals for each service over the five-year period.



Where integration has unproven impact and outcomes

Although there is evidence of referrals being made into the service, by health partners predominantly, along with self-referrals, there is limited evidence of services within 'Healthy You' being integrated. The clinical contact centre assesses the appropriateness of all referrals, including the Stop Smoking service, and calculates an Audit-C for every patient referred, assessing eligibility for the Alcohol service. The clinical contact centre confirms to the patient within 48 hours that their referrals has been processed. It is reported that referrals are more appropriate from GP practices where Health Trainers are based and this process works well. It is also reported that referrals from the Tier 2 Adult Weight Management service to the Falls Prevention service work efficiently, as do referrals from the Falls Prevention service to other Health Trainer services. The service should theoretically enable patients to access one service intervention whilst waiting for others, but stakeholders frequently reported that whilst referrals are made, these are not followed up and the Service is not optimally integrated.

Teams reported feeling that they worked in silo from other teams within 'Healthy You' and interviewees reported that patients are passed "pillar to post" due to poor communication about referrals and eligibility criteria internally, non-collaborative working with different providers of the contract and inefficient communication with referrers into the 'Healthy You' service. Stakeholders reported that the Tier 3 Adult Weight Management Service is currently not integrated within the wider 'Healthy You' service but felt that integration would be desirable. Moreover, it was reported that the Tier 3 MoreLife service does not report outcome data under Everyone Health reporting, as it is considered its own service. Stakeholders report needing better support for patients moving from one service to another and currently staff resource is spent referring patients to more appropriate services as a consequence of receiving inappropriate referrals. It was suggested that patients would be less likely to get lost in the service if staff knew more about which service they were referring patients to, enabling them to follow up referrals.

Do stakeholders report that integrating behaviour change services is able to improve service users' outcomes

It is clear from our qualitative investigation that the 'Healthy You' service does not currently function in an integrated way. Stakeholders would like to see an integrated approach to service delivery in order to improve patient outcomes, but this requires better collaboration both internally and externally, as well as improved communication of referrals, service intervention eligibility criteria and waiting list times across the service.

Objective 5: *Strengths and limitations of the current service offer*

What are the strengths of the service?

Strengths of the overall service were reported to be the wide range of service interventions offered by the 'Healthy You' Service, along with the ability for patients to self-refer into all services except for the Tier 3 adult weight management service. Stakeholders reported the eligibility criteria were accommodating for patients and more inclusive than criteria of external services. The outreach work of Health Trainers, particularly the ability to deliver Health Checks, was reported to be effective at forging relationships with local communities and underrepresented groups and identifying people at risk of unhealthy lifestyle choices who would otherwise deem themselves to be healthy, e.g. those who are physically inactive but eat healthily. There were some reports of good communication across teams, but this sentiment was not shared across the whole 'Healthy You' Service. Staff and patients were reported to value the use of objective biometric outcomes to measure progress within the Falls, Adult Weight Management and Diabetes services. Stakeholders reported multi-lingual, trained and clinically supervised staff as being a strength of the Service, particularly for the Diabetes, Stop Smoking and Adult Weight Management services. Stakeholders also reported the benefit of Health Trainers having local knowledge of services, activities and events to refer patients to, particularly those with minimal associated cost. In-person services were reported to be a strength for promoting social connection and improving patient outcomes, and consideration was given to ensuring clinic location are convenient and accessible for patients. Clinical Partners and patients are reported to know the 'Healthy You' brand. See Appendix 4 for the full SWOT analysis.

Based on the analysis of secondary data collated by Living Sport via annual reports, some of the main strengths of 'Healthy You' as a whole were the establishment of successful collaborations with partners, offering patient-tailored and accessible interventions to the general public that suit their needs, having KPIs that focus on quality and increasing service popularity among the public, as measured by the substantial increase in referrals in year 3. Furthermore, as of year 2 of operation there was also evidence of good, collaborative working between the six district's coordinators who have been sharing workload and knowledge with one another. See Appendix 5 for the full list of strengths, including those identified for each Tier. However, please note that more information was available for Tier 1 than Tiers 2 and 3.

What are the limitations of the service?

Limitations of the overall Service were reported to be that patients are often passed "from pillar to post" due to inefficient internal referrals systems, limited communication and lack of staff knowledge and understanding of eligibility criteria of each of the service interventions. Staff are not always reported to know how to make referrals and are unable to communicate referral updates to patients, which sometimes leads to patient attrition. There was little support among stakeholders for how KPIs are currently measured and reported. Stakeholders reported that KPIs measure quantity instead of quality and too much resource is taken up trying to meet the KPIs instead of delivering person-centred and tailored support to patients. The Service does not currently meet the needs of patients who prefer 1:1 support who may find group classes intimidating or would prefer not to exercise in groups due to the risk of Covid-19 transmission. It was reported that the Service would benefit from better coordination and collaboration with existing patient pathways to sustain patient progress. It was reported that the service interventions work in silo, with little integration between individual services, although this was particularly felt by Tier 3 Adult Weight Management and Alcohol services.

All services except for Alcohol and Stop Smoking services reported the issue of receiving 'inappropriate referrals'. It was reported that inappropriate referrals partially resulted from GPs receiving an incentive to refer patients into Weight Management services. Adult Weight Management staff reported patient attrition after 12-weeks being problematic for the service and were considering ways to retain patients. It was reported that the location and timings of some in-person classes or appointments may not be convenient for some groups of people such as people working shifts or those requiring weekend/evening availability. Issues with data-sharing across Providers and technological difficulties were reported to be problematic within the Service. The District Councils reported that the 'Healthy You' service sometimes duplicated existing Public Health work in their localities. There was high attrition for staff reported in the Alcohol and Mental Health Health Trainer services, alongside reports that staff do not feel qualified enough to meet the needs of the patient populations. Staff safety was reported to be a necessary consideration, with staff reporting feeling safer working from existing community places or GP practices, instead of lone working. Finally, stakeholders reported that there was ultimately not enough time for relationship-building with patients for them to provide holistic support, ensuring that the patient is navigated through a personalised Service. See Appendix 4 for the full SWOT analysis.

Some of the weaknesses of the 'Healthy You' service as a whole, identified from the secondary data analysis, were the limited budget for Service delivery, the non-standardised approach to data collection with generally low patient return rates of the measures and some duplications in the reporting processes to commissioners. The weaknesses identified for Tier 1 were Districts sometimes displaying a "my patch mentality", having implications for a lack of accountability and short-termism, whereas the main weakness of Tiers 2 and 3 were the long waiting times. See Appendix 5 for more information.

What are the opportunities for the service?

'Exercise on referral' was suggested a potential offer for any new service as this is frequently requested by patients to the clinical contact centre and was reported in interviews to be a popular option in other parts of the country. Any new service should provide staff with opportunities to communicate and meet each other, to enable learning about each service and share best practice. Any new service requires better collaboration between all contractors and partners to deliver the service and use a shared IT system which is routinely updated with referral information. Staff should have meaningful behaviour change conversations with patients at each contact using coaching skills. It is necessary to establish clearer eligibility criteria for each service intervention along with clear communication of the referral process shared both internally and externally. Consideration should be given to each patient having a 'Healthy You' coordinator who can support them to navigate the service based on their identified needs, providing a more holistic approach, instead of patients 'falling between the gaps'. This would enable a more integrated Service. A new service might consider embedding Health Trainer staff back into GP practices, which was reported to facilitate better communication with GPs, resulting in more appropriate referrals.

Whilst a virtual service is reported to work well for Tier 3 Adult Weight Management services, a hybrid approach to service delivery may be considered for all other service interventions, providing more flexibility and reducing accessibility issues for some patients. Outreach work, including NHS Health Checks, should continue to be offered with any new service as this is reported to promote community connections and initiate healthy lifestyle conversations with people who many not otherwise engage with the service. Staff should receive quality training and clinical supervision where appropriate. Staff should feel confident in their roles to deliver specialist services offered by the Service. A condensed set of KPIs using biometric data/objective measures may be considered to motivate patients and prevent KPIs feeling irrelevant. Finally, there should be a coordinated approach to collecting KPI data so that staff do not complete multiple similar forms, which is time-consuming.

For the Tier 3 Adult Weight Management service, the eligibility criteria could be adapted to encompass a quality-of-life measure and to review the Body Mass Index (BMI) criteria. The Tier 2 Adult Weight Management service should facilitate mandatory 'homework' as part of the course and offer engaging asynchronous resources to promote engagement. The eligibility criteria for a Falls Prevention service could encompass a frailty assessment and initial consultations should be completed in-person to ensure accurate assessments and prevent inappropriate referrals. A level 3 Fitness and Mobility Exercise (FAME) class may be considered for supporting more people at-risk of falls to develop strength and balance. The generic Health Trainer service may consider offering more than four standard sessions of support to promote engagement and facilitate sustained behaviour change. Any new service may consider offering gender-specific groups to meet the cultural needs of patients. See Appendix 4 for the full SWOT analysis.

Some of the opportunities of the 'Healthy You' service, highlighted by the secondary data analysis, were continuing engagement with the local communities, investing in the right staff, improving its data collection and streamlining its reporting process. Additionally, it was recognised that having a long-term contract in the future might be beneficial for solving many of the service's current challenges, leading to better retention of staff and more lasting partnerships. Some of the key areas Tier 1 might want to focus on to achieve its goals, were improved information sharing with commissioners and partners, investment in upskilling its workforce and streamlining its referrals process. As for Tiers 2 these were strengthening the referral pathway with Tier 1 and more insight sharing between the delivery partners of Tier 2 and Tier 1. Similarly, for Tier 3, improved information sharing with the delivery partners of Tier 1 was identified as a key area of opportunity. See Appendix 5 for more information.

What are the threats to the service?

There are several threats to the overall service. It is reported that communication within the 'Healthy You' service is ineffective and staff teams work in silo. It is reported that inappropriate referrals are made both internally and externally and this is likely due to people having an unclear knowledge of the referral processes and eligibility criteria of each service intervention. There is limited effective collaboration reported within the Service or with external agencies. Long waiting times are reported for some service interventions which is reported to lead to patient attrition. The viability of community clinics is questioned due to venue costs, unreliable public transport links for patients and inflexibility of session times/locations. Staff morale is reported to be low across some teams which has affected staff retention in those areas. Technical difficulties with IT equipment and data sharing previously prohibited communication with Providers. The cost-of-living crisis specifically threatens how some patients are able to engage with sessions, due to the cost of travel to in-person sessions, the cost of facilitating classes at venues and where financial hardship may impede on patients' ability to adopt healthy lifestyles. Specific threats to the Adult Weight Management service includes high staff workload, inappropriate GP referrals and the availability of weight loss injections. See Appendix 4 for the full SWOT analysis.

Some of the threats of the 'Healthy You' service as a whole, identified from the secondary data analysis, were the potential difficulties expanding due to limited funds and financial uncertainty and not having enough data to showcase its good work. See Appendix 5 for more information.

Objective 6: *Recommendations for future service model*

What key insights can be drawn from the evaluation to inform future service delivery?

Our qualitative investigation identified that any future service should consider a hybrid approach to delivery, including both in-person and virtual options. It was suggested that the eligibility criteria for Tier 2 Adult Weight Management services could be adapted so that the BMI is higher as these patients tend to require more staff support, and an upper age could also be implemented because patients aged 65 and older are referred to the Falls Prevention service instead. It was suggested that objective metrics which are not just weight-based, such as glucose and cholesterol, would be useful for Adult Weight Management services. Future service delivery may consider more flexible scheduling of sessions to engage different groups of patients, such as shift workers.

Recommendations for Tier 3 Adult Weight Management services included growing a bigger multidisciplinary team, making the service more targeted to those in greatest need of support and to consider how the landscape may change with the weight loss medications now available, such as considering whether the 5% weight loss KPI is still appropriate. It was recommended that a harm reduction approach is most appropriate for patients with higher support needs and any service should address underlying precipitating factors to unhealthy lifestyle behaviours, e.g. financial hardship, social isolation and stress. For the Falls Prevention service, it was suggested that there could be a role for a level 3 FAME class or the offer of some 1:1 FAME classes to engage patients initially who may require more support. It was suggested that patients need a single point of contact to navigate the 'Healthy You' service and promote integration and so a new service may consider adopting a 'Care Coordinator' approach. It was reported that prior to Covid-19, Health Trainers were effectively based within GP practices and there are suggestions that this model should be re-implemented to promote communication and appropriate referrals from GPs. A suggestion was made for a new service to consider offering shorter more intensive blocks of behaviour change delivered in hyperlocal areas, essentially replicating a place-based approach to service delivery.

From reviewing routinely collected service user feedback, it is recommended that Districts consistently collect and report feedback from patients using 'Healthy You' services. If this data is routinely collected, it can be used to demonstrate the impact of the service/programme to commissioners, keep staff morale high and helping with learning and development. Furthermore, reporting negative feedback could also be powerful, provided the mentioned shortcomings had been proactively addressed by the service as it can showcase a culture of transparency where service users are listened to, and their concerns are taken seriously.

Are there any existing services similar to the Integrated Behaviour Change Service nationwide, and what can we learn about them to help inform future service delivery across Cambridgeshire?

Seven different Healthy Lifestyle Services are presented in Appendix 6. The services cover varying geographies across England including two from the Eastern region; Gloucestershire County Council Healthy Lifestyles Service, Norfolk County Council, Surrey County Council, Oxfordshire County Council, Lincolnshire County Council, Essex County Council, Nottinghamshire County Council. This table was developed via publicly available information on the internet. The aim of these programmes is to improve health outcomes, address health inequalities, and promote sustainable lifestyle changes within local communities. The services provided to support with these outcomes are fairly consistent including, Weight Management, Stop Smoking and Alcohol Services as well as a focus on healthy eating and physical activity. Furthermore, these services were delivered in similar formats often offering a mixture of 1:1 and instructor-led group support as well as online resources and self-directed activities. All services offered referral pathways for both patients (self-referral) and partner organisations/colleagues such as health care professionals. Some differences were seen across services when considering the target audiences, with a general approach to supporting the wider populations, including families, children and young people and adults. However, in addition to this, some services outlined clear target groups including males (Essex, weight management) and adults affected by substance misuse (Norfolk).

The outcomes and KPIs and therefore any success measures of these programmes are not publicly reported.

Can current services be delivered using a place-based approach?

Most services felt they were already delivering services using a place-based approach and all stakeholders reported that a place-based approach would be an effective approach to service delivery to tackle health inequalities. It was suggested that a place-based approach should use a targeted approach to reach patients with greatest need and are likely to require more support from staff to achieve their goals. There is a need for a place-based approach to focus on prevention and for a service to use data-driven insights to identify areas of highest priority, such as East Cambridgeshire and Fenland. It was suggested that existing office spaces could be adapted into wellbeing hubs to be used by patients. It is recommended that more community outreach work is required by a place-based approach to service delivery. A place-based approach to service delivery may need to consider weighting services by priority areas rather than ensuring that all services have the same resource shared equally. Some District Councils were concerned that they would not have a service delivered in their locality if a place-based approach worked in this way. A place-based

approach could work with community services or social prescribers to identify patients most in need of services.

Limitations of this evaluation

Stakeholders interviewed and those who participated within a focus group were recruited using convenience sampling and had been identified by colleagues at Cambridgeshire County Council for involvement within this evaluation. Many of these staff were employed by Everyone Health who are currently responsible for delivering the contract, which may have introduced some bias into the data collected.

The qualitative data analysis of secondary data and quantitative KPI data analysis used reports and data provided by Everyone Health, which Health Innovation East were unable to quality assure. Some KPI data did not include Tier 3 Adult WM services. The secondary qualitative data did not include much data on Adult Weight Management services. Everyone Health changed KPIs throughout the 5-year contract and so the KPI data examined within this evaluation may be positively skewed.

Summary

This comprehensive, thorough and robust mixed-methods evaluation examined the effectiveness of the 'Healthy You' Service to meet key performance indicators, demonstrate integration and assessed how the Service responded to challenges of excess demand and capacity. The evaluation also sought to respond to whether there could be a role for a place-based approach to service delivery and what could be learned from similar Services nationally. Service user feedback of services is reported to be largely positive, the breadth of service interventions is considered to be an attribute and the Service's community and outreach work is effective at engaging with people from deprived areas and those from underrepresented groups. However, there is limited evidence of teams working collaboratively across the Service, with staff having limited communication with other staff and limited knowledge of other services. Staff do not follow up on referrals and patients do not have a smooth transition through the Service.

KPIs are burdensome for staff to report on and KPI-related data is inconsistent and mostly subjective as goal-setting cross Health Trainers varies widely. KPI performance was poor across the period of delivery, with the Service not meeting 59% of its KPIs in the first year to 42% of KPIs not met in its fourth year, although this did vary by service intervention. It is recommended that the list of KPIs is reduced and objective and biometric data is used wherever possible. Many services are over-capacity, often a result of inappropriate referrals, which could be managed with better integration across services. Service users were over-represented by females and older adults, compared to 2021 census data. Those from Non-White and deprived backgrounds

were under-represented at referral, however were retained within services at completion, as opposed to those of White ethnicity.

A new service may consider using a hybrid approach to deliver services and should consider implementing a place-based approach, at least as part of its offer. Whilst most other Services nationally use a generic approach to promoting healthy lifestyle behaviours amongst families, some Services have used a more targeted approach to engage people with substance misuse behaviours or to specifically engage Men. There is infrastructure within the existing model which aligns with a place-based approach such as the generic Health Trainers who deliver outreach work and NHS Health Checks, which could be maximised within service redesign to ensure that people most in need of the service are accommodated. It is recognised that patients most in need of these services may require more motivation, effort and creative approaches from staff to engage, compared to the generic patient population currently engaged by the service which have lower support needs and require less motivation from staff. Below are a list of recommendations that commissioners may consider for service redesign, to address some of the challenges faced by the Service which were identified throughout this evaluation.

Recommendations

We present the following recommendations, since reviewing all findings produced from this mixed-methods evaluation, for the commissioner to review and consider implementing within any new integrated behaviour change service commissioned for Cambridgeshire in 2025.

1. Develop a condensed set of KPIs based on objective and biometric outcome data, including blood pressure, Hba1c, BMI, weight, waist circumference and CO2 monitoring, where appropriate.
2. Offer a hybrid approach for delivery (face-to-face and virtual) of all service interventions.
3. Health Trainers to be based in GP practices and existing community spaces, such as libraries and faith centres.
4. Develop a 'care coordinator' approach to service delivery so that each patient has a point of contact navigating them through the service.
5. Referral paperwork for Tier 2 Adult Weight Management services should include a blood pressure reading from the GP.
6. Patients receiving weight loss injections under Tier 3 Adult Weight Management services should receive some in-person contact, for safety monitoring purposes.
7. The 'Healthy You' brand is well-known and should remain.
8. Eligibility criteria, referral processes and waiting list times for each service intervention should be updated and effectively communicated to all staff on a regular basis.
9. Staff should receive regular appropriate training and have the opportunity to communicate and meet with other 'Healthy You' staff on a regular basis.
10. Any staff member should be able to view live referrals in the system and provide patients with updates on their referral
11. To address and tackle health inequalities, a new service may consider adopting a targeted approach to service delivery to reach patients who require more staff motivation to engage and have higher support needs.

Appendices

Appendix 1: Focus Group and Interview Topic Guides

The evaluation of Cambridgeshire County Council's Integrated Healthy Lifestyle Change Service

Focus group topic guide for key stakeholders – Service Leads and Management overseeing service integration

Introduction

- *Hi, my name is [name] and I am a member of the evaluation team based at Health Innovation East working on the Evaluation of Cambridgeshire County Council's Integrated Healthy Lifestyle Change Service. I will be conducting the focus group today. [If another staff member is present, introduce them also].*
- *Thank you for agreeing to participate in this focus group which will feed into the wider evaluation we are undertaking along with a series of recommendations for service re-design. The evaluation seeks to identify the strengths and limitations of the current service model and discuss referrals and integration of services. This focus group is scheduled to last an hour.*
- *I have a number of questions that I would like for you all to discuss about the services you are delivering as part of the Integrated Healthy Lifestyle Change service. Your participation is voluntary and so you are not obliged to answer questions if you do not wish to.*
- *Views expressed in this focus group should be considered confidential and I ask that anything that has been discussed today stays in this virtual room and is not shared further please. This hopefully creates a more welcoming environment for people to share their honest views on the service. All of your data from this focus group will be de-identified and kept confidential in reporting.*

Checks:

- Can I check that you have read and understood the participant information sheet? Do you have any questions before we begin?
- Can I please confirm that you are happy to be video recorded and I will begin the recording?

So thank you again for agreeing to take part in this focus group, we will now begin the questions.

[Begin recording]

I'd like to find out some more about the service(s) you are responsible for delivering currently.

1. Thinking about the services you deliver, what does the Service currently do well?
   Prompt: strengths of current model.

2. What does the Service not do so well currently?
   Prompt: weaknesses of current model.

3. How are the services working together?
   Prompts: Are services integrated effectively? How do service users move between services or Tiers? Does this happen effectively? How do services receive referrals? What does effective integration look like? What impact does effective integration have on service users, if any?

4. Do you think the current Service offer meets the needs of local communities?
   Prompt: Why? Whose needs does it meet and whose needs does it not meet? Unmet needs?

5. Could the current Service offer be delivered using a place-based approach?
   Prompt: Why? How? What might this look like? Are services doing this already? What could this offer? Are there any lessons learned from the Covid-19 pandemic that may be useful?

Okay, thank you so much for all of your contributions, that's the end of this focus group.

[Stop recording]

If you need to contact me afterwards, please email me – my email address is listed on the Participant Information Sheet.

Thank you for taking part and for your time, goodbye.

The evaluation of Cambridgeshire County Council's Integrated Healthy Lifestyle Change Service

Interview topic guide for key stakeholders – Service Leads and Management overseeing service integration

Introduction

- *Hi, my name is [name] and I am a member of the evaluation team based at Health Innovation East working on the Evaluation of Cambridgeshire County Council's Integrated Healthy Lifestyle Change Service. I will be conducting the interview today.*
- *Thank you for agreeing to participate in this interview which will feed into the wider evaluation we are undertaking along with a series of recommendations for service re-design. The evaluation seeks to understand better the strengths and limitations of the current service provision and identify any issues and opportunities for service re-design. We expect the interview will last approximately 45 minutes and no longer than an hour.*
- *I have a number of questions that I would like to ask you about the services you are delivering as part of the Integrated Healthy Lifestyle Change service. If there are questions you prefer not to answer, please let me know, and we will move on. You don't need to give a reason.*
- *I would like to reiterate that this interview is confidential unless you raise anything that may put yourself or someone else at risk, in which case we would be required to follow safeguarding procedures. Your data from this interview will be de-identified and kept confidential. Where possible, please do not name colleagues or service users you have worked with.*

Checks:

- Can I check that you have read and understood the participant information sheet? Do you have any questions before we begin?
- Can I please confirm that you are happy to be video recorded and I will begin the recording?

So thank you again for agreeing to take part in this interview, we will now begin the questions.

[Begin recording]

SECTION 1: Current service provision

I'd like to find out some more about the service(s) you are responsible for delivering currently.

1. How well do you think services are improving health outcomes for *all* service users?
2. What is currently working well for the service(s) you deliver?
3. What is currently not working so well for the service(s) you deliver?

4. Is there anything that the service(s) could do better?
5. What are your thoughts on how well the broad range of programmes within the healthy you service work?
6. How do you work with other service providers to meet the needs of service user?
7. What does the referral process for the service look like?
   prompt; who makes the referral, which service do they come from?
8. How well do you feel the service engages local communities and service users?
9. In your opinion, is the way the service is currently delivered the most appropriate model for reaching people at highest risk of poorer health?
10. How do current services meet the needs of service users with the highest risk?
11. Are you aware of any groups of people who may not be accessing your service, but may benefit from it?
12. Can you identify any "lessons learned" from delivering services through Covid-19 pandemic and the cost-of-living crisis, which has changed how you now deliver the service(s)?

SECTION 2: Service re-design

Thank you. Now I would like to move on to talk about what a new service might look like and any recommendations you may have.

13. What are your thoughts on moving the service to a more place-based approach for delivery? **Definition (if needed):***"A **Place-based** approach involves local collaborations often involving health and care organisations to coordinate services and improve population health and wellbeing".*
14. What would be required to integrate your current service(s) with a place-based approach?
15. Is there anything that might be problematic with a place-based approach to service delivery?
16. Services currently use a deprivation index to identify those at highest risk of poorer health. How could a new service identify service users at highest risk?
17. What could improve integration between services to ensure that service users are not lost in the system or between Tiers?
18. Is there anything that is not currently happening which should be considered for future service provision?
19. Is there **anything else** you would like to add which we haven't already discussed?

Okay, thank you, that's the end of interview.

[Stop recording]

If you need to contact me after the interview, please email me – my email address is listed on the Participant Information Sheet.

Thank you for taking part and for your time, goodbye.

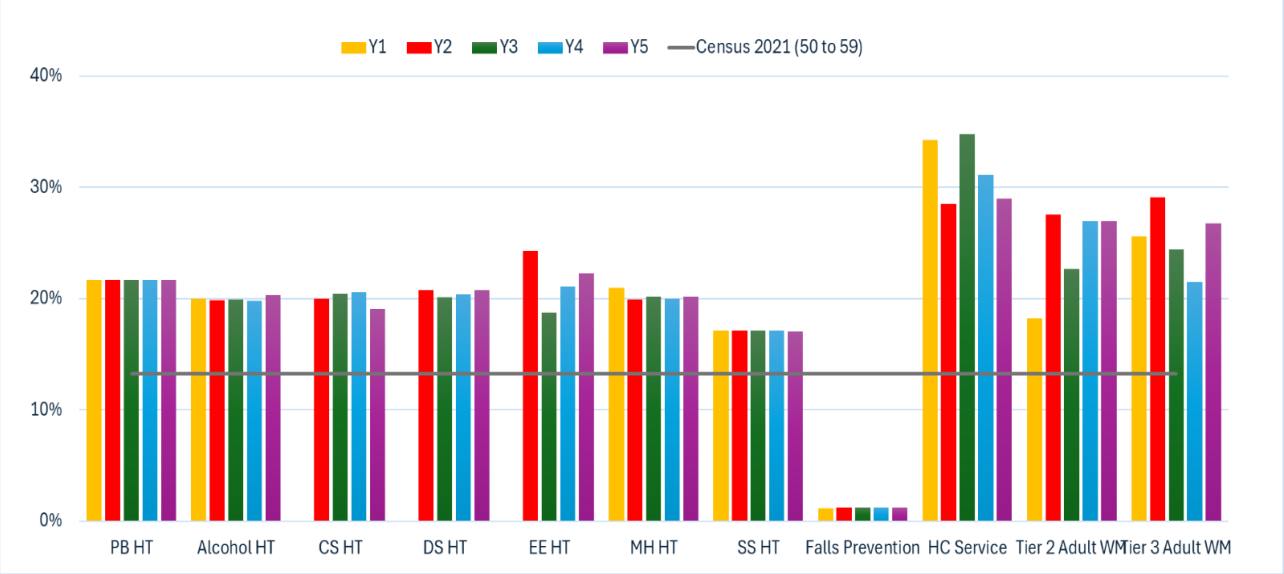
Appendix 2: Number of KPIs by service each year

	Year 1	Year 2	Year 3	Year 4
PHT	11	15	19	22
Alcohol HT	7	16	13	15
Falls Prevention	13	18	18	18
MHHT	11	18	18	20
EEHT	11	11	11	9
CSHT		14	14	11
DHT		13	12	18
SS	28	30	31	31
Tier 2 Adult WM	20	16	17	19
Health Checks	3	3	3	3
Tier 3 Adult WM	5	33	43	21

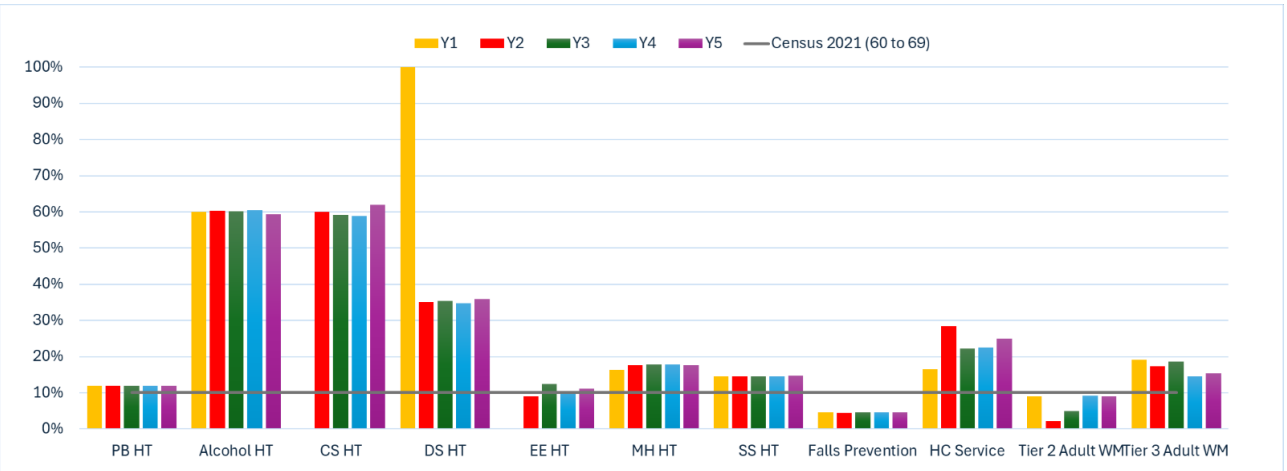
Appendix 3: Demographics data

Age

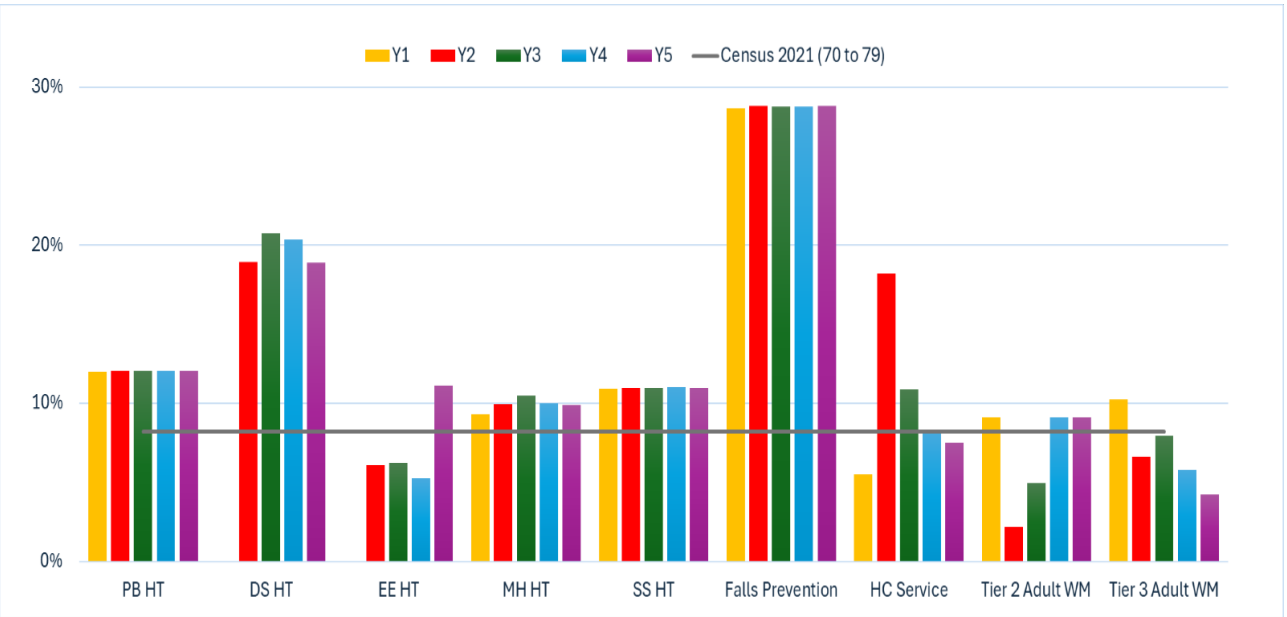
Percentage of service users at the 51-60 age bracket at referral across the five years, against relevant data from Census 2021 for the local authority.



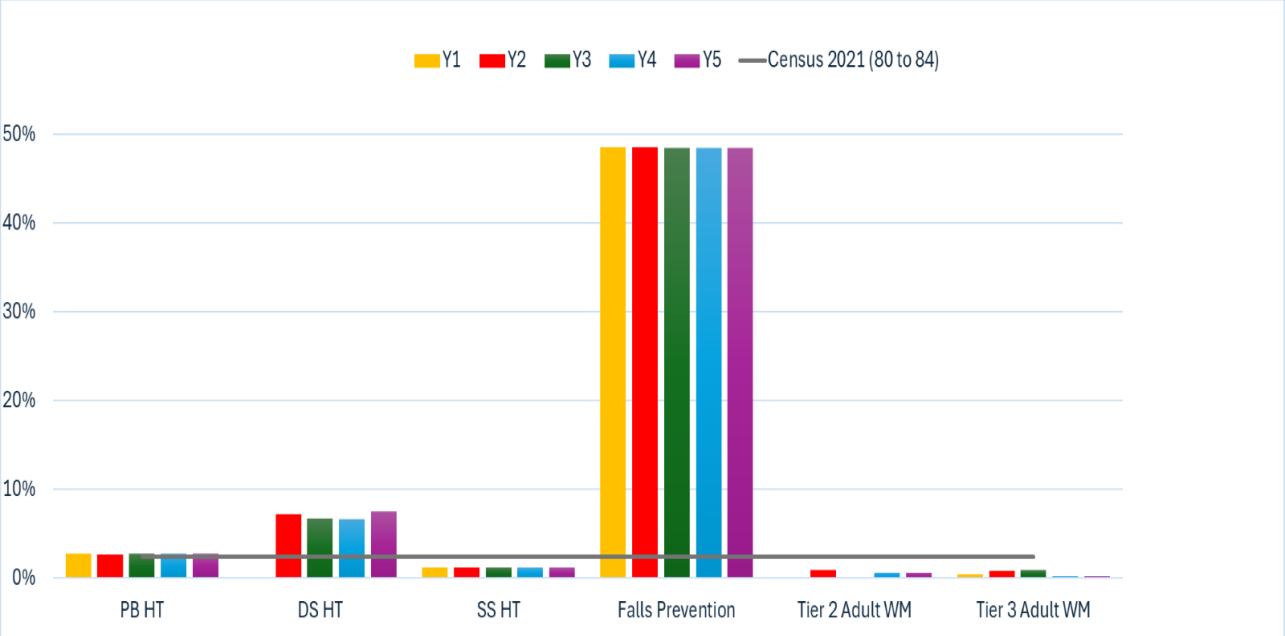
Percentage of service users at the 61-70 age bracket at referral across the five years, against relevant data from Census 2021 for the local authority.



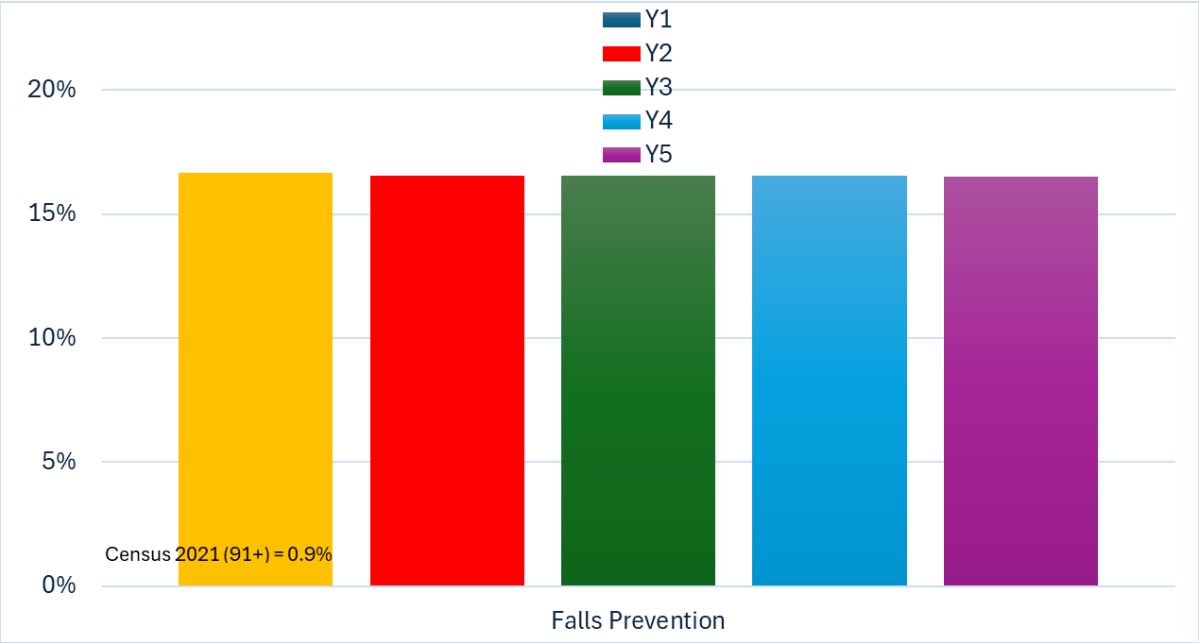
Percentage of service users at the 71-80 age bracket at referral across the five years, against relevant data from Census 2021 for the local authority.



Percentage of service users at the 81-90 age bracket at referral across the five years, against relevant data from Census 2021 for the local authority.

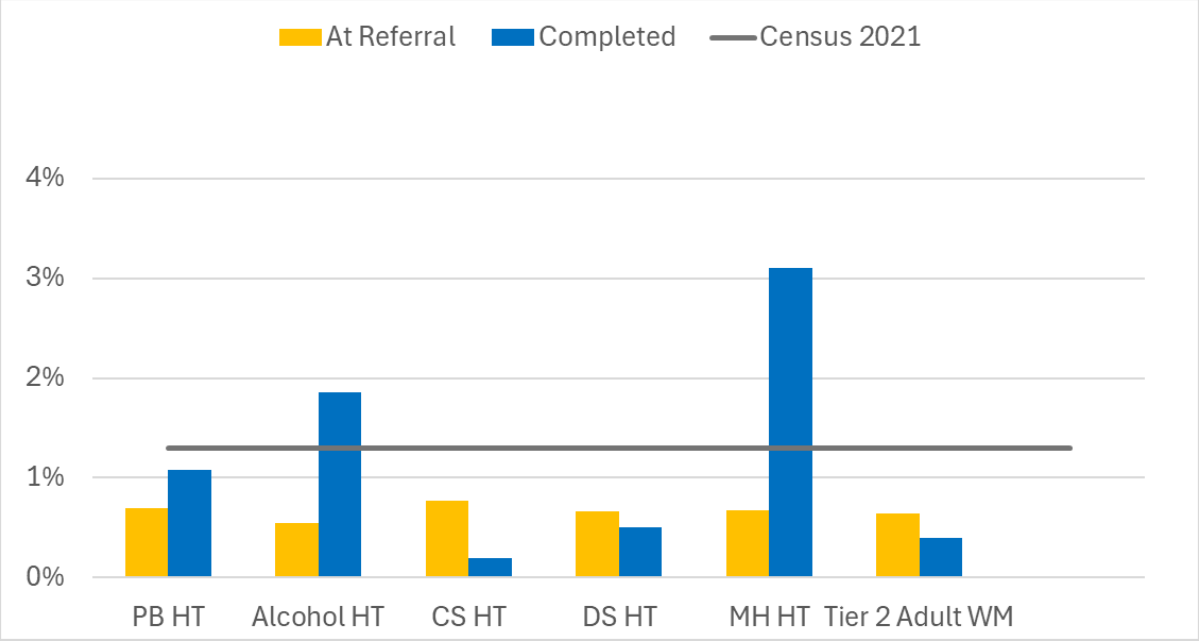


Percentage of service users, aged 91+ at referral across the five years, against relevant data from Census 2021 for the local authority.



Ethnic Background

Percentage of service users from Other ethnic backgrounds at referral and completion across the five years, against relevant data from Census 2021 for the local authority.



Appendix 4: SWOT analysis of primary data collected from stakeholder interviews and focus group

Strengths												
District Councils	**T2WM**	**T3WM**	**Stop Smoking**	**Alcohol**	**Diabetes**	**Mental health**	**Falls**	**Generic HT**	**Health Checks**	**Living Sport**	**Contact centre**	**Overall service**
Affordable - use own services, IT, resources	Range of services offered are suitable for different patient needs	Range of services offered suitable for different patient needs	Trained staff	IBA Training	High engagement with patients		Staff are responsive to patient needs	HTs use evidence-based resources	Convenient for some patients	In-person support promotes social connection	Flexible staffing resources	Responsive to meeting increasing demand, e.g. Living Spot implemented
Understand needs of the local population	Objective outcomes for measuring success, e.g. BMI, 5% weight loss, BP	Multidisciplinary skilled team	Good links with PCNs supports engagement	Referrals are appropriate	Objective outcome measure: Hba1c		Convenient clinic locations across region	HTs adapt and work creatively to meet patient needs	Outreach work can reach underrepresented groups	Signposting to online resources	Translation service offered at triage	Good communication across teams

Strengths												
District Councils	**T2WM**	**T3WM**	**Stop Smoking**	**Alcohol**	**Diabetes**	**Mental health**	**Falls**	**Generic HT**	**Health Checks**	**Living Sport**	**Contact centre**	**Overall service**
Flexible and tailored service: responsive to resident feedback and move to online after Covid-19	F2F sessions have convenient locations	Fresh Start sessions are inclusive	Clinics in GP practices promote engagement	Staff have adapted their approach to promote engagement with service	High staff and patient retention		High patient engagement	HTs have local knowledge of services/events and community connections	Health Check availability on website	Existing place-based approach works well		Eligibility criteria is more accommodating than other services
Collaborative working with local partners and across Districts	Person-centred approach		Multi-lingual staff		Multi-lingual staff		FAME programme is effective	Outreach work is effective		Triage process is effective		Self-referral into T1 and T2
	Social benefits for patients attending classes		Strict protocol for smoking cessation		Staff are trained and receive clinical supervision			Texting system motivates and prompts patients				Staff appreciate previously hosted shared learning events
	Newsletter sent to patients				F2F appointments in GP practices							People are familiar with the Healthy You brand

Strengths												
District Councils	**T2WM**	**T3WM**	**Stop Smoking**	**Alcohol**	**Diabetes**	**Mental health**	**Falls**	**Generic HT**	**Health Checks**	**Living Sport**	**Contact centre**	**Overall service**
												Wide range of services offered to patients
												Service meets the needs for patients who do not require high support

Weaknesses												
District Councils	**T2WM**	**T3WM**	**Stop Smoking**	**Alcohol**	**Diabetes**	**Mental health**	**Falls**	**Generic HT**	**Health Checks**	**Living Sport**	**Contact centre**	**Overall service**
Technical difficulties with IT access and data sharing	Attrition after 12-weeks	MoreLife is least popular	Focus is on KPIs and not enough on person-centred approach	Name of service is stigmatising	Limited staff capacity	Confusion from patients and clinical Partners over name of the service, e.g. counselling /therapy service	Focus on KPIs instead of delivering a more person-centred approach	F2F clinics in GP practices enabled collaboration with GPs and more appropriate referrals			Inappropriate referrals to HT services due to limited local knowledge	Service is not currently holistic - staff need to be trained to have healthy lifestyle conversations with patients and identify support needs organically

Weaknesses												
District Councils	**T2WM**	**T3WM**	**Stop Smoking**	**Alcohol**	**Diabetes**	**Mental health**	**Falls**	**Generic HT**	**Health Checks**	**Living Sport**	**Contact centre**	**Overall service**
Reporting on KPIs is time-consuming	Phone call at 6m & 12m is not effective at ensuring engagement	MoreLife does not deliver physical activity sessions	Administration burden: prescriptions, risks etc,	High staff and patient attrition	Demand from GPs for the Service but Service cannot meet this demand.	Lots of safeguarding issues raised	Inappropriate referrals from GPs	Not all HTs have local knowledge			Patients often ask for exercise on referrals, not currently offered	Staff need to know how to make referrals and how to communicate this to patients
Better coordination between Tiers is needed	Inappropriate referrals from GP	Some patients require 1:1 support, not currently offered by the Service	Translation service not effective for consultations	Siloed working from generic HTs		High staff attrition	Patients are unaware of the service - few self-referrals	Limited contact with patients to make sustained behaviour change			Cannot signpost patients to venues which are not available or accessible to some patients	Some patients are passed from service to service
Better communication across the Service is needed	Class timings are not suitable for shift workers	Patients provide self-report weight measurements		Previously facilitated F2F clinics had good engagement with patients and clinical Partners		More thorough screening of patient into the service	Falls questionnaire completed on the phone - not always an accurate portraya	Difficulties data sharing with GPs			Referrals not routinely followed up	Some patients prefer virtual but service is moving to all F2F

Weaknesses												
District Councils	**T2WM**	**T3WM**	**Stop Smoking**	**Alcohol**	**Diabetes**	**Mental health**	**Falls**	**Generic HT**	**Health Checks**	**Living Sport**	**Contact centre**	**Overall service**
							l of patients' abilities					
Complicated for clinicians to refer into the Service	Fully virtual service was not successful	Siloed from other services		Appointment timings may be inflexible		Staff require more specialist training	Uptake across clinic locations vary	HTs unaware of sessions times for T2/T3 services				Group sessions can be intimidating for some patients
Duplication of KPIs	HTs cannot view BP reading on SystmOne	Limited communication about referrals between services					Lone working with clinically vulnerable population	KPIs do not reflect when patients drop off for positive reasons				Siloed working due to high workload and limited capacity
							Need for more wraparound, ongoing support outside of classes	Limited communication across HT services				Limited communication across service
							Does not work	Deprivation index may not				Limited knowledge and

Weaknesses												
District Councils	**T2WM**	**T3WM**	**Stop Smoking**	**Alcohol**	**Diabetes**	**Mental health**	**Falls**	**Generic HT**	**Health Checks**	**Living Sport**	**Contact centre**	**Overall service**
							effectively as part of a Falls pathway	be suitable				understanding of referrals across Service
							Referrals not followed up					KPI reporting detracts from delivering patient-centred services
							Eligibility criteria exclude a wide range of patients who could benefit					KPIs assess quantity, not quality of service interventions
												Whilst service engages patients most in need, it does not support them most effectively

Opportunities													
istrict Councils		**T2WM**	**T3WM**	**Stop Smoking**	**Alcohol Diabetes**	**Mental health**	**Falls**	**Generic HT**	**HHealth Checks Living Sport**	**Contact centre**	**Overall service**		
User feedback is valued more than KPI data	Staff require training in specific health conditions, e.g. long Covid, menopause	Weight loss injections introduced	Hybrid approach is convenient for patients				Patients who engage with exercise at home are more likely to have better outcomes	Sleep hygiene is more commonly cited as a patient need		Place-based approach needs to be developed to reflect specific needs of local communities	Patients would prefer 1:1 F2F exercise classes, rather than groups	Exercise on referral is requested by patients	
Access to shared systems	Hybrid offer for	Revi	Cost of smoking is the biggest				Stricter eligibility criteria to	Patients need more			Hybrid model of delivery	Staff require regular in-	

Opportunities												
with subcontractors/Partners	all services	eweligibilitycriteriaofBMI	driver for cessation				prevent inappropriate referrals	then 4 sessions				person opportunities to meet and learn about other services
Need for one set of KPIs	Gender-specific classes to be considered	Consideroweight	No service currently offered to patients who are less motivated to quit				Falls assessment in-person to prevent inappropriate referrals	HTs responding to cultural needs, e.g. Gender-specific classes			Holistic approach to healthy lifestyle change is needed	Living Sport and Healthy You should be combined to enable better communication

Opportunities												
		is impact quality of life, instead of just BMI and com										

Opportunities												
		orbidities										
Target those most at need within schools, rather than school as a whole	GPs to provide referrals with a BP reading to prevent back and forth of referrals	Virtual service is most resource-effic	Staff need longer to form connection with patients to provide more holistic support				Offer a level 3 FAME class	Shared communication between GPs and HTs				Behaviour change conversations should be initiated by staff at every sessions

Opportunities												
		ient										
Combine other Public Health contracts to join up resources for more patients	More asynchronous resources for patients	Virtual service is suitable for patients who a	Set up clinics in CGL				Better advertisement of the service	HTs based in GP practiced prior to Covid-19 worked effectively				An allocated staff member should coordinate a resident's behaviour change - holistic approach

Opportunities												
		reunable to leave the their home										
Valued shaping the KPIs in year 1		T3WM should be in t					Virtual service can work well	Streamlined data collection - forms are repetitive				Clearer eligibility criteria and referral process for each service

Opportunities												
		egratedwithallotherservices										
Coordinated approach to funding awards to prevent double-funding of services		T3WMshouldb					Additional home sessions should be compulsory and engaging	BMI may be a better indicator of those in need than deprivation index				Coaching and additional support offer for patients with higher needs

Opportunities												
		enable to refer within the Service instead of always										

Opportunities												
		s b a c k t o G P										
							Eligibility criteria to consider frailty markers					More outreach work to complete HealthChecks on people who consider themselves healthy
							Potential for staff clinical supervision from CPFT staff					
							Service needs to reach patients for prevention instead of post-fall.					

Opportunities												
							Referrals to community-based services need to be followed up more effectively					

S

Threats												
District Councils	**T2WM**	**T3WM**	**Stop Smoking**	**Alcohol**	**Diabetes**	**Mental health**	**Falls**	**Generic HT**	**Health Checks**	**Living Sport**	**Contact centre**	**Overall service**
Technical issues with IT and software	GP incentives to refer patients into the service	F2F services previously under-utilised	Community-based clinics costly and less well-attended	CGL stars is more effective at picking up referrals			Confusion around eligibility criteria	No universal approach across HTs to goal-setting		Some larger geographies require more resource	Call handlers have limited local knowledge	Internal communication is ineffective
Difficulty sharing data between Providers	High proportion of inappropriate referrals of which 1/4 are re-referred onto other	Staff very busy responding to patient enquiries about weight loss injections	Co2 validation difficult to obtain across region				Limited triage pathways for more appropriate Falls services	Patients have more complex needs and lifestyles since cost-of-living crisis				Inappropriate referrals internally and externally

Threats												
District Councils	**T2WM**	**T3WM**	**Stop Smoking**	**Alcohol**	**Diabetes**	**Mental health**	**Falls**	**Generic HT**	**Health Checks**	**Living Sport**	**Contact centre**	**Overall service**
	providers: Slimming World, Weight Watchers etc.											
No financial appraisal of the contract	Staff workload very high	High waiting lists for PCC patients due to no funding	PCNs do not view smoking as a priority				Increasing waiting lists for Falls service and external services which impacts demand	HTs unable to follow-up on referrals outside of their service				Limited knowledge of referral pathways/signposting for all HY services
Non-collaborative approach to delivering services	Cost of patients to travel to sessions	Inappropriate referrals from GPs receiving incentive for making referrals					Public transport links unreliable for some patients reliant on them to attend classes	HTs unaware of T2 and T3 service offers or wait list times				New commissioning cycles can be disruptive for staff HR processes and the Service
Competition between multiple subcontra	Anxiety of patients exercising in group,	More capacity is needed from the Health					Patient population is prone to DNAs or drop-offs					Staff retention

Threats												
District Councils	**T2WM**	**T3WM**	**Stop Smoking**	**Alcohol**	**Diabetes**	**Mental health**	**Falls**	**Generic HT**	**Health Checks**	**Living Sport**	**Contact centre**	**Overall service**
ctors for funding	e.g. Covid-19	Psychologist										
Multiple providers of the contract causes confusion to external Partners	Limited communication with GPs	Broad eligibility criteria from NICE and ICB about weight loss injections					Patients fearful of moving onto different services					Viability of community clinics: staff travel time and patients not attending
High staff attrition and turnover	Venue costs have increased	Strikes from GPs on the working time directive meant that GPs were refusing to complete the referral pro forma					Some patients at risk of falling may be missed due to deprivation index					Long waiting lists lead to patient attrition
	Patients wanting weight loss injections view T2 services	Patients receiving weight loss injections will provide					Limited collaborative working with external partners					Lack of collaborative working within the Service, or with external

Threats												
District Councils	**T2WM**	**T3WM**	**Stop Smoking**	**Alcohol**	**Diabetes**	**Mental health**	**Falls**	**Generic HT**	**Health Checks**	**Living Sport**	**Contact centre**	**Overall service**
	as a 'tickbox'	self-report weight to Nurse Prescriber										organisations
		Very small service for extent of demand										Service must continue to adapt and respond to changing patient demographics/needs
		Some patients requiring the service may not attend GP practice and so will not be eligible for referral										Consider a more flexible programme/ offer

Appendix 5: SWOT analysis of the Healthy You Service and each of the three Tiers, based on secondary data

Tier type	Strengths	Weaknesses	Opportunities	Threats
T1	Place-based local offer for local people		More information/insight sharing between the commissioners and Tier 1	Short-termism and lack of accountability, hindering service innovation.
	Adaptable and agile	"My patch" mentality	To establish a better relationship with their provider, Everyone Health	
	a) ao external shocks (Covid-19)	To invest in upskilling their workforce		
	b) bo respond to local demands	To streamline the service to reduce service user confusion		
	United and uniform	To work towards raising the profile of the service		
	Successful collaboration	To move towards central handling of T1 referrals to enable more wider trend analysis as opposed to district handling		
	a) aetween districts			
	b) borking with partners			
	A dedicated Healthy Lifestyle Advisor*			
	Having Living Sport as an apolitical organisation for data collection, evaluation and advocacy across all districts in Tier 1			

Tier type	Strengths	Weaknesses	Opportunities	Threats
	Efficient referrals system			
T2	Long waiting times, Tier 1 taking referrals to support	More information/insight sharing between the delivery partners of Tier 2 and Tier 1		
		To work on strengthening the referral pathway between Tier 2 and Tier 1 (as of Y2)		
T3	Long waiting times	More information/insight sharing between the delivery partners of Tier 3 and Tier 1		
Healthy You as a whole	Adopted a personal support approach from Y1			
	Increase in community engagement straight after the end of the pandemic	Limited budget	To continue engaging with communities and listen to local voices	Given the limited budget, expansion of the service might be difficult
	Some districts using automated administration systems	Relied on partnerships and collaborations for additional budget	To continue working in partnership	Uncertainty in funding due to a partial reliance on partners
	Using qualitative data to illustrate service user's personal stories	Some contracts not CPI-linked, influenced by changes in inflation	To identify and recruit the right workforce (some historical difficulties with staff not being aappropriatelytrained at the start of the programme)	A potential loss of service users due to duplicate services offered
	Have started promoting the service at community events and festivals	Some duplications in the quarterly reporting to commissioners	To improve data collection	Lack of key outcome measures data, potentially vital for further commissioning

Tier type	Strengths	Weaknesses	Opportunities	Threats
	A substantial increase in SystmOne referrals received during Y3 of operation, predominantly due to successful collaboration with partners	Problems with SystmOne access in Y3 led to a backlog of patient referrals and increased waiting times (now resolved)	To further streamline the quarterly reporting to commissioners	
	KPI focus amended in Y3 to measure quality rather than quantity	Service launched without assessment measures in place, neither for the nutritional or the WM programmes (started developing these late in Y1)	Longer-term contract for reduced administrative costs, employment security, financial stability and stronger relationships with partners.	
	Strives to offer a range of suitable and accessible activities to suit the general public	Questionnaires have not been standardised across districts (unclear if still the case but service actively working on improving data collection measures and increasing patient return rates)	To invest in data/technology/automation	
	Exceeded most of its KPIs in Y3	To update the service's library of resources		
	Good, collaborative working between the six district's coordinators, sharing workload and knowledge (as of Y2)			

* this role been key to processing referrals, improving access to S1, increasing understanding of professionals of the Healthy you service and creating resources for patients

Appendix 6: Place-based working Healthy Lifestyle Service models

COverview						
Gloucestershire County Council Healthy Lifestyles Service	**Norfolk County Council**	**Surrey County Council Oxfordshire County Council**	**Lincolnshire County Council Essex County Council Nottinghamshire County Council**			
The Healthy Lifestyles Service in Gloucestershire provides an integrated approach to support individuals and families in achieving healthier habits and reducing risks of long-term health conditions.	- An integrated alcohol and drug behaviour change service. - DrinkCoach offer expert guidance from an alcohol treatment specialist in the form of up to six coaching sessions.	Thrive Tribe Integrated Lifestyle Service, bringing together a number of services that focus on promoting the adoption of healthy lifestyle behaviours and the prevention of associated poor health outcomes at universal and individual levels.	Healthy Place Shaping integrates health promotion, sustainable infrastructure, and community wellbeing he Edible Streets Guide produced by Oxford Brookes University and based on a pilot street in Barton, describes how communities can transform the space on the	Thrive Tribe eight management service for adults. he contract contains measures including the number of healthy lifestyle outcomes achieved, the proportion of individuals supported from	Active Essex Physical Activity and Sport Partnership for Essex, Southend and Thurrock. hey work with local partners in place-based teams to a) ensure the power of physical activity and sport can transform lives b) fulfil the vision and mission of the	The ICS has four aims: Improve outcomes in population health and healthcare; Tackle inequalities in outcomes, experience and access; Enhance productivity and value for money; Help the NHS support broader social and economic development. Place Based Partnerships (PBP) have also

			pavement outside your front door or the grass verge you pass every day on your way to work. Advice on creating growing spaces at a larger scale is now available through a 'Community Garden Playbook' ark and Stride intervention encouraged primary school children to walk to school.	deprived areas, and individuals' self-reported wellbeing	Essex system strategy, 'Fit for the Future'	been established in 2022. These are collaborative arrangements formed by the organisations responsible for arranging and delivering health and care services in a locality or community.

Target audience						
Gloucestershire County Council Healthy Lifestyles Service	**Norfolk County Council**	**Surrey County Council**	**Oxfordshire County Council**	**Lincolnshire County Council**	**Essex County Council**	**Nottinghamshire County Council**
Adults and families* in Gloucestershire aiming to improve their health and lifestyle habits. *Families in Gloucestershire with children aged 5-15 who want to adopt healthier lifestyles	It provides treatment and aids recovery for Norfolk adults who are affected by substance misuse, as well as helping to build community resilience.	Adults and children	Local communities, with a focus on reducing health inequalities		Residents needing lifestyle changes, including tailored male-focused services Intention to offer greater levels of support to those who need it the most.	Nottinghamshire residents (children, young people, adults and families)

Services offered						
Gloucestershire County Council Healthy Lifestyles Service	**Norfolk County Council**	**Surrey County Council**	**Oxfordshire County Council**	**Lincolnshire County Council**	**Essex County Council**	**Nottinghamshire County Council**
- **Weight management**: Personalised plans to achieve healthy weight through diet and activity.	Tailored **drug and alcohol** support to suit individual needs. Services include medical treatment. Needle exchange	One for Lot 1: One You Surrey; Integrated Lifestyle Service. • **Stop Smoking** Support			health-related behaviour change services including; **Eat well**, **manage our weight**, **move more**, **quit**	Your Health Notts to support Nottinghamshire residents (children, young people, adults and families) to **get**

Services offered						
Gloucestershire County Council Healthy Lifestyles Service	**Norfolk County Council**	**Surrey County Council**	**Oxfordshire County Council**	**Lincolnshire County Council**	**Essex County Council**	**Nottinghamshire County Council**
- **Physical activity**: Support to increase movement with tailored exercise plans. Strategies to build sustainable healthy habits. - **Smoking cessation**: Advice and tools to quit smoking effectively. - **Alcohol reduction**: Guidance to moderate or stop alcohol consumption. **Nutrition** education for families. - Fun, family-oriented		• Adult **Weight Management** • **Alcohol Prevention** One contract for Lot 2: Child and Family Healthy Weight Programme. • Child and Family Weight Management Programme. Awarded to Active Surrey			**smoking** and **drink less**. Diabetes Prevention Physical Activity and Sport Partnership for Essex, Southend and Thurrock.	**active**, **lose weight**, **reduce alcohol intake** and **quit smoking**. The service will also provide support for **falls prevention** and family **weight management**.

Delivery Method						
Gloucestershire County Council Healthy Lifestyles Service	**Norfolk County Council**	**Surrey County Council**	**Oxfordshire County Council**	**Lincolnshire County Council**	**Essex County Council**	**Nottinghamshire County Council**
- One-on-one coaching sessions (virtual and in-person). - Group workshops. - Online resources and tools. The BeeZee Families Academy* is a programme designed to provide families with the skills and knowledge to improve their health together. By focusing on both nutrition and activity, the service helps families create lasting lifestyle changes in a supportive and	- 1:1 sessions or group sessions They have hubs in Norwich, Thetford, King's Lynn and Great Yarmouth but also see people in the community.	• Stop Smoking Support - Evidence based interventions to support Service Users 12 years+ who smoke tobacco to stop smoking successfully and permanently. • Adult Weight Management - To support Service Users (18 years +) to achieve a clinically beneficial weight loss and focus on diet and physical activity together, rather than attempting to modify either diet or physical activity alone. • Child Weight Management –			Eligible residents will continue to be offered a holistic health assessment, and will have access to online support programmes to help make changes to health-related behaviours. Active Essex dedicate an entire team to contribute to this. The team works with a network of locally trusted organisations. Together they ensure the sector and Essex communities have capacity, support and resource to	A partnership and collaboration that brings together NHS services, local authorities and other local partners across Nottingham and Nottinghamshire to collectively plan and deliver joined up health and care services to improve the lives of the population

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interactive environment: - Weekly group sessions focused on interactive, family-oriented activities. - Online, self-directed course format.		To provide a healthy weight programme for children up to 17 years, who are overweight or obese and their families. The children will have been identified as being on or above the 91st BMI centile. The programme will encourage healthier lifestyle changes in the short term and in the long term assist them to reach and maintain a healthy BMI.			build on what is strong locally. Move More program: 1-on-1 coaching and physical activity plans	

Referral process						
Gloucestershire County Council Healthy Lifestyles Service	**Norfolk County Council**	**Surrey County Council**	**Oxfordshire County Council**	**Lincolnshire County Council**	**Essex County Council**	**Nottinghamshire County Council**
- Self-referral -referral by a healthcare professional.	-self referral - referral from other agencies	- Self-referral = Health care professionals	- Self-referral - Health care professionals	- Self-referral - Health care professionals	- Self-referral - Health care professionals	- Self-referral - Health care professionals

Eligibility criteria						
Gloucestershire County Council Healthy Lifestyles Service	**Norfolk County Council**	**Surrey County Council**	**Oxfordshire County Council**	**Lincolnshire County Council**	**Essex County Council**	**Nottinghamshire County Council**
Must be a resident of Gloucestershire; specific programmes may have additional requirements. *Gloucestershire families with children aged 5-15.	Norfolk adults who are affected by substance misuse DrinkCoach eligibility = quiz is designed to tell you how your drinking could be affecting your health.					

Additional features						
Gloucestershire County Council Healthy Lifestyles Service	**Norfolk County Council**	**Surrey County Council**	**Oxfordshire County Council**	**Lincolnshire County Council**	**Essex County Council**	**Nottinghamshire County Council**
- Resources for stress management and mental wellbeing. - Family-oriented initiatives.	The service demonstrates innovation and implements evidence-based good practice to deliver the best possible outcomes for individuals and their families. There's a sharp focus on reducing harm caused to children.				Male-specific weight loss through football (Man v Fat)	